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Longer-term remedies for chronic pain management

We want to commend Clarke and colleagues for highlighting an important and current issue in their commentary "Canada's hidden opioid crisis: the health care system's inability to manage high-dose opioid patients. Fallout from the 2017 Canadian opioid guidelines" in the September issue of *Canadian Family Physician*.[1] The article identified the unintended consequences resulting from the 2017 "Guideline for opioid therapy and chronic noncancer pain"[2] including the reluctance to properly manage patients with pain and, in some cases, the abandonment of those with opioid use disorder (OUD). These outcomes should not be too surprising given the one-sided, policy-driven solutions addressing only the supply side of opioid prescribing.[3] While the commentary offers potential solutions to the current dilemma, the emphasis of the article appears to be on building a multidisciplinary model of care involving "pain physicians with OUD training, addiction medicine physicians, clinical psychologists, and other allied health professionals."[1] This model seems incongruous with the authors' comments that point to the inaccessibility of multidisciplinary clinics (MDCs) as a considerable problem, especially in rural centres. Currently in Ontario, the Ministry of Health and Long-Term Care funds only 18 hospital-based pain clinics and a single community-based MDC within the greater Toronto area.[4]

On the other hand, the authors suggest that

> A multidisciplinary model of care that could be facilitated in any setting and could meet the needs of patients struggling with pain and OUD would involve pain physicians with OUD training, addiction medicine physicians, clinical psychologists, and other allied health professionals as needed by the community.[1]

It is not clear to us whether the authors advocate the addition of physicians with OUD or addiction training in existing MDCs, or suggest additional MDCs including physicians with OUD or addiction training. In any case, it seems that the authors are still attempting to articulate a strategy to create capacity through specific health professionals who themselves are in very short supply.

Instead, we suggest that the health system (including medical schools) seeks a more robust response to addressing not only OUD but also the core issue of chronic pain management. This is not a new proposal but rather shifts the focus to longer-term remedies that, although more complex, could solve more than the "problem du jour" and address the serious issue of chronic pain in our population.[5]

Family medicine is often the front line for pain patients and witnesses first-hand the acute pain and, in some cases, patients' transition to chronic pain. Often well-intentioned, many family physicians are ill-equipped to properly assess, diagnose, and manage chronic pain in its entirety. Many readers are familiar with the lack of training in family medicine clerkship, where almost half of programs fail to provide any training in pain management, and those that do offer a mere average of 48 minutes.[6] Thankfully, this increases to a whopping 33 hours during the entire family medicine residency; however, the range is highly variable from 2 to 180 hours![7]

Integrating a core program into family medicine curricula to encompass the basics of assessing and treating chronic pain with appropriate nonpharmacologic and pharmacologic (including the safe prescribing of all analgesic medications) interventions would help to strengthen the already basic biopsychosocial foundation employed in primary care.[8]

Thinking outside the box, practising family medicine physicians could be provided additional training with the creation of designated "secondary pain" centres where most pain patients could be managed in the community.[9] Furthermore, incorporating family physicians with OUD training into existing family health teams could add to a feasible and sustainable solution. While allied health professionals are mentioned, it is worth highlighting specifically that pharmacists (who are much more accessible even in rural communities) could play a critical role not only in the prevention and "policing" of opioid misuse practices but also in addressing uncomplicated OUD.

The authors, nevertheless, should be congratulated for drawing our attention to a serious public health issue and the consequences of applying a "simple solution" to a complex problem. Multidisciplinary clinics, potentially the "gold standard," can be effective, but we have already shown that they are likely not practical. Assuming "this time is different" is likely not a wise bet. While short-term solutions are required, we would urge the authors and policy makers to reconsider the valuable skills and contributions of family physicians who are on the front lines in the rural communities every day. Many in primary care, with supplementary pain training, will be able to support not only their patients and colleagues but also address uncomplicated OUD and provide a venue for following pain patients longitudinally in the community.

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None declared

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Response

Our article "Canada's hidden opioid crisis: the health care system's inability to manage high-dose opioid patients" was written with the aim of highlighting a critical health care gap for high-dose opioid-dependent patients at risk of being abandoned or forced to taper in the wake of the 2017 Canadian opioid guidelines.[1,2] We intended to stimulate discussion and drive solutions for some of the highest-risk Canadians caught in the current "opioid crisis."

We thank Dr Busse and his colleagues and also Drs Deshpande and Mailis for their correspondence. With this reply, we hope not only to stimulate further discussion, but also to give policy makers and regulatory bodies food for thought, in the coming years, to create balanced policies with respect to the management of complex patients with chronic pain. A balanced approach to solving the opioid crisis recognizes 2 distinct subgroups of affected individuals. Policies focused on harm reduction in the intravenous drug use population are called for as a solution to mitigate our increasing death toll. Upstream resources are required for chronic pain patients taking high-dose opioids who need help, some of whom are also battling a coexisting opioid use disorder (OUD). A national program is needed that integrates chronic pain and addiction medicine services across Canada.

Dr Busse and colleagues miss the mark by suggesting that the timing of the College of Physicians and Surgeons of Ontario's investigations into Ontario's physicians is at all relevant. Of the 86 physicians investigated, 1 lost his licence and several others required remediation.[3]

The College of Physicians and Surgeons of British Columbia (CPSBC) developed its own legally enforceable standard informed by the Centers for Disease Control and Prevention opioid guideline.[4] The CPSBC modified the practice standard for prescribing