The College of Physicians & Surgeons of Manitoba

STANDARD OF PRACTICE FOR PRESCRIBING OPIOIDS
THEMES FROM RESPONSES TO CONSULTATION

Statistics

- The College received 88 responses
  - MDs: 58
  - Other Health Professionals: 8
  - Public persons, including patients: 8
  - Organizations, including other regulated health professions: 14
- Several of the submissions from physicians were joint submissions by clinic, practice area, geographic area, etc., so the numbers are indeed much higher.

1 – Need for Resources for Patients (this is the #1 response and was mentioned by almost every respondent)

- "We should be advocating for better support for physiotherapy and clinical psychology services as these are key components in managing pain effectively but are completely out of reach for our low-income patients who comprise a larger portion of the opioid addicted patients as well." MD
- Need an increase in pain clinic resources, funding, and staffing which has a 12-18 month waiting list
- Need an increase in resources, funding, and staffing at opiate assessment clinic at HSC
- Need an increase in addictions specialists
- Greater need for interdisciplinary care
- Need an increase in physiotherapy (which was just reduced)
- "[We] support this recommendation but recognize the challenge in maintaining updated knowledge of all available non-opioid treatment options. A main barrier for patients' use of non-opioid treatment option is the dearth of accessible publicly funded non-pharmacological treatment resources such as Cognitive Behavioral Therapy, physiotherapy, massage therapy, chiropractor therapy. These resources are even fewer in rural/remote Manitoba." Nurse Practitioners Association of Manitoba
- "There is a lack of such consultative specialist. Is there a plan to develop a rapid access consultative service to ensure providers in community (especially those located rurally and remotely) have quick access to such specialists? Not having such consultation service availability would jeopardize timely access to appropriate pain management and may lead to patients seeking non-prescribed substances to ease their pain thus negatively impacting their substance use disorder." Nurse Practitioners Association of Manitoba

- “Having to consult an appropriate specialist and/or multidisciplinary program when the patient experiences a substantial and persistent increase in pain or decrease in function resulting in abandonment of the trial will undoubtedly create a tremendous increase in wait times for patient assessment by the multidisciplinary pain management program in our province.” MD
- Referrals to specialists and programs have lengthy timelines in the province
- “Before anything is done regarding this Standard, I would recommend that doctors and their patients have better access to pain specialists and their programs. Patients no longer have access to hospital based, outpatient physiotherapy programs. Many patients do not have the financial means to pay for expensive community therapy treatments. We have taken a huge step backwards in the treatment of patients’ pain.” MD
- “The requirement to have a consultation for all patients on more than 90mg of morphine equivalent is going to put increased demands on the specialty services. What additional resources are in place to respond to this so that patients can continue to be seen in a timely way? While we know that pain clinic psychology & physiotherapy are effective, access to these resources is limited. It is very unfortunate that access to physiotherapy has essentially been cut off except for people who have the funds or private insurance to pay for it. It would be easier for people to successfully taper off opioids if they were able to access these other treatments to support them & manage pain. Can additional resources be funded to assist patients tapering off opioids?” MD

2 – Need for Resources for Doctors

- “We need an increased tariff for dealing with this on our end and don’t give me the old familiar line of “that’s up to DoctorsMB and MHSAL”. If the College wants to address this issue, it needs to address it globally which includes resource allocation, or at least a recommendation for increased resources.” MD
- Access to DPIN not available to all physicians
- “As I read them I immediately thought of 2 patients that I inherited years ago that are on very large doses of narcotics and are way above the amounts recommended. I also immediately envisioned getting a "letter" about them and wondered if there would be a mechanism for us to pre-notify someone (?CPSM?) about our patients like this and, thereby, perhaps gain access to some help about managing them? For example - might there be streamlined access to expertise in the Addictions Unit or Pain Clinic (one of mine is already involved in Pain Clinic) that bypasses the incredibly long wait?” MD
- “All of this information needs to be gathered in order to try to prescribe appropriately, but gathering this information and consulting appropriately with team members takes time. Almost every patient is booked for a 15 minute visit, regardless of the reason for presentation. This information typically cannot adequately be gathered in 15 minutes if the patient is unknown to you. Once the information has been gathered and documented, there may be a possibility of seeing the patient in shorter future visits.” MD

- There is a need to develop an online/telehealth consultative service to support practitioners.
- "I understand that the various checks & referrals recommended are in place in order to try to prevent fraudulent access to prescriptions, diversion & general overprescribing of sedative medications. My concern is that making these a requirement for all doctors in all settings is going to be very time consuming for doctors in practice & if it is too burdensome & some requirements seem unnecessary, it may all be ignored. We do have to remember that the majority of doctors & patients are using opioids appropriately & we are setting a standard for all in order to address misuse by a minority. Some compromise in the requirements might make it easier for all to follow." MD
- "There will also be a substantial time requirement on the part of the college to enforce this standard. Are there going to be additional resources to meet that need?" MD
- "In the preamble you mention upcoming ORT courses. While it is important to increase the number of professionals trained in treatment of opioid addiction, I think it would be useful for the general medical community to have inter-professional training on pain management. The College could liaise with the University CPD Department to develop a course on pain management & prescribing practices in regards to opioids, benzodiazepines & other sedatives. This could be launched prior to the standard on opioid prescribing being released & would assist doctors in following the 2017 guidelines on pain management & this related standard." MD
- "The College will concentrate on those patients with the very highest daily prescribed milligram morphine equivalents per day."
  "Although I understand there is a need to focus resources and surveillance, from my experience and observation of other physicians' opioid prescribing the problems begin with even small occasional amounts because of ease of addiction to, and diversion of, any and all opioids. I strongly recommend that physicians be prohibited from prescribing opioids unless they are actually trained, licensed and monitored in that activity. It is completely backwards that any MD can prescribe any opioid in any amount while the opioid replacements methadone and Suboxone require a very specific and higher amount of training and monitoring. If it were the reverse, many many lives could have been saved." MD
- "Increased education on topics (including safer prescribing for physicians, interpretation of urine drug screens, how to do a benzodiazepine taper) in particular IMG physicians, working in northern communities such as the Pas, Flin Flon, Thompson, and surrounding communities. Education is also needed for management of health regions." MD

3 – The Importance of Opioids in Pain Management

- "The pain clinic asks referring physicians for a commitment to keep prescribing the opioid if it is started by them to manage chronic non-cancer pain. This practice needs to be reconsidered." MD

- “Function is the goal, and if someone functions in society, works, pays taxes, and is on a stable dose of opioids, how is messing that up going to help anyone is my question. Function is less number specific than outcome driven. That is the art of medicine. I hope the art is not being lost in the process of dealing with pain, real, imagined, and magnified by life’s ups and downs, and individual’s response to those circumstances.” MD
- “If a patient taking more than 90 mg morphine equivalents daily is new to a physician’s practice, it would be reasonable to consider a trial of opioid tapering, however for patients in a physician’s practice for a long period of time being maintained on a stable dose of opioid and having documentation supporting stability in pain level, physical and psychosocial functioning, having to subject that patient to a change in management seems unreasonable at best and possibly detrimental to the well being of the patient.” MD
- The Standard states “Except in circumstances of exceptional need and clearly documented benefit, never prescribe more than 90 milligrams morphine equivalents per day”. One physician submitted the following: “Opioid use is considered in patients with moderate to severe pain who have failed to achieve adequate or reasonably expected benefit using non-opioid modalities. The term “exceptional need” defies definition. There is absolutely no supportive evidence in the literature or even general consensus as to what this standard threshold will be or even what it refers to i.e. is it asking for exceptional need regarding severity or degree of patient suffering? If so, how much more suffering in addition to being in sever pain must our patients experience in order to satisfy the threshold of being in exceptional need? This term should not be included in a standard as it has no evidence to support its inclusion, not method of measurement and no clear meaning.” MD
- “This document seems to take the level of accountability expected in an inner-city addictions medicine unit, with high risk patients and apply this level of investigation and patient mistrust to all patients including low risk patients and low dose prescriptions. I believe there should be amendments for low-risk, low dose patients that allows physicians to choose wisely and appropriately regarding the level of assessment they require.” MD

4 – The Importance of Opioids in Pain Management – Patient Perspectives

- “The over 95% of pain patients [not addicted to opioids] want only one thing from these medicines that control pain levels, and that is to have the ability to do ordinary, normal daily activities and to have some control over pain levels and spikes of pain that can happen suddenly and without notice.” Public person
- “As a chronic pain patient, I am saddened and dismayed upon reading the new proposed standards on opiate prescriptions…. I understand that there is much pressure to create new guidelines because of the overdoes deaths from opiates. However, I am greatly concerned about the result on the many patients who, like me, are only able to have a life because of their opiate prescriptions.” Public person

- "It almost looks as if you do intend to have some patients saved, and some allowed to sink, as your pictures suggest, and that you want to add the humiliation of various tests before prescriptions for medicine can be written by a doctor and filled at a pharmacy. [These] Canadians are innocent victims, not potential criminals. Do not make life worse for Canadians with incurable chronic and persistent pain conditions." Public person
- "I feel as though the image used… is far more revealing than the College perhaps intends. The way they depict the amount of opioids prescribed really does show what the College thinks of patients like me. The swimmer is farther and farther away from a life buoy based on the amount of opioids prescribed on a daily basis. For me, my prescriptions of opiate medications are a life buoy, and one being taken farther and farther away from me. The College sees me a sinking liability, not a person to be rescued…. How can I trust my medical care when it's being shown you expect me to drown? It is unacceptable and inexcusable to leave me to sink. The only reason I have any sort of life is because my medications, both opiate and non-opiate. Take it away from me and you *will* have a sinking swimmer, and one that is only sinking because of the actions of the College." Public person
- "Please don't target the actual pain patients, as this will only serve to drive people to suicide (due to severe pain) or having to start taking street drugs, to end the very real pain that they are facing." RN/chronic pain patient

5 – Follow-up in Community Seven Days after Surgery or Acute Incident *(significant number of comments)*

- "It is completely unreasonable to assume a patient can get a follow up appointment with their family physician in 3-7 days. Most often it takes weeks to months." MD
- Even if the patient can obtain follow-up within 3-7 days, the discharge summary will not have arrived at the physician's office
- In fly-in remote communities, a physician may only be there once a month, so the patient will have no access to opioids for a period of time
- 14 or 30 days are alternative suggestions for follow-up time periods

6 – Abandoned Patients/Tapering

- "I suspect there will be a massive flood of patients seeking prescriptions once this mandate comes to pass as physicians will be scared and stop prescribing. What is your potential plan for dealing with the huge number of narcotic and benzodiazepine dependent patients who will now flood the emergency rooms looking for meds?" MD, HSC ER
- Doctors may abandon patients as opioid patients are time consuming
- Doctors may simply decrease dosages too rapidly for the patient to be in strict compliance with the standard

- "Areas not covered by the Standard of Practice that need to be given consideration: How are opioids to be discontinued? Some physicians now simply cut patients off "cold turkey" rather than make the effort to regulate the opioid dose, engage other modalities, taper off or enlist the patient in opioid replacement therapy. This can put a patient into acute withdrawal, precipitate a search for other sources of opioids and subsequent death from overdose if the source is contaminated with fentanyl. Physicians must take responsibility for the prescribing mistakes of the past, whether their own or their colleagues'." MD

7 – Increase Consumption of Illegal Opioids

- "You do realize that patients will turn to using illicit narcotics and there will be a huge spike in overdose deaths as this ramps up." MD
- "The restriction on prescribing opioid medicine is causing a crisis of its own, including suicide and going to the street for illegal opioids." Public person
- "When the Standard is implemented there could be a sudden, marked decline in the availability of usual prescribed opioids on the black market (i.e. prescribed opioids diverted for recreational use) within the province. This could force some habitual recreational users of these "typical" prescribed opioids to seek out heroin or other less reliable sources of opioid (i.e. fentanyl) in order to avoid withdrawal. This could lead to a cluster of overdose events shortly after the standard is implemented." MD

8 - Transition to Standard

- "We potentially need a model of service provision which will provide patients who are outside the guidelines with physicians who will slowly reduce the opiates until they reach the guidelines." MD
- Instead of an overnight adoption, allow for a one-year transition implementation to the new standard

9 – Reliance on Standard for Better Prescribing Practices

- "I think the Standard will help me as I place limits on my prescribing. It allows me to shift the "blame" for implementing steps that I am willing to do, but which my patients often resist. I only have a few patients to who I have been prescribing outside of the parameters of the new standard. The standard will enable me to insist on limiting doses and prescribing intervals. I have a few patients who are receiving more than the recommended doses (not started by me), but who have no red flags for diversion or misuse. I remain concerned about my prescribing to them. With this new standard I expect that I will require them to attend a consultation for a second opinion on whether to continue the current dose or to titrate downward – and that is probably a good thing." MD

10 – Interdisciplinary Approach Important for Pain Management

- "It is impressive that the CPSM is in the forefront in Canada to create such a standard, including using an interdisciplinary process that crossed physician specialties. Addressing the public health crisis will require action by multiple disciplines and sectors". Manitoba Institute for Patient Safety
- "A collaborative approach – working with health care providers, pharmacy, social services, this is a very public issue to manage." Other Healthcare Professional
- "I would encourage CPSM to link with the [College of Pharmacy of Manitoba] to also create a standard of practice for pharmacists around opioids. Having 2 separate colleges addressing the situation in a formal structure will make this more effective." Pharmacist
- "Compelling evidence exists to demonstrate that physiotherapy is a safe and effective alternative to opioids for relief of acute and chronic musculoskeletal pain…. [We] suggest that you include non-pharmacological therapy much earlier than suggested in the Standards document. While opioids may be indicated with very acute conditions, physiotherapy can also be beneficial at this early stage to reduce inflammation and pain to encourage mobility. Waiting until the client is at a dosage of 90 milligrams per day before recommending physiotherapy or other non-pharmacological therapies is to little and too late." College of Physiotherapists of Manitoba
- "Your College may wish to consider recommending that, whenever feasible, physicians seek a psychological consultation concerning diagnosis and treatment planning for chronic pain. Finally, physicians should be encouraged to have open and honest discussion with patients to inform mutual decision about whether to start, continue, or end opioid therapy." Manitoba Psychological Society
- "Manitoba Chiropractors Association are prepared to partner in the reduction of use of opioids and the chiropractors of Manitoba can provide non-pharmacological treatments as part of the solution."

11 – No Need for Opioids for Certain Conditions

- "I would like to see specific mention of conditions for which chronic opioid therapy is rarely indicated. For example, there is evidence against using opioids for low back pain, one the most common reasons patients are on opioids. Other common uses of opioids include headaches, fibromyalgia, neck pain. Opioids are the last resort for these conditions, yet they are the most common reasons for prescribing." MD
- "I wish I had a stronger guideline and I could say, "it is not allowed. All chronic users must be tapered off for diagnoses such as non-specific headache and chronic non-operative joint pain."" MD

12 – Test for Continuing to Prescribe Opioids

- No consensus regarding the test for continuing to prescribe opioids: reduction in pain and/or improvement in function and/or improvement in quality of life are all components of which there is disagreement.
- "Manitoba Psychological Association recommends that prescription of opioid medication should be guided equally by the dual objectives of reducing pain severity and improving physical, psychological, and social functioning."

13 – Other Pharmacological Approaches

- Does this also apply to T3s? (lots of questions and comments about T3s)
- "To raise for discussion that the protocol includes a recommendation for a time limit for prescribing narcotics in the first class. i.e. 0 to 50mme/d thus including Tylenol #3. In my experience a great many abusers of substances are using polypharmacy including Tylenol #3. Tylenol #3 In addition to being used as part of a cocktail of other substances I believe is often diverted to be used as a source of income and functions as a gateway drug for exposure to narcotics." MD
- "Also, it should be stated that most acute pain can be managed with non steroidal anti-inflammatories and acetaminophen alone or in combination rather than acetaminophen and codeine or acetaminophen and oxycodone which are often used. This is often how the addiction starts." MD
- "Over the last 20 years it seems that my practice has become one of predominantly treating Fibromyalgia and Chronic Pain patients. Most of my patients have their own family physician but I have been worried at the different opioids and other medications they have been prescribed and especially the large quantities dispensed. I use a combined approach. I do not prescribe Morphine, Percocet, Hydromorphone, Oxycodone, Fentanyl, etc. I only occasionally prescribe Tylenol #3 but usually no more than 15-20 at a time. I do have grave concerns about prescribing Duloxetine and Pregabalin for this condition and I refuse to do so. Many studies seem to be enthusiastic about them, although one Australian study was very unimpressed with Pregabalin for Sciatica and in my experience the side effects far outweigh any benefits. There are also may patients for whom NSAIDs are not appropriate.

  1) Unless I have misunderstood the recommendations, it would seem that I have tcut our prescribing the very occasional T#3 for Fibromyalgia and of the occasional migraine and am being encouraged to prescribe something which I feel is not appropriate. Is this correct?

  2) Would we be allowed to prescribe T#3 for the patients with these conditions?" MD

14- Northern Matters

- 1. “Due to profound shortages in staffing and funding of primary care, access and capacity of primary care remains very limited. While we affirm the proposed deadlines for follow up of prescribing in acute and chronic prescriptions these limitations will, at times, make them difficult or impossible to achieve. This relates to the following standards:
- a. Part I a) Community follow up within 3-7 days is rarely attainable with current resources. This could lead to inadequate postoperative and acute analgesia or increased emergency room visits for patients in Northern communities or living on reserve.
- b. Part 1 a) To facilitate dispensing follow-up and safe prescribing of medications after patient seen by emergency provider for acute pain or seen by a specialist for post-op pain, there should be a clinic note or some sort of clear documentation sent beforehand to the primary care provider before the patient is seen. This should include rationale and plan for opioid prescription provided by the emergency provider or specialist.
- c. Part II (e) iii. , Part II (f), Part III (c) iv., Part IV (c)ii. -ability to follow up within 1 month is frequently not possible and multiple scheduling demands frequently result in rescheduled appointments making guaranteed access for reassessment within 3months challenging at times. Recommendations and standards when practicing within this context would be necessary if this is standard were to be implemented in our current practice.
- 2. Access to opioid replacement therapy in community or local addictions consultation is currently not available in any of the communities we provide services to.
- 3. Currently there is no provision or standard related to prescribing for individuals prescribed opioids who travel. Many northern patients frequently travel for prolonged periods (>1-3mo) or live in different communities for portions of the year. This has implications for dispensing and frequency of reassessment.
- 4. “Currently there is no provision or standard related to prescribing for individuals prescribed opioids who travel. Many northern patients frequently travel for prolonged periods (>1-3 mo) or live in different communities for portions of the year. This has implications for dispensing and frequency of reassessment.” MDs

15– WCB Experiences with their Opioid Policy

- The WCB medical consultants provided numerous letters outlining their experiences with injured workers prescribed opioids. All also adopted as common an extremely detailed submission of proposed changes to the draft Standard of Practice.
- “In the 2017 year alone, the team of physicians and a nurse in the WCB Healthcare Department completed 2,400 real-time reviews pertaining to prescribed opioids for injured workers. For many reviews, there is communication, often via phone call discussion, with the prescribing physician. In more complicated cases, the reviews are supplemented with an in-person history and physical examination.

- What we have observed over the years is consistently dismal outcomes associated with long-term opioid use, including typically no meaningful improvement but rather, often a worsening of pain and a deterioration of function over time, as well as an array of adverse consequences directly attributable to the prescribed opioids. These consequences, which often become distinct long-term medical issues in and of themselves, include:
    - impairments of cognition;
    - impairments of sleep;
    - dental breakdown requiring extensive dental restoration attributed to xerostomia stemming from opioid use;
    - loss of libido attributed to low testosterone levels stemming from opioid use; drug-seeking behaviors; and
    outright addiction, with all its consequences.
- Based on the Manitoba WCB Healthcare Department's experience with thousands of real-time longitudinal reviews over the past 6 years since the inception of the WCB Opioid Policy, it is clear that the evaluation of function associated with opioid use is a critical determinant of the risk-to-benefit ratio of prescribed opioids. This observation is concordant with authoritative guidelines on opioid prescribing practices: *Interagency Guideline on Prescribing Opioids for Pain*, (Washington State 2015 Guideline)3, and *CDC Guideline for Prescribing Opioids for Chronic Pain, United States, 2016* (CDC 2016 Guideline). A standard for opioid prescribing practice that does not include the obligatory relationship between pain relief and a measurable improvement of function will fail to advance the College's stated goal of clearly identifying the safest way for doctors to treat pain and ensure maximum patient well-being. Nor will it intervene in the current opioid public health crisis, which has developed in part due to the prescribing practices of physicians." MD

Accolades

- "Congratulations! A very impressive body of work, and a great contribution on behalf of the CPSM to safer prescribing of opioids. Very well done indeed." MD
- "Thank you for the work you've done on this desperately needed standard." MD
- "Thank you for allowing comments from the non-medical community." Public Person
- "I applaud CPSM for taking this important step in guiding practice around opioid prescribing." Other healthcare professional
- "The Benzo parts are great – tapering off or at least down as a requirement is a powerful help to me." MD
- "I am delighted to see such clear guidelines." MD
- "The new Standard will provide clinicians with the necessary steps to follow to enhance patient safety and reduce opioid-related harms when an opioid is prescribed." College of Pharmacy of Manitoba
- "These Standards will help guide physicians, other prescribers, and dispensers toward safer prescribing practices and help prevent opioid addiction and further harms to our communities." Acting Chief Provincial Public Health Officer

Disapprovals

- “While establishing a standard is laudable, on the other hand it is lamentable that it is only now being considered, i.e., the crisis is already upon us and we must learn, and react, from our mistakes, many regrettably fatal, having missed the chance to be pre-emptive”. MD
- “I am all for reduction and for meeting guidelines, but who is going to pay for it? Once again, it is on the backs of Family Docs. Once again, the College is all about dictating what we should do without a plan about how to achieve it.” MD
- “I’d like to get those people off [Tylenol 3] but, of course, they tell me that they have “measurable clinical improvement in pain and/or function and/or quality of life evaluations and maintenance of a satisfactory level of improvements” … i.e. They tell me that they are much better with Tylenol #3 and worsen without it. If I ask them for a pain scale with and without they will, 100% of the time, tell me they were 9/10 without and 4/10 with. No one ever says “oh, pain or quality of life assessment tool… ok, you caught me. I don’t really need it.” i.e. Part VI is old news to those of us who would like to get people off. It didn’t work in the past for these people who were on Tylenol #3 for the last 30 years and it won’t work.” MD
- “As a prescriber this standard will place me in a situation where my carefully planned pain management program could be used to threaten my licence to practice medicine.” MD
- “Of course, because of the already unenthusiastic attitudes towards pain patients and treatment will most likely ensure that many doctors will find Pain Medicine uninviting further decreasing the care available to the large and increasing numbers of patients suffering poor pain control. We require more well trained and educated doctors as the pain demographic mushrooms. Documents like these will drive doctors to avoid pain medicine, let alone opioids.” MD
- “The current weak level of education about pain among doctors, let alone amongst the patients we serve means these guidelines should be available until the opioid crisis is ended and rescinded as the scientific validity of these guidelines in pain care is missing.” MD
- “We all know there is a huge problem with all types of addictions in Manitoba. This is a societal problem and the College should not be singling out physicians just because we are prescribers.” MD

Miscellaneous Comments

- “My concern is that without sufficient enforcement by the College these standards will not be effective. I hope that will be proactive review of prescribing data to flag high/inappropriate prescribers so they can be educated to improve their practice”. MD
- “A similar standard is needed for benzodiazepines and related Z-drugs”. MD

- "I realize that our self-governing position is a privilege, and we are responsible to government and ultimately to the public…. Opioid abuse and deaths are currently hot topics politically. Responsible self-governing includes both what we change as a practice and how we implement change within our profession. We don't need to be reactionary or impulsive in our changes, we need to decide what is reasonable and safe as a minimum level of accountability." MD
- "Cannabis is the solution to ending the opioid epidemic…. It works more effectively than opioids with nor adverse side effects, especially when using high CBD cannabis, without THC." Public person
- "I support the repeal of the entire Controlled Drugs and Substance Act." Public person
- "I believe it would be beneficial to remove opioid prescribing from primary care, and move it into an interdisciplinary pain program, where physio/rehab/addiction assessment /cbt/dbt is available. In one community in the US opiate prescribing was removed from primary care, and the rates of opiate prescribing dropped precipitously. People with chronic pain often have comorbidities - HT/DM/IHD - so by having a chronic pain clinic on an ongoing basis would be helpful to give the needed attention to the pain. Or perhaps an opiate Rx should come only from a home clinic - preventing the walk-in clinic approach to chronic pain." MD
- "We use a 'loophole' in ER, where the facility allows up to 6 tabs of what's in stock to be given to patients without having to use a triplicate prescription. It keeps our names off the list. Unfortunately, it also does not allow other care providers to track opioid use from our ER. This is typically for acute pain (renal colic), but we also use it as a bridge for chronic pain opioid users…

  Is this a common problem that should be addressed?" MD
- "Given that the majority of overdose deaths lie within the illicit drug user population, I believe that targeting legitimate surgical/pain patients in Canada only serve to decrease the quality of care. In British Columbia, for example, the number of chronic pain patients who die from narcotic overdose has not changed for 10 years, despite the massive upward swing in narcotic OD's. The narcotic deaths that we are seeing now are mainly from illegal narcotics that are mixed with other illicit drugs. It is not the acute pain or chronic pain patients who are the problem here". RN
- "It is totally reasonable that the College expect all future prescribing of opioids follows their current guidelines. However, expecting physicians to follow the current guidelines on those who already depend on a certain medical regimen is opening a Pandora's Box. We can be sure that there will be anger and resistance especially if the patient feels that they have greatly benefited from their regimen. I have personally been made aware of 2 clients who after having been on an opioid and benzodiazepine combination for years (30+ years) were told that this was an addiction and unnecessary. (They were both married family men who were able to work full time and support a family but had chronic pain issues.) They were sent by their well-meaning physicians to the Addictions Foundation, taken off these medications and seemed to be doing well. Both however died within one year from suicide. (One man attributed his suicide to his unresolved pain issue which had been stable prior to the medication change.)" MD

Surprises

- "Treatment of terminal pain is more than just in patients with cancer and the term non-cancer pain is not helpful and may unfairly discriminate against the care of terminal patients without cancer. Some of the terminal cardiac patients who require narcotics have a life expectancy beyond the usual 3 months that we see with cancer, but are nonetheless terminal." MD
- "Respectfully, it is appropriate Sport and Exercise Medicine Physicians should be included in the list of available specialists to consult… including pain clinic, psychiatry, psychology, pharmacist, addiction specialist, physical therapist, kinesiologist, chiropractor, and practice colleague. [Sport and Exercise Medicine physicians] believe we have been and can continue to be assets in appropriate front-line conservative treatment of pain conditions." MDs
- "If physicians are not authorized to dispense more than a one-month supply of any opioid, is there an exception for, or allowance of, professional judgment for those clients that may travel such as snowbirds?" Other healthcare provider

Technical Input

- A number of specialists and organizations provided very specific comments, reasons for amendments, and even rewording of specific sections, wording changes, and line by line review. These were extremely helpful, and some input was incorporated into the revised Standard of Practice. No examples are included here, but there were many.

Organizations That Submitted Comments

Canadian Medical Protective Association
College of Dieticians of Manitoba
College of Occupational Therapists of Manitoba
College of Pharmacists of Manitoba
College of Physicians and Surgeons of Alberta
College of Physiotherapists of Manitoba
College of Registered Nurses of Manitoba
Manitoba Chiropractors Association
Manitoba Dental Association
Manitoba Institute for Patient Safety
Manitoba Psychological Society
Nurse Practitioner Association of Manitoba
Acting Chief Provincial Public Health Officer, Manitoba