To the CPSO:

The following are my comments on the draft Prescribing Drugs Policy.

Mostly it is well written however I have some specific suggestions for the section on prescribing opioids.

"No Refill Policies"

In the world of pain management, especially with the prescribing of opioids, we are expected to assess and document a number of outcome measures in order to ensure that an opioid refill is appropriate.
Thus advising patients that the normal practice of the clinic is: "no refills without a follow-up appointment" is necessary. There will always be rare exceptions, such as weather or acute illness, but having such a policy gives some responsibility to patients and manages expectations. Please rewrite this paragraph to acknowledge this.

Narcotics and Controlled Substances

Before Prescribing

The process for developing the CDC Guidelines was seriously flawed [see Schatman 2017, attached]
Since we have the 2017 Canadian Opioid Guidelines developed after a much more rigorous and transparent methodology, I suggest that any references to the CDC Guidelines be removed.

When Prescribing

Again, I suggest removal of the reference to the CDC Guideline for reasons already noted

The wording of Paragraph 2 could be improved as it is not fully Canadian Guideline congruent. I suggest that you quote or at least paraphrase directly from Recommendation 6 of the Canadian Guideline - including the subtext:

"We recommend restricting the prescribed dose to less 90mg morphine equivalents daily rather than no upper limit or a higher limit on dosing
Some patients may gain important benefit at a dose of more than 90mg morphine equivalents daily.
Referral to a colleague for a second opinion regarding the possibility of increasing the dose to more than 90mg morphine equivalents daily may therefore be warranted in some individuals. "

Paragraph 3 should also be reworded to be more Guideline congruent. Suggest quoting or at least paraphrasing Recommendations 9 and 10:

"For patients with chronic noncancer pain who are currently using 90mg morphine equivalents of opioids per day or more:

We suggest tapering opioids to the lowest effective dose, potentially including discontinuation, rather than making no change in opioid therapy.
Some patients are likely to experience significant increase in pain or decrease in function that persists for more than one month after a small dose reduction; tapering may be paused and potentially abandoned in such patients."

"For patients with chronic noncancer pain who are using opioids and experiencing serious challenges in tapering, We recommend a formal multidisciplinary program." (where available)

Office Policies and Practices: Setting and Managing Patient Expectations

'No Narcotics" Prescribing Policy

I would suggest that this section should be strengthened. Many primary care physicians are simply opting out of pain management in order to get out of prescribing opioids at all. They are advertising that they are accepting new patients but then making excuses why they can't accept a given patient with pain on opioids. I think there should be a statement indicating that CPSO considers it a standard of care that primary care physicians should be able to provide at least some pain management services for patients including the appropriate prescribing of opioids. The posting of signs in offices indicating "No Narcotics Prescribed" should be deemed unprofessional behaviour by physicians.

Treatment Agreements

Although I support at written Treatment Agreement as nice to have evidence of an informed consent discussion, the Canadian Opioid Guidelines did not find persuasive evidence that they reduce the risk of harm. That is why it ended up in the Expert Guidance section rather than a Recommendation. Therefore calling them "…an effective tool for ensuring proper utilization…" is a stretch.

Monitoring Patients

There is no evidence that keeping a separate narcotics log for each patient results in any harm reduction. This is especially true in the era of EMRs. This reference should be removed.

There is no mention of the use of urine drug testing as a potential monitoring tool. This was also mentioned in the Expert Guidance section of the Canadian Guidelines.

The rest of the document is well written.

I hope that these suggestions are helpful. I am available to discuss any of the suggestions I have made above.