Safe Prescribing of Opioids:
Frequently Asked Questions for Physicians

Some of the information contained in this document was reproduced from the College of Physicians & Surgeons of British Columbia's FAQ regarding Opioids

What is the rationale for the Standard?

The CPSM's Standard of Practice for the Prescribing of Opioids is motivated by the opioid crisis. The current public health crisis involving prescription (and non-prescription) opioid misuse is driven, in part, by physician prescribing. The profession has a collective responsibility to mitigate its contribution to the problem of prescription opioid-related harms. We are also tasked with offering evidence based treatment to those affected by opioid use disorder (opioid addiction).

The opioid crisis has several dimensions, including an epidemic of opioid use disorder complicated by a crisis of poisoning by fentanyl and its lethal analogues. Prescribing of medications with high-risk profiles (opioids, benzodiazepines, gabapentin etc.) has contributed to a rise in prescription drug abuse, opioid use disorder, and overdoses. There is an ethical and professional responsibility to mitigate the contribution of prescription medications to the overall problem. This Standard is thus aimed at **primary prevention** of all the risks and harms that are associated with the use of opioids.

Physicians need to pay attention to emerging research and clinical guidelines that inform clinicians about the dangers of chronic use of high-risk medications such as long-term opioids for chronic non-cancer pain. Physicians need to familiarize themselves with evidence based approaches to treating opioid use disorder and preventing overdose. The *Canadian Guideline for Opioids for Chronic Non-Cancer Pain* provides up-to-date clinical guidance to complement this Standard. Many other valuable resources are listed on the CPSM's website as well.

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What does this Standard address?

This Standard addresses instances of prescribing opioids for acute, post-operative, and chronic non-cancer pain. It does not address palliative care, active cancer care, end-of-life care, opioid replacement therapy, or the management of opioid use disorder.

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How does this Standard recognize different patients' needs?

Recognizing that different categories of patients require a different approach to prescribing opioids, the Standard differentiates prescribing opioids by the following patient categories:

- Patients requiring acute or post-operative analgesia.
- An initial trial of opioids for chronic non-cancer pain in opioid naïve patients prescribed up to 50 mg morphine equivalent.
- Patients currently prescribed between 50 and 90 mg morphine equivalent.
- Patients currently prescribed in excess of 90 mg morphine equivalent.
- Patients new to a member's practice and already taking opioids for a significant period of time.
- Adolescent patients.
- Continued prescribing of opioids for patients with chronic non-cancer pain.

This is the only Standard in Canada that provides physicians with a differentiation by patient category. It is also the only Standard that includes provisions for adolescents. These patient differentiations should enable physicians to quickly access the relevant provisions for their patients.

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Should physicians stop prescribing high-risk medications?

Emphatically, no. Each class of prescription medication is indicated for some patients. The key message contained in the Standard is that physicians should take due care and consideration before either starting these medications or continuing them for long-term use. This is due to the risks involved for both the individual patient and the public at large.

The Standard does not support inappropriate or rapid withdrawal of long-term prescription medications. It endorses a thorough discussion of benefits versus harms of long-term prescription medication use with individual patients. Where tapering to a lower dose (or to discontinuation) is the clinically appropriate course, physicians are advised to taper medications slowly to minimize physical and psychological withdrawal.

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What about patients who have been on long term high-risk medications for many years?

The College acknowledges that such patients (such as those "inherited" from other physicians) have complex care needs.

Primary prevention strategies, such as those intended by this Standard, may prevent patients from advancing to prolonged use of high-risk medications. However, those who have been on these medications long term may pose enduring clinical challenges.

These patients must not be refused care, discriminated against, or dismissed from one's practice solely on the basis of their long-term medication use or diagnosis. Physicians are encouraged to consult with their multidisciplinary colleagues and/or experts in the management of the complex patient on opioids. This may include pain and/or addiction medicine specialists.

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Should physicians continue to prescribe opioids for chronic pain?

Opioids are one of the tools available to physicians for the treatment of chronic non-cancer pain. Managing pain is a duty of care and the Standard is intended to assist physicians with caring for their patients when it comes to pain management. Physicians have to be especially discerning when it comes to prescribing opioids long term. Risks and benefits of continuing opioids should be thoroughly discussed with individual patients and decisions about long term therapy should be made in collaboration with individual patients and the members of their interdisciplinary care team.

It is important to remember that patients living with chronic non-cancer pain can reasonably expect to experience at best a modest improvement in their pain when treated with opioids. Indiscriminate opioid prescribing is associated with significant patient and societal harms. There is no evidence that long term opioid treatment is indicated or effective for certain medical conditions including chronic headache disorders, fibromyalgia, and axial low back pain. If you have such patients, carefully review their care. If a slow taper is indicated, consult the Standard for tapering considerations.

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What other resources can physicians offer their patients with chronic pain?

Physicians should optimize available non-opioid treatment options, including non-opioid pharmacotherapy and non-pharmacological treatment modalities for chronic pain. The latter may include considering a referral to psychology, psychiatry, sports medicine, physiotherapy, occupational therapy, kinesiology, chiropractic, and dietary experts.

The College encourages physicians not to dismiss the option of offering physical or exercise therapy to patients who do not have the coverage or personal resources for physiotherapy or rehabilitation programs. Physicians can prescribe simple exercise regimes and monitor functional improvement where other resources are not available. Additionally, patients who do not have access to psychologists may still benefit from advice from their physician about cognitive behavioural therapy techniques that may assist them in living with chronic pain. This may involve significant time with patients but can achieve long term benefits.

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What are the goals of implementing the Standard of Practice?

- To set clear expectations regarding what is required from physicians before prescribing an opioid and while monitoring a patient on an opioid prescription.
- To support physicians in offering their patients evidence-based pain management within a framework that recognizes the benefits and risks of opioid prescribing.
- To promote pain management through an interdisciplinary approach.
- To reduce opioid prescribing related harms to the public.
- To protect patient access to ongoing health care.

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What is the College's approach to safe prescribing of opioids?

The College wants to work with its members to implement the Standard and achieve these goals in a collaborative way. The College is facilitating education by updating its website with useful materials on opioids for physicians and patients. The website will also provide links to high quality continuing education programs on safe opioid prescribing and the management of opioid use disorder (opioid addiction).

The College will, on an ongoing basis, identify and assess low and moderate risk opioid prescribing and provide supportive education in order to avoid the need for future investigations.

The College will also identify, investigate, and monitor high-risk or problem opioid prescribing practices in an effort to improve prescribing and protect the public from opioid-related harms.

The College expects physicians will respond positively to educational interventions to improve their quality of opioid prescribing by its members. Further intervention, including disciplinary action, may be warranted in circumstances where physicians are either unwilling or unable to address deficiencies through a collaborative and remedial approach.

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What is the Physician Prescriber Profile?

The Physician Prescriber Profile is one of the tools the CPSM will use moving forward to assist physicians in improving their opioid prescribing practices. The Prescriber Profile is a personalized prescribing report that will be mailed, on an annual basis, to all physicians who prescribe opioids in Manitoba. The profile will compare each individual prescriber's opioid prescribing practices to that of their peers in a similar practice. It will also provide patient –
specific information regarding prescribing that falls outside of current Canadian guidelines, utilizing standardized quality indicators. The intent of the prescriber profile is to provoke individual reflection and engagement in prescribing education and quality improvement. More information on how the CPSM will support its members in interpreting the prescriber profile in a practical way will follow in months to come.

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