

## FAQ

# Safe Prescribing of Opioids and Sedatives

The following attempts to address some of the questions raised by the profession.

### **What is the rationale for the standard?**

The revised professional standard has a long history and several iterations going back to 2012 when it was titled *Prescribing Principles*. The document has evolved from a guideline to a standard. Several things have changed in BC, in particular, the emergence of an “opioid crisis” of staggering proportions. This opioid crisis has several dimensions, including an epidemic of substance use disorder (SUD) combined with a crisis of fentanyl poisoning. To the extent that prescribing of medications with high-risk profiles (opioids, benzodiazepines, etc.) has contributed to a rise in SUD and opioid use disorder (OUD), and to overdoses, there is an ethical and professional responsibility to mitigate the contribution of prescription medications to the overall problem. This standard is aimed at **primary prevention** of all the risks and harms that can come from the use of opioids and sedatives.

### **Why has it changed?**

There is more information available to the public on the dangers of both prescription and illicit drugs—people who use either illicit drugs or medications with high-risk profiles, are more aware. Physicians are also more aware—there is more research and data informing clinicians about management of substance use disorder, and the dangers of chronic use of high-risk medications like long-term opioids for chronic non-cancer pain. Most importantly, the *Canadian Guideline for Opioids for Chronic Non-Cancer Pain* provides up-to-date clinical guidance to complement this standard. As clinical and public health issues like the opioid crisis evolve, so will the standard.

### **Should physicians stop prescribing high-risk medications?**

Emphatically, no. Each of these classes 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, because of the risks involved for both the individual patient and the public at large. The newly revised standard does not support inappropriate withdrawal of long-term prescription medications; it endorses a thorough discussion of benefits versus harms of long-term prescription medications with patients. Where tapering to a lower dose (or to discontinuation) is the clinically appropriate course, physicians are advised to taper slowly to minimize physical and psychological withdrawal.

## 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, prevent patients from advancing to prolonged use of high-risk medications; those who remain on these medications long term will 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. Any report of physicians summarily discharging a patient from care or misapplying the standard to the detriment of a patient would be investigated by the College.

## Do all patients need to receive less than 90 mg MEDD?

Standards #6 and #7 require documentation of the rationale for all prescriptions of opioid medication, and avoidance of higher doses unless there is clinical indication for this. Physicians must critically analyze medication regimens for chronic non-cancer pain and other patients with complex care needs, and exercise judicious, safe prescribing. Risks associated with concurrent medical conditions (e.g. sleep apnea, chronic lung disease, cognitive impairment, etc.) and aging must be routinely reassessed. *Some physicians may have misinterpreted the document as a standard of dosage alone when it was intended to be a standard of documentation of thoughtful prescribing.* It does not say that a physician must not prescribe >90 MEDD per day, it states that if prescribing greater than 90 mg MEDD, physicians must have and carefully document the rationale for their decision, must frequently reassess the dose, and must at least offer to work with patients to wean them to the lowest effective dose.

## What if the patient is on opioids and benzodiazepines?

Benzodiazepines should not be prescribed as an ongoing prescription if the patient is also on long-term opioid treatment (LTOT). This does not refer to patients who intermittently use an opioid medication. This standard does not apply to patients with active cancer, or receiving palliative care where combinations of sedative medications may be warranted. Apart from these populations, there is no clinical data to support this long-term combination, and coroners’ data shows it to be unsafe. Physicians should discuss these issues with their patient and suggest a choice for monotherapy. If and when tapering opioids, and more especially benzodiazepines, physicians should do so **slowly** (sometimes many months) to minimize withdrawal discomfort and psychological distress. And, they should develop a treatment plan and reasonable timeline for the taper, including the pharmacist when appropriate. Blister packing can be a very useful strategy in this context.

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

Medication is just one part of the treatment plan for most chronic and nonmalignant pain conditions. The drug programs section of the College website contains an FAQ section with useful [resources](#) for patients. 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.

**Why are stimulants left out of this standard?**

Stimulants are medications that can be diverted for non-medical use and have addictive potential. For these reasons they are similar to the medications listed in this standard. However, there are several ways they are dissimilar to the sedatives and opioids, and their risk profile and the patient populations that use them are sufficiently different from the high-risk medications listed here. Mention of stimulant medications has been removed to make the standard clearer, and more focused on opioids and sedatives. As always, the College reminds registrants to use appropriate clinical guidelines when prescribing any medication that has significant potential risks.

**Should random urine drug testing be performed?**

The 2017 *Canadian Guideline for Opioids for Chronic Non-Cancer Pain* recommends random urine drug testing (rUDT) as a useful tool and the College standard simply asks physicians to consider it. It is useful to determine if a patient who is about to start on a high-risk medication is also using other medications or substances that could place them at significant risk. If patients are on long-term therapy, and are new to a practice, performing baseline testing is worthwhile. If patients are at risk of SUD, or if there is evidence that they may be diverting medication, rUDT can clarify what substances and medications a patient is on, enable early intervention, and link patients to the care they require.

**Why does the College mention restrictions in the amount of medications prescribed?**

Simply put, less medication in the community means less risk. With high-risk medications, stewardship is important. This includes the amount of medication patients are prescribed post-operatively or after an acute care admission to hospital. Many opioids prescribed in such situations go unused and can be diverted for non-medical use, or they are taken longer than necessary, increasing the risk of addiction. It is also important to not prescribe quantities of more than 250 doses, or three months' supply: it enhances adherence to treatment regimens, permits more frequent reassessment, decreases risk of overdose, and mitigates risk of theft and diversion. If larger quantities are being requested for travel purposes, there are other options, such as finding a treating physician at their destination community.