CPSBC | College of Physicians and Surgeons of British Columbia

Practice Standard

Safe Prescribing of Opioids and Sedatives

Effective:	June 1, 2016
Last revised:	May 6, 2022
Version:	4.7
Next review:	January 2025
Related topic(s):	Access to Medical Care Without Discrimination; Prescribing Methadone

A **practice standard** reflects the minimum standard of professional behaviour and ethical conduct on a specific topic or issue expected by the College of its registrants (all physicians and surgeons who practise medicine in British Columbia). Standards also reflect relevant legal requirements and are enforceable under the *Health Professions Act*, RSBC 1996, c.183 (*HPA*) and College Bylaws under the *HPA*.

Registrants may seek guidance on these issues by contacting the College or by seeking medical legal advice from the CMPA or other entity.

PREAMBLE

This document is a practice 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 problematic prescription medication use, 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. Registrants are expected to follow the *2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain,* which is complementary to, and should be read in conjunction with, this standard.

This standard does not apply to active cancer care, palliative care, and management of substance use disorders. Registrants are expected to follow relevant clinical guidelines and established best practices in managing patients with these conditions. Nothing in this standard interferes with a registrant'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), registrants are directed to follow accepted clinical guidelines and the *Prescribing Methadone* practice standard, when initiating and implementing opioid agonist treatment (OAT). It is incumbent on all registrants 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 Professionalism* and the College standard *Access to Medical Care Without Discrimination* prohibit discrimination based on medical condition and complexity. **Registrants 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 problematic use of prescription medications.**
2. Registrants must base decisions to prescribe opioids and sedatives on a thorough understanding of their patient. This includes:
    a. Conducting and documenting a comprehensive assessment including patient history, physical examination, and relevant investigation results.
    b. Conducting a comprehensive reassessment at least every three months.

   c. Basing decisions to continue long-term treatment with opioids and sedatives on objective evidence of benefit. 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 registrant, alternative treatment strategies, and a plan for the eventual possible discontinuation of the medication.

4. Registrants 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 registrants 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.

7. For patients on LTOT, registrants must always prescribe the lowest effective dose of opioid medication.

   a. Registrants 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. Such tapers must be slow to minimize patient discomfort. Patients attempting a taper need supportive counselling and frequent follow-up.

   c. The College recognizes that these attempts may not always be successful; however, the option must not be abandoned.

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. Registrants must play an active role in controlling the amount of opioid and sedative medication in the community. Excessive prescribing exposes patients to the risk of more chronic use, and unused medication can be stolen or diverted for non-medical use.
10. Registrants 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 in unique ways. 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 develop and registrants 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 registrant must taper and discontinue one of them after making all efforts to involve the patient in this decision and providing a thorough explanation.
    b. If prescribing opioids or sedatives, registrants must document their advice to patients that they must avoid other central nervous system and respiratory depressants including alcohol, cannabis, and some over-the-counter medications.
    c. Registrants must exercise caution in prescribing opioid and sedative medications with muscle relaxants, sedating antidepressants, anticonvulsants, antipsychotics and other sedating medications.

If patients with complex care needs are receiving multiple sedating medications, the registrant 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.