of the Centre for Medicine, Ethics and Law at McGill University and author of *Death Talk: The case against euthanasia and physician-assisted suicide*, writes in an email to *CMAJ*.

Alex Schadenberg, executive director of the Euthanasia Prevention Coalition, likewise argues that the rationale offered to support the Quebec College of Physicians' proposal is lacking. Providing comfort has nothing to do with intentionally ending a life, he says, and physicians are not charged for improper use of opioids if a patient dies as a result of accepted pain-relief practices.

"If we were to go down the route they are talking about, it would create more confusion," says Schadenberg, who believes, if the College's proposal became law, doctors would be under more scrutiny when patients on pain medication die. "Why did they use that high amount? Did they use it to kill the pain or kill the patient?"

Also expected to drive the euthanasia agenda this fall is Bill C-384, a private member's bill introduced by Francine Lalonde, that seeks amendments to the Criminal Code to permit the "right to die with dignity." The bill survived first reading and is expected to be debated in the House of Commons unless Parliament is dissolved as a result of a nonconfidence vote in the minority government.

The bill states that medical practitioners would not be considered to be committing homicide when they assist in the deaths of people who are at least 18 years old, have severe "physical or mental pain without prospect of relief" and have "provided a medical practitioner, while appearing to be lucid, with two written requests more than 10 days apart expressly stating the person's free and informed consent to opt to die."

Schadenberg forecasts that, as with two previous attempts to legalize euthanasia, the bill will fail, in part because its language is too broad. He also takes particular issue with the phrase "appearing to be lucid." That is quite different, he says, from actually being lucid, which in itself can be difficult to assess. — Roger Collier, *CMAJ*

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Regulatory colleges to set painkiller guidelines

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Faced with staggering increases in opioid prescribing, rising rates of addiction and criminal activity, as well as an apparent vacuum in national leadership, provincial colleges of physicians and surgeons are banding together to craft opioid use guidelines.

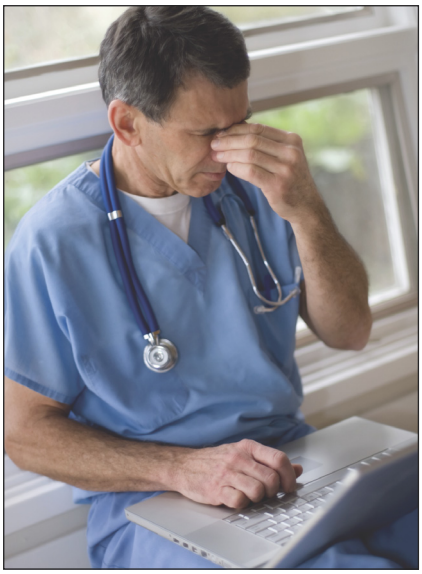
Draft guidelines have been circulated to a national advisory group of experts in a bid to achieve consensus and are expected to be finalized in October as part of the provincial colleges' unprecedented move to create national clinical practice guidelines.

Canadian doctors prescribe almost twice as many of the powerful and addictive painkillers as they did a decade ago, making Canadians among the world's top consumers of prescription opioids.

While that likely means better pain control for select groups — such as cancer and palliative care patients — the colleges are concerned that physicians are inappropriately prescribing opioids for all manner of ailments. Others suggest that the colleges also hope to obviate rising concern about physician liability.

Janet Wright, assistant registrar of the Colleges of Physicians and Surgeons of Alberta, says the regulatory colleges decided to step in because no one had created national guidelines. "It is really unusual for regulatory bodies to produce guidelines and we had lots of discussion about whether we should. … But there was a void."

Wright adds that the colleges also felt compelled to act because doctors have identified opioid prescribing as a "tough practice area." A survey conducted by the College of Physicians and Surgeons of Ontario found that family physicians ranked chronic pain management second only to mental health as a challenging area of clinical practice.



Surveys indicate that one of the most puzzling challenges that doctors face is appropriate use of opioids for chronic pain management.

In British Columbia, "we found out that most doctors don't really know the rules of the road when prescribing for someone with chronic noncancer pain," says Dr. Robert Vroom, deputy registrar for the College of Physicians and Surgeons of BC. "Why should we be punishing our doctors for something they don't know? This is one of those big gaps in their education and we thought we should do something to help doctors rather than beat them up."

The draft clinical practical guidelines now being circulated were created by an academic group at the Institute for Work and Health in Toronto, Ontario, that had earlier developed a chapter on opioids for the Ontario college's guidelines on chronic noncancer pain, says Dr. Andrea Furlan, evidence-based practice coordinator for the Institute. It's expected the guidelines will eventually be maintained, and regularly updated, by the new Michael G. DeGroote National Pain Centre being established at McMaster University in Hamilton, Ontario.

Wright says the colleges jointly funded the National Opioid Use Guide-

line Group to oversee the initiative and stresses that the guidelines are being developed independently. No pharmaceutical company or other external funding was accepted in development of the guidelines. "We have been extremely scrupulous and it is very important for us to have scientifically rigorous and well-supported guidelines."

The colleges plan to link up with a number of partners to disseminate the guidelines, Wright adds. "We want to roll these out in a useful way and measure if they improve practice."

For example, when doctors start someone on opioids, there might be a treatment contract or a screening process to see if the patient is at risk of addiction. Alberta may also conduct academic detailing on the guidelines.

Ultimately, it's hoped the new clinical practice guidelines will help to resolve what has become the altogether problematic issue of opioid prescribing, which Wright says ranges from good clinical care to "almost criminality."

In the past, too many dying people lacked good pain management because many doctors, nurses, patients and families had a fear of opioids, she says. "So you want to make sure people get really good pain control, but at the other end is the abuse problem."

Fischer says that increases in prescribing — and problems with drug abuse — are in large part driven by prescribing for the "bottom of the severity spectrum" of pain. "We dish out [opioids] far too readily for trivial problems."

That has resulted in a phenomenal increase in consumption. Per capita, Canadians rank third in the world in the use of prescription opioids — just behind the United States and Germany, says Benedikt Fischer, a criminologist with the Centre for Applied Research in Addictions and Mental Health at Simon Fraser University in Burnaby, BC.

Moreover, the gap between Canadian consumption and the rest of the developed world amounts to "light years," says Fischer, lead author of a study that indicated prescribed opioids are now the predominant form of illicit opioid use in Canada. (*CMAJ* 2006; 175[11]:1385-7). "The fact is we live in a society where the medical system generously dishes out potent and potentially addictive substances at a rate seven times the rate in the United Kingdom and something like 30 times the rate in Japan."

Canadian per capita retail spending on opioid drugs (adjusted for inflation) more than doubled between 1998 and 2007, according to the *Canadian Rx Altas,* 2nd Edition. There's been a lock-step increase in addiction problems among the general population, including street users (*Can J Public Health* 2009; 100[2]:104-8) .

So endemic has opioid use become that the International Narcotics Control Board stated in its 2008 report that abuse of prescription drugs has replaced heroin abuse as a key concern in Canada, particularly the use of oxycodone (OxyContin), which is twice as addictive as morphine. According to the board, and United Nations data, Canadian consumption of oxycodone increased to about 110 mg per capita in 2006 from less than 10 mg per capita 10 years earlier.

Many claim there's been a parallel increase in addiction and criminal activity. For example, in a seven-week period, five pharmacies in Sudbury, Ontario, were robbed — two of them at gunpoint — by individuals looking for supplies of OxyContin, says James Desault, a pharmacist who was on Sudbury's former OxyContin/Narcotic Abuse Task Force. There is "substantial" money to be made by selling pills on the street and "something needs to be done before someone gets killed."

But Fischer warns it would be unwise to focus on a single drug. "I always strongly urge people not to reduce this to an oxycodone problem because there is usually a sequence of development — people might start off becoming addicted to codeine and when that is not enough any more, they escalate."

He also says that resolving the problem will require more collaboration between pain management and addiction experts. "These people operate in different universes and there needs to be a lot of cross conversation that is not really happening."

An attempt to bridge those two solitudes was made in 2006 when Health Canada convened a national workshop on preventing problematic use of psychotropic pharmaceuticals. It eventually recommended that an independent organization, similar to ones in France and the US, be established to monitor abuse, but nothing has come of that.

Getting a handle on the actual dimension of the problem is made even more problematic by the lack of accurate information. "We don't have much data and we are sort of puzzle-building at the moment," says Fischer, who is part of a team that received a Canadian Institutes of Health Research grant to study nonmedical use of opioids in the general and street populations.

Questions about prescription drug use and abuse were added to Health Canada's annual Canadian Alcohol and Drug Use Monitoring Survey for the first time in 2008. More than 20% of the Canadians surveyed reported having used opioid pain relievers — such as oxycodone and aspirin (Percodan), meperidine (Demerol® Hydrochloride) and oxycodone — in the prior 12 months. Of those, 1.5% reported using the drugs to get high. Among those aged 15–24, that rose to 4.9%. — Ann Silversides, *CMAJ*

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