Lydia Hatcher, Lori Montgomery, Murray Opdahl, Nadia Plach, Mark Ware, and **Erica L. Weinberg.**

Competing interests

Dr Jovey has consulted for or been a member of speakers' bureaus for AstraZeneca, Bayer, Biovail, Boehringer Ingelheim, Eli Lilly, Janssen-Ortho, GlaxoSmithKline, King Pharmaceuticals, Merck Frosst, Mundipharma Australia, Nycomed, Pfizer, Paladin, Purdue Pharma, Sanofi-Aventis, Valeant, and Wyeth. **Dr Squire** has received grants and research support from Pfizer; speakers honoraria from Janssen-Ortho, Eli Lilly, Boehringer Ingelheim, Paladin, Merck Frosst, and AstraZeneca; and consulting fees from Valeant, Janssen-Ortho, Pfizer, Purdue, Eli Lilly, Boehringer Ingelheim, Paladin, Merck Frosst, and AstraZeneca. **Dr Williamson** has received speakers honoraria from Pfizer, Purdue Pharma, Eli Lilly, and Boehringer Ingelheim.

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Clustering of opioid prescribing—what is really going on?

In the recent study by Dhalla et al,[1] the statement that "the findings in this study suggest that family physicians might be able to reduce opioid related harm by writing fewer prescriptions" is unsupported by the data presented. Further, in the absence of information regarding the appropriateness of the prescriptions written, such action might harm patients.

The authors have failed to consider alternate explanations for the data. This study used data from the Ontario Public Drug Program; it is important to remember that this population has less access to determinants of health and will likely be a sicker population than the general Ontario population. In addition, those requiring opioids might have more severe illnesses. It is possible that the variation in prescribing is related to the fact that many family doctors prefer to avoid seeing patients with chronic pain. There are a number of potential reasons that might contribute to this. The cases are complex and time consuming. People with chronic pain have been found to have the worst quality of life and high levels of depression compared with patients suffering from other chronic diseases.[2] They have often suffered job loss or are on disability leave, so there are forms that must be completed. Many have been injured in motor vehicle accidents, so there might be lawsuits requiring the involvement of the health care professional.[3] There is also inadequate training and education in medical school for chronic pain management—in fact veterinarians get 5 times more education regarding pain management than physicians do.[4] In many cases, family physicians with an interest in pain management have had to seek specific training offered through continuing medical education programs, through the Canadian Pain Society Special Interest Group refresher courses, or through mentorship networks such as those offered

by the Nova Scotia Chronic Pain Collaborative Care Network. It is possible that some of the physicians in this study have developed an interest in assisting people with pain and are prescribing appropriately according to the guidelines available.

Opioids are a key treatment for moderate to severe pain. There is little argument that they are appropriate in acute and cancer pain. There is evidence that opioids exhibit efficacy in some people with chronic pain.[5,6] This study did not collect data that allowed for an assessment of appropriateness of prescribing and therefore should not make suggestions to decrease opioid prescribing or to increase regulatory scrutiny, as this might have an adverse effect on the quality of life of many people living with pain. There is a substantial problem with access to appropriate treatment for people with pain in Canada,[7] and there is a need for a national strategy to address the problems of undertreatment, lack of education, and inadequate funding for research.[8]

It is very important to ensure a balanced perspective in this area so that we do not cause further harm to a group of people who are already suffering.

—Mary Lynch MD
President, Canadian Pain Society

Competing interests
None declared

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The opioid crisis in North America

The study by Dhalla et al[1] contributes to our understanding of the effects and causes of the opioid crisis in North America. Numerous studies have documented a dramatic increase in opioid-related harms, including rising rates of opioid addiction, overdose, emergency department visits, and hospitalizations. These harms closely parallel the unprecedented increase in the prescribing of controlled-release opioids. These harms are dose-related. In one cohort study, pain patients taking 100 mg/d of morphine equivalent or more had a 9-fold increased risk of fatal or non-fatal overdose, compared with patients taking 1 to 20 mg/d.[2] The annual risk of overdose in the 100 mg/d group was 1.8%. Morphine at 100 mg/d is equivalent to only 30 mg of oxycodone twice daily. To my knowledge there is no other medication prescribed in primary care with such a high rate of life-threatening events.

Dhalla's study demonstrates that there is a subgroup of physicians who are high prescribers. This suggests that educational interventions can be tailored to specific communities and individual physicians. I've met many high prescribers over the years; most impressed me as compassionate and caring. But they were influenced by an intense and sustained pharmaceutical marketing campaign that promoted a few simple but false messages: there is no ceiling dose for opioids; addiction is rare in pain patients; and opioids are very safe. Research, by Dhalla and by others, has shown the terrible suffering and harm that these messages have caused.

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We can't feel their pain, but we can understand their fears

The editorial by Jessica Fulton[1] is admirable. She is an author who, in a scientific journal, looks at the issue of opioids for chronic, non-malignant pain from the point of view of the patient. It is refreshing to read of her ability to anticipate her patients' fears in meeting a new physician who might have strong personal beliefs against a therapy upon which the patient depends. Patients are well aware of the terrible consequences of being cut off from their medications by an ill-informed physician, one who might also add a stern lecture based on personal philosophy rather than evidence.

Those who suffer from chronic noncancer pain have a poor quality of life, sometimes described as the lowest quality of life of any chronic noncancer disease. They have an increased risk of suicide and all-cause mortality.[2-6] However, when it comes to therapy, they often see the medical establishment as obstructive and antagonistic. It is disheartening to read that those of us who do try to mitigate our patients' suffering are singled out as being in the highest quintile of family physicians and that our prescribing habits are somehow linked to mortality from opioids.[7] It seems apparent to me that the physicians who do prescribe opioids are likely those with who have a chronic pain–focused practice and probably consult with the patients most severely affected by pain, who in turn have the highest mortality due to their respective diseases.[6] None of the articles