College of Physicians and Surgeons of British Columbia

Practice Standard

Safe Prescribing of Opioids and Sedatives

Preamble

This document is a standard of the Board of the College of Physicians and Surgeons of British Columbia.

College's Position

Opioids and sedative medications have high-risk profiles. Historically, prescribing these medications has contributed to the rise in people living with substance use disorder (SUD).

The profession has a collective ethical responsibility to mitigate its contribution to the problem of prescription medication misuse, particularly the over-prescribing of opioids and sedatives. The fundamental purpose of this standard is **primary prevention** of overdose, addiction, and other harms of the use of opioids and sedatives.

This standard does not apply to active cancer care, end-of-life care, and management of substance use disorders. Physicians are expected to follow relevant clinical guidelines and established best practices in managing patients with these conditions. Nothing in this standard interferes with a physician's obligation to provide aggressive symptom management to patients with active cancer, or nearing the end of their lives. In the treatment of opioid use disorder (OUD), physicians are directed to follow accepted clinical guidelines or seek expert opinion when initiating and implementing opioid agonist treatment (OAT). It is incumbent on all physicians to have an approach to identify patients with these complex care needs, and to manage or refer these patients in a manner consistent with their training, scope of practice, and location.

The high-risk medications covered by this standard include opioids, benzodiazepines (including the Z-drugs zopiclone and zolpidem), and other sedative-hypnotics such as barbiturates.

Long-term opioid treatment (LTOT) refers to the prescribing of opioid medications on a continuous daily schedule.

Standards

1. The CMA *Code of Ethics* and the College standard *Access to Medical Care* prohibit discrimination based on medical condition and complexity. **Physicians must not exclude**

or dismiss patients from their practice based on their current use of, or request for, opioids or sedatives, or a suspicion of misuse of prescription medications.

2. Physicians must base decisions to prescribe opioids and sedatives on a thorough understanding of their patient. This includes:
    a. Conducting a well-documented, comprehensive assessment including patient history, physical examination, and relevant investigation results.
    b. Conducting a comprehensive re-assessment at least every three months.
    c. Basing decisions to continue long-term treatment with opioids and sedatives on objective evidence. Continuing to prescribe only because these medications were previously prescribed is not acceptable.
3. When initiating treatment with an opioid or sedative medication, patients must be fully informed of the risks and benefits of such treatment. This includes holding and documenting a discussion about the rationale for a treatment regimen, expectations and goals of patient and physician, alternative treatment strategies, and a plan for the eventual possible discontinuation of the medication.
4. Physicians must use appropriate and available strategies to mitigate risk of harm when asked to prescribe or renew a prescription for opioid or sedative medications, including:
    a. Reviewing patients' medication profile, and consulting PharmaNet (if available) before prescribing the high-risk medication. This will prevent harmful drug interactions and combinations, and prevent patients from obtaining multiple prescriptions from multiple providers for the same medication.
    b. Considering random urine drug testing (rUDT) before initiating treatment, or as a baseline test for patients on long-term opioids and sedatives. Annual, or more frequent, rUDT and/or random pill counts must be considered for patients at risk of SUD, or if medication diversion is suspected.
    c. Documenting their recommendation of take-home naloxone to all patients who are at risk of respiratory depression as a consequence of receiving opioid medications.
5. Patients must be advised about the dangers of taking opioid or sedative medications while performing safety-sensitive occupations, providing child or elder care, and driving.
6. When considering continuing LTOT:
    a. Physicians must **document their discussion** with patients that non-pharmacologic therapy and non-opioid analgesics are preferred for chronic non-cancer pain (CNCP), and that the potential benefit of LTOT is modest and the risk significant.
    b. Physicians must **advise patients** that evidence points to risks outweighing benefits in providing LTOT for certain medical conditions including headache disorders, fibromyalgia, axial low back pain, and functional somatic syndromes.
7. For patients on LTOT, physicians must always prescribe the lowest effective dose of opioid medication.

a. Physicians must be confident, and document, that there is **substantive evidence of exceptional need and benefit** for doses >90 morphine equivalent daily dose (MEDD) of prescribed opioids.

b. For all patients on LTOT, but particularly those on >90 MEDD, the merits of tapering to the lowest effective dose must be emphasized. The decision to taper must be made collaboratively. Such tapers must be slow to minimize patient discomfort. Patients attempting a taper need supportive counselling and frequent follow-up. The College recognizes that these attempts may not always be successful.

c. Even if an attempt at tapering fails, patients must regularly be offered the option of tapering their medications.

8. The College recognizes the particular challenge of patients who have been receiving high-dose opioids, and other high-risk profile medications, for many years. It is unacceptable to decline to accept these individuals as patients. Management of such patients must be individualized, but all of the considerations of this standard apply including regular thorough assessments, and regularly offering to taper high-risk medications. Medications must not be abruptly discontinued—"bridging" prescriptions during assessment of these patients is entirely acceptable to avoid dangers of withdrawal.

9. Physicians must play an active role in controlling the amount of opioid and sedative medication in the community. Excessive prescribing from acute care settings exposes patients to the risk of more chronic use, and unused medication can be stolen or diverted for non-medical use.

    a. When treating acute pain or discharging patients from acute-care settings or post-operatively, physicians must prescribe no more opioid medication than necessary.

    b. For patients on long-term therapy, physicians must not provide prescriptions allowing dispenses of opioids or sedatives that exceed a three-month supply or 250 tablets, whichever is less.

    c. Physicians must document their discussion with patients about safe storage and disposal of unused prescription medications.

10. Physicians must carefully consider concurrent medical conditions in the context of decisions to prescribe or continue to prescribe opioid or sedative medications:

    a. Heart failure, obesity, sleep apnea, chronic lung disease, and renal or hepatic insufficiency compound the risk of these medications. Elderly patients are also particularly vulnerable.

    b. Patients must be regularly screened for the presence or emergence of mental health disorders (particularly mood disorders) which may complicate management.

    c. In the course of managing patients on opioids or sedatives (particularly while tapering), a substance use disorder may be unmasked and physicians must be able to diagnose and manage this appropriately, or refer to a clinician with experience in addiction medicine. Medications such as opioids and

benzodiazepines must not be abruptly discontinued and must be tapered slowly to minimize the effects of withdrawal.

11. Combining opioids or sedatives with other medications compounds risk of harm:

    a. Co-prescribing medications such as benzodiazepines, sedatives, and opioids significantly compounds risk of death due to overdose. If long-term treatment is considered for these medications, the physician must work collaboratively to taper and discontinue one of them.

    b. If prescribing opioids or sedatives, physicians must document their advice to patients that they must avoid other central nervous system and respiratory depressants including alcohol, marijuana, and some over-the-counter medications.

    c. Physicians must exercise caution in prescribing opioid and sedative medications with muscle relaxants, sedating antidepressants, anticonvulsants, antipsychotics and other sedating medications.

    d. If patients with complex care needs are receiving multiple sedating medications, the physician must consider seeking the opinion of relevant consultants such as psychiatrists, pain specialists, addiction medicine specialists, pharmacists, and others to work toward a collaborative medication regimen that minimizes risk as much as possible.

The College advises that the *2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain* is complementary to, and should be read in conjunction with, this standard.

Physicians may seek advice on these issues by contacting the College and asking to speak with a member of the registrar staff, or by seeking medical legal advice from the CMPA.