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FROM THE College

President's Message

Dear Members of the College of Physicians and Surgeons,

There has been a lot of activity at the CPSM Council since the last newsletter.

As a result of Council's strategic organizational priorities, we now have four working groups preparing recommendations for Council in 2020 and then to the profession and stakeholders for consultation.

The Standards of Practice for Prescribing Benzodiazepines Working Group was suggested by many of you when the Standard of Practice for Prescribing Opioids was put in place. We have had a robust literature review, and reviewed guidelines from other jurisdictions. Our aim is to decrease the morbidity and mortality related to these drugs, while balancing their usefulness in certain conditions.

The Maintaining Boundaries – Sexual Involvement with a Patient Working Group has looked at policies in multiple jurisdictions. With the chairmanship of Mr. Allan Fineblit, a Public Representative on Council, will be drafting a new CPSM Standard of Practice. The working group will also be making recommendations for policies and procedures, all of which will be designed to protect the public while being educational and fair to the membership.

The Surgical Facilities Accreditation Working Group, chaired by Dr. Wayne Manishen, is looking at how we ensure the safety of the public in non-hospital facilities that perform procedures without anesthesia or conscious sedation.

Finally, the Standard of Practice for Authorizing Cannabis Working Group, chaired by Dr. Brent Kvern, is reviewing and updating our current Standard of Practice for Authorizing Cannabis now that recreational cannabis is legal in Canada.

In response to your concerns around new rules prohibiting Manitoba doctors from speaking to nurses in Nunavut, our Registrar, Dr. Anna Ziomek, responded quickly with our counterparts in Nunavut to put a much more reasonable procedure in place which permits Manitoba registered physicians to provide treatment by telemedicine in Nunavut without registering in Nunavut.

We received an excellent response to our request for physicians to serve on committees. As opportunities arise, we will be in touch with you.

I want to wish you all the best this holiday season and look forward to a productive 2020.

Dr. Ira Ripstein *CPSM President*

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REGISTRAR NOTES

As we approach the end of 2019, we will be saying good bye to Deputy Registrar, Dr. Terry Babick as he will retire at year end. Dr. Babick has been with the College since 1999, initially as a consultant in the complaints department and then Deputy Registrar since May 2002. His contributions to the College have been many and we will miss his presence here.

On January 12, 2020 we will welcome Dr. Ainslie Mihalchuk to the College in her new role as Assistant Registrar. Dr. Mihalchuk will oversea the Standards Department and the Physician Health Program here at the College. Dr. Mihalchuk has recently been the Acting Chief Medical Officer of the Winnipeg Regional Health Authority. She will continue with her family practice part-time.

Dr. Karen Bullock Pries has been appointed Assistant Registrar, from the position of Director of Complaints and Investigations. Dr. Bullock Pries has been with the College since November 2015. She held the position of Medical Consultant in the Complaints & Investigations Department and was appointed to Director of Complaints & Investigations.

I am looking forward to working with both Dr. Mihalchuk and Dr. Bullock Pries in their new roles.

NEW COLLEGE WEBSITE

The new website is now live! The design of a new website has been a major project over the last several months and we are pleased with the outcome. I invite all of you to visit www.cpsm.mb.ca to view the site and provide your feedback. I believe you will find the new site much more intuitive and easier to navigate. Thank you for your patience as the go live date was somewhat delayed, as with almost all IT projects (at least all in my experience).

College Working Groups

The four working groups that were struck on Council's direction are well underway. The diversity of opinions and expertise have made these working groups very interesting and should create recommendations that protect the public and are fair to physicians. The number of members on each working group are:

- Standards of Practice for Prescribing Benzodiazepines – *15 members with 4 CPSM staff*
- Maintaining Boundaries – Sexual Involvement with a Patient – *11 members with 4 CPSM staff*
- Surgical Facilities Accreditation – *16 members with 5 CPSM staff*
- Standard of Practice for Authorizing Cannabis – *14 members with 4 CPSM staff*

These working groups will submit recommendations to Council in 2020 and then once approved by Council we will send them out for consultation with the membership and stakeholders.

Thank you to the many volunteers on these working groups, your expertise, perspective, and contributions are extremely valuable.

Registration Renewals

This was the first year of the annual renewal under the RHPA and all went smoothly. There were a number of new questions this year, including requesting the names of medical directors for those practising in non-institutional settings, inquiring on plans for storage patient records following the end of practice and a question seeking information on physician office laboratories.

Total renewals statistics for 2019-2020 were:

- Completed Physician Renewals: **3261**
- Incomplete Physician Renewals: **22**

  Total: 3283

- Completed Corporation Renewals: **1998**
- Incomplete Corporation Renewals: **62**

  Total: 2060

The Standards of Practice of Medicine and the Practice Directions

The College is setting up a 4-year review cycle for the CPSM Standards of Practice of Medicine and the CPSM Practice Directions. The documents will be reviewed to determine ongoing relevance, best practices, and whether new standards are required to reflect changes in the practice of medicine and shifting societal norms.

Some of the items may require Working Groups to review, others will be done internally. Examples of these include Patient Records which requires a Working Group while Home Births does not.

Any changes to the Standards of Practice require consultation with the members, Manitoba Health Minister, other provincial health regulatory authorities, and any other individual or organization as Council considers appropriate. The Practice Directions do not require consultation, but Council can require consultation as it deems appropriate.

I hope that you will agree that the CPSM has successfully moved several initiatives forward this past year, always focusing on our mandate of public protection. We look forward to 2020 to continue with, and undertake new initiatives.

I would like to wish each and everyone of you, and your families, a wonderful holiday and all the best in 2020.

Max Rady College of Medicine

Message from Dr. Brian Postl, Dean, Max Rady College of Medicine

Dean, Rady Faculty of Health Sciences & Vice-Provost (Health Sciences), University of Manitoba

I am delighted to share with you that the University of Manitoba Max Rady College of Medicine Undergraduate Medical Education program received full accreditation of its program leading to an MD degree until 2027-28 and received one of the most positive results nation-wide since new accreditation standards were implemented in 2013.

The rigorous accreditation process, which takes place every eight years for Canada's 17 medical schools, is led by the Committee on Accreditation of Canadian Medical Schools (CACMS) of the Association of Faculties of Medicine of Canada and the Liaison Committee of Medical Education (LCME) of the Association of American Medical Colleges.

Receiving full accreditation for eight years is an extremely positive result and one that speaks to the incredible amount of work and commitment to a high-quality teaching and learning environment by the college's leadership, faculty, staff, students and our partners and affiliates in health care.

I want to once again sincerely thank and acknowledge all of the deans, department heads, faculty, senior administrators, support staff, learners and our many partners and affiliates who have contributed to our UGME program and to our successful accreditation. See full list here.

The three-day accreditation site visit to the Max Rady College of Medicine took place in April 2019 by representatives of CACMS and LCME. In advance, under the leadership of Dr. Aaron Chiu, associate dean, quality improvement and accreditation, the college undertook an institutional self-study and prepared a comprehensive Data Collection Instrument (DCI) which answered, addressed and supported each of the required elements in 12 broadly themed standards. As well, the Manitoba Medical Students' Association provided an Independent Student Analysis report to the accrediting bodies in advance of the survey visit.

At the conclusion of the visit, the surveyors cited the Max Rady College of Medicine's commitment to social accountability as a leader amongst Canadian medical schools. As well, the surveyors commended our leadership in academics and health care in the province and pointed to the successful implementation of the new UGME curriculum, led by Dr. Ira Ripstein, associate dean, UGME, and developed under the leadership of Dr. Keevin Bernstein, director of curriculum renewal, and Dr. Diane Moddemann, director of curriculum.

Indeed, we implemented many improvements over the last several years to benefit the college's learners, learning environment, faculty and the MD program as a whole. I want to sincerely thank Dr. Aaron Chiu, associate dean, quality improvement and accreditation, who steadfastly led us through a 'mock review' and the correction of those areas identified as at risk for non-compliance.

The CACMS and the LCME voted to grant full accreditation for the maximum eight-year term and requested a status report on nine elements for review in September 2021. Out of a total of 94 elements, there were three elements assessed as unsatisfactory and six assessed as satisfactory with monitoring. The college has begun to address each of these.

While the accreditation process occurs every eight years, it is not an end point. It really is an ongoing opportunity for the Max Rady College of Medicine to engage in continuous quality improvements and innovations of our UGME program, our teaching and learning environments and how we evaluate and enhance the education of future physicians.

From the Complaints Committee

Reporting of Unprofessional Behaviour

The College Complaints Committee recently reviewed two complaints involving a physician's use of inappropriate profanity during surgery.

The College would like to remind its members of the importance of practising professional behaviour at all times (CMA Code of Ethics, Sections 31 to 36) and their obligations to report inappropriate behaviour to the College (CPSM Standards of Practice of Medicine, Schedule F Duty to Report Another Member).

Quality Improvement Program Update

The College of Physicians and Surgeons of Manitoba is mandated by legislation to supervise the practice of its members.

The purpose of the Quality Improvement Program is to help ensure the provision of safe medical care to Manitobans. The program will encourage continuing quality improvement activities, and continuing practice improvement for its members. As well, it will provide a new mechanism for the CPSM to interact with members to gather detailed information about their practice, to encourage them to reflect on this information, and to plan their continuing professional development (CPD) around needs they identify in their practice. Over time, this should lead to improved care for their patient populations.

A physician's professional education is a lifelong process. New pharmaceuticals are developed, medical care evolves, and practice standards change as a result of technological advances and other developments. Physicians must be vigilant in order to update their knowledge, strengthen their skills, and ensure that they adhere to accepted ethical and professional standards in their practices.*

Over 200 Family Physicians have participated in the Quality Improvement Program since its launch in January 2019. The first and second groups have completed their process, and a third group of 95 participants began at the end of September. Feedback from participants has largely been positive, and we have received suggestions for program improvement which we appreciate.

Starting in 2020, we will begin to include some speciality groups (General Surgery, Pediatrics, Psychiatry). The College will be contacting physicians practising in these speciality groups by email to provide further information about the program.

The College would like to thank participants for the effort they expend as they go through the program. We hope that it will help to reinforce lifelong learning and continuous improvement. Our members continue to demonstrate their dedication to their patients, practices, and communities.

Information about the Quality Improvement Program can be found on the CPSM website.

https://cpsm.mb.ca/standards/quality-improvement-program

**Adapted from the Supreme Court of Canada's decision on CPD for lawyers.*

Assess Your Own Medical Records

Do your medical records meet the required Standard of Practice?

Record keeping is an ongoing challenge for many physicians. As the Quality Improvement Program has initiated chart reviews, the extent of this challenge is being recognized. Good medical records are critical to patients and provides a mechanism to facilitated ongoing care. The CMPA also stresses the importance of clear documentation in the event of any issues arising from practice.

As part of the Quality Improvement Program, and other College programs, some physicians will undergo a chart review. This means that a trained reviewer will review patient charts using a standardized method. The content of the patient record is critical in this process to ensure the reviewer can follow the patient's history and care plan.

Here is a self-evaluation checklist of items to assist you in improving your record keeping.

http://www.cpsm.mb.ca/assets/Quality%20Improvement/Medical-Records-Self-Evaluation.pdf

You must ensure that the information captured in a patient record meets this required Standard of Practice.

http://www.cpsm.mb.ca/assets/Standards%20of%20Practice/Standards%20of%20Practice%20of%20Medicine.pdf#page=23

The Importance of Reviewing Previous Stillbirth Workup During the Care of a Subsequent Pregnancy

Healthcare providers in maternity care are strongly advised to ensure the completeness of stillbirth workup on all stillbirths. Stillbirth workup should include an active attempt to obtain viral serology, genetic chromosomal analysis, bacterial microbiology, a screen for metabolic disorders, placental pathology, autopsy (if possible), and any clinical indicators for placental insufficiency or evidence of fetal growth restriction. Physicians are reminded to ensure that they review the results of the stillbirth workup and document in the hospital chart and the clinic charts the results of such workup.

In subsequent pregnancies the patient may seek care by the same maternity healthcare provider or may see another maternity healthcare provider. It is prudent that the maternity healthcare provider involved ensure that such past workup is reviewed. This could be done by obtaining past hospital records or corresponding with the previous healthcare provider for reports of the previous stillbirth workup.

There have been several cases reviewed by the MPHSC where such a previous workup was never reviewed. Such workup, on many occasions, identifies risk factors that may be recurrent in a future pregnancy.

Management of Patients Who Present for Assessment Because of Perceived Decreased Fetal Movements

It is not uncommon that patients during pregnancy present to clinics and hospitals with decreased or absent fetal movement. It is essential to recognize that detection of the fetal heart rate solely is insufficient to assess the wellbeing of the fetus in these circumstances. Healthcare providers are strongly advised to ensure that, at a minimum, a non-stress test is performed, reviewed, and documented as being reactive or not. Other methods of fetal surveillance may also be indicated, including, an ultrasound examination of the fetus with a biophysical profile and Doppler studies.

New Legislation – Protecting Canadians From Unsafe Drugs Act

Amendments to the Food and Drugs Act are to strengthen the regulation of therapeutic products and improve the reporting of adverse reactions by hospitals. It is intended to increase drug and medical device safety in Canada by strengthening Health Canada's ability to collect information and to take quick and appropriate action when a serious health risk is identified. It will be mandatory for hospitals to report serious adverse drug reactions and medical device incidents to Health Canada, effective December 16, 2019. It applies to prescription and over the counter drugs, vaccines, gene therapies, cells, tissues and organs, and medical devices.

Information can be obtained here:

https://www.patientsafetyinstitute.ca/en/toolsResources/Vanessas-Law/Pages/default.aspx

Autonomic Dysreflexia Patient Safety Issue

The Physical Medicine and Rehabilitation, Department of Medicine, University of Manitoba is rolling out awareness and teaching about autonomic dysreflexia in spinal cord injury to the doctors of Manitoba. This is a life-threatening condition that occurs in people with spinal cord injury, and although is low volume for exposure to each practitioner, is of extremely high importance for MD's to have awareness of and to not miss recognizing AD as it is life threatening. What we know so far is that this is extremely under recognized and there HAVE been serious events coming out from the lack of recognition of this condition, including seizures, stroke and death.

All are invited, by the Department, to take part in an online learning module. There is a pre- and post-knowledge test before and after doing the online educational module. The department would then use the pre vs post test results to measure the efficacy of the learning module. The first 100 participants who have completed the module and follow-up questionnaire will receive a $50.00 Amazon.ca gift card in honorarium.

By following the link below and completing the survey, you will have provided implied consent.

https://www.surveymonkey.com/r/YDXV3JM

Thank you in advance for your participation, for any questions please feel free to contact

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From the Investigation Committee

Would You Know If You Were Missing Important Test Results?

The Investigation Committee has recently considered several matters where physicians had ordered tests or consultations but were unaware that the requests had not been received. As a result, tests had not been conducted or the patients were still waiting for appointments to be scheduled.

THE COLLEGE STANDARD OF PRACTICE STATES:

A member who orders a diagnostic test or makes a referral to another health care professional must have a system in place to review the test results and the results of referrals to other health care professionals and have reasonable arrangements in place to follow-up with the patient when necessary.

Most members appreciate the importance of reviewing diagnostic results and have an effective system for this task. The Committee directed that members be reminded of the importance of knowing what tests remain outstanding in this context. This may be important in several scenarios, including where:

- a patient who understands "no news is good news" will be falsely reassured regarding the results of a diagnostic test such as a biopsy or mammogram when in fact no result has been received by the physician; or
- a patient continues to wait for an appointment with a specialist or for a diagnostic test when in fact the request has not been received.

The Committee recognized that this type of tracking has some practical difficulties, including knowing when to become concerned about the lack of a report in the context of a test or consultation where wait times are known to be long. The Committee also considered that patients may have a role to play in this, but stressed that the physician bears the primary responsibility and must take reasonable steps to ensure that requests made by them are carried out as planned and that results are received and acted upon. Where patients are asked to follow up in regard to a test or consult, the information provided to them should be very specific in terms of the action they are to take, and when they are to take it. Effective communication about the reason for the test can help improve compliance. A system of reminders in the EMR or with office staff may be helpful, including "bring forward" instructions for review of applicable requests. Making use of fax confirmations or making follow up phone calls to confirm appointments are other useful tools to consider.

Ultimately, each member must decide the best option for their circumstance, but must have a reasonable system for assuring that requisitions have been received, and that appropriate alerts will address reports that remain outstanding.

So, if you cannot say that you would know if you are missing important test results, it is time to be proactive!

From the Child Health Standards Committee

Hypoglycemia: Detection, Management and Transport Advice for Sick Infants

The Child Health Standards Committee has recently reviewed a number of cases of sick young infants with hypoglycemia that was not identified or could have been prevented during transport.

Infants at risk for hypoglycemia: All sick infants, including those with suspected sepsis, moderate-severe dehydration, severe gastroenteritis; infants who are NPO or expected to have poor oral intake during their transfer; infants with a suspected ingestion causing hypoglycemia (e.g. oral hypoglycemic agents); infants with pre-existing conditions such as metabolic disease, CPT-1 deficiency (Inuit infants), hypopituitarism, adrenal insufficiency, or hyperinsulinemia; newborns who are premature (<37 weeks), large for gestational age, small for gestational age, and/or infants of diabetic mothers.

Why sick infants are at risk of hypoglycemia: Lack of oral intake, low glycogen stores, increased metabolic needs related to sepsis or other critical illness, metabolic diseases.

Symptoms of Hypoglycemia

Mild Symptoms	Severe Symptoms
Jitteriness or tremulousness	Apnea or tachypnea
Limpness, mild lethargy	Seizures
Difficulty feeding	Cyanosis
Eye rolling	Cardiac failure / arrest
Weak or high-pitched cry	Episodes of sweating
	Pallor
	Hypothermia

Measure bedside glucose: All sick infants, especially those with suspected sepsis, moderate or severe dehydration, severe gastroenteritis, or ingestion of oral hypoglycemics. All infants with symptoms of hypoglycemia or suspected hypoglycemia. All infants with known at risk metabolic or endocrine disease (e.g. CPT-1, hypopituitarism, adrenal insufficiency, or hyperinsulinemia).

Thresholds for Investigation and Treatment of Hypoglycemia

	Birth to 72 hours of age	≥72 hours of age
Therapeutic goal	2.6	3.3
Investigation threshold	2.6	2.8*

*A critical sample should be sent to help determine etiology and confirm lab glucose level. It may be drawn earlier than the time frame suggested if an endocrine or metabolic condition is suspected.

Note: *Call Children's Emergency for a pre-printed order sheet for investigation of de novo hypoglycemia (critical sample). 204-787-4244.*

Reference: Canadian Pediatric Society Position Statement: The screening and management of newborns at risk for low blood glucose

Initial Management of Hypoglycemia in a Sick Infant:

- D10W 2 ml/kg IV for infants < one month of age
- D10W 5 ml/kg IV for infants ≥ one month of age
- Consider using 0.5 ml/kg intrabuccal dextrose gel (40%) for infants with no IV, as a temporizing measure.
- Glucagon may be given IM if there is no IV access and no dextrose gel (0.03 mg/kg/dose, maximum 1 mg).
- Repeat the bedside blood sugar in 30 minutes.
- Call Neonatology regarding further advice for newborns (204-787-2071) or Children's Emergency for advice regarding older infants (204-787-4244).
- If two boluses or doses of dextrose gel are required, start an infusion of dextrose starting at a maintenance rate (e.g. D10W at 80ml/kg/24h for newborns; D10W-0.9% NaCl at 4ml/kg/hour for older infants).

Prevention of Hypoglycemia During Transport:

- For critically ill newborns and infants being transferred, discuss the type of IV fluid and rate with the PICU/NICU/ Emergency Department physician accepting the patient.
- For infants who will be NPO during transport, establish an IV, ensure a minimum maintenance rate (4 ml/kg/hour) and use IV fluids containing dextrose (D10W-0.9% NaCl for newborns, D5W-0.9% NaCl for older infants).
- For advice regarding infants not requiring transfer call the Social, Northern and Ambulatory Pediatrician (SNAP) on call (204-787-2071).

REFERENCES

Canadian Pediatric Society Position Statement: The screening and management of newborns at risk for low blood glucose

WRHA Neonatal Clinical Practice Guideline: Hypoglycemia in Newborns

Reporting a Leave of Absence

A leave of absence from practicing medicine may arise in many instances – personal medical, to attend ill family members, maternity/paternity leave, sabbatical-type leaves, or personal travel or breaks. When you decide to take a leave of absence from practice, this must be reported to the College. However, you must carefully consider what you will be doing and what you report to the College because you may still be practicing medicine.

For instance, it is possible that you may still want to continue with certain activities, which are not directly related to ongoing clinical practice and hands-on patient care such as teaching, mentoring medical students, administrative work, and committee work. Or you may wish to occasionally look at medical charts and do follow-up work. These activities are considered to be practicing medicine. If this is the case, you must be very specific when you report this change to the College's Qualifications Department. It will make a difference in whether or not you remain on the "practicing" register (with a change in primary practice information) or being transferred to the "non-practicing" register.

When reporting a leave of absence, please specify whether the leave is medical in nature. When reporting a medical leave of absence, you will be referred to the Physician Health Program at the College.

It is also important to consider how critical and other test results will be followed during your absence and arrangements must be made for this depending upon your practice. Similarly, arrangements should be made for your patients to seek medical care during your absence, if possible, and depending upon the type of leave.

The Standards of Practice of Medicine sets out the requirements for closing, leaving or moving a medical practice, as follows:

13(1) *A member must give notice of the member's intention to close their medical practice, to take a leave of absence or to relocate their practice or otherwise cease to practice medicine in Manitoba to:*

(a) the member's patients or their representatives;
(b) the college;
(c) other members with whom the member refers or consults;
(d) the Department of Health, Seniors and Active Living;
(e) any regional health authority in which the member has privileges;
(f) a personal care home at which the member has privileges that is not operated by a regional health authority;
(g) if applicable, Canadian Medical Protective Association;
(h) Doctors Manitoba.

13(2) *The notice must include:*

(a) the date of closure, absence, relocation, or other cessation of practice;
(b) information about where the patient's records are to be located; and how the records can be transferred to another member or how copies can be obtained; and
(c) particulars of any arrangements for care that have been made for the member's patients.

13(3) *Clause (2)(b) does not apply if the patient records are maintained by a trustee under The Personal Health Information Act who employed, engaged or granted privileges to the member.*

Storage and Disposition of Patient Records and Supplies

14(1) *A member who closes their medical practice or takes a leave of absence must:*

(a) ensure the secure storage of any patient records for the remainder of the retention period required by subsection 11(3) and the retention of appointment records for the remainder of the period required by subsection 10(2) and the subsequent destruction of the information in accordance with The Personal Health Information Act; and
(b) give the college a copy of the notice sent to patients and information about to whom the notice was sent and the arrangements that have been made for the secure storage of the patient records and appointment records.

14(2) *A member who ceases to engage in medical practice, temporarily or permanently, or who closes a medical practice, must safely dispose of medication, laboratory specimens, equipment and supplies.*

14(3) *The obligations under this section are in addition to any other requirements relating to patient records under the Act, The Personal Health Information Act, and any other enactment, by-law, standard of practice, code of ethics and practice direction with which a member must comply.*

43(1) *The member must individually notify (i.e. not through a notice posted in the office) of the closure, relocation, leave of absence or cessation of practice each patient who:*

(a) has an appointment booked prior to the date of closure, absence or relocation;
(b) calls to arrange an appointment prior to the date of closure, absence or relocation.

43(2) *The notice to the College must include:*

(a) the date of closure, relocation, absence or cessation of practice;
(b) a forwarding mailing address and contact information for the member; and
(c) if the member is ceasing medical practice in Manitoba, forward all unused Manitoba Prescribing Practices Program (M3P) prescription forms in the possession of the member to the Manitoba Pharmaceutical Association and notify the College when this has been done.

43(3) *Unless a member is leaving a medical practice due to illness or other urgent circumstances, at least 90 days' notice must be provided to each of the persons described in subsection (1).*

PRESCRIBING PRACTICES PROGRAM

CHIEF MEDICAL EXAMINER'S DEATH REVIEW

This was provided in the Update to Council but is considered so important it is being included in the newsletter as well.

The College participates in the Adult Inquest Review Committee of the Chief Medical Examiner to review all deaths involving prescription medications. These reviews indicate that **stimulant-related deaths are climbing rapidly** while opioid deaths have levelled off. **Alprazolam** and **Gabapentin**, as well as **diphenhydramine**, have become significant drugs of abuse in Manitoba.

To enhance patient safety, knowledge of this data of these deaths is important for all prescribing physicians:

- **Alprazolam** is the benzodiazepine that contributed to the largest number of overdose deaths last year.
- The opioid responsible for the largest number of overdose deaths, either as a primary cause or a major contributing factor is **codeine** between 2013-18.
- Most opioid deaths can be attributed to one or more opioids combined with other drugs.
- The two drug classes that were the top contributors to opioid overdoses were **benzodiazepines** and **antidepressants** from 2014-17.
- The two over-the-counter ingredients that contributed to the largest number of deaths in 2018 were **diphenhydramine (including Gravol)** (16 deaths) and **dextromethorphan** (3 deaths).
- **Gabapentin** was a contributing cause to 25 drug and overdose deaths from 2016-18.
- **Alprazolam**, **Zopiclone**, and/or **SSRIs** contributed in total to 11, 9, and 8 drug and overdose deaths respectively from 2016-18.

The lessons learned from this provincial death data should transform physician prescribing practices. Physicians are urged to be mindful of polypharmacy - the overall risk may outweigh the benefit from individual medications. Physicians should be reminded that opioids, benzodiazepines, antidepressants, Z-Drugs, antipsychotics, and gabapentin all interact with each other often contributing to these deaths. See Drug Interactions 1 and Drug Interactions 2

Physicians are urged to take the following approach to polypharmacy:

- Set the stage
- Get a detailed history of every drug (DPIN or e-Chart ungrouped)
- Reformulate list of active problems (acute or in remission)
- Discontinue what is not indicated, not being taken, diverted, or reduce dose if appropriate
- Taper what can't be discontinued abruptly
- One at a time (if feasible)
- More frequent visits; increased supports; frequent safety messaging; enlist loved ones
- Be patient but persistent
- Listen to and actively collaborate with community/ hospital pharmacist!

Following the College's review of each death involving prescribing medication, prescribers receive a letter from the College plus relevant resources, plus a summary of the Medical Examiner's report highlighting the manner of death, cause of death, notable circumstances of death, toxicology findings, and summary of relevant DPIN data. The letter may also include feedback regarding unidentified learning needs. The approach taken emphasizes education.

Recognizing the risk of benzodiazepines and Z-Drugs, as a Strategic Priority, the College has a Working Group preparing a draft Standard of Practice for Prescribing Benzodiazepines and Z-Drugs. Expect to see a draft in the spring.

The above was presented to Council on December 13, 2019. Click here to view the complete presentation.

New Recommendations Regarding Unwitnessed (home) Inductions with Buprenorphine/Naloxone in Manitoba

The College convened a working group of experts in the treatment of opioid use disorder in the spring of 2019. This working group has been tasked with assisting College staff in developing a new Recommended Practice Manual for the use of buprenorphine/naloxone in the context of Opioid Agonist Therapy in Manitoba. The College receives frequent requests for guidance on the issues the working group is discussing. The working group has thus elected to publish its preliminary recommendations, in the areas of care that generate the most frequent inquiries, in the College newsletter. One of these areas is unwitnessed (home) inductions with buprenorphine/naloxone.

Below is a link to the recommendations of the working group in a draft document. Physicians are encouraged to adopt and incorporate these recommendations into their Opioid Agonist Therapy practices without delay. Please note that once the work of the working group nears its conclusion, there will be an opportunity for the members to weigh in on the content of the draft manual before it is finalized.

However, should you have any questions about the interpretation of the guidance published in the draft in the interim, please do not hesitate to contact the chair of the working group, Dr. Marina Reinecke at the CPSM. It is the working group's hope that you will find this guidance document useful in providing care to your patients on buprenorphine/naloxone.

CLICK HERE FOR DRAFT DOCUMENT

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