References

1. Clarke H, Bao J, Weinrib A, Dubin RE, Kahan M. Canada's hidden opioid crisis: the health care system's inability to manage high-dose opioid patients. Fall-out from the 2017 Canadian opioid guidelines. *Can Fam Physician* 2019;65:612-4 (Eng), e376-8 (Fr).
2. Busse JW, Craigie S, Juurlink DN, Buckley DN, Wang L, Couban RJ, et al. Guideline for opioid therapy and chronic noncancer pain. *CMAJ* 2017;189(18):E659-66.
3. Tadrous M. Opioids in Ontario: the current state of affairs and a path forward. *Expert Rev Clin Pharmacol* 2018;11(10):927-9. Epub 2018 Aug 30.
4. Mailis A, Lakha SF. From (Ontario Ministry of Health and Long-Term Care) policy to implementation: a retrospective look at a community-based patient-centered model of care for chronic pain. *Can J Pain* 2019;3(1):114-25.
5. Schneiderhan J, Clauw D, Schwenk TL. Primary care of patients with chronic pain. *JAMA* 2017;317(23):2367-8.
6. Schiel Zoberi K, Everard KM, Antoun J. Teaching chronic pain in the family medicine clerkship: influences of experience and beliefs about treatment effectiveness: a CERA Study. *Fam Med* 2016;48(5):353-8.
7. Zoberi K, Everard KM. Teaching chronic pain in the family medicine residency. *Fam Med* 2018;50(1):22-7.
8. McCarberg BH. Pain management in primary care: strategies to mitigate opioid misuse, abuse, and diversion. *Postgrad Med* 2011;123(2):119-30.
9. Fogelman Y, Carmeli E, Minerbi A, Harash B, Vulfsons S. Specialized pain clinics in primary care: common diagnoses, referral patterns and clinical outcomes – novel pain management model. *Adv Exp Med Biol* 2018;1047:89-98.

Response

Our article "Canada's hidden opioid crisis: the health care system's inability to manage high-dose opioid patients" was written with the aim of highlighting a critical health care gap for high-dose opioid-dependent patients at risk of being abandoned or forced to taper in the wake of the 2017 Canadian opioid guidelines.[1,2] We intended to stimulate discussion and drive solutions for some of the highest-risk Canadians caught in the current "opioid crisis."

We thank Dr Busse and his colleagues and also Drs Deshpande and Mailis for their correspondence. With this reply, we hope not only to stimulate further discussion, but also to give policy makers and regulatory bodies food for thought, in the coming years, to create balanced policies with respect to the management of complex patients with chronic pain. A balanced approach to solving the opioid crisis recognizes 2 distinct subgroups of affected individuals. Policies focused on harm reduction in the intravenous drug use population are called for as a solution to mitigate our increasing death toll. Upstream resources are required for chronic pain patients taking high-dose opioids who need help, some of whom are also battling a coexisting opioid use disorder (OUD). A national program is needed that integrates chronic pain and addiction medicine services across Canada.

Dr Busse and colleagues miss the mark by suggesting that the timing of the College of Physicians and Surgeons of Ontario's investigations into Ontario's physicians is at all relevant. Of the 86 physicians investigated, 1 lost his licence and several others required remediation.[3]

The College of Physicians and Surgeons of British Columbia (CPSBC) developed its own legally enforceable standard informed by the Centers for Disease Control and Prevention opioid guideline.[4] The CPSBC modified the practice standard for prescribing

opioids several times so that it is now largely, but not entirely, consistent with the 2017 Canadian opioid guideline and is still legally enforceable.[5] Pursuant to the introduction of the practice standard, patients with chronic pain have been abandoned and physicians have refused to prescribe opioids. The CPSBC has not acknowledged that the practice standard caused patient abandonment and physicians' refusals to prescribe opioids and instead has blamed physicians for this entirely foreseeable outcome. The trepidation of physicians to continue to prescribe "high-dose" opioids to legacy patients is very real, as are the real-world consequences of implementing the Canadian opioid guideline no matter how well meaning the intentions. Ivory tower recommendations are at odds with the despair experienced by many people living with chronic pain. Suicide is a desperate action taken by some individuals using high-dose opioids facing rapid tapers.[6,7] At national pain and addiction meetings, physicians routinely discuss patients with chronic pain who have chosen to end their lives out of helplessness over opioid-related physician practices.

The opioid guideline is not the sole cause of these deleterious effects, but the introduction of the daily maximum of 90 mg as the safe dose, followed by recommendation 9, was poorly thought out by the guideline authors given that they provided no practice guidelines on how to taper in a safe, effective, and compassionate manner.

In fact, Busse et al mischaracterize their own recommendation on tapering. Tapering is not presented as a patient choice but as a physician directive. Recommendation 9 states the following: "We suggest tapering opioids to the lowest effective dose, potentially including discontinuation, rather than making no change in opioid therapy."[2] Nowhere does the recommendation state that the physician should consider keeping the dose the same if the patient is functioning well. It suggests discussing risks and benefits of tapering with the patient, which is something clinicians routinely do when recommending a course of action. The recommendation is classified as *weak,* but to the practising physician it is exceptionally strong, because provincial medical regulators have stated they expect physicians to comply with its recommendations.

Equally disturbing is the discussion that follows the tapering recommendation. Many patients will experience depression, insomnia, and severe pain exacerbation at the suggested rate of taper of 5% to 10% of the total dose every 2 to 4 weeks. The recommendation states that tapering may be halted or reversed if pain or loss of function "persists for more than one month."[2]

This advice is unsound; the taper should be reversed immediately if the patient experiences loss of function.

The guideline goes on to list "substance misuse" as an indication for tapering, and it advises that the prescriber refer to a "local expert" if tapering is associated with "the emergence of significant mental health symptoms and/or ambiguous drug-related behaviours."[2] At best, this advice is meaningless; at worst, it is dangerous. The proper diagnostic term is *opioid use disorder,* not *substance misuse* or *ambiguous drug-related behaviours*. Randomized trials have demonstrated conclusively that maintenance therapy with buprenorphine is far more effective than tapering for patients with prescription OUD.[8-10]

Finally, nowhere does the guideline mention the risks of tapering in patients with OUD. During tapering, patients with OUD typically experience withdrawal symptoms and a powerful urge to use opioids. At the same time, their tolerance is lowered, putting them at risk of overdose if they resume their previous opioid dose. We know of cases of fatal overdose following opioid tapering.

We are grateful to the College of Physicians and Surgeons of Ontario for recently reversing course and acknowledging that clinical judgment should take precedence over the guideline: "There will be times when it is necessary to deviate from [the guidelines] in the best interests of patient care."[11] We implore physicians to ignore the guideline's recommendation to taper patients with OUD. Physicians who prescribe opioids for chronic pain should know how to diagnose prescription OUD and to initiate office-based treatment with buprenorphine.

Finally, quibbling over the prevalence of patients with chronic pain who have a coexisting OUD also misses the mark. Whether the exact prevalence of OUD among people with chronic pain is 5.5%, 10%,[1] or 20%,[12] the denominator (ie, the total number of patients who consume an opioid for chronic pain) is in the millions, thereby placing large numbers of the Canadian population at risk. Our position remains unchanged.[1] Without appropriate revision, the 2017 Canadian opioid guideline is causing more harm than necessary.

Regarding the correspondence from Drs Deshpande and Mailis, we are in absolute agreement with their position of implementing additional pain and addiction medicine modules as core training components of the family medicine curriculum. This would lead to improved primary care for Canadians in the years ahead. And most experienced pain physicians would also agree that the current level of training for the treatment of complex chronic pain and OUD is abysmal given that the country is in the midst of a crisis. We believe Drs Deshpande and Mailis' call for increased resources for the training of future family physicians is a key part of the solution. However, Canada cannot afford to wait 5 years to improve pain and addiction management on the front lines of health care. We must tackle this problem immediately and with a multifaceted approach that embeds expertise within community-based family heath teams, that increases capacity in centres with expert knowledge, and that creates new multidisciplinary treatment centres.

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References

1. Clarke H, Bao J, Weinrib A, Dubin RE, Kahan M. Canada's hidden opioid crisis: the health care system's inability to manage high-dose opioid patients. Fallout from the 2017 Canadian opioid guidelines. *Can Fam Physician* 2019;65:612-4 (Eng), e376-8 (Fr).
2. Busse JW, Guyatt GH, Carrasco A, Akl E, Agoritsas T, da Costa B, et al. *The 2017 Canadian guideline for opioids for chronic non-cancer pain.* Hamilton, ON: National Pain Centre; 2017. Available from: **http://nationalpaincentre.mcmaster.ca/documents/Opioid%20GL%20for%20CMAJ_01may2017.pdf.** Accessed 2019 Nov 6.
3. Grant K. Only Ontario doctor disciplined for over-prescribing opioids agrees to give up his licence. *Globe and Mail* 2018 Mar 26.
4. Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain—United States, 2016. *JAMA* 2016;315(15):1624-45.
5. College of Physicians and Surgeons of British Columbia. *Safe prescribing of opioids and sedatives.* Vancouver, BC: College of Physicians and Surgeons of British Columbia; 2019. Available from: **www.cpsbc.ca/files/pdf/PSG-Safe-Prescribing.pdf**. Accessed 2019 Nov 6.
6. Chang DC, Klimas J, Wood E, Fairbairn N. A case of opioid overdose and subsequent death after medically supervised withdrawal: the problematic role of rapid tapers for opioid use disorder. *J Addict Med* 2018;12(1):80-3.
7. Hoffman J, Goodnough A. Good news: opioid prescribing fell. The bad? Pain patients suffer, doctors say. *New York Times* 2019 Mar 6.
8. Fiellin DA, Schottenfeld RS, Cutter CJ, Moore BA, Barry DT, O'Connor PG. Primary care-based buprenorphine taper vs maintenance therapy for prescription opioid dependence: a randomized clinical trial. *JAMA Intern Med* 2014;174(12):1947-54.
9. McCabe BE, Santisteban DA, Mena MP, Duchene DM, McLean C, Monroe M. Engagement, retention, and abstinence for three types of opioid users in Florida. *Subst Use Misuse* 2013;48(8):623-34. Epub 2013 Jun 10.
10. Weiss RD, Potter JS, Fiellin DA, Byrne M, Connery HS, Dickinson W, et al. Adjunctive counseling during brief and extended buprenorphine-naloxone treatment for prescription opioid dependence: a 2-phase randomized controlled trial. *Arch Gen Psychiatry* 2011;68(12):1238-46. Epub 2011 Nov 7.
11. Bodley S. Opioid prescribing. Addressing the challenges of legacy patients, the effect of the Canadian guidelines and the importance of patient collaboration. *Dialogue* 2019;15(2):9-11.
12. Degenhardt L, Bruno R, Lintzeris N, Hall W, Nielsen S, Larance B, et al. Agreement between definitions of pharmaceutical opioid use disorders and dependence in people taking opioids for chronic non-cancer pain (POINT): a cohort study. *Lancet Psychiatry* 2015;2(4):314-22. Epub 2015 Mar 31.