and stopped over the next 3 to 4 weeks while the new one is only increased by 10% to 20% each week. A patient switched from a high dose of one opioid to very low doses of another opioid could develop serious harms such as withdrawal, hyperalgesia, loss of function, and possibly hospitalization. This method is not referenced.

With regard to tapering of opioids, we have seen many patients prescribed sudden decreases in dosing (up to 50%) to completely stopping opioids, despite no history of aberrant behaviour. Many physicians are unaware of the negative physical and emotional effects of withdrawal. Some patients will look for pain medications from the "street" or from friends—not to get high, but just to feel better. Older patients end up in the emergency department where the admission might be recorded as an opioid-related harm! The values and preferences statement does acknowledge that harm might come from tapering and that it might have to be halted, but there is no mention in the guideline. Capable physicians are being singled out for regulatory reviews because these hard-to-taper patients that others have not been able to manage are referred to them.

Multidisciplinary opioid-reduction programs (recommendation 10). This recommendation is laudable but highly impractical, as Canada lacks multidisciplinary programs for pain, let alone opioid reduction. Timely access to addiction and mental health treatment is absent across the country.

Conclusion

Have multiple guidelines reduced harm from opioids? The Centers for Disease Control and Prevention in the United States has documented reduced prescribing of opioids since 2010,[12] and there have been similar reductions in Canada.[13] However, the opioid-related overdose deaths have continued to climb in both countries owing to illicit opioid–related deaths. Guidelines will do nothing to reduce these opioid-related deaths[14] nor will they help to diminish the stigma of chronic pain where patients can end up doctorless and in precarious physical and mental health, with nowhere to turn.

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Competing interests
Dr Gallagher accepts honoraria for educational talks from Purdue Pharma.
Dr Hatcher has been an advisory board or committee member for Purdue Pharma, Lilly, AstraZeneca, Tilray, and Paladin and has received honoraria or speaker fees from Purdue Pharma, Lilly, Tweed, Catalytic Health, Tilray, Knight Therapeutics, CME AWAY, mdBriefCase, and the College of Physicians and Surgeons of Ontario. She was an expert panel member for the 2017 Canadian opioid guideline update.

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Cet article se trouve aussi en français à la **page 105**.

CLOSING ARGUMENTS — YES

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- *The 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain* are biased toward reducing the use of opioids and provide insufficient evidence to support this bias.
- The guidelines make recommendations that will harm patients mentally and physically.
- Prescribing of opioids has reduced considerably in the past 5 years, yet opioid-related deaths continue to rise.
- The guidelines will harm more people than they help.

The parties in these debates refute each other's arguments in rebuttals available at **www.cfp.ca**. Join the discussion by clicking on "Respond to this article" at **www.cfp.ca**.

NO Falsehoods caused the opioid crisis and falsehoods keep it going. Worries that the 2017 Canadian opioid guideline[1] will *cause* harm show how far away from appropriate practice we have been tugged by misinformation.

Purdue Pharma executives pleaded guilty in the United States to inappropriately promoting opioid products.[2] The admittedly illegal activities include falsely claiming that long-acting opioids have a lower abuse

potential than other opioids do and perpetuating the myth that oxycodone is less potent than morphine. In Canada, Purdue Pharma recently settled a class-action lawsuit involving people harmed by the opioid crisis, as well as provincial and territorial governments; Purdue Pharma did not admit guilt in Canada.[3]

The United States opioid-related death rate tripled between 2000 and 2014 and now the rate of opioid-related deaths—more than 30 000 per year—exceeds motor vehicle collision deaths by a wide margin.[4] In Ontario, the opioid-related death rate doubled between the 1990s and 2000s—this was driven by a 5-fold increase in the oxycodone-related death rate that coincided with the public funding of a long-acting oxycodone product sold by Purdue Pharma.[5]

Correlation does indeed mean causation when sales of a drug of abuse that is prone to causing fatal overdoses accelerates at the same time as overdose deaths. But we do not need to rely on observational data. Indirect comparisons between the short-term randomized controlled trials of opioids included in the 2017 opioid guideline show no benefit of higher doses of opioids but increased harms.[1]

This overwhelming evidence would make the plan uncontroversial for any other medication: reduce prescribing. The guideline recommends using lower doses (<50 mg of morphine equivalent per day).[1] There is a recommendation to *attempt* tapering in patients taking high-dose opioids but that tapering should be "abandoned" if it causes problems. Both of these recommendations are weak, indicating that "different choices will be appropriate for individual patients," and the evidence for each of the recommendations is available for scrutiny.[1]

The staid Canadian guideline was developed with an inclusive process and takes an incremental approach, so it endorses some common yet questionable practices. For example, the guideline recommends opioid rotation when there is a poor response even though this is based on evidence from case series. Opioid rotation keeps patients whose symptoms do not respond to appropriate opioid trials taking opioids. There is also an expert guidance statement that touts long-acting opioids for "comfort and simplicity of treatment" and that shockingly parallels Purdue's illegal marketing by insinuating that *short*-acting opioids are associated with misuse. The guideline from the US Centers for Disease Control and Prevention does *not* recommend either rotation or long-acting products.[6] This might be because the American guideline process was independent of pharmaceutical companies, unlike the Canadian guideline, which was tilted by the involvement of 7 of 13 (54%) nonvoting experts who declared being paid by Purdue Pharma or other opioid manufacturers, 1 member of the 4-person steering committee declaring funding from Purdue Pharma, past funding to the host institution from Purdue Pharma, and 1 member of the voting guideline panel being paid by Purdue Pharma while the guideline was being developed even though that was not supposed to be allowed.[1] Purdue Pharma's illegal marketing campaign that got clinicians to focus on opioids for all sorts of chronic pain might explain why we have guidelines for only *opioids* in chronic pain as opposed to guidelines for how to meet the needs of people with pain.[2]

Despite the conciliatory approach, some wanted the Canadian guideline to further endorse current hazardous prescribing. This recalcitrance has kept opioid prescribing and harms at breathtaking heights for more than a decade.

Some physicians will continue prescribing opioids at whopping doses. This will happen even when the indication is unclear. Worsening pain from opioid withdrawal will be mistaken for a need to continue opioids. Opioid-induced hyperalgesia—the tendency for long-term opioid use to *cause* pain—will be ignored. Prescribing will be incited by the noble but misguided belief that some doctors can divine the patients who only benefit from opioids. This argument sometimes reaches even further to claim that high-dose prescribing of opioid products actually *prevents* nonmedical opioid use. This assertion is contradicted by decades of data including recent studies that suggest little connection between prescribing reductions and nonmedical opioid use.[7]

The main effect of these specious arguments is the same as the falsehoods that triggered the opioid crisis. Denying that physician prescribing of opioids has caused the opioid crisis keeps us in it, just as denying that human activity has caused climate change keeps it going.

In fact, opioid harms are rampant because opioids are overprescribed. We will not end the opioid crisis by continuing to prescribe opioids in the same way—in high doses for all sorts of conditions.

Barbiturates used to be prescribed for all sorts of conditions including anxiety, headaches, chronic pain, and insomnia. Barbiturate prescribing dropped as knowledge of questionable benefits and serious risks including dependence and fatal toxicity took hold. Today barbiturates are used less frequently and usually for clearly defined purposes such as for palliative care, procedural anesthesia, and medically assisted dying.

Ending the opioid crisis is just as straightforward but there is a huge financial incentive to keep it going. Purdue Pharma's revenue from just long-acting oxycodone is estimated at $30 billion and its opioid products are still publicly funded in Canada.[8] We are still prescribing these products in vast quantities and thousands of Canadians die from opioid toxicity each year.[9,10]

The guideline will not cause harm because it will not—itself—substantially change opioid prescribing, just as previous opioid guidelines have not. The opioid crisis will be over when governments, regulators, professional bodies, clinicians, and patients all renounce its core falsehoods.

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Competing interests
Dr Persaud was a member of the voting guideline panel for *The 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain.* He conducts research funded by the Canadian Institutes of Health Research, Health Canada, the Ontario SPOR Support Unit, and the Government of Ontario. He is also an Associate Editor for *CMAJ*. He was previously funded by a Physician Services Incorporated Graham Farquharson Knowledge Translation Fellowship.

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CLOSING ARGUMENTS — NO

Nav Persaud MSc MD CCFP

- Claims that the 2017 opioid guideline is harmful expose how badly we have been misled about opioids.
- Purdue Pharma triggered the opioid crisis by spreading illegal and inappropriate falsehoods about opioids that accelerated prescribing and harms including deaths.
- Opioid prescribing and harms remain at untenable levels because falsehoods obscure the otherwise obvious response to the crisis: reduce opioid prescribing.
- Opioid-related harms including deaths will be reduced by curbing opioid prescribing, and the guideline recommendations might be thoughtfully implemented as a small step away from prevailing falsehoods and toward sensible pain management.

The parties in these debates refute each other's arguments in rebuttals available at **www.cfp.ca**. Join the discussion by clicking on "Respond to this article" **www.cfp.ca**.