

OPIOIDS: We can do better

The statistics on opioid use in Canada are disturbing. Canada ranks second only to the United States in per capita consumption of prescription opioids, and the consumption of prescription opioids in the European Union and Australia/New Zealand is less than half that in North America.¹ Deaths related to opioids have increased dramatically in many parts of Canada and some jurisdictions have declared the high rates of opioid consumption to be public health emergencies.

ISSUES ASSOCIATED WITH THE INCREASING USE OF OPIOIDS

Opioids can reduce pain, improve a patient's ability to function, and produce a feeling of well-being or euphoria.² Pain, however, is complex in origin. Other factors can also profoundly affect suffering and disability. When psychosocial or mental health issues, or both, contribute significantly to distress, opioids may not prove effective.

Opioids are prescribed for acute pain (such as pain related to a bone fracture), for cancer-related pain, and for chronic pain related to a variety of medical or neurological conditions. Their use for chronic non-cancer pain is particularly noteworthy since a significant portion of the Canadian population experiences this type of pain.³ Moreover, research has found that patients with depression and other mental health disorders, with illnesses related to alcohol and other substance use disorders, and those already abusing or dependent on opioids are much more likely to be prescribed opioids.⁴

Common side effects of opioids include sedation, dizziness, nausea, vomiting, constipation and respiratory depression. Tolerance is also a relatively common occurrence, and physical dependence is nearly universal in patients taking opioids daily for more than several weeks. Other side effects can include delayed gastric emptying, immunologic and hormonal dysfunction, muscle rigidity, and myoclonus.⁵ Hyperalgesia may occur and the patient may seek additional pain relief. The regular use of opioids in pregnancy can result in both premature delivery and opioid withdrawal in newborns.² Moreover, opioids may cause death, and the risk is increased with the concomitant use of other sedatives.⁶

Opioid reduction is a challenging goal for patients and their physicians. Rapid reduction may result in a range of withdrawal symptoms, and tapering protocols are available. Some patients on reduced opioid regimens report improvements in mood and pain.⁷

Drug diversion is another significant issue for some patients and physicians. A patient's friends and family may divert prescription drugs for abuse. Some may self-medicate, or may trade or sell medications they've taken from those with whom they live.⁸ Physicians should therefore engage patients in discussions about drug security and the risk of diversion.

PHYSICIANS CAUGHT IN THE MIDDLE

Physicians experience significant pressure to help reduce pain quickly, especially for patients with chronic non-cancer pain who have no relief from acetaminophen and NSAIDs. Difficult interactions with demanding, aggressive, or even threatening patients add to the pressure physicians feel to prescribe opioids or escalate dosages.

While physicians are not obligated to continue a treatment started by another physician, doctors may also inherit patients already being treated with large quantities of opioids, sometimes without clear indications for their continued use. Drug seeking behaviours, double-doctoring, and prescription fraud occur, and this can be even more difficult to handle in provinces and territories without medication or opioid monitoring systems in place.⁹

Physicians experience significant pressure to help reduce pain quickly, especially for patients with chronic non-cancer pain who have no relief from acetaminophen and NSAIDs.



THE CMPA'S EXPERIENCE

Opioid prescribing has been a cause of medical-legal difficulties for CMPA members for some time. There were 151 CMPA cases from 2010 to 2015 involving allegations of patient harm related to opioid prescribing and administration. These cases relate mostly to opioids prescribed for the treatment of chronic non-cancer pain.

These matters break down as follows:

Medical-legal matters	Number	%
Civil legal actions	57	38.8
Regulatory (College) complaints	90	59.6
Hospital complaints	4	2.6

The CMPA has identified three main themes in these cases:

- **Patient assessment:** Some CMPA members were criticized for their failure to assess patients appropriately for indications for opioids in the treatment of chronic non-cancer pain. Inadequate assessments typically occurred at opioid initiation, renewal, and when increasing the dosage.
- **Concomitant prescription of opioids and other sedatives:** In some cases, the prescription of opioids at the same time as other sedatives (e.g. benzodiazepines and psychotropic medications) resulted in patient over-sedation, respiratory failure, and death.
- **Drug-seeking behaviour:** In some cases, physicians were challenged to identify opioid-dependent patients and curb inappropriate prescribing to them. Not all physicians in the cases reviewed used validated assessment tools and treatment agreements. There was additional risk associated with not implementing compliance assessments, for example using urine screening for other abused drugs. There were examples of patients who “doctor-shop” or “double-doctor,” while others threatened physicians to prescribe opioids.

ADDRESSING OPIOID USE AND ABUSE

The physician's role: Prescribing appropriately

Canadian physicians can take additional steps to assess the indications for starting opioids for acute and chronic pain and prevent the abuse of the opioids they prescribe, thus improving patient safety and reducing their own medical-legal risk.

The CMPA has developed a resource, [Opioid prescribing for chronic non-cancer pain](#), to help physicians.

Risk management steps may include performing careful patient evaluations; having clear indications for starting opioids; developing a well-defined treatment plan; obtaining informed consent; conducting periodic reviews (monitoring); consulting with other physicians or providers when necessary; documenting all informed consent discussions, warnings, and treatment agreements in the medical record; and complying with applicable laws and regulations.¹⁰

Physicians can also consult the *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain*.⁷ The guideline recommends approaches for initiating and monitoring opioid therapy, ways to manage opioid misuse and addiction, precautions to reduce prescription fraud, and how to work collaboratively with pharmacists. The Opioid Manager¹¹ from McMaster University may also be useful, as this point-of-care tool summarizes the essential information and advice from the guideline.

Another resource is the U.S. Centers for Disease Control and Prevention's (CDC) 2016 recommendations on the use of opioids in treating chronic pain outside of active cancer treatment, palliative care, and end-of-life care.¹²

Many medical regulatory authorities (Colleges) also provide resources such as tips on patient assessment, opioid selection, patient monitoring, narcotic flow sheets, treatment agreements, and drug program updates.

Depending on the nature of the concern, physicians with questions about opioid prescribing or managing medications can also consult with online prescription monitoring systems if available, or contact their College, a pharmacist, or the Institute for Safe Medication Practices (ISMP Canada). CMPA members with medical-legal questions should contact the Association to speak with a physician advisor.

The role of other stakeholders

While physicians are a key part of the solution to opioid abuse in Canada, others also play important roles.

Electronic monitoring systems such as electronic prescribing, electronic prescription monitoring, and narcotics monitoring programs are important tools. The federal, provincial, and territorial governments have a role to play in supporting their implementation. National-level anonymized data on prescription drug-related treatment would also be useful to improve care in future cases. Governments may provide funding for further research on the abuse of prescription opioids, and may amend legislation and regulations regarding medications used to treat opioid overdoses in emergency situations. Governments can also raise public awareness about opioid addiction and the public health consequences of opioid misuse, and enhance access to community resources that might pre-empt opioid abuse by Canadians.

The Federation of Medical Regulatory Authorities of Canada has intensified its focus on the prescription and diversion of drugs that are subject to significant abuse. This includes recommending regulations, practice audits or assessments of prescribing, and possible consequences for physicians when their prescribing is not aligned with good practices. It is anticipated that physicians will benefit from and be motivated by data and feedback on their prescribing patterns.

Medical schools and physician continuing professional

development should include more training on pain management, safe opioid prescribing practices, and opioid abuse.

Pharmacists must also continue to manage opioid prescriptions carefully and dispense opioids safely. Effective communication among pharmacists, physicians, and patients is vital. Pharmacists play a key role in recognizing patterns of opioid abuse or misuse.¹³ If possible, physicians might consider keeping in contact with pharmacists in their community.

Patients and families can also impact the extent of opioid use and possible abuse. Healthcare providers should encourage patients who are considering opioids to ask questions; educate themselves about these medications; know the potential benefits and risks; and be aware of alternative treatments, if any. Patients should be familiar with the dangers of drug diversion and should be able to explain how they will prevent this. Patients should also be able to express how they will avoid drug misuse and who to speak to when they have concerns about their prescribed medications.

1. Silversides A. Background: Canada's prescription opioid crisis. EvidenceNetwork.ca [Internet]. Winnipeg (MB): University of Manitoba; 2014 Jul 31 [cited 2016 March 4]. Available from <http://umanitoba.ca/outreach/evidencenetwork/archives/19635>
2. Canadian Centre on Substance Abuse. Prescription opioids. Canadian drug summary [Internet]. July 2015 [cited 2016 April 4]. Available from: <http://www.ccsa.ca/Resource%20Library/CCSA-Canadian-Drug-Summary-Prescription-Opioids-2015-en.pdf>
3. Fischer B, Argento E. Prescription opioid related misuse, harms, diversion and interventions in Canada: A review. Pain Physician [Internet]. 2012 [cited 2016 April 8];15: ES191-ES203. Available from: <http://painphysicianjournal.com/2012/july/2012;15;ES191-ES203.pdf>
4. Edlund M, Martin B, Devries A, Fan M, Braden J, Sullivan M. Trends in use of opioids for chronic noncancer pain among individuals with mental health and substance use disorders: the TROUP study. Clin J Pain 2010 Jan; 26(1):1-8
5. Benyamin R, Trescot A, Datta S, Buenaventura R, Adlaka R, Sehgal N, Glaser S, Vallejo R. Opioid complications and side effects. Pain Physician 2008 Mar; 11;2 Suppl:S105-20.
6. Centers for Disease Control and Prevention. National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention. Opioid overdose: prescription opioids page [Internet]. Atlanta (GA): Centers for Disease Control and Prevention; updated 2016 March 16; [cited 2016 April 22]. Available from: <http://www.cdc.gov/drugoverdose/opioids/prescribed.html>
7. National Opioid Use Guideline Group, Michael G. DeGroot National Pain Centre. Canadian guideline for safe and effective use of opioids for chronic non-cancer pain [Internet]. Hamilton (ON); McMaster University; 2010 April [cited 2016 Mar 7]. 126 p. Available from: http://nationalpaincentre.mcmaster.ca/documents/opioid_guideline_part_b_v5_6.pdf
8. Shehnaaz S, Agarwal A, Khan N. A systematic review of self-medication practices among adolescents. Journal of Adolescent Health [Internet]. 2014 Jul 1 [cited 2016 March 7]; 55(4):467-83. Available from: [http://www.jahonline.org/article/S1054-139X\(14\)00276-6/pdf](http://www.jahonline.org/article/S1054-139X(14)00276-6/pdf) doi:10.1016/j.jadohealth.2014.07.001
9. Canadian Medical Protective Association. Preventing the misuse of opioids. CMPA Perspective [Internet]. 2015 June [cited 2016 April 25];5-7. Available from https://www.cmpa-acpm.ca/en/safety/-/asset_publisher/N6oEDMrzRbCC/content/preventing-the-misuse-of-opioids
10. Toombs, J. Commonsense opioid risk management in chronic non-cancer pain. Practical pain management [Internet]. 2008 [cited 2016 March 7]; 8(3). Available from: <http://www.practicalpainmanagement.com/treatments/pharmacological/opioids/commonsense-opioid-risk-management-chronic-non-cancer-pain>
11. Opioid Manager [Internet]. Hamilton (ON); McMaster University Michael G. DeGroot National Pain Centre; 2010 [cited 2016 April 26]. Available from: <http://nationalpaincentre.mcmaster.ca/opioidmanager/>
12. Dowell D, Haegerich TM, Chou R. CDC Guideline for prescribing opioids for chronic pain — United States, 2016. Morbidity and Mortality Weekly Report (MMWR);65:1-49 [Internet]. Atlanta (GA): Centers for Disease Control and Prevention 2016 March [cited 2016 April 25]; DOI: doi.org/10.15585/mmwr.r6501e1
13. University of Massachusetts Medical School NOW [Internet]. Worcester (MA): University of Massachusetts Medical School; 2014 June 5. [video]. Key role for pharmacists in stemming opioid abuse crisis; 2014 June 5 [cited 2016 Mar 7], 3 min 43 sec. Available from: <http://www.umassmed.edu/news/news-archives/2014/06/Key-role-for-pharmacists-in-stemming-opiate-abuse-crisis/>



Opioid prescribing for chronic non-cancer pain

The Canadian Medical Protective Association (CMPA) offers the following risk management information for physicians who prescribe opioids to their patients for chronic non-cancer pain. This is a summary of suggestions based on the opinions of peer experts commenting on CMPA medical-legal files and the published literature.

■ INFORMATION AND KNOWLEDGE

- Regularly seek up-to-date knowledge about medication and non-medication pain relief options, including treatment indications, contra-indications, medication interactions, and adverse effects.¹
- Consider whether your practice complies with recognized clinical practice guidelines.

■ PATIENT ASSESSMENT, INFORMED CONSENT, AND MANAGING EXPECTATIONS

- Carefully assess the patient's symptoms and ability to function. Consider first whether non-medication analgesia options are appropriate or adjunctive and whether non-opioid analgesics may be more appropriate to prescribe.² If opioids are being considered, be mindful of other medications the patient is taking and any past history of opioid or substance abuse, in addition to potential under-recognized or under-treated mental health conditions.
- Before starting opioid therapy, obtain the patient's informed consent. The expected benefits of both pain relief and improved function should outweigh the patient's risk factors for opioid-related harms.¹ Provide explanations for changes in prescriptions and the potential for ongoing risks.
- Consider the origin and nature of the pain. Manage expectations regarding pain relief.³
- Consider offering opioids on a trial basis and have a strategy to discontinue opioid therapy for cases where pain does not improve.⁴
- Consider using a validated pain scale and take into account patient age, size, risk factors for misuse and dependency, as well as opioid naiveté.⁵
- Obtain agreement on the patient's and clinician's respective responsibilities for managing opioid therapy. Clearly communicate opioid use and refill policies to patients. Set clear boundaries and expectations for behaviour. Consider using treatment agreements.⁶ If a treatment agreement is used, verify the patient understands and accepts it.
- Warn patients to avoid driving or operating machinery,⁷ and document this in the medical record.

■ PATIENT MONITORING AND OPIOID SUPPLIES

- Monitor patients who have been prescribed opioids, including a periodic reassessment of the benefits and risks of ongoing opioid therapy.¹ Some provinces and territories have helpful prescription drug monitoring programs. Review the patient's goals, overall control of pain, side effects, and other options.
- Prescribe exact amounts of medication based on what patients should need until the next appointment,¹ and consider shorter time periods between appointments.



■ CONSULTATION, DOCUMENTATION AND SECURITY

- Consult with peers, pharmacists or other experts (such as physicians specializing in addiction or pain management) when needed.¹
- Consider screening for addiction and dependence, and then referring patients to substance use resources or creating a tapering plan.⁶
- Document all medication-related discussions, including informed consent discussions, and treatment decisions in the medical record.¹ Ensure a copy of any treatment agreement signed by patients is also retained in their medical record. Prescription pads and medication supplies should be securely stored.⁸
- Talk to patients about secure medication storage at home and the risks of diversion.¹

TREATING ACUTE AND POST-OPERATIVE PAIN

Non-opioid pain medications or therapies may not provide adequate pain relief for patients, and the severity of the pain may warrant opioids. A patient's previous history of addiction or substance abuse should be considered before prescribing. Careful opioid prescribing is important. Consider the following:

- Explain potential benefits and risks to patients.
- Limit the number of doses prescribed based on the expected duration of pain.
- Remind patients to return any unused opioids to a pharmacy.
- Inform patients that opioids are intended for short-term use only.
- Warn patients to avoid driving or operating machinery.
- Document consent and warnings in the medical record.



1. Canadian Medical Protective Association. Preventing the misuse of opioids. CMPA Perspective [Internet]. 2015 June [cited 2016 April 26];7(3):5-7. Available from https://www.cmpa-acpm.ca/en/safety/-/asset_publisher/N6oEDMrzRbCC/content/preventing-the-misuse-of-opioids
2. Schnitzer TJ. Non-NSAID pharmacological treatment options for the management of chronic pain. Am J Med [Internet]. 1998 Jul 27 [cited 2016 April 26];105(1B):45S-52S. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/9715834>
3. Chou R, Fanciullo G, Fine P, Adler J, Ballantyne J, Davies P, Donovan M, Fishbain D, Foley K, Fudin J, Gilson A, Kelter A, Mauskop A, O'Connor P, Passik S, Pasternak G, Portenoy R, Rich B, Roberts R, Todd K, Miaskowski C, American Pain Society-American Academy of Pain Medicine Opioids Guidelines Panel. Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. J Pain [Internet]. 2009 Feb [cited 2016 April 26]; 10(2): 113-130. Available from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4043401/> doi:10.1016/j.pain.2008.10.008
4. Argoff C, Viscusi E. The use of opioid analgesics for chronic pain: Minimizing the risk for harm. Am J Gastroenterol Suppl [Internet]. 2014 [cited 2016 April 26]; 2:3-8. Available from: <http://www.nature.com/ajgsup/journal/v2/n1/full/ajgsup20143a.html> doi:10.1038/ajgsup.2014.3 doi:10.1038/ajgsup.2014.3
5. Sehgal N, Manchikanti L, Smith H. Prescription opioid abuse in chronic pain: A review of opioid abuse predictors and strategies to curb opioid abuse. Pain Physician [Internet]. 2012 [cited 2016 April 26]; 15:ES67-ES92. Available from: http://www.thblack.com/links/RSD/PainPhys2012_15_ES67_RxOpioidAbuseInChronPain-26p.pdf
6. National Opioid Use Guideline Group. Canadian guideline for safe and effective use of opioids for chronic non-cancer pain [Internet]. Hamilton (ON); McMaster University, Hamilton; 2010 April [cited 2016 Mar 7]. 126 p. Available from: http://nationalpaincentre.mcmaster.ca/documents/opioid_guideline_part_b_v5_6.pdf
7. Pain EDU, Improving pain through education, Articles [Internet]. Zacharoff K. Chronic opioid therapy: driving and work safety. Newton (MA):Inflexion; 2010 Feb 2; cited 2016 April 26]. Available from: https://www.painedu.org/articles_timely.asp?ArticleNumber=31
8. American College of Preventive Medicine [Internet]. Use, abuse, misuse, and disposal of prescription pain medication, clinical reference. Washington (DC); 2011 [cited 2016 Apr 26]. Available from: <http://www.acpm.org/?UseAbuseRxClinRef>

