Opiates & Chronic Pain in Canada: Current Evidence, Past Lessons, Future Policies

By: Annie Rogers, Canadian Chronic Pain Patient

Pt.1. My Story: From Honours Student to Chronic Pain Patient & Over a Decade of Pain

When my jaw was damaged during a routine dental procedure in 1999 and I was diagnosed with a severe case of Temporomandibular Joint Disorder (and later with the additional diagnosis of Complex Regional Pain Syndrome) my whole life changed. I had been on the Dean's Honour List in my last year of university and applying to graduate schools when I was injured, preventing me from completing my Honours thesis or taking up the graduate scholarship I had won. All of my dreams had to take a backseat to the daily struggle of just living with the pain. My condition feels a little like an ear/sinus infection and a toothache mixed together, with the added sensation of knives behind my eyes and tight muscle pain in my neck, cheeks, temples, throat, shoulders and upper chest. My mouth only opens to about 2.5cm and, when talking or chewing makes my jaw muscles especially tight, my lower jaw slides forward so my bite is no longer properly aligned. I spend much of my day with a heating pad on the side of my face trying to keep my muscles relaxed so my teeth stay aligned. Sometimes I literally hear the throbbing of my jaw in my ears: "woosh-woosh-woosh" becomes the background music of my life. On top of that, I now have allodynia, a condition where non-painful stimulus become painful, so that my clothing against my neck, or a light caress of my cheek, or even the wind can feel painful against my skin. The pain gets better and worse, but it never fully goes away. I live day to day, moment to moment, trying to make it until the next lull in the pain. Unfortunately, those lulls are brought about, more often than not, by taking opiates.

Opiates Were a Last Resort for Me, But They Allow Me a More Functional Quality of Life

By combining a slow-release Morphine formulation for my daily pain with a fast-acting type of the same opiate to be used only sparingly, for extreme 'breakthrough' pain, I have been able to regain some aspects of my life that the pain had previously stripped away. Medications of any kind, but particularly opiates, were a last resort for me. I have tried everything else medically offered and I will eagerly try any new treatments as they become available. My reluctance to treat my pain with opiates was linked to common misconceptions about addiction and opiates. Conversations with various pain specialists in the years following my initial injury, as well as my own research on the subject, convinced me that the scientific consensus on opiates is very different from what the media and popular culture had led me to believe.

Pt.2. Opiates: Risks are Manageable; Benefits are Incalculable

Scientific Consensus Supports Opiates (Evidence-Based, Systematic Reviews)

In recent years, in response to growing public concerns about prescription misuse, a number of scientific consensus statements and national guidelines for prescribing opiates have been written and, perhaps surprisingly to some, the most scientifically rigorous of them all continue to support the use of opiates to treat pain in patients who lack addiction risk factors (See 'Recommended Resources').[1] The premiere Canadian policy document was produced in 2010 by the National Opioid Use Guideline Group (NOUGG), an umbrella group of all the provincial medical regulatory bodies. This group convened a National Advisory Panel representing family physicians, pain and addiction specialists, nurses, pharmacists, psychologists and patients. The panel then employed a systematic review of all high-quality scientific studies pertaining to opiates to create a set of consensus policy recommendations to be used by Canadian doctors. It took three years to produce the resulting document, but the "Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain

(CNCP),"[2] is an easy to read 164-page set of recommendations complete with evidentiary underpinnings. It offers Canadian doctors concrete tools to screen for addiction risk factors, citing evidence that the risk of addiction to opiates falls from 3.3% for those with risk factors to 0.19% for those without.[3] Other studies have found a high correlation between drug cravings and addiction, but found that the majority of chronic pain patients *never* experience cravings for their medications.[4] The evidence clearly contradicts the public's fears about the addictiveness of these medicines, at least for chronic pain patients. The guide further states that "patients deserve to have their chronic pain treated. Opioids can be a useful and appropriate treatment option. Harms associated with opioid use can be reduced…"[5] Such harms, other than addiction, are mild; nausea, drowsiness, constipation, and itchiness are the most common. On the other hand, the benefits of opiates for chronic pain patients are immeasurable.

Low Risk of Addiction with Opiates & Chronic Pain

Morphine allows me an objectively better quality of life. If you made a list of life experiences, like the ability to chat on the phone with friends, or to laugh at a sitcom (smiling hurts), or sleep through the night, or have a hobby, or exercise, or eat a meal without pain, I would be able to check many more boxes while properly treated with morphine than when I am not. If there is a better measure for the effectiveness of a pain medicine than how well it lets the person live a full life of human experiences, I can't imagine what it would be. (It is certainly better than the highly problematic and subjective 'standard pain scale' where a '10' marks the worst pain 'imaginable'). These are the terms upon which we should be judging our chronic pain treatment programs: real measureable human experiences which we know are essential components of a healthy human life. If the medicine lets the person live again, it is effective, if it does not help with any of these metrics, or if the side effects themselves interfere with too many human experiences, then it is not. The risks of opiates under proper medical supervision are minimal, while the benefits are measured in people living fuller lives, participating in their communities and being there with their loved ones in the moments that matter.

Benefits of Opiates

A 2010 study of Canadian chronic pain patients found that "[c]hronic pain is associated with the worst quality of life as compared with other chronic diseases such as chronic lung or heart disease."[6] This is likely the reason why people in pain are up to twice as likely to commit suicide as the general population.[7] Chronic pain can exasperate other medical conditions, and uncontrolled pain has even been shown to compromise immune function, promote tumor growth and jeopardize healing, with "increased morbidity and mortality following surgery."[8] This further increases the healthcare costs of this already very expensive problem; the Canadian Pain Society estimates that the full annual cost of chronic pain in Canada, including healthcare costs and costs to the economy due to lost productivity, at $560-630 billion.[9] When one compares these costs with the risks associated with opiate use (0.19% risk of addiction, constipation, drowsiness etc.) it is hard to understand why we are so reluctant to prescribe these medications to treat our people; the benefits clearly outweigh the costs.

Costs of Under-Treated or Untreated Pain

Pt.3. Oxycodone: Origin of the Prescription Drug Crisis

The history of the problem can be traced to one particular opiate formulation, Oxycodone, which was developed by Purdue Pharma in the mid-1990s and which was aggressively peddled throughout North America over the next decade. Since 2004, Purdue has paid over $630 million in state and federal courts who found that they illegally misled doctors about the drug's risks in order to promote sales.[10] It has even been charged that Purdue purposefully made their 'slow-release' formulation (Oxycontin) more addictive, concealing the fact that they included a fast-acting component in medication (the faster a drug effects the brain, the more it feels like a 'high' and the more addictive it is).[11] [12] Having a drug engineered

Oxycodone Makers Guilty: Made Oxy More Addictive, Hid Facts from Doctors

to be more addictive, while doctors were misled to believe it was less so, meant it didn't take long for Oxycodone to spread throughout North America, causing a corresponding increase in addiction-related problems and opiate-involved deaths. Oxycodone even came to replace weak opioid brands like Codeine; between 1997 and 2006, while prescriptions for the new strong opiates like Oxycodone were increasing by 200-600%, the American "sales of codeine and meperidine dropped 25% and 28%, respectively."[13] A comprehensive report (shockingly claiming to be the first meta-study ever produced on this important subject!) was compiled at McGill University in 2014 and entitled *Determinants of Increased Opioid-Related Mortality in the United States and Canada, 1990–2013: A Systematic Review.*[14] It found that while prescriptions for Oxycodone on the Ontario public drug plan were skyrocketing between 2003 and 2008, the "rates for all other opioids decreased or remained flat, and opioid-related mortality increased."[15] In fact, they cited another Ontario study that showed that "annual opioid-related mortality rates increased 41% and oxycodone-related mortality increased 416% after OxyContin was added to the provincial drug formulary."[16] Clearly the increase in mortality, and the prescription drug crisis itself, was being driven by *one* prescription opiate only: Oxycodone. This is why Ontario removed Oxycontin from its public drug plan in 2012.[17]

Oxycodone: Cause of High Opiate Mortality & Addiction Rates

Pt.4. Ending the Oxy Crisis & Today's Prescription Crisis: Anti-Opiate Sentiment

The series of measured responses adopted by Ontario in the wake of the Oxycodone crisis, like electronic prescription-monitoring programs, crush-proof tablets, and new prescribing guidelines for doctors (which uphold the patient's right to pain treatment while offering better risk-factor screening procedures) successfully changed the way prescriptions were written in this province and did much to curb its prescription drug problem. The evidence shows that rates of prescription misuse in Ontario that were clearly trending upwards have been sloping steadily downwards since 2011.[18] (Street Oxycodone today is largely being driven by the black market, especially smuggled in from America where prescription oversight is more lax, rather than from Canadian doctors' offices). The Canadian public's fears about "doctor shopping" and internet prescriptions also appear to be mostly unfounded: the McGill opiate mortality meta-study found that doctor shopping was only a factor in 2% of Ontario opiate deaths and they found no instances of internet prescriptions being used.[19] In fact, despite public feelings to the contrary, many recent studies suggest that Canada does not currently have a problem with doctors overprescribing opiates. Instead, the opposite may be true: studies show that Canadian doctors are actually *overly reluctant* to prescribe opiates, even for conditions for which medical consensus clearly supports their use. In addition, there have been numerous reports of doctors refusing to take on new patients if they require prescriptions for chronic pain,[20] I myself was on a waiting list for a new GP for over five years after my family doctor's retirement, despite my willingness to travel outside my small southern-Ontario city in my desperate search to find one.

Ontario's Successful Policies: Electronic-Prescription Monitoring etc.

Canadian Doctors Today: ***Overly Reluctant*** *to Prescribe Opiates (Against Medical Consensus)*

Further, individual doctors and entire Canadian pain clinics have been instituting 'no-narcotics' policies, refusing to prescribe opiates to any patient for any reason (besides maybe cancer, which seems to be the only *acceptable* cause of pain), despite the fact that such policies are actively discouraged within medical regulations produced by the College of Physicians and Surgeons of Ontario (CPSO).[21] One Canadian survey concluded that even among doctors with a stated interest in treating chronic pain [GPs] or in palliative care [PCs] "thirty-five percent of GPs and 23% of PCs would never prescribe opioids for noncancer pain, even when described as 'severe.'"[22] That means that among doctors who regularly treat pain patients, doctors who *should* know the relatively minor risks of opiates and the concrete ways to mitigate these risks,

Universal Healthcare? 'No-Narcotics,' Arbitrary Dose-Caps & 'No New Chronic Pain Patients' Policies

35% won't use the best tool modern science currently has for relieving suffering. I can't help but picture my fellow sufferers, those I see in pain clinic waiting rooms, with mangled limbs from car accidents, with wheel chairs or walkers, with healing scars but lasting pains, or those with invisible injuries causing visible agony. This study suggests that up to one third of their doctors refuse to even prescribe them codeine to relieve their suffering. Or they could have a doctor who places an arbitrary cap on the amount of opiates they prescribe, regardless of the patient's condition. Such caps range from a 50mg to a 300mg per day limit, depending on the feelings of each individual practice, but not, as far as I can tell, based on any evidentiary underpinnings (or an acknowledgement of the differences in strength between different opiate formulations, or of the different ways individual physiologies could react to the same amount of medicine).[23] Hospitals no longer serve chronic pain patients at all; if you come in with a broken leg they may give you something for the pain, but if your doctor forgets to write one of your regular opiate prescriptions and then goes on vacation for three weeks (as happened to me), no hospital or walk-in clinic in Canada can legally help you.

Pt.5. Opiates: The Gold Standard of Pain Relief (a.k.a. What Alternatives?)

Opiate Reluctance: Incentivizing Sub-Standard, Risky, Invasive or Unproven Treatments

The unfortunate truth is that there are few alternatives to opiates for treating moderate to severe pain, which means that opiate-reluctance among physicians necessarily results in under-treated or untreated pain patients. Opiates have long been the standard by which all other pain relievers are measured, and though they are far from perfect, the sad fact is that after conservative non-pharmacological treatments fail, there are not many other options a doctor can offer their suffering patients. Compassionate physicians want to do *something* for their patients, so when policy-makers (or others) tie their hands by making them afraid to prescribe opiates, we are incentivizing doctors to recommend sub-standard treatments, or more invasive ones (like risky surgeries), or unproven 'alternative' modalities, or even to prescribe medications that carry a greater health risk than the opiate we are trying to avoid. 'Interventional Pain Clinics', which provide more invasive treatments than traditional pain clinics, like nerve-block injections or spinal cord stimulation (both of which carry a risk of death), seem to be replacing the multi-disciplinary pain clinic model (which usually included opiates as one aspect of their treatment programs) throughout Southern Ontario. In addition, NSAIDS,[24] the most commonly prescribed alternative pain reliever, carry a risk of heart attack, stroke and fatal stomach bleeding; hospitalization due to these stomach bleeds have been shown to contribute a significant Canadian healthcare cost.[25] This is objectively worse than the constipation, drowsiness and the 0.19% risk of addiction that I face with my opiate medication. It is only when opiates are taken improperly, when doses are increased rapidly, when an oral pill is crushed, snorted or injected, when opiates are taken to achieve a 'high' rather than to relieve pain, that they become as mortally risky as the supposedly 'safe' NSAIDS.

In my experience, the most common rationalization used by opiate-reluctant doctors today to convince themselves that they are still doing 'good', even as they deny their patients access to pain relief, involves a complicated new area of medical research called 'Opiate Induced Hyperalgesia' (OIH). The term describes a condition where the opiates that a patient takes to relieve their pain actually begins to cause more pain. It is a newly identified condition, with human trials barely showing up in medical journals before 2001,[26] so I don't think it's unfair to suggest that OIH has not yet had time to survive the whole scientific gauntlet (full-scope experimentation, peer reviewed publishing, repetition of results etc.). When compiling the comprehensive evidence review that accompanies their jointly produced meta-study of all current medical knowledge about opiates, the American Pain Society and the American

Academy of Pain Medicine "identified no study of opioid-induced hyperalgesia (abnormal pain sensitivity) that met inclusion criteria."[27] The NOUGG writers seem to concur; they differentiate between 'adverse effects' which are supported by high quality evidence from randomized-controlled trials (RCTs) and 'medical complications' which are from non-RTCs with "no evidence regarding the frequency of medical complications, the relationship between length of time on opioids and occurrence of medical complications, or whether the complications are permanent or transient."[28] OIH is included in the NOUGG document as a 'medical complication,' not as an 'adverse effect.' Even the writer of one of the two meta-studies on OIH reminds readers that it is "important to recognize that most of the human studies provide only indirect evidence for OIH in clinically relevant settings."[29] And most of these 'relevant' settings are methadone clinics, not chronic pain clinics. Despite the lack of clear evidence specifically about OIH and chronic pain patients, almost every doctor I have seen in the last five years has suggested that I should be *really* worried about OIH (despite the fact that I lack any of the symptoms), and no doctor had ever even mentioned its existence to me before five years ago. As of writing this report, none of the major medical websites like Drugs.com, WebMD, or the Mayo Clinic include OIH as a possible risk, side effect or complication for Morphine.[30] Nevertheless, for a doctor who is already reluctant to prescribe opiates, OIH is a very tempting idea; it allows them to disregard their patients distress because they can convince themselves that failing to use the most effective alleviator of suffering available is actually in their patient's own best interest: "I can't prescribe you opiates, it might be making your pain worse" is becoming a common, though unfounded, refrain heard by chronic pain patients in their individual doctors' offices. Until the day that we have enough high-quality evidence to move OIH to the 'adverse effects' section of the NOUGG document we should not be using the potential complication as a way to justify 'no narcotics' policies, or arbitrary caps on opiates, or dismantling individual patients' hard-won pain management regimens.

We must ensure that there actually *are* safe and effective alternative treatments available before we declare, as did Health Minister Jane Philpott as part of her opiate strategy speech on June 17 2016, that "opioids are not the best choice for the treatment of chronic pain."[31] Obviously it would be 'best' if my pain could be effectively treated non-pharmacologically, or even better if my underlying condition itself could be cured, but if such ideal treatments fail, what then are physicians to do? Chronic pain patients would love a non-addictive alternative treatment option; to be able to treat my pain without the stigma of being an opiate-user would be such a profound relief. Research into new medications and possible ways to mitigate the harms of our existing drugs must be a priority, but until then, we can't discount our one strong weapon in the battle against pain.

Pt.6. Not All Opiates Are Created Equal

The story of Oxycodone makes clear an essential fact: There are important differences among opiates. There are differences in addictiveness, ease of misuse (pill crushability etc.) and street marketability. The quicker a medicine reaches the brain, the more euphoria is felt and the more addictive it is (at which point, research shows that various social/genetic/personality/personal-history factors come to bear on whether the person exposed to that euphoric effect actually becomes an addict). Some opiates are formulated to have more of these addictive qualities than others, and unsurprisingly these opiates, like Oxycodone and Fentanyl, have caused almost all of our recent problems (Morphine is over 100 years old, but the prescription drug crisis only really started around 1995, shortly after Oxycodone came to

market). Moreover, slow-release formulations of any of these opiate brands are generally thought to be less addictive than the fast-acting versions of the same drug because 100mg released slowly affects the brain less than 10mg released quickly.

Bad Policy Ignores Differences: O.N. & B.C. Make Ineffective & Harmful Opiate Policies

If we ignore these differences, we cannot make good public policy. For example, Ontario recently decided to remove high-dose Morphine and a few other opiates from the Ontario Drug Benefit Formulary, which covers the cost of medications for people who are over 65, live in a long-term care home, receive social assistance (including disability assistance), or have high drug costs relative to their income. This decision is in effect limiting the less-addictive type of opiate (Morphine) in the least addictive format (slow-release medicines are usually high-dose, whereas fast-acting, more addictive ones are typically low dose). It is actually the small-dose, fast-acting opiates, the type more often prescribed for transitory (non-chronic) pain, like a broken leg, but used only sparingly by those in chronic pain, that carry the greater risk of addiction and have a bigger street value. Moreover, the amount of euphoria felt by a patient taking a short-acting opiate increases when their temporary condition begins to heal. This is obviously not the case for *chronic* pain patients. We cannot protect our citizens from opiate-related risks if we focus on people with chronic but not temporary pain, or if we prioritize fast-acting, low-dose formulations, or if we expressly limit prescriptions of the least-addictive, longest-established opiate brands (like Morphine or Hydromorphone rather than Oxycodone or Fentanyl). Nevertheless, these are precisely the errors made not only by Ontario, but also in the reactionary new guidelines for B.C. doctors produced by the College of Physicians and Surgeons of British Columbia in June of this year.[32]

Pt.7. Fentanyl: A Black-Market Crisis

Smuggled Fentanyl: The Scourge of the Street

It is not surprising that the community hardest hit by the Fentanyl crisis has opted for some of the most reactionary policy choices as of late, but I fear that few of B.C.'s new recommendations will actually help with the serious problem of Fentanyl-related overdoses, and they may in fact do a great deal of harm. The reason for this is that the current Fentanyl crisis is NOT a "prescription drug" problem, but instead it is a "black market drug" problem. Evidence shows that the Fentanyl which has become such a problem in recent years did not originate from doctor's prescriptions; rather, it was illegally manufactured outside of Canada, most often smuggled from China.[33] Once thought to be a safer alternative to pill-form opiates, medical Fentanyl is a patch applied to the skin of patients who are significantly impaired by pain or to those needing end-of-life care (it is a very strong medicine, mainly used to treat severe suffering). Street Fentanyl, on the other hand, comes in the form of a pill, adapted illegally from stolen patches or, more commonly, imported in powder or pill-form from China. Illegally manufactured fentanyl powder is then pressed into pills here in Canada or the powder itself is cut into virtually every other drug on the black market; cocaine, crystal meth and heroine tested at Vancouver's Insite Clinic have all been found to secretly contain this potentially deadly opiate.[34] The reason that Fentanyl is a bigger problem on the west coast of Canada then becomes clear: B.C. is closer to the source of the problem; Chinese drug smugglers, not Canadian doctors' offices.

In the public's mind, any pill is a 'prescription drug', and any 'prescription drug' comes from a doctor. If Canadian doctors stopped writing Fentanyl prescriptions tomorrow there would be little or no change to the rate of Fentanyl deaths going forward.[35] Rules like those in the new B.C. guidelines which require that doctors keep records proving that they actively discouraged all of their patients from opiate therapy, regardless of the patient's condition or what medical consensus says about that condition, will also fail to impact black-market

fentanyl rates. Blaming physicians and their vulnerable patients for this problem may make us feel like we are accomplishing something; scapegoating always feels powerful, but in the end we are all worse off for it. We are creating a culture of suspicion between doctors and their patients, between the public and doctors, among doctors themselves, and between the public and those unlucky people who are forced to treat their pain with opiates. Those courageous and compassionate doctors who continue to take on chronic pain patients in this political climate often begin to get a reputation as such, and as their practices fill with people legitimately needing prescriptions for opiates, those doctors begin to stand-out on paper, especially compared to their opiate-reluctant colleagues. Such fully-legitimate physicians may then find themselves under suspicion for being a 'pill mill,' and even if such a misunderstanding is rare in Canada, doctor's fears of being seen as such are not. Our Canadian physicians have been working hard to stop prescription misuse, and they *were* misled about Oxycodone, it is not fair for them to be treated as drug pushers (or to hold them to account for lax American prescription standards) by our popular culture. Doctors should not be afraid to follow their own best-practice guidelines; they need to be free to prescribe what they believe is right for their patients, based on the strongest empirical evidence available, not based on the feelings of the populace or on externally imposed regulations which are more informed by fear than by fact.

Culture of Suspicion Hurts Everyone, Including Doctors

Pt.8. Making Pain Management (Not just Opiates) a Priority

It is necessary then, to ensure that the entire Canadian healthcare community is fully aware of the strongest empirical evidence and the consensus medical opinions about opiates and pain management. Clearly, a federally supported and widely disseminated set of best-practice evidence-based guidelines for prescribing opiates would be an invaluable tool for physicians (a document like that produced by the NOUGG). In this time of rampant misinformation, such guidelines would also set the tone of our national conversation as both science-based and compassionate and would do much to combat the problem of opiate-reluctance among Canadian doctors (while also putting a system in place to protect high-risk patients from opiate misuse). But we must go further: we need to make *pain management,* not just opiates and their control, a priority in our Canadian healthcare system. Unfortunately, we are currently failing Canadian pain patients on multiple fronts. A 2009 study of pain-research in Canada found it to be "grossly under-funded … with less than 1% of total funding from Canadian Institutes of Health Research and only 0.25% of total funding for health research going to pain related studies."[36] This at a time when global pain research is flourishing! New understandings of chronic pain as a condition in its own right, rather than just being a symptom of other diseases, has led to new ideas about possible causes and treatments for pain. New imaging technologies, which have allowed us to better understand the links between the brain, the nervous system and pain, have also stimulated new research. Does Canada not want to be a part of this important global research initiative? This lack of spending on pain research has wider implications than just our role in the global health community. A 0.25% spending rate on pain research creates trickle-down effect: When there is little money being spent on pain research, there are few academics in Canadian universities doing research projects on the subject, which means that medical students are not exposed to such research, and that it is harder to woo the smartest graduate students or any new PhDs with an interest in pain research to Canadian universities, which in turn means that there aren't any professors who specialize in pain to teach the next generation of GPs and specialists. The end result is a decided lack of focus on pain, its causes and its treatment, in Canadian universities. According to the Canadian Pain Society, a recent survey of the curricula of Canadian universities' medical programs found

Pain Research in Canada "Grossly Underfunded"

Vets Get Up to 5x More Training in Pain Than Doctors!

that veterinarians receive *five times* more training in pain management than doctors who treat humans![37] As of 2012 when Elizabeth McCallum explored these issues in an article for MacLean's Magazine, "[n]o medical school in Canada offers a specialized degree in pain management."[38] Not only that, but only 32.5% of Canadian schools with degrees in the field of human medicine offer a mandatory course specifically on pain or pain management.[39] This suggests that two-thirds of GPs could go through their entire 5 year medical education without a single class specifically focussing on pain! (Pain treatment instruction would be integrated into other classes though, focussing on pain as the symptom of other diseases). If Canadian chronic pain patients cannot be guaranteed that their GP has received adequate training in pain management, it becomes even more necessary for them to have easy access to qualified pain specialists. Unfortunately a review by Fischer and Argento found that "access to specialist pain treatment is highly limited and inadequate"[40] citing a study by Philip Peng et al. who found that the median wait time for a public multidisciplinary pain clinic in Canada was 16 months, and that some patients had to wait up to five years for specialized treatment.[41] These wait times reflect a fact that Canadian health spending seems to be ignoring: between 15% and 29% of the Canadian population experiences chronic pain.[42] These long waiting lists are even more shameful when one takes into account the fact that the majority of these sufferers are seniors[43] and that 32.6% of people waiting for care at Canadian pain clinics have thoughts about suicide.[44]

Up to a 5 Year Wait for Pain Clinics & Specialists (Average Wait = 16 Months)

Chronic pain advocacy groups usually highlight the patient's right to treatment for their pain, a right which was enshrined in the United Nations 1961 'Single Convention on Narcotic Drugs,' to which Canada was a signatory. The Convention legally obligates countries to ensure access to opiates for the treatment of their citizens' pain. Further, if a country's drug policy can be shown to place unnecessary barriers to a sufferer's treatment it could be seen as a violation of the obligation to protect against cruel, inhuman and degrading treatment. But how many patients, already struggling with daily unrelenting pain, will have the means and the stamina to fight for their rights? Writing this report was difficult for me; it took many days, caused me a significant amount of pain and had a high opportunity cost because I have so few productive hours in a week. Every time I considered stopping, I thought of all the other people in Canada who are in pain like me, but worse. People who *couldn't* create a document like this, or for whom the consequences in terms of future pain are just too great. I thought of my fellow sufferers who weren't lucky enough to have received a university education before getting injured as I did, allowing me to read scientific studies and communicate clearly. Fears for my own future were also a motivator. Lately I find myself thinking about recent examples of small, but important, pleasures the medications have allowed me to enjoy, such as teaching my niece how to draw, chatting over lunch with my mother, or having a date night at the movies with my husband. Will I still be able to enjoy such activities, even occasionally as I do now, this time next year? In a world where doctors are prevented, either explicitly or implicitly, from prescribing opiates, my quality of life will be significantly diminished. We must remember that these decisions about our national opiate policy affect the daily lives of millions of Canadians who suffer chronic pain, millions who are worried about their futures and are looking to their government to protect them.

United Nations: Suffering Patients Have the Legal Right of Access to Opiates

Pt.10. Conclusion: Prescription for the Future

I applaud Health Minister Jane Philpott for making the development of a national opiate strategy a priority for her government and I particularly support her emphasis on basing public policy on high-quality evidence. I hope the issues I've raised in this report, and some of the

Evidence -Based National Opiate Policy Protects Doctors & Patients

sources used to produce it (like the NOUGG document), become part of the discussion at her upcoming national opiate summit (announced as part of her June 17, 2016 speech).[31] We need strong federal leadership to set the tone for this debate as both compassionate and evidence-based and to combat simplistic erroneous ideas like 'big doses are bad, small doses are good,' or 'if it's called a "prescription drug" it must have been "prescribed,"' which are not only wrong but can inadvertently cause a great deal of harm. To combat such misinformation, a federally supported set of best practice guidelines needs to be widely distributed among Canadian doctors and other health workers on the front-lines. As physicians incorporate official opiate safety guidelines into their practices, which include ways to screen for addiction risk factors and to encourage compliance among patients (without treating pain patients with suspicion), they should become less reluctant to prescribe opiates. This is one of the stated goals of the NOUGG document: "the intent of the *Canadian Guideline* is to improve comfort and confidence in using opioids for CNCP {chronic non-cancer pain} among clinicians, particularly primary-care providers, while preserving patient and public safety."[45] Yet opiate reluctance does not seem to have decreased since it was published in 2009; most of the new hardline anti-opiate policies have been instituted in the last five years. The most well-researched policy document does little good if it fails to be seen by the physicians who need it most; therefore, a plan to ensure widespread dissemination of information is crucial.

New Policies to Be Widely Distributed to All Canadian Healthcare Workers

Government support is also necessary to ensure that doctors are not so afraid of anti-opiate backlash, from the public or medical licensers, that they fail to use their own consensus-backed expertise to treat their patients. Our efforts to stop the growing problem of illegal black-market Fentanyl and Oxycodone are essential but they need not interfere with the continued functioning of our currently well-regulated legal prescription-market. New ways to improve prescription safety, to establish Canada-wide proven safety-measures, and new ways to prevent addiction for temporary pain patients (who are more at risk than chronic pain patients) should also be explored. Federal funding for research into new pain treatments, ways to mitigate the harms of our existing drugs (including NSAIDS), and into the underlying causes of chronic pain itself, would create a trickle-down effect ensuring that our medical schools are at the forefront of pain research and that our doctors are equipped with the most up-to-date information. We must remember that the harms of addiction and accidental overdose from illegal opiate-use are much more visible than the harms of under or un-treated chronic pain.

Invisible Epidemic: Chronic Pain Patients Hide Their Pain & Their Opiate Therapy (We Are Your Friends, Your Colleagues & Your Family)

People in pain tend to try to hide it from the world, not wanting to be defined by our illnesses or to burden others with our problems, and this is doubly true for those of us who suffer the added stigma of needing opiates to treat our pain. The numbers suggest that all Canadians know at least one person who suffers from chronic pain and who may or may not be prescribed opiates for that pain; they may be your colleague at work, the person you chat with at the coffee kiosk every morning or at the park where your kids play together, or even a close friend or a relative. (It could even be you someday.) If our medications are working and we are able to be functional, chronic pain patients will rarely tell others about our condition or that it was opiates that allowed us to be out in the world. If our pain conditions are still severe even when properly treated, we are even less in the public eye as we are stranded at home or in care facilities. While the hazards of opiates are widely publicized, the benefits of opiates are largely invisible. It is up to the rest of us Canadians, then, to remember the suffering of our fellow-citizens and the simple steps we could take to ease that suffering, as we plan our future policies regarding opiates and chronic pain.

Sources & Recommended Resources

[1] See the Following Guides (Which Include Full Systematic Reviews) Produced by:
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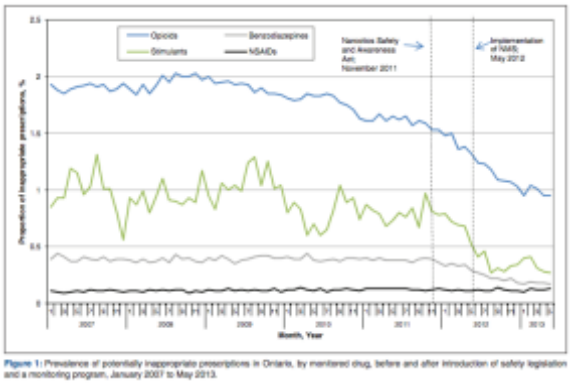

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