An open, online survey of family physicians on the impact of the standard on the Safe Prescribing of Drugs with Potential for Misuse/Diversion issued by the College of Physicians and Surgeons of British Columbia on managing pain

British Columbia declared a public health emergency in April 2016 following a sharp rise in opioid-related deaths due to adulteration of street drugs with imported illicit fentanyl.[1] The College of Physicians and Surgeons of BC endorsed the US Centers for Disease Control Guideline for Prescribing Opioids for Chronic Pain (CDC guideline)[2] in April 2016, and in June 2016, published a prescribing standard[3] that reflected the 12 CDC guideline recommendations. Much of the standard is considered typical best practice for prescribing substances with the potential for addiction and diversion. One contentious part of the standard is that doses above 50 morphine milligram equivalents (MME) "warrant careful reassessment and documentation" and doses above 90 MME "warrant substantive evidence of exceptional need and benefit." This standard and guideline are similar to the national guideline[4] that was updated in 2017, but lacked guidance that a taper could be stopped if the patient's function declined or significant pain persisted.

An open, online anonymous survey of BC family physicians was used to assess how they responded to the standard and how patients were doing as a result. Physicians were also asked about substance abuse, mental illness, and nonpharmacologic pain management resources in their community. After 4 months, 198 complete responses were received.

Eighty-eight percent of respondents had read the College's standard. Twenty-four had not read the standard, and ten of those reported that the standard had no impact on their prescribing. Those who had read the standard were more likely to reduce dosages over 50 MME and 90 MME and were significantly more likely to stop prescribing opioids for chronic noncancer pain ($p < .001$). They were also significantly more likely to reduce opioids in those with active cancer or palliative care situations, which were excluded from the standard in its first revision.

Respondents were asked if patients had increased function, reduced function, or had more pain after a taper or discontinuation of their opioid as part of meeting the standard. The results about function were divided with 44% reporting increased function and 56% reporting decreased function. However, 79% of respondents reported that patients had more pain as a result of tapering or stopping opioids.

If respondents had noticed decreased function or increased pain they were asked about their subsequent actions. Most noted they had resorted to other medications such as NSAIDS or neuropathic adjuvant medications, although a number of respondents noted that these were already maximized or had been trialed before. The most frequent response from the 78 comments was that they halted the taper or went back to the most effective dose. Many reported significant stress from long conversations, ruptured physician-patient relationships, and lack of alternative therapies that the patient could access due to availability or affordability.

Respondents who work as generalist family physicians, who did not have extra education in substance abuse or mental health, were most likely to be concerned about scrutiny of their prescribing ($p = 0.001$). Those who graduated after the year 2000 were more likely to be concerned about scrutiny but not more likely to stop prescribing ($p = 0.03$). Interestingly, those who finished medical school prior to 2000 had rather opposite approaches, where they more frequently answered "not at all concerned" or "so concerned that they were reducing and stopping their prescribing." Those who had extra pain education continued to be concerned about prescribing even if they did not see many pain patients.

Respondents were asked how the College could be more helpful to them in managing patients' pain and almost every respondent registered a comment. Sixteen felt the current guideline and approach to prescription review should be continued. The most common comment was that a more collaborative, educational, and less-judgmental approach would be helpful. The second most common comment suggested the College should play an advocacy role for more and timely access to multidisciplinary pain clinics and affordable nonpharmacological therapies for pain. Many noted that they had few options to offer patients as they had maximized

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non-opioid therapies and there was a lack of nonpharmacological therapies their patients could access and/or afford.

Four respondents reported that they knew patients who had gone to the streets for opioids and had died from an overdose. Two seemed to be a patient or former patient of the physician-survey participant. Another death was reported by a substance abuse physician and another by a physician in a smaller community. The reason given for the use of illicit opioids seemed to be that patients could not tolerate a reduction in their opioid dose and had either been cut off abruptly or tapered rapidly enough that they sought illicit medications.

This study shows that despite the intention to reduce harm from opioids, the standard is causing collateral damage to patients with chronic pain, and to a lesser degree to patients with cancer pain or those receiving palliative care. Physicians' interpretations of the standard seem highly influenced by their perceived relationship with the College and a more collaborative approach to safe prescribing is recommended by respondents. For physicians to manage chronic pain with less dependence on opioids, there is a clear need for greater access to nonpharmacological therapies, funding of alternative medications, and timely access to multidisciplinary clinics.

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A full report on this survey is available from the author (rgallagher@providencehealth.bc.ca).

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