June Council Meeting

Friday, June 19th, 2020 | 10:15 a.m.
Virtual Meeting
1661 Portage Avenue

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5 min	10:15 am	1.	Opening Remarks	---
0 min	10:20 am	2.	Agenda – Approval Call for Any Conflicts of Interest	---
0 min	10:20 am	3.	Approval – Minutes March 2020 Council Meeting	2
45 min	10:20 am	4.	Standard of Practice for Authorizing Medical Cannabis – Approval for Consultation	8
45 min	11:05 am	5.	Accredited Facilities Criteria – Approval for Consultation	15
15 min	11:50 pm	6.	Break	
45 min	12:05 pm	7.	Standard of Practice for Prescribing Benzodiazepines and Z-Drugs – Results of the Consultation – For Information i. **Additional Responses – See Documentation starting at page –160**	28
20 min	12:50 pm	8.	Strategic Organizational and Operational Priorities Update – For Information	128
5 min	1:10 pm	9.	Audit & Risk Management Committee Terms of Reference Amendment – For Approval	132
10 min	1:15 pm	10.	2020/21 Operating Budget – For Approval	139
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0 min	2:15 pm	15.	End Meeting	

Meeting of Council, March 13, 2020

A meeting of the Council of The College of Physicians and Surgeons of Manitoba was held on Friday, March 13, 2020 at the College offices, 1000-1661 Portage Avenue, Winnipeg, Manitoba.

1. CALL TO ORDER

The meeting was called to order at 8:00 a.m. by the Chair of the meeting, Dr. Ira Ripstein.

PRESENT:
- Dr. Brian Blakley, Winnipeg
- Dr. Heather Domke, Winnipeg
- Dr. S. Jay Duncan, Brandon
- Dr. Jacobi Elliott, Grandview
- Dr. Brent Kvern, Winnipeg (9:19)
- Dr. Daniel Lindsay, Selkirk
- Dr. Matthew MacDowell, Assoc. Member
- Ms Lynette Magnus, Public Councillor
- Dr. Wayne Manishen, Winnipeg
- Ms Marvelle McPherson, Public Councillor
- Dr. Ira Ripstein, Winnipeg
- Dr. Nader Shenouda, Oakbank
- Dr. Eric Sigurdson, Winnipeg
- Dr. Josef Silha, Winnipeg (8:25 a.m.)
- Dr. Roger Süss, Winnipeg
- Dr. Anna Ziomek, Registrar

REGRETS:
- Dr. Kevin Convery, Morden
- Dr. Brian Postl, Winnipeg

TELECONFERENCE:
- Ms Leslie Agger, Public Councillor
- Ms Dorothy Albrecht, Public Councillor
- Mr. Allan Fineblit, Public Councillor
- Ms Leanne Penny, Public Councillor
- Dr. Heather Smith, Winnipeg
- Dr. Brett Stacey, Flin Flon
- Dr. Alewyn Vorster, Treherne

ABSENT:
- Dr. Ravi Kumbharathi, Winnipeg

STAFF:
- Ms Kathy Kalinowsky, General Counsel
- Ms Karen Sorenson, Executive Assistant
- Dr. Garth Campbell, Medical Consultant
- Mr. Dave Rubel, Chief Operating Officer
- Dr. Karen Bullock Pries, Assistant Registrar
- Dr. Marilyn Singer, Quality Improvement

2. ADOPTION OF AGENDA

IT WAS MOVED BY DR. ERIC SIGURDSON, SECONDED BY DR. HEATHER DOMKE:
CARRIED:

That the agenda be approved with the following addition:
- COVID-19 pandemic and the physician's responsibilities be added following Committee Reports.

Dr. Ira Ripstein introduced Ms Leanne Penny as a Public Councillor appointed to the Council by the Minister.

3. CALL FOR CONFLICT OF INTEREST AND IN CAMERA SESSION

Dr. Ira Ripstein called for any conflicts of interest to be declared. There being none, the meeting proceeded. Similarly, there was no request for an in-camera session.

4. ADOPTION OF MINUTES

IT WAS MOVED BY DR. ERIC SIGURDSON, SECONDED BY DR. HEATHER DOMKE:
CARRIED

- That the minutes of the December 13, 2019 meeting be accepted as presented.

5. STANDARD OF PRACTICE FOR PRESCRIBING BENZODIAZEPINES

At its June 2019 meeting, Council directed the Registrar to establish a Working Group to develop a Standard of Practice for Prescribing Benzodiazepines. The Working Group composed of practitioners encompassing diverse practices and specialties has submitted its draft to Council and submitted the following recommendations:

1. Distribute the draft Standard of Practice for Prescribing Benzodiazepines and Z-Drugs for consultation with the membership, stakeholders and the public.
2. Include Benzodiazepines and Z-Drugs in the list of M3P Drugs.
3. Alprazolam be removed from the Formulary.

There was much discussion noting the Standard was thought provoking for medical care and would cause positive changes in physician prescribing and should be distributed for consultation. Many of the prescribing requirements in the draft Standard will be adopted upon circulation of the Standard. The need for supportive resources for the members was discussed. The importance of this Standard of Practice to enhancing patient safety was discussed at length and can not be emphasized enough.

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY DR. BRIAN BLAKLEY:
CARRIED WITH ONE OPPOSED

1. That the draft Standard of Practice for Prescribing Benzodiazepines and Z-Drugs, be distributed for consultation with the membership, stakeholders and the public.
2. Include Benzodiazepines and Z-Drugs in the list of M3P Drugs, in conjunction with the College of Pharmacists of Manitoba.
3. Recommend to the Monitored Drug Review Committee that Alprazolam be removed from the Manitoba Drug Benefits and Interchangeability Formulary.

6. STANDARD OF PRACTICE/PRACTICE DIRECTIONS

To start the review process, Council will review the Standards of Practice/Practice Directions on a 4-year cycle.

i. Standard of Practice –Seatbelts/Helmets

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY DR. NADER SHENOUDA that:
CARRIED

The Standard of Practice for Seatbelt and Helmet Exemptions in Schedule C be approved as follows:

No member of the CPSM should ever write a seatbelt or helmet exemption. Available and acceptable alternatives to non-use of a seatbelt include reconfiguration, use of padding or other accommodations. There are no medical conditions that justify exemptions from seatbelt or helmet use.

ii. Practice Direction – EKG Interpretation & Billing Eligibility

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY DR. ROGER SÜSS that:
CARRIED

The Practice Direction on EKG Interpretation and Billing Eligibility is approved as presented.

iii. Standard of Practice – Out of Hospital Births – For Information

CPSM staff provided the College's current "Standard of Practice – Home Births" to individuals and organizations that are currently involved with this practice for their input and/or recommendations to update the existing Standard of Practice. Feedback was provided to the CPSM.

Councillors had conflicting views on whether the current Standard of Practice should remain as is, be rescinded or completely re-done.

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY DR. SIGURDSON that:
CARRIED

A Working Group will be formed to recommend a new Standard of Practice – Home Births to Council.

7. FUTURE OF QI COMMITTEE

At its February meeting, the Central Standards Committee passed a motion to recommend to Council that the

- responsibilities and functions of the QI Committee be absorbed into the Central Standards Committee and end the Quality Improvement Committee; and
- At least one third of the voting members of the Central Standards Committee be public representatives, similar in proportion to other CPSM Committees.

The elements taken into consideration included the overlapping mandates of the two Committees, importance of public representatives for transparency, public input, accountability, and preventing doctor group think, expediency in management of issues, knowledge and development of QI processes by current committee members, and the timing for implementation.

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY DR. BRIAN BLAKLEY that:
CARRIED

The amendments to the Central Standards Bylaw and the Governance Policy be approved as presented, to be effective June 19, 2021.

8. STRATEGIC ORGANIZATIONAL PRIORITIES UPDATE

Councillors were presented with a brief synopsis and discussed the issues identified, and progress of the Working Groups:

i. Standard of Practice for Authorizing Cannabis
ii. Standard of Practice Boundary Violations
iii. Non-Hospital Medical or Surgical Facilities Accreditation

Council discussed the following as possible strategic organizational priorities to be considered in the June Council meeting when the priorities are set for the upcoming year:

- Continuity of Care
- Work of Central and Provincial Standards Committees
- Complaints and Investigations Streamlining

The Registrar was asked to prepare a report on the work undertaken by the Inquiries Committee (increase in numbers, resources, appropriate staff, financial matters) for the June Council meeting.

The Registrar was asked to prepare a report for the June Council meeting on the system issues that arise from a review in Complaints, Standards, or Program Review Committee.

9. PRIVACY POLICY

CPSM has in its possession very confidential information including patient records, in addition to personal information regarding its members. It is incumbent upon CPSM to protect this information both within CPSM Departments and the CPSM itself. This privacy policy creates normative standards for approaching confidentiality issues and will serve as reassurance to third parties the information they provide to CPSM will be properly maintained.

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY DR. NADER SHENOUDA that:
CARRIED

The Privacy Policy be approved as presented.

10. APPOINTMENT OF PUBLIC REPRESENTATIVES

The Minister may be requested to appoint the current Inquiry Committee members to the s. 89 roster from which CPSM can choose members for the Complaints/Investigations/Inquiry Committees.

IT WAS MOVED BY DR. JACOBI ELLIOTT, SECONDED BY DR. BRIAN BLAKLEY that:
CARRIED

That the following individuals be appointed by the Minister and put onto the roster of public representatives in accordance with section 89 of the RHPA:

- Ms Sandra Benavidez
- Mr. Ryan Gaudet
- Ms Sandra Martin
- Ms Heather Reichert
- Ms Diana Yelland

11. CEO/REGISTRAR'S REPORT

Dr. Ziomek provided Council with a written report for information outlining the matters currently being dealt with at the College. Dr. Ziomek spoke verbally to this report and answered the questions presented by the Councillors,

12. COMMITTEE REPORTS

The following Reports were presented to Council for information:

- Executive Committee
- Audit & Risk Management Committee
- Complaints Committee

- Investigation Committee
- Program Review Committee
- Quality Improvement Committee
- Central Standards Committee

13. COVID-19 PANDEMIC

Heightened concerns were express by Councillors on the declaration of a pandemic for COVID-19 and how the governance of the medical profession might be affected including:

- Responsibilities and duty to provide care during the pandemic
- Standard of care during a pandemic
- Ability to obtain information from Shared Health and the provincial government
- Need to communicate with members (lack of health care system connectivity for many)
- Practice management (social distancing and care)
- Virtual medicine
- Personal Protection Equipment scarcity
- Ability of the healthcare system to respond in a major pandemic
- Emergency Registration of physicians
- Cancellation of MCC/Royal College/CFPC exams
- Virtual meetings at CPSM

14. IN CAMERA SESSION

An in camera session was held, and the President advised that nothing be recorded in the minutes.

There being no further business, the meeting ended at 12:25 p.m.

_____
Dr. I Ripstein, President

_____
Dr. A. Ziomek, Registrar

COUNCIL MEETING – JUNE 19, 2020

NOTICE OF MOTION FOR APPROVAL

SUBJECT:

Standard of Practice for Authorizing Medical Cannabis

BACKGROUND:

Need for an Updated Standard

Cannabis is unique compared to medications prescribed by physicians. Consider the following: it is now available recreationally in stores, there is limited good-quality evidence to support cannabis use for most medical conditions yet a legal regime establishes the ability for medical practitioners to authorize it, there are no uniform titration and dosage schedules, no standardized THC:CBD ratios, dispensers may provide variable products, and patients may have extremely strong expectations of its almost mythical healing powers for many diverse conditions.

In the age of recreational cannabis, many might ask why is there a need for medical cannabis? First, there is clinical evidence demonstrating the efficacy of cannabis for some medical conditions and those patients should have access to a medical source no different than other drugs. Second, while available recreationally, many patients may obtain reimbursement from insurance or other organizations. Last year Veterans Affairs Canada spent $75 million on medical cannabis and has forecast an increase.

The Working Group

A Working Group was composed of representatives from:

- College of Physicians & Surgeons of MB (physician and public representatives)
- Psychiatry – Adult and Child/Adolescent
- Physical Medicine and Rehabilitation
- Family Medicine, including those who regularly authorize and who have not
- Rural and Northern Family Medicine Practices
- College of Registered Nurses of Manitoba
- College of Pharmacists of Manitoba

The Working Group, chaired by Dr. Brent Kvern, was convened to draft recommendations to Council by delivery of a draft Standard of Practice on Authorizing Medical Cannabis. The areas of specialty were chosen for their diverse knowledge of and clinical experience with medical

cannabis. The Working Group met on several occasions and reviewed drafts of this Standard of Practice. The members of the Working Group were very active in their participation and freely expressed their opinions professionally.

Relevant Information and Considerations in Making this Standard

Ethical requirements

- Authorizing a patient's use of cannabis for medical purposes is a clinical decision and is comparable to prescribing a medication.

- Members may be presented with belief systems and great expectations of some patients for the alleged healing powers of cannabis. Members must always determine the strict clinical need and evidence for medical cannabis, balanced against the known harms and risks, as compared to patients' legally obtaining recreational cannabis.

- Members who authorize medical cannabis should be aware of the role industry may play from time to time is promoting cannabis for health and wellness.

Legal framework

- Medical cannabis is authorized not prescribed.

- There is limited good-quality evidence to support cannabis use for most medical conditions, yet the federal *Cannabis Act and Regulations* have established a process by which health care practitioners can authorize medical cannabis. As a result, patients determined to have a medical need can access a legal source of authorized cannabis from medical practitioners.

- It is important to note in this regard that only persons over 18 years can legally purchase recreational cannabis in Manitoba. Individuals of any age can receive a medical authorization that would permit them to obtain cannabis.

- In authorizing cannabis for medical purposes, the federal *Cannabis Act* and Regulations must be complied with by members when authorizing medical cannabis.

Available evidence

- Non-pharmacological interventions such as cognitive behavioural therapy and brief behavioural interventions have proven benefit in treating many conditions for which medical cannabis may be authorized.

- Mental health conditions are prominent among the reasons for which patients self-select to opt for cannabis use.

- The Health Canada document has excellent information on medical cannabis for physicians and should be consulted prior to authorizing cannabis. https://www.canada.ca/content/dam/hc-sc/documents/services/drugs-medication/cannabis/information-medical-practitioners/information-health-care-professionals-cannabis-cannabinoids-eng.pdf

- Clinical recommendations for the use of certain cannabinoids may change rapidly as the pace and scope of research may expand now that cannabis is legal in Canada and several US states. Currently (2018 review) there is medical evidence as set out in the above Health Canada source that certain cannabinoids *may* be beneficial for only a small number of indications.
    - Palliative care
    - Chronic neuropathic pain
    - Nausea and vomiting due to chemotherapy
    - Seizures
    - Tremors, spasticity, and inflammation in multiple sclerosis
    - Stimulation of appetite in patients with severe weight loss due to HIV/AIDS and possibly cancer.

- There is evidence that the risks of medical cannabis are numerous and include, but are not limited to, the following mental health illnesses as set out in the above Health Canada source:
    - anxiety,
    - PTSD,
    - depression,
    - bipolar,
    - schizophrenia,
    - psychosis,
    - suicidal ideation, suicide attempts and mortality, and
    - amotivational syndrome.

- Other adverse effects include the potential for
    - diminished cognition, psychomotor performance, and driving,
    - hyperemesis syndrome
    - carcinogenesis and mutagenesis of cannabis smoke.

- The risk of cannabis on developing brains (i.e., under the age of 25 years) is supported by clear medical evidence. The risks, harms, and benefits of cannabis in the elderly are not well established.

- More research is needed to characterize the mental health impact of medical cannabis. High-quality trials of long-term exposure are required to further characterize safety issues related to the use of medical cannabinoids.

Dosage and active ingredients

- Cannabis has many aspects that do not fit well with the traditional medical model for drug prescribing. Uniform dosing and titration schedules have not been established. The cannabis product itself can vary significantly by producer making its effect unpredictable and unreliable. The user is likely exposed to a product that may have varying ratios and amounts of THC and CBD cannabis components, even within the same strain and same producer. Thus, the cannabis effect may be highly and unexpectedly variable. Not only does this contribute to the difficulty in patients receiving precise doses but dispensers are not obligated to provide the cannabis product strength (e.g. CBD-prominent, CBD-THC-balanced, THC-prominent) recommended or authorized by the member.

Drug Program Information Network (DPIN)

- Health Canada indicates:

  > "Cannabis is not an approved therapeutic product, unless a specific cannabis product has been issued a drug identification number (DIN) and a notice of compliance (NOC)."

- Accordingly, medical cannabis, which is not deemed to be a drug by Health Canada, can be authorized but not prescribed, and is not recorded in DPIN.

Use of the Standard

As a Standard of Practice, this is a mandatory requirement of expected conduct of all members. Standards of Practice are normative, describing how a practitioner is to practice, at a minimum, as evidenced by their observable behaviour and actions. The Standard uses the language of "must" which is imperative, rarely the permissive "may". The Standard is established to regulate the quality of practice by the members of the CPSM. The Standard will be used to assist members in their practice. Additionally, the Standard will be used for assessing physician performance in peer review processes or in complaints and investigations.

Consultation

All Standards of Practice are distributed to the membership, stakeholders, and the public for consultation. Input will be sought and may be incorporated by Council prior to adoption. At this point, approval is being sought to distribute this Standard and seek consultation with the membership.

It is expected the consultation will elicit significant interest amongst many physicians. It is also expected this document will have a direct impact not only on how some physicians authorize medical cannabis, but also on patient care for some of those patients.

PUBLIC INTEREST RATIONALE:

"A college must carry out its mandate, duties, and powers and govern its members in a manner that serves and protects the public interest." S. 10(1) RHPA

The section at the beginning on the Need for a Standard of Practice also forms part of the public interest discussion.

The conditions where cannabis is most commonly authorized remain sources of debate in medical circles. Physicians must consider multiple factors when authorizing medical cannabis. Good clinical judgment and an evidence-based approach remain key to safe and appropriate authorization. This Standard will set CPSM's minimum requirements for all physicians authorizing medical cannabis and ensure authorizing when clinically indicated for good patient care.

RECOMMENDATION OF WORKING GROUP:

The recommendation of the Working Group is for Council to approve the draft Standard of Practice for Authorizing Medical Cannabis, as attached, for distribution and consultation with the membership, stakeholders and the public.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE MEETING OF THE COUNCIL OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON JUNE 19, 2020, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WILL MOVE:

Council hereby approve the draft Standard of Practice for Authorizing Medical Cannabis for distribution and consultation with the membership and stakeholders.

DRAFT FOR WORKING GROUP – NOT FOR DISTRIBUTION

STANDARD OF PRACTICE FOR AUTHORIZING CANNABIS FOR MEDICAL PURPOSES

This Standard articulates the standard of practice and ethical requirements for all members using their clinical skill, knowledge, and judgment in authorizing cannabis for medical purposes.

Members are expected to educate themselves on authorizing medical cannabis, including clinical pharmacology, dosing, potential therapeutic uses, warnings, adverse effects and toxicity.

There is useful information in Health Canada's 2018 'Information for Health Care Professionals – Cannabis (marihuana, marijuana) and the Cannabinoids': https://www.canada.ca/en/health-canada/services/drugs-medication/cannabis/information-medical-practitioners/information-health-care-professionals-cannabis-cannabinoids.html - and in the College of Family Physicians of Canada's 2018 'Simplified Guideline for Prescribing Medical Cannabinoids in Primary Care: https://www.cfp.ca/content/cfp/64/2/111.full.pdf Members are also expected to educate themselves respecting legal requirements for authorizing medical cannabis under the federal *Cannabis Act* and Regulations.

1. Every member is professionally responsible for each medical cannabis authorization they provide to a patient. In deciding whether to authorize medical cannabis, each member must exercise the level of clinical judgment expected by the profession.

2. A member must only authorize medical cannabis:
    a. for a patient under their professional treatment; and
    b. when the medical cannabis authorized is required for the condition for which the patient is receiving treatment.

3. Prior to authorizing cannabis for medical purposes, a member must:
    a. make a diagnosis using the principles of good medical care set out in Part 2 of the Standards of Practice of Medicine;
    b. ensure that other conventional therapies have been tried or considered for the patient's diagnosis;
    c. advise the patient as to all material risks and benefits and the level of scientific evidence supporting the efficacy of the proposed treatment;
    d. discuss any other drug use, including recreational cannabis use and the risk for diversion, particularly if authorizing growth;
    e. advise that cannabis may cause impairment, including advising the patient of the dangers associated with driving, operating heavy machinery, performing safety sensitive tasks, and providing child or elder care while impaired[1]; and
    f. establish a plan for follow up and management.

[1] Members are reminded that they must be aware of and comply with statutory reporting duties in the context of disease or disability, including a treatment regime, that is expected to cause impairment to any relevant authorities (e.g. the Registrar of Motor Vehicles).

4. In authorizing cannabis for medical purposes, a member must:
    a. document on the patient record how the requirements of section 3 of this Standard are satisfied, including notation of:
        i. relevant discussions with the patient,
        ii. the clinical reasons for which the medical cannabis is authorized, and
        iii. the rationale for the amount authorized, including if authorizing the patient to grow; and
    b. make reasonable efforts to communicate with other members involved in the patient's care, including the patient's primary health care provider, as appropriate, and document same.

5. A member who authorizes medical cannabis must not:
    a. be legally or beneficially involved with a licensed producer/dispenser other than for the purpose of providing expert opinion, independent and impartial education, or conducting clinical research approved by an ethics board;
    b. be a licensed producer/dispenser;
    c. have a clinical encounter with patients at the same premises of any licensed producer/dispenser; or
    d. otherwise contravene the Conflict of Interest provisions in the Standards of Practice of Medicine.

6. A member must not under any circumstances dispense or provide medical cannabis to any patient.

7. A member must keep a separate log for all authorizations cannabis for medical purposes separate from the patient's chart. The log must include patient's name, PHIN, quantity and dosages, and name of licensed producer or grower. This log must be available for inspection by the College at any time.

8. A member who is treating a patient admitted in a health care facility, or resident in a personal care home, and who also has privileges therein, may order that the patient may use medical cannabis if the member is satisfied that:
    a. the patient has previously been provided with an authorization to obtain cannabis for medical purposes by another member that continues in effect;
    b. the order is limited to the amount of cannabis needed for the period of admission or residency; and
    c. medical cannabis is required to ensure continuity of care respecting the diagnosis for which medical cannabis was authorized.

9. A member who is treating a patient admitted in a health care facility or resident in personal care home must comply with all sections of this Standard in order to authorize medical cannabis, including where a prior authorization has expired.

10. A fee must not be charged for completing a form for authorizing medical cannabis.

COUNCIL MEETING – JUNE 19, 2020

NOTICE OF MOTION FOR APPROVAL

SUBJECT:

Accredited Facilities Bylaw Review Working Group

BACKGROUND:

The College has the statutory power to make bylaws accrediting facilities and the diagnostic or treatment procedures that may be performed at a facility. As per the legislation, this applies to any facility in which a registrant performs or causes to be performed diagnostic or treatment services, such as a non-hospital medical or surgical facility or a nuclear medicine facility, other than a hospital of health care facility operated by the government. Additionally, these facilities keep patients for no more than 23 hours.

There is a need for the College of Physicians and Surgeons of Manitoba to review the criteria defining a non-hospital medical and surgical facility that requires accreditation by the College. Currently the Accredited Facilities Bylaw Part B requires accreditation of non-hospital surgical facilities that i) utilize procedural sedation or local, regional, or general anesthesia provided that the standard of care requires monitoring of vital signs or ii) any other procedure the Committee directs. No other procedures have yet been directed.

The Minister of Health, Seniors, and Active Living will be provided with a copy of the report and recommendations. The RHPA requires before making a bylaw, the Minister be provided with the proposed bylaw for review and comment and Council must review and consider any comments received. A senior member of Shared Health participated in this Working Group.

DISCUSSION:

The Working Group has provided a report and recommendations for the criteria determining which non-hospital medical or surgical facilities should be accredited to ensure patient safety. See attached Working Group Report and Recommendations.

PUBLIC INTEREST RATIONALE:

> "A college must carry out its mandate, duties, and powers and govern its members in a manner that serves and protects the public interest." S. 10(1) RHPA

The Public Interest is pervasive throughout the report, particularly the sections on Regulation and Concerns Identified with Existing Approach to Facility Accreditation. These will not be repeated here.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE MEETING OF THE COUNCIL OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON JUNE 19, 2020, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WILL MOVE:

Council approves the recommendations of the Accredited Facilities Working Group for distribution and consultation with the membership, stakeholders, and the Minister.

ACCREDITED NON-HOSPITAL SURGICAL FACILITIES WORKING GROUP
Report to Council for June 2020

TERMS OF REFERENCE – PURPOSE OF WORKING GROUP

The current Accredited Facilities Bylaw requires accreditation of non-hospital surgical facilities that:

i) utilize procedural sedation or local, regional, or general anesthesia provided that the standard of care requires monitoring of vital signs or;
ii) any other procedure the Committee directs. (Article 13, Accredited Facilities Bylaw)

There are no specific procedures listed that require accreditation. An additional, or different, criteria might be risk based, and include risk of infection, or other criteria based upon the public interest.

The purpose of the Working Group is to review Part B of the Accredited Facilities Bylaw and recommend the criteria determining which non-hospital medical or surgical facilities should be accredited to ensure patient safety.

The Working Group should develop draft revisions to Part B of the Accredited Facilities Bylaw that will be circulated to the members, stakeholders, and the public in spring 2020 and finalized for implementation in 2020.

MEMBERSHIP OF THE WORKING GROUP

The Working Group was comprised of specialists in the following areas: Dermatology, Gastroenterology, Otolaryngology, Urology, Anesthesia, Radiology, Ophthalmology, Infectious Disease, and Physiatry. There was representation from Nursing and Shared Health and a member of the public. The CPSM President and Assistant Registrar as well as General Counsel participated. The Working Group was chaired by a member of Council.

FRAMEWORK FOR THE WORKING GROUP

The Working Group utilized the following framework to make its recommendations as to what criteria should be used to accredit facilities.

I - Risk to the patient (patient safety) is the basis upon which CPSM should accredit facilities.

II –These are the risks to patients in facilities that are diagnosing and performing treatment:

a) Infection
b) Anaesthesia < ---- > sedation continuum
c) Invasiveness
d) Complexity of procedures

e) Potential for complications
f) Safe equipment and operation
g) Qualifications of staff (RN, technicians)
h) Qualifications of physicians (including requirement for anesthesiologist)
i) Sole practitioner facility
j) Appropriate patient selection
k) other

III – The current criteria of procedural sedation do not fully address the above risks to patients in facilities.

IV – Other criteria should be used to determine which non-hospital surgical facilities require accreditation.

V – Certain procedures require accreditation to address the above risks to patients:
a) Review by area of specialty
b) Compare to other jurisdictions

VI – Are there any procedures that fall into the above risks and the new criteria, but could be excluded based on a solid rationale?

VII – The role of Medical Director is critical to successful CPSM accreditation and oversight.

VIII – A jurisdictional scan of other provinces was reviewed.

REGULATION

The College of Physicians and Surgeons of Manitoba has as its **statutory mandate a duty to serve and protect the public interest**. Patients have a right to safe and good medical care and to be protected from harm, whether care is administered in a hospital or private practice facility. It is CPSM's expectation that each member operating a private clinic must adhere to appropriate measures to ensure no harm comes to patients. Clinics are subject to review by CPSM at any time to ensure recommended practices and procedures are being carried out safely and consistently.

CPSM strives towards achieving **right touch regulation whereby its resources are utilized to address the most significant risks to the public. It endeavours to ensure that the level of regulation is proportionate to the level of risk to the public**. While many medical procedures might have one or several of the risk factors listed in the framework above, the Working Group considers some risks to be minimal and therefore no accreditation is required. For instance, PAP smears are invasive and carry a risk of infection, yet are administered so frequently with minimal harm, that it does not warrant accrediting almost every family physician's office. Similarly, a superficial skin biopsy for diagnosis and treatment would be in this category.

Medical treatment services and procedures can be performed in a wide range of facilities from a tertiary hospital to a physician's office in the community. Hospitals are fully accredited through Accreditation Canada. Doctors' offices are not accredited. There is an in-between area that CPSM is called upon by the legislation to accredit. These are the non-hospital surgical facilities also known as accredited facilities. The role of this Working Group is to determine what type of facilities performing what treatments, services and procedures should be accredited by the CPSM. Members of the public must be satisfied that when they undergo medical treatment services or procedures it is done in a facility accredited by an external body if there is a threshold level of risk identified with that medical procedure.

Evidence for which procedures and/or criteria should be considered for accreditation have been identified with input from complaints received by the CPSM. Other important input has been obtained from conversations about experiences and lessons learned with other Canadian Regulatory Colleges, namely British Columbia, Alberta, Saskatchewan and Ontario, all of whom have a more expansive and robust practice of facility accreditation than Manitoba.

The recommendations and amendments put forward by the Working Group are to ensure the minimum standard of care in non-hospital surgical facilities in the province. All non-hospital diagnostic and treatment facilities in which medical and surgical procedures are deemed by Council as having sufficient risk, are recommended to be accredited by CPSM.

Furthermore, for transparency it is important for physicians seeking to perform certain medical treatment services or procedures outside a hospital, to know if their facility must be CPSM accredited. This is important for physicians to understand the requirements prior to investing in equipment, facilities, and staff. This can be achieved by both having this knowledge and working with CPSM in the early planning stages and well prior to embarking upon renovating facilities or ordering equipment.

CONCERNS IDENTIFIED WITH EXISTING APPROACH TO FACILITY ACCREDITATION

The current Accredited Facilities Bylaw applies to any procedure that is carried out with concurrent use of procedural, local, regional, or general anesthesia provided that the standard of care requires the monitoring of vital signs or; or any procedure that the Committee directs must be performed in an accredited facility. The first issue to be determined is whether this is the correct definition of anesthesia. The second issue must address the lack of clarity around procedures. The problem is that the current bylaw does not indicate what procedures must be accredited, nor has the Committee ever defined what procedures exist – therefore, the College, physicians, and the public have no way of knowing what procedures should be accredited other than those requiring anesthesia.

An alternative way to manage the lack of a list would be to define the additional overarching criteria (e.g. use of laser including but not limited to the eye and skin) that would be applied to determine the need for a clinic to undergo accreditation. The existing CPSM criteria for non-

hospital facility accreditation are very limited and as identified do not fully address many of the important risks to patient safety inherent in medical and surgical procedures provided in non-hospital facilities.

The Working Group was advised that CPSM is aware of concerns from both members of the public and physicians with procedures where sedation, infection control, or use of lasers could be issues. CPSM has received complaints about circumcisions that have had adverse outcomes.

Another concern that arises when procedures are not performed up to standards is the cost to the public health system for problems encountered. This has been reported to the College on many occasions in dermatology and cosmetic medicine, where complications with non-insured services often require the use of insured health dollars to treat patient harm.

CONCERNS WITH PRIVILEGING

A final concern identified relates to the act of privileging physicians to perform procedures in a non-hospital facility. The current bylaw permits the Facility Director to grant privileges which are the same as an RHA or hospital. If the privileges are any different than the RHA or hospital, then the Program Review Committee is to decide whether to grant privileges. The question has arisen as to whether this Committee is best suited to grant privileges.

The body granting privileges should have the expertise, education, and knowledge of best practice to pass judgment on the whether that applicant physician should be granted privileges. As a body formed of physicians from diverse practices, the expertise, education, and knowledge of best practice might be lacking in those instances of specialist privileges. For example, if an applicant physician is applying for privileges in gastroenterology, then the body best suited to assess qualifications for privileges is a body with expertise, education, and knowledge of best practice in gastroenterology. Such a body exists in the departments whose expertise is utilized to grant privileges for Shared Health or RHAs. Patient safety and the public interest can be best protected by having consistent privileges hospitals and non-hospital facilities to prevent those who are unable to obtain SH or RHA privileges from obtaining privileges in a non-hospital accredited facility. Accordingly, it is recommended that the privileging be the same as that granted for Shared Health and RHAs.

As Shared Health is a government appointed/funded body, members may perceive a conflict of interest with economic factors restricting privileging and opening of new facilities offering publicly funded health care services. Additionally, members may feel privileging decisions could be attached by Shared Health to program-based, site on-call requirements as is currently mandated for elective privileges offered to physicians within hospitals.

The following is the proposed process recommended by the committee for granting privileges to a practicing physician who does not already have privileges granted by Shared Health or a Regional Health Authority.

1) Physicians who are currently providing services within a non-hospital surgical facility will be granted privileges through a grandfathering clause.
2) New applicants would be reviewed through the Shared Health credential review process with a recommendation for privileging made to the Program Review Committee for decision.
3) A non-refundable assessment fee, payable to the College and shared with Shared Health could be charged.
4) Privilege granting would remain with the CPSM for these individuals to minimize any potential or perceived conflicts of interest in the decision-making process.

JURISDICTIONAL SCAN

A jurisdictional scan was undertaken of Ontario, Saskatchewan, Alberta, and BC to better understand how other Colleges have approached Non-Hospital Facility Accreditation. Saskatchewan, Alberta, and BC have taken the approach of listing the procedures which, if performed outside of a hospital, require accreditation by the College. This has resulted in a list of hundreds of procedures for those provinces. Ontario by contrast does not have a specified list of procedures but rather uses a core set of criteria to identify which facilities will require accreditation. Of note, there lacks a consistent approach between the provinces for which listed procedures require accreditation. Examples include Lasik, orthopedics, surgical abortions and assisted reproductive technologies which may require accreditation in one province but not another.

The Assistant Registrar and General Counsel interviewed representatives from each of the provinces to gain insight into their reasons for and lessons learned from their individual approaches to non-hospital facility accreditation. Attached at the end is a summary of the highlights of each conversation and pertinent documents, policies and standards listed on their respective websites.

DRAFT RECOMMENDATIONS

The Working Group makes the following **recommendations:**

I – Amend the Accredited Facilities By-Law to establish the criteria and procedures for which non-hospital medical or surgical facilities require CPSM accreditation:

Article 13 - Application of this Part

13.1 Part B of the Bylaw applies to all non-hospital medical or surgical facilities that carry out diagnostic and treatment services and procedures, subject to section 183 of the RHPA. All non-hospital medical or surgical facilities in which diagnostic and treatment services and procedures that have a sufficient risk of potential harm to

a patient must apply for, obtain, and maintain accreditation from the College prior to providing any such treatment services or procedures.

13.2 The criteria for assessing sufficient risk of potential harm to a patient include:
- 13.2.1 Level of Anesthesia and/or Sedation
- 13.2.2 Need for Medical Device Reprocessing (infection risk)
- 13.2.3 Complexity of Procedure and Risk of Complications

13.3 The following treatment services and procedures have a sufficient risk of potential harm to the patient to require accreditation:

13.3.1 Any procedure that is carried out or should be carried out in accordance with generally accepted standards of care with the concurrent use of procedural sedation, See definition of procedural sedation

13.3.2 Any procedure that is carried out with oral sedation where large doses of oral sedatives are required or should be required in accordance with generally accepted standards of care for patient comfort (pain and and/or anxiety.) See definition of oral sedation

13.3. 3 local regional or general anesthesia, provided the standard of care requires monitoring of vital signs as a result of the administration of the drug to induce sedation or anesthesia; or

13.3.4 Procedures involving:

- 13.3.4.1 the use of drugs by injection which are intended or may induce a major nerve block or spinal, epidural or intravenous regional block;
- 13.3.4.2 flexible endoscopic evaluation of the gastrointestinal or genitourinary tract;
- 13.3.4.3 cataracts and retinal procedures;
- 13.3.4.4 Lasik therapeutic procedures;
- 13.3.4.5 Deep, major, and complicated procedures that may require more resources than are commonly available in a medical office. Surgeons should make decisions as to the appropriate location for these surgical procedures in accordance with the resources necessary for unexpected complications and with generally accepted standards of care. These procedures may include:
  - A. resection of a deep, major or complicated lesion;
  - B. surgical and diagnostic procedures with risk of bleeding from major vessels, gas embolism, perforation of internal organs, and other life-threatening complications or requiring sterile precautions to prevent blood borne deep closed cavity or implant-related infections;
- 13.3.4.6 any tumescent liposuction procedure involving the administration of dilute local anesthesia;

13.3.4.7 assisted reproduction technology, uterine evacuation procedures, and hysteroscopy;
13.3.4.8 hyperbaric oxygen therapy;
13.3.4.9 hemodialysis;
13.3.4.8 Any procedure that the Committee directs, which must be performed in an approved, non-hospital medical or surgical facility, in order to meet the minimum acceptable standard of care for that procedure.

14.1 "Oral sedation" means an altered state or depressed state of awareness or perception of pain brought about by pharmacologic agents and with is accompanied by varying degrees of depression of respiration and protective reflexes in which verbal contact with the patient can be maintained. This is specific to the use of oral medication alone. An example may include oral dosing of opioids and/or benzodiazepines that produce the above states.

19.1.2 delete ASA Level III from the procedures that can be performed in an accredited facility, and only those with ASA Levels I and II may have procedures performed there.

II - **Create new Practice Directions** to include more specifics on **surgical procedures and interventions** performed in non-hospitals, whether an accredited facility or not. The practice directions should address cosmetic injections, fillers, venous sclerotherapy and laser use, hair transplant and autologous platelet rich plasma therapy. Documents published by Colleges in Alberta, BC and Saskatchewan are excellent resources for the creation or adoption of CPSM documents.

III- **Revise the current bylaw to include the following grounds for when inspections of non-hospital surgical facilities may be performed at the discretion of the CPSM:**

1. If there is a change in or addition to treatment services or procedures offered or renovations/relocation of the facility.
2. If there is a critical incident, complaint, report or suspicion of violation of standards that is credible and significant.

IV- **Strengthen the Role of Medical Director including responsibility for the following in addition to the responsibilities in the current Bylaw**:

1) the procedures are performed in accordance with current accepted medical practice,
2) Change the name to Medical Director from Facility Director and revise definition in Bylaw
3) Adopt the Medical Director Roles and Responsibilities Acknowledgement document (Alta)

4) Medical Director to act in accordance with the Regulation and other CPSM requirements
5) advising CPSM if these if a change in or addition to treatment services or procedures offered or renovations/relocation of the facility
6) advising CPSM If there is a critical incident, complaint, report or suspicion of violation of standards that is credible and significant.

V – **Amend the Bylaw regarding Privileging to use the Same Privileges that are granted by Shared Health or the Regional Health Authorities:**

18.1 A member must have privileges at an accredited facility prior to performing any of the services and procedures listed in Part B;
18.2 The Medical Director must only grant and renew privileges for a member to perform procedures in an accredited facility if:
  18.2.1 those privileges are the same as granted by Shared Health or a Regional Health Authority or are recommended through the Shared Health credentialing process;
  18.2.2 those privileges are and remain in good standing; and
  18.2.3 the Medical Director is satisfied that the applicant is a suitable and competent candidate for, and the treatment services and procedures are within the privileges requested and within the knowledge, skill, and judgment of the applicant.
18.3 The Medical Director must annually renew privileges.
18.4 Within 15 days of granting or renewing privileges the Medical Director must provide to the College particulars of the privileges granted in the facility.
18.5 Any member who performs services and procedures without obtaining privileges in the facility and any Medical Director who permits a member to perform services and procedures without privileges in the facility may be found guilty of professional misconduct.

VI – **General Re-write of the Accredited Facilities Bylaw, Part B** as it is difficult to follow, and some items can be included in a Practice Direction or Policy rather than bylaw which requires the review of the membership and Minister when amended.

APPENDIX – JURISDICTIONAL SCAN

Saskatchewan:

http://www.cps.sk.ca/imis/CPSS/Programs_and_Services/Non-Hospital_Treatment_Facility_Program.aspx

- Similar size program (12 facilities) and staff allocation for NHSF accreditation to CPSM; work on a 3 year cycle of accreditation
- Borrowed much of their criteria/standard/procedure list from CPSA
- Additions to the CPSA criteria/procedure list include: hyperbaric oxygen therapy, cardiac exercise stress testing, hemodialysis and any Assisted Reproductive Technology procedure (ART)
- Minister of Health approval (Health Facilities License) required before private facilities can offer many fee-for-service procedures like those listed above
- Additional procedures are added as they are identified as needing accreditation
- Have developed two policies to better regulate practice for both insured and non-insured procedures that may fall outside of their Non-Hospital Treatment Facility Program

http://www.cps.sk.ca/imis/CPSS/CPSS/Legislation__ByLaws__Policies_and_Guidelines/Legislation_Content/Policies_and_Guidelines_Content/Performing_Office-based_Insured_Procedures.aspx

http://www.cps.sk.ca/imis/CPSS/CPSS/Legislation__ByLaws__Policies_and_Guidelines/Legislation_Content/Policies_and_Guidelines_Content/Performing_Office-based_Non-insured_Procedures.aspx

Ontario:

https://www.cpso.on.ca/Physicians/Your-Practice/Quality-in-Practice/Clinic-Inspections-Special-Programs/Out-of-Hospital-Premises-Inspection-Program

- Much larger program with 300 facilities assessed over a 5 year cycle
- Use a criteria based-approach and have avoided lists
- Have expanded to include procedures like adult circumcision, cataracts and Endo Venous Laser Therapy given identified risk to the public
- Encountered issues with endoscopists trying to get around facility accreditation by not offering anesthesia to patients; adjusted standard of practice to say that physicians must offer anesthesia as part of endoscopy service
- Major current challenge with community-based interventional pain practices; looking to BC for guidance and policy
- Have developed two Standards Documents for Endoscopy and Interventional Pain

https://www.cpso.on.ca/admin/CPSO/media/Documents/physician/your-practice/quality-in-practice/clinic-inspections-special-programs/ohpip-standards-endoscopy-colonoscopy.pdf

https://www.cpso.on.ca/admin/CPSO/media/Documents/physician/your-practice/quality-in-practice/clinic-inspections-special-programs/ohpip-standards-interventional-pain.pdf

British Columbia

- Use three major criteria to determine what procedures should be on the list requiring accreditation
    - Risk of the procedure (anticipated and unanticipated risks)
    - Sedation level – divided into 3 classes
        - Class 1 = deep/general anesthetic or major regional +/- Class 2 & 3
        - Class 2 = IV sedation and/or analgesia where the patient is responsive and breathing without assistance (includes inhalants)
        - Class 3 = Local anesthesia only +/- oral sedation but not IV sedation/analgesia or inhalants
    - Medical Device Reprocessing (infection risk)
- Use a balance of the criteria and the list to ensure Doctors know what the requirements are for a Non-Hospital Facility vs. Clinic environment as well as identifying procedures that can only be performed in hospital
- Developed a standard for neuromodulators and cosmetic fillers such that only physicians can perform such acts or delegate to an RN with appropriate training
- Have a well-developed statement and standard on laser safety

https://www.cpsbc.ca/files/pdf/PSG-Laser-Safety-for-Physician-Practice-Summary.pdf
https://www.cpsbc.ca/files/pdf/NHMSFAP-AS-Laser-Safety.pdf

- Warned of the importance of over-communicating and seeking consultation with membership as these changes to the by-law and practice direction are being finalized
- Anticipating finalization of a standard of practice for interventional pain, dovetailing this with a provincial credentialing initiative to regulate where and by whom these procedures can be done
- Must have credentials in a provincial facility to perform those same procedures in the non-hospital accredited facility.

Alberta:

http://www.cpsa.ca/accreditation/non-hospital-surgical-facility/

http://www.cpsa.ca/standardspractice/medical-services-requiring-accreditation-outside-hospitals/

http://www.cpsa.ca/accreditation/physician-approvals/

http://cpsa.ca/wp-content/uploads/2015/03/NHSF_Standards.pdf

- Utilize a procedure-based process for both accreditation and privileging and find this to be hard to manage and labor intensive; suggest they are looking to move away from this and more towards overarching criteria
- Perform office inspections for medical device reprocessing and can often follow-up for clinics outside of the scope of the Non-Hospital Surgical Facility in this regard
- Have developed a standard for Platelet-rich-plasma; stem cell work is only permitted in Non-Hospital Facilities

http://www.cpsa.ca/wp-content/uploads/2019/08/PRP-Guidelines-August-2019.pdf

http://www.cpsa.ca/wp-content/uploads/2018/02/Stem-Cell-Regenerative-Therapy-Standards.pdf

- Current challenge with use of ketamine for both pain and psychiatric indications; working on a document to better articulate where, for what and by whom this can be administered
- The Alberta Government just announced it intends to use non-hospital accredited facilities to provide publicly funded surgeries to decrease the provincial waiting list.

Further Note

All jurisdictions review facilities outside of their usual cycle if changes are made based upon set criteria (e.g. addition of new procedures) and/or if concerns are raised about safety. In addition, all jurisdictions place responsibility on the Medical Director to ensure standards are met and the practices are safe within the facility.

COUNCIL MEETING – JUNE 19, 2020

BRIEFING NOTE

SUBJECT:

Standard of Practice for Prescribing Benzodiazepines and Z-Drugs

BACKGROUND:

Standard Approved for Consultation

Council approved distributing the draft Standard of Practice for Prescribing Benzodiazepines and Z-Drugs to the membership and public for consultation purposes on March 13, 2020.

DISCUSSION:

The Consultation Process and Results

The Standard of Practice was distributed to the membership, stakeholders, and public for consultation. A notice was also placed in the Saturday Winnipeg Free Press seeking public responses to the consultation. The consultation period was from April 29 to May 29, 2020. The consultation yielded 124 responses. The diversity of those submitting comments included patients who are prescribed Benzodiazepines and Z-Drugs, other regulated health professionals, some organizations, and numerous CPSM members representing a variety of practices.

The physicians' passion for their profession and their patients was evident throughout the responses. A lot of careful thought was put into providing responses by many. The richness of the responses provides CPSM with a wealth of practical guidance from all perspectives in formulating this Standard. Most importantly, the consultation demonstrates the draft Standard is viewed very favourably by the membership. The consultation also demonstrates the importance of Benzodiazepines and Z-Drugs to some patients, yet yielded warnings of the dangers of prescribing from other patients or their families. This overall favourability by the medical profession should assist its acceptance by the profession.

Several patients provided feedback both for and against easier access to these drugs. Several provided individual experiences.

Attached is a copy of a summary document entitled "Themes from Responses to Consultation" which summarizes the consultation results by theme, comments, statistics, and organizations that have provided comments. There are two sections entitled Accolades and Disapprovals which are self explanatory. Also included is a list of organizations who contributed comments on the draft Standard of Practice.

It is important that Council understand that not all members, other regulated health professions, public persons, and organizations agreed with all contents in the Standard of Practice. However, there is overwhelming support for the draft Standard. The Standard will be a much improved document having heard and received input from many diverse opinions.

All feedback received have been included in an attachment. Identifying information has been redacted though Councillors will be provided with a name key for members' feedback. An email will be sent to each contributor, thanking them for their input.

The Standard

While the thoughtfulness, detail, and extent of the consultation feedback has been very rewarding, this necessitates time for review, as expected. In reviewing the feedback, careful thought is required to ensure understanding of the comments, implications of changing the standard, and resource requirements that are imposed upon both the physician and the health care system.

The consultation period only closed on Friday, May 29, 2020, which was only a week prior to this submission to Council being mailed to Councillors. **The Working Group will meet to review the feedback and will make revisions as required. It is intended that Council review the new and revised Standard of Practice for Prescribing Benzodiazepines and Z-Drugs in its September meeting.**

In the interim, we will plan and work towards implementing the strategy for the successful adoption of this Standard by the profession throughout the Province, if subsequently approved by Council.

PUBLIC INTEREST RATIONALE

"A College must carry out its mandate, duties, and powers and govern its members in a manner that serves and protects the public interest." s. 10(1) RHPA

While Council has always identified the importance of safe prescribing of these drugs, the consultation reinforced the importance of patient safety and the need by the profession for this Standard of Practice. Similar to the Opioids Standard of Practice, this Standard will assist physicians in improving their prescribing practices and will highlight the lack of clinical evidence for certain long-term prescribing and the dangers of Benzodiazepines and Z-Drugs.

STANDARD OF PRACTICE FOR PRESCRIBING BENZODIAZEPINES AND Z-DRUGS
Themes from Responses to Consultation

STATISTICS

The College received 124 responses:

- MDs: 98
- Public persons, including patients: 10
- Organizations, including other regulated health professions: 16

THEMES FROM RESPONSES

1. Extremely helpful for improving Prescribing Practices
2. Patient Safety will be enhanced
3. This Standard is a necessity, timely, or even overdue
4. Zopiclone (and other Z-Drugs) should not be included in the same Standard as Benzodiazepines
5. M3P triplicate prescribing supported by many, but not all
6. Supportive of Alprazolam removed from the formulary
7. Need for resources for physicians provided by CPSM
8. Need for more healthcare system options and alternatives
9. Assistance in Tapering or better tapering guidelines
10. Patient can be treated successfully with good prescribing – don't make the barriers too great to prescribe these drugs
11. Drugs that may be addicting and abused require this special standard of practice
12. Tough to implement this Standard with legacy patients
13. Specific provision required for one-time use in advance of a medical procedure
14. Limiting Opioids, then Benzodiazepines/Z-Drugs just pushes some patients to other drugs street or OTC
15. Several Sleep physicians had specific comments on their prescribing

ACCOLADES

- Excellent, timely, useful, needed, knowledgeable, well researched, well balanced
- Thank you
- Clear and impactful, hugely important initiative, a job well done

DISAPPROVALS

- Complying with all elements requires much greater time so need a higher billing tariff
- Launching this during a pandemic is questionable

ORGANIZATIONS and GROUPS THAT SUBMITED COMMENTS

- Canadian Deprescribing Network
- Canadian Medical Protective Association
- College of Dietitians of Manitoba
- College of Medical Laboratory Technologists of Manitoba
- College of Occupational Therapists of Manitoba
- College of Pharmacists of Manitoba
- College of Physicians and Surgeons of Alberta
- College of Physicians and Surgeons of British Columbia
- College of Physicians and Surgeons of Ontario
- College of Physiotherapists of Manitoba
- College of Registered Nurses of Manitoba
- Manitoba College of Family Physicians
- Manitoba Health, Seniors, and Active Living
- Manitoba Public Insurance – Driver Fitness Division
- Nurse Practitioner Association of Manitoba
- Palliative Care Program, WRHA

PATIENTS and FAMILIES

- Several patients advised of the importance of these drugs to their care
- Several families advised of the dangers of these drugs, including addictions and death, by use by family members

PALLIATIVE CARE

- A group of palliative care physicians provided a lengthy and thoughtful paper highlighting their concerns with the draft Standard of Practice and with general prescribing matters arising from the distinct requirements of palliative care. Some of these concerns are beyond benzodiazepines and Z-Drugs. CPSM will reach out to this group to address these matters.

Responses from the Public

Hello! My name is . I'm a patient in XXX, Manitoba that is going to be HEAVILY effected by the new benzodiazepines prescribing practices you are working on and I need to speak to somebody about this ASAP, as this change was NOT discussed with me, it was just sprung on me and I explain in the "meat" of this email how I have been attempted to taper off of my anxiety medication more than once in the past with major failure, and I feel that this here is literally setting patients like myself up for this.

I am a long time methadone maintenance patient (7+ years and STABLE for those 7+ years) and extreme anxiety case dealing with the death of a parent. I NEED my case reviewed, because I am being forced to taper off of a medication that I have been stable on and taking for a very long time. If it was going to impact me in any negative way mortality wise, I would have been dead long ago when my doctors had me on 6mg daily clonazepam and I was taking heroin and fentanyl patches. NOT when an addictions specialist at Oats methadone clinic prescribes it in place and has already tried to begin a taper in the past, seen extreme failure of my treatment and a very ugly relapse in my mental health issues and in my addictions recovery, and it is just plain unethical and ridiculous that I am being forced to taper off of or threaten full termination if I will not agree, when said taper has never been discussed with me, the patient. This is something that must be discussed, planned for, and then enacted. It is NOT done this way. What are you trying to do? Because it's nothing positive in my case. Please respond post haste, I have an appointment with NP XXX to discuss this and I will be telling him this as well. I work with the Manitoba harm reduction network very closely in many ways, and my patient advocates, one of which is in the addiction medicine and psychiatry field, have said 100% this is not ethical treatment of a patient and their needs. This is causing me extreme distress, so I do need to hear back from somebody. I really hope that is heard and taken seriously, because I'm actually horrified for myself and what I'm going to go through withdrawing from this medication, and for the other patients in Manitoba that are going to be surprised by a random cut in their meds this week. Because you are going to cause relapse and suicide, that is the only thing that will come from that. I'm not saying this for myself in particular, but if it's this prevalent in my everyday thoughts, I know I won't be the only one. And somebody else might not be as lucky as I am having a whole support network in the medical and addictions treatment fields to answer their distressed calls. Please, please consider this before you start pressing doctors to just remove these medications. I very much understand benzodiazepines and the risk that they may pose to a person's health in combination with certain things, but this has been reviewed, attempted, failed and reinstated already. I went through this once, and I'm literally at your mercy and begging you not to do this to me again. Not now, in the middle of a pandemic where anxiety is already sky high and everybody is forcibly isolated from each other, and not without discussion between myself as the patient, the prescribing doctor and my psychiatry team. My current psychiatrist has, let me make this very clear. Never. Met. Me. Not once. I was seeing doctor XXXX. I was actually not even made aware that he retired TWO YEARS AGO, until this last week while all of this has happened and the lady that took his place is somebody that I have absolutely no rapport with, and they haven't even bothered to reach out to me and let me know why they disagree with writing me a letter to continue with my therapy as is. How, again, is this situation even possible?? I would love to know this, so please. I would absolutely more than appreciate it if somebody could contact me about this XXX; I am available

24/7 to speak with you on this, I want to get this cleared up as soon as possible please and thank you. I will speak with my psychologist after this upcoming doctors appointment with XXXX, and hopefully, with somebody regarding this whole situation.
Thank you, and have a wonderful day.

Patient.

I am on a Z drug for sleep. I take it very sparingly. My doctor has always discussed the addictive possibilities and never gave me more then a 30 day supply. When he refilled the prescription he ensured I was not actually taking one every night.

However, when I first started taking this drug I was reluctant and looked it up on the health canada website. My GP was not aware that the new revised starting dose for Zopiclone was changed to 5mg. He did say that was a very low dose and indeed I got no benefit and we quickly moved up to 7.5mg.

Patient

To whom this may apply at CPSM:

With respect, for the DPSM to proceed with a Draft Standard of Practice, inclusive of transparency to the general public to review the document, and provide feedback, I would like to say, that I appreciate the opportunity to participate in what I have for at least two decades, considered a serious ongoing omission on the part of the CPSM, to have not taken this on earlier.

I am a retired RN, with clinical practice in Manitoba and BC, raised a family through 1970 to 1990's, while caring for an aging parent, beloved aunts, and close friends who needed me for some degree of medical overview at different times during that period.

As the well respected family physician of my aging mother said to me, early on in those years of care, "Ativan and related benzodiazepines, are never to be prescribed to your mother again, indeed anyone who is aging, as they bring minimal useful results in the short term, and an egregiously harmful mental downside, in the long term."

To that point in time, I had been completely unaware of the potential harmful side effects of this family of medication. Indeed, the effects long term for my own mother, were that she required care for years.

Two beloved aunts, fell hapless victim to the prescribing of Benzodiazepine meds, considered an Rx standard of care in nursing home facilities. In spite of my own and other protests to cease

the prescribing of these med, both facilities, while espousing the best of intentions, insisted upon the correctness for use, as good standard practices medication for anxiety and or insomnia and agitation.

One of my aunts, entered a local senior care facility with excellent agility and balance, while she was still in possessed of reasonable sentient abilities, but, within four months, fell and broke her hip. I was there often, distressed for her, and speaking to staff, constantly, as she eventually became confused and agitated, struggling with her balance, literally deteriorated, before my eyes.

My cousin's mother, who was a bright eyed conversationalist, and still working part time, had entered hospital with an emergent flare up of a long standing facial neural issue, whom I saw the evening prior to her first night in the hospital for tests and evaluation. The next morning, my cousin called me, disturbed to find her mother, tied to the bed and unable to arouse her upon entering the room. The night staff were unhelpful, until the chart revealed that my cousin's mother had been prescribed a Benzodiazepine combination medication, which was for the gerontology ward, standing chart meds, for agitation and sleeplessness.

Over the past two decades, that list of people whom I have known, close friends, cousins and other family, whose stories of significant similarity, who were effected exactly the same way, has grown.

In addition, my own research into studies for Benzodiazepines, with regularity over that time, verified and validated that despite this growing body of research, that was questioning the real efficacy of Benzodiazepines against their obvious significant risks for dementia and untimely death, that those results, were swept aside.

I have been warning people I love and anyone who would need to know, whose parents are considering entering a senior care facility, either voluntarily or through social services assessments, to do due care and diligence with clarity to the administration of any standing medication charted, that would always prohibit Benzodiazepine medications.

My husband and I have included this specific prohibited codicil into our own health care directives, as it seemed the only way in which we could protect ourselves against a standing order for Benzodiazepines.

I will add here, that just three months ago, waiting on the gurney in queue for Cataract surgery, upon questioning the RN who was about to start an IV with "something to make you a little more comfortable and a bit drowsy", learned that a Benzodiazepine was in that bag. I had to refuse the administration of that medication and request a IV solution without that infusion of medication.
It astonished me to realize how prevalent and wide spread the liberal use of a medication that can do so much harm, is daily administered to patients who would not ever think to make such an inquiry.

IF and WHEN the final version of the Standard of Practice from the CPSM council comes into effect, from this writers point of view, it must address all and every application of use, for Benzodiazepines, including day surgeries, with the awareness for harmful side effects forward in mindfulness, if the efficacy of this amendment for the use of Z-drugs, is to be properly controlled going forward.

So yes, not surprising that I am gratified to finally see that the CPSM is now willing to place a draft Standard of Practice into place for the consideration of the public and professionals to draw up a final version to amend forward.

I sincerely hope that there will be sufficient agreement to effect a fulsome and proper amendment of standard of practice, and most important, that the resulting passage of the final version, will be announced to the general public.

Patient

Subject: **Response to Draft Standard of Practice for Prescribing Benzodiazepines and Z Drugs**

As a member of the public serving on the working group it was a wonderful experience and I am forever grateful for that opportunity.

The need for and completion of this Draft Standard is an excellent example of the Colleges roles to protect the public and ensure patient safety.

In terms of process it was very informative and based on Death Reviews and other research and clinical evidence. The group was a diverse group of physicians and from many specialties and they were not afraid to question each other in very respectful ways. The end result is a document that clearly reflect responsibilities of the physicians and ways to proceed with patient management.

The document clearly indicated groups that were to be excluded, included and encouraged physicians to consult with others when appropriate.

As an aging community I was particularly pleased to see a section specific to older adult patients.

As a person who lives in one of those assisted living complexes with a majority of older adults and a person who regularly visits nursing homes, one hears of numerous people talking about their many medications, including some from these groups and I also witness frequent falls. To the College - keep up the good work. I hope at some time the College will review use/abuse of gabapentin - based on many horror stories of people who have used it.

I have always had a difficult time sleeping, both while working and in retirement. I was prescribed ZOPLICONE about 10 years ago and still continue to take a half pill of the 5 mg. at night. I would be very disappointed if physicians decided to discontinue letting people have this prescription, especially if not offering something equally as good to help people who don't sleep well. It is much better to use this than have the elderly look for some illegal medication for a night's sleep. I think there are ways the physicians can regulate the amount and dosages they give so that those already using this medication can continue to use it effectively. I hope you will consider this when making a constructive decision and really consider all Manitoba citizens and not just those you think will "overdose"!! Thank you.

Patient

I am writing to the CPSM Council to give my feedback and personal experience with the drug Zoplicone.

I have been taking 5mg of Zoplicone for many years in order to improve the quality and duration of my night time sleep. At this point in my life I am aware that I am "addicted" to Zoplicone. Several years ago I had forgotten to bring it along on a week's vacation. For that one week I was unable to sleep for more than two hours at any given time during the night. Needless to say I was fairly exhausted during the entire week.

I have serious concerns as to withdrawal effects for patients if the CPSM Council makes the decision to limit access to Zoplicone. I know of many women in Winnipeg who will face the same issues. There will need to be a gradual weaning and some "tried and true" sleep replacement medication.

Patient

Re: Formal Consultation on a new Standard of Practice for Prescribing Benzodiazepines and Z-Drugs

I am writing to you as a member of the public who has been taking Lorazepam on and off for 10 years. I was diagnosed with early onset Parkinson's 10 years ago. The initial prescription for Lorazepam was to treat anxiety if I remember correctly. The initial prescription came from a psychiatrist and was for 1.0 mg 3 times a day. I took it for a while but heard bad things about Lorazepam and I was afraid of becoming addicted so I stopped taking it.

Fast forward a few years later, I was prescribed it again by my general practitioner for sleep. In

the meantime, my symptoms had deteriorated and I now get disabling headaches and rigidity in my head and neck. I am also taking Levocarb, Levocarab CR for my Parkinson's as well as Mirtazapine and Zoplicone and Melatonin for sleep. My neurologist is dead set against taking Lorazepam. However, that is the only medication that I take that gives me some relief from my headaches. I have been prescribed over a dozen different medications some opioids, some not. I have had ECT, deep brain stimulation, Botox injections, long acting anesthetic injections in my neck to help with pain. But after all of these treatments and medications, again the only one that gives me temporary relief is the Lorazepam. I understand the concerns about it. But at some point, getting addicted to it does not concern me as I also have to think about quality of life of which I have none right now. If I have to go outside my house or have family over the only way I can get a couple hours reprieve is if I time my taking of the Lorazepam according to the social visit. Otherwise the pain is too great. Though I am torn because I hear how bad it can be, on the other hand, if I have a chronic progressive disease and it helps with my quality of life then why I shouldn't take it. I am concerned as well and don't want to feel guilty taking it, which might be maybe once or twice a month. I would like to take it more often, but not sure now if I should, but I want to.

These are my concerns regarding Lorazepam. I should offer that the doctors have tried me on other (longer lasting?) benzodiazepines, such as Diazepam and cyclobenzaprine but I don't seem to get the same effect as I do with the Lorazepam.

Patient

This is in response to your consultation document on benzodiazepines.

I am quite concerned about your proposed new practice direction on this topic. I've been taking lorazepam for insomnia for some time now. I'm an older adult. My doctor has prescribed it for insomnia, but I also find it useful to calm anxiety and grief and to help me sleep when I'm in pain from arthritis and a chronic neck and shoulder problem. I take 1/2 of a standard dosage pill about 3 or 4 times a week. The amount I take hadn't increased over the years, or has done so only slightly. I find it's easy to use and has no side effects. Being able to take lorazepam and knowing it is available to me when I feel I need it has greatly increased my quality of life.

I think the College is taking a harsh position on the use of medications such as lorazepam, and is likening its use to that of opioids. We live in an age, and at a particular time, when anxiety medication is more needed than at any previous time in history. Isn't the College really taking the position that we shouldn't, as a society, need or use these drugs except for a limited time or purpose? That we should all somehow be able to cope better? (And isn't this so at a time when access to mental health services in Manitoba is extremely limited?)

In my view, medical regulatory bodies should not take strong negative positions on the prescribing and use of medications that help people deal effectively with situations of anxiety,

pain and insomnia, as long as those medications are not opioids. The College should deal only with necessary practice guidelines, and should take a very cautious and restrained approach to what is essentially a law-making function. Citizens should not be deprived of medications they feel they need except in compelling circumstances, which the College has not made a case for here.

Patient

For starters, let me applaud the College for planning to give out practice guidelines for physicians with regards to benzodiazepines and Z-drugs. These are compounds for which the risks often outweigh the benefits and for which there are non-chemical alternatives. Moreover, the section addressing elderly patients is much appreciated.

However, the proverbial elephant in the room is the absence of any mention of *off-label* prescribing to children. This is not an uncommon practice. It is understandable that the College is in a difficult position: Addressing the issue may be perceived as endorsing off-label prescribing. On the other hand, not addressing the matter is, in my opinion, not acceptable. Given that some physicians are likely to continue off-label prescribing to children, there need to be even more stringent standards than for adults. If the elderly warrant separate standards, it defies logic that children -who are at at least at equal risk as elderly patients- would not. I strongly encourage the College to address this issue in the new guidelines.

Patient

My psychiatrist, Dr. X, whose clinic I attended for approximately twenty years retired in 2016 and I believe the last prescription he gave me for Lorazepam was in November 2016. His statement was: “You should not have a problem getting Lorazepam from a family doctor because you use such a small amount.”

He normally gave me a prescription for 90 x 0.5 mg of Lorazepam that I would cut in half; thus the prescription would last approximately one year. Occasionally I would need the 0.5 mg as having been through major depression and left with intermittent depression and anxiety, there often are life situations whereby I would wake up subsequent mornings around 3:30 and without Lorazepam at bedtime, this sleep problem could go on for weeks. I did not need Lorazepam for falling asleep but for sleep maintenance. My anxiety is such that I need daily Zantac to prevent discomfort of excess stomach acid that appears to be a symptom of anxiety.

When I went to my family doctor for prescription refill in September 2017, I got the “look” and Dr. XXXX reluctantly gave me a prescription for 60 x 0.5 mg. This “look” like I was some drug-dependent crook caused additional stress that was not anticipated and thus my sleep problem was exacerbated. I returned for refill in November 2017 at which time I was desperate and ended

up crying and felt like jumping off a bridge after that appointment. I was given a prescription for 60 x 0.5 mg and referred to Geriatric Psychiatry at St. Boniface Hospital.

I was not a significant enough case to see a psychiatrist at St. Boniface but met with Resident XXXX and if I felt like a crook while visiting my family doctor this visit was even worse and I was told: "We do not prescribe Lorazepam." There was no question of what works for me and the fact that I had been using the medication for years and used a very small amount; I was told that I was addicted. Antidepressant medication was recommended; I said I would never take antidepressants again as I have tried most brands and found them all to be next to useless. Also, why would I spend $60 per month on antidepressant medications when I could get results with Lorazepam for a cost of a few dollars per month? Also, I have never been on an antidepressant that did not create sleep problems (except for Zoloft that caused so much weight gain causing more depression). Thus, Ms. XXXX's cure would leave me in a far worse situation and no medication to solve the initial sleep problem. I was given the option of attending Cognitive Behavioural Therapy (CBT) and since I had never tried any counseling, decided I should make the effort and I attended all of the sessions; however, CBT does very little for anxiety that develops while one is sleeping.

My first session with CBT caused me such anxiety that I did not understand until the session was over – the feeling in my hands was like they were on fire; I thought lotion would help but I did not have any and I could not understand why my hands were so painful. It was not until I left the building that my hands returned to normal and I realized that anxiety expressed in my hands (I normally have hyperhidrosis but my hands were dry; this was extreme).

After the disaster at St. Boniface I decided it was time for a change of family doctors and around midsummer I went to XXX Medical Clinic on XXX and saw Dr. XXXXX who fairly quaked – she was not about to fill a prescription for me for Lorazepam! She did not even ask what I wanted to see her about but recommended that I go to Access West adjacent to the Grace Hospital.

I made application at Access West during the summer and I forget the details; however it was November before I managed to secure an appointment and discussed history with a Resident and then saw Dr. XXXX. The first thing on my list was that I had a FOBT that I received in March but was reluctant to complete because I did not want the result going to my former family doctor. I had several other issues to discuss and I also asked for a prescription of Lorazepam. I mentioned that I had been rationing the old prescription and had approximately 20 tablets. Dr. XXX gave me a prescription for 30 tablets but I was advised not to fill the prescription until November of the next year. So what am I to use in the interim?

Well, having reached 75 years of age, I know that one can take a medication vial to Mexico and get a refill – no prescription needed (this does not apply to all pharmacies in Mexico). In January a friend had an option to go to Mexico in a group as a couple who booked had to drop out. For a $3,000.00 trip and two visits to a pharmacy, I was able to purchase 2 x 40 tablets of 2.0 mg of Ativan! Now, when I am totally overwhelmed, and the Federal Government will not allow MAID for depression, I now do not have to die of exposure in a field. I can take my Mexican supply and

a bottle of water to my choice of location and, hopefully, the problems are over as I have adequate dosage with little risk of failure.

So I wonder how many people have a situation that is far worse than mine, who do not subscribe to a newspaper and have no way of offering an opinion? My mental state has never been wonderful but with the challenges of life, job losses, occasional missteps, as well as the misery of family matters - these things accrue and there is a very dim light at the end of the tunnel. If it was not stressful enough that my psychiatrist retired, that my previous family doctor subsequently blindsided me by her reaction (thanks to cpsm), that I was treated like an addict and offered the easy road of antidepressants by Geriatric Psychiatry (thanks to cpsm), then rejected by a clinic because of my mental health (thanks to cpsm); this situation has exacerbated my mental health and anxiety over the last two years and who do I have to thank for my reaching this the dead end? I was forced to take a trip to Mexico and perform tablet cutting but few others have that option. So, sweep me under a rug like you do everyone else and your problem is solved.

Patient

In conclusion, I believe the prescription dates stated are correct from the vials; I have no intention of lying about my usage of the medication in question.

Responses from CPSM Registrants

My name is XXXX and I'm an internal medicine Resident in Winnipeg. To speak anecdotally, the number of inappropriate prescriptions for Xanax, as well as benzodiazepines and Zopiclone I've seen over my short time as a physician has been shocking. I could speak at length, but I don't have to tell you the deleterious outcomes many of these patients have had because of these medications.

I am fully in support of the complete removal of alprazolam from all formularies (I switch my patients to clonazepam on admission for this very reason), as well as restrictions on prescriptions of all z-drugs, particularly in the elderly and vulnerable populations.

I already use MP3 for narcotic prescriptions for my end of life cardiac patients, so would have no problem using this process also for benzodiazepines. I don't believe I have ever prescripted a Z-drug (not even sure what that is, besides Zopiclone)

Thank you for this great work.

I have few comments/concerns:

- do you have an estimation of how many people are dependent on benzo?
- clinics/doctors...who tends to over prescribe Benzo. Are you taking any action against them?
- ***Benzodiazepines withdrawal*** is a life threatening condition . What resources you prepare for patients (many of them) who will be need urgent detox.
- As I work at HSC-ER....I was told by patients that they are getting Xanax from outside Canada (free delivery) . it's very cheap. Any legal action against that?
- If my patient is getting it from other Canadian provinces (Kenora is just few hours away). What should I do in this situation?

Excellent , we need such a document
As an Emergency physician we frequently see ongoing prescriptions in patients who habitually "overdose" either as self harm or intoxicant.
My opinion is that these medications are useful in the short term only, usually pending more appropriate long term treatment As with narcotics I think there should only be one prescriber , a designate in his/ her absence should only prescribe a bridging amount.
Also I would support (and participate if necessary) in chart audits of physicians who prescribe outside of the guidelines to ensure standard of care

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The addition of Z-drugs to the M3P program will undoubtedly lead to a change in prescribing practices for treatment of insomnia.

Specifically, the "annoying-ness" of filling out a triplicate for something like Zopiclone will likely push prescribers to use drugs that are not on the M3P program for this therapeutic indication instead.This would likely increase prescriptions for antipsychotics, antidepressants (TCAs, trazadone), or even Benadryl to treat insomnia.

Given the the inferior efficacy and side-effect profile of these agents for treating insomnia, as well as the higher relative risk of death in overdose with these drugs (most of which have clinically relevant cardiovascular toxicity in overdose, unlike Z-drugs), I'm not convinced that this change would actually lead to the stated goal of harm-reduction.

I really like the document. It contains lots of great information and clear standards while still being succint. My only suggestion would be to have a section addressing "legacy" patients. If a physician takes over care of a complex patient already on both benzos and opiates, it would not be recommended to abruptly discontinue the medications. The way it currently reads, physicians may fear that they could be in violation for prescribing both medications in this situation, which could lead to discrimination in refusing to accept such patients into a practice or abandoning them, or cutting them off inappropriately.

Thanks for this, will be very useful in practice and in teaching new learners,

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Thank you for this excellent and timely information. I would interested in how other Canadian provinces with lower rates of use of z drugs and bdz drugs have coped with anxiety and sleep problems.

Re: SOP for Prescribing Benzos and Z-drugs

I am writing this response as an individual physicians and speak only for myself.

Thank you for requesting feedback on this Draft Standard of Practice. I do have some comments:

1) Feasibility / Practicality: As has been identified before, every SOP must take into account the ability of prescribers to implement the standard. We all want to be physicians of the highest standard, and we all want to improve our practice patterns that need to improve. But if the College defines SOP's that require resources of time, specialist consultation and testing resources that are not readily or practically available, then it will be perceived as a setup for failure and physicians will simply refuse to prescribe or refuse to follow the SOP, or accelerate their recession from practice. If the issue is complex, it means it will require time to address it. If the documentation required is extensive, it will require time to produce that documentation. If we are expected to provide that time, it needs to remunerated, or it is not practical. I made the same comment about the opioid prescribing SOP and the College made no visible effort to support Doctors Manitoba in requiring MH to recognize this as a huge time burden. It is, frankly, a cop out to simply say that the College has nothing to do with remuneration. The College must work in concert with Doctors Manitoba and with Manitoba Health. The College is not a silo unto itself that needs not concern itself with these other bodies or processes. If the College takes this position, it will continue to be viewed as an Ivory Tower, out of touch with the rank and file. And no amount of consultation with us will solve that if the College does not listen.

   To do justice to this issue, to follow the SOP as described in draft, will require a minimum of 30 mins at each visit. We need to be paid at half our hourly rate to perform this Standard of Practice. Please don't ignore this issue.

2) You want us to do a DPIN or eChart search on these patients. Stop suggesting DPIN searches – none of us have access to DPIN. As for eChart – it often fails to launch, and it is not accessible in PCH's. These are problems with fixes, yet they have existed for a couple years without solutions. Perhaps the College needs to throw its considerable weight behind these problems to create the fix.

3) Point #4 is vague and I don't know what is required of me here. Be specific or don't include it in an SOP.

4) Point #7 is problematic. Pt's don't have time to attend a pharmacy every 30 days. Pt's don't have the ability to afford another dispensing fee every 30 days. We already have problems with holiday days, pharmacy and physician business closure days, etc., conflicting with the conclusion of a 30 day prescription and obtaining the next fill. For patients who have a long-standing history of filling 90 day prescriptions reliably and on time – not early, there should be an ability to prescribe for 90 days and have it dispensed if the physician feels this is appropriate.

5) As a general comment, utilization of urine drug screens is problematic. Dynacare does not accept samples for this purpose and will not forward them to WRHA centres. The WRHA centres (hospital labs) only accept them in certain hours which are not widely known and are cranky and resistive when we try to access them at all. If this testing is required, it must first be accessible at Dynacare labs, 6 days per week, unsupervised production of the sample.

6) Point #9 (c) and 10(d). The wait list for an Addiction Specialist, Pain Clinic Specialist or other substance use disorder specialist such as a Psychiatrist are essentially non-existent. How can you seriously say that we must be able to manage substance use disorder or refer when referral basically is non-existent.

7) The concerns about use in the elderly are well-taken and are a difficult but good target for prescribers. Many patients are extremely distressed with untreated insomnia and many have trialled and failed most other approaches. So this has not been easy in the past. There should be some exceptions to our target population, though, that are beyond your identified list of exclusions (palliative, end of life, bipolar, etc.). Specifically, the geriatric patient with dementia in a PCH under direct supervision of nursing staff when aggression poses a greater risk of harm to self or others and other non-pharmacologic management tools and other pharmacologic tools have been attempted and found to be ineffective. For some of my patients, this remains the best and safest option for them, and I don't want to have to fit them into a paradigm and guideline designed for the functional elderly in the community at large. Also, patients with neuromuscular disorders such as spinal cord injury and other neurodegenerative disorders that manifest as recurrent or persistent muscular spasm (MS, MD, CMT, ALS, CP, etc.) – these individuals benefit from benzodiazepine use and should not be included in the SOP.

8) The College should publish a document on College Letterhead that physicians can provide to patients who are going to be "encouraged" to undertake a reduction, a taper, or a rotation to a different class of medications that basically says something like: "you may not like what your physician is engaging you to do, but your physicians is managing your care in accordance with the Standards of Practice which we mandate and, if they do not meet our Standards, they are subject to censure and ultimately removal of their license. If you have questions about this

standard, please contact the College at: ....” . A document like this would be very helpful for us in attempting to follow this proposed SOP.

A soapbox, sanctimonious commentary that I will offer because I don’t often take the time to communicate:

The CPSM is a well-respected institution. But every disciplinary or regulatory body needs to have members that feel that their perspective and needs are being heard and accepted by that body. It’s a balance. We will accept the guidance, leadership and regulation of the College, if the College hears us and heeds us. In recent years, I have observed that the College has sought the input of its members more actively than it has in the past. That is appreciated. As a second-generation physician who has known Medicine in Manitoba for my entire life, I accept that the Practice of Medicine is a noble profession, and a privilege. The College must also know and accept that Medicine is also a business, and that it does not operate in a vacuum or on an ethereal plane of altruism alone, bereft of influence from Revenue Canada, the banks, and Manitoba Health. These are bodies that care nothing for altruism and give no quarter when acting in opposition to a physician. This is the real world in which the everyday physician must try to navigate while retaining the nobility and inspiration to selflessness that brought each of us to this profession. When creating an SOP, please respect that we must walk with one foot in each of these worlds and it is not an easy path. The role of College must not only be to protect the best interests of the public. It must also be to consider the instruments by which it operates. It is a poor swordsman that does not look after his sword.

Thank you for welcoming feedback from members on the draft practice standard on the prescription of benzodiazepines and Z drugs. As the medical advisor to the Manitoba Public Insurance Driver Fitness division, I have a keen interest in this matter. In the Drug Impaired Driving educational sessions that we provide for physicians and other health professionals, we highlight the potential perils associated with driving among individuals who are prescribed these agents. This is reflected in the CMA Guide for determining medical fitness to operate motor vehicles, which also highlights the peril associated with combination with alcohol.
Our advice to prescribers is that they should advise ANY patient provided with a new prescription or an increase in dosage that they should temporarily stop driving until they can be reassessed by the prescriber (please note that this would generally not call for a notification of MPI in accordance with the mandatory reporting requirement). The prescriber can determine whether it is reasonable to resume driving when the clinical reassessment is conducted. Should some degree of functional impairment be suspected at the time of reassessment, the prescriber should at that point report to MPI with an appropriate recommendation, which could be that the patient’s driver license be suspended or that a functional driving assessment be conducted.
I would like to recommend that some of the above be included in the final document. In my opinion, a stronger emphasis on the potential for adverse driving outcomes would be appropriate.

I am a child psychiatrist, working with children and teens who have Autism and/or Developmental Delay. I infrequently use benzodiazepines for my patients, but I have found a small amount of lorazepam helpful prior to procedures like blood work, dental appointments, when behavioural interventions have not been effective. It would be helpful when you are giving a small quantity for families to use, that it not be on triplicate. We had a lot of problems with arranging for families or pharmacies to pick up triplicate prescriptions for stimulant medications.

Overall, it is a good initiative though.

It will help to use in a limited fashion.
Some patient's with anxiety response to Benzo better than other medication.These patients when deprive Bezo they seek drugs that is available on the street.

Some elderly patients need in a limited manner,specially who
are unable to use other medication due to QT prolongation.

Some patients who are aggressive,to calm them & to prevent further escalation
need Benzo on an emergency basis or for intervention.

Patients who go through withdrawal need Benzo until they are out of danger.

It will be useful to have Benzo to use with some recommendation .

You have asked for comment on your draft proposal.

1. Do you think a safety profile should be included for diphenhydramine in its various forms and brands which some use as a sleep aid, and which may become more popular if and when stricter protocols are in place for Zopiclone? I realize what the patient buys OTC has nothing to do with the College but maybe some guidance can be included.

2. What is your feeling about doing an informed drug screen for those patients the FD suspects is selling the benzos etc? A negative screen may support that hypothesis and may heighten the debate with the patient to discontinue?

You have probably assessed material from other countries. This one from the Royal Australian College of General Practitioners looks comprehensive if this assists you.

https://www.racgp.org.au/download/Documents/Guidelines/Addictive-drugs/Addictive-drugs-guide-B.pdf

I have already sent some comments in. Since then I have been thinking that there may be more patients out there than we think that are selling these drugs. I thought that there could be some comment on that including the possibility of doing an informed drug screen as appropriate, as I mentioned in my previous email.

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my comments (three comments inserted) on this draft standard.

Thank you for the opportunity to review.

In general, this draft of the Standards is significantly improved compared to an earlier version that I reviewed.

This sentence needs revision for clarity
These drugs are a known major contributor to a significant number of prescription medication-related deaths including opioids, especially due to polypharmacy, in Manitoba.

The explicitly stated treatment sequence (ie non-pharmacologic FIRST) in this statement is potentially problematical. Most general physicians do not have training in evidence-based non-pharmacologic treatments such as CBT, and access to such care may be delayed or impossible in many jurisdictions. Perhaps something more like:
"If there is acceptable access to evidence based non-pharmacologic treatment such as CBT, the physician should consider this treatment first."

1. Reasonable efforts are to be used to optimize non-pharmacological treatment modalities first and then optimize non-benzodiazepines or non-Z-Drug treatment modalities.

South of the 49th a doctor must document in the chart that a patient has been told that if they have a prescription for a benzo and take it and drive their collision insurance may be invalid . The package insert advises that you should not operate heavy equipment if yuo use a benzo and a car is considered heavy equipment. Insurance companies started reviewing patient's records before paying a claim

Over all this requirement had a positive effect for patients and doctors

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I have just reviewed the draft benzodiazepine standards and I am impressed. All I want to say is a job well done! These standards strike perfect balance between keeping our patients safe and the challenges in getting patients off from long term benzodiazepines. These standards will provide perfect guidance including regimen for tapering these drugs.

Thank you for developing this standard. I appreciate that it is for patient safety but I feel like it will help with the stress and sanity of family physicians as well by providing clarity and adding strength to our cautions.

Here are my thoughts that came up as I read through the documents:

Standard of Practice For Prescribing Benzodiazepines and Z-Drugs

A) Alprazolam is disproportionally involved with concerning outcomes. If we get rid of Alprazolam is it not expected that the next most popular benzodiazepine will simply take its place? Won't those same patients simply present and exclaim how much they are suffering and the doctor will give them a different benzodiazepine.

B) eChart, DPIN and/or Accuro or the connection between these systems is so often down/unreliable that I would hope that under new standards, pharmacists will contact us if flags arise that we have missed

C) So many people (especially nurses and other shift workers) misuse Diphenhydramine and Dimenhydronate, especially the latter. Should they be prescription only so their use can be tracked on DPIN?

D) Maybe it's just me by "Z-Drugs" diminishes the concerns. It sounds like a teenager name for something or a clever advertising name. I suggest another name such as sleeping pills, sleep aids, non-benzodiazepain sleep aid or just name them. To a lesser extent I get the same feel from "Benzos". That sounds like something I buy at the movie theatre concession.

E) I would guess that the doctors who are most concerned about their prescribing and whether they are doing it right probably prescribe the least. Conversely, the doctors that inappropriately prescribe the most are the least concerned. Both types of prescribers could benefit if on the CPSM website, behind password protection, they could go and see where they rank. Perhaps I can only see that I am 17th/1000 family doctors or perhaps I can see all 1000 family doctors and we can all see where we are on the list and see others as well. The list could be by physician specialty - ie. I can see family doctors only. Palliative Care doctors see their group etc.

F) Is there a typo "Describing" vs "Prescribing" at the bottom of page 3 of the Standard of Practice For Prescribing Benzodiazepines and Z-Drugs document

G) You mention that the Standard does not address the use of Benzodiazepines in palliative care, acute seizures, akathisia and alcohol withdrawal. I have at least one patient I have been refilling clonazepam for restless leg syndrome. This was prescribed initially by the Sleep Disorder Specialist. Is this another exception?

H) I believe in December you sent out the notification that this document was coming. In there was a link to a Power Point presentation from the ME's office relating to the number of deaths in 2017-2018 and 2018-2019. Does a monthly Mitte protect from overdose? Would weekly not be better? I feel like this would be more effective than M3P which is going to be a massive stressor on doctors (this will take a massive amount of time (time spent x number of people x Q 3 monthly = massive time spent)

I) Would mandated compliance packaging above age 70 be worthwhile

Draft - Schedule N document

A) I agree that the initiation of opioids and benzodiazepines in the hospital is problematic. It seems to me that about 7 or 8 years ago Seven Oaks Hospital ER established a policy of No Opioids in the ER. Benzodiazepine policy to minimize risks are key. When people come to us, post hospital on a benzodiazepine, that is difficult. All benzodiazepines initiated for sleep, in patients who were admitted, should be discontinued before discharge. Discharge summaries that arrive after the patient's follow up visit with family medicine should be unacceptable. I'm not referring to the unhelpful nurse generated summary and prescription list. I'm referring to a proper medical discharge summary by the attending physician with an explanation for why all medications change occurred. Having this arrive 1 week, or a month or sometimes even a year after discharge is unacceptable. When I see a patient one week after

discharge with no medical d/c summary and the patient is on a benzodiazepine, the only information I have to go on is the patient history, "they said I need this". Three months later when the proper discharge summary arrives that patient is already hooked. Family physicians cannot understand why hospitalists are allowed to get away with this (dangerous) when family doctors are censured (reasonably so) if they send someone to the ER without adequate communication. (Sorry for the rant)

B) Dr. XXXXX book Goodnight Mind is brilliant. I took an 8 hour workshop with her last November. I tell all my patients on sleep medications they must read this book and use her strategies in managing their sleep. Her basic premise should form the basis of all sleep aid prescriptions. Winnipeg's Dr. XXXXXX was in the audience and I'm sure, would vouch for this approach.
C) I wonder if there should be an age at which the use of a benzodiazepine with a half live of more than 2-4 hours must be reported to MVB/MPI. This would be a huge motivator and also make the roads safer as it will result in drug reduction, discontinuation, testing where appropriate and license removal where appropriate.

D) Should a contract be used in all Benzodiazepine prescriptions including risks, possible drug testing etc?

I think this standard is going to be very helpful for us.

I agree with everything regarding caution with prescribing bentos and Z drugs.

I have seen a small percentage, probably in the 1-2% range, that see to tolerate larger than usual doses. Most of people are either somewhat or very predisposed to the side effects. I have no idea what to do with these very rare cases. I agree that avoiding prescribing benzos is critical. In circumstances where I have taken someone over, if I did not provide them the Rx they wanted, they usually left my practice, which is convenient for me, at some level. The occasional patient who has been on stable doses, and is functioning at a normal level, working at a productive job, not requesting additional doses, sometimes with comorbid conditions like ADD, continues to receive above average dose amounts, with monitoring of course.

Any guideline will apply to at least 95% of the population, perhaps 97%, maybe even 99%, but the patient who does not seem to understand that the average is not universal, the one at the extreme end of the curve, remains a patient, and deserves to receive treatment that is individualized for them, even if it does not meet the average guideline requirements.

I am 99.5% in agreement, recognizing that individualized therapy remains the goal, in the context of what the average patient given the average dose benefits/suffers.

I asked my colleague Dr. XXXXXX for her thoughts on this standard and her remarks are in the attachment. I think this is a very good initiative. Another great resource is mysleepwell.ca (from Dalhousie U).

What about initial therapy in an anxiety disorder/crisis (bridging to SSRI/SNRI) with limit of 4 week use? **This Standard does not apply to the use of these drugs in the treatment of palliative and end-of-life patients, acute seizure disorders, bipolar/psychotic disorder, and alcohol withdrawal.**

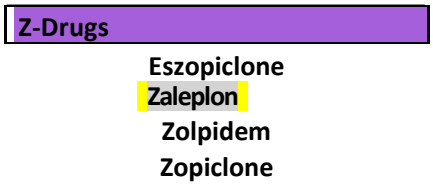
Also, what about the use of triazolam? I believe this drug should be taken off formulary/not prescribed as it is short-acting, causes behavioral adverse effects and is prone to severe withdrawal/rebound anxiety (average half-life is 2 hours) - I can't think of an appropriate clinical use considering the other options available

Flurezepam is also very unsafe as it accumulates (especially in the elderly) causing a severe hangover effect and is one of the longest acting BZDs

Could this be an opportunity to minimize the choices of BZDs available for prescribing? Rather than just targeting Xanax because of its street desirability...

Alprazolam (Xanax) has been identified as a drug with significant risks of abuse and diversion in Manitoba.

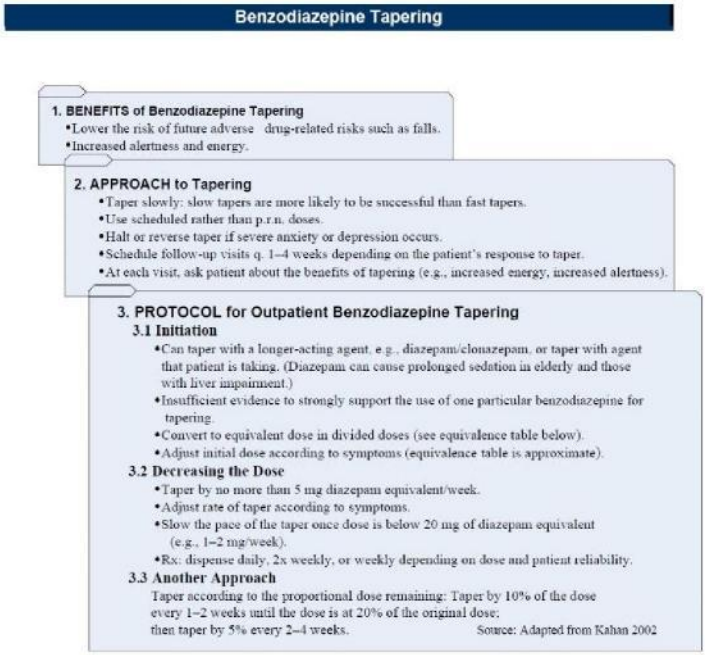
Not avilable in Canada



Zaleplon	20 mg	NA	NA	20 mg

Would a link to the "Ashton manual" be helpful here? This UK reference is mentioned above in the equivalency chart but they also have a really great page with slow withdrawal tables to help switch/taper benzos.

https://www.benzo.org.uk/manual/bzsched.htm
Click on Chapter II
COMMENT IS ON NUMBER 3.



As a sleep physician, I just wanted to bring to your attention, that we may use benzodiazepine drugs not necessarily for the treatment of insomnia, but as a modality to treat REM behavior disorder, some parasomnias, and in rarer situations restless legs syndrome.

Some provision should be made to accommodate sleep physicians for the prescribing of these medications on a more long term basis, given these diagnoses do not ususally go away on their own.

Excellent document , thank you .

Just a practical question : I have plenty of patients on relatively small doses eg zopiclone 7.5 mg or lorazepam 1 mg hs or clonazepam 1 mg hs. With the attached recommendation I would then have to switch patients to diazepam equivalent, and taper . The attached recommendation suggests tapering by 1-2 mg a week. Is there any evidence that tapering slower, eg 1 mg/month, is harmful or less successful ?

Really excellent work! The summary was clear and impactful. I am excited to be able to quote this in the future in my work as a geriatrician.

At the very end, the tapering guideline (from the 2002 reference) contradicts some of the information in the 2018 benzodiazepine receptor agonist deprescribing guideline that was appropriately referenced earlier stakeholder material. I would like to see the 2018 guideline incorporated. Specifically, the evidence is not good for the switching to a longer acting benzo and the accumulation in older adults may actually cause harm. Also, by using diazepam instead of the more general decrease of 25% every 2 weeks (one of the examples of a slow taper) with skipped days at the end of the taper the 2018

guideline addresses more medications in the class. The support materials for the 2018 guideline including the algorithm are already developed and available online.

Thank you very much for seeking broad feedback. You time and effort is clear and important.

Geriatrician

Thank you for making this a priority for our Manitoba College! The document is generally easy to read and digest. Greater emphasis on the benefits of tapering off these medications is suggested as this is what ultimately sells the plan to patients. Highlighting the number to treat and number to harm also sheds significant doubt to the clinical use of these medications. Also, it would be helpful to understand why there are differences amongst authors in the benzo and z-drug equivalencies table. Giving explicit examples of tapering from various benzos/z-drug starting doses would be helpful. Thank you again for this hugely important initiative.

Thank you to all who worked on the Standards of Practice for Benzodiazepines and Z drugs.

I believe it is an excellent and much needed document. It will provide guidelines for safer prescribing and support for many physicians who struggle to de-prescribe benzodiazepines. Through my work in Addiction Medicine I have successively de-prescribed benzodiazepines for all but 2 individuals who entered our program on a combination on Benzodiazepines and opioids. As I think of these individuals was good to see the statement "Tapering of long term benzodiazepines and/or Z drugs is very difficult,..."

Thanks for doing this Draft. Would you consider a later deadline and perhaps a reminder email for members to send feedback? We are all drowning in covid emails and I wouldn't want this to get lost in inboxes.

Some useful info is included in the consultation request but not in the Draft, such as the map showing our higher prescribing #s. Would you consider including this in the SOP itself?

You mention there will be resources attached? Would CFP allow you to refer readers to their excellent deprescribing bzd article? You refer to it in the consultation document but not the statement. The Alberta College Clinical Toolkit has at least two links that don't work; would you consider seeing if they have an updated version with functional links? The info is still searchable but it would be better if the links worked directly.

We have great CBT-I in this province and so many CBT-I apps available and other free internet/app based treatments available esp now during covid while internet/phone treatments are becoming more available - will these all be in the resource list?

One problem we have is patients running out and then complaining they need a refill otherwise they'll have a withdrawal seizure. I have a contract that states no early fills for any reason (lost, stolen, left backpack up north, left them in a car that got burned out and then fell in a river, cat knocked them into

a toilet). Is this defensible? Point 9c in the Draft discourages “abruptly discontinuing” the meds so perhaps addressing early fill requests could be helpful. Ideally the dispensing interval could be shortened, sometimes to daily dispensing, but some patients aren’t covered for this and it can be expensive, and some can’t get to the pharmacy daily. Some guidance on this may also help, as some feel their hands are tied when pts run out early. I have also heard of some docs feeling they need to keep prescribing BZD so the patients will keep coming back to them for other purposes such as HIV follow up.

Would you consider a max advisable dose, above which dispensing interval would have to be shorter? No one needs more than 2mg clonazepam/day in my experience... but there are still psychiatrists prescribing this strength bid. In my experience if I can get pts down to 1.25mg-1.5mg/day max they actually feel better and function better, esp if they buy into SSRI and/or other evidence backed sleep med or other sleep intervention. But they never buy into alternate treatment until the taper is underway.

I have literally ONE alprazolam patient - I never rx it - and would be happy for alprazolam to be delisted as long as perhaps we could apply to have certain patients continued on it if they were demonstrated to be stable on it and at high risk for bad outcomes if they were switched to another agent.

I don’t think adding to the M3P program would be as helpful as asking pharmacists to consider not filling certain rxs... I’ve seen DPINs showing patients getting anywhere from 30-90 alprazolams or clonazepams every week or two, and I feel the pharmacists do have a role to play in contacting the prescribers and considering refusing to fill.

Thanks again for addressing this.

Hello again,

Would you consider attaching this guideline specific to seniors in your SOP?

https://ccsmh.ca/wp-content/uploads/2019/11/Benzodiazepine_Receptor_Agonist_Use_Disorder_ENG.pdf

We all know it is TOUGH getting the older ladies off their bzd but it is so worth doing when you see how much better they feel and function and then you don’t have to lose sleep over whether their life ending hip # is just around the corner.

Thank you for your hard work on this matter; the SOP looks excellent!

The document doesn't seem to say 'draft' on it; can/should members start implementing it immediately? Can I forward this SOP to colleagues?

It was with mixed feelings that the palliative care group read about the proposal to change the M3P program to include the prescribing of benzodiazepines and Z-drugs. Like all physicians, we are aware and concerned that benzodiazepines and Z-drugs are often prescribed inappropriately. This inappropriate prescribing can lead to issues with morbidity in the elderly, and issues of substance abuse

in all patient populations. These issues can then contribute to the death of Manitobans, within the context of polypharmacy and overdose. These are concerning issues, and we fully support the monitoring and reduction of inappropriate benzodiazepine and Z-drug prescribing.

However, benzodiazepines, like opioids, are integral medications for providing comfort for palliative patients as they approach end of life. End of life symptom management guidelines include benzodiazepines (predominantly midazolam, lorazepam and clonazepam), along with opioids to ensure comfort for the dying. To further complicate things, Canada has recently been experiencing shortages of medications, due to the COVID-19 pandemic, such as midazolam, methotrimeprazine, and in some rural areas, injectable and liquid opioids. This has required palliative care providers to look to other benzodiazepines and sometimes other classes of medications, to ensure comfort for our patients at end of life. It is necessary that several different benzodiazepines and opioids be readily available to Manitoban palliative care providers to ensure our patients experience comfort at end of life now, and after, the pandemic has passed.

The current M3P prescribing system does not allow anything but the hand delivery of original M3P prescriptions. This has led to inequitable and unacceptable delays in providing quality end of life care for housebound palliative patients, especially those that are remote, rural, and in First Nations communities. As you know, palliative care is defined as a basic human right by the WHO, and timely access to medications is necessary for quality end of life care. Timely access to medications has not always been possible due to the restraints of the current prescribing model.

We have greatly appreciated the openness of the College to respond to the palliative care group and make provisions for us to prescribe opioids by faxing the M3P form, and by e-prescribing for the duration of the COVID-19 pandemic. This has allowed us to improve end of life care, see more patients, and to deliver care in a manner that is safer for both our health care providers and our vulnerable population.

The palliative care group is hoping that during the pandemic, and after it has passed, that palliative care providers will be allowed to prescribe any currently regulated M3P medications (eg. opioids), and any additional medications that might be added to the M3P program (eg. benzodiazepines), by fax or e-prescription.

To help the CPSM fully understand the impact of the current system on palliative patients, families and health care providers, two Manitoba palliative care programs have spent several months drafting a proposal regarding the prescribing of controlled medications for our patient population. It outlines our concerns about the current prescribing model, and our proposal to improve the process in the future. Please take the time to read and consider the changes in the proposal we have attached. We would be very happy to meet in person, or by virtual means, to more fully explore this issue with the College.

NOTE ATTACHED WAS AN 11 PAGE DOCUMENT TITLED -

WRHA Palliative Care Program
Controlled Medications and Palliative Care -
A Prescribing Practices Proposal

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Controlled Medications and Palliative Care - A Prescribing Practices Proposal

Introduction

The prescribing of narcotic medications is currently controlled by the Manitoba Prescribing Practices Program (M3P), which was introduced in 1990[1]. For the purposes of this proposal, the term "narcotics" will be used to refer to any medication listed under the M3P. It includes opioids and other medications with misuse potential, and is currently being reviewed with the intent of adding benzodiazepines and Z-drugs.

The initiation of this program, along with numerous programs across Canada, was largely intended to reduce fraudulent prescriptions. Prescribing patterns could be monitored, and the College of Physicians and Surgeons of Manitoba (CPSM) were able to contact prescribers regarding inappropriate prescribing, or to inform them about patients who were found to be utilizing multiple prescribers. The current stated objectives of M3P include reducing prescription forgeries, decreasing double doctoring, and promoting & supporting appropriate drug use management[1].

The Drug Program Information Network (DPIN) was introduced in 1994[2]. Since then, prescribers have been able to review a patient's dispensing record and detect possible concerns for narcotic abuse or diversion. With the advent of the DPIN, the triplicate was changed to a duplicate pad. As the DPIN became a way for monitoring narcotic prescribing, the M3P specialized prescription pad now exists primarily to prevent forgery, prescription diversion, and also serves as a way to decrease the total number of narcotic prescriptions.

This proposal will provide an overview of the system within Manitoba. It will draw comparisons to different monitoring programs in Canada, and offer a proposal for prescribing that would improve the quality and efficiency of care for Manitoba's palliative patients. We understand that any changes cannot be taken lightly, specifically acknowledging the ongoing opioid crisis and the increasing misuse of benzodiazepines in our province and across Canada.

Current Prescribing Process

At this time, the M3P requires that a pharmacy receive the original copy of a narcotic prescription utilizing the duplicate pad.[1] This prescription must be received in person prior to the pharmacist filling the prescription. For the majority of prescribers, this system is not too

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onerous. For example, a family physician has most patients visiting his/her office to receive the prescription, which is then given to the patient to deliver to the pharmacy.

However, palliative care patients deserve special consideration. Palliative care is a basic human right, and good palliative care necessitates rapid access to end of life symptom management medications,[3] even for patients who cannot easily visit a physician's office. For palliative care patients, end of life symptom protocols involve the use of both opioids and benzodiazepines; and care of these patients occurs not only in hospitals, but also in long-term care facilities, hospices and patient homes.

For palliative care patients at home, physician coverage includes large urban areas or broad rural jurisdictions. For example, there are 400-500 patients enrolled on the Winnipeg Regional Health Authority (WRHA) palliative care program at any given time, and the majority of these patients are managed at home. Rurally things are similar. For example, Southern Health-Santé Sud has approximately 150 patients enrolled at any given time, and they are spread over an area of over 27,000 square kilometers. It is common for a palliative care physician to receive multiple phone calls a day from patients, nurses and caregivers about needing a prescription for an opioid, benzodiazepine or other controlled medication. Many times, these requests are urgent and cannot be anticipated.

It is often difficult to deliver the original duplicate copy to the patient/family or pharmacy. This is especially true for cases where:

- The patient/family or pharmacy is far away, such as for patients who live rurally, remotely or in First Nations Communities. For many of these patients, palliative care physicians provide consultative services and, at times, take over medication prescribing. This is especially true for complex symptom management, which often involves methadone based analgesia.

- Palliative patients are receiving end of life care at home and require the hand delivery of M3P prescriptions to pharmacies. For these patients, there are two ways in which the prescriptions are delivered to their pharmacies:
    - By the physicians, who take time out of their workday to drive around and drop off prescriptions, often at multiple pharmacies.
    - By a caregiver, who sometimes has to leave a vulnerable patient alone at home to drop off a prescription, and again to pick up the medication.

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There are also several other concerns for the care of palliative care patients and physicians with the current prescribing model. These include the following issues:

- Compromised continuity of patient care
    - Many physicians choose not to write prescriptions for medications covered under the M3P. For palliative care patients, this can result in decreased contact with their regular physician.

- Prescriber safety
    - Narcotic seeking patients are aware that physicians carry duplicate M3P pads. Palliative care physicians in Winnipeg have been targeted with break-ins, in attempts to obtain these prescription pads.

- Patient and community safety
    - Given the added difficulty of prescribing medications with an M3P pad, physicians often prescribe more medication at time to avoid the hassle of refills. This leads to unnecessary narcotic medications in the home and increases the risk to the patient and his/her family as these medications become at risk of diversion.

    - Lost or stolen duplicate pads
        - Although it is required to report a lost duplicate pad, this does not guarantee that it will not be used to obtain fraudulent narcotic prescriptions.
        - Stolen duplicate pads contain sensitive patient information and prior dispensing records. As a result of a theft, patient names, addresses, PHIN numbers, and type / quantity of narcotics dispensed are known. This results in increased risk to our already vulnerable patients.

- Potential for documentation errors
    - Increasingly, offices have electronic records. Requiring paper duplicate prescriptions means these either need to be scanned into charts, or rewritten in the electronic medical record (EMR). Rewriting presents the potential for errors. Scanning means that the usual medication searches are unhelpful.

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Comparison of M3P to Programs across Canada

There are no national requirements for narcotic control or monitoring programs across Canada[4]. As such, individual provinces and territories have developed their own unique systems (although Yukon is shared with Alberta). Most of Canada currently has some form of narcotic control and monitoring in place; the exceptions being Quebec, Prince Edward Island, Northwest Territories, and Nunavut. There is a large degree of variability in the different programs, which are summarized below (table 1).

Provincial prescribing programs have been modified over time, demonstrating an adaptability to the current landscape in which they are operating. A few notable changes have included Nova Scotia's transition from a paper-based system to a secure e-prescribing system[5], and Saskatchewan's elimination of specialized prescription pads.

Table 1 (Information from corresponding college website, unless otherwise denoted):

Province / Territory	Specialized Prescription Pad?	Allow for faxing narcotic Rx?	Electronic Prescribing?
Manitoba	Yes	No	No
British Columbia	Yes	No	No
Alberta/Yukon	Yes	Yes	No
Saskatchewan	No	Yes	No
Ontario[6]	No	Yes	Yes
New Brunswick[7]	No	No	Required
Nova Scotia	If electronic not used	No	Available
Newfoundland[8]	Yes	Yes	No

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Proposed Changes and Anticipated Benefits

Currently, pharmacists are already aware when a patient is enrolled on the province wide Palliative Care Drug Access Program (PCDAP). We request that narcotic prescriptions for palliative care patients be accepted by **any** of the following three mechanisms:

- Via fax through an electronic prescribing (e-prescribing) system, without use of the duplicate pad.
    - The electronic prescribing system would need to meet provincial standards to ensure confidentiality of health information and prevent fraudulent usage
    - The electronic system should ideally have electronic alerts that would trigger when:
        - High dose opioids, benzodiazepines and other sedating or controlled medications are prescribed, individually or in combination
        - Controlled medications are being released too early
    - The prescriber would need to write on the prescription that the patient was registered on the PCDAP
    - To avoid medication errors, dosages and total amounts filled would be written out in both numerals and words.

- The duplicate pads could still be used to write prescriptions which can be hand delivered to pharmacies, by patients, family members or physicians.

- The duplicate pads could still be used to write prescriptions, which could then be faxed to pharmacies, allowing them to dispense the medication.

Our current system, as it is officially written, does not allow anything but the delivery of original M3P prescriptions. This has led to inequitable and unacceptable delays in providing quality end of life care to housebound palliative care patients, especially those that are remote, rural, and in First Nations communities.

We strongly advocate that each prescriber be given the ability to order narcotics for palliative patients by any of the three methods listed above, as he/she sees fit, depending on the location and nature of the patient-physician interaction.

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It must be stressed that to modify the current system, but to only go so far as to allow faxing of the M3P hard copy prescription, does not solve many of the concerns we have listed above. Specifically, it only partially solves the time delay issue, as it still requires additional driving to a fax machine for physicians after a home visit (which could be many kilometers away in rural areas). It also doesn't address the inability to easily access information on previously prescribed narcotic medications during an interaction with a home- based palliative patient.

If e-prescribing was allowed for palliative patients, physicians could carry computers equipped with an EMR. This would allow easy retrieval of previously e-prescribed medications to address concerns and interactions, improve legibility, and ensure the timely and safe prescribing of controlled medications - all while assessing the patient in his/her home. A comparison of time delays between e-prescribing and delivery of an original M3P prescription is provided below (see table 2).

Table 2.

	M3P Hard Copy Rx		**E-prescribing Monitored Medication**	
	Steps	**Time to complete**	**Steps**	**Time to complete**
Write Rx	Obtain M3P pad Write M3P Rx	1-2 weeks 2 minutes	Enter e-prescription Acknowledge computer generated alerts	2 minutes 1 minute
Communicate with pharmacy(ies)	Verify medication availability	5-10 minutes	Verify medication availability and receipt of e-prescription	5-10 minutes
Generate electronic form of M3P Rx	Send to pharmacy to have them start on Rx (pending receipt of the original) Scan M3P Rx into electronic chart (or put in paper chart)	5 minutes 5 minutes (if done)	N/A N/A	
Deliver M3P Rx for housebound patient	Hand deliver M3P Rx to pharmacy, patient home, or pick up location Mail M3P to rural, remote or first nation community	5-45 minutes 2-5 days	N/A N/A	

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Prescribing of Controlled Substances during the Covid-19 Pandemic

To help physicians cope with the limitations brought on by virtual visits, and to ensure ongoing medication availability to patients during the Covid-19 Pandemic, there have been recent changes to narcotic prescribing. Health Canada announced permissible exemptions for the prescribing of controlled substances under the *Controlled Drugs and Substances Act* (CDSA) on March 19, 2020.[9]

The CPSM and the College of Pharmacists of Manitoba (CPhM) responded to this direction, with input from its members, by temporarily allowing for more flexibility in the prescribing of controlled substances in Manitoba.[10] For the duration of the pandemic, it has now become permissible to hand deliver an original M3P prescription, fax a copy of the M3P prescription, or e-prescribe for patients registered on the provincial PCDAP.[11] These changes were welcomed by palliative care physicians, as they reflected a willingness of the Colleges to address the current limitations within the M3P system for remote and virtual visits, which suddenly became a reality for many non-palliative physicians who had not experienced these issues previously. It is our hope that the flexibility to address these limitations will continue after the pandemic has settled.

At the time of preparing this document, the prescribing changes have had numerous benefits for palliative patients including: significantly decreasing prescribing time, allowing smaller amounts of medication to be prescribed more frequently, and decreasing the need for vulnerable patients or their families to visit a hospital/clinic for the sole purpose of picking up a prescription. We acknowledge that it is too early to tell if there have been any negative consequences to this new prescribing model, but the palliative care teams throughout the province are closely monitoring our patient populations for any adverse events that might occur.

Future Directions

On a larger scale, we hope that provincial-wide changes can be implemented in the future, which will allow the e-prescribing of all controlled medications, for all patients.

Given the changes to the monitoring of narcotic medications, it seems the only outstanding reason for the province to continue the use of a hard copy M3P pad is to act as a deterrent to physician prescribing.

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When physicians choose not to get duplicate pads, the prescribers who do not write duplicate prescriptions have an "easy-out" when they decline fulfilling a patient request. In some

situations, this can reasonably lead to a decrease in inappropriate prescribing; but in other instances, it puts the onus on other prescribers in walk-in clinics and emergency rooms to further address the concern and offer patient education.

Although the use of specialty prescription pads can decrease inappropriate prescribing, other methods such as physician audit and education are also effective. For example, in Saskatchewan, a province that did away with its specialty prescription pad program, educational programs and an electronic prescription review program led to a 63% reduction in benzodiazepine use, a decrease in meperidine and pentazocine prescribing by milligrams, and a significant conversion of immediate release opioids to sustained released forms.[12] This education was met with acceptance by physicians and done on a cost neutral basis. [12]

As clinics move further away from paper charts and towards virtual visits and e-prescribing, we would suggest that a longer term alternative to the M3P pad would be the development and support of electronic controls on e-prescribing. Ideally, the future of e-prescribing would include modifications to allow controlled medications to be flagged in real time, limited in dose, and marked for immediate feedback. This would improve monitoring, and hopefully drive educational initiatives for individual prescribers and the Colleges. Initiatives to monitor and improve medication safety through e-prescribing programs are currently underway in Canada through Canada Health Infoway, together with Health Canada.[13]

Conclusion

Delivering the highest quality of patient care is of upmost importance to all physicians delivering palliative care services. Our proposed changes would allow these physicians to optimize the prescribing and delivery of crucial medications to patients near the end of life. As a result of these changes we are confident that physician time would be more appropriately utilized to focus on patient care.

Implementing these changes would require a coordinated effort between the College of Pharmacists of Manitoba (CPhM), College of Physicians and Surgeons of Manitoba (CPSM), College of Registered Nurses of Manitoba (CRNM), as well as the WRHA and other Provincial Regional Palliative Care Programs. We would look forward to an ongoing collaborative discussion with all the Colleges so that we can meet simultaneous common goals of excellent patient care and public safety.

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À l'écoute de notre santé

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As a practicing C&A psychiatrist, I could not be more enthusiastic about this standard of practice coming into action. The widespread practice of benzo prescription is not at all supported by evidence, and I applaud any measure that might restrict this inappropriate prescribing. I have no specific input about the content of the document beyond expressing my broad enthusiasm. I think it is overdue.

As a new rural family practitioner, the largest proportion of my patients who are on chronic opiates, benzodiazepines and z drugs are inherited from other practitioners.

They are generally extremely resistant to coming off these medications, and the suggested alternative therapies such as CBT are extremely difficult to access. As such, guidelines such as these put an unfair burden on new practitioners to do tapers without any expertise in doing so, and without any alternative therapy to offer our patients.

I have had similar issues in following opiate prescribing guidelines: consulting a pain clinic is an excellent idea if they were available, but it is usually 12-24 months to access these services. This is, honestly, unacceptable. In addition, our only local addiction physician has left for another province.

Unless the CPSM is planning to work with the province to implement new supports for physicians to help wean these patients, I foresee similar difficulty in this situation. One only has to look to the US to see what happens when guidelines (opiates) suddenly remove habit forming drugs from the market without an exit strategy. Many of these patients have simply switched to street drugs, leading to the overdose crisis with fentanyl laced street opiates.

I would propose adding to the guidelines specific sections outlining what should be done if a taper fails. I would also strongly suggest having some kind of consult service available to help physicians deal with these patients. Or perhaps guidelines should be this stringent, but only be applied to new starts. Unfortunately, even your guidelines seems to recognize the extreme difficulty in weaning chronic benzo and z drug patients.

I have reviewed the draft standard and agree fully with the proposed standard. I also agree with the CPSM proposal to delist Alprazolam and to require an MP3 Rex for these medications.

During this pandemic with anxiety already heightened is this the time to be altering patients meds?

I noticed there is no mention of in office use. I really only prescribe before a painful cosmetic procedure. Therefore would dispense in office supply while patient in clinic or Prescribe 2-3 tablets.

Should there be an exception to getting urine drug testing for Ambien if only using so short term for procedures??
Should there be clauses about these very short term prescriptions?

I appreciate the chance to review this proposed standard of practice. I think the goals are laudable and sensible, but I have significant concerns about the feasibility of following this in everyday practice for the majority of family physicians. Concerns about benzos have been present since my rather recent medical training started in 2012. As a relatively recent graduate, an extreme reluctance to prescribe these medications has been burned into me. I do not think I have ever initiated a z-drug, and have probably prescribed a benzo on an outpatient basis a handful of times. That being said, a review of my prescribing practices would reveal frequent prescription of these medications as I am often contending with years, sometimes decades, of profligate prescriptions of sedating medications. I try to have the recommended conversation about tapering to discontinuation every time I prescribe one of these. It is rare a patient takes me up on it.

I wonder if an explicit statement that "patient preference" is not a valid reason to defer attempting a taper is warranted?

I am also concerned based on my experience in the Dauphin Primary Care Outreach Clinic in which I prescribe opioid replacement therapy, being one of 4 physicians in the region to do so. We frequently get referrals of legacy opioid patients who are not doing well with tapers of their opioids initiated by family physicians and start to demonstrate aberrant behaviours; we frequently come across patients for whom the family doctor has misinterpreted the guidelines and cut people off their opioids abruptly, prompting seeking of street sources. I think it is fair to say that primary care providers are generally confrontation-averse, and many are unable or unwilling to schedule the time to prescribe M3P substances with the appropriate warnings and review prior. Many of these patients get dumped on addictions and pain services and end up in limbo for months to years.

Is it possible for the CPSM to endorse or create a tool similar to the McMaster Pain Centre tool for Opioids for Chronic non-cancer pain that guides physicians through the process of assessing benzo and z-drug prescription and a program for tapering? Failing that, will the college be able to advocate for government funding of specialized clinics with multidisciplinary support that will give patients the best chance of tapering and discontinuing benzos? I would envision an expansion of the scope of RAAM and PCOC clinics, for example.

The population I find most frequently uses both prescription and street-obtained benzos are those with a history of childhood trauma and the associated psychiatric comorbidities of personality disorders and substance use disorders, as well as depression and anxiety. There is a preponderance of these patients in Indigenous communities. I am concerned that concerted efforts to reduce prescribing will significantly undermine trust between Indigenous communities and settler physicians without widespread, meaningful engagement with the official and unofficial power structures of existing reserves and other Indigenous communities.

I know the CPSM just sets standards for physicians, but I worry that a high standard applied without the necessary buy-in from government funders and affected communities will lead to more harm than good in the short to medium term, and questionable benefit in the long term. I would like to see consideration of a step-wise approach in escalation of standards to allow the public messaging and community involvement that would make reduction of benzo prescribing a success.

From my point of view, this is a comprehensive and well composed briefing.

I can't agree more with the standard of Benso's and Z drugs prescription as outlined by this report I

have seen the devastating results of over prescribing and over dosing of these medications

I have reduce prescribing these medication as much as I can and appreciate the guidelines given in this report

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In general, these types of drugs should NOT be prescibed in the longer term without psychiatric input for justification. In this way one can avoid the opiod crises in the USA. I personally never prescribe these drugs.

Thank you for the care and thought you have devoted to developing the draft Standard of Practice for Prescribing Benzodiazepines and Z-Drugs, and for the opportunity to provide feedback. The recommendations and stipulations in the document are reasonable and appear to have been crafted in a way that takes properly into account the best interests of the patient and the clinical realities faced by prescribing physicians.

Please be aware that in the long-term care of institutionalized patients with severe or profound developmental disabilities some of those patients who suffer either from seizure disorders or chronic spasticity have been placed on benzodiazepines (typically many years ago). In general such patients continue to tolerate the drug well and benefit from the anticonvulsant and muscle relaxant properties of the benzodiazepine they are on.

Benzodiazepines prescriptions should be monitored by prescribing physician and dispensing Pharmacist,. And refills should not be authorized.

I have long been opposed to these drugs and have attempted to wean patients off them with little success. Most patients just go to another prescriber to get these drugs

It has been my contention that they are from the dependency aspect at least as bad as opiods and should be prescribed in the same restricted manner. This makes the average patient realise that these drugs have significant adverse potential.

Please don't write guide lines that put all the effort and blame on the physician.

If we now have to write a triplicate prescription for a patient it would enhance my efforts in weaning patients off these drugs.

Thank you for considering my opinion and comments.

I think the guidelines provided are reasonable. I was always wondering why the Benzos were not on the list of controlled meds (M3P prescribing list.)

Thank you for the opportunity to share my feedback.

While I am supportive of a conservation strategy for benzodiazepines, I would not support the inclusion of zopiclone, nor its addition to the triplicate list.

There is, a very real need for medications that assist with insomnia and adding this class of relatively safe medications is an overreach.

Inevitably prescribing practices will migrate so that other medications such as trazodone, Benadryl and the atypical antipsychotics become favored. In my view none of these has a safety profile that is better and does not result in a net patient safety gain.

I would in general, advocate for the continuing classification of Z drugs as they remain.

I agree this change is necessary but it must not be enforced harshly on our older patient who have been taking these drugs for years.

Very pleased to be informed on the gravity of the negative outcomes of Benzos and Z-drugs. Only been using these medications mostly for sleep aid in hospitalized surgical patients on as needed basis. I would be very supportive of a guideline that would address alternative or limitations on prescribing these drugs especially on a scheduled regular use. Thanks

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While considering appropriate indication for prescribing Benzo and other Z drugs, prescriber should make every effort to make sure the patient is using medication as prescribed, In addition to using minimal effective dose, prescribing for shorter intervals, using urine drug screening, prescriber can Bubble pack medication to check compliance Pill counting- Bring the patient with all medication for appointment

In my practice, this has greatly improved medication compliance and decreased diversion.

Small suggestion

I still see some family doctors prescribing diazepam to attempt to assist with the management of alcohol use disorder. I suspect it is done with the thought of this being a "replacement therapy"

It might be worthwhile to add a comment about this specifically

In keeping with this I would suggest adding the term "acute" prior to alcohol withdrawal.

Thanks for your work on this.

We all are trying I guess to limit prescriptions for Benzodiazepines, Z-drugs, Opioids but we do not have enough alternative solutions.

Before we set strict standards we have to educate public and expand mental health resources on every level.We need to coach people how to cope with stress and anxiety starting from school. Mental education is a key factor. For now you probably should base standards on the basis of judgment of well educated physicians. If some of us are going up above an average in prescribing pattern it should be noticed by the College and approached. Otherwise awareness for all of us created by your letter is good step for improvement.

I am not sure why these two classes are being 'lumped together' for discussion. I recommend that Benzos be considered first as this issue is a no-brainer. Excessive prescribing is well documented and this needs to be addressed. The evidence for the use of Z drugs and abuse is less so. One thing at a time. I would be less inclined to dispense with Benzos if they are included with Z drugs for a vote. If you just recommend changes regarding Benzos I would heartily endorse this. Not so sure about Z drugs yet.

Thank you for your communication on benzodiazepines and Z-Drugs prescription.

I reviewed the draft. I understand these group of meds are sensitive, regarding long term side effects , dependency and risk of abuse in different age groups.

I basically prescribe such medications quite rarely for very limited indications like seizures. I never use these meds for insomnia or anxiety.

I really want benzodiazepines in triplicate but zopiclone not because widely used and slow in giving dependency

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I support the new policy.

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read the draft. Nothing to add

I have reviewed the new practice standard proposal for benzodiazepines and z drugs. While I do believe this a good direction I have some concerns about some patients who will not take well to any changes to their medicine regimens and will put us physicians in a very difficult spot. In my past experience some patients are extremely demanding and manipulative to physicians and are not compliant to adjustments ie tapering of bzp’s. I would be grateful if the College could provide some guidelines for dealing with such patients. In my experience some patients see multiple doctors and this may also come as an issue.

I do agree though that these medications should be judiciously and carefully prescribed as to minimize harm while considering their benefits.

I generally agree with the draft as is; It may be helpful to add a statement about exercising caution in withdrawing benzodiazepines/Z-drugs abruptly after long term use and acute increase in seizure risk. It would seem any indication one would use Alprazolam for could be achieved with lorazepam with a less emphatic peak effect and lower abuse potential. Is there an option to propose removing Alprazolam from the formulary altogether?

I have added my $0.02 worth in comment bubbles to the document.

The arrival of benzodiazepines into clinical practices in the 60s was met with enthusiasm
Suggest this should be in the full term (i.e. 1960s, 1970s etc).

The misuse of Alprazolam is particularly problematic and appears to be disproportionately associated with misuse, fatal and non-fatal overdoses, paradoxical excitation, and withdrawal/rage responses, as well as traffic accidents and crime-related harms.
alprazolam does not need to be capitalized
Perhaps change the first "misuse" to inappropriate

Drugs of dependence have important therapeutic uses, but there is a need to ensure the supply of these medicines is clinically appropriate. The Standard tries to strike the best balance between the benefits benzodiazepines provide for many patients with the risk posed to some patients. The Working Group was assisted in achieving this balance by reliance upon the newly issued *Deprescribing Benzodiazepine Receptor Agonists: Evidence Based Clinical Practice Guideline* issued by the College of Family Physicians of Canada which is referenced in the Standard.

change to "has been written in a manner so as to..."

Change to "appropriate" or "appropriately selected"

I think the way this sentence if draft contradicts the important messaging above about potential harms of benzo use. It should have the same tone/alignment with above content.

This is an important element of this document and would suggest creation of 2 easy to consume table on 1. the appropriate use and recommendation of seeking the lowest effective dose and; 2. key bullet points of deprescribing in both younger and older adults.

Council seeks to work with the College of Pharmacists of Manitoba to include Benzodiazepines and Z-Drugs in the list of M3P Drugs.
Should a maximum number of tablets or duration therapy (i.e. 2 weeks) before requiring re-evaluation also be considered for new prescriptions?

Council will also recommend to the Monitored Drug Review Committee that Alprazolam be removed from the Manitoba Drug Benefits and Interchangeability Formulary.

While I appreciate that alprazolam is the most commonly used and with shorter half-life that is it potentially more additive, but it is not clear to me that removing alprazolam will lead to less overall benzo prescription. It would be possible that prescribers will just switch to lorazepam or other than is marginally safer.

This is XXXXX, Clinical Assistant in XXXXX Medical center, Winnipeg, Manitoba.

I really appreciate the initiative of setting standard of practice for benzodiazepine and Z-drug in Manitoba.

I found it very helpful in practice, and I am of the opinion that including these drugs in m3P list might be helpful reducing the inappropriate use of these medications in practice.

Thank you for sharing the valuable information.

I support setting very tight limits on alprazolam, if not getting rid of it all together.

The one issue I can foresee with needing a triplicate for benzos is when we prescribe diazepam for withdrawal.

Our ER group in Steinbach made it a policy probably about 15 yrs ago to not have triplicate prescriptions in the ER group at all.
No one writes triplicate prescriptions. This has helped our patients immensely and eliminated people coming to the ER looking for a narcotic prescription.

If we suddenly start writing triplicate prescriptions again, patients will figure out quickly that they can badger us about adding other drugs onto their triplicate prescription. It's just bringing another fight into the ER that we have enjoyed not having.

There are too many people in our community that do not have family physicians - especially in the group of people that generally require diazepam for withdrawal - that we can send these people out without a prescription and then foist the responsibility for writing diazepam withdrawal scripts onto the walk -in or same day prescribers.

I realize the goal is to prescribe fewer potentially harmful or addicting medications.
But at the time same, this will increase the number of prescribers that will have triplicate prescription pads at their disposal.
I don't know if that is a good thing.

This will work well if there is a move to ensure that there is a physician who specializes in treating addictions in every regional centre community.

Thank you for the opportunity to provide input into this Standard of Practice. I do not have anything to add ... I support this Standard of Practice and I do like that there is supportive information and that there are supportive tools available to help the clinicians in implementing this change in practice. While it will not be easy to deprescribe in this patient population, it is the correct course of action given what we know about these drugs where the harm often outweighs the benefit.
Thank you for tackling this challenging problem.

I do not prescribe these drugs very ofter but I know with the current M3P can pose problems with access for some patients.

I would recommend that you consider a couple of less abused drugs in these groups as to put them all in the M3P will I believe cause problems for patients who legitimately need these. Currently Tylenol #3 and Tramacet are not M3P and if they were I can tell you that there would be a mess with prescribing these with M3P. Perhaps you could put the similar idea behind the application for the benzodiazepine and Z drug group.

Hi: I have read through the member and stakeholder briefing. I agree that these medications need to be safely prescribed, and are at times over prescribed which can contribute to serious and occasional fatal outcomes. 15% of the Manitoba population represents a lot of patients receiving these medications.

It is unclear to me if the briefing applies to cancer patients who are getting either life saving or life prolonging treatment. Cancer patients don't fit into the general population, the palliative care population, or the end-of-life populations you have addressed, but who have complex needs that often include anxiety/depression and insomnia.

I am worried that putting time consuming processes in place like the M3P program will be a significant barrier that will hinder physicians, like me, who prescribe these medications appropriately in cancer patients. I can see that putting extra barriers in place will prevent some clinicians from appropriately prescribing these agents to cancer patients who need them.

Creating a whole new process that all clinicians have to jump through, for an issue that is complex, but may not apply to everyone seems harsh.

I wonder if other approaches, like sending reminders to high prescribing clinicians or sending letters to chronic users might be two examples of ways the College could move forward without creating hoops that every clinician must go through.

These comments are meant for consideration. I realize that a lot of work has gone into the development of the benzo standard and that many will not agree with my points.
In general, I think the document should be less redundant and shorter to that physicians are more likely to read it and consider it useful. I have created a suggested version that condenses the material from 4 pages to 2.

Many are not familiar with the meaning of the term “Z-drugs”. I think this should be indicated at the beginning of the document as Zolpidem, Zopiclone, and maybe others if they apply. (Is Zalepon available in Canada?)

I have seen some of the presentations on benzos and I am not an expert on their abuse although I prescribe low doses commonly. I just hope that the “experts” are interpreting data correctly. Is the extra caution with alprazolam caused by inherent danger in the drug itself or the fact that it was the most commonly used benzo? It seemed that everyone was taking it in the past.

The consultation letter introducing the Standard indicates that alprazolam is “disproportionately” associated with abuse and overdose. It matters if the “disproportionate” term means disproportionate frequency in abusers compared to other drugs or disproportionate compared to the number of alprazolam prescriptions. I am not aware of any pharmacological reason that alprazolam should generate more abuse. Perhaps the focus should be on prescribing philosophies rather than a specific drug. Has the drug become a scapegoat for bad prescribing? I do think that whatever drug is prescribed for psychological reasons will be associated with psychological problems, just as antibiotics are associated with infection, but are not the cause of infections. The fact that it was associated with more deaths than many does not mean that it was the cause. Patients who take benzos are likely to be people with anxiety and mental illness and those people are more likely to abuse and attempt suicide. I am not necessarily a proponent of any drug.

I am also not aware of data indicating how many suicides were prevented by or associated with various drugs, but the issue is important. These drugs do help a lot of people, particularly in low doses.

Over decades, I observe that there seems to be a benzodiazepine merry-go-round. I remember when valium was thought to be a safe, effective drug, but that changed. Then we used to routinely prescribe Dalmane for sleep but that has fallen out of favor now. Alprazolam is the current drug of attention, and I suspect that another will emerge in 5 or 10 years as bad. As long as we have new drugs maybe that is OK.

The consultation letter introducing the Standard “reminds physicians to be mindful of polypharmacy...” but physicians are not allowed permission to use DPIN so we are not able to see what other drugs have been prescribed, enabling polypharmacy. This should be changed. It is an administrative fix that could save lives. Pharmacists do not have the time to consult for each prescription.

Part 8 – “ A new start for Alprazolam must include urine drug screen testing of patients.” Is there evidence to suggest that this screening is worthwhile? A “new start” is less likely to be abused than a chronic user and more likely to have a negative urine test. Who orders the test? Does this urine test include opioids, benzos or anticonvulsants or what? After the test, what do we do with the results? Does the patient have to wait for the results before filing the prescription? Who enforces this?

The recommendation to use the lowest effective dose is prudent, but conflicts with several published guidelines that indicate that treatment should attempt to reach the maximum recommended “target dose”.

The “BENZODIAZEPINE RECEPTOR AGONIST EQUIVALENCY ESTIMATES” chart seems suspicious. I think that 10 mg of valium has much more effect than most of the others.

- Cognitive behavioural therapy, brief behavioural interventions and tapering protocols have a proven benefit in sedative-hypnotic discontinuation and are also beneficial in improving sleep.

Tapering protocols help sleep?

- The number needed to treat with a benzodiazepine and/or Z-Drugs to get improved sleep is 13, whereas the number needed to harm is only 6.

Needs a reference. This is not consistent with real world practice.

1. Reasonable efforts are to be used to optimize non-pharmacological treatment modalities first and then optimize non-benzodiazepines or non-Z-Drug treatment modalities.

...before prescribing benzos

2. To mitigate risk of harm the member must use reasonable efforts to review the patient's current and past medications utilizing DPIN or eChart or consult with a pharmacist to obtain DPIN. This will mitigate the risk of harmful drug interactions and combinations, and will prevent patients from obtaining prescriptions from multiple providers.

Physicians do not have access to DPIN and eChart is not useful for this purpose. Is it realistic to expect pharmacists to conduct a DPIN search for each anticipated prescription? Are they on board with this?

4. Long term use must be supported by current clinical evidence indicating that benzodiazepines and Z-Drugs may be appropriate for certain patients.

Vague. Which patients?

3. Discuss the following with the patient and document it in the medical record:

This is medical school stuff.

6. Appropriate use must be discussed with the patient with explicit instructions on the quantity and anticipated days supply, which must be noted on the prescription in the form of a dispensing interval.

This is already on prescriptions...

7. Only write a prescription for a maximum of three months, but never authorize the dispensing of more than a one-month supply of any benzodiazepine and/or Z-Drug. An exception to dispensing for more than one month, up to three months would be:
    a. For patients in remote communities; and
    b. For patients travelling, if the patient has been on a stable long-term prescription.

Most of my patients on benzos take, perhaps, 0.25 of ativan twice a month. Should they really come in for a renewal after every other pill?

8. Alprazolam (Xanax) has been identified as a drug with significant risks of abuse and diversion in Manitoba. Recognizing these risks, if in exceptional circumstances considering a start, the member must have extremely strong current clinical evidence. A new start for Alprazolam must include urine drug screen testing of patients. Use reasonable efforts to replace existing Alprazolam prescriptions with a longer acting benzodiazepine in accordance with the attached equivalency table. If not replaced, then document why not possible.

Evidence of what? Who decides if the evidence is adequate? Do members "posess" evidence or is it available from the literature? Perhaps "justification" is meant.

9. Members must carefully consider all concurrent medical conditions in the context of decisions to prescribe or continue to prescribe these medications:

Addressed in #5 above.

10. Combining benzodiazepines and/or Z-Drugs with themselves or with other medications compounds risk of harm:

Covered above.

Patients who are on zopiclone or benzodiazepine for years are very hard to negotiate stopping these meds. Patients gets so upset in ever reducing dose of zopiclone.
Some doctors don't use or don't like using M3P Rx
So it is very challenging to start M3P Rx for patients that had been on these meds for sometime (not even started by prescribing physician)
It is role of physicians to ensure safety of patients with these drugs.
Regulations can be set for not starting new patients on these meds except as was forementioned and only by psychiatrist

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I have reviewed the document and standards as shared by CPSM for Consultation - Draft Standard of Practice Benzodiazepines/Z-Drugs.

I believe it is a well crafted document and professional standard. My recommendation is that inclusion of Cognitive Behavioral Therapy recommendations for addressing the underling diagnosis be considered and that recommendation documented in the patients medical records. With information provided as an alternative to pharmacological approach be included in the standard as a reminder to practitioners.

My name is XXX, I'm a second-year medical student. I have received the email from CPSM requesting feedback on the draft standard of practice for prescribing benzodiazepines.

Before entering medical school, I was a pharmacist working in Manitoba. I have seen first-hand the damage inappropriate prescribing can cause. Overall I want to voice my support for this document. These changes are long overdue, and I think they will go a long way to reduce the harms I used to see on a daily basis.

I support the idea of one-month dispensing limits. I understand the exception for 3-months for those working remotely, however I encourage CPSM to implement some method of secure communication between physician and pharmacy to certify that the physician is allowing this. On a weekend, physicians are harder to reach by the pharmacy, and some ill-intentioned patients will exploit this to pressure the pharmacist to dispense a larger quantity by stating they "are going away" or "working in a remote community". This is a very difficult situation for the pharmacist, and we don't always make the right decision because we aren't able to reach the physician.

One way to solve the above problem is to establish a contract between patient, physician, and pharmacy. Having the patient only use one pharmacy for their narcotics or benzodiazepines helps the pharmacy staff get to know the patient better, and the physician can inform the pharmacy in advance of any special requests. This could help the pharmacist better assess whether patients genuinely require that larger dispensing supply.

On a different note, I support the withdrawing of coverage for alprazolam. It has no role in modern prescribing, and if we can convince Pharmacare and NIHB to withdraw coverage, it will help convince many patients to transition to a safer alternative. (unfortunately, I suspect many low-income patients sell Alprazolam on the streets to supplement their income)

Lastly, I support CPSM's goal of placing benzodiazepines and Z-drugs on the M3P list. Although it will add inconvenience for patients, it will help deter a lot of misuse. It may also help pharmacists assess patients for side effects as they will need to come in to drop off these M3P prescriptions.

Thank you for giving me this opportunity to provide feedback, and I appreciate CPSM's work on this important issue.

Zopiclone is a drug very much used in practice for extended period of times for Insomnia.
Guidelines for the treatment of insomnia includes as first-line cognitive behavioral therapy.
Unfortunately Clinical Psychology as well as Psychiatric Services in Manitoba is almost non-existent and we have to rely on private clinical psychologist.
These professionals are very good but their fee structure are very high.
As a result of these restrictions we are sometimes forced to go on to the next step and that is to prescribe pharmacotherapy despite the consequences that we are aware of.

After reviewing the draft of The Standard of Practice for Physicians Who prescribe Benzodiazepines and Z-Drugs to Patient. I have the following suggestions:

1. a patient-education pamphlet regarding the benzodiazepine and Z-drugs made available and be distributed to patients by the physicians.

2. Please include detailed information regarding the referral sources within Manitoba, such as CBT, behavioral therapy, pain clinic/specialists, addiction medicine specialist, etc.

3. any strategies or proposal that will shorten the waiting period once the referral is made?

This is an excellent document. Congratulations to the participants.

I support the Draft standard for the Standard of Practice Benzodiazepines/Z-Drugs.

After reviewing the attached draft, I disagree with including benzodiazepine and Z drugs in the list of M3P Drugs.

It is concerning to go through the attached statistics, however, it is not the time to take a step like that.

Since I received the draft email, I have been trying to counsel patients to avoid use zopiclone for insomnia and provide alternative like melatonine or Trazadone. The patients are very resistant.

I have been trying same counseling for two years since I head similar recommendation in St Paul conference in Vancouver for primary care, unfortunately, got same response from patients.

Adding those drugs to M3P drug list, would add more burden on the physicians in addition to the stressfully time we are going through now.

In my opinion, more patient awareness is needed.

Thank you for the email
some patients still asking for medications for insomnia beside zopiclone , so is it safe to prescribing temazepam in addition?

The current draft guidelines are general in nature. I compliment the steering committee for their hard work in synthesizing this generic document for our standard of practice for this very serious public health concern related to all the stakeholders involved.

This concern warrants this new standard for the potential harms of such agents. Accordingly, standards of practice must be enacted for an index to detect and investigate an extreme behaviour related to prescribing practices. This could be an enigma and could warrant inquiry.

There could be special situations considered for the prescriber related empathic attitudes, bias or prejudices, consumer diversity and difficult patients with co-occurring psychiatric and medical co-morbidities who could be impatient, impulsive and borderline in personality and the pharmacist dispenser. The prescriber is truly only able to control that arm of the prescription and must be clear with that end for the purpose of bio-safety of medication administration.

This could be complex where each stakeholder has a position related to the index point outside of the parameter or boundary of reference. The key determinant of the index point is related to the conditional balance and sensitivity combined with the ultimate awareness of the burden of responsibility.

Examination generally and then specifically into subgroup analyses related to diversity, ethnicity, social determinants of health could provide transparency so as to emphasize that one measurement may not fit all due to covariates that must be considered for solutions and or resolutions of the matter.

Additionally, I would like to raise a significant concern given that many physicians may believe, given the regulations and the impact of an infraction of such regulation would have on their personal and professional lives that they may prefer not to treat difficult patients. This may be misconstrued as a bias and/or prejudicial in expression. Notwithstanding, each physician could have preferences for their safety and their rights from legal regulatory challenges.

A constituent part or ingredient of this index standard could include a qualifier for diversity of all stakeholders including their cultural identity and social determinants for an empathic attitude by the regulatory inquiry investigator and committee.

A specific statement should encompass subgroups that have certain characteristics, previous drug dependency and social determinants of health that induce vulnerabilities for dependency and the difficulties in the induction of durable and tolerable control and/or possible curative solutions for that group with effectiveness.

Such patients with covariates such as previous drug dependency, prescription and non-prescription, socio-economic status, mental health, cognitive disabilities, lack of impulse control could be extremely difficult for the primary care practitioner.

Accordingly, a primary care or other practitioner that takes on this endeavour must be impeccable with integrity, be open to for a critical inquiry and make no assumptions about the consumer or the vendor.

Mostly, the prescriber of the prescription must have all parts of the prescription inserted and the inscription and subscription must be signed with conviction and authority and without the press of urgency.

These standards are sufficient for the norm but not necessarily for every patient or physician who could be *outliers*.

I believe that a statement of empathic attitudes regarding each stakeholder may be provided for in this index standard prior to finalizing the draft as a virtual document gold standard of this our public concern subject to change and evolve overtime with more evidence.

I fully support the DRAFT for Benzodiazepines and Z-Drugs.
I have no changes to suggest.
Congratulations to all the members of the working group.

Benzodiazepines rarely the preferred or sole drug of abuse. The 80 % of benzodiazepine abuse is part of polydrug abuse, most commonly with opioids. (**Addiction Benzodiazepines :Part** I **American Family Physician. Apr 2000 15;61 (7) :2121-2128 and Part II(American Family Physician.2000 Apr 15;61(8):2401-2408.)**

The estimated 11-15% of adult population has taken a benzodiazepine one or more times during preceding year. Only 1-2% developed tolerance/addiction. Therefore, as such addiction rate is very low.

Alprazolam is highly lipophilic, short acting drug. This drug is very effective for short term treatment. In my experience, it causes less anterograde amnesia and sedation as compared to other drugs. However, I am not regular prescriber of Alprazolam.

In my opinion, Alprazolam is safe drug if prescribed after appropriate assessment. ***It should not be removed from Manitoba Drug Benefits and Interchangeability Formulary.***
Physicians who overprescribe can be characterized by the four "Ds"--- dated, duped, dishonest and disabled.

Above mentioned reference article is very useful to address some of the concerns.
Other concerns I have that some of ***pharmacist(s****) are dispensing* ***opioids (Tylenol I) and antihistamines (sedative effect****) large quantity (DRUG INTERACTIONS AND POLYPHARMACY) without any assessment*. Nursing professional restricted not to prescribe benzodiazepines ,opioids and Z-drugs including anti-depressants because of limited training.

This email is with regards to your consultation to change the standard of practice for prescribing benzodiazepines and Z-drugs. If council moves forward to removing Alprazolam from the formulary and requiring an M3P to prescribe benzodiazepines and Z-drugs I feel we would be heading in the right direction towards decreasing tolerance, dependence, addiction overdoses, and deaths across the province.

I read with interest the proposed prescribing practice changes for benzodiazepines and Z-drugs. I have two comments regarding the proposed practice standard.

First, the charting requirements are quite involved- how does the College propose to enforce this standard of care? Will it only be enforced for “flagged” physicians?

Second, I have no difficulty with the drugs moving to MP3 prescription as a way to deter prescribing. I am not convinced that the charting requirements are necessary.

Suggestions
By all means to avoid those drugs in elderly Before prescribing assess risk of addiction (Hx of substance use disorder ,life style ETOH use ,FHX mental health issues ,social Hx Revisit and reassess patients need for the therapy to continue ,potential benefit vs harm Aim for short term therapy Restrict amount refilled by fax or phone Review alternatives (different class of medications ,CBT ,life style changes ,behavioural approaches)

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it looks like a good plan,regarding benzo and Z drugs prescription.

I am in agreement with the Draft Standard of Practice (as shown) to be implemented.
Benzo's (all) and Z drugs should be on the M3P list (in my opinion) or at least prescribed in a similar way as Tylenol #3 is prescribed with no "repeats".

I found the draft to educative, & beneficial to patients. It will need to be implemented.
There are few patients, who suffer from insomnia, where none of of the medical and / or non medical alternatives to benzodiazepines do not work at all.
A judicious use of benzodiazepines, with explanation should be allowed on a case by case basis. This is in addition to the elencated exceptions.

I read the draft for standards of the above meds.

Having these on a triplicate will be problematic. There are many MD groups that do not carry triplicates as they are “too much work,” and as a result rely on other MDs to prescribe these meds. Putting these meds on a triplicate will worsen the this problem. Patients will potentially need to see more than one

doc for the same problem, causing increasing healthcare costs, delaying care while waiting for appointments and potentially having withdrawal problems while waiting for a prescription from another MD.

The other problem is only having a month supply at a time. This is a huge cost and inconvenience for patients. They end up paying for 3 dispensing fees (for 3 separate prescriptions) instead of one dispensing fee. Also, they need to physically pick up or have someone pick up their meds (or have delivered which increases cost) 3 times as often.
If you can't trust the patients you are prescribing these meds to use appropriately, you shouldn't be prescribing them. Penalizing them with inconvenience and higher cost is not a solution to correct prescribing practices and frankly, just an avoidable extra cost for patients.

Please take these into consideration,

May 28th 2020

Feedback re Draft Standard of Practice for Prescribing Benzodiazepines and Z-Drugs

While overall I think the Draft Standard of Practice is a good document, there are a few areas I would like to comment on.

~ It is difficult to draft a document which addresses all patients taking a benzodiazepine. As described in the accompanying Psychiatry article, there are many patients who continue on a low dose of benzodiazepine for many years without escalating their dose. It might be useful to emphasise that the prescriber should be watchful for escalation of dose & particularly cautious in regards to high dose use.

~ I wonder if it will be very burdensome for the average doc in practice to have to write a M3P prescription for every benzodiazepine or Zdrug. Will FAXing of these prescriptions be allowed?

~I think there needs to be a stronger highlighted statement about avoiding abrupt termination of a long term benzodiazepine prescription. This should specifically describe withdrawal symptoms & risk of seizure & psychotic symptoms with abrupt termination of a prescription particularly if it is for a higher dose or higher potency benzodiazepine & specify that tapering is recommended. As we saw when college guidelines on opioid prescribing were published, in some cases, doctors abruptly discontinued opioid prescriptions resulting in acute distress for their patients.

Emphasise counseling or therapy to manage anxiety & withdrawal symptoms & that this would increase the likelihood of successful tapering by giving the patient new skills rather than relying on pills.

~ In regards to the warnings about combining sedatives, I think it would be appropriate to specifically mention diphenhydramine (Gravol, Nytol) as this frequently contributes to overdose deaths & is usually not considered to be a risk by most doctors.

~Alprazolam: I think the wording in the guideline could be stronger here. In regards to justification for starting a new prescription for alprazolam, I wonder what "extremely strong current clinical evidence " you are anticipating?

In regards to switching from alprazolam to another benzodiazepine, I suggest replacing "reasonable effort" with " every effort"

~I fully support the plan to remove alprazolam from the Manitoba Drug Benefits and Interchangeability Formulary as there are significant problems associated with the use of alprazolam. Rebound anxiety between doses & escalation of doses is common & high dose abuse of alprazolam is frequently seen in addiction treatment.

Unfortunately, removal from the formulary may not have a significant impact on the problem of high dose benzodiazepine abuse & overdose deaths, as high dose users will probably switch to another benzodiazepine. I note that in the attached psychiatry article, clonazepam was the benzodiazepine of choice for high dose users in 2008, & I recall that in the early 1990s high dose use of Diazepam was a problem.

Looking back to when Oxycontin was removed from the Formulary & we thought this would be helpful in tackling the opioid problem. It actually resulted in more severe problems when people switched to IV use of hydromorphone & fentanyl.

We can't always anticipate the unintended effects of our interventions.

It will be important to have adequate resources to treat patients presenting with anxiety symptoms rather than relying on benzodiazepine prescriptions to give quick but temporary relief of symptoms. We will also need resources to support those who are tapering off benzodiazepines.

Thank you for your consideration of these comments.

Agree about recommendations
Agree about add z-drugs and benzodiazepines to MP3

Concern about chronic use pt that coming to our practice and already taking benzodiazepines for long time and very resistant to start tapering it

---

I have reviewed the document and think approach is appropriate. Suggestion of triplicate will improve control as suggested. Tapering of benzodiazepines might be challenging on population with prolonged use as you describe.

I read Draft & agreed with Standards for Benzodiazepine/ Z Drugs

I will follow Guidelines in my practice

As a family physician working in the Northern Community, I find myself dealing with a lot of patients on benzodiazepines or Z drugs. Managing these patients is very challenging especially when they are on

these medications for a long time. I believe that having an evidence-based standard of practice for prescribing benzodiazepines and Z-drugs is a great idea.

I have read the document, great information about the situation.

We have some minority of people on these drugs.

We will be setting a goal to control supply and decreasing the dose and ultimately stop these drugs.

More trouble will be seen with the people who are already addicted and on these drugs for years.

We will try to play our part with our best effort.

First of all I would like to say thank you for providing me an opportunity to give feedback on standard of practice for prescribing benzodiazepines and Z Drugs. I reviewed it and I found it very interesting and informative. It's very long awaited. I'll try my best to apply these standards in my practice and try my best to counsel my patients regarding addiction potential and will try my best to cut patients down who are already on either alone or in combination with opioids, benzodiazepines, gabapentin, SSRIs and zopiclone.

Clinical assistant.

The road to treat the already addicted patients is a difficult road, the patient usually stats that "you don't feel the pain I have".
Some of these patient have a very good reason to keep taking these drugs, Chronic LBP (not surgically amenable); generalized fibromyalgia,
Chronic fatigue syndrome, etc.
In my practice I have had terrible cases, others, a few, very good results.
What I felt is missing is a sociological explanation to this problem, in my opinion this is caused by Poverty, which is an element that nobody
has been able to eradicate from any society.
My commitment is that I will keep trying to remove the drugs as many as possible.

Is there any thought about how to deal with this matter.?

We have already faced so many obstacles after applying narcotic standard of practise in Manitoba like: long waiting for pain management clinic, no access or lack of access to services , lack of found for certain services that not covered by Manitoba health or even private insurances .
2. Lack of clear guideline for practitioners and lack of education for public:
There was same issue with narcotics standard of practise . We faced so many angry , upset patients who suddenly found out their medication dosage will be ajust and will receive monthly supply and down

the road may not been on narcotics for pain control. I think we need to educate publics about this matters before we surprise them with another standard of practise.
3. Same understanding about standard of practise across provinces and between all family doctors and specialist.:

We have faced a difficulty to convince patients after specialist or emergency doctors prescribed narcotics for patients in emergency and or inpatients setting. I personally encountered situation that patients received narcotics or Benz in above setting and advised to see family doctor for either continue care or further management.

At the end ,I would like to take the opportunity to thank CPSM for taking action to
control Benz misuse in Manitoba and hope it helps to lower family physicians and healthcare providers burnout.

With regards to the statement, “A new start for Alprazolam must include urine drug screen testing of patients,” what will the guidelines be concerning the results of such a screen? Will a review of the results of the screen be necessary before actually providing the prescription? This might not always be practical.

“Only write a prescription for a maximum of three months.” I think I know what that means, but I want to be fully certain that I understand. Does this allow for future prescriptions for the same medication after three months time? Does it instead mean that after the initial three months one must choose a completely different treatment, assuming that some sort of treatment is still indicated?

Very well conceived and written document. As I was aware of its coming, I started many months ago to specifically review those patients who are taking Alprazolam. Although they are relatively few in number, all were initiated on Alprazolam and maintained by a treating psychiatrist. Some of these clinicians are now retired, and the burden of prescribing Alprazolam now falls to the family physician. To be very frank, I have greater success in tapering opioids than Alprazolam. Although I have a much larger number of patients on opioids, the challenge with Alprazolam is greater. Of course that does not remove the requirement for continuing to try, but patients are very satisfied with their Alprazolam and do not seem to be quick to change. The entire process will be very challenging for our profession, but very worthy of our best efforts. This culture of drug-induced well-being will be difficult to alter. After all, anxiety and insomnia truly impact upon our activities of daily living and the qualities of our lives. Thank you for your attention.

I have discussed your draft standard with my colleagues who work with me in the Seizure/Epilepsy Clinic at Health Sciences Centre (Drs. XXXX, XXXX, and XXXX) and wanted to provide the following comments regarding the Draft Standard of Practice.

I recognize that you have specifically stated that it does not address prescribing for acute seizure disorders but I think our concerns need to be taken into account to prevent restricted accessibility to an important class of medications in the treatment of seizure disorders. I

recognize the reason behind the Draft Standard of Practice and we have no objection to the desire to curtail unnecessary prescription of these medications.

Clobazam is a benzodiazepine which, to my knowledge, is never prescribed for anything but seizure prophylaxis. Clonazepam, a long-acting benzodiazepine, is also used on occasion for prophylaxis. Its use increased a few years ago when a shortage of Clobazam resulted in many patients being switched to Clonazepam, some of whom did not switch back. Requiring an M3P prescription for these medications would place an unnecessary impediment to prescribing these medications without dangerous gaps in continuity. M3P prescriptions require that a physical prescription with a short duration of validity be given directly to the patient. Many of our patients live in remote communities or are from poor socioeconomic backgrounds so increasing the frequency with which they need to attend clinic appointments is a significant burden. Additionally, accessibility to the Seizure Clinic would decrease if we needed to increase follow-up appointments for these patients.

Lorazepam and Midazolam are used as rescue medications to abort a prolonged seizure or cluster of seizures in patients with epilepsy and can reduce the need for Emergency Room visits. They also give an important element of control to patients and their caregivers. These are generally prescribed in small quantities and renewed on a regular to ensure a stock of medication does not expire.

I would recommend that if you proceed to require M3P prescriptions for benzodiazepines or in some other way restrict prescribing of these medications then you provide an exception for Clobazam and Clonazepam where the prescription states that the medication is being used for the prophylaxis of a seizure disorder. Similarly, an exception for Lorazepam and Midazolam where the prescription states that it is for the purpose of abortive therapy for a seizure disorder would be warranted.

Thank you for your attention to this matter and for giving us an opportunity to provide this feedback.

Draft for standard to practice Benzodiazepine and Z drugs, was reviewed. It is well organized, helpful and clear to follow.

I read the draft that was sent by the college in regards to the standards of practice for prescribing Benzodiazepines and the Z-Drugs. I found these standards to be balanced, acceptable, and very achievable. Thank you.

I reviewed the draft with the standards of practice for prescribing Benzodiazepines and Z-Drugs. I believe that these standards are well balanced and acceptable. Thank you.

I have been doing some serious procrastinating with respect to reviewing the draft. I am absolutely thrilled with it. I provided countless prescriptions for Ativan 1 mg tabs times 10 tabs. I would tell my patient that if they returned in a week needing more, we would have one discussion. If they returned in six months needing more we would have a very different discussion. I am not sure whether one can teach common sense, but the expectations within the standard will help ensure common sense practice.

I have one suggestion. In section 8 it suggests using "reasonable efforts to replace existing alprazolam prescriptions with a longer acting benzodiazepine in accordance with the attached equivalency table". I would suggest identifying which benzodiazepines are longer acting on the table. I think I knew that stuff 20 years ago when all of these drugs were coming online, but I would have to personally look up the pharmacokinetics (and then probably pick diazepam). Showing which ones are longer acting will make it easier for the docs.

May 21, 2020

To: CPSIVI
cpsmsopbenzo@cpsmmb.ca

RE: Standards of practice for prescribing Benzodiazepine and Z. drugs

I reviewed the long document, it is very important to create a comprehensive standards of practice for prescribing benzodiazepine and Z. drugs. I think it is a multifactorial problem why the benzodiazepine use has increased since 1960 for the last 60 years. It is a societal problem way of life.

1. **It is mostly social isolation, nobody has a times for other human beings, family, children relations the whole family and friends structure Is eroded, lonely person only rely on medication.**
2. **There is a lack of specialist and long waiting list to see as consultant, psychiatrist, and psychogeriatric and pain management dinic.**

I hope we can find the root cause why the benzodiazepine and Z drugs are increasing. Once w we find the root cause for the excessive use of benzodiazepine and how to relieve the suffering and pain of our patients, who rely only on benzodiazepine. Maybe with more study we will be able to find the alternate treatment to help our suffering patients population decrease, pain, loneliness and suffering in Isolation. It is a good start to find a reasons also to learn a lesson from Covid 19 isolation. It has increased human fears, human being Is fearful of each other and the isolation has Increase the risk more anxiety, depression, anger and frustrations. Psychosomatic type pains and various psychosomatic complaints. More people complaining insomnia, depression, anxiety and panic attack.

I hope this is satisfactory

Sincerely yours,

May 28, 2020

Dear Dr. Ziomek and members of the committee,

I would like to submit my thoughts on the DRAFT Standard of Practice for Prescribing Benzodiazeoines and Z-Drugs.

I fully support examination of this issue and especially how the medical community can address the ongoing crisis of opioid deaths. Effective guidelines will require a nuanced approach in order to address the complexity of the issues involved.

The DRAFT Guidelines begins with what I see as a potentially patronizing reminder that *"Every member is professionally responsible for each prescription the member provides to the patient."* When is a physician not professionally responsible for any and every prescription they provide a patient?

Broad, over-arching guidelines may fail to recognize that different patient populations have different needs and face different risks. From 2001-2011, I worked as part of an assertive community treatment team that provided care to a group of patients with severe and persistent mental illness, primarily psychotic illnesses. More than a third of this population wrestle with co-occurring substance use problems. In working with this population I almost never prescribed benzodiazepines or Z-drugs.

Since 2011 1 have worked in a private practice setting, while also consulting one day a week at the Operational Stress Injury Clinic. I see patients only in consultation through a family physician or other health professionals. Patients often come with complex, longstanding and often refractory symptoms. Sleep issues as a primary or co-occurring symptom are common. For patients with mood disorders sleep is often a problem even between episodes of mood disturbance. For those experiencing mania or hypomania it is without question necessary to regulate sleep in order to get control of the symptoms.

The recognition of misuse of these medications especially in a small group of individuals with substance use issues is important. However an over-reaction by prohibiting use of these effective agents will have a broad impact. It will likely work counter to helping physicians to focus on collaborative decision making discussions with patients. A significant part of my clinical time is spent discussing with patients the risks and benefits of medications, various therapies,

ECT, rTMS etc... I rarely dictate decisions but much prefer laying out options. My patients (with few exceptions for individuals with competence issues) are able to weigh the risks and benefits and make the decision.

In February 2020 I attended the Winter Seminar Psychopharmacology Master Class given by Dr. Carl Salzman under the auspices of Harvard Medical School. In the seminar on anxiolytics and hypnotics Dr. Salzman addressed the issue of state organizations restricting use of these medications. He commented to the more than 200 psychiatrists in attendance that, in his opinion, there seemed to be *"a kind of hysteria"* around this issue. He pointed out that these medications undoubtedly have a role in treating ongoing mental health concerns. My understanding is that clinical research has shown that patients can use Z-drugs at stable doses over the long term and that this group of medications is not prone to tolerance and dose-escalation.

Untreated chronic insomnia and anxiety take a huge toll on patients' lives. Using existing tools, with necessary cautions and limitations, can help ease these burdens. Guidelines that implicitly intimidate physicians to avoid using such tools will be unfortunate. I fully support taking steps to lessen the tragic effects of the opioid crisis. I question whether such guidelines will indeed do so.

I appreciate the CPSM going to the trouble of soliciting input from members and thank you and the committee for reading my comments.

Sincerely,

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M.D. FRCPC

Further to my submission yesterday I wanted to bring your attention to a relevant article published in the AJP in Sept 2019 which I suspect you are already aware of titled

Reducing Suicidal Ideation Through Insomnia Treatment (REST-IT): A Randomized Clinical Trial https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2019.19030267

The authors conclude that

"Although the results do not support the routine prescription of hypnotic medication for mitigating suicidal ideation in all depressed outpatients with insomnia, they suggest that coprescription of a hypnotic during initiation of an antidepressant may be beneficial in suicidal outpatients, especially in patients with severe insomnia."

Regrettably, I missed the deadline for feedback on the proposed standard on gabapentin and benzodiazepines. I hope you can still accept my view for consideration. I have itemized my ideas below.

1. The rational underpinning the need to develop a standard pertains to data which demonstrates that when examining drug overdoses in our province, these two drug groups are over represented. I would argue that attempted or completed suicide is driven by factors that are not drug specific. Rather, they are due to psycho-social problems and/or mental health problems. I am not aware of data that demonstrates that by removing access to a particular drug we can reduce rates of attempted or completed suicide. My understanding of the opiate literature is actually quite the opposite. On demand access to safe injection sites has decreased the overdose rate for opiates. As much as I find social problems troubling, I am far more troubled by the fact that the document supports the notion that as physicians we can have substantial impact on these complex problems with singular actions like becoming more reflective on our prescribing of gabapentin and benzodiazepines.

2. I work with patient who have chronic functional pain. I agree that the data for opiods, gabapentin and benzodiazepines is not robust. However, this can be said for many drugs that I use. In my specialty for example, Crohns' disease demonstrate a mere 20% remission rate to biological therapy: 80% of users will not achieve remission. The drug is costly and associated with a myriad of serious risks. Yet, I offer this as first line therapy to patients with even modest disease due to the absence of other effective therapies. I can offer examples in GI oncology where the response and cure rates are even more dismal with horrendous side effect profiles for example, metastatic pancreatic cancer. Thus, the lack of robust data for gabapentin does not dissuade me from using it in debilitating conditions when other effective therapy is absent.

3. In patients with chronic functional abdominal pain I am often aiming to discharge them from an emergency room and provide them with tools to manage their pain and avoid hospital presentation. I use opiods and benzodiazepines regularly in this particular situation. The patient needs to be selected, educated and overseen. This is a very time consuming component of practice. I worry that by creating doubt about utility and concern about suicide, the standard will be inadvertently used by many colleagues as an opportunity to disengage from this patient population. I urge the authors of the document to reflect and provide guidance to mitigate against this predictable response from physicians.

3. Despite being in a teaching hospital, I have seen several patients suffer either seizures or delirium when an eager young physician has abruptly stopped long term benzodiazepines. Their indication for doing so pertained to wanting to tackle the benzodiazepine problem. I was glad to see that guidelines were provided about how to taper a benzodiazepine. I would urge underscoring that it is vital to first ask whether the benzodiazepine is causing any ill effects. In my view, societal issues with drug misuse should not negatively impact an individual patient who is using a drug for a defined health problem and receiving the desired benefit.

4. It is indeed appropriate to seek consultation with a pain specialist and explore non drug approaches to pain. However, the proposed document should explicitly recognize that time to consultation with a pain specialist may exceed a year and most patients cannot pay the costs of psychological assessment and treatment. Therefore, there should be recognition that the physician and the patient may be forced to make drug therapy the mainstay of the treatment plan due to absence of other feasible options.

In my view, the College has identified a very difficult societal problem, namely, high rates of attempted/completed suicide or recreational drug misadventure. My understanding is that this problem is steadily increasing across all socio-demographic groups. In my view, setting standards for prescribing of drug classes is an ill-conceived approach to the problem as outlined above. I worry about the unintended consequences to the patients whose conditions often require us to consider therapy that has risks and lacks robust data. We do this daily for a myriad of medical diseases and should continue doing so for patients with chronic pain.

Responses from Other Professions And Stakeholders

Thank you for the opportunity to contribute to the consultation on the Draft Standard of Practice Benzodiazepines/Z-Drugs.

COTM will defer to those with the knowledge and experience to be able to provide you with the fulsome feedback you are seeking.

Nevertheless, we do acknowledge how important this work is to support the health and well-being of Manitobans.

College of Occupational Therapists of Manitoba (COTM)

As a nurse practitioner working with people who use drugs and alcohol in Manitoba I fully support the proposed changes to remove alprazolam from the formulary and include benzodiazepines and z-drugs on the list of M3P drugs. These changes in combination with drafting a Standard of Practice will hopefully decrease over dose and allow for better screening of substance use in primary care.

On behalf of the College of Physiotherapists of Manitoba, I would like to thank you for the opportunity to comment on your draft Standard of Practice Benzodiazepines/Z-Drugs.

We congratulate you on recognizing the need for this new Practice Standard and the work that has ensued thus far. Physiotherapists are interested in this Standard of Practice because we find that Valium is often a contributor to falls and mobility issues in our shared clients. We also recognize the addictive nature of these drugs.

The completion of your work on this project will benefit many Manitobans. Thank you.

Thank you for providing us with the opportunity to provide feedback on your draft standard of practice for prescribing benzodiazepines and z-drugs.

From a dietetics perspective, we do not have any concerns from with the content. We did note that there was no mention of potential drug-nutrient interactions or interactions with herbal supplements, however, perhaps communicating this type of information falls more within the responsibilities of the pharmacist.

We also noted, in item 9 b., that patients are to be regularly screened for the presence or emergence of potential mental health disorders, however there are no parameters provided for this screening. For example, is a specific tool to be used, are patients to be screened by a mental health practitioner, etc. There could be variability in how this particular item in the standard is interpreted.

Please let us know if you have any questions regarding the above comments.

College of Dietitians of Manitoba

Firstly I would like to applaud the College for the actions they have taken in preparing and undertaking this Standard of Practice. The data supporting the need for a new standard is certainly eye-opening. As a community pharmacist in the Prairie Mountain RHA, I can certainly attest to the prevalence of BZD and z-drug prescribing and the awkward position we are put in as pharmacists when a technically valid prescription is presented to us where the benefit is less apparent. A more stringent standard as drafted will certainly support any efforts we make at reducing the impact of the harm these drugs may cause.

I would certainly also support both measures listed in the consultation document: the addition to the M3P list and de-listing of alprazolam. Perhaps the removal of alprazolam could be step-wise allowing for a transition period where patients could be tapered and/ or switched. One suggestion I would make is a requirement for the prescriber to use some type of screening/risk assessment tool (similar to the opioid risk assessment tool) to formally assess patient risk *prior* to initial prescribing or within a defined period for "grandfathered" or previously treated patients. Such a process would help bring proper attention to the risk vs. benefit of prescribing these drugs in the critical initiation phase and may alleviate some of the pressure to prescribe that some practitioners must feel. Again, highlighting the risks for diversion and abuse is of critical importance. In my practice, I have seen benzodiazepine prescriptions for patients as young as in their teens and obviously in vulnerable situations where misuse or diversion is a high risk and have felt obligated to refuse to fill or otherwise intervene.

Finally, I would like to highlight the role pharmacists can play in the deprescribing of these drugs. With a high level of knowledge of dosage forms, equivalencies, tapering tools and the potential for compounding intermediate dosage forms when necessary, as well as often the most frequent contact with our shared patients, pharmacists can and should often play an active role in planning and providing feedback during and after benzodizepine and z-drug tapers. I, for one, would be more than happy to collaborate with physicians in preparing tapering schedules and making regular contact during the progress. Of course, this in no way should substitute for in office assessments, but as our current pandemic is teaching us, we have to be creative and use all resources at our disposal. I would like to see a joint effort among pharmacists and physicians to work on this issue, including reaching out government to create funding models to support deprescribing with pharmacists referral, initiation and assessment models and commensurate tariffs for physicians for their efforts in deprescribing. I would encourage Doctors Manitoba and Pharmacists Manitoba to spearhead efforts to this effect

Thank you for your continued efforts in enhancing patient safety and for the opportunity to provide feedback for this very important endeavour.

Pharmacist/Manager

On behalf of CPSA, thank you for allowing us the opportunity to review the draft prescribing standard and share feedback.

Members from our Physician Prescribing Practices Department (a physician and two pharmacists) provided the following:

> Overall, a strong, easy to follow document. It's different from CPSA's approach in that the standard does not include other drugs with a potential for harm/misuse, such as opioids. There is overlap in prescribing best practices between BZRAs and opioids, but CPSM may have a different plan of action than us in this regard.

What we found in AB when our standard of practice went out was that certain physicians interpreted it as no patients should be on these medication or that patients should be immediately tapered, which wasn't our intention and can do more harm than good. To minimize unintended negative impact on patients, a clause that addresses abrupt discontinuation or rapid tapering may be useful.

Another point to possibly consider could be to include advice on not refusing to accept new patients because of their medication regimen, unless this is covered in a separate standard.

In #8, there is a clause to require UDS before each alpraz initiation: we have mostly shied away with being prescriptive on the UDS question, as it is impractical for AB physicians. The situation in MB may be different, and there may well be good reason for the approach taken. If this is to be, we would suggest including resources on UDS and proper interpretation of test results.

There are a few minor comments in the attached document.

If you have any other questions or require additional information, please let me know how I may be of assistance.

CPS Alberta

DRAFT

Schedule N - Prescribing Benzodiazepines and Z-Drugs (including Zopiclone and other drugs)[1]

PREAMBLE

This Standard establishes the standard of practice and ethical requirements of all members in relation to prescribing benzodiazepines and/or Z-Drugs for maximum safety for all patients whether in the community or in a health care facility. **This Standard does not apply to the use of these drugs in the treatment of palliative and end-of-life patients, acute seizure disorders, bipolar/psychotic disorder, and alcohol withdrawal.** Medical evidence of the risk to benefit ratio of prescribing benzodiazepines and/or Z-Drugs is altered over time, so prescribing these drugs must be in accordance with current medical knowledge. These drugs are a known major contributor to a significant number of prescription medication-related deaths including opioids, especially due to polypharmacy, in Manitoba. This Standard recognizes that:

- Every member is professionally responsible for each prescription the member provides to the patient.
- In prescribing benzodiazepines and/or Z-Drugs each member provides their clinical judgment, which is to be that of a member acting reasonably in the circumstances with current medical knowledge.
- Initiating benzodiazepines and/or Z-Drugs in hospital substantially increases the risk of long-term use and dependency.
- Cognitive behavioural therapy, brief behavioural interventions and tapering protocols have a proven benefit in sedative-hypnotic discontinuation and are also beneficial in improving sleep.
- The number needed to treat with a benzodiazepine and/or Z-Drugs to get improved sleep is 13, whereas the number needed to harm is only 6.

STANDARD OF PRACTICE

1. Reasonable efforts are to be used to optimize non-pharmacological treatment modalities first and then optimize non-benzodiazepines or non-Z-Drug treatment modalities.

2. To mitigate risk of harm the member must use reasonable efforts to review the patient's current and past medications utilizing DPIN or eChart or consult with a pharmacist to obtain DPIN. This will mitigate the risk of harmful drug interactions and combinations, and will prevent patients from obtaining prescriptions from multiple providers.

[1] See Table near end for drugs included in this Standard.

Commented [FG1]: Note- List in the companion brief includes akathisia in the exclusions, but not bipolar/psychotic disorder

Commented [FG2]: Suggest adding recommended frequency for re-checking, e.g. q3months for pts on long term BZRAs or before every rx/refill

3. Members must prescribe the lowest effective dosage of benzodiazepines or Z- Drugs for the shortest possible duration and only exceed the maximum recommended dosage in exceptional circumstances.
4. Long term use must be supported by current clinical evidence indicating that benzodiazepines and Z-Drugs may be appropriate for certain patients.

Commented [FG3]: For #3 and 4, suggest adding a note to document rationale.

5. Discuss the following with the patient and document it in the medical record:
    a. Treatment goals including specific and realistic goals and an eventual possible discontinuation strategy;
    b. Non-pharmacological therapies;
    c. The benefit of long-term benzodiazepines and Z-Drugs treatment is modest; d. Risks; and
    e. These drugs cause impairment. Advise them of the dangers of driving, operating heavy machinery, or performing safety sensitive tasks, providing child or elder care if impaired.

6. Appropriate use must be discussed with the patient with explicit instructions on the quantity and anticipated days supply, which must be noted on the prescription in the form of a dispensing interval.

7. Only write a prescription for a maximum of three months, but never authorize the dispensing of more than a one-month supply of any benzodiazepine and/or Z-Drug. An exception to dispensing for more than one month, up to three months would be:
    a. For patients in remote communities; and
    b. For patients travelling, if the patient has been on a stable long-term prescription.

Commented [KS4]: ...and risks have been assessed.

8. Alprazolam (Xanax) has been identified as a drug with significant risks of abuse and diversion in Manitoba. Recognizing these risks, if in exceptional circumstances considering a start, the member must have extremely strong current clinical evidence. A new start for Alprazolam must include urine drug screen testing of patients. Use reasonable efforts to replace existing Alprazolam prescriptions with a longer acting benzodiazepine in accordance with the attached equivalency table. If not replaced, then document why not possible.

Commented [KS5]: If UDS is possible,then screening seems reasonable.

9. Members must carefully consider all concurrent medical conditions in the context of decisions to prescribe or continue to prescribe these medications:

a. Heart failure, obesity, sleep apnea, chronic lung disease, and renal or hepatic insufficiency and other chronic conditions or pregnancy compound the risk of these medications in unique ways.
b. Patients must be regularly screened for the presence or emergence of mental health disorders (particularly mood disorders) which may complicate management.
c. In the course of managing patient care on these drugs (particularly while tapering), a substance use disorder may develop or reveal itself, and physicians must be able to appropriately diagnose and manage the patient's care needs. Appropriate care management can include referral to a physician with expertise and can include slow tapering of benzodiazepines and Z-Drugs to minimize the effects of withdrawal and does not include abruptly discontinuing these drugs.

10. Combining benzodiazepines and/or Z-Drugs with themselves or with other medications compounds risk of harm:
    a. Determine the lowest effective dose of benzodiazepines and/or Z-Drugs needed to achieve or maintain the treatment goals and periodically consider a trial of slow tapering. Use tapering guidelines and equivalency tables attached to this Standard of Practice. Where tapering is not feasible, if there is documented benefit to the patient, then continue with the treatment. Tapering of long term benzodiazepines and/or Z-Drugs is very difficult, though not impossible.
    b. If prescribing benzodiazepines and/or Z-Drugs, physicians must document their advice to patients that they must avoid other central nervous system and respiratory depressants including alcohol, cannabis, and some over-the-counter medications.
    c. Physicians must exercise caution in prescribing these drugs with muscle relaxants, sedating antidepressants, anticonvulsants, antipsychotics and other sedating medications.
    d. If patients with complex care needs are receiving multiple sedating medications, the physician must consider seeking the opinion of relevant consultants such as psychiatrists, pain specialists, addiction medicine specialists, pharmacists, and others to work toward a collaborative medication regimen that minimizes risk as much as possible.
    e. Only in exceptional circumstances prescribe opioids together with benzodiazepines and/or Z-Drugs. Patients must be informed of the increased risk of death with this combination, and the discussion documented.
    f. Only in exceptional circumstances prescribe two or more benzodiazepines and/or Z-Drugs concurrently unless in the context of a taper.

Commented [KS6]: ...and SUD/addictions (current or past)

Commented [KS7]: Support materials could include a template for discussions &/or tx agreement.

OLDER ADULT PATIENTS

11. Benzodiazepines and/or Z-Drugs have been identified as problematic medications for use in older adults and carry significant risks. Large scale studies consistently show that the risk of motor vehicle accidents, falls and hip fractures, leading to hospitalization and death, can more than double in older adults taking benzodiazepines and/or Z-Drugs. Older patients, their caregivers and their health care providers should recognize these potential harms when considering treatment strategies for insomnia, agitation or delirium.

12. For older adult patients recognize that new starts of benzodiazepines and Z-Drugs must be carried out with extreme caution and not be used as first choice for insomnia, agitation, or delirium, nor for managing behaviours arising from dementia and delirium.

13. Ensure that dosaging takes into consideration declining renal, hepatic and cognitive function in older adult patients.

Commented [KS8]: Dosing?

Commented [KS9]: And polypharmacy

14. In prescribing for older adult patients, the member must recognize and discuss with the patient additional risks, including but not limited to:
    a. Falls and subsequent fractures related to sedation, confusion, drowsiness and postural instability;
    b. Impairment of psychomotor skills, judgment, and coordination increases the risk of motor vehicle and other accidents;
    c. Negative effects on cognition, memory, delirium and a possible link to cognitive decline and dementia.

APPLICABLE DRUGS FOR THIS STANDARD

Commented [FG10]: Suggest a clause discouraging abrupt withdrawal or ultra-rapid tapering

Commented [KS11R10]: I second that! See algorithm below.

Benzodiazepines		Z-Drugs
Alprazolam (Xanax®)	Lorazepam (Ativan®)	Eszopiclone
Bromazepam (Lectopam®)	Midazolam (Versed®)	Zaleplon
Chlordiazepoxide (Librium®)	Nitrazepam (Mogadon®)	Zolpidem
Clobazam *to be started by Neurologists only	Oxazepam (Serax®)	Zopiclone
Clonazepam (Rivotril®)	Potassium-Clorazepate	
	Temazepam (Restoril®)	

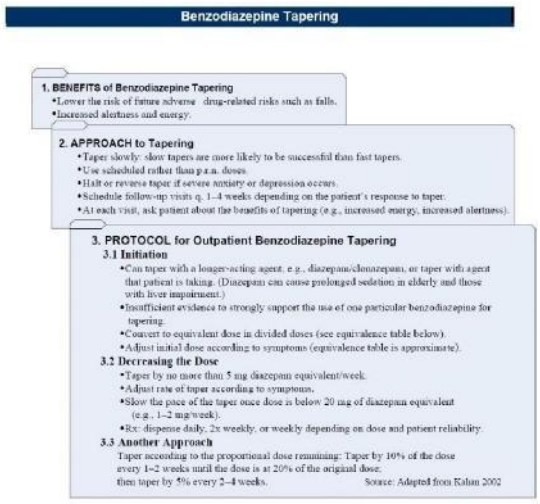
Diazepam (Valium®) Flurazepam (Dalmane®)	Triazolam (Halcion®)	

BENZODIAZEPINE RECEPTOR AGONIST EQUIVALENCY ESTIMATES (Diazepam 10 mg as reference)

	Ashton	Kalvik et al.	Shader & Greenblatt	Alessi-Severini et al.
Diazepam	**10 mg**	**10 mg**	**10 mg**	**10 mg**
Alprazolam (Xanax®)	0.5 mg	1 mg	1 mg	1 mg
Bromazepam (Lectopam®)	5 mg	6-12 mg	NA	10 mg
Chlordiazepoxide (Librium®)	25 mg	20-50 mg	50 mg	20 mg
Clobazam	20 mg	NA	NA	20 mg
Clonazepam (Rivotril®)	0.5 mg	1-2 mg	0.5 mg	0.5 mg
Potassium Clorazepate	15 mg	15 mg	15 mg	NA
Flurazepam (Dalmane®)	30 mg	30 mg	30 mg	30 mg
Lorazepam (Ativan®)	1 mg	1-2 mg	2 mg	2 mg
Oxazepam (Serax®)	20 mg	30 mg	30 mg	20 mg
Nitrazepam (Mogadon®)	10 mg	10-20 mg	10 mg	10 mg
Temazepam (Restoril®)	20 mg	20-30 mg	30 mg	30 mg
Triazolam (Halcion®)	0.5 mg	0.5 mg	0.25 mg	0.25 mg
Zaleplon	20 mg	NA	NA	20 mg
Zolpidem	20 mg	NA	10 mg	NA
Zopiclone	15 mg	NA	NA	7.5 mg

Ashton H. benzo.org.uk: Benzodiazepine Equivalence Table. http://www.benzo.org.uk/bzequiv.htm. Published 2007. Kalvik A., Isaac P., Janecek E. Benzodiazepines: Treatment of anxiety, insomnia and alcohol withdrawal. Pharmacy connection Sept/ Oct 1995 20-32. Shader RI, Greenblatt DJ. Can you provide a table of equivalences for benzodiazepines and other marketed benzodiazepine receptor agonists? *J Clin Psychopharmacol*. 1997;17(4):331. Alessi-Severini S, Bolton JM, Enns MW. Sustained Use of Benzodiazepines and Escalation to High Doses in a Canadian Population. *Psychiatry Serv*. 2016;67(9):1012-1018.

TAPERING GUIDELINES



Canadian Guideline
http://nationalpaincentre.mcmaster.ca/opioid/

Please accept this feedback on behalf of all the staff with CRNM. Overall, the standard was a nice length and easy to read. The following feedback is from various team members, so the 'format' of the feedback will vary;

1. The term "exceptional" is repeatedly used but doesn't have a clear definition and can become a reason to 'work around' this standard without changing prescribing practices. Criteria on what determine a situation to be exceptional could be useful.

2. suggested changes to strengthen understanding of what is expected:
Standard #10a, Determine the lowest effective dose of benzodiazepines and/or Z-Drugs needed to achieve or maintain the treatment goals and periodically consider a trial of slow tapering. Use tapering guidelines and equivalency tables attached to this Standard of Practice. Where tapering is not feasible, if there is documented benefit to the patient, then continue with the treatment. Tapering of long term benzodiazepines and/or Z-Drugs is very difficult, though not impossible.

Determine the lowest effective dose of benzodiazepines and/or Z-Drugs needed to achieve or maintain the treatment goals and periodically consider a trial of slow tapering. Use tapering guidelines and equivalency tables attached to this Standard of Practice. Where tapering is not feasible, if there is documented benefit to the patient outweighing the potential harms, then continue with the treatment. Tapering of long term benzodiazepines and/or Z-Drugs is very difficult, though not impossible.

3. Suggested changes to strengthen understanding of what is expected:
Standard #10 b, If prescribing benzodiazepines and/or Z-Drugs, physicians must document their advice to patients that they must avoid other central nervous system and respiratory depressants including alcohol, cannabis, and some over-the-counter medications.

If prescribing benzodiazepines and/or Z-Drugs, physicians must document their advice to patients that they must avoid other central nervous system and respiratory depressants including alcohol, cannabis, and some over-the-counter medications. Documentation should/must include information on the material risks of combining other CNS and/or resp depressants with benzodiazepines and/or Z-Drugs.

4. Suggested changes to strengthen understanding of what is expected:
Standard #11, Benzodiazepines and/or Z-Drugs have been identified as problematic medications for use in older adults and carry significant risks. Large scale studies consistently show that the risk of motor vehicle accidents, falls and hip fractures, leading to hospitalization and death, can more than double in older adults taking benzodiazepines and/or Z-Drugs. Older patients, their caregivers and their health care providers should recognize these potential harms when considering treatment strategies for insomnia, agitation or delirium.
to
Before any prescribing for older adults (whether a continuation of current prescriptions or new prescriptions), document a discussion of the harms vs benefits for benzodiazepine and/or z-drugs prescribing which includes, as a minimum, that benzodiazepines and/or Z-Drugs are problematic medications for use in older adults and carry significant risks. Large scale studies consistently show that the risk of motor vehicle accidents, falls and hip fractures, leading to hospitalization and death, can more than double in older adults taking benzodiazepines and/or Z-Drugs. Older patients, their caregivers

and their health care providers should recognize these potential harms when considering treatment strategies for insomnia, agitation or delirium.

5. last bullet on page one: is there a further explanation regarding what "number needed to get improved sleep" vs number needed to harm' means?

6. For standard #3, #8, #9 & #10a, suggest adding documentation as an explicit requirement

7. For standard #9b, suggest adding that the type of screening tools utilized be documented

8. For standard #9c, what timelines suggest adding timelines for the risk assessment

9. For standard #11, suggest adding the following wording (in bold): Older patients, their caregivers and their health care providers **should recognize** these potential harms when considering treatment strategies for insomnia, agitation or delirium.

Also,What will this look like for the older patient, their caregivers? This seems to be a lofty expectation unless there is education provided.

For standard #13, suggest adding documentation as a requirement that also includes a notation regarding the tools utilized. (eg. MOCA, MMSE)

CRNM

The College of Medical Laboratory Technologists of Manitoba supports the standard as created for prescribing Benzodiazepines and z-drugs.

Thank you for inviting CPSO to comment on the CPSM's draft Standard of Practice for Prescribing Benzodiazepines and Z-Drugs. Dr. Whitmore forwarded your request to our department and we've reviewed the draft standard.

We understand the challenge of striking the appropriate balance between serving patient needs and setting reasonable expectations for physicians, especially as it pertains to the prescribing of opioids and other controlled substances. Ultimately, we believe the CPSM is best placed to set the standards of practice for its members. While we are not submitting a formal response, we have a few informal comments below that we hope you may find helpful.

CPSO does not have a specific policy around prescribing benzodiazepines and Z-drugs, but we do have a *Prescribing Drugs* policy, which was recently updated and which sets out our expectations for prescribing drugs generally (linked here for your reference). We note that many provisions in the CPSM's draft standard are consistent with expectations that we've set out.

We also wanted to share some observations based on our experiences with setting expectations for opioid prescribing in Ontario, of which you may already be aware. Previously, the *Prescribing Drugs* policy was interpreted as endorsing and setting a requirement to follow the prescribing recommendations in the 2017 Canadian opioid guidelines. While this was not the intention of the policy,

physicians tended to interpret these as specific targets, leaving certain patients at risk of harm. CPSO revisited its opioid strategy and has since revised the policy to remove these specific references and make it clearer that a physician's clinical judgment is paramount. In our experience, the use of more prescriptive language in our policy led to unintended effects, which compromised patient safety. CPSO notes that the CPSM's proposed standard might similarly be perceived as prescriptive in nature, and raise the risk of similar results as we've seen here in Ontario. Again, we recognize the challenge of striking the right balance in this area.

Thank you once again for the opportunity to provide our comments.

College of Physicians and Surgeons of Ontario

My apologies that this is past the deadline of May 29, 2020.

Firstly, I would like to thank the College of Physicians and Surgeons of Manitoba for including the Manitoba College of Family Physicians in the original working group on the DRAFT Benzodiazepine/Z-Drug Standard of care. I am hopeful that the input of our representative was helpful to the development of this standard of care.

Personally, I very much appreciate the resources provided along with this standard. I feel that these are very important for Family Physicians who may be in solo, or small group practice.

As the MCFP, we have no particular concerns or comments on the DRAFT Standard as presented. We look forward to the much needed implementation of this Standard to ensure patient safety with these challenging medications.

If CPSM is interested in partnering with the MCFP, we would be very open to working together to provide educational sessions on this topic. I feel that our organization is well placed to help CPSM ensure that Family Physicians are aware of this new standard, and are meeting their professional obligations.

We look forward to working further with CPSM in the future on other projects, and Standards of care.

Thank you for inviting Manitoba Health, Seniors and Active Living (MHSAL), to provide comments on the proposed new Standard of Practice for Prescribing Benzodiazepines and Z-Drugs. I am providing a response to this request on Ms. XXXX's behalf.

I can advise that MHSAL does not have specific comments regarding the new draft practice direction. However, once the College of Physicians & Surgeons of Manitoba (CPSM) presents its recommendation to MHSAL's Manitoba Monitored Drugs Review Committee (MMDRC) to remove Alprazolam from the Manitoba Drug Benefits and Interchangeability Formulary, as stated within the "Consultation to Members and Stakeholders" document; this recommendation will be reviewed through usual processes and procedures.

Thank you for your continued efforts to ensure safe prescribing practices in Manitoba.

Further to your request for feedback on your standard, please find the enclosed with tracked changes. These are suggestions from one of our esteemed medical consultants who has expertise in this realm. Thank you for the opportunity to weigh in on this excellent document, and for creating this timely and necessary standard.

College of Physicians & Surgeons of British Columbia

DRAFT

Schedule N - Prescribing Benzodiazepines and Z-Drugs (including Zopiclone and other drugs)[1]

PREAMBLE

This Standard establishes the standard of practice and ethical requirements of all members in relation to prescribing benzodiazepines and/or Z-Drugs for maximum safety for all patients whether in the community or in a health care facility. **This Standard does not apply to the use of these drugs in the treatment of palliative and end-of-life patients, acute seizure disorders, bipolar/psychotic disorder, and alcohol withdrawal.** Medical evidence of the risk to benefit ratio of prescribing benzodiazepines and/or Z-Drugs is has altered over time, so prescribing these drugs must be in accordance with current medical knowledge. In Manitoba, tThese drugs are a known major contributor to a significant number of prescription medication-related deaths including opioid overdoses, especially particularly due to polypharmacy, in Manitoba. This Standard recognizes that:

- Every member is professionally responsible for each prescription the member provides to the patient.
- In prescribing benzodiazepines and/or Z-Drugs each member provides their clinical judgment, which is to be that of a member acting reasonably in the circumstances with current medical knowledge.
- Initiating benzodiazepines and/or Z-Drugs in hospital substantially increases the risk of long-term use and dependency.
- Cognitive behavioural therapy, brief behavioural interventions and tapering protocols have a proven benefit in sedative-hypnotic discontinuation and are also beneficial in improving sleep.
- The number needed to treat with a benzodiazepine and/or Z-Drugs to get improved sleep is 13, whereas the number needed to harm is only 6.

Commented [RC1]: I feel that somewhere in the preamble there should be mention of whether this standard is being provided about their use for anxiety, insomnia, or both. It currently isn't clear.

STANDARD OF PRACTICE

1. Reasonable efforts are to be used to optimize non-pharmacological treatment modalities first and then optimize non-benzodiazepines or non-Z-Drug treatment modalities.

2. To mitigate risk of harm the member must use reasonable efforts to review the patient's current and past medications utilizing DPIN or eChart or consult with a pharmacist to obtain DPIN. This will mitigate the risk of harmful drug interactions and combinations, and will prevent patients from obtaining prescriptions from multiple providers.

[1] See Table near end for drugs included in this Standard.

3. Members must prescribe the lowest effective dosage of benzodiazepines or Z- Drugs for the shortest possible duration and only exceed the maximum recommended dosage in exceptional circumstances.
4. Long term use must be supported by current clinical evidence indicating that benzodiazepines and Z-Drugs may be appropriate for certain patients.

5. Discuss the following with the patient and document it in the medical record:
    a. Treatment goals including specific and realistic goals and an eventual possible discontinuation strategy;
    b. Non-pharmacological therapies;
    c. The benefit of long-term benzodiazepines and Z-Drugs treatment is modest;
    d. Risks; and
    e. These drugs cause impairment. Advise them of the dangers of driving, operating heavy machinery, or performing safety sensitive tasks, providing child or elder care if impaired.

6. Appropriate use must be discussed with the patient with explicit instructions on the quantity and anticipated number of days supply, which must be noted on the prescription in the form of a dispensing interval.

7. Only write a prescription for a maximum of three months, but never authorize the dispensing of more than a one-month supply of any benzodiazepine and/or Z-Drug. An exception to dispensing for more than one month, up to three months would be:
    a. For patients in remote communities; and
    b. For patients travelling, if the patient has been on a stable long-term prescription.

8. Alprazolam (Xanax) has been identified as a drug with significant risks of abuse and diversion in Manitoba. Recognizing these risks, if in exceptional circumstances considering a start, the member must have extremely strong current clinical evidence. A new start for Alprazolam must include urine drug screen testing of patients. Use reasonable efforts to replace existing Alprazolam prescriptions with a longer acting benzodiazepine in accordance with the attached equivalency table. If not replaced, then document why not possible.

9. Members must carefully consider all concurrent medical conditions in the context of decisions to prescribe or continue to prescribe these medications:
    a. Heart failure, obesity, sleep apnea, chronic lung disease, alcohol use disorder, and renal or hepatic insufficiency and other chronic conditions or pregnancy compound the risk of these medications in unique ways.
    b. Patients must be regularly screened for the presence or emergence of mental health disorders (particularly mood disorders) which may complicate management.
    c. In the course of managing patient care on these drugs (particularly while tapering), a substance use disorder may develop or reveal itself, and physicians must be able to appropriately diagnose and manage the patient's care needs.

Commented (RC2]: Something here about indication. i.e. if for sleep, this recommendation is true. If for anxiety conditions, they may provide a small supply for very occasional use; eg. For social anxiety disorder (not generalized anxiety disorder). The psychiatrists on their working group can provide direction on this.

Commented (RC3]: I don't understand this. Do they mean: Long term use for individual patients must be supported by clinical findings?

Commented (RC4]: I would never recommend this 3 month prescription for something that is mainly short-term use only. This standard could have an unintended consequence of causing physical tolerance. Instead, leave out the 3 months.

Appropriate care management can include referral to a physician with expertise and can include slow tapering of benzodiazepines and Z-Drugs to minimize the effects of withdrawal and does not include abruptly discontinuing these drugs.

10. Combining benzodiazepines and/or Z-Drugs with themselves or with other medications compounds risk of harm:
    a. Determine the lowest effective dose of benzodiazepines and/or Z-Drugs needed to achieve or maintain the treatment goals and periodically consider a trial of slow tapering. Use tapering guidelines and equivalency tables attached to this Standard of Practice. Where tapering is not feasible, if there is documented benefit to the patient, then continue with the treatment. Tapering of long term benzodiazepines and/or Z-Drugs is very difficult, though not impossible.
    b. If prescribing benzodiazepines and/or Z-Drugs, physicians must document their advice to patients that they must avoid other central nervous system and respiratory depressants including alcohol, cannabis, and some over-the-counter medications.
    c. Physicians must exercise caution in prescribing these drugs with muscle relaxants, sedating antidepressants, anticonvulsants, antipsychotics and other sedating medications.
    d. If patients with complex care needs are receiving multiple sedating medications, the physician must consider seeking the opinion of relevant consultants such as psychiatrists, pain specialists, addiction medicine specialists, pharmacists, and others to work toward a collaborative medication regimen that minimizes risk as much as possible.
    e. Only in exceptional circumstances prescribe opioids together with benzodiazepines and/or Z-Drugs. Patients must be informed of the increased risk of death with this combination, and the discussion documented.
    f. Only in exceptional circumstances prescribe two or more benzodiazepines and/or Z-Drugs concurrently unless in the context of a taper.

OLDER ADULT PATIENTS

11. Benzodiazepines and/or Z-Drugs have been identified as problematic medications for use in older adults and carry significant risks. Large scale studies consistently show that the risk of motor vehicle accidents, falls and hip fractures, leading to hospitalization and death, can more than double in older adults taking benzodiazepines and/or Z-Drugs. Older patients, their caregivers and their health care providers should recognize these potential harms when considering treatment strategies for insomnia, agitation or delirium.

12. For older adult patients recognize that new starts of benzodiazepines and Z-Drugs must be carried out with extreme caution and not be used as first choice for insomnia, agitation, or delirium, nor for managing behaviours arising from dementia and delirium.

13. Ensure that dosaging takes into consideration declining renal, hepatic and cognitive function in older adult patients.

14. In prescribing for older adult patients, the member must recognize and discuss with the patient additional risks, including but not limited to:
    a. Falls and subsequent fractures related to sedation, confusion, drowsiness and postural instability;
    b. Impairment of psychomotor skills, judgment, and coordination increases the risk of motor vehicle and other accidents;
    c. Negative effects on cognition, memory, delirium and a possible link to cognitive decline and dementia.

APPLICABLE DRUGS FOR THIS STANDARD

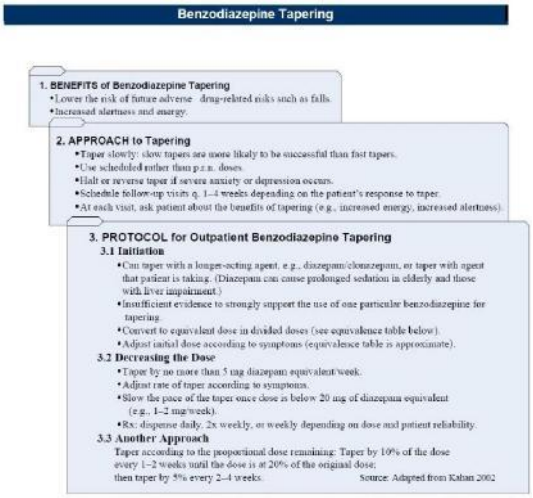
Benzodiazepines		Z-Drugs
Alprazolam (Xanax®)	Lorazepam (Ativan®)	Eszopiclone
Bromazepam (Lectopam®)	Midazolam (Versed®)	Zaleplon
Chlordiazepoxide (Librium®)	Nitrazepam (Mogadon®)	Zolpidem
Clobazam *to be started by Neurologists only	Oxazepam (Serax®)	Zopiclone
	Potassium-Clorazepate	
Clonazepam (Rivotril®)	Temazepam (Restoril®)	
Diazepam (Valium®)	Triazolam (Halcion®)	
Flurazepam (Dalmane®)		

BENZODIAZEPINE RECEPTOR AGONIST EQUIVALENCY ESTIMATES
(Diazepam 10 mg as reference)

	Ashton	Kalvik et al.	Shader & Greenblatt	Alessi-Severini et al.
Diazepam	**10 mg**	**10 mg**	**10 mg**	**10 mg**
Alprazolam (Xanax®)	0.5 mg	1 mg	1 mg	1 mg
Bromazepam (Lectopam®)	5 mg	6-12 mg	NA	10 mg
Chlordiazepoxide (Librium®)	25 mg	20-50 mg	50 mg	20 mg
Clobazam	20 mg	NA	NA	20 mg
Clonazepam (Rivotril®)	0.5 mg	1-2 mg	0.5 mg	0.5 mg
Potassium Clorazepate	15 mg	15 mg	15 mg	NA
Flurazepam (Dalmane®)	30 mg	30 mg	30 mg	30 mg
Lorazepam (Ativan®)	1 mg	1-2 mg	2 mg	2 mg
Oxazepam (Serax®)	20 mg	30 mg	30 mg	20 mg
Nitrazepam (Mogadon®)	10 mg	10-20 mg	10 mg	10 mg
Temazepam (Restoril®)	20 mg	20-30 mg	30 mg	30 mg
Triazolam (Halcion®)	0.5 mg	0.5 mg	0.25 mg	0.25 mg
Zaleplon	20 mg	NA	NA	20 mg
Zolpidem	20 mg	NA	10 mg	NA
Zopiclone	15 mg	NA	NA	7.5 mg

Ashton H. benzo.org.uk: Benzodiazepine Equivalence Table. http://www.benzo.org.uk/bzequiv.htm. Published 2007. Kalvik A., Isaac P., Janecek E. Benzodiazepines: Treatment of anxiety, insomnia and alcohol withdrawal. Pharmacy connection Sept/ Oct 1995 20-32. Shader RI, Greenblatt DJ. Can you provide a table of equivalences for benzodiazepines and other marketed benzodiazepine receptor agonists? *J Clin Psychopharmacol*. 1997;17(4):331. Alessi-Severini S, Bolton JM, Enns MW. Sustained Use of Benzodiazepines and Escalation to High Doses in a Canadian Population. *Psychiatry Serv*. 2016;67(9):1012-1018.

TAPERING GUIDELINES



Canadian Guideline
http://nationalpaincentre.mcmaster.ca/opioid/

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May 27, 2020

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Re: Response to Proposed *Standard of Practice for Prescribing Benzodiazepines and Z-Drugs*

Dear Council Members,

On behalf of the Nurse Practitioner Association of Manitoba (NPAM), we would like to say thank you for taking a step forward in the battle against prescription medication dependence. NPAM has recognized this as a significant safety issue for some time but felt disempowered in advocating for strategic change to improve the safety of patients through improved prescribing of benzodiazepines and z-drugs. We have hosted several education sessions for Nurse Practitioners (NPs) to support best practice treatment of anxiety and insomnia with the goal of reduced prescribing of these medications, in favor of other non-pharmacological approaches. We feel these sessions have made a significant positive impact on the prescribing practices of NPs as well as providing non-pharmacological strategies to better address these health challenges long-term.

We support the recommendations within the proposed standard but raise concern for two areas:

1) Vague language e.g. "reasonable efforts" can be difficult to interpret unless examples are provided. While we appreciate person-centered care and professional judgment, it may be helpful to provide examples of what "reasonable efforts" are intended to imply. For instance, does this relate to the frequency of medication review, who the prescriber consults with (formally or informally) to identify if other strategies could be offered? While we do not intend for this process to be onerous, case reviews with colleagues can be very supportive in reinforcing best practice and identifying new resources, research, or applicable guidelines.

2) Listing benzodiazepines and z-drugs on the M3P list While we commend the significance this will impart on prescribing practices for these medications, it is important to recognize that numerous rural and northern communities across Manitoba are struggling to recruit and retain prescribers, leaving over-full practices with pressured schedules. It is desired that current faxing of M3Ps would continue to be approved as clinical practice moves to more virtual allowances for patient engagement. This would also support safer prescribing for isolated patients that can be seen virtually but are not able to collect the paper copy of M3P. Faxing is also more secure when prescriptions go direct from prescriber office to pharmacy.

Ideally supportive clinical tools would accompany this standard for embedding into electronic medical records which has been shown to improve the identification and clinical management of patients with dangerous medication combinations. We have found such tools related to opioid prescribing have

been helpful and improved documentation for completeness and efficiency. These tools also help prompt discussion during medication review appointments with patients and family.

We trust that with this new standard, associated clinical practice tools and patient handouts (e.g. infographics of risks and alternatives) will be developed to support patient education and shared decision making. We also trust there will be future educational sessions to support prescriber implementation of this standard along with best practice tools and case study examples for deprescribing.

Again, we commend you in taking this bold strategic approach to improve prescribing practices across Manitoba related to at-risk medications and medication combinations. Please do not hesitate to reach out to us in the future for feedback and educational opportunities for NPs so healthcare in Manitoba can be as accessible and safe as possible for our patients.

Sincerely,

CEO, NPAM
Email: _____

CMPA.ACPM
Empowering better healthcare | Pour l'avancement des soins de santé

May 21, 2020

Dr. Anna Ziomek
Registrar, College of Physicians and Surgeons of Manitoba
1000 – 1661 Portage Avenue
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Via email: cpsmsopbenzo@cpsm.mb.ca

Dear Anna,

Thank you for the opportunity for the Canadian Medical Protective Association to participate in the Consultation on a new Standard of Practice for Prescribing Benzodiazepines and Z-Drugs.

The CMPA delivers efficient, high-quality physician-to-physician advice and assistance in medical-legal matters, including the provision of appropriate compensation to patients injured by negligent medical care. Our evidence-based products and services enhance the safety of medical care, reducing unnecessary harm and costs. As Canada's largest physician organization and with the support of our over 100,000 physician members, the CMPA collaborates, advocates and effects positive change on important healthcare and medical-legal issues.

The CMPA is not in a position to comment on the medicine. We do offer the following suggestions for your consideration regarding clarity, understanding and ease of reading.

In a number of places, the policy refers to reasonable, appropriate and exceptional without giving guidance as to what reasonable and exceptional might mean in this context. Examples: Bullets 1, 3, 6, 10e, 10f.

Page 1

a) This sentence may cause the reader to stumble – "These drugs are a known major contributor to a significant number of prescription medication-related deaths including opioids, especially due to polypharmacy, in Manitoba."

We would suggest, "These drugs are a known major contributor to a significant number of prescription medication-related deaths in Manitoba, including deaths involving opioids and especially those involving polypharmacy."

b) “In prescribing benzodiazepines and/or Z-Drugs each member provides their clinical judgment, which is to be that of a member acting reasonably in the circumstances with current medical knowledge.” Use of the term “provides” here is unusual, and would suggest “exercises”.

c) “1. Reasonable efforts are to be used to optimize non-pharmacological treatment modalities first and then optimize non-benzodiazepines or non-Z-Drug treatment modalities.” Some members may not know what the College thinks is reasonable, and some clarity around that would be helpful.

Page 2:

a) “5. Discuss the following with the patient and document it in the medical record:

a. Treatment goals including specific and realistic goals and an eventual possible discontinuation strategy;

b. Non-pharmacological therapies;

c. The benefit of long-term benzodiazepines and Z-Drugs treatment is modest;

d. Risks; and

e. These drugs cause impairment. Advise them of the dangers of driving, operating heavy machinery, or performing safety sensitive tasks, providing child or elder care if impaired. “

The preceding is a combination of statements and actions that could cause confusion.

Suggestion:

“5. Discuss the following with the patient and document it in the medical record:

a. Treatment goals including specific and realistic goals and an eventual possible discontinuation strategy;

b. Non-pharmacological therapies;

c. The modest benefit of long-term benzodiazepines and Z-Drugs treatment;

d. Risks associated with treatment; and

e. The impairment caused by these drugs, particularly the dangers of driving, operating heavy machinery, or performing safety sensitive tasks, providing child or elder care if impaired. “

b) “6. Appropriate use must be discussed with the patient with explicit instructions on the quantity and anticipated days supply, which must be noted on the prescription in the form of a dispensing interval.”

This is perhaps better worded as, “Explicit instructions must be provided to the patient regarding appropriate use, quantity, and number of days the supply is anticipated to last. A dispensing interval, indicating the number of days the supply is anticipated to last, must be noted on the prescription.”

c) “7. Only write a prescription for a maximum of three months, but never authorize the dispensing of more than a one-month supply of any benzodiazepine and/or Z-Drug. An exception to dispensing for more than one month, up to three months would be:

a. For patients in remote communities; and

b. For patients travelling, if the patient has been on a stable long-term prescription.”

Suggested: “7. Prescriptions for Benzodiazepines and Z-drugs are to be written be for a maximum of three months, with dispensing to be authorized for no more than a one month supply. On an exceptional basis, members may authorize a dispensing interval of up to three months in the following situations:

a. patients in remote communities; or

b. patients travelling, if the patient has been on a stable long-term prescription.”

d) “8. Alprazolam (Xanax) has been identified as a drug with significant risks of abuse and diversion in Manitoba. Recognizing these risks, if in exceptional circumstances considering a start, the member must have extremely strong current clinical evidence. A new start for Alprazolam must include urine drug screen testing of patients. Use reasonable efforts to replace existing Alprazolam prescriptions with a longer acting benzodiazepine in accordance with the attached equivalency table. If not replaced, then document why not possible.”

Suggested: “Alprazolam (Xanax) has been identified as a drug with significant risks of abuse and diversion in Manitoba. Recognizing these risks, members should only considering starting this medication in exceptional circumstances and must have extremely strong current clinical evidence. When starting Alprazolam, members must include urine drug screen testing of patients. Use reasonable efforts to replace existing Alprazolam prescriptions with a longer acting benzodiazepine in accordance with the attached equivalency table. If Alprazolam is not replaced, then document why this is not possible.”

e) “c. In the course of managing patient care on these drugs (particularly while tapering), a substance use disorder may develop or reveal itself, and physicians must be able to appropriately diagnose and manage the patient’s care needs. Appropriate care management can include referral to a physician with expertise and can include slow tapering of benzodiazepines and Z-Drugs to minimize the effects of withdrawal and does not include abruptly discontinuing these drugs.”

Suggested: “c. In the course of managing patients taking these drugs (particularly during tapering), a substance use disorder may develop or reveal itself, and physicians must be able to appropriately diagnose and manage the patient’s care needs. Appropriate management can include referral to a physician with expertise, and slow tapering of benzodiazepines and Z-Drugs to minimize the effects of withdrawal. Appropriate management does not include abruptly discontinuing these drugs.”

We hope these comments will be of assistance to the College in finalizing the revised practice standard.

Yours sincerely,

College of Pharmacists of Manitoba

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Dear CPSM Colleagues,

Thank you for the opportunity to provide feedback on The College of Physicians and Surgeons of Manitoba (CPSM) Standard of Practice for Prescribing Benzodiazepines and Z-Drugs.

Data from the Adult Inquest Review Committee (AIRC) of the Chief Medical Examiner's Office show that this Standard of Practice is necessary to address the prescribing and dispensing practices of benzodiazepines in Manitoba. The College of Pharmacists of Manitoba (CPhM) is pleased to comment on several aspects of this standard of practice as it relates to the overlap in care between prescribers and pharmacists.

Day Supply Limits

Standard #7 reads as follows:

> 7. Only write a prescription for a maximum of three months, but never authorize the dispensing of more than a one-month supply of any benzodiazepine and/or Z-Drug. An exception to dispensing for more than one month, up to three months would be:
>
> a. For patients in remote communities; and
> b. For patients travelling, if the patient has been on a stable long-term prescription.

CPhM is supportive of limiting the dispensing of benzos/z-drugs to a maximum of one-month supply, as this can help reduce the number of overdose deaths. This strategy is already in use in several other provinces around Canada, and it provides an opportunity for additional healthcare professional contact, assessment, and support.

However, the exception criteria #7(a) is of concern as it does not define what a remote community is, and therefore a large number of the population may qualify under this criterion. Northern and remote communities are equally at risk of benzodiazepine/z-drug misuse and providing a blanket exemption for simply living in a remote community may not be protective of populations that may require more frequent healthcare professional support.

Therefore, it may be preferable to consider removing criteria #7(a) and expanding more on criteria #7(b) with additional parameters that permit the use of professional judgment. For example:

> Only write a prescription for a maximum of three months, conducting and documenting a comprehensive assessment each time, but never authorize the dispensing of more than a one-month supply of any benzodiazepine and/or Z-Drug. An exception to dispensing more than one month and up to three months can be considered in exceptional circumstances for patients who are on a stable dose. Communication and collaboration with the patient's pharmacy should be conducted, and reasoning must be well documented.

The prescriber should be encouraged to contact the patient's pharmacy or to indicate on the prescription why more than a one-month supply may be necessary.

Tapering of Benzodiazepines/Z-Drugs

Standard #10 briefly touched on tapering of benzodiazepines/z-drugs, while tapering guidelines were provided on page 5 of the standard. However, it may be beneficial to address this crucial issue in more depth. A separate standard # is suggested to be dedicated to emphasizing the need to regularly assess long-term benzodiazepine/z-drug use. For example, a comprehensive assessment should be conducted and documented every 3 months or with every new prescription and tapering to the lowest effective dose should be initiated as soon as possible.

It may also be worthwhile to outline some criteria around red flags that would warrant immediate re-assessment of benzodiazepines/z-drug use. For example, as outlined in the CEP clinical practice tool:

- Deteriorating function despite increase in dose
- Dishonesty with respect to prescriptions as reported by patient or their pharmacy
- Involvement with law enforcement
- Active misuse of another substance, etc.

Collaborating and communicating with the pharmacy team when tapering is in progress is beneficial, as the pharmacy maintains ongoing documentation on patient interactions and any issues/concerns they may have noted over time. Providing the pharmacy with a patient care plan related to the taper would keep all healthcare providers informed, especially as the patient will likely contact the pharmacist if they are experiencing any withdrawal symptoms, or if they are requesting any early refills.

There are additional resources available on tapering of benzodiazepines, which may be helpful to link within the standard for added practice support:

- The Centre for Effective Practice: Managing Benzodiazepine Use in Older Adults.
- Deprescribing website https://deprescribing.org

I'm available to discuss any or all parts of this response, and I'm happy to bring forward any questions for discussion within our team.

Sincerely,

College of Pharmacists of Manitoba

Submission to The College of Physicians & Surgeons of Manitoba *Draft Standard of Practice for Prescribing Benzodiazepines and Z-Drugs* Consultations by the Canadian Deprescribing Network - submitted May 29th, 2020

The Canadian Deprescribing Network welcomes this opportunity for stakeholders to comment on the ***Draft Standard of Practice for Prescribing Benzodiazepines and Z-Drugs***.

Who are we?

The Canadian Deprescribing Network (CaDeN) is a group of healthcare leaders, clinicians, decision-makers, academic researchers and patient advocates working together to mobilize knowledge and promote the deprescribing of medications that may no longer be of benefit or that may be causing harm. Our goals are to raise awareness and eliminate the use of potentially inappropriate medications for older Canadians, and ensure access to safer drug and non-drug therapies. CaDeN uses a practical, comprehensive, ecological approach to optimize medication use through coordinated action across Canada's health system.

CaDeN experts have studied and published on different national and international policies aimed at promoting and implementing best practices related to the use of sedative-hypnotics (benzodiazepine and z-drugs). In 2019, CaDeN members published an international scan of intended and unintended outcomes of limiting sedative-hypnotic use in community-dwelling older adults which is very relevant to this Standard.[1]

In addition to its expertise, CaDeN has worked with a number of different Canadian jurisdictions to implement needs-driven, evidence-based policies aimed at improving medication appropriateness. For example, in Manitoba, CaDeN worked on an initiative to help address the opioid crisis in partnership with the provincial government in 2018-2019.[2]

Comments on the draft *Standard of Practice for Prescribing Benzodiazepines and Z-Drug*

The publication of a *Standard of Practice for Prescribing Benzodiazepines and Z-Drug* is a much-needed framework which will help ensure these medications are prescribed according to best practices and support maximum safety for patients in Manitoba. After reviewing the document, we respectfully wish to bring the following points to the attention of The College of Physicians & Surgeons of Manitoba.

1. ***Making sure members and their patients of all ages are aware of the risks associated with the use these medicines***

   We are pleased to see the draft Standard start by highlighting the troubling evidence surrounding the use of sedative-hypnotics in older people with insomnia, with a number-needed-to-treat (NNT) of 13, and a number-needed-to-harm (NNH) of 6.[3] The Standard also informs members of specific harms linked to sedative-hypnotics, e.g. Point 11 stating that *"Large scale studies consistently show that the risk of motor vehicle accidents, falls and hip fractures, leading to hospitalization and death, can more than double in older adults taking benzodiazepines and/or Z-Drugs."* An important correction to flag here would be that the **evidence around risk of motor vehicle accidents does not only concern older adults.** A cohort

study of 409 171 adults (median age 42) showed that use of sedative hypnotic is associated with increased motor vehicle crash risk, equivalent to blood alcohol concentration levels between 0.06% and 0.11%.[4] This information is particularly relevant, as a large proportion of sedative-hypnotics users are mid-age and younger adults.

2. ***Reinforcing non-pharmacological approaches***

We are equally pleased to see that according to most recent clinical guidelines on the treatment of insomnia, Point 1 of the Standard states that *"Reasonable efforts are to be used to optimize non-pharmacological treatment modalities first..."*. We suggest that further guidance be given clarifying which non-pharmacological treatment modalities are available to patients across Manitoba. In July 2019 the Centre for Effective Practice published a tool for clinicians aimed at managing benzodiazepine use in older adults.[5] For both anxiety and insomnia, safe alternatives are listed alongside level of evidence and resources, services and supports available for patients of all ages. We would hope to see this excellent tool referenced, or examples of different strategies to consider, to help better support members who aim to direct patients to non-pharmacological approaches in accordance with clinical guidelines (such as mysleepwell.ca, an online hub of cognitive behavioral therapy for insomnia (CBTi), or the following brochure providing CBTi tips and techniques, developed by a research team affiliated with the Université de Montréal). Overall, improved access to safe alternatives is key for patients to avoid exposure to potentially harmful medications and thus, members need to feel equipped in that regard.

When looking at specific non-pharmacological measures that we suggest be reinforced in the Standard, the role of caffeine used as a result of oversedation, and contributing to anxiety and insomnia, cannot be underestimated. Caffeine reduction should be considered as a strategy to facilitate benzodiazepine and z-drug deprescribing. Caffeine is a known stimulant. People who take benzodiazepine and z-drug frequently experience daytime fatigue leading them to ingest caffeinated drinks. This results in anxiety and insomnia (e.g. racing thoughts) even at small doses, which can increase a patient's desire to use a sedative. CaDeN members experience in sedative-hypnotic tapering have identified caffeine reduction (e.g. switch to decaffeinated beverages) as a successful strategy to minimize rebound insomnia and anxiety. We urge the College to include this information in the Standard.

3. ***Supporting members by providing evidence-based tools***

The following wording, found under Point 10a) of the Standard, struck us as being directive and did not provide appropriate guidance for members: *"Tapering of long-term benzodiazepines and/or Z-Drugs is very difficult, though not impossible."* To facilitate the safe tapering of these medications, it is essential to flag that several evidence-based tools exist for healthcare professionals to play a pivotal role and maximize patient engagement, including:

- **Deprescribing benzodiazepine receptor agonists evidence-based clinical practice guideline.[6] Public and healthcare provider targeted knowledge mobilization tools (based on the guideline) such as pamphlets, infographics and whiteboard videos are also available.**
- **Direct-to-patient educational material on the harms of benzodiazepines, easy-to-follow tapering protocols and suggestions for non-drug alternates which yielded a**

27% termination in chronic benzodiazepine use at the six-month follow-up versus 5% in the treatment as usual group.[7] Patients in this randomized controlled trial had been taking benzodiazepines for an average of 10 years.

- Letter which can be used by primary care doctors to advise patients about reducing or stopping sedative-hypnotic medications. Several studies have demonstrated the efficacy of this type of letter. For example, Gorgels et al. showed that 26% of the patients who received a letter reduced their benzodiazepine consumption 21 months after receiving the letter.[8]

Evidence-based materials referenced in the Standard include benzodiazepine tapering guidelines from the *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain*, in which switching to a long-acting benzodiazepine such as diazepam is described as a possible approach. We would like to flag concern, as this is risky in terms of side effects, especially for older adults. Additionally, long-acting agents such as diazepam have not been shown to reduce incidence of withdrawal symptoms or improve cessation rates more than tapering shorter-acting ones.[6] Thus, the inclusion of this tapering approach should be reconsidered in the Standard.

4. *The importance of interdisciplinarity*

To help physicians implement non-pharmacological treatments, identify deprescribing candidates and put in place a safe tapering program in accordance with best practices, a multidisciplinary approach needs to be encouraged. Randomized controlled trials have shown sedative-hypnotics deprescribing rates of 43% when pharmacists and physicians worked in collaboration, in the community setting.[9] Engaging pharmacists can also address Points 10b and 10c of the Standard, to help identify the "other" or "over the counter" medications. As for Point 10d, unlike the other specialists listed, where referral to a consultant may be required, a pharmacist will be automatically involved through dispensing the patient's medications. Thus, we would like to see the College of Physicians & Surgeons of Manitoba encourage consistent engagement and collaboration with pharmacists. In hospital setting, the publication of a recent implementation guide to promote sleep and reduce sedative-hypnotic initiation for noncritically ill patients described key interventions which can be led by various healthcare professionals, such as nurses, social workers, psychologists or pharmacists.[10] Adopting an interdisciplinary approach is central to support patients adequately, help them manage their health condition appropriately and should be reinforced in the current Standard, especially as this team-based care approach is growing across in Canada.

5. *Unintended consequences linked to delisting alprazolam*

Our group would like to share concerns upon reading that "*Council will also recommend to the Monitored Drug Review Committee that alprazolam be removed from the Manitoba Drug Benefits and Interchangeability Formulary*." When Australia restricted access to alprazolam by making it a controlled drug in 2014, alprazolam use decreased, however, this decrease was accompanied by an increase in substitution (often multiple benzodiazepines), diverting patients to street access, and overdose mortality.[11,12] Although overdose deaths involving alprazolam declined, there was a steady increase in any overdose death in which a benzodiazepine contributed, suggesting that limiting access to individual benzodiazepines might not impact on overall benzodiazepine-related mortality. Similarly, the US Medicare Part

D restriction of reimbursement policy for benzodiazepines led to high rates of substitution with zolpidem, which was still covered under the policy program, and a significant increase in out-of-pocket spending for benzodiazepines.[13,14] A parallel rise occurred in prescriptions for other classes of sedative-hypnotics such as antipsychotics. Following the delisting and subsequent substitution to other medications, there was an increase in fracture rates observed among patients admitted to nursing homes.[15] There is a dearth of evidence to support that delisting alprazolam will improve patient safety, but rather evidence demonstrates that it will lead to harm. Unless the College can detail how unintended consequences and patient harm will be minimized, we suggest that this position be reconsidered.

6. ***Beware of equally harmful pharmacological alternatives***

Our group is concerned that, as described above with the alprazolam example, flagging a specific class of medication such as benzodiazepines or z-drugs will lead to substitution with other sedating agents that have not been shown to be effective nor safe.[16] Common medications used off-label to treat insomnia in Canada include low-dose quetiapine as well as trazodone. Both of these have been linked to falls in older adults. Trazodone can cause daytime sedation and has been associated with a higher risk of mortality and falls in an observational study of depressed elderly. Quetiapine has been linked to cognitive decline and increased mortality. We urge the College to include this information in the Standard. Once again, the right information must be conveyed to members to avoid unintended consequences which will affect patients.

Conclusion

The Canadian Deprescribing Network wishes to reiterate the need for such a Standard and congratulates the College for pursuing this approach. To summarize, in light of the current evidence around implementation of successful policies aimed at ensuring appropriate use of sedative-hypnotics, to support best practices, it is essential for The College of Physicians & Surgeons of Manitoba to:

- **Equip its members with the right evidence-based tools;**
- **Reinforce non-pharmacological approaches, and flag the role of caffeine as a result of, and contributor to sedative-hypnotic overuse;**
- **Encourage an interdisciplinary approach; and**
- **Reconsider specific policies on substitution to avoid unintended consequences linked to the implementation of specific policies such as substitution with other harmful.**

On behalf of the Canadian Deprescribing Network:

Co-Director, Canadian Deprescribing Network
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Senior Medical Director, Seniors Health Strategic Clinical Network, Alberta Health Services

Co-Director, Canadian Deprescribing Network
Professor, Medicine and Pharmacy, Université de Montréal

Assistant Professor, Department of Family Medicine, University of Ottawa
Co-Founder of the Canadian Deprescribing Network and Chair of Health Care Provider Subcommittee

President, Manitoba Association of Senior Centres

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COUNCIL MEETING – JUNE 19TH, 2020

ITEM FOR INFORMATION

SUBJECT:

Strategic Organizational Priorities and Strategic Operational Priorities

BACKGROUND:

Last year Council discussed Strategic Organizational Priorities and Strategic Operational Priorities considered important for CPSM. The idea behind identifying these Priorities was that by establishing organizational and operational priorities the College can successfully plan and utilize its resources for future initiatives in a disciplined manner. Below are the Organizational Priorities that Council last June directed be initiated.

Organizational Priorities

Standard of Practice for Prescribing Benzodiazepines
Streamlined Registration
Telemedicine
Artificial Intelligence & The Practice of Medicine
Standard of Practice for Authorizing Cannabis
Continuity of Care - After Hours Coverage
Maintaining Boundaries – Sexual Involvement with a Patient
Governance Review
Standards of Practice of Medicine Document Review/Update

The Strategic Organizational Priorities have been tracked over the past year in the Progress Chart that is attached. Council has reviewed this Progress Chart at each of its quarterly meetings.

COVID-19 caused some disruption and delay in achieving every Strategic Organizational Priority. However, even with the pandemic, three of the four major Strategic Organizational Priorities that were CPSM stand-alone priorities had Working Groups that delivered final Reports/Recommendations and a consultation on the Standard of Practice for Prescribing Benzodiazepines and Z-Drugs was undertaken. The Working Group on Maintaining Boundaries – Sexual Involvement with a Patient has advised its report should be presented to Council in September for consideration to distribute for consultation. The Standards of Practice and Practice Directions four-year review cycle was initiated in January with quick reviews of the

helmet/seatbelt, EKG Interpretation Eligibility, and Home Births, but was then stalled completely by the COVID-19 pandemic. Hopefully, this should resume this fall, but will place it in a delay, so perhaps a five-year review will be more appropriate. The Strategic Organizational Priorities Progress Chart has been updated to reflect this.

What staff are recommending this year is twofold. First, that the remainder of this year be utilized to **catch-up** on the Strategic Organizational Priorities. Second, that **Virtual Medicine Standard of Practice** (and other rules) be updated to reflect the changes and experiences gained by the several months of extensive use by the profession. This is important and timely as crucial elements of practicing medicine changed very significantly during this pandemic, recognizing virtual care, new technologies, and new prescribing practices to mention just a few items. It is considered that these changes will not be temporary, but permanent in some way – just how needs to be determined.

The FMRAC priority on streamlined medicine was proceeding nicely for the Expedited Licensure but was paused due to the pandemic. This work should be resuming shortly. The Portable Licence is running into a roadblock as various provinces require changes to the Acts and no Government has provided a firm commitment to pursuing this at this time.

Operational Priorities

Electronic Document & Records Management System
Information Technology Strategic Roadmap
CPSM Physician Portal IT Development
1661 Portage Avenue Lease Renewal
FIRMS College-Wide Risk Assessment
Standards Department Review
Streamlined Registration
Patient Assistance and Mediation in Complaints/Investigations
Complaints and Investigations Streamlining

COVID-19 also had an impact on the proposed starting date for the Electronic Document and Records Management System – which will move CPSM into a fully paperless environment when completed. However, we have re-initiated this priority project and are in the midst of completing the RFP selection of a successful proponent to partner with us.

We have continued to work virtually with our IT Support Provider – Broadview Networks to plan and scope out four major strategic IT projects that will position CPSM as an information leader in state-of-the-art technology. Overall cloud strategy; virtual server replacements; enhanced virtual/remote connection to facilitate “working from home” and in-depth security assessment

and vulnerability analysis toward a cybersecurity strategy roadmap for CPSM are major project initiatives planned.

The CPSM Lease at 1661 Portage Avenue will expire in July 2021. CPSM has retained a Commercial Real Estate agent to assist our review and analysis of the current market – options that exist for our office requirements – and/or in anticipation of lease negotiations with the current landlord for an extension.

During the past year the Government introduced the *Regional Health Authorities Amendment Act (Health System Governance and Accountability)* which included changes to the CPSM Provincial Standards Committees. This was added to the Standards Department Review and was just starting to get underway when the COVID-19 pandemic put a hold on this work at the Government level, CPSM, and the Legislature. With the hiring of the new Assistant Registrar, Dr. Ainslie Mihalchuk, the priorities, policies, and goals of the Standards Department will be assessed and revised to ensure it better achieves its statutory mandate of supervising the practice of medicine and reviewing the professional competence of members.

A FMRAC priority, Streamlined Registration is still in the planning process as above, and once the parameters are set, its implementation will be an operational priority.

The College in Ontario initiated a review and streamlining of its complaints and investigations resulting in significantly improved times for concluding complaints and investigations and other favourable metrics. Arrangements were made for the Assistant Registrar, Dr. Karen Bullock Pries, and others to attend the offices of CPSO to learn of their successes with a view to emulating some practices and changes where appropriate to improve the complaints and investigations processes here. This was paused due to COVID-19. The Complaints & Investigation Department is in the process of interviewing candidates to fill an important position to support those complainants facing emotionally trying matters such as boundary violations in their navigation of their complaint and its investigation. This was also paused due to COVID-19.

PUBLIC INTEREST RATIONALE

“A college must carry out its mandate, duties, and powers and govern its members in a manner that serves and protects the public interest.” S. 10(1) RHPA

The Strategic Organizational Priorities have been chosen in accordance with the mandate to serve and protect the public interest. The public interest rationale is addressed when each Strategic Organizational Priority is brought forward to Council, whether through the Terms of Reference for the Working Group, the recommendations from the Working Group, approving consultations, and approving the Standard of Practice or Bylaw.

CPSM
ORGANIZATIONAL PRIORITIES
NEW INITIATIVES
PROGRESS TRACKING

Initiative	FMRAC Working Group	Start Date	Finish Date	CPSM Working Group	Council Reviews Draft	Consultation	Council Approval	Implementation Readiness Go-Live	Goal Status	Additional Comments
Benzodizaepine Prescribing Standard of Practice		Sep-19	Sep-20	Started Oct 2019	Mar-20	May-20	Sep-20	Sep-20	On Track	Consultation Delayed due to COVID-19
Cannabis Authorization Standard of Practice		Sep-19	Sep-20	Started Nov 2019	Sep-20	July/August 2020	Sep-20	Sep-20	On Track	
Streamlined Registration - Fast Track Application	FMRAC-Started								Not Started	
Streamlined Registration - Portable Licence	FMRAC-Started								Not Started	Amendments to Acts Required in many jurisdictions
Artificial Intelligence	FMRAC-Started								Not Started	
Telemedicine Across Jurisdictions	FMRAC-Started								Not Started	
Extended/ After Hours Coverage		2015	Jun-19	Finished 2019	Mar-19	N/A	N/A	N/A	Achieved	Initiative paused for Healthcare system transformation
Maintaining Boundaries - Sexual Involvement with a Patient		Sep-19		Started Sept 2019	Sep-20	Oct-20	Dec-20	Dec-20	On Track	Report Delayed due to COVID-19
Governance Review		Jun-19	Dec-19	Started Sept 2019		N/A		TBD	Achieved	
Standards of Practice Ongoing Review - 4 Year Cycle		Jan-20	Dec-24						Delayed	Delayed due to COVID-19
Accredited Facilities Criteria		Sep-19		Started Oct 2019	Jun-20	July/August 2020	Sep-20	Jan-21	On Track	

Last revised: June 1, 2020

COUNCIL MEETING – JUNE 19, 2020

NOTICE OF MOTION FOR APPROVAL

SUBJECT:

Audit & Risk Management Committee Terms of Reference

BACKGROUND:

At the February 21, 2020 meeting of the Audit & Risk Management Committee, committee members discussed the role and importance of the committee and its mandate. Management conducted a review and update of the Terms of Reference to the Committee – which was brought forward for discussion.

CPSM Management has recognized that there are several important gaps within the current Terms of Reference. In this regard – management conducted an in-depth review of the Terms of Reference to identify these gaps and opportunities for improvement. Updates to the proposed Terms of Reference include:

- **Elaborate on the purpose of the Committee** - There is a need to emphasize as well as distinguish the purpose of the Committee with respect to its finance, audit and risk management duties.

- **Change the name of the Committee to -** Finance, Audit & Risk Management Committee

- Include finance responsibilities of the committee related to the annual review and approval of the Financial plan (Operating Budget); review of the quarterly (periodic) financial reports and approval of any/all changes to the College reserves

- **Expand/clarify the risk management responsibilities of the Committee -** There is a need to specify the expectations of the risk management duties of the Committee and the College.

- Add the requirement/responsibility to conduct an annual review of the Terms of Reference of the committee directly in the Terms of Reference document

Both the proposed and the current Terms of Reference are attached with sections highlighted to indicate amendments.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON JUNE 19, 2020, DR. JACOBI ELLIOTT, CHAIR OF THE AUDIT & RISK MANAGEMENT COMMITTEE, WILL MOVE THAT:

Council approve the changes as attached and as recommended by the Audit & Risk Management Committee

(AMENDED – PROPOSED)

4.9. **Finance, Audit and Risk Management Committee Terms of Reference**

4.9.1. Authority

4.9.1.a. In accordance with the RHPA, The Affairs of the College and Code of Ethics Bylaw, policies approved by Council and the authority delegated to the Finance, Audit and Risk Management Committee by Council pursuant to section 17 of the RHPA to make investment decisions on behalf of the College.

4.9.2. Purpose

4.9.2.a. The purpose of the Finance, Audit and Risk Management Committee is to assist Council in its oversight of:

4.9.2.a.i. the financial operations and investment activities of the College;

4.9.2.a.ii. the integrity of the College's financial planning;

4.9.2.a.iii. the quality and objectivity of the College's financial reporting and controls;

4.9.2.a.iv. the independence, qualifications, and appointment of the external auditor;

4.9.2.a.v. the performance of the external auditor; and

4.9.2.a.vi. the effectiveness of the College's risk management practices.

4.9.3. Responsibilities

4.9.3.a. The Audit and Risk Management Committee shall have the following duties and responsibilities:

4.9.3.a.i. Financial Management and Reporting

4.9.3.a.i.I. Periodic review of the College's investments and investment strategies, and approval of investment decisions in accordance with Council policies, as set out in the Affairs of the College and Code of Ethics Bylaw and the Governance Policies.

4.9.3.a.i.II. An annual report for the Council as to Registrar compliance with Financial and Investment provisions of this Governance Policy.

4.9.3.a.i.III. Current information for the Council on significant new developments in accounting principles for not-for-profits or relevant rulings of regulatory bodies that affect the organization.

4.9.3.a.i.IV. Review of the College's annual financial plan (Operating budget) and recommend approval to Council.

4.9.3.a.i.V. Review the appropriateness of the rates and amounts of honoraria and stipends to be paid by the College.

4.9.3.a.i.VI. Periodic review of the College's financial operations, and report to Council on any significant financial results.

4.9.3.a.i.VII. An annual report to Council on the appropriation of reserves in accordance with Council policies, including recommendation on any significant changes to the reserves.

4.9.3.a.i.VIII. A self-monitoring report on the appropriateness of the Council's own spending based on criteria in the Council policy on Council expenses, including periodic random audit of the Council members' expenses, including honoraria and stipends.

4.9.3.a.ii. External Audit

4.9.3.a.ii.I. Recommendation for the annual membership meeting decision on the appointment of an independent financial auditor.

4.9.3.a.ii.II. Recommendation for the annual membership meeting approval of the audited financial statements.

4.9.3.a.ii.III. Review and discuss the annual audit plan with the external auditor, including the auditors' independence, materiality levels, areas of focus, engagement fees, and other matters of significance.

4.9.3.a.ii.IV. An opinion for the Council, based on evidence required by the external auditor, as to whether the independent audit of the College was performed in an appropriate manner, including the authority to meet independently with the College's auditors.

4.9.3.a.ii.V. An annual report to Council highlighting the committee's review of the audited financial statements and any other significant information arising from their discussions with the external auditor.

4.9.3.a.iii. Risk Management

4.9.3.a.iii.I. Periodic review of the College's risk assessments on operational, financial, reputational, regulatory, and IT and cyber security risks, and evaluate risk mitigation strategies and activities.

4.9.3.a.iii.II. Annual evaluation as to whether CPSM is meeting its legislative duties under the RHPA.

4.9.3.a.iii.III. Annual review of the College's disaster recovery and business continuity plans.

4.9.3.a.iii.IV. Yearly assessment of the adequacy of the College's insurance coverages.

4.9.4. Composition

4.9.4.a. Finance, Audit and Risk Management Committee shall consist of:

4.9.4.a.i. The President Elect/Treasurer;

4.9.4.a.ii. At minimum two other members;

4.9.4.a.iii. A public representative who is a qualified accountant;

4.9.4.a.iv. A person who is either a member or non-member with significant experience in risk management;

4.9.4.a.v. Additional public representatives as required to ensure one third representation by public representatives; and

4.9.4.a.vi. The President and Registrar as non-voting, ex officio committee members.

4.9.5. The President-Elect/Treasurer shall serve as the chair of the Finance, Audit and Risk Management Committee.

4.9.6. The Finance, Audit and Risk Management Committee shall review its Terms of Reference on a yearly basis to ensure its continued effectiveness and recommend to Council any changes that are deemed necessary.

Current

4.9 Audit and Risk Management Committee Terms of Reference

4.9.1 Authority

4.9.1.a In accordance with the RHPA, The Affairs of the College and Code of Ethics Bylaw, policies approved by Council and the authority delegated to the Audit and Risk Management Committee by Council pursuant to section 17 of the RHPA to make investment decisions on behalf of the College.

4.9.2 Purpose

4.9.2.a The purpose of the Audit and Risk Management Committee is to provide:

4.9.2.a.i Recommendation(s) for the annual membership meeting decision on the appointment of an independent financial auditor and to serve as liaison with the auditor on behalf of Council.

4.9.2.a.ii An opinion for the Council, based on evidence required by the external auditor, as to whether the independent audit of the College was performed in an appropriate manner, including the authority to meet independently with the College's auditors.

4.9.2.a.iii Current information for the Council on significant new developments in accounting principles for not-for-profits or relevant rulings of regulatory bodies that affect the organization.

4.9.2.a.iv An annual report to Council highlighting the committee's review of the audited financial statements and any other significant information arising from their discussions with the external auditor.

4.9.2.a.v A self-monitoring report on the appropriateness of the Council's own spending based on criteria in the Council policy on Council expenses, including periodic random audit of the Council members' expenses, including honoraria and stipends.

4.9.2.a.vi An annual report for the Council as to Registrar compliance with Financial and Investment provisions of this Governance Policy.

4.9.2.a.vii An annual recommendation to Council as to the rates and amounts of honoraria and stipends to be paid by the College in the following year.

Current

4.9.2.a.viii Support and monitoring of the risk management activities of the College and providing advice to Council on identified key risks and risk management activities.

4.9.2.a.ix Manage the College's investments, including the authority to make investment decisions for the College in accordance with Council policies, as set out in the Affairs of the College and Code of Ethics Bylaw and the Governance Policies.

4.9.2.a.x An annual recommendation to Council as to whether the internally restricted reserve for the potential wind-up costs of the College should be increased in the next fiscal year and, if so, by what amount.

4.9.3 Composition

4.9.3.a Audit and Risk Management Committee shall consist of:

4.9.4.a.i The President Elect/Treasurer;

4.9.4.a.ii At minimum two other members;

4.9.4.a.iii A public representative who is a qualified accountant;

4.9.4.a.iv A person who is either a member or non-member with significant experience in risk management;

4.9.4.a.v Additional public representatives as required to ensure one third representation by public representatives; and

4.9.4.a.vi The President and Registrar as non-voting, ex officio committee members.

4.9.4 The President-Elect/Treasurer shall serve as the chair of the Audit and Risk Management Committee.

COUNCIL MEETING – JUNE 19, 2020

NOTICE OF MOTION FOR APPROVAL

SUBJECT:

CPSM 2020-2021 Operating Budget

BACKGROUND:

While it is the responsibility of the Registrar to prepare an annual operating budget and manage the operations of the College to that budget, the Audit and Risk Management Committee has responsibility to review the annual operating budget and recommend its approval to Council.

Based on key parameters established - the operating budget for the 2020-2021 fiscal year projects revenues of $8,410,721, expenses of $8,342,401 for a projected excess of revenues over expenses in the amount of $68,320. The budgeted forecast for the future fiscal year 2021-2022 indicates a deficiency of revenue over expenses of $129,642 and an excess of revenue over expenses in 2022-2023 of $88,440.

Attached are the CPSM 2020-2021 budgeted Statement of Operations presented in two formats – by nature of expense (employee costs, committee meetings, office expenses etc.) and by core function (Qualifications, Complaints, Standards etc.). This second format was adopted at the request of FMRAC for comparative purposes with other MRA's across the country.

Annual Inflationary Increase for Certificates of Practice

A provision in the CPSM Fee Bylaw provides for an automatic inflationary increase in fees annually:

> "3. The fee for the annual certificate of practice shall automatically increase by an amount equal to the Manitoba Consumer Price index to cover inflationary costs."

There is no provision for waiving this automatic inflationary increase in special or extraordinary circumstances such as a pandemic.

In making this decision to not increase the annual fees, the Audit and Risk Management Committee discussed the extraordinarily unique circumstances this year including the negative financial impact to many members' medical practices from the COVID-19 pandemic, the favourable financial results of 2019/20 of a net income of $483,000, and the forecasted net income of $132,000 in the 2020/21 operating budget. It was noted that if the automatic

inflationary increase was not included in the 2020/21 operating budget, the impact to net income would be a reduction of $64,000 to $68,000.

To achieve the desired result of excluding the automatic inflationary increase, the Audit and Risk Management Committee recommends that Council follow this process to pass one new motion:

i. to recognize the negative financial impact to many members' medical practices from the COVID-19 pandemic, the favourable financial results of 2019/20, and the forecast positive net income in the 2020/21 operating budget and thereby delete Article 3 in the Fee Bylaw:

   "3. The fee for the annual certificate of practice shall automatically increase by an amount equal to the Manitoba Consumer Price index to cover inflationary costs."

ii. to approve the 2020/21 operating budget with the inflationary adjustment removed; and

iii. to reinstate Article 3 in the Fee Bylaw effective January 1, 2021.

PUBLIC INTEREST RATIONALE:

"A College must carry out its mandate, duties, and powers and govern its members in a manner that serves and protects the public interest." s. 10(1) RHPA

The Operating Budget is sufficient for CPSM to not compromise fulfilling its statutory mandate to serve and protect the public interest.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE COUNCIL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON JUNE 19, 2020, DR. JACOBI ELLIOTT, CHAIR OF THE AUDIT AND RISK MANAGEMENT COMMITTEE, WILL MOVE THAT COUNCIL APPROVE:

i. recognizing the negative financial impact to many members' medical practices from the COVID-19 pandemic, the favourable financial results of 2019/20, and the forecast positive net income in the 2020/21 operating budget, that Article 3 in the Fee Bylaw be deleted:

   "3. The fee for the annual certificate of practice shall automatically increase by an amount equal to the Manitoba Consumer Price index to cover inflationary costs."

ii. approving the 2020/21 Annual Operating Budget with the inflationary adjustment removed as presented; and

iii. reinstating Article 3 in the Fee Bylaw effective January 1, 2021.

(Expenses by function)

College of Physicians & Surgeons of Manitoba

Statement of Operations - Direct Costing

FY's 2020-21 to 2022-23

	2018-19 Actual	2019-20 Actual	2020-21 Budget	Increase/ (Decrease)	%	2021-22 Estimate	%	2022-23 Estimate	%
Revenues									
Physician & Resident License Fees	5,623,731	5,898,381	6,006,019	107,638	2%	6,218,187	4%	6,573,928	6%
Educational Register Fees	94,425	91,975	78,850	(13,125)	-17%	95,794	21%	98,390	3%
Clinical Assistant License Fees	30,167	31,350	34,200	2,850	8%	42,600	25%	49,800	17%
Physician Assistant License Fees	34,216	40,500	37,350	(3,150)	-8%	39,300	5%	40,500	3%
Medical Corporation Fees	358,227	370,461	363,000	(7,461)	-2%	380,550	5%	396,750	4%
Other Fees and Income	445,310	433,976	345,625	(88,351)	-26%	288,125	-17%	288,125	0%
Interest Income & Change in Market Value	168,998	173,758	190,678	16,920	9%	185,401	-3%	187,354	1%
Government Funded Program Revenues	1,211,375	1,434,711	1,355,000	(79,711)	-6%	425,000	-69%	321,409	-24%
	7,966,448	**8,475,112**	**8,410,721**	**(64,390)**	**-0.8%**	**7,674,958**	**-8.7%**	**7,956,256**	**3.7%**
Expenses									
Governance	147,389	158,252	140,250	(18,002)	-13%	141,006	1%	141,781	1%
Qualifications	882,324	918,511	946,883	28,371	3%	982,477	4%	1,016,822	3%
Complaints and Discipline	1,326,440	1,436,654	1,627,731	191,077	12%	1,591,192	-2%	1,530,609	-4%
Standards	927,510	927,900	1,053,952	126,052	12%	1,140,950	8%	1,167,814	2%
Operations and General Administration	2,398,837	2,420,208	2,437,343	17,135	1%	2,636,717	8%	2,716,445	3%
IT	1,049,609	842,104	806,171	(35,933)	-4%	828,804	3%	847,573	2%
Government Funded Program Expenses	1,178,458	1,288,367	1,330,071	41,704	3%	483,454	-64%	446,773	-8%
	7,910,568	**7,991,997**	**8,342,401**	**350,404**	**4.2%**	**7,804,599**	**-6.4%**	**7,867,816**	**0.8%**
Excess (Deficiency) of Revenue Over Expenditures	**55,881**	**483,115**	**68,320**	**(414,794)**		**(129,642)**		**88,440**	

(Expenses by nature)

College of Physicians & Surgeons of Manitoba

Statement of Operations - Direct Costing

FY's 2020-21 to 2022-23

	2018-19 Actual	2019-20 Actual	2020-21 Budget	Increase/ (Decrease)	%	2021-22 Estimate	%	2022-23 Estimate	%
Revenues									
Physician & Resident License Fees	5,623,731	5,898,381	6,006,019	107,638	2%	6,218,187	4%	6,573,928	6%
Educational Register Fees	94,425	91,975	78,850	(13,125)	-17%	95,794	21%	98,390	3%
Clinical Assistant License Fees	30,167	31,350	34,200	2,850	8%	42,600	25%	49,800	17%
Physician Assistant License Fees	34,216	40,500	37,350	(3,150)	-8%	39,300	5%	40,500	3%
Medical Corporation Fees	358,227	370,461	363,000	(7,461)	-2%	380,550	5%	396,750	4%
Other Fees and Income	445,310	433,976	345,625	(88,351)	-26%	288,125	-17%	288,125	0%
Interest Income & Change in Market Value	168,998	173,758	190,678	16,920	9%	185,401	-3%	187,354	1%
Government Funded Program Revenues	1,211,375	1,434,711	1,355,000	(79,711)	-6%	425,000	-69%	321,409	-24%
	7,966,448	**8,475,112**	**8,410,721**	**(64,390)**	**-0.8%**	**7,674,958**	**-8.7%**	**7,956,256**	**3.7%**
Expenses									
Employee Costs	5,282,374	5,514,558	5,645,965	131,407	2%	5,246,216	-7%	5,402,843	3%
Committee Meetings	337,828	402,732	513,152	110,420	22%	438,006	-15%	462,086	5%
Professional Fees	532,364	445,338	488,536	43,199	9%	355,380	-27%	312,245	-12%
Service Fees	472,405	190,096	161,549	(28,547)	-18%	165,588	3%	169,727	2%
Legal	93,077	141,303	217,778	76,475	35%	252,622	16%	156,800	-38%
Building & Occupancy Costs	410,356	421,668	444,772	23,103	5%	451,883	2%	459,671	2%
Office Expenses	588,104	614,295	606,200	(8,095)	-1%	630,455	4%	639,993	2%
Capital Assets	194,060	262,007	264,450	2,443	1%	264,450	0%	264,450	0%
	7,910,568	**7,991,997**	**8,342,401**	**350,404**	**4.2%**	**7,804,599**	**-6.4%**	**7,867,816**	**0.8%**
Excess (Deficiency) of Revenue Over Expenditures	**55,881**	**483,115**	**68,320**	**(414,794)**		**(129,642)**		**88,440**	

COUNCIL MEETING – JUNE 19, 2020

NOTICE OF MOTION FOR APPROVAL

SUBJECT:

Appointment of Public Representative and Committee Membership

BACKGROUND:

1 – PUBLIC REPRESENTATIVE ON COUNCIL

Under the RHPA there are six public representatives on Council. Dorothy Albrecht was appointed by Council in July 2018 to replace a public representative who resigned part way through their appointment. Ms. Albrecht's term ends at this AGM. Dr. Ripstein contacted Ms. Albrecht who indicated her willingness to continue to serve.

2 – COMMITTEE MEMBERSHIP

Appointments to Committees are made annually. There is an attempt to provide continuity and experience on Committees where appropriate yet take advantage of the skills and attributes of the Councillors and others appointed to the Committees.

A skills and attributes matrix was circulated to the new Councillors for input to seek to determine their best fit for Committees. Dr, Ripstein has attempted to contact all new members and those Councillors being recommended for appointments to new committees.

The Executive Committee is responsible for making a recommendation to Council for Committee membership. The Executive Committee makes the following recommendations for Committee membership in the attached lists.

MOTION:

NOTICE IS HEREBY GIVEN THAT AT THE MEETING OF THE COUNCIL OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA, ON JUNE 19, 2020, DR. JACOBI ELLIOTT, PRESIDENT-ELECT, WILL MOVE:

Council approves that Ms. Dorothy Albrecht be appointed as a public representative on Council for a four year term and that membership in Committees be appointed as per the attached lists for Committee Membership 2020/21. at the Executive Committee meeting on May 29, 2020.

Council Members

	Executive	Audit & Risk Mgmt	Standards	Program Review	Quality Improvement	Complaints	Investigation	Inquiry
Agger, Leslie				Pub Rep	Pub Rep			
Albrecht, Dorothy			Pub Rep		Pub Rep			
Blakley, Dr. Brian						Councillor		
Convery, Dr. Kevin							Councillor	
Elliott, Dr. Jacobi (President Elect)	Councillor	Chair	Ex O-NV	Ex Officio	Ex O-NV			
Fineblit, Allan	Pub Rep							
Kumbharathi, Dr. Ravi				Councillor				
Lindsay, Dr. Daniel				Councillor				
Magnus, Lynette		Pub Rep					Pub Rep	
Manishen, Dr. Wayne				Chair				
McLean, Dr. Norman					Councillor			
McPherson, Marvelle	Pub Rep		Pub Rep					
Penner, Dr. Charles		Councillor						
Penny, Leanne						Pub Rep		
Postl, Dr. Brian	Councillor	Councillor						
Ripstein, Dr. Ira (President)	Chair	Ex O-NV	Ex O-NV	Ex Officio	Ex O-NV			
Seager, Dr. Mary-Jane			Councillor					
***Shenouda, Dr. Nader**							Chair	
Sigurdson, Dr. Eric (Past President)	Councillor		Councillor					Chair
Smith, Dr. Heather						Chair		
Stacey, Dr. Brett						Councillor		
Suss, Dr. Roger			Chair		Councillor			
Nguyen, Dr. Audrey (Associate Member)			Councillor					
Ziomek, Dr. Anna (Registrar)	Ex O-NV	Ex O-NV	Ex O-NV	Ex O-NV	Ex O-NV			

External Members

Anderson, Dr. Brent				Member Rep				
Cadieux, Ray		Pub Rep					Pub Rep**	
Hosseini, Dr. Boshra					Member Rep			
Kabani, Dr. Amin				Member Rep				
Kirkpatrick, Dr. Iain				Member Rep				
Kvern, Dr. Brent							Member Rep	
Leicht, Dr. Richard					Member Rep			
Naidoo, Dr. Jenisa				Member Rep				
Polimeni, Dr. Christine			Member Rep		Chair			
Popowich, Dr. Shaundra						Member Rep		
Prud'homme, Dr. Shannon					Member Rep			
Reitmeier, Dr. Shayne						Member Rep		
Sparling, Heather				Gov't Rep				
Stansfield, Katherine			Pub Rep					
Vorster, Dr. Alewyn					Member Rep			

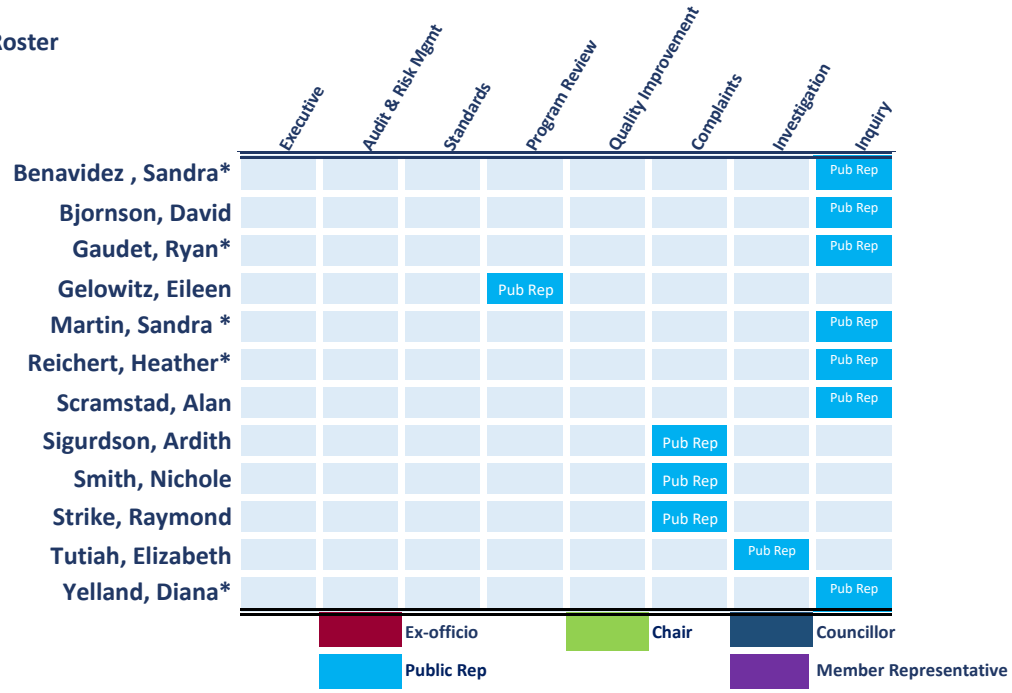
*** Two Year Term**

**** To complete IC matters from 2019-2020**

Ex-officio | Chair | Councillor

Public Rep | Member Representative

Public Representatives on Roster



*** March Council Recommendations to Minister for S.89 Roster**

Subject to Approval by Minister (Renewal)

CPSM Members Appointed to the Inquiry Panel
2020-2021

Sal	Last Name	First Name	Field of Practice
Dr	Ahmed	Munir	Family Med
Dr	Andani	Rafiq	Family Med
Dr	Anderson	Brent Ronald	General Surgery
Dr	Basta	Moheb Samir Samy	Family Med
Dr	Bejjani	Jimmy	Family Med
Dr	Bello	Ahmed Babatunde	Psychiatry
Dr	Bergen	Calvin James	Family Med
Dr	Bernstein	Keevin Norman	Internal Med, Nephrology
Dr	Bhangu	Manpreet Singh	Anesthesia Incl; Perioperative Med
Dr	Blouw	Richard Hendrik	GP
Dr	Bryski	Lisa Maria	Family Med, Emergency Med
Dr	Buchel	Tamara Lynn	Family Med
Dr	Buduhan	Gordon	Thoracic Surgery
Dr	Butler	James Blake	Radiation Oncology
Dr	Campbell	Barry Innes	Psychiatry
Dr	Cavett	Teresa Dylite	Family Med
Dr	Cham	Bonnie Paula	Hematology
Dr	Chan	Ming-Ka	Pediatrics
Dr	Chudley	Albert Edward	Pediatrician
Dr	Corbett	Caroline	Obstetrics & Gynecology
Dr	Dashefsky	Sidney Martin	Diagnostic Radiology
Dr	Derzko	Lydia Ann Lubomyra	Family Med
Dr	Dixon	Nancy Lee Jane	Family Med, Incl; Care of the Elderly
Dr	Dyck	Michael Paul	Psychiatry
Dr	Fishman	Lawrence Blaine	Otolaryngology
Dr	Ghorpade	Nitin Namdeo	Cardiac Surgery
Dr	Gilmore	Jonathan	Family Med
Dr	Goldberg	Aviva	Nephrology/Pediatrics
Dr	Grocott	Hilary Peter Thomas	Anesthesia
Dr	Hanlon-Dearman	Ana Catarina de Bazenga	Pediatrics
Dr	Harris	Kristin Renee	Family Med
Dr	Harris	Patricia Eileen	Internal Med
Dr	Henderson	Blair Timothy	Diagnostic Radiology
Dr	Herd	Anthony Michael	Admin, Family Practice, Incl; Family Med & Emerg Med
Dr	Hrabarchuk	Blair	Internal Medicine
Dr	Hynes	Adrian Francis Mary	Psychiatry
Dr	Jellicoe	Paul Arthur	Pediatric Orthopedic Surgery
Dr	Jones	Jodi Lynn Plohman	Otolaryngology
Dr	Kakumanu	Ankineedu Saranya	Radiation Oncology
Dr	Kean	Sarah Lynn	Gynecologic Oncology, Obstetrics & Gynecology
Dr	Kettner	Joel David	Community Med, General Surgery
Dr	Knezic	Kathy Ann	Family Med
Dr	Kraut	Allen Gerald	Internal Med, Occupational Med
Dr	Lane	Eric Stener	Family Med
Dr	Lavallee	Barry Denis Allan	Family Med
Dr	Leonhart	Michael Warren	Family Med

Dr	Manji	Rizwan Abdulmalik Samji	Caridac Surgery, Critical Care Med
Dr	Martens-Barnes	Carolyn	Family Med
Dr	McCammon	Richard James	Family Med
Dr	Nair	Unni Krishnan	Anesthesia
Dr	Nashed	Maged Shokry	Radiation Oncology
Dr	Peterson	John David	Emergency Med Family Practice
Dr	Porhownik	Nancy Rose	Internal Med, Respirology
Dr	Price	James Bryan	Family Med
Dr	Ross	Timothy K.	Family Med
Dr	Roux	Jan Gideon	Family Med
Dr	Samuels	Lewis	Orthopedic Surgery
Dr	Scott	Thomas Jason Paul	Family Med
Dr	Shah	Ashish Hirjibhai	Internal Med, Interventional Cardiology
Dr	Simmonds	Reesa	Family Med
Dr	Singh	Harminder	Gastroenterology/Internal Med
Dr	Sommer	Hillel Mordechai	Physical Medicine & Rehabilitation
Dr	Spencer	Mandy Lee	Family Med
Dr	Stephensen	Michael	Family Med
Dr	Tagin	Mohamed Ali Mashhoot	Neonatal-Perinatal Med
Dr	Taraska	Vincent Aloysius	Internal Med
Dr	Thompson	Susan Bomany	Orthopedic Surgery
Dr	Van Dyk	Werner Willem Adriaan	Family Med
Dr	Weiss	Elise Collette	Family Med
Dr	Yaffe	Clifford Stephen	General Surgery

CPSM Appointments to Inquiry Committee from S.89 Roster

- David Bjornson
- Alan Scramstad

March Council Recommendation to Minister for S.89 Roster Subject to Approval by Minister (Renewal)

- Ms Sandra Benavidez
- Mr. Ryan Gaudet
- Ms Sandra Martin
- Ms Heather Reichert
- Ms Diana Yelland

COUNCIL MEETING – JUNE 19, 2020

ITEM FOR INFORMATION

SUBJECT:

Registrar/CEO's Report

1 - COVID-19

At the end of February in my last report to Council I wrote:

> **"Pandemic Planning**
> CPSM is participating with the Province, Shared Health, and RHAs on possible pandemic planning for the corona virus. The CPSM website has a link to the provincial website on coronavirus which is updated daily."

How things changed quickly! By the time the last meeting of Council was held on March 13, the situation had already changed and there was an extensive discussion on COVID-19. Since then, until recently, COVID-19 has been at the forefront of all of us. I have provided updates to Council since then.

In Manitoba to date we have not experienced the significant numbers of cases elsewhere in Canada or worldwide and for that I am truly grateful.

I want to stress that although CPSM doors closed to the public, work continued at CPSM.

Daily Covid-19 Meetings of Senior Leadership Team

Senior leadership of Registrars and senior staff met daily by Zoom to determine the best course of action during these challenging times. Priority action charts were prepared and updated daily. The frequency of the meetings diminished over time to twice per week.

Supporting Practice of Medicine Changes

It became quickly apparent that practice of medicine had to change and change very quickly in this pandemic.

CPSM released two messages from the President and Register and three sets of FAQs (and updates) that changed the practice of medicine including:

- Clarifying the mandatory duty to continue practicing medicine
- Advising of what the standard of practice is during a pandemic
- Permitting virtual medicine in many situations (in conjunction with new fee tariff)

- Working with the College of Pharmacists of Manitoba to allow physicians to prescribe up to 30 days of home carries for methadone and suboxone instead of daily witnessed doses at the pharmacy
- New rules for prescribing in virtual medicine, including M3P drugs
- Expanding the scope of practice
- Setting rules for medical students and residents to practice without challenging their certification exams
- Setting rules for practicing with and without Personal Protective Equipment
- Caution against prescribing precautionary treatment drugs for COVID-19, jointly with the Colleges of Pharmacy and Registered Nurses
- Ordering of non-essential diagnostic testing
- Waiving CME/CPD requirements for the QI program

Registration Matters

The main initiative CPSM pursued to address registration matters during the COVID-19 challenge was to have Council approve a Practice Direction to register specialists from the graduating 2020 cohort on the provisional register. Registration of students enrolled in other universities for electives will be limited due to the travel restrictions and the limitation on these electives now.

CPSM worked with Shared Health to register recently retired physicians within the healthcare system. While Both BC and Ontario respectively registered International Medical Graduates for very short term licenses, Manitoba declined to do so.

Delay of Non-Covid-19 Matters Initially

CPSM delayed certain other activities such as the Strategic Organizational Priorities Working Groups on Medical Cannabis, Accredited Facilities, Boundaries, and Benzodiazepines. After the last Council Meeting Council was ready to go with a Council Update which mainly was the precursor to launching the consultation of the Standard of Practice for Prescribing Benzodiazepines, which CPSM was also prepared to launch. Situational awareness indicated this would not have the desired impact in the early days of the pandemic in Manitoba and so it was delayed initially.

In the initial stages of the pandemic, registrations continued, and there was much work with the 2020 graduating students and residents. Complaints and Investigations initially focused on the most serious matters. MANQAP had the Program Review Committee extend the accreditation of diagnostic, X-ray, and laboratory facilities to not interrupt service at this critical time.

I want to make it clear that most staff continued their regular daily jobs, but just from their homes – registrations of new members continued, accounts were paid, complaints were reviewed, investigations were undertaken, physician health program experienced heightened activity.

Other Committee work was also be placed on hold initially, unless there were immediate or pressing matters of public safety.

Workplace

All staff worked at home – the dedication of staff to continue to serve the doctors has been extremely strong and cohesive and they have much pride in trying to assist members providing healthcare during this pandemic. All staff continued to work fulltime.

Recently, CPSM has developed a staff plan for the gradual return to work. Manitoba continues to slowly and cautiously relax some restrictions on the COVID-19 public health orders that have been in place over the past several months. Accordingly, it will be essential that all CPSM staff continue to respect social and physical distancing requirements & practice strict hand hygiene. This is the best defense – both at home and when in the office. Staff have been advised to stay home if ill. Several staff have been attending at the office periodically, with an increased number recently. May 25th marked the start of the phased approach for CPSM to begin returning to work. Numerous safety measures set up will help ensure a safe return to work plan. This is an adjustment, but we are trying to make the transition as seamless as possible while we try and break some old habits and learn new ones. This will take time and patience. Staff will try and make these adjustments as smooth as we can as we look for ways to make our "new practices" part of a safer and healthier workplace.

Restarting Initiatives

Like many of you, with the declaration of the COVID-19 pandemic, most physicians were incredibly busy adapting to the new practice of medicine during a pandemic and a bombardment of information. That changed over time and many physicians were not as busy as usual at their practices and less information was being distributed.

Accordingly, some of the initiatives that were paused due to COVID-19 were re-started. For instance, the Committees and Working Groups began to meet virtually to continue with their work.

Similarly, the election of Councillors was paused initially and then started and completed.

These are unusual times, and CPSM still is trying to react with the times, being respectful of its members' needs and the duty to serve the public interest by still proceeding with those items and initiatives which are suitable to the virtual world that we find ourselves in.

CPSM Work Continues

At the outset of the pandemic, some CPSM functions were suspended, especially those involving meetings or because some staff had new work priorities brought on by COVID-19. Other CPSM functions such as Registration continued to operate using the new iMIS data base and operating system. As the pandemic unfolded perhaps differently than expected and we realized that most

physicians did have spare time, we re-launched many of our Committees and Working Groups by Zoom. CPSM also continued with its regular work in Complaints/Investigations, Quality Improvement, and Standards. The practice auditors conducted their audit virtually. Deloitte was able to undertake the entire financial audit remotely. Physician Health has seen a jump in cases, particularly very complex cases.

Working with Other Organizations

Staff have worked collaboratively with the Colleges of Pharmacy and Registered Nurses, Shared Health, Health/Seniors/Active Living, Doctors Manitoba, CMPA, FMRAC, the University, the certifying Colleges (Royal College, CFCP, and MCC), and the Alliance of Regulated Health Professions Regulators. We also had a telephone conversation with the Minister of Health and advised of these updates. We have also responded to many inquiries from our members. I have also been asked to participate in the weekly meeting with the CMOs of the region.

FMRAC – Federation of Medical Regulatory Authorities of Canada

Working with the other Registrars became very important as we all experienced similar concerns and challenges brought on by COVID-19. The support received from the Registrars was helpful and we collaborated on similar approaches to the many challenges brought on by COVID-19. FMRAC was able to provide unified responses to certifying colleges, residents, universities, and regional health authorities on exams and registration matters. CPSM was assisted in receiving permission to use messaging and policies developed by the larger colleges which have specialized resources in communications, policy, and planning. As Registrars we met weekly to address the necessary changes to regulation brought about by COVID-19.

The Annual Educational Conference scheduled to be held in June was cancelled.

2 – PRESCRIBING PRACTICES

The Prescribing Practices Program has undertaken three very time-consuming and difficult reviews of prescribing practices. One of the reviews was undertaken with the College of Pharmacists of Manitoba and the College of Registered Nurses of Manitoba. This tri-partite interdisciplinary review is a first in the province.

Two sessions on Opioid Agonist Treatment were conducted virtually and received favourable feedback.

The regular work of the Prescribing Practices Program continued.

3 – PHYSICIAN HEALTH PROGRAM

The Physician Health Program has seen increased cases of complexity recently, perhaps brought on by the stresses and particularly unique circumstances of the pandemic. Dr. Mihalchuk is already working with various medical care groups in the province to raise physician awareness and understanding of the supportive role of Physician Health Program and the need for self-reporting and reporting of colleagues to ensure patient safety.

4 –SYSTEM ISSUES ARISING FROM REVIEWS IN COMPLAINTS/INVESTIGATIONS, STANDARDS, AND PROGRAM REVIEW COMMITTEE

At the March Council Meeting, I was asked to report on the health system issues that arise in Complaints/Investigations, Standards, and Program Review Committee.

CPSM has no jurisdiction over system issues, but on occasion a system issue arises which I report to the Manitoba Clinical Leadership Committee (of which I am a member), the group of Chief Medical Officers of the province (who I now meet with monthly), or the CEO or CMO of Shared Health (with whom I have a working relationship), or the Deputy Minister who I meet with quarterly.

Examples of system issues that have been advanced include the following:

- Point-of-Care Testing at the Snow Lake Health Centre
- Supervision of Physician Assistants in an Emergency Department
- Provision of Critical Care Services
- Closure of 24 Dynacare diagnostic lab service centres
- Canada Blood Services

5 – INQUIRY COMMITTEE

At the March Council Meeting, I was asked to report on the work undertaken by the Inquiry Committee at this June meeting.

The Investigation Committee closed 44 files last year. Many resulted in no further action or provided the member with advice for improvement. When possible, deficiencies in care or conduct were addressed through education, supervision or voluntary conditions on a member's practice.

When the Investigation Committee has determined that the concerns arising about a physician (or other member) are very serious and education would not be appropriate or sufficient, or the member does not agree to conditions on their practice, the Committee will consider if formal discipline is required. This includes consideration of whether there is sufficient evidence to establish that the charges could successfully be proven (based on a balance of probabilities), and whether it is in the public interest to do so. If the criteria are met, the matter should be referred to Inquiry. The most common examples of such

matters have historically involved allegations of sexual impropriety, but more recently, we have had a number of cases involving serious deficiencies in care or other very unprofessional/unethical conduct causing harm.

When a matter is referred to Inquiry, there is a hearing of the allegations against the member. The hearing usually takes place at the College and is similar to a trial, but less formal and subject to different rules. The Brown room is arranged like a court room and lawyers representing the Investigation Committee present their case to a panel of 3 persons (2 doctors and one public representative). The member is usually represented by their own lawyer.

The process of investigating an issue, and then completing all the steps to prepare for and participate in a hearing, is time consuming and expensive. It often entails hundreds of hours of work for support staff, the investigator and College lawyers with intermittent involvement of the Investigation Chair. For lengthy and complex hearings, the Investigation Committee often retains a lawyer to assist with the prosecution because of the demands on internal counsel to meet the many other demands of the College for their services.

The following are examples of activities and associated costs:

1. Investigation:

- Communicating with the member and the patient/complainant through written correspondence
- Reviewing relevant medical records and other documents (can be voluminous)
- Interviewing physicians, patients and potential witnesses
- Arranging and paying court reporters to record and transcribe interviews
- Engaging experts to review the care and provide reports that address specific questions
- Preparing an investigator's report that details all the relevant information for the Investigation Committee to consider.
    - This includes an explanation of the expected standard and how the member has compared against that standard.
- Facilitating a meeting of the Investigation Committee to discuss the relevant issues (note that committee is paid only for the meeting time and not for their review of the documents)
- Preparing draft charges for the Committee to consider

2. Hearing preparation:

Once the Investigation Committee determines that charges of professional misconduct are warranted, the following activities are required:

- Drafting and finalizing details of the charges
- Providing disclosure of the relevant documents to the member
- Communicating with the member (usually through their lawyer) about which, if any, charges are acknowledged and to which they will plead guilty
- Preparing written submissions for the Inquiry Hearing. This is a detailed account of the information considered necessary to prove the charges
- Preparing oral arguments for presentation at the hearing
- Meeting with experts and other witnesses to assist them with preparation for the hearing

3. Participation in the Hearing:

Like a trial, the member can plead guilty or not guilty to all, or some of, the charges and this will have bearing on the length and complexity of the hearings.

- Oral arguments are presented
- Experts and other witnesses may be called to provide evidence and be cross examined
- A court reporter is present at all times to record the proceedings. The reporter may be required to produce transcripts of the various testimonies.
- 3 panel members preside over the process and their participation involves
    - Review of all relevant documents provided in advance of, and at the hearing
    - Hearing of all evidence
    - Deliberation of the issues
    - Preparation of a report that details their decision (guilty/not guilty) and the reasons for that decision
- Panel members are given legal assistance by an independent lawyer

4. Penalty hearing:

If a guilty verdict is determined (or pleaded to) there must be consideration as to the appropriate penalty.

- Lawyers review all potentially relevant precedents across Canada and prepare a document detailing these matters
- Lawyers prepare written presentations regarding recommendations for penalty and the rationale
- Lawyers present oral arguments to the panel at a penalty hearing
- The panel considers the arguments and prepares a decision which details their resolution and orders.
- As with the original hearing, the panel is provided with independent legal advice throughout the process
- Panel members and their independent lawyer track their hours and are paid for the time required to carry out all of the above responsibilities at the initial hearing and the penalty hearing.

Although all hearings to date have been conducted under *The Medical Act*, both *The Medical Act* and *The RHPA* allow for an award of costs against the member if the member is found guilty of one or more of the charges against them. Generally, it is part of the imposed penalty to pay the costs associated with the process.

COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA

2020-2021 MEETING DATES

MONTH	MEETING DATE			COMMITTEE	OTHER DATES
July 2020	Tues	21	13:30	Complaints	01: Canada Day - CPSM Closed
August 2020	Thur	13	08:30	Quality Improvement	03: Civic Holiday - CPSM Closed
	Wed	26	08:00	Executive Committee	
	Mon	31	09:00	Inquiry	
September 2020	Fri	04	08:30	Central Standards	07: Labour Day - CPSM Closed
	Tues	08	17:00	CHSC	
	Wed	09	08:00	Program Review	
	Wed	09	08:30	Investigation Committee	
	Tues	15	13:30	Complaints	
	Fri	25	08:00	Council	
October 2020	Thur	15	8:30	Quality Improvement	12: Thanksgiving Day - CPSM Closed
	Tues	27	13:30	Complaints	
November 2020	Tues	03	17:00	CHSC	11: Remembrance Day - CPSM Closed
	Wed	04	08:30	Investigation Committee	
	Fri	06	08:30	Central Standards	
	Tues	10	08:00	Executive	
	Thurs	12	08:30	Finance, A & R	
	Thur	19	15:00	MPHSC	
	Wed	25	08:00	Program Review	
December 2020	Tues	01	13:30	Complaints	24 Dec - 31 Dec: CPSM Closed
	Wed	09	08:00	Council	
	Wed	16	08:30	Investigation Committee	
January 2021	Thur	07	08:00	Quality Improvement	01: New Years Day - CPSM Closed
	Tues	19	13:30	Complaints	
February 2021	Fri	05	08:30	Central Standards	
	Wed	10	08:30	Investigation Committee	
	Wed	17	08:00	Executive	15: Louis Riel Day - CPSM Closed
	Mon	22	08:30	Finance, A & R	
	Wed	24	08:00	Program Review	
March 2021	Tues	02	13:30	Complaints	23: Councillors/ER/PA/Cl.A Nominations Out
	Fri	19	08:00	Council	
April 2021	Thur	08	08:00	Quality Improvement	02: Good Friday
	Wed	14	08:30	Investigation Committee	
	Tues	20	13:30	Complaints	13: Councillors/ER/PA/Cl.A Nominations Closed
	Fri	30	08:30	Central Standards	20: Councillors/ER/PA/Cl.A Ballot Out
May 2021	Wed	12	08:00	Executive Committee	04: Ballots In - Councillors/ER/PA/Cl.A Election Day
	Wed	12	09:30	Registrar Review	24: Victoria Day - CPSM Closed
	Wed	19	08:00	Program Review	
	Tues	25	13:30	Complaints	
	Wed	26	12:00	Finance, A & R	
June 2021	Wed	09	08:30	Investigation Committee	FMRAC: 04-07
	Fri	11	08:00	Council	

MPHSC - Maternal & Perinatal Health Stanards Committee

CHSC - Child Health Standards Committee

Council Meeting
Attendance Record
2019-2020

		Meeting Date			
Councillor	Electoral District	21-Jun-19	13-Sep-19	13-Dec-19	13-Mar-20
Ms D. Albrecht	Public Representative				
Dr. B. Blakley	Winnipeg				
Dr. K. Convery	Central				
Dr. H. Domke	Winnipeg				
Dr. S. Duncan	Brandon				
Dr. J. Elliott	Parklands				
Mr. A. Fineblit	Public Representative				
Dr. B. Kvern	Winnipeg				
Dr. R. Kumbharathi	Winnipeg				
Dr. D. Lindsay	Interlake				
Dr. Matthew MacDowell	Associate Member				
Ms L Magnus	Public Representative				
Dr. W. Manishen	Winnipeg				
Ms M. McPherson	Public Representative				
Dr. B. Postl	University of Manitoba				
Dr. I. Ripstein	University of Manitoba				
Dr. N. Shenouda	Eastman				
Dr. E. Sigurdson	Winnipeg				
Dr. J. Silha	Winnipeg				
Dr. H. Smith	Winnipeg				
Dr. B. Stacey	Northern				
Dr. R. Suss	Winnipeg				
Dr. A. Vorster	Westman				
Dr. D. Mabin	Northern				

In Attendance
Not In Attendance
Not on Council

SELF-EVALUATION OF COUNCIL

The CPSM is interested in your feedback regarding your experience at the Council meeting. The results of this evaluation will be used to improve the experience of members and to inform the planning of future meetings.

	Strongly Disagree	Neutral	Strongly Agree	Comments
How well has Council done its job?				
1. The meeting agenda topics were appropriate and aligned with the mandate of the College and Council.	1	2	3	
2. I was satisfied with what Council accomplished during today's meeting.	1	2	3	
3. Council has fulfilled its mandate to serve and protect the public interest	1	2	3	
4. The background materials provided me with adequate information to prepare for the meeting and contribute to the discussions.	1	2	3	
How well has Council conducted itself?				
5. When I speak, I feel listened to and my comments are valued.	1	2	3	
6. Members treated each other with respect and courtesy.	1	2	3	
7. Members came to the meeting prepared to contribute to the discussions.	1	2	3	
8. We were proactive.	1	2	3	

Feedback to the President				
9. The President/Chair gained consensus in a respectful and engaging manner.	1	2	3	
10. The President/Chair ensured that all members had an opportunity to voice his/her opinions during the meeting.	1	2	3	
11. The President/Chair summarized discussion points in order to facilitate decision-making and the decision was clear.	1	2	3	
Feedback to CEO/Staff				
12. Council has provided appropriate and adequate feedback and information to the CEO	1	2	3	
My performance as an individual Councillor				
13. I read the minutes, reports and other materials in advance so that I am able to actively participate in discussion and decision-	1	2	3	
14. When I have a different opinion than the majority, I raise it.	1	2	3	
15. I support Council's decisions once they are made even if I do not agree with them.	1	2	3	
Other				
16. Things that I think Council should start doing during meetings:				
17. Things that I think Council should stop doing during meetings:				

Thank you for these excellent guidelines!

Bravo for the plan to make benzodiazepines and Z-drugs part of M3P!

Glad to hear that prescriptions for Alprazolam are particularly discouraged.

Is there any information on why benzodiazepine and Z-drugs Rx's are so high in MB?

The guidelines for indications and tapering look very helpful.

Thanks, again.

I'm sure these guidelines will save lives and improve the lives of many patients and their families.

Thank you for soliciting the members comments and opinions about this document.
After having read it carefully, I feel that I can support it without reservation.
I extend my thanks to those who did the research to create this guideline/policy.

Please hold this very important document. I feel rushed and I would like more time to review.

Just having read it I am already thinking how it is going to affect daily interactions.

The pandemic and this!! No hold for 1year.

I believe a move to place prescribing benzodiazepines to the triplicate format is a mistake.

Though I believe the intention behind moving benzodiazepines to a status requiring triplicate prescriptions are well intentioned, I worry that there will be unintended complications and that such a move is unlikely to reduce consumption in the near or midterm.

I do not carry triplicate prescriptions, as do other physicians and also have many legacy clients on long term benzodiazepines. If the college were to implement these changes would there be measures in place to deal with the clients on benzodiazepines whose physicians do not use triplicate prescriptions or would those physicians be obligated to start using triplicates?

In medicine we are in constant conflict of data and guidance, and complex cultural expectations that range from expectations of living a stress and pain free life, to life is difficult and pain is inevitable.
We have guidance such as McMaster pain management that in 2010 gave guidance of maximal morphine equivalence of 200mg per day changed in

2017 to maximal morphine equivalence of 90mg morphine per day and the death rate from opiates seems unchanged. The current opiate crisis seems to parallel the prescribing of opiates from the medical profession, and in Manitoba at least, those were prescribed with the triplicate system.

Though I believe that full tolerance to benzodiazepines, like opiates, takes only a matter of weeks, I also believe that others will have conflicting beliefs. I also believe that chronic benzodiazepine use is a complex cultural issue and the solution should involve the entire community with education, not just physicians.

I am a family physician working in rural area. My patients also include people living on the reserve.
When I began practicing in the region I had many patients who would come in just for benzodiazepine or opioid prescription.
I was very clear with these patient regarding my way of practice - will not prescribe continuously but I encouraged them to wean off and discussed a plan regarding the same.
Few of the patients followed the plan, some moved on to other PCP while others tried to insist that they needed them.
I have some patient's on T#3 for some chronic pain issues who cannot take NSAIDs because of CKD.
I also have few patients on zopiclone and they are aware of side effects like decline in cognition, memory issues and chances of fall.
I also discuss that opioids can make them tolerant and they might need more and more dose which compounds the side effects.
I guess that people in my community have an idea that I prescribe these medications only for a short term and for palliative care.

I strongly believe that as physicians we have a very significant role in dealing with this crisis.

Thank you for the opportunity to respond to the draft.

I can appreciate that many hours of hard work has been directed towards this document.
So it bothers me to have any additional comments at all.

But
I feel "must" should be used consistently, if that is the intent.
eg:
"Must" in stead of "are to be"

"Must" points should be easier to recognize and stand out.
In the document the "must" is sometimes hidden later in the sentence.

Also, the actual crucial word that describes the point is sometimes partially hidden in the sentence or point or appears too late in the sentence.
For example: The doctor must:
followed by the points in bullet form with the crucial word early in the sentence - even starting the sentence. The crucial word can even be highlighted.

If it is not definitely a "must" it should not be under "must". A debatable "must" is probably not a "must".

Clear as mud??.... I would love the document to be easier to read and for it to be very easy to recognize the point immediately as the eyes move to the next bullet - just scanning the document quickly should enable the doctor to recognize the points easily. This should make it more user friendly.

College of Physicians and Surgeons of Manitoba

Winnipeg MB

May 29, 2020

Re: Feedback on Draft Standard of Practice for Benzodiazepines and Z-Drugs.

Dear Sir or Madam:

I am responding to your request for feedback on a draft Standard of Practice (SoP) mandating how doctors treat anxieties and insomnia.

Benzodiazepines, and Z-drugs are used safely by many Manitobans every day. This Standard will now mandate what we must ask our patients, and what we must document in the medical record. I understand those who wrote the Draft are attempting to reduce abuse and dependency. In my opinion this Standard will make it more difficult and less pleasant for patients to obtain, and doctors to refill their medications to treat these increasingly common conditions.

I am responding as a family doctor. Family Physicians know their patients well, and have already been monitoring the use of these drugs, and limiting their unnecessary use.

My response is also given within the context of how our culture is evolving. It appears the College has forgotten we live in a time of granting more individual rights. We have the right to hasten our death (MAID), to refuse resuscitation (DNR), to refuse medical care even when unable to communicate (Health Care Directive). We also have the right to privacy of our medical records, the right to choose and change our gender or sexual orientation. Even when it comes to self-treatment of insomnia and anxiety, one can easily buy and consume cannabis, alcohol and "over the counter" medication without any oversight. Society and governments increasingly value the rights of an individual.

Below, I will outline my specific concerns:

1- In the preamble of the Draft Standard, in the last Bullet Point, it states that the "Number needed to treat ... to get improved sleep is 13, whereas the number needed to harm is only 6". There is no source for this statistic. **If the statistic is accurate, why allow any Manitoban to use these drugs. Defend this quote or remove it.**
2- **The Draft Standard uses "must" an astounding 18 times** to mandate how a doctor must interact with a patient regarding the use of these medications.
3- **The Standard requires EACH** encounter involving refills of these medications to follow those 18 "musts". It does not allow for an existing chart entry that has previously outlined the discussion/plan to give relief for this Standard's requirements.

4- **A consequence of this Standard will be increased office visits** to discuss, plan, and document the use of these medications. If the College expects a Physician to fulfill 18 musts, an office visit will be required each time. A doctor would not have time to address the primary concern of a patient and fulfill this standard when the patient says at the end of a visit: "Oh doctor, I also need my medications refilled."

5- **This Standard would keep a doctor from responding to a phone call or fax from the pharmacist,** a practice that is currently widespread. This needs to clarified in the Standard.

6- A College Standard of Practice dictates an outward behavior that must be followed completely by Manitoba's doctors. What **Family Physicians have been doing through relationships and collaboration must now be done via the use of questions and restrictions and this will cause our patients to experience shame**. Since there are thousands of Manitobans who really do suffer from anxiety and/or insomnia and most have responsibly used these prescription medications for years, they will be in for an emotional shock when their doctor suddenly begins to ask for the information this Standard mandates. They will suspect their doctor doubts their story. Why else would the doctor be asking these type of questions?

7- **These questions** include **making sure they really need their medications** (point 4 and 5), and **that the dose they have been using is not too high** (point 3). The doctor "must **prescribe the lowest effective dosage**" (point 3 and 10 a) for the **"shortest possible time"** (point 3) and **"consider a trial of slow tapering"** (point 9c) to reduce their dose or to get them to stop taking it (point 5). And with each prescription the doctor **must "discuss... and document it in the medical record"** (point 5)... **"an eventual possible discontinuation strategy"** (Point 5a). Suddenly our patients need to come in prepared to convince their doctor that they really do need these medications, that they don't wish to experiment with a dose that has been working well, nor wish to stop taking these medications. **Essentially, they need to come prepared to defend their need to get treatment for their anxiety! I submit their anxiety will escalate after this encounter.**

8- **I feel Point 9c (and point 2) is particularly offensive to our patients. It asks the doctor to view each of our patients as having a possible substance abuse disorder**. The Standard (point 9) states a doctor "must carefully consider....in the context of decisions to prescribe or continue to prescribe..." whether a "substance abuse disorder" will "develop or reveal itself". How can a doctor determine this except by asking very specific questions during a patient encounter? Remember, the majority of these patients have been stable on the existing appropriate dose for a long time. They won't be able to understand why their doctor is now asking questions about them abusing the drugs she/he has been prescribing for years. **They will stumble over the idea that their doctor is now blaming them for being an abuser** when they have only been taking the medication as prescribed.

9- Furthermore, physicians are also encouraged to "utilize DPIN or eChart or consult with a pharmacist" (point 2) essentially **to see if they are abusing the medicine by "obtaining prescriptions from multiple providers"**.

10- Your doctor can **"only write a prescription for a maximum of three months", but "never authorize the dispensing of more than a one-month supply"**(point 7). This

means that **in 90 days a patient will be forced to return to their doctor to get a new Rx**. At that new appointment, the same Standard will apply and the cycle will repeat.

11- There is a caveat in Point 7. If you live in a remote community, or you are traveling the Standard makes an exception to the rule of a 30-day supply**. This Standard does not define a remote community**. But the **one who travels for more than 30 days is easily defined. They are the financially secure**. So if you are too poor to travel for more than 30 days, you are restricted in the amount of medication the pharmacist can dispense, and you will be penalized with monthly 30 dollar dispensing fees, while your well off neighbor can get 3 months of medications for one dispensing fee. The poor patient pays 90 dollars for 3 months, the rich pay 30 dollars for 3 months. **It is illogical to believe someone who travels, or someone from a remote community can be considered more trustworthy than those who live close by or can't travel**. Either a person can or cannot be trusted for more than 30 days of pills.

12- A patient **cannot go to their pharmacy a few days early**, as the pharmacist must refuse an early refill request.

I submit that this Standard places shaming restrictions on those who require help with Benzo's and Z-drugs. The patients most affected by this Standard are seniors. They will be traumatized by their doctor's application of this Standard. They already have a muffled voice. While others can and do use have cannabis, many of our seniors would never use this. They only know the medications regulated by this Standard and feel they have been using them safely.

Furthermore, this Standard as written is paternalistic. If the public knew the consequences they would insist you rewrite the Standard removing the paternalistic approach, the illogical penalties to the poor, and the resultant dedicated office visit every 3 months for a new prescription.

I concede there are dangers inherent in taking these medications. And a discussion with a doctor is entirely appropriate. But this is what responsible doctors have been doing their entire career.

Yes, the College needs to protect. What is not appropriate is beginning that discussion from a position where each patient is a potential abuser and needs paternalistic medical care. Paternalism in medicine should not be experienced by anyone in our culture.

Please reconsider your approach to this Standard.

FAX TO:

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Winnipeg, Manitoba

May 28, 2020

The College of Physicians &
Surgeons of Manitoba
1661 Portage Avenue
Winnipeg, Manitoba
R3J 3T7

Dear Sirs/Madam:

RE: DRAFT STANDARD OF PRACTICE --
-----PRESCRIBING BENZODIAZEPHONES AND Z-DRUGS

This letter is in regard to your announcement in the Winnipeg Free Press dated May 9, 2020 regarding input on the above.

I believe all persons who are prescribed BENZODIAZEPINE drugs should be PERSONALLY told they can become addicted in as little as Three Weeks. There should be full disclosure by the Physician as a lot of people do not read the form given out at the Drug store or understand it properly.

I began taking Lorasapam (1 mg at Bedtime) on April 2, 2018 for anxiety and difficulty sleeping when my Husband was very ill and dying in Hospital. I tried to go off the Lorasapam on May 13th and had a bad reaction and the next day my Doctor increased the dosage to 2 mg daily (0.5 mg at 9:00 AM, 0.5 mg at 4:00 PM and 1 mg at Bedtime).

In September 2018, my Pharmacist offerred to help me wean myself off the Drug (with my Doctor's concurrence). It took nine months to get down to 0. It was a dreadful, frightening experience as I was 79 years old and living alone. I was not told it was addictive when I was given the drug and thought I could go off it when I chose. Another Pharmacist warned me about it when I had been on it daily for a month. I was alarmed and went to my Doctor who said ' Oh, No -- maybe 3 or 4 months, low dose, etc., don't worry". I am not complaining about my Doctor as I like him very much but he should have known better. He was trying to help me through a very difficult period in my life.

Thank you for the opportunity to express my views on the Diazepam Drugs which I think are dangerous, easier to go on than off. A friend of mine took his own life after being on Zoplicone for 10 years.

Yours sincerely,

TELEPHONE.