Addressing inaccurate claims about the Canadian opioid guideline

The commentary by Dr Clarke and colleagues published in the September issue of *Canadian Family Physician*, "Canada's hidden opioid crisis: the health care system's inability to manage high-dose opioid patients,"[1] includes several inaccuracies regarding the 2017 "Guideline for opioid therapy and chronic noncancer pain,"[2] including some we have already addressed after 3 of the article's authors made the same misrepresentations in a different journal.[3,4]

Clarke and colleagues suggest that the 2017 Canadian opioid guideline led to regulatory investigations of doctors who prescribe high doses, yet the reference they provide makes clear this investigation began in November 2016, 6 months before the guideline was published.[5]

Clarke and colleagues state that the 2017 Canadian opioid guideline directs physicians to taper patients taking stable opioid doses equivalent to 120 mg of morphine, and who report good pain relief, improved function, few side effects, and no aberrant behaviour. It does not. Recommendation 9 (which suggests tapering opioids to the lowest effective dose for patients with chronic noncancer pain using ≥90-mg morphine equivalents of opioids per day) is a weak recommendation, meaning that most informed patients would choose the recommended course of action, but an appreciable minority would not.[2] With weak recommendations, clinicians should recognize that different choices will be appropriate for individual patients, and they should help patients arrive at decisions consistent with their values and preferences. The final decision to attempt a trial of opioid tapering rests with the patient. The patients described by the authors would likely choose not to taper.

Clarke and colleagues state that the "Canadian opioid guidelines estimate the prevalence of OUD [opioid use disorder] in patients with chronic noncancer pain who were prescribed an opioid to be 10%."[1] It does not. The studies we reviewed provided evidence of moderate certainty for a 5.5% (95% CI 3.91 to 7.03%) risk of OUD among patients prescribed opioid therapy for chronic noncancer pain.[2] The authors discuss the potential harms that might result among patients with OUD who are tapered as recommended by the guideline; however, the guideline does not apply to this population. As the guideline outlines very clearly, it is not intended to address the use of opioids in patients with the following:

- cancer-related pain;
- OUD or substance use disorder;
- acute or subacute pain (pain lasting <3 months); and
- pain or suffering associated with end-of-life care.[2]

Clarke and colleagues suggest that recommendation 10 (a strong recommendation for a formal multidisciplinary program for patients with chronic noncancer pain who are using opioids and experiencing serious challenges in tapering) is impractical. We agree that this recommendation is resource-dependent, which is why the guideline provides the following associated remark:

> In recognition of the cost of formal multidisciplinary opioid reduction programs and their current limited availability/capacity, an alternative is a coordinated multidisciplinary collaboration that includes several health professionals whom physicians can access according to their availability (possibilities include, but are not limited to, a primary care physician, a nurse, a pharmacist, a physical therapist, a chiropractor, a kinesiologist, an occupational therapist, an addiction medicine specialist, a psychiatrist, and a psychologist).[2]

The 2017 Canadian opioid guideline is available at **www.magicapp.org/public/guideline/8nyb0E** in an interactive, multi-layered format, with patient decision aids for all weak recommendations.

If followed, the 2017 Canadian opioid guideline[2] will promote evidence-based prescribing of opioids for chronic noncancer pain.

—Jason W. Busse DC PhD
Hamilton, Ont
—David Juurlink MD PhD
Toronto, Ont
—D. Norman Buckley MD
—Gordon H. Guyatt MD MSc
Hamilton, Ont

Competing interests

All authors were members of the steering committee for the Canadian opioid guideline. **Dr Juurlink** has received payment for lectures and medicolegal opinions regarding the safety and effectiveness of analgesics, including opioids. He is a member of Physicians for Responsible Opioid Prescribing, a volunteer organization that seeks to reduce opioid-related harm through more cautious prescribing practices. **Dr Buckley** reports grants from Purdue Pharma and Janssen Inc outside the submitted work.

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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.

—Amol Deshpande MD MBA
—Angela Mailis MSc MD FRCPC
Toronto, Ont

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None declared