College of Physicians and Surgeons of British Columbia

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Patients with chronic pain need family physicians—it's unprofessional to turn them away [1]

A real case*

A 38-year-old man with severe peripheral neuropathy complicating type 1 diabetes relocated from Calgary to Greater Vancouver. At the time, he was on long-term opioid monotherapy (no sedatives) at a modest, stable dose, well within the range suggested in the College standard *Safe Prescribing of Drugs with Potential for Misuse/Diversion [2]*, and the new Canadian guideline. He approached a number of clinics about becoming a patient. Some reportedly turned him down outright, advising that they never prescribe opioids for chronic non-cancer pain. Several asked him to complete an application form, only to contact him later to say they have no capacity in their practice. Is this acceptable?

An article in the September/October 2016 edition of the College Connector titled *Can a physician turn a prospective patient away? [3]* describes how physicians are expected to respond in such circumstances:

> *Rather than dismissing prospective patients summarily because they are taking long-term opioids and/or benzodiazepines or Z-drugs for chronic pain, they should be told in clear and simple terms at the outset that the College's standard for prescribing these drugs has evolved based on emerging scientific evidence. Patients should be advised that they will be prescribed*

> *medications cautiously, in accordance with the standard, which means that combinations of opioid analgesics (strong pain medications) and sedatives (usually sleeping medications) are not allowed.*

The standard *Safe Prescribing of Drugs with Potential for Misuse/Diversion* does not prohibit long-term opioid therapy; it makes it safer. It obliges physicians to "Base decisions to prescribe long-term psychoactive medications, including LTOT, on well-documented, comprehensive initial assessments and frequent (at least every three months) reassessments." This cannot be done without seeing the patient.

For a new patient, that will almost always mean a series of visits—one or two each for history, physical assessment, discussion of old records, and investigations. Based on the assessment, it may be appropriate to advise that the medications are not indicated and must be tapered. At that point, the patient may choose to follow the treating physician's advice or seek care elsewhere. A taper may unmask a substance use disorder that must be recognized and treated, often with opioid agonist therapy—an opportunity to save a life.

In some circumstances stable monotherapy in modest doses for a condition like diabetic neuropathy is entirely appropriate and should be continued.

The College acknowledges that this is challenging medicine, but medicine is a demanding occupation. A family physician who can manage diabetes or COPD is capable of providing primary care for the one in five adults who live with chronic persistent pain.

Chronic non-cancer pain, inappropriate use of psychotropic medications, and addiction are all medical conditions. The CMA *Code of Ethics* prohibits discrimination on the basis of medical condition. In the event of a complaint, discrimination may be considered unprofessional conduct worthy of sanction.

Family physicians are urged to take advantage of relevant College courses and the Practice Support Program (PSP) Chronic Pain module. GP consults with respected colleagues are also helpful. Physicians who are struggling with this inherently challenging area of practice are welcome to call the College or the CMPA for advice.

***Note:** The details in this case study have been changed to protect the privacy of the patient.

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