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

References
1. Dhalla IA, Mamdani MM, Gomes T, Juurlink DN. Clustering of opioid prescribing and opioid-related mortality among family physicians in Ontario. *Can Fam Physician* 2011;57:e92-6. Available from: **www.cfp.ca/content/57/3/e92.full.pdf+html**. Accessed 2011 Apr 1.
2. Choinière M, Dion D, Peng P, Banner R, Barton PM, Boulanger A, et al. The Canadian STOP-PAIN Project—part 1: who are the patients on the waitlists of multidisciplinary pain treatment facilities? *Can J Anaesth* 2010;57(6):539-48.
3. Lynch ME. *Surviving your personal injuries claim and litigation: a guidebook.* Halifax, NS: Queen Elizabeth II Health Sciences Centre; 2003.
4. Watt-Watson J, McGillion M, Hunter J, Choinière M, Clark AJ, Dewar A, et al. A survey of prelicensure pain curricula in health science faculties in Canadian universities. *Pain Res Manag* 2009;14(6):439-44.
5. Noble M, Treadwell JR, Tregear SJ, Coates VH, Wiffen PJ, Akafomo C, et al. Long-term opioid management for chronic noncancer pain. *Cochrane Database Syst Rev* 2010;(1):CD006605.
6. Furlan AD, Sandoval JA, Mailis-Gagnon A, Tunks E. Opioids for chronic noncancer pain: a meta-analysis of effectiveness and side effects. *CMAJ* 2006;174(11):1589-94.
7. Peng P, Choinière M, Dion D, Intrater H, Lefort S, Lynch M, et al. Challenges in accessing multidisciplinary pain treatment facilities in Canada. *Can J Anaesth* 2007;54(12):977-84.
8. Lynch ME. The need for a Canadian pain strategy. *Pain Res Manag* In press.

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.

—Meldon M. Kahan MD MHSc FRCPC FCFP
Toronto, Ont

Competing interests
None declared

References
1. Dhalla IA, Mamdani MM, Gomes T, Juurlink DN. Clustering of opioid prescribing and opioid-related mortality among family physicians in Ontario. *Can Fam Physician* 2011;57:e92-6. Available from: **www.cfp.ca/content/57/3/e92.full.pdf+html**. Accessed 2011 Apr 1.
2. Dunn KM, Saunders KW, Rutter CM, Banta-Green CJ, Merrill JO, Sullivan MD, et al. Opioid prescriptions for chronic pain and overdose: a cohort study. *Ann Intern Med* 2010;152(2):85-92.

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

cited in Fulton's editorial provides convincing data on causation of mortality, but rather promote the questionable assumption that the opioids themselves are responsible for the increased mortality in the most severely affected patients.[8,9] A climate of fear is created and physicians might be dissuaded from making correct medical decisions when treating these unfortunate patients.

Given the above, it is all the more reassuring that Dr Fulton can "sit on the same side of the desk" as her patients to discuss their prescriptions.

—David L. Shulman MD CCFP FCFP
Thornhill, Ont

Competing interests

Dr Shulman has been on advisory boards and has facilitated small group educational sessions for family physicians on behalf of the following organizations: PARC (a chronic pain patient advocacy group), the Canadian Consortium for the Investigation of Cannabinoids, Purdue Pharma, Eli Lilly, Solvay, Janssen-Ortho, Valeant, and Paladin.

References

1. Fulton J. Opioids pain and personality. The story of a substitute physician. *Can Fam Physician* 2011;57:271 (Eng), 272 (Fr).
2. Andersson HI. The course of non-malignant chronic pain: a 12-year follow-up. *Eur J Pain* 2004;8(1):47-53.
3. Macfarlane GJ, McBeth J, Silman AJ. Widespread body pain and mortality: prospective population-based study. *BMJ* 2001;323(7314):662-5.
4. Smith BH, Elliott AM, Hannaford PC. Pain and subsequent mortality and cancer among women in the Royal College of General Practitioners Oral Contraception Study. *Br J Gen Pract* 2003;53(486):45-6.
5. McBeth J, Silman AJ, Macfarlane GJ. Association of widespread body pain with an increased risk of cancer and reduced cancer survival: a prospective, population-based study. *Arthritis Rheum* 2003;48(6):1686-92.
6. McBeth J, Symmons DP, Silman AJ, Allison T, Webb R, Brammah T, et al. Musculoskeletal pain is associated with a long-term increased risk of cancer and cardiovascular-related mortality. *Rheumatology* (Oxford) 2009;48(1):74-7.
7. Dhalla IA, Mamdani MM, Gomes T, Juurlink DN. Clustering of opioid prescribing and opioid-related mortality among family physicians in Ontario. *Can Fam Physician* 2011;57:e92-6. Available from: **www.cfp.ca/content/57/3/e92.full.pdf+html**. Accessed 2011 Apr 1.
8. Dhalla IA, Mamdani MM, Sivilotti ML, Kopp A, Qureshi O, Juurlink DN. Prescribing of opioid analgesics and related mortality before and after the introduction of long-acting oxycodone. *CMAJ* 2009;181(12):891-6. Epub 2009 Dec 7.
9. Jovey RD. Response to paper by Dhalla et al [Rapid Response]. *CMAJ* 2009 Dec 22. Available from: **www.cmaj.ca/cgi/eletters/181/12/891#256916.** Accessed 2011 Apr 7.

Response

The contrasting responses to our study illustrate that physicians hold widely divergent opinions regarding the prescribing of opioids for chronic noncancer pain. Sometimes, however, the opinions are so strident that the facts are overshadowed.

Here are some facts about opioids and chronic noncancer pain:

1. The long-term use of opioids for chronic noncancer pain is supported by very little evidence; the evidence that does exist is of poor quality.[1]
2. Almost all trials span less than 4 months and include only very carefully selected patients.[1]
3. The few available observational studies suggest that the long-term risks of opioids in real-world clinical practice might exceed the benefits.[2,3]
4. Despite a lack of evidence, opioid prescribing for chronic noncancer pain has increased dramatically over the past 20 years, as have the number of deaths involving prescription opioids.[4,5]
5. Most opioid-related deaths are accidental and occur in relatively young people who have also consumed alcohol or other central nervous system depressants.[4-6]
6. Most opioid-related deaths occur in individuals who have been prescribed opioids.[4,7]

Having stated these facts—all of which are repeatedly downplayed by pharmaceutical companies and the physicians with financial ties to them—we turn to the comments on our article.

Longhurst[8] ascribes to us political motives, but does not specify what these might be. As clinicians and researchers with an interest in patient safety, our motivation is the promotion of safe prescribing, with the ultimate goal of better outcomes for patients. Regrettably, several of Longhurst's comments suggest that he did not read our paper carefully. For example, we clearly stated that we analyzed publicly funded prescription claims and we did not assert that physicians had "caused death" or that "opiates are bad."

As noted above, we agree with White[9] that opioid-related deaths are typically associated with the use of alcohol or other central nervous system depressants. We also agree that the risk of mortality increases with opioid dose.[7,10,11] But 3 important points remain. First, patients frequently receive opioids at doses far in excess of those recommended in clinical practice guidelines.[12-14] Second, the mortality risk is elevated even at seemingly moderate doses (ie, 50 to 100 mg of morphine per day, and possibly