Fifth Session - Thirty-Ninth Legislature

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Legislative Assembly of Manitoba

Standing Committee on Social and Economic Development

Chairperson
Mr. Tom Nevakshonoff
Constituency of Interlake

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MANITOBA LEGISLATIVE ASSEMBLY
Thirty-Ninth Legislature

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LEGISLATIVE ASSEMBLY OF MANITOBA

THE STANDING COMMITTEE ON SOCIAL AND ECONOMIC DEVELOPMENT

Monday, January 31, 2011

TIME – 1 p.m.

LOCATION – Winnipeg, Manitoba

CHAIRPERSON – Mr. Tom Nevakshonoff (Interlake)

VICE-CHAIRPERSON – Mr. Rob Altemeyer (Wolseley)

ATTENDANCE – 11 QUORUM – 6

Members of the Committee present:

Hon. Mses. Marcelino, Oswald

Mr. Altemeyer, Mrs. Driedger, Messrs. Goertzen, Martindale, Nevakshonoff, Pedersen, Reid, Mrs. Rowat, Mr. Saran

PUBLIC PRESENTERS:

William D.B. Pope, College of Physicians and Surgeons of Manitoba

WRITTEN SUBMISSIONS:

John E. Gray, Canadian Medical Protective Association

MATTERS UNDER CONSIDERATION:

Bill 14–The Prescription Drugs Cost Assistance Amendment Act (Prescription Drug Monitoring and Miscellaneous Amendments)

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Mr. Chairperson: Good afternoon. Will the Standing Committee on Social and Economic Development please come to order.

Your first item of business is the selection of a Vice-Chairperson. Are there any nominations?

Mr. Doug Martindale (Burrows): I nominate Mr. Altemeyer.

Mr. Chairperson: Mr. Altemeyer has been nominated. Are there any other nominations? Hearing no other nominations, Mr. Altemeyer is elected Vice-Chairperson.

This meeting has been called to consider Bill 14, The Prescription Drugs Cost Assistance Amendment Act (Prescription Drug Monitoring and Miscellaneous Amendments).

For the committee's information, we have with us today a group of students from Booth University College working toward their social work degrees. The course they are taking related to their attendance here today is called Contemporary Issues and Social Work Practice and deals with poverty, crime, health and other current issues as they relate to society–to social policy. On behalf of all honourable members, I welcome you here today.

How long does the committee wish to sit this afternoon?

Mr. Martindale: I recommend that we follow our usual practice and sit till 9 p.m. and then re-evaluate. Just kidding. Unless there is some surprises we don't know about, I think we can probably finish this in an hour or less.

Mr. Chairperson: Is that agreeable to the committee? *[Agreed]*

A written submission from Dr. John E. Gray of the Canadian Medical Protective Association has been received and distributed to the committee. Is it the will of the committee to include this document in the *Hansard* transcript of today's meeting? *[Agreed]*

We have one presenter registered to speak today. So, at this point, I would call on Dr. William D.B. Pope of the College of Physicians and Surgeons of Manitoba to speak to the committee on Bill 14.

Mr. Pope, do you have any written materials for the committee?

Mr. William D.B. Pope (College of Physicians and Surgeons of Manitoba): I do, Mr. Chair.

Mr. Chairperson: The Clerk's assistants will distribute them. You may proceed when ready.

Mr. Pope: Thank you, and thank you for the opportunity to speak briefly to this bill, Mr. Chair.

The College of Physicians and Surgeons of Manitoba has for years been connected with the Manitoba Prescribing Practices Program which was created in the early 1990s. This government-sponsored program was provided with information on physician prescribing of narcotics and controlled medications through the DPIN system. When

individual physicians prescribed outside a defined dosage range, they were identified and the program reviewed their prescribing patterns with them to provide education and modification if appropriate.

About five years ago, the program was put on hold because of funding and, most importantly, because the college did not have the legislated authority to review patient prescribing by physicians generically without a specific concern having been raised.

Since that time we have asked for legislative amendments to allow us to reinstitute this program, and the template we requested is presently used in three provinces to our west: Saskatchewan, Alberta and British Columbia.

Over the past year Manitoba Health has been very good about meeting with us, and with the Manitoba Pharmaceutical Association, I should add, to define a new form of the Manitoba Prescribing Practices Program. The suggestion is that a new process–this new process will be, in fact, facilitated by Bill 14.

We have been told that the advisory committee identified in section 3.1 will be established with appropriate health-care regulatory authority representation. This committee will review and recommend levels of appropriate prescribing, which will become the established criteria. And we understand that Ontario is establishing a similar process to Manitoba's, and we expect that the standards recommended by the Manitoba committee and approved by the Minister of Health (Ms. Oswald) will be similar to those in Ontario and the other three provinces to our west.

Furthermore, the act permits Manitoba Health to provide this college with information on prescribing trends, and, if we then so request, Manitoba Health will provide us with more specific, detailed information about individual prescribing patterns of Manitoba physicians, and this will then lead to further review and educational enhancement.

Provided that the standards are established in the manner that is noted, my council has indicated support in principle for this bill, and we very much look forward to working with Manitoba Health to continue to provide safe health care for the people of Manitoba. Thank you.

Mr. Chairperson: Thank you, Dr. Pope.

Are there any questions from the committee? Comments?

Hon. Theresa Oswald (Minister of Health): Yes, thank you very much, Dr. Pope, and welcome students. There is all kinds of opportunity in your midst to ask interesting questions to a man such as Dr. Pope. Don't let him get out without asking him something interesting, and I guarantee that the answer will be interesting too, and very rarely will the beginning and the end be too far apart.

I want to thank you for your presentation today, and I want to assure you, as has done the Department of Health, that the requests and concerns that you have raised regarding representation from the College of Physicians and Surgeons on the advisory body–that is indeed the plan to go forward, and also other concerns that you may have about the sharing of information of individuals when appropriate is entirely the path that we intend to take based on your good counsel and, of course, recommendations over all that have come from other bodies such as the office of the Auditor General and the expert panel that was convened some years ago.

So we thank you for your support in these matters. We know that, as we work together, we will be able to do better by patients in Manitoba by ensuring that prescribing practices are the best that they possibly can be and that drug utilization is as appropriate as possible. So thank you again for your attendance today.

Mr. Chairperson: Any comment, Mr. Pope, on that–or Dr. Pope?

Mr. Pope: Nothing further, Mr. Chairperson, thank you. The minister said it. We do very much look forward to moving forward with this. My senior regulatory authority colleagues are very passionate about bringing this forward and improving the quality of health care on all sides, and particularly in an educational fashion. So thank you for this opportunity.

Mrs. Myrna Driedger (Charleswood): I too would like to welcome all the students here. I think it's a great experience to have, to see public policy in development, and we're one of the few provinces where you'll see such a process like this. So this is a great opportunity.

And, to Dr. Pope, just a couple of questions. How broad was the consultation within the college in terms of this legislation?

***** (13:10)

Mr. Pope: Because it was relatively soon and, in fact, we hadn't expected committee to occur until much later in the season, it's been primarily our council, but of course the elected council of the college is the one that makes the decision. And I have actually discussed this as well with Doctors Manitoba and have had support from them and indicated to them that they would be included, hopefully, in the consultations that do occur further about setting the standards, and the main thing was that we would–that physicians and others would be included in the process of developing the standards and that the standards would be similar right across from Ontario west. So that–and many of those numbers have already been decided or have been worked on, and so I think one of the beauties of having a national standard for all of this is that, in fact, the numbers are there, and we can build on what other provinces have done and it won't take as long to develop the numbers as it might if we were doing this as a solo performance.

Mrs. Driedger: Have you had consultation with other provinces in terms of, you know, the percentage of physicians that might be seen to be inappropriately prescribing drugs?

Mr. Pope: I think the important thing here–and certainly Saskatchewan, Alberta and British Columbia have been doing this for a long time, and we did this as well, we found this when we were still carrying out our previous programs, is that at any given moment, the numbers will vary depending upon the drugs and the way in which society is approaching these medications. And I think we're all aware of OxyContin and what's happened right across the country with this, and Manitoba was relatively free from it until the last few years when we seem to have unfortunately been catching up with our neighbours. And the really valuable pooling of these sorts of programs is that, once identified or once the individual prescribers are identified and are approached about their manners, they are often looking for help, for assistance, looking for education, looking for support in how to modify what they prescribe. In particular, concerns about whether or not patients will say to them–the patients who are misusing these medications tend to be very good. They've–they're very sophisticated at obtaining the medications. And in other cases it's illness, and the doctors need to know from us that they have the support of the regulatory authority to modify the prescribing to help the patients get over the needs and also that they're not out there on their own, and that's the real value of this kind of large-scale program is that they know that they have support not only from their regulatory authority but from the doctors' associations as well.

And so what happens is, initially, there may be a relatively high identified number and with time and sometimes not that long, it improves dramatically. Saskatchewan, our sister province next door, began doing this with benzodiazepines, and I understand from Dr. Ziomek, my assistant registrar, who was speaking with my colleagues there, that they've been able to cut the prescribing of benzodiazepines in Saskatchewan by nearly 50 per cent in as little as two and a half years.

So we think that there will be real successes from this as well as it's–as long as it's carried out sensibly, respectfully with our members.

Mrs. Driedger: What has caused this big prescribing increase in OxyContin? What–I mean, it's been around for a while. What's happened in the last few years that has led to this?

Mr. Pope: I think there are a number of issues. The first is that it is a particularly powerful drug. Addiction dependency to it comes very quickly. And it's also a very good analgesic because of the other side effects are relatively minimal. And so from that point of view it's actually a very good drug. And the second thing I think is that it's somehow crept into a much broader group of–area of society than the narcotics previously had been. And so I think we've all read in the newspapers about the numbers of young people and parties in the 20-somethings, who suddenly have become open to or receiving narcotics and particularly OxyContin and have become very addicted to it very quickly. And I think, as a result of all of that as well, it's become more obvious. There have always been large numbers of individuals who have been addicted to narcotic medications. Many of them were not people who had a lot of say in society, and so society could look the other way. Now it's going right across from those who are the very poor or disadvantaged to the professionals and the children of those professionals. And those individuals are not willing to remain quiet and let this rest. And so the publicity around it has made it much more obvious. I think that's–it's a social change. Is it good? It's hard to say, but I think that's–those are the reasons to me why it's more obvious now than it was, maybe not more prevalent, but more obvious.

Mr. Chairperson: Mrs. Driedger, time for questions has expired. If you wish to continue, you'll have to seek leave of the committee to do so. I see you do.

Mrs. Driedger: Mr. Chairman, I just have a couple more questions, so I do ask leave of the committee.

Some Honourable Members: Agreed.

Mr. Chairperson: Agreed. Continue, please.

Mrs. Driedger: Dr. Pope, would it be common for OxyContin to be given to a 96-year-old woman that has arthritis?

Mr. Pope: I think it would depend on the patient, the environment and whether or not there have been other medications which, in fact, were not working in those individuals. I haven't prescribed narcotics now for some time, although I am an anesthesiologist, so I wouldn't want to comment on an individual patient, but, I think, like–as the lawyers say, Mrs. Driedger, it depends.

Mrs. Driedger: And just a final question. The advisory committee that is referenced in the legislation, who do you feel would be appropriate or what groups of people or individuals do you feel should be on that committee, and is that part of the negotiation with the government in setting up the advisory committee?

Mr. Pope: Yes, and, in fact, I should say the government's been very forthcoming about this. When we thought that we would be going to committee later in the year, the then assistant deputy minister did set up monthly meetings with us and with the Manitoba Pharmaceutical Association to do, among other things, determine who might we–might be recommending to be members of this committee. I think we want to start by having those most intensively involved. So, clearly, the Pharmaceutical Association, the College of Physicians are the key individuals. But veterinary medicine and dentistry have always been permitted to prescribe narcotics so they will certainly be consulted. Manitoba Health has to be an integral member of this, and the other group where I'm not sure what will happen, but–is the First Nations and Inuit Health Branch because there are large numbers of patients who receive medications in that area. It would be important for them to all be part of this as we develop it.

We would hope that, in due course, nursing midwifery, those regulated health professions which will be permitted eventually to prescribe narcotics once the feds change their approach, will be very much part of it, and we already have a conjoint statement on prescribing and–that works with nursing medicine and pharmacy so that we work as a team with this, and I think that's the quickie bit. Any of us, if we individually go out there and try to in some way suggest that we have the answer, it's not going to work. We need all the key players to come together and make this a team effort.

Mrs. Driedger: It brought up one more question, and I beg the indulgence of the committee, but I understand that Manitoba Pharmacare doesn't track prescriptions filled by First Nations, so how is–I guess, how does–how do you view this legislation working then? And you mentioned having them, you know, the federal branch at the table, you know, because I understand that Manitoba Pharmacare doesn't track prescriptions filled by First Nations, inmates or patients who opt to pay cash for their drugs. So we're going to–probably with this legislation, while it's probably a step in the right direction, it looks like we are still a long way from fully addressing some of the challenges. How do we, in your view with this legislation, maybe deal with some of these issues?

Mr. Pope: I'll do the political thing and punt that back to the minister in this case, because it is something that pharmacy, medicine and nursing have been asking for, for a long time. I realize, however, that the difficulty is that it's–you don't necessarily have the authority to make that happen over certain areas and then–so we would strongly encourage that the prescription Drug Program Information Network have all prescriptions entered individually from all patients, particularly for narcotics and controlled drugs. But I'm not sure that's something that Manitoba can enforce. I would encourage support for that, however.

An Honourable Member: Thank you.

Mr. Chairperson: Okay, seeing no further questions, Dr. Pope, I thank you for your presentation.

Mr. Pope: Thank you, Mr. Chair.

Mr. Chairperson: There are no other presenters registered to speak.

Is there anyone else in attendance who wishes to make a presentation on this bill? Seeing none, we will move on to clause-by-clause consideration.

During the consideration of a bill, the enacting clause and the title are postponed until all other

clauses have been considered in their proper order. Also, if there is agreement from the committee, I will call clauses in blocks that conform to pages with the understanding that we will stop at any particular clause or clauses where members may have comments, questions or amendments to propose.

Is that agreed? *[Agreed]*

Does the minister responsible for Bill 14 have an opening statement?

Ms. Oswald: I would just reiterate that this is an important step forward on the issue of prescribing recommended by the College of Physicians and Surgeons, the office of the Auditor General, an external review panel and by doctors that have offered their sage advice on how to go forward. It's our belief that this can be done in a way that is primarily about education, which I believe to be key. But it is not without an opportunity for individuals who appear to be deliberately prescribing in an inappropriate manner to be dealt with accordingly.

***** (13:20)

Mr. Chairperson: Thank you, Madam Minister.

Does the critic from the official opposition have an opening statement?

Mrs. Driedger: No, I don't, but I do have a number of questions that I would like to ask of the minister.

Mr. Chairperson: Thank you, Mrs. Driedger.

We'll go to clause by clause, and you can ask your questions at the appropriate point.

An Honourable Member: Okay.

Mr. Chairperson: Shall clauses 1 and 2 pass?

Some Honourable Members: Pass.

Mrs. Driedger: Can the minister identify for us the drugs that will be included as a monitored drug? I understand that it will happen through regulation, but is there already a list determined as to what some of those medications will be?

Ms. Oswald: Well, certainly, on the discussion of this bill, OxyContin has been the drug that has been named over and over again, but, as you rightly say, it will not be the only drug; it will be primarily drugs that are considered controlled drugs, and that work is ongoing. I'm not prepared to, you know, list them on the record at this time. That work continues, but we'll endeavour to do our best to share that information with the member as we go forward.

Mr. Chairperson: Seeing no further questions, clauses 1 and 2–pass.

Shall clauses 3 through 5 pass?

Some Honourable Members: Pass.

Mrs. Driedger: I would just like to ask the minister, in terms of the advisory committee, when does she anticipate that this committee will be established, and will there be one or more than one, and who might be, from her point of view, on the committees?

Ms. Oswald: Well, again, as we said earlier, we have taken the advice of the College of Physicians and Surgeons, and we have made a commitment to them, which we will follow to ensure that they are represented on that advisory committee. We're going to continue to take advice from our partners on the appropriate representation. We do have, existing now, as the member is well aware, the–I'm sure she's well aware, in fact–we do have a committee of experts known as the Manitoba Drug Standards and Therapeutics Committee, or MDSTC, that has been doing some work up to now and have, in and of themselves, requested a broadened scope, if you will, in order to be able to do these retrospective reviews and also to be able to offer some advice on prescribing practices. It's currently composed of three physicians and three pharmacists, but we are not married to maintaining that specific composition for that group. We think that we can broaden that; we heard some advice from Dr. Pope just now about those that will be able to prescribe in the future. We know that it will certainly begin in a very similar structure, but we are open to amending its membership as we go forward.

So, as I say, this won't be a committee that is new; it will be a committee that will have an expanded mandate as they have requested in the past and, indeed, will very likely have new membership as well.

Mrs. Driedger: Would the new membership include, say, the federal government, so that you can start to look more closely at tracking prescriptions filled by First Nations, inmates or patients who opt to pay cash for their drugs? Like, how are you going to deal with that issue, because if that is not dealt with, then this legislation certainly isn't going to be able to address this issue as fully as it needs to be.

Ms. Oswald: Yes, we welcome their participation.

Mr. Chairperson: Seeing no further questions, clauses 3 through 5–pass; clause 6–pass.

Shall clauses 7 and 8 pass?

Mrs. Driedger: Can the minister indicate, in this letter that was put before us by–I understand it's a physician, John Gray–Dr. John Gray, he did raise an issue about reasonable limits on the authority of inspectors to enter the office of a health professional and to require the production of clinical records without a warrant. I guess I would ask: How will these–how will doctors' prescribing practices for these drugs be actually monitored?

Ms. Oswald: So the amendments in this bill are indeed going to allow for retrospective evaluation of drug utilization, and there will be a process whereby initially information can be gathered by, you know–if there's a suspicion, first of all, it can be referred to the college and the college will be able to review an allegation, if you will, or maybe better, set a concern, that perhaps there's a prescribing practice going on here that, you know, isn't deliberately malicious, but it's not the best recommended practice. And once the college has an opportunity to review this particular prescribing practice, they can then ask for more specific and detailed, perhaps individual, patient information to delve into the process. They don't get that right off the bat in the name of striking that delicate balance between the privacy of the patient and investigating an allegation, and then it's through that process of them requesting from the department the specific kinds of information that they want. It will be provided back to them, and then they can proceed through their regular regs and processes to investigate an individual member.

So it's not going to be the heavy hand of government marching into a doctor's office saying show me all your records. It will be carefully proceeded through the regulatory body, and I believe this is the reference that Dr. Pope made earlier about there being no legislative authority up until this change that would allow for that to happen, and by making these changes they will be able to, in a more fulsome way, fulfill their duties in protecting the public in this way.

Mrs. Driedger: If it's a retrospective review, how will the college be informed and by whom? Like who has the ability to report a physician or are they picking it up through tracking of, you know, charts? Like how does it actually come about that the college will be informed to look at some of these prescribing practices?

Ms. Oswald: The advisory committee or the expanded role of the drug and standards therapeutics committee will go through the process of doing these retrospective reviews in places where they have concerns. There are times now where, in reviewing prescribing that is going on, that they have wanted to have the ability to just have an educational conversation with a doctor, but their mandate did not allow them to do that. So there is infrastructure now that enables them to have a look at prescribing that they're just not sure about, so they'll be able to use existing data, and perhaps there will be an ability to enhance this data that will enable them to speak with the department and refer to the college in situations where they're concerned about an individual's prescribing.

Mrs. Driedger: Doctors have asked for access to DPIN so that they can identify those patients that are doctor shopping and have received multiple or frequent prescriptions for a narcotic like OxyContin, and I think that they feel–and I understand they've been asking for this for quite some time because they feel that there would be better control over this issue.

Can the minister indicate why the government has not agreed to give doctors access to DPIN, and if you're looking further into doing that?

***** (13:30)

Ms. Oswald: Yes, I can inform the member that this has been the subject of ongoing conversation, and it does speak to the delicate balance that I spoke of earlier from allowing all doctors all access all the time to all patients. And, while all of us in this room would love to believe that this would always be handled with the utmost confidentiality, there are individuals that have raised, you know, very serious concerns about privacy, which is why we have endeavoured to have a staged process. So the initial stage does not begin with total and complete access to DPIN. But when there is a concern being raised through the committee or otherwise from the college, the steps that we are taking is to gather the information that is being requested, all information that's relevant to the college's investigation and to provide it to the college. So there is that one step in between that doesn't allow for, heaven forbid, you know, in the rarest of circumstances even, you know, any spurious use of all access to all information. We believe that this is the correct process to go to preserve the confidentiality of the majority of patients who are not doing anything untoward.

But I would state on the record that we remain open to monitoring closely how this process will work, and if indeed we do need to review access to

DPIN by physicians, we don't want to take that step at this time for the reasons I described about confidentiality, but recognize that, you know, the issue that has developed with OxyContin, which, of course, is the drug we're talking about today. You know, the member would well know that one year from now there will be something else that will replace it, and so we need to make sure we're creating an infrastructure by which you can insert name of any drug and we'll be protecting the public in that way.

We remain open to looking at what steps we may need to take in future. But we think that this strikes the balance now between protecting the privacy of all citizens while opening the door now, enabling these reviews of prescribing practices and helping the college protect the public, which is, of course, their primary mandate.

Mrs. Driedger: I understand that doctors, you know, can access some of that information by calling a pharmacist. But they have said that the process is too time consuming. Is there a way of ensuring that they get speedier information than what they are getting right now in order to be able to, you know, address the issues that they're concerned about?

Ms. Oswald: Well, certainly, we know that information is going to move more swiftly in any number of realms with the electronic medical record, you know, and a component thereof, you know, called the DPIN viewer where doctors will have, you know, some access to information. But I do think that, you know, if the member is suggesting that this particular legislation isn't going to be too helpful if the wheels of the department aren't moving in a very nimble and rapid way, I would agree, and so we need to make sure that that information is asked and received as swiftly and accurately as possible.

Mr. Kelvin Goertzen (Steinbach): Just a question. I know it's–might be–deviates slightly from the specific issue that the bill is looking to address, but it deals with OxyContin and pharmacists, and the minister is well aware–all of us are–about armed robberies that have been happening at the pharmacies, and no quick and easy solution, I recognize that, although some have already taken the steps, I understand, of not either having OxyContin at the pharmacy or advertising they have a limited amount of it. In the discussion of this bill or perhaps this is a more general discussion that the minister has with the professionals, has that concern been expressed and does she have any thoughts about what we could do to address the safety of pharmacists who are dealing with the drug that's become quite popular on the street?

Ms. Oswald: Yes, thank you very much for the question. It is one that certainly has been part of the discussion when it comes to the monitoring of controlled substances, and while, as the member rightly says, this particular bill is dealing with the supply side of things, if you will, making sure that the college and this advisory committee now have expanded authority to deal with the doctors that may be prescribing OxyContin and others in a way that is excessive.

There has been some suggestion that by making moves such as these or even the move that we made earlier, moving OxyContin to part 3, you know, has caused the crime. I don't think that causation has been established, necessarily, and, you know, it does beg the question that when people say, well, if you make the drug harder to get, then you're going to see an increase in crime. The opposite side of that, I suppose, is, well, then, you know, should we make it easily available to everyone so there would be no crime? You know, again, one has to try to strike that delicate balance.

So at the same time that moving the drug OxyContin to part 3 and the development of these amendments was taking place, there was also a working group established, a pharmacy security and safety task group. It's chaired, in fact, by the deputy minister of Healthy Living. On that group, there are representatives from Manitoba Health and the Manitoba Pharmaceutical Association, the Manitoba Society of Pharmacists, of course, a voluntary society that represents community pharmacists and justice and law enforcement. And they've been working together to come up with a variety of manners on the demand side to do the best that they can to be protecting pharmacists. And the signs that you've seen on pharmacies such as, there is no OxyContin on premises, it must be ordered, these were ideas or this was an idea that I understand came out of that group, and there are others in the work to deal with safety and security in pharmacies.

So we, I think, are trying to strike that balance, and it is an issue that I believe, and I'm reasonably certain you do too, requires ongoing observation and review to make sure that people are safe. I should say, on the other side of all of this, that in addition to listening to doctors that are very interested in the prescribing, being evaluated and monitored, I've also

had concerns raised from doctors and indeed from citizens who say, you know, OxyContin isn't a bad drug when it's being used as it's intended to be used; please, please, don't make the rules such that no patient in Manitoba can ever have OxyContin, because it can be, you know, significant in one's management and recovery of a variety of issues.

So, you know, without making sure that nobody ever has access to OxyContin, we think that by making these kinds of moves we're striking a balance, and I would agree that continuous review of this needs to occur on the supply, as this is the case, and the demand side.

Mr. Goertzen: Thank you, Madam Minister, for the answer. I agree with you. I don't want to see a time when the drug isn't available for its intended purposes because many of us probably know individuals, if it's not our own personal experiences, who have benefited from pain management or different sorts of things through the prescription, popular prescription, of the drug.

I also agree that the moving of the drug to schedule 3 probably didn't result in crime; it probably just changed it, and, in many ways, I think pharmacists feel that they themselves are more at risk now because of that.

And the movement away of the prescription from pharmacies, is that something you think might continue? Do you see a day where pharmacists will say, you know what, it's not worth the physical risks that we might have because of the desire to get this drug onto the street, and they might just simply say, we're not going to be prescribing, in sort of a real-time basis, this drug and that everybody will have to order it or get it, sort of, at a separate place to–for their own protection? Do you see that Manitoba might be moving in that direction, not the government direction, but the individual pharmacists might be saying, this is too great a risk for us to bear?

***** (13:40)

Ms. Oswald: Difficult to say. It's, you know, a hypothetical situation that, you know, I mean not to belittle your question or your statement by saying that, which is why I think it's something that is one that we need to continue to watch. We know that when we change the way that things have always been done, there are always questions and issues. I know the moving of pseudoephedrine, you know, we've talked on the crystal meth file a number of times before; that raised some consternation among pharmacists and it would appear that we have made it through that storm, if you will, reasonably smoothly. But we are going to, through this group that I've mentioned to you and now also through our continued involvement with the pharmacists that are appointed to the MDSTC, or perhaps it will have a new name as we go forward, we will listen to their advice on this issue. As I said earlier, it may be OxyContin today, but, you know, six months or one year from now, there will be another drug of choice that is requiring us all to be working together to ensure it's available as appropriate and not being acquired in ways that hurts people.

Mr. Goertzen: Maybe more of a comment than a question. A lot of the discussion has been focused on the possibility of pharmacists improperly prescribing either incorrectly or more nefarious reasons for that. I think there's also, from a patient perspective, from a public safety perspective, there's good reason for individuals who have reason, medical reason, to have OxyContin or other drugs that might come out in the future and be the subject of this problem as well to not have too much of it. There certainly are cases where, and I've read of them, where individuals have been robbed because of the fact they have significant amounts of OxyContin in their possession, and it's unfortunate that things have sort of moved that way in society. But individuals themselves are at risk even if they possess the drugs for a good reason, to put themselves in harm way because they might become a target. And word gets around, even in families, about who has OxyContin for different reasons, and addiction's a powerful thing, and sometimes family barriers aren't enough to protect individuals when it becomes clear that someone in the family has a significant amount of OxyContin even for legitimate reasons.

So not only, I think, is there value in the legislation from the perspective of ensuring that medical professionals are sort of staying within standard, but also in terms of patients not having too much of a drug that has become valuable on the street and could put them in harm's way, because there certainly are cases where individual patients have become known to have the information or to have drugs of OxyContin brought in and then become a target from those who want to steal from them. So more of a comment. You're welcome to comment back if you want, but more of a comment than a question to the minister.

Ms. Oswald: It's sage advice.

Mrs. Driedger: Can I ask the minister in reference to moving OxyContin to part 3 of the Pharmacare formulary, since that has happened, have you been noticing anything interesting in your department looking at these, you know, requests coming forward for patients to be on OxyContin? Because I understand that doctors have to contact Manitoba Health for approval before patients can obtain Pharmacare coverage for their prescription. Have you been noticing any trends or interesting prescribing practices, or have you already got information that you can deal with so that once, you know, we move forward with this legislation that you can really hit the ground running?

Ms. Oswald: Yes. It's pretty early on, but there seems to be somewhere in the neighbourhood of about a 20 per cent decline. So you ask me if there's anything interesting happening; I think that's kind of interesting. But I'm not sure that I'd be prepared to absolutely establish causation at this point. It's possible, but that's really going to be the function of what this legislation and, by extension, the advisory committee and the college will be able to delve into more significantly. Has this happened because people that were overprescribing don't want to take the trouble now? Maybe. Is it happening for different reasons altogether, like a focused attention by the media and society thereby that people are just nervous about being known to be prescribers of OxyContin, so now they've moved on to something else? I really can't speculate, but it's not unusual for prescribing practices to change when, of course, drugs get moved like this and this really would be no different.

So thank you, Ms. Hill, for running in and saying that this is what the initial summary shows us, about a 20 per cent dip, and we'll see if that holds.

Mrs. Driedger: Does the minister have any sense of how many OxyContin prescriptions are written on a monthly basis?

Ms. Oswald: I'd have to check.

Mr. Chairperson: Okay, seeing no further questions, clauses 7 and 8–pass; clause 9–pass; enacting clause–pass.

Shall the title pass?

Some Honourable Members: Pass.

Mrs. Driedger: Just a final question to the minister. Wait times for addictions in Manitoba are very, very long, and, you know, we've been raising this issue for quite some time, and, you know, Dr. Lindy Lee has made comments about that too. She's been very vocal about saying that patients with addictions are dying on waiting lists and that a lot of, you know, the issues we might be able to resolve if we had better treatment for addictions in Manitoba. Can the minister give us some indication of, you know, where the government's plan is in order to improve wait times for addictions treatment in Manitoba?

Ms. Oswald: Well, certainly, we know that we have to take a multipronged approach to the dealing of mental health issues and addictions. We want to work to build capacity on a number of fronts and we are committed to do that.

As it relates to the scope of this legislation though, I think one of the most important things that we can do is work to make sure that all of the systems that we have in place, whether it's a regulatory body that oversees the conduct of professionals or the development of a committee that can do more than it has ever been allowed to do before on the supply side, so that individuals that are apt to become addicted may not have a supply of a drug like OxyContin or others as readily available, I think that that's a critically important step that we can take on the continuum of dealing with the issues of addictions. As noted by Dr. Pope earlier, reasons that people become addicted in the first place right down to doing what we can to continue to invest in addiction services, and we're committed to do that.

Mrs. Driedger: Just a final statement. I don't dispute that this is an important component of all of that and we do support the legislation. We think it's going to help. But it's only part of the step. And I just guess– the final comment I would like to make is I do think the government's got to do a much better job of addressing the wait-list for people that are on–that are addicted, because that is where there is a significant problem still in Manitoba, and when you've got young people, children dying because they are unable to access treatment, that side of this equation also needs some very, very serious addressing, and I would just urge the government to, you know, put lots of focus on to that as well.

Mr. Chairperson: Seeing no further questions, title–pass. Bill be reported.

The hour being 1:48, what is the will of the committee?

Some Honourable Members: Committee rise.

Mr. Chairperson: Committee rise.

COMMITTEE ROSE AT: 1:48 p.m.

WRITTEN SUBMISSIONS PRESENTED BUT NOT READ

Thomas Nevakshonoff, MLA
Chair
Standing Committee on Social and Economic Development
Room 234, Legislative Building
450 Broadway
Winnipeg MB R3C 0V8

Dear Mr. Nevakshonoff,

Re: Bill 14 – Prescription Drugs Cost Assistance Amendment Act (Prescription Drug Monitoring and Miscellaneous Amendments)

The Canadian Medical Protective Association ("CMPA") is pleased to offer its comments to the Standing Committee reviewing Bill 14, *The Prescription Drugs Cost Assistance Amendment Act (Prescription Drug Monitoring and Miscellaneous Amendments)*, which purports to strengthen the monitoring of the prescribing of narcotics and other controlled drugs by enabling professional regulatory bodies, such as the College of Physicians and Surgeons of Manitoba, to work with Manitoba Health to monitor the prescribing practices of its members.

Executive Summary

Notwithstanding the laudable objectives of the Bill, namely to reduce narcotic drug abuse, the CMPA is concerned about the scope of the authority in the existing *A*ct with respect to the inspection of clinical records. It is respectfully submitted that Bill 14 should include amendments to subsection 10(2.1) of the *Act* to place reasonable limits on the authority of inspectors to enter the office of a health professional and to require the production of clinical records without a warrant.

The CMPA also submits that s.10.1(1) of the *A*ct (section 7 of the Bill) should be amended to require that, before making a referral to the College, the Minister have reasonable grounds to believe that the prescribing or dispensing practices of a member are inappropriate or not in accordance with generally accepted prescribing or dispensing practices.

CMPA's Mandate

The CMPA is the principal provider of medico-legal assistance to physicians in Manitoba and across Canada. It is a not-for-profit mutual defence organization operated by physicians, for physicians. The most obvious expression of the CMPA's assistance to its members is the provision of legal representation, including representing members when a claim or complaint is brought against them and assisting members when their privileges are being threatened. Equally significant are the broader advisory services the CMPA provides to its members on a multitude of medico-legal issues, including risk management, research and education.

In this regard, the CMPA, is an interested stakeholder in any legislative proposals that might have implications for Manitoba physicians, including legislation governing physicians' prescribing practices.

Inspection of Records

The CMPA is disappointed that the government did not take the opportunity with the introduction of Bill 14 to propose amendments to subsection 10(2.1) of the existing *Act*, which permits inspectors to enter the office of a health professional and to require the production of clinical records related to specified drugs without a warrant. Subsection 10(2.4) only requires that a warrant be issued in circumstances where an inspector has been prevented from exercising his/her powers.

As you are aware, physicians owe a duty of confidentiality to their patients. Any requirement that mandates physicians to provide patient information without the patient's consent has the potential to threaten the necessary relationship of trust between the doctor and patient. Indeed, patients may be dissuaded from seeking medical attention if they are aware that their health care provider may be required without a warrant to disclose their personal health information to an inspector appointed by the Minister under the *Act*.

In the CMPA's view, an inspector should be required in every case to present a warrant prior to being able to enter the office of a health care professional or to require the production of clinical records. This may be accomplished by amending subsection 10(2.1) as follows:

The minister may appoint inspectors who may, at any reasonable time and upon presentation of a warrant and identification,

(a) enter any of the following places:

(i) the office of a medical practitioner, dentist, pharmacist, registered nurse or midwife,

(ii) the office of a group of health care professionals, including, without limitation, any described in subclause (i),

(iii) a hospital, surgical facility or other health care facility in which records relating to specified drugs are kept; and

(b) require the production of, examine, audit and make copies of any records, including medical or clinical records, kept in that place that relate to specified drugs.

To the extent that these amendments to subsection 10(2.1) are adopted, subsection 10(2.4) would be redundant and should be repealed.

Referral to Professional Regulatory Body

Amongst the amendments proposed in Bill 14 is a new provision in the *Act* that would permit the Minister to make a referral or complaint to a health professional's regulatory body where the Minister believes, based on advice from an Advisory Committee, that the health professional's prescribing or dispensing practices may be inappropriate or not in accordance with generally accepted practices.

The CMPA respectfully submits that the proposed scope of the Minister's authority in subsection 10.1(1) is unnecessarily broad and that a higher threshold should be imposed. The Association asserts Bill 14 should require the Minister to have reasonable grounds to believe that a health professional's prescribing or dispensing practices may be inappropriate or not in accordance with generally accepted prescribing or dispensing practices before making a referral or complaint to the health professional's regulatory body.

Given the potentially serious consequences that a referral or complaint may have on a health care provider's professional reputation, the Minister should be statutorily required to have reasonable grounds before exercising his/her discretion to make such a referral or complaint. The CMPA respectfully submits that subsection 10.1(1) (section 7 of the Bill) should be amended to read as follows:

If the minister has reasonable and probable grounds to believe, based on advice from an advisory committee established under section 3.1, that the prescribing or dispensing practices of a member of a profession that has authority to prescribe or dispense a drug or other item ~~may be~~ are inappropriate or not in accordance with generally accepted prescribing or dispensing practices, the minister may refer the matter, or make a complaint about the matter, to the regulatory body governing the person's profession.

The CMPA wishes to express its gratitude to the Standing Committee for the opportunity to comment on Bill 14, *The Prescription Drugs Cost Assistance Amendment Act (Prescription Drug Monitoring and Miscellaneous Amendments).*

Yours sincerely,

John E. Gray, MD, CCFP, FCFP
Executive Director/Chief Executive Officer

JEG/lg

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Dr Michael R. Lawrence, CMPA President
Dr Lawrence Groves, CMPA Councillor

The Legislative Assembly of Manitoba Debates and Proceedings
are also available on the Internet at the following address:

http://www.gov.mb.ca/legislature/hansard/index.html