Misleading conclusions

The dramatic rise in opioid-related deaths, emergency room visits, and adverse events in the United States and Canada is of substantial concern to health care regulators, family physicians, and patients. Unfortunately, the study by Dhalla et al[1] provides little insight into the causal relationships associated with the increase in opioid-related mortality, and mistakenly concludes that the problem is somehow related to the very large variance between family physicians who prescribe opioids and those who do not.

There is strong evidence that unintentional opioid-related mortality is primarily dose-related and is more typically associated with alcohol or other substance use or abuse.[2]

Family physicians and chronic pain patients need to be aware of the real causes of the dramatic rise in opioid-related deaths, emergency visits, and adverse events when considering the risks and benefits of the use of opioid treatments for chronic pain.

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Competing interests
None declared

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Mind the gap

Do not put your faith in what statistics say until you have carefully considered what they do not say.

William W. Watt

The article by Dhalla et al on opioid prescribing and opioid-related mortality[1] reminds me of the phrase used by train and bus conductors as we step off their vehicles. They say it to ensure our safety and our safe progress as we embark on our journeys. We need to "mind the gap" between what the authors' population-based number-crunching actually tells us and what they conclude. In focusing solely on opiate prescriptions, these authors oversimplify the many "gaps" in care that might have led to so many tragic deaths.

First we must note the gap between the massive numbers of chronic pain sufferers (1 in 5 Canadians) and the pain education received by medical students (only 16 hours compared with 87 hours for veterinarians). Family physicians, who care for most of the patients with chronic pain, receive only 3.44 hours of chronic pain management training during their residencies. And there are no licensure requirements for Canadian physicians in pain management.[2-5]

Our health ministry covers the cost of drugs, excluding less abuse-prone formulations (eg, tramadol, transdermal buprenorphine). Ideal chronic pain management includes biopsychosocial and rehabilitative treatment along with patient education and self-management, and exists in only a few publicly funded pain clinics, most of which have 3- to 5-year wait times.[6] The gulf between recommended and received pain care is especially great for the most financially threatened members of our society—those included in this study.

Then there is the gap between what we are told about the 408 people who died in 2006 and the fact that they were each provided with "at least 1 publicly funded opioid prescription in the year before death."[1] What other drugs and substances were in their bodies when they died? (Most opioid-related deaths are linked to multiple substances, including recreational drugs, alcohol, and benzodiazepines or other sedatives.[7]) Did these patients suffer from chronic pain, addiction, mood disorders, or other medical conditions that predisposed them to overdose?

An unbridgeable chasm exists between the data presented and the authors' conclusion that "family physicians might be able to reduce the risk of opioid-related harm by writing fewer opioid prescriptions." Statistics 101 teaches that correlation does not mean causation. Yet the implication is clear: if I wrote an opiate prescription 364 days before my patient died, I am responsible.

This leap of logic seems especially naïve considering that there is no mention of universal precautions in opiate prescribing, wherein patients are screened for addiction and risk of inappropriate medication use before opioid treatment is initiated.[8] This concept has been widely adopted as an educational requirement for practising physicians in the United States, yet it is mostly ignored in Canada. Ordering urine drug tests might be a surrogate marker for those physicians attempting to

screen for opioid misuse. Such data would have provided useful information on how many family physicians in Ontario are aware of universal precautions.

Using a gratuitous comparison between falling HIV-related deaths and rising opiate-related deaths is ironic, considering that the increased chances of HIV survival came about after very vocal political action by the gay community. This led to massive research and development and markedly improved medical treatments, all of which turned a death sentence into a manageable disease. One can only hope that chronic pain sufferers, along with those of us who dream of restoring functional and satisfying lives, will eventually achieve the same.

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Opioid prescribing—a matter of ethics

I was deeply disappointed that the editors of *Canadian Family Physician* felt that Dhalla and colleagues' paper on opioid prescribing[1] should be relegated to online-only status. From an ethical perspective, this is one of the most important issues for family physicians in Ontario. In medicine we often fail in our duty to help our patients as much as we ideally should; sometimes we even make honest mistakes that result in adverse patient outcomes. Opioids are different. Through overprescribing—in