Opioid prescribing: An essential skill for physicians and a collective knowledge we must not lose

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Throughout the last 15 years, the increase in opioid-related harms has been situated as a problem with a class of drugs rather than the problematic health outcomes from historical roots of socioeconomic inequality in our society and its lack of institutional support for prevention and treatment of substance use.[1] Sadly, this narrative has such a wide brush that it has painted over those who use opioids safely and benefit from them. When this brush is used with little attention to distinguishing populations who may benefit from opioids, we have seen the negative impact on physicians' education and further restriction of their prescribing.

We all come from a place of trying to minimize the harms we see occurring in our clinical world, and there are many different worlds out there. Depending on their experience and perspective, readers will have different views about opioids. Trying to balance them all is difficult. The tragedy of poisonings from illicit opioids should not be allowed to cause a second tragedy: that of failure to provide relief from suffering for people living with severe pain or shortness of breath.

Access to appropriate pain management has been proposed as a basic human right,[2] and physicians need to have the skills to prescribe safely when to do so is not only appropriate but required. The right to pain management is not the right to demand opioid therapy for all pain syndromes, but the right to have access to a variety of potentially effective pharmacological and nonpharmacological therapies. This is complex medicine and involves a village of different providers, as well as governments willing to fund access to a greater variety of therapies.

Regulators, including the College of Physicians and Surgeons of British Columbia, have a perspective and policies shaped by societal pressure to reduce the harms caused by illicit and prescribed opioids. This is reinforced by reviewing the worst prescribing profiles, combined with the relative invisibility of underprescribing. The recommendations to limit the dose and taper opioids that came from multiple associations and regulators has led to a failure of protection for those in the general population with medically appropriate opioid use for pain or dyspnea who have suffered significant collateral harms during the opioid crisis.[3,4] We have been made painfully aware in our daily work that many BC physicians misinterpreted the College standard from 2016 with respect to those who the standard did *not* apply to, and we are not alone in having made this observation.[5] Unfortunately, the College audit system causes stress to many physicians rather than providing the intended strategic assistance to those dealing with complex cases. In recent years, there has been greater clarification about the standard and greater personal input to clinicians. Despite this, the current system still appears to have a double standard of sending frequent letters to those who prescribe a lot, and few or none to those who rarely prescribe opioids, irrespective of their practice patient profile. This motivates physicians to modify their opioid prescribing to avoid further inquiries from the College and/or to refuse to accept new patients who are already on opioids or have chronic diseases that may require opioids.

The United States Harrison Act in 1914 prohibited the sale of opioids outside of a registered physician's signed prescription, which began the criminalization of the use of opioids.[6]

This editorial has been peer reviewed.

In the years following the promulgation of the Act and its resulting court challenges, many physicians who prescribed opioids were censored, fined, jailed, and stripped of their licence to practice.[7] Such stigma developed against the use of opioids that an article on cancer pain management from 1941 stated the following:

> The use of narcotics in terminal cancer is to be condemned if it can possibly be avoided. . . . Every two or three weeks sterile hypodermic injections of saline solution are substituted for the narcotic medication for eight to twenty hours in order to prove the continued need for the drug.[8]

Seeing other physicians punished for prescribing, and reading articles like the above, dampened opioid use, which resulted in patients into the 1950s and 1960s having access to opioids only in the last few weeks of life, if at all.[9] Physicians trained during those times learned to fear and avoid opioids rather than learn to treat pain effectively and safely. The knowledge base of appropriate prescribing was lost. The pendulum must not swing that far again.

For this reason, we present two articles on how to prescribe opioids for those patients who are likely to benefit. Prescribing opioids effectively and safely for dyspnea and pain relief should be an essential skill for all family physicians and specialists who manage patients with advanced illness. Our articles focus on cancer pain and persistent pain in frail older adults, but the information we have tried to present, in a practical and succinct way, is relevant for all types of pain where opioids are indicated.

We recognize that receiving a letter from the College can be stressful, but when the letter is about opioid prescribing, remember that the College does not have any clinical information about patients. The only way for them to know if an automated trigger from PharmaNet records represents a cause for concern for public safety or not is to ask you. Do not consider an inquiry letter as an indication that you are in trouble with the College. Providing you have a documented clinical assessment of the patient and demonstrate that you have used clinical judgment and evidence-based decision making in prescribing the medication, it will be unlikely to result in further inquiry. The Canadian Medical Protective Association (CMPA) is always willing to guide you if you receive an inquiry letter from the College or a College letter about a patient complaint. The CMPA website has advice for physicians who may become anxious about a College inquiry (www.cmpa-acpm.ca/en/advice-publications/browse-articles/2013/coping-with-a-college-complaint), as well as guidance on how to write a response letter (www.cmpa-acpm.ca/static-assets/pdf/cis/considerations_for_members_in_preparing_responses_to_college_complaints-e.pdf).

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If you suspect your patient may have both pain and a substance use disorder, then it is wise to seek the resources of the British Columbia Centre on Substance Use. There are specific care guide resources. There is a Rapid Access Addiction Clinic at St. Paul's Hospital, where patients can receive initial treatment for both disorders and can access the 24/7 Addiction Medicine Clinician Support Line (www.bccsu.ca/24-7). Family physicians should be prepared to continue the ongoing medications that are advised/started by those physicians. If your patient is not willing to address their opioid use disorder, then you should advise them that you need to taper and stop the opioid. Never stop opioids abruptly or taper rapidly enough to induce acute withdrawal because this is harmful to the patient and may drive them to seek illicit opioids. Please consult *A Guideline for the Clinical Management of Opioid Use Disorder* (www.bccsu.ca/wp-content/uploads/2017/06/BC-OUD-Guidelines_June2017.pdf) for clinical advice.

We hope these articles renew your commitment to care for all patients with chronic pain, whatever the cause. Careful assessment, safe prescribing, and use of well-established principles need to be maintained to uphold the unique worth of individuals and their right to relief from pain and suffering in a safe, but sufficient, health care environment. ■

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