T 604-733-77

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,

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?

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.