When the exception becomes the norm: a mixed methods study on management of sleep disorder by family medicine preceptors

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Abstract:	Background: Most prescriptions for sedative-hypnotics are written by family physicians yet little research examines how family physician residents learn to prescribe them. Given the influence of preceptors on resident prescribing, this study explored how family physician preceptors manage sleeping problems. Methods This mixed methods study included a quantitative survey of family physician preceptor attitudes to treatment options, perceptions of patient expectations and family physicians' self-efficacy beliefs, followed by qualitative semi-structured interviews, using case vignettes. Quantitative data were analyzed using descriptive statistics and qualitative interviews were analyzed using thematic analysis. Results Forty-seven preceptors affiliated with a postgraduate training program in Alberta completed the survey (47/76, 62%) and 10 were interviewed. Most respondents agreed they had sufficient expertise to use non-drug treatment (n=34, 72%). 43 (91%) had made efforts to reduce prescribing and 45 (96%) felt able to support patients empathically when not using sleeping medication. Qualitative data showed management of sleeping disorder was emotionally challenging. While participants

	hesitated to prescribe sedatives, all reported 'exceptions' to prescribing, many of which included indications within guideline recommendations. Participants were reluctant to intervene with management plans of colleagues. Interpretation Preceptor participants were confident using non-pharmacological management, and hesitant to use sedative-hypnotics. Legitimate use of sedatives was presented as exceptional behaviour, but was consistent across participants, representing a social norm. Avoidant behaviour and failing to acknowledge emotional and social dimensions of prescribing, risks suppressing a more balanced approach to prescribing.

COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	7
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	1
Occupation	3	What was their occupation at the time of the study?	4
Gender	4	Was the researcher male or female?	1
Experience and training	5	What experience or training did the researcher have?	4
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	7
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	7
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	4
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	5
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	6
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	6
Sample size	12	How many participants were in the study?	6, 8
Non-participation	13	How many people refused to participate or dropped out? Reasons?	8
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	6
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	No
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	8, Table 1
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	Appendix 2
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	No
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	7
Field notes	20	Were field notes made during and/or after the inter view or focus group?	no
Duration	21	What was the duration of the inter views or focus group?	7
Data saturation	22	Was data saturation discussed?	7
Transcripts returned	23	Were transcripts returned to participants for comment and/or	No (participant

Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	7
Description of the coding tree	25	Did authors provide a description of the coding tree?	Appendix 3
Derivation of themes	26	Were themes identified in advance or derived from the data?	7
Software	27	What software, if applicable, was used to manage the data?	7
Participant checking	28	Did participants provide feedback on the findings?	no
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	Table 3
Data and findings consistent	30	Was there consistency between the data presented and the findings?	9
Clarity of major themes	31	Were major themes clearly presented in the findings?	9-10
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	Table 3, Appen

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

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Abstract

Background:

Most prescriptions for sedative-hypnotics are written by family physicians yet little research examines how family physician residents learn to prescribe them. Given the influence of preceptors on resident prescribing, this study explored how family physician preceptors manage sleeping problems.

Methods

This mixed methods study included a quantitative survey of family physician preceptor attitudes to treatment options, perceptions of patient expectations and family physicians' self-efficacy beliefs, followed by qualitative semi-structured interviews, using case vignettes. Quantitative data were analyzed using descriptive statistics and qualitative interviews were analyzed using thematic analysis.

Results

Forty-seven preceptors affiliated with a postgraduate training program in Alberta completed the survey (47/76, 62%) and 10 were interviewed. Most respondents agreed they had sufficient expertise to use non-drug treatment (n=34, 72%). 43 (91%) had made efforts to reduce prescribing and 45 (96%) felt able to support patients empathically when not using sleeping medication. Qualitative data showed management of sleeping disorder was emotionally challenging. While participants hesitated to prescribe sedatives, all reported 'exceptions' to

prescribing, many of which included indications within guideline recommendations. Participants were reluctant to intervene with management plans of colleagues.

Interpretation

Preceptor participants were confident using non-pharmacological management, and hesitant to use sedative-hypnotics. Legitimate use of sedatives was presented as exceptional behaviour, but was consistent across participants, representing a social norm. Avoidant behaviour and failing to acknowledge emotional and social dimensions of prescribing, risks suppressing a more balanced approach to prescribing.

INTRODUCTION

Avoiding inappropriate use of sedative-hypnotics is a healthcare priority in Canada.[1,2] At any given time, it is estimated that approximately 12% of Canadians use sedatives, increasing to 16.5% of older adults.[3] Use of sedatives is associated with significant morbidity including falls, cognitive impairment, and health-care costs.[4–6]

Historical legacies of misuse and abuse of prescription medication, arising from lenient prescribing trends in the past,[4,5,7] stimulated development of a range of approaches to avoid and reduce inappropriate prescribing. Guidelines on the management of insomnia[8,9] emphasize risks associated with use of these medications, particularly risks of tolerance and dependence, and encourage physicians to use non-pharmacological approaches as first-line management. Choosing Wisely, Canada[1] educates patients to understand sleeping pills are not the best option and Choosing Wisely messages are increasingly integrated into undergraduate[10] and postgraduate medical education.[11] In addition to promoting rational prescribing, physicians are encouraged to deprescribe sedative-hypnotics,[12] and actively review the need for medication, particularly in older patients. Several provinces implemented prescription monitoring programs, including BC (1993-1997), Ontario (2011-2013)[4] and Alberta[13] (2013[14]-present). Despite these efforts, the number the numbers of patients prescribed sleeping medication has remained relatively unchanged since 2013.[3]

One group of physicians with potential to reduce prescribing rates are family medicine residents. Each year, Canada graduates approximately 780 new family physicians.[15] Family physicians, as a group, are responsible for the initiation and maintenance of most community-based prescribing, including nursing homes and long-term care facilities, where sleeping medication is often prescribed. Family physician graduates also work as hospitalists, providing

care to relatively stable in-patients. Systematic reviews exploring management of sleep disorder[16] and use of sedative-hypnotics by family physicians,[17] indicate family physicians have ambivalent attitudes towards prescribing[16–18] sedative-hypnotics. Physician attitudes are important,[19,20] as they influence confidence towards management, the ability to empathically respond to patient requests and how physicians prescribe for different patient groups. Yet, how family physicians learn to prescribe is rarely mentioned, although the importance of role-modelling when learning to prescribe is recognised.[21] Development of medical learners' professional identities, including understandings of their professional norms, values and roles, is influenced by socialization through both formal and informal instruction,[22,23] such as occurs with role-models and mentors. The importance of how learning occurs in context, is widely recognized as significant in medical education.[24,25] This understanding draws from a social constructivist approach, in which learning and development are conceptualized as the transformation of socially shared activities into internalized processes.[22,26]

Given that most family resident training takes place in clinical practice, under the supervision of family medicine preceptors, the aim of this study was to develop an understanding of family physician preceptor attitudes towards and management of sleep disorder. Our research question was: '*how do family physician preceptors manage sleep disorders in clinical practice*?'

METHOD

Study Setting

This study was set in the Family Medicine Residency program, Calgary, Alberta which provides clinical training for 70 family medicine residents each year. Supervision is provided by family

physician preceptors who work in academic teaching clinics (n=46) and community-based family medicine clinics (n=30).

Study design

This is a mixed methods study, consisting of quantitative survey data and qualitative interviews. Mixed methods designs build on the individual strengths of qualitative and quantitative data, while supporting the contextualisation of findings to make them more useable for stakeholders.[27] We used an explanatory sequential (two-phase) design[28] first collecting and analyzing quantitative data, and then conducting interviews to help interpret the quantitative data and explore the relationship between family physician attitudes and practices.

Research team

The research team consists of two academic family physicians (MK, MOB), two pharmacists working in academic clinics (TH, SK), a psychologist (THill) and a PhD student (SC). MOB has experience with quantitative data analysis and MK/TH/THill/SC have experience in the conduct and analysis of qualitative data.

Data sources

Quantitative A survey tool based on previous research[19] was designed, piloted with four family physicians and modified. The final survey asked participant demographics, and a series of Likert questions exploring family physician attitudes to treatment options (questions=5), family physician's perceptions of patients (questions=2), family physician's self-efficacy beliefs

(questions=3) and prescribing self-efficacy (questions=4). A copy of the survey is available (APPENDIX 1).

Qualitative To probe preceptor attitudes, we devised a semi-structured qualitive interview guide. This invited participants to outline their management in response to a series of vignettes. We developed vignettes to reflect common clinical scenarios, informed by the team's clinical experience and research literature which indicates physicians perceive some patients as more 'deserving' of medication, while others are less likely to receive prescription.[17,29] Vignettes can be advantageous in qualitative research to tease out differences between responders' self-reported behaviour and their actual behaviour.[30] They offer participants distance and space to provide a discursive interpretation, and the situated context of a vignette can be used to explore the main influencing factors of an individual's decision or explanations.[30] A copy of the interview guide is available (APPENDIX 2).

Recruitment & data collection

All family physician preceptors affiliated with the urban Family Medicine Residency Program, University of Calgary, Alberta, were eligible to participate (n=76). A letter outlining the study was emailed to preceptors by the residency program. Two reminders were sent at two weekly intervals. The letter included a consent form and a link to the survey. Following completion of the survey, respondents were asked if they were interested in participating in a qualitative interview. To incentivize response rates, survey participants were offered the opportunity to enter a draw for an Apple watch, while interviewees were offered $100 to participate.

Survey data were collected in Jan – May 2021 and interviews were conducted between Jun – Oct 2021. Interviews were conducted by pharmacists TH and SK, who were known to some of the participants as clinical team members. All participants who volunteered were interviewed (convenience sampling). Interviews were conducted by Zoom, to accommodate public health measures during COVID, at a time convenient to participants, audio recorded and transcribed verbatim. Interviews lasted between 40-70 minutes and continued until we reached data sufficiency.[31] Participant sociodemographic data was separated from interview data and transcripts anonymized to protect participant identity, the identifying key devised and retained by a member of administrative staff.

Analysis

Quantitative descriptive statistics were calculated for survey data and chi square testing examined for difference in response with participant characteristics (gender, years in clinical practice, site of clinic). Qualitative data were analyzed thematically[32] using NVivo 12 software. Transcripts were read independently by MK and SC to identify preliminary codes. These were then reviewed by the entire team and each team member independently applied initial codes to two interview transcripts each. The team met to refine codes and an inductive codebook was generated. SC and MK proceeded to code the entire dataset using a mix of deductive and inductive coding. Analysis was reviewed and discussed with the larger team through a series of team meetings.

Data integration

Survey findings were used to help interpret and deepen qualitative data analysis through discursive team meetings.

Ethics

This study was approved by the Conjoint Health Research Ethics Board, University of Calgary.

Results

Participants

Forty-seven preceptors completed the survey (47/76, 62%) and 10 family physicians were interviewed. Overall, our sample contained more survey respondents (68%) and interviewees (80%) working in academic teaching clinics. Demographic characteristics of participants are available in Table 1.

Survey data

Survey results indicated practitioner confidence in managing sleep disorders using non-pharmacological approaches was generally high. Thirty-seven (79%) participants agreed treatment did not need to be supported with medication use and only 5 (11%) participants believed the advantages of sleep medication outweigh the disadvantages. Forty-two participants (89%) agreed management of sleep problems was within their remit. Most respondents agreed they had sufficient expertise to use non-drug treatment (72%) and did not feel overwhelmed managing patients with psychosocial problems (70%).

The results indicated widespread efforts to reduce prescribing of sleep medication (91%) with broad success (70%). Almost all respondents felt able to support patients empathetically (96%) when not prescribing sleep medication.

Participants' perceptions of patients' expectations diverged. While 45% of participants responded neutrally to the statement that patients would be dissatisfied if they did not prescribe medication, 11 (23%) agreed with this statement and 15 (32%) disagreed. Twenty respondents (43%) agreed that it was difficult for family physicians to motivate patients to choose non-medicine treatment, while 21 (45%) disagreed.

Fewer men than women agreed with the statement 'the advantages of sleep medication outweigh the disadvantages' ($p=0.015$) and the statement that 'there are no non-drug alternatives for sleep problems that are as effective as drugs' ($p=0.046$). Physicians with <16 years of clinical practice were more likely to agree that they were trying to prescribe less sleeping medication without success, than those with fewer years of practice ($p=0.023$).

Interview findings

We identified three overarching themes from interview data: preceptors' general approach to managing sleeping problems; preceptor hesitancy prescribing medication, which we termed 'sedative wariness' and preceptors' 'exceptions' to their general approach.

1. General approach to sleep disorder – a symptom, not a diagnosis

Sleeping problems were viewed as a complex presentation with a wide differential. History-taking was key and necessitated 'delving into the story behind the insomnia'. Practitioners described this process as exploring the 'bigger picture', to 'get a sense' of things, or looking 'in the background', as well as identifying patients' main concerns in relation to the impact of sleep difficulty and their expectations

around sleep. Participants emphasized the importance of acknowledging patients' distress. Treatment was described as challenging, necessitating a highly individualized approach to care. This, as noted by one participant, made prescribing decisions for sleep disorder different from other disorders such as, for example hypertension. Treatment was not considered 'black and white' but required comfort with uncertainty. They contrasted this approach with inflexible adherence to guidelines.

2. Sedative wariness

Most participants promoted non-pharmacological approaches as first-line treatment, including sleep hygiene and cognitive-behavioural therapy for insomnia (CBT-I). Participants reported using a wide suite of educational resources, including customized patient information leaflets to support non-pharmacological management.

Participants hesitated to initiate medication, while acknowledging they perceived patients often expected them to do so. They described their attitudes towards medication in affective terms; 'not loving' or 'hating' sedatives. Only one participant openly acknowledged sedative prescribing, describing their approach as 'old school' in their openness to prescribe medication as a first-line treatment despite being aware of colleagues' hesitancy to prescribe them. There was an ethical dimension alongside the emotional one, whereby participants justified 'rule-breaking' as 'doing the right thing for the patient'.

3. When exceptions become the norm

While participants stated explicitly they aimed to use non-pharmacological management approaches and were wary of using medication, all admitted they did, at times, prescribe sedatives. These were presented as deviations from routine care, collectively termed 'valid exceptions'. 'Exceptions' were nevertheless,

consistent across interviewees. This included prescribing sedatives for short-term use or for patients presenting with acute grief or stress reactions, or in situations where the physician carefully balanced risks and harms, as part of harm reduction strategies. Physicians' descriptions of their prescribing in such situations was in keeping with guidelines, yet they presented this prescribing as concessionary and atypical, and expressed discomfort for 'breaking the rules'. Rather than rely on diagnostic criteria, physicians often justified these decisions based on experience and personal knowledge of the patient. A second 'exception' to sedative prescribing was consulting a colleague's patient. Participants hesitated to change a colleague's management. Management for this group of patients was presented as 'a bridge' or 'band-aid' which could be uncomfortable.

Synthesis of quantitative and qualitative results

Quantitative findings show family physician preceptors felt they had sufficient expertise to manage sleep disorder without medication, while expressing patient empathy, including when caring for patients with complex problems. Participants were mixed in their perception of patient expectation and how these were managed. Participants navigated patient expectations, adopting shared decision-making approaches, on a case-by-case basis. Physicians were hesitant to prescribe medication. All participants recognized medication could play a role, particularly in acute settings, but were hesitant to acknowledge this, describing prescribing in such situations as 'exceptions'. Participants were reluctant to intervene with management plans of colleagues.

Interpretation

Our findings indicate that family physician preceptors emphasized an approach to management which starts by understanding the problem; sleep disturbance was viewed as a symptom, not a diagnosis.

Preferred management involved patient education and non-pharmacological treatments such as sleep hygiene and CBT-I. Participants were hesitant to use medication, even when legitimately indicated, and they used holding strategies to manage patients of colleagues.

To interpret our findings further, we reflected on the social history of sedative and hypnotic use. From widespread use in the 1980s, contemporary literature and policy emphasizes the risks inherent in use of this class of medications, with widespread focus on preventing or avoiding medication initiation and deprescribing.[5,12] Many such interventions focus on individual physician behaviour including, in some provinces such as Alberta, monitoring of individual prescribing rates.[13] Our data indicate that while physicians expressed self-efficacy in management as individuals, prescribing was also impacted by social norms. There was a shared understanding that prescribing was inherently something to be avoided, resulting in some emotional dissonance for participants as they attempted to practice patient-centred care. One possible interpretation of our data is that physicians have become avoidant of sedative-hypnotics, even in cases where they may have a potentially helpful role. This phenomenon has been suggested in the case of opioids.[33,34] Social 'taboo' around prescribing sedatives has been noted in one UK study that observed a reluctance on the part of older GPs to be interviewed on the topic, which the authors suggest 'may reflect the blame, shame and lingering responsibility felt by longer-practising GPs';[29] the study also found that current practitioners felt 'a sense of responsibility for avoiding the risks associated with past benzodiazepine use'.[29] By blanketing all sedative-hypnotic use as harmful, patients may be denied medication which could ease distress in the acute setting[35] or off-set risks in situations of harm minimization. Indeed, given that sedative use is the norm, albeit selectively, failing to engage in open discussion about prescribing risks obfuscating inappropriate prescribing. Some participants adopted a 'hard-line' approach, indicating that avoidance of sedatives altogether was preferable, given their 'taboo' status.

The problems from lack of dialogue over appropriate prescribing may also present in another way. Several participants perceived patients as expecting medication and felt it was challenging to dissuade patients from wanting medication. In contrast, research shows if patients are made aware of the risks, they are open to alternative approaches particularly when providers are supportive.[6,36] One potential explanation for anticipated difficulties was participants' recognition of the functional and mental impact of sleep deprivation. The role of physician empathy in prescribing for sleep disorder is well documented;[15–17] physicians recognize the 'misery'[37] of being unable to sleep and feel torn between empathizing with a patient and promoting rationale prescribing. More open dialogue may thus in fact help relieve some of the emotional burden or dissonance that practitioners may be experiencing.

Balancing the risks and benefits of treatment while accounting for the patient's context is at the heart of evidence-based medicine.[38,39] While our data suggests that is how family physician preceptors approach the management of sleep disorder, there was also an unintended collusion of medication avoidance or 'turning a blind eye', expressed in emotional and moral terms. Several implications arise from our findings. The practice of prescribing is generally presented as objective, in accordance with guidelines, and independent of context. Our study suggests physician empathy is central to sedative prescribing. Further research exploring the reasons and affective aspects of how physicians respond to patients' circumstances,[40] by explicitly exploring 'prescribing dilemmas,' has potential to bridge the gap between cognitive knowing and attitudes. Rather than dismissing emotions, discursive dialogue which acknowledges affective issues, as in say reflective small groups, could enable a deeper sense of self-efficacy, identified as foundational for prescribing.[17,19] This is important when considering training so that young physicians do not replicate avoidant or 'band-aid' approaches to patient care.

Another implication attends to the broader social context in which physician's find themselves prescribing. Our study draws attention to the tensions between individual prescribing autonomy and social prescribing norms for sedative-hypnotics. Social norms are powerful drivers of human behaviour;

in relation to sedative-hypnotic use, there is an implicit corollary between being a good physician and avoiding sedative use. In our data, for some physicians, this social norm, as re-enforced by monitoring of prescribing[41] and censure of colleagues, resulted in prescribing wariness, or for some participants avoidance. Regrettably, this meant some patients, who could have benefitted from short-term use of medication, were denied treatment. A more balanced approach to prescribing could, we postulate, promote poised use, without the need to resort to exceptional pathways, which are in fact, de rigueur – where 'rationale' prescribing is no longer viewed as 'irrational' but legitimate. Future research could explore these possibilities in educational studies in family medicine residency programs.

Limitations

This study has several limitations. The study is set in Calgary, Alberta, where many physicians practice a patient medical home model of care, with access to behavioural health consultants and CBT-I. Barriers to such care is often cited as a reason why physicians are more likely to prescribe medication.[17] Many of our participants worked in academic teaching clinics, which may not have similar time pressures to community practice. Our study would benefit from replication in other provinces, with broader community physician representation. Interviews were conducted by pharmacists known to participants, which may have led to social desirability in responses to interview questions, despite trying our mitigate technique of using vignettes.

Conclusion

Family physician preceptors are powerful role models, key influencers of tomorrow's prescribers of sedative-hypnotics. Teaching physicians were overall confident in their use of non-pharmacological management, adopting evidence-based approaches as first-line. In the majority, they were hesitant to use sedative-hypnotics. Legitimate use of sedatives was presented as exceptional behaviour, when in fact it

was the norm across participants. Interventions targeting individual physician attitudes, complemented by a balanced approach to permitted use of medication, could result in more open discussion on the use of this group of medication. In this way, fundamental challenges of sedative prescribing, which are emotional and social, rather than logarithm decisions, can be addressed rather than avoided.

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Table 1. Demographic characteristics of participants

Variables	Survey n (%) total n=47	Interviews n (%) total n=10
Sex		
Male	19 (44.19)	4 (40)
Female	24 (55.81)	6 (60)
Non-binary	1	
Years in Clinical Practice		
< 5 years	3 (6.38)	1
6 - 15 years	19 (40.43)	6
> 16 years	25 (53.19)	3
Types of Clinic		
Community Clinic	15 (31.91)	2 (20)
Academic Teaching Sites	32 (68.09)	8 (80)

Subscale	Question anchor	Strongly Disagree n (%)	Disagree n (%)	Neutral n (%)	Agree n (%)	Strongly Agree n (%)
Family physician attitude to treatment options	1.The advantages of sleep medication outweigh the disadvantages *	10 (21.28)	19 (40.43)	13 (27.66)	5 (10.64)	0
	2.There are no non-drug alternatives for sleep problems that are as effective as drugs**	25 (53.19)	12 (25.53)	4 (8.51)	3 (6.38)	3 (6.38)
	3.I don't have time to treat sleep problems using non-drug therapies	10 (21.28)	24 (51.06)	8 (17.02)	3 (6.38)	2 (4.26)
	4.Non-medicine treatment of sleep problems is the business of other professionals	21 (44.68)	21 (44.68)	3 (6.38)	1 (2.13)	1 (2.13)
	5.Non-drug treatment of sleep problems needs to be supported with medication	12 (25.53)	25 (53.19)	10 (21.28)	0	0
Family physician perception of the patient	6.If I do not prescribe a medication to a patient with sleep problems s/he is dissatisfied	3 (6.38)	12 (25.53)	21 (44.68)	10 (21.28)	1 (2.13)
	7.It is difficult for a family doctor to motivate a patient with sleep problems to choose a non-medicine treatment	3 (6.38)	18 (38.30)	6 (12.77)	16 (34.04)	4 (8.51)
Family physician self-efficacy beliefs	8.When I am not prescribing medication for sleep problems I feel like I am not empathic	17 (36.17)	28 (59.57)	1 (2.13)	0	1 (2.13)
	9.I have the expertise to use non-drug treatment for sleep problems	0	5 (10.64)	8 (17.02)	27 (57.45)	7 (14.89)
	10.I often feel overwhelmed when a patient presents with psychosocial problems	8 (17.02)	25 (53.19)	9 (19.15)	5 (10.64)	0
Prescribing self-efficacy	11.I have tried in the past to prescribe less sleep medication	1 (2.13)	0	3 (6.38)	25 (53.19)	18 (38.30)
	12.I intend to prescribe less sleep medication but don't know how	5 (10.64)	23 (48.94)	13 (27.66)	6 (12.77)	0
	13.I am trying at the moment to prescribe less sleep medication but without success***	8 (17.02)	27 (57.45)	7 (14.89)	4 (8.51)	1 (2.13)
	14.I am trying at the moment to prescribe less sleep medication and have succeeded in doing so	0	2 (4.26)	12 (25.53)	27 (57.45)	6 (12.77)

*p=0.015, female to male; **p=0.046, female to male, ***p=0.023, physicians > 16 years in practice

Table 3: Qualitative analysis of family physician preceptors' management of sleeping problems

Theme	Subtheme	Illustrative quote
General approach to sleep disorder	Sleeping problems are a symptom, not a diagnosis	I would want to really flesh that out first. So, asking sort of why is it that you're not sleeping and what's going through your mind when you're laying down, and I would suspect that that would unearth quite a bit of kind of emotional baggage and, you know, grief, maybe depression. (Participant 4) Explore kind of those bigger picture things, and just try to really get a sense of this patient's context. (Participant 6) Look at all the other factors that might be affecting this person….. You know, who knows what else is going on? (Participant 8)
	Acknowledging patient distress	Sleep is an emotional discussion, right? Like, people get very upset about the lack of sleep, or perceived poor sleep. [Patients] who are not getting sleep lose the ability to be perfectly rational. (Participant 3) You need to balance compassion for the patient's experience, much like, I think, you know, depression or anxiety. It's – it affects different people in different ways. And so, you can never really assume how debilitating someone's – or bothersome someone's insomnia is. (Participant 4)
	Individualising care – balancing risks and breaking rules	Insomnia treatment …is very challenging…you need to balance compassion for the patient's experience…But that needs to be balanced with the fact that a ….lot of the most common treatments that people have been

		on or exposed to or heard about are quite dangerous or risky when misused. (Participant 4) It's very dissimilar to the approach to a lot of other meds, you know. Like managing asthma…. It's individual medicine it doesn't follow guidelines. It's like you're breaking rules so that you can actually do what's right…. There's as many ways to manage substance use and sleep and pain as there are people who have those problems. […] and you really have to do it differently every time. (Participant 2) I don't have a sort of formula for it. (Participant 7) It's a very situational kind of thing. (Participant 8) You have to be really comfortable with uncertainty. …. It's like you're breaking rules so that you can actually do what's right. (Participant 2)
Sedative wariness	Non-drug treatment as first-line	I try to avoid medication wherever possible or at least build it into a more comprehensive plan (Participant 4) So, I try to focus first on non-pharmacological interventions whenever possible, whether that's you know is it organic or not organic. (Participant 2)
	Medication hesitancy	I'm not a huge one in favour of medications. I don't believe in medications. If we do use them, try not to use the benzos, use the tricyclic or something else, depending on the patient, whether it's safe or not. (Participant 8)

		I'm not a huge fan of Zopiclone. But ….I might use, I might use Zopiclone. And why? Just because it's super short-term, you know. , I don't love the Benzo's. I certainly don't want them to take Gravol. Because we just know it doesn't benefit the sleep cycle. You know, it makes things worse. I think Benzo, is similar to treating your sleep with booze, which many people do. You know and get sleepy with booze, but then it wrecks the sleep cycle. So then over time they get more tired and over time they may get more depressed. (Participant 1) There's a lot of fear. There's a lot of fear that you're going to harm the patient. There's a lot of fear that if you prescribe like this as an attending the College is going to come after you. (Participant 2) So Z-drugs, I use very, very sparingly – very, very sparingly. (Participant 9) I am slightly – I call it crazy – I hate [Z]-drugs, and usually when patients talk to me about insomnia, they want a Z-drug…. I'm very hesitant about it. … I think all of these drugs to treat insomnia sometimes mask the problem. (Participant 3) I also try and get them to not jump to medication as kind of a first line. And if they're going to take kind of a medication route, to just be aware of the breadth of different options. (Participant 4)

		Benzos seem to be pretty taboo right now. Or like in the past few years, they've really gotten a really bad rap. (Participant 10)
When exceptions become the norm	The exceptional indication	So, there are definitely significant exceptions regarding Z-drugs, I have easily, like, five patients I can think of that I do prescribe without question for…..There are totally reasonable exceptions, but I won't understand if a person meets my reasonable expectation or exception criteria if I don't have this conversation with them. So, you know, with an acute stressor like this, I think that we had come up with this a little bit in, like, talking about some of my past examples, I automatically see a lane into my exception pathway. (Participant 3) I feel comfortable in choosing patients that I'm going to be able to get off of them once we get them through whatever (Participant 2)
	Prescribing for another physicians' patient	You can't step into another provider's shoes and expect to change, you know, a multi-decade treatment plan over the course of a week. (Participant 4) How do you manage a treatment plan that you maybe don't personally agree with, but that has been initiated by another prescriber? And so, the idea of sort of immediate patient safety being a number one consideration and then not trying to kind of go off and do your own thing, but involve, you know, their provider in whatever you want to do or whatever you think needs to be done as a long-term plan. (Participant 4)

		Not my patient, don't have a relationship with them, hard to have a tough conversation [about deprescribing]" (Participant 3) There are some of our colleagues that if you were to try and suggest some alternative strategies would be [pause] a little sensitive. (Participant 5) This is one of those things, it's not my patient, I have to sort of Band-Aid the situation (Participant 8)

Appendix 1 Sleep Safe Survey

Years in clinical practice	<5	6-10	11-15	>16
Gender				

Management of Insomnia

1. The advantages of sleep medication outweigh the disadvantages

☐ Strongly disagree	☐ Disagree	☐ Neutral	☐ Agree	☐ Strongly agree

2. There are no non-drug alternatives for sleep problems that are as effective as drugs

☐ Strongly disagree	☐ Disagree	☐ Neutral	☐ Agree	☐ Strongly agree

3. I don't have time to treat sleep problems using non-drug therapies

☐ Strongly disagree	☐ Disagree	☐ Neutral	☐ Agree	☐ Strongly agree

4. Non-medicine treatment of sleep problems is the business of other professionals

☐ Strongly disagree	☐ Disagree	☐ Neutral	☐ Agree	☐ Strongly agree

5. Non-drug treatment of sleep problems needs to be supported with medication

☐ Strongly disagree	☐ Disagree	☐ Neutral	☐ Agree	☐ Strongly agree

6. If I do not prescribe a medication to a patient with sleep problems s/he is dissatisfied

☐ Strongly disagree	☐ Disagree	☐ Neutral	☐ Agree	☐ Strongly agree

7. It is difficult for a family doctor to motivate a patient with sleep problems to choose a non medicine treatment

☐ Strongly disagree	☐ Disagree	☐ Neutral	☐ Agree	☐ Strongly agree

8. When I am not prescribing medication for sleep problems I feel like I am not empathic

☐ Strongly disagree	☐ Disagree	☐ Neutral	☐ Agree	☐ Strongly agree

9. I have the expertise to use non-drug treatment for sleep problems

☐ Strongly disagree	☐ Disagree	☐ Neutral	☐ Agree	☐ Strongly agree

10. I often feel overwhelmed when a patient presents with psychosocial problems

☐ Strongly disagree	☐ Disagree	☐ Neutral	☐ Agree	☐ Strongly agree

11. I have tried in the past to prescribe less sleep medication

☐ Strongly disagree	☐ Disagree	☐ Neutral	☐ Agree	☐ Strongly agree

12. I intend to prescribe less sleep medication but don't know how

☐ Strongly disagree	☐ Disagree	☐ Neutral	☐ Agree	☐ Strongly agree

13.. I am trying at the moment to prescribe less sleep medication but without success

☐ Strongly disagree	☐ Disagree	☐ Neutral	☐ Agree	☐ Strongly agree

14. I am trying at the moment to prescribe less sleep medication and have succeeded in doing so

☐ Strongly disagree	☐ Disagree	☐ Neutral	☐ Agree	☐ Strongly agree

15. Would you like to add any comments?

Please go to the next page!

Consent for Qualitative Interview

Would you be willing to participate in a 30-45 minute interview about how you teach about insomnia in family medicine? (Consent sheet will be provided to participants)

If Yes – please include your email so we may contact you

Email:

Thank you!

Appendix 2 Sleep Safe Study: Interview Schedule

Interview questions

Part 1: General exploration

Can you tell me about your approach to managing insomnia?

Part 2: Clinical vignettes
Is it OK if we run through some cases we frequently encounter?

Case 1
A 60 yoa woman attends asking for some help to sleep as her husband died ten days ago. They were married for 30 years. She is on Ramipril for hypertension but is otherwise well.
How might you approach this case?

What issues does this raise for learners?

Part B: During the course of the consultation, she mentions that she got some pills from her sister and wonders if she can get some more, she thinks its called ativan.

How might you approach this case?

What issues does this raise for learners?

Case rationale: This case is chosen as it relates to family physician's perception of the patient e.g. the 'deserving patient' (Sirdifield, 2013).

Case 2
A 35 yoa secretary, a patient of your colleague, attends for renewal of her escitalopram and zopiclone, she has been on these medications for 3 years and feels overall well but wishes to continue her pills. You are running behind in clinic.

How might you approach this case?

What issues does this raise for learners?

Part B What if the patient was asking for quetiapine?

Part B is added to explore family physicians use of antipsychotics, widely used off label for insomnia.

How might you approach this case?

What issues does this raise for learners?

Case rationale This case is chosen as it raises the issue of context in relation to a) managing a patient of a colleague. b) time management and clinical management.

Case 3

A 47 yoa man, with a documented history of alcohol problems attends to ask for more clonazepam. He is on AISH income support for depression and chronic back pain. He has seen psychiatry in the past. He has been taking clonazepam for many years and occasionally asks for an early refill, which has been sanctioned by his doctor. He is presently 10 days early.

How might you approach this case?

What issues does this raise for learners?

Case rationale This case is chosen as it is a more complex case and offers an opportunity to explore self-efficacy and team approaches to insomnia. It also offers an opportunity to explore physicians' perceptions of patients (for example, in contrast to Case 1).

Do you have any other comments or issues you'd like to raise?

Thank you

Appendix C. Themes, subthemes and illustrative quotes

General approach to sleep disorder	Sleeping problems are a symptom, not a diagnosis	Exploring the problem	And I would want to really flesh that out first. So, asking sort of why is it that you're not sleeping and what's going through your mind when you're laying down, and I would suspect that that would unearth quite a bit of kind of emotional baggage and, you know, grief, maybe depression, maybe some, you know, ruminating thoughts or guilt or whatever it is that she's processing that's going through that. Participant 4 [Explore] kind of those bigger picture things, and just try to really get a sense of this patient's context. So, yeah, like how is she coping, what are her support systems, what is she doing to help herself through this difficult time. Yeah, and then like in the background is there a family history of mental health issues, and is there a previous history of sleep disturbance and those kind of things. Certainly if she's using any unhealthy coping mechanisms like alcohol or stuff like that, that can affect sleep. Really try to get a sense of what her expectations are, especially if she's expecting a prescription for a sleep medication, what she knows about sleep medications or what she knows about healthy sleep habits. I would try to get a sense of that. Participant 6 so look at all the other factors that might be affecting this person….. You know, who knows what else is going on? Participant 8 Insomnia can be part of other health problems right? So you know, just you know back to the sleep history, trying to figure out well are they not sleeping because of pain? Are they not sleeping because they've got major depression that hasn't been treated properly and it's like

			an organic piece there? Participant 10
		Exploring takes time	If I'm running behind my clinic, this is something that warrants a deeper dive and a more in-depth conversation. Which obviously isn't going to be feasible on the day. So, I would refill and ask the – just, you know, let the patient know there is – there's other alternatives out there and this may or may not be an appropriate medication for you, but I can't really tell based on, you know, a limited interaction today. So, I'd really like it if we could connect for a bit of a longer session and talk about what this has been doing for you in the past, whether it's still working, make sure that you're aware of, you know, all the risks and alternatives that go along with this. Participant 4 Like a refill, refill, done. […] If we're running behind and this is a refill and we are swamped it's unlikely that I would have the resident do anything more than, "There's other options out there have you thought about these?" Participant 5 But I think certainly patient expectations around insomnia is a huge thing. Like sometimes it's actually like I can't even get to treatment on the first or second visit because it's just managing patient expectations. Participant 6
		Sleep disorder can be emotional - for patient - for physician	But it's such an emotional topic for patients and some of the concepts in CBT for insomnia are so counterintuitive that it takes a while to really help people understand it. Participant 2 I think sleep is an emotional discussion, right? Like, people get very upset about the lack of sleep, or perceived poor sleep. [Patients] who are not getting sleep lose the ability to be perfectly rational. Participant 3

			Looking at that emotionality. Participant 7
	Individualising care	Different from other presentations	It's very dissimilar to the approach to a lot of other meds, you know. Like managing asthma. Yeah, there's a little bit of individualization in someone's asthma action plan, but there's only so many ways you can create an asthma action plan. Participant 2 I don't have a sort of formula for it. Participant 7 It's a very situational kind of thing. Participant 8
		Individualize plans	So, then rapid follow up to go to other layers of stress management and maybe teach her Body Scan. She would probably be really amenable to it. I've known her for a long time, and she likes that sort of thing. You know she's not someone that would want to be taking Zopiclone. Participant 1 It's individual medicine it doesn't follow guidelines. It's like you're breaking rules so that you can actually do what's right…. So it's just a matter of knowing when patients are the exception and when you have to work with these drugs smartly and safely to help your patients. Participant 2 where clinical judgment and therapeutic relationship with the patient and kind of a longitudinal multi-step treatment plan come into play. Participant 4
	Balancing risks and breaking rules	Medication awareness	I'm not a huge fan of Zopiclone. But ….I might use, I might use Zopiclone. And why? Just because it's super short-term, you know. , I don't love the Benzo's. I certainly don't want them to take Gravol. Because we just know it doesn't benefit the sleep cycle. You know, it makes things worse. I think Benzo, is similar to treating your sleep with booze, which many people do. You know and get sleepy

			with booze, but then it wrecks the sleep cycle. So then over time they get more tired and over time they may get more depressed. Participant 1 I am slightly – I call it crazy – I hate [Z]-drugs, and usually when patients talk to me about insomnia, they want a Z-drug…. I think I've seen such terrible consequences for my patients and for family members on Z-drugs that I'm very hesitant about it. … I think all of these drugs to treat insomnia sometimes mask the problem. Participant 3 So, on one hand, you need to balance an unsafe mixture of GABAergic medications with, you know, your risk of seizure if you disrupt kind of the balance that's been struck with long-term tolerance. So, in a situation like that, I guess social and medical stability is probably my biggest consideration. I would not want to make any medication changes that are going to disrupt a medically stable for the time being situation. With that being said, that status quo doesn't sound very acceptable from a risk standpoint to me. And so, the very frank discussion that I would have would be, look, mixing, you know, alcohol and benzos is not safe, these are the potential risks. You know, there's not – going cold turkey on either one of those is not a good way of tapering down and is quite dangerous. This is where it's really important to kind of assess where the patient's at first before trying to make any kind of recommendations. Participant 4 I also try and get them to not jump to medication as kind of a first line. And if they're going to take kind of a medication route, to just be aware of the breadth of different options. Participant 4

			So we all know that it's not our go-to strategy, but we also accept that there is a role in certain situations and that we'd be willing to meet our patients sort of half-way with that. And then we do lots of counselling around potential adverse effects and consequences of using things like Z-drugs. Participant 7 Ah, this is your classic difficult patient. We have many red flags in this story, the chronic pain, the alcohol, the benzodiazepine use, etc., the early refills. These are all red flags and dangers and cautions with that medication. So really, you're thinking in the back of your mind we need to get this guy off of this medication because he's either subverting it, so selling it to somebody else, or he's taking too much himself, highly risky in a person drinking alcohol. Participant 4 This guy can kill himself if he's not careful, and you could be a participant in that, which you don't really want to be. So I think – and then you can't, if he's been on it a long, long time, you don't want to suddenly pull it and withdraw from benzodiazepine, you know. He'll get delirious and seize or shaking and sweating and anxious, and, you know, in being off it, so there's not an easy way. Participant 8 I'm not a huge one in favour of medications. I don't believe in medications. If we do use them, try not to use the benzos, use the tricyclic or something else, depending on the patient, whether it's safe or not. Participant 8 So Z-drugs, I use very, very sparingly – very, very sparingly. Participant 9

			Benzos seem to be pretty taboo right now. Or like in the past few years, they've really gotten a really bad rap. Participant 10
		Balancing and breaking rules	You have to be really comfortable with uncertainty. Participant 2 Just because something is not first line in long-term use doesn't mean that it's not appropriate in specific situations. real life medicine isn't kind of a black and white, that guidelines that say, you know, you should try not to use certain medications in situations doesn't mean that you can ever use them and that it's not ever appropriate to use them. Participant 4 insomnia treatment in general, and it's that it's very challenging, it's something that I think often you need to balance compassion for the patient's experience, much like, I think, you know, depression or anxiety. It's – it affects different people in different ways. And so, you can never really make an assumption bout how debilitating someone's – or bothersome someone's insomnia is. But that's something that always needs to be balanced with the fact that a lot of the treatments and a lot of the most common treatments that people have been on or exposed to or heard about are quite dangerous or risky when misused. Participant 4 You're trying to balance risks and benefits for a patient. Participant 7
		Give and take	I always say like I'm not saying you can't have your meds, I will give you your meds if that's what you want. But I just want to talk about some other options just to know if you're aware of them. Participant 2

			I am not taking this away from you. This is not – today we are not taking this away from you. But I do want to make sure that we're using the best methods for you to sleep the most efficient and to feel the best you can feel, especially after a good night's rest. And would you be open to other options, if there are better options? Participant 9 My approach usually, when a patient requests for something, is the first thing I say to them is like, yeah we can totally get you something like that. Like I just kind of agree with them. And then I go on to explain, and we also have some other options so let's discuss kind of what all the options are and then we can decide what would be best for you. Participant 10
	Establishing therapeutic alliance	Establishing trust – showing compassion	You just have to stop judging, and you have to keep them safe. Participant 2 I try really hard to come at it from, like, not a point of judgment, like, I don't want them to feel embarrassed or ashamed of whatever the reasoning behind the early dispensing or the early refill request is, but just to understand. Participant 3 I think that this case has a lot of room for judgment. Right? And it's hard to be non-judgmental. And I learned it really hard, because I used to work at [cups] downtown, right? And so, you saw – I saw a lot of, you know, street-involved or homeless or [unintelligible 00:55:58] dependent and alcohol and drugs and, like, there's so much more complexity to their social circumstance that I had to learn to be non-judgmental. Participant 3 Because, like, grief is hard. Like, I don't know that I would

			necessarily, like, wag my finger at her about it. Participant 3 It takes patient buy-in, and that alone also takes time in hearing and validating their experiences and trying to develop a bit of a therapeutic alliance before stepping into your management plan. Participant 4 I think that one thing that I try to emphasize is the centrality of that patient trust and validating that patient experience, and not just being focused on kind of a single minded de-prescribing paradigm. Participant 4 being able to suggest and offer alternatives to that, there needs to be that understanding that they know that you understand what they're going through. And sometimes that can happen on the first visit, and sometimes that's something that's built with time. Participant 4 I think that one thing that I try to emphasize is the centrality of that patient trust and validating that patient experience, and not just being focused on kind of a single minded de-prescribing paradigm. Participant 4 I tend not to be hard-nosed about that [laughs] because it doesn't really help. Participant 5 Don't focus too much on the sleep and realise you have somebody who's grieving, and that's your first thing is to listen to this person and offer support. Participant 8 I'd have them be very cautious about how you

			approach them, because they're having a difficult time and you're being a support for these people. Participant 8 So, then I'll have to be a little more sensitive around talking about that medication. Because they don't have the established relationship with me. Participant 9 I would hope it's somebody that I know already, that I have a bit of a therapeutic relationship with. I guess I would like to understand just where she's, like just how things are affecting her. Participant 10
		Shared decision-making	You know, and depending on how that went, if the patient was not open at all – like it's – I mean it's a bit like stages of change in motivational interviewing, if they were totally pre-contemplative, then you handle it like that. …. And if they're totally pre-contemplative, you leave it open, like you know, that's totally fine, it's your health. It's your choice. Participant 2 You're much more likely to be successful and engaging with the patient and keeping them on side if you are a collaborator. Participant 5 Look for opportunities to see if they're in that contemplative phase. Participant 7 Like, This is – I'm not telling you this is how we're going to do things. This is – we're going to decide as a, as a team. Participant 9
		Sharing evidence	**exception battling: either I have the conversation or I have the battle about me not prescribing. Participant 3

			It was a beautiful study but it was like 40% improvement using credible rating scales. Participant 5 I have a really good hand-out. Participant 6 I usually have like my RxFiles with me. Because most of them know Zopiclone. Most of them know, like Melatonin. So, I'll have that with me so that we can go through the RxFiles together to see, "OK. Well how does it work? What's the evidence for it? Participant 9 Like I'll do a little bit of the top guidelines with them maybe. Participant 9 I'll say, This is the evidence. Like this is the evidence for and against. This is where I'm coming from. Participant 9
Deviations from standard care	Valid exceptions		[…] So it's just a matter of knowing when patients are the exception and when you have to work with these drugs smartly and safely to help your patients. Participant 2 So, there are definitely significant exceptions regarding Z-drugs, I have easily, like, five patients I can think of that I do prescribe without question for…..There are totally reasonable exceptions, but I won't understand if a person meets my reasonable expectation or exception criteria if I don't have this conversation with them. So, you know, with an acute stressor like this, I think that we had come up with this a little bit in, like, talking about some of my past examples, I automatically see a lane into my exception pathway. Participant 3 There is a difference between somebody who's had the occasional Z-drugs for flying and stuff like that and then somebody who's regularly on it. Participant 5

			I think I am a little less hesitant to use sedatives because I feel comfortable in choosing patients that I'm going to be able to get off of them once we get them through whatever. Participant 7
		Short duration Acute stress	prescriptions listed but like they're for five days. Participant 2 And so, for a very, very brief period of time, I prescribed for him. Participant 3 based on it's a short period of time. Participant 6 And I think I justify that based on it's a short period of time, it's an extremely stressful period of time. Participant 6 You're seeing someone who's more in acute distress and you may be more willing to give them a simple temporary solution. Participant 7 I don't believe in medications. If we do use them, ….I use it very short term. I set that expectation very early, But in the short-term, it could potentially help. Participant 8
	Caring for a colleague's patient	Can't step into another providers shoes	Bring it up, but, again, not my patient, don't have a relationship with them. Participant 3 Something that I've – in my own personal practice – realized over the course of locum-ing for several physicians is that you can't step into another provider's shoes and expect to change, you know, a multi-decade treatment plan over the course of a week. And so, there's always a bit of a balance there, and I think a lot of that

			depends on how the interaction goes with the patient and how responsive the patient is. There's no sense in fragmenting or – a relationship with a patient or making the patient feel either nervous or discriminated against or anything like that when, you know, you're not the one that's going to be able to really speak into that patient's treatment plan on an ongoing basis, or deal with the symptoms if your proposed alternative doesn't work. Participant 4 So I approach it from a perspective of this isn't my patient, I want to respect the fact that I don't know their history, I don't know what they've been – like what the decisions are that have been made by their previous physician, or their regular physician I should say in this case. So I'll approach it from a perspective of I'm probably not going to change things today, and I shouldn't, maybe, because this is not my patient, I'm not responsible for their ongoing care, but with the same knowledge that I can take an opportunity to do some education with a patient. Participant 6 You don't know how that all ended up like that, so rather than focusing on that, it's just how do we go from here and making suggestions. Participant 8 I mean if somebody's been on zopiclone and I can see from the record it's been pretty stable and that's what they've been using, usually I'm not, I don't really like being another chef in the kitchen, I don't like adding to something or like I don't know the history so maybe she's tried a lot of things. Participant 10
		Don't step on toes	There are some of our colleagues that if you were to try and suggest some alternative strategies would be [pause]

			a little sensitive. Participant 5 You're not wanting to step on the toes of the primary doctor but trying to maintain some consistency with the messaging between the primary doctor and you. Participant 7 You don't want to offend our colleague, and we all live in a glasshouse and we don't want to throw rocks. Participant 8
		Balancing 2 (navigating uncertainty); bridge, band aid, patchwork, planting a seed	I think about that, this is not my patient, this is not my patient to have that discussion with. I am covering for a colleague to some extent. But I'm still responsible for prescribing. So, it's balancing those two things. I will bridge you until then, these are the reasons I'm not giving you a long prescription, because I am uncomfortable, these are not how these drugs are meant to be used, and there's maybe more work that needs to be done. Participant 3 And it's this really fine balance, because I really believe that I have to take responsibility for every prescription I write, and I can't hide behind this idea of, well, if somebody else does it, so I'm just covering for them. Right? Because that's a little bit of that horrible locum practicing or that horrible, like, walk-in medicine style, where, "Oh, this person's been on it for ages, I don't need more history, just keep going." Like, I have to be responsible for what I prescribe. Participant 3 I will bridge you until then, these are the reasons I'm not giving you a long prescription, because I am uncomfortable, these are not how these drugs are meant to be used, and there's maybe more work that needs to

			be done. Participant 3 of how do you manage a treatment plan that you maybe don't personally agree with, but that has been initiated by another prescriber? And so, the idea of sort of immediate patient safety being a number one consideration and then not trying to kind of go off and do your own thing, but involve, you know, their provider in whatever you want to do or whatever you think needs to be done as a long-term plan. Participant 4 I would probably probe the patient a little bit, time permitting, and just get a sense of, first of all, whether there's any significant, like, immediate red flags, you know, like, escalating doses of Zopiclone or early refills or things like that. Something like that, I would probably flag – I would refill, you know, a short course and ask them to follow-up with their primary provider and probably send them a message. If it doesn't seem like there's anything like that, then I would probably throw out a bit of a prompt to the patient and just say, you know what, there could be some alternatives here that might work better for you. Participant 4 So then do I put a bit of a patchwork plan together to get him to the primary doctor so that he can fix the problem. That's I think the ideal scenario, so I don't want him to go into withdrawal, I want to set some limits though, so I may not give him – I wouldn't like to give him his usual dosing, but I might give him enough to just keep him out of the emergency room until his primary doctor can see him. Participant 6 I might just give them a shorter prescription. Participant 6

			To summarise, my approach to these patients is always what's your stage of change. Because if their stage of change is like pre-contemplative then you're definitely not going to make a change, and I'm definitely not going to make a change if I'm not their primary care physician. But if I can provide – it's like smoking cessation, and like, you know, even if I was seeing somebody who's a smoker who's not my patient, I'm still going to say where are you at with being ready to quite, you know, quitting smoking is the best thing you can do for your health, et cetera, et cetera. So I might try to fit in a little education there. But if I get a lot of resistance from the patient then I'm not going to push it. Participant 6 Again, this is one of those things, it's not my patient, I have to sort of Band-Aid the situation, to plant the seeds and have them follow up in the short term, because there's going to need to be a discussion here about everything, about how to treat alcohol abuse disorder, about how to taper off benzodiazepines, and the signs of, you know, the early refills, etc, combined with alcohol, are a very risky business and inappropriate. And so yeah, there's going to have to be some discussion about that. Participant 8 And then to start the conversation of, "Well, maybe this is the medication that – like do we need it or can we do better with something else for it?" And I won't take it away necessarily from them, not at the first visit of interacting with them. Participant 8 But something that I would flag as, "Hey, this is something important that maybe you want to discuss

			with your family doctor, or you're welcome to come back and talk to me about it, if you're comfortable doing so." But I would talk to them about the risks and benefits with something like this, with long-term use. Participant 9
Strategies Used			I try to focus first on non-pharmacological interventions whenever possible. Participant 2 I try to avoid medication wherever possible or at least build it into a more comprehensive plan. Participant 4 CBTI Sleep hygience Body Scan Reground how they view sleep Mindfulness Sleep doctor Journalling Sleep diary