



**THE MANAGEMENT OF
PAIN IN DENTAL PRACTICE**
NOVEMBER 17, 2010

**SYMPOSIUM ON
THE MANAGEMENT OF PAIN
IN DENTAL PRACTICE**

**November 17, 2010
Toronto, Ontario**

**FINAL REPORT
April 2011**



**Royal College of
Dental Surgeons of Ontario**

Ensuring Continued Trust

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INTRODUCTION

Guelph Police announced Monday they put “a substantial dent” in the local illegal prescription drug trade. Police said Project Script led to 22 arrests and 61 charges. Nearly 800 tablets, including 548 Oxycodone tablets, were taken off the street during the coordinated raid that occurred Oct. 27. “There’s an obvious, if not substantial, dent right now in the drug trade,” Guelph Police spokesperson Sergeant Doug Pflug said. Police also seized more than half a kilo of marijuana and about 30 g of cocaine. All told, the drugs seized had an approximate street value of \$31,405.

Police said the investigation and arrests came as a result of the increase in related calls for service surrounding the misuse, abuse and diversion of prescription medication. “We’ve targeted and taken street level dealers off the street,” Pflug said. “It’s good in the sense we addressed just who is supplying addicts and youth.”

Oxycodone is a powerful painkiller sometimes referred to as ‘hillbilly heroin.’ It provides a relatively cheap high for addicts and is subject to abuse by teens and young adults. “There’s been a dramatic rise in the abuse and trade of prescription drugs over the years,” Pflug said. It’s definitely become a trend.” Those arrested in the bust ranged in age, from 20 to 67, and location, including Guelph, Hamilton, Erin and Alma.

Guelph Mercury, November 22, 2010

On Wednesday March 4, 2009 officers from the Orangeville Police Service arrested and charged two males involved in the sale of illicit drugs in front of Orangeville District Secondary School.

At approximately 10:30 a.m police officers were at the school for an unrelated matter when they received information that two males were possibly attempting to sell prescription drugs to students outside of the school. Tyler David Harron, 20, of

Orangeville and a 17-year-old male were arrested and taken into custody by police. The identity of the 17 year old is protected by the Youth Criminal Justice Act. Both males were in possession of a large quantity of prescription drugs and cash.

Further investigation revealed that the drugs had been stolen as the result of a break and enter to an Oxford Street residence early Tuesday morning. Among the items seized by police were several syringes and large quantities of Morphine, Dimenhydrinate, Ativan, Cyclobenzaprine and over \$1000 in cash.

The two accused males were not students of the school.

Orangeville Police Service media release, March 5, 2010

A Toronto man travelling to Sarnia for drug deals has been sentenced to a year of house arrest. Joseph Cachia, 63, pleaded guilty in Sarnia's Superior Court to possession of oxycodone for trafficking on Dec. 19, 2008 in Sarnia.

Sarnia police had been tipped Cachia, who drove a Lincoln Aviator sports utility vehicle, was coming to Sarnia every week to sell oxycodone. He was seen making short stops at homes and a local hotel. His vehicle was stopped as it came into Sarnia during a snowstorm Dec. 19.

A search found 163 oxycodone pills, a debt list, \$910 and one Viagra tablet. Six prescription bottles were found including two found hidden in a flashlight's battery compartment. He was entitled to have oxycodone but the number of pills exceeded his prescriptions. He had developed an addiction due to multiple fractures after he was hit by a drunk driver. That led to the drug crime which ruined his life, the court was told.

Sarnia Observer, December 3, 2010

The excessive use of prescription narcotics and controlled substances has emerged as a public health and safety issue here in Canada, in the United States and other jurisdictions around the world. Drug abuse has truly become a global problem, impacting societies in ways that have not been seen before.

Canada is one of the world's top per capita users of prescription narcotics. In Canada, Ontario is at the top of the list of narcotic use per capita.¹

Many indicators paint a fairly grim picture of the impact of this on the health and safety of Ontarians:

- Since 2000, the Coroner's Office has reported a fivefold increase in oxycodone-related deaths and a 41 per cent increase in overall narcotic-related mortality in Ontario following the addition of long-acting oxycodone to the Ontario Drug Benefit (ODB) Formulary.²
- There is also a significant trend indicating that patients are taking higher doses of narcotics, some with no medical reason, and that more people are obtaining excessive quantities of narcotics leading to abuse, misuse and the diversion of these products for sale on the street. Between 1991 and 2009, the number of prescriptions in Ontario for oxycodone drugs rose by 900 per cent, far more rapidly than any other narcotic within the ODB Program.³
- Prescription narcotics have also become a highly lucrative street commodity resulting in widespread diversion and trafficking by both individuals and organized crime groups. Between 2005 and 2008, prescription drug arrests and charges in Ontario increased by 99 per cent and 197 per cent respectively. There has also been a significant increase in pharmacy robberies and thefts for prescription narcotics,

¹ Haydon et al, Prescription Drug Abuse in Canada and the Diversion of Prescription Drugs into the Illicit Drug Market. Canadian Journal of Public Health, December 2005

² Dhalla, I et al, Prescribing of opioid analgesics and related mortality before and after the introduction of long acting oxycodone, CMAJ, December 7, 2009; 121 (8); Office of Chief Coroner of Ontario 2009

³ Dhalla, I et al, Prescribing of opioid analgesics and related mortality before and after the introduction of long acting oxycodone, CMAJ, December 7, 2009; 121 (8); Office of Chief Coroner of Ontario 2009

and a corresponding increase in risk to the health of Ontarians and the safety of pharmacists across the province.

- The Ministry of Health and Long-Term Care spent \$156 million on narcotics for Ontario Drug Benefit Program recipients in 2009-2010 for 3.9 million prescriptions. This equates to an average of over six prescriptions per person and an annual cost of \$260 per person.
- Narcotics abuse-related admissions to publicly funded treatment and addiction services in Ontario doubled from 2004-2008.

There are also increasing narcotic-related crime and health risks from abuse of narcotics and other controlled substances. According to the provincial government, in Toronto prescription drug arrests doubled between 2005 and 2008, while prescription drug charges rose by almost 200 per cent.

Research from the Centre for Addiction and Mental Health (CAMH) in Toronto in 2009 showed a dramatic increase in the number of people seeking detoxification treatment for opioid dependence. The cause of this increase is the use of prescription pain medication, not heroin.

The study published in the January 2009 Canadian Family Physician found that over a five-year period, of the people coming to the Medical Withdrawal Service of CAMH for the treatment of opioid dependence, those having a problem with OxyContin® increased steadily from fewer than 4 per cent to 55 per cent.⁴

The most recent research has also shown that patients are receiving strong pain medications such as morphine and OxyContin® at doses higher than recommended. The study, published on January 25, 2011 in the journal Open Medicine, looked at prescriptions for patients aged 15 to 64 that were paid for by Ontario's public drug plan.⁵

During the 2003 to 2008 study period, doctors in the province often prescribed opioids on a long-term basis. In one in three cases, the doses for non-cancer patients were higher than recommended by Canadian clinical guidelines.

⁴ Canadian Family Physician, January 2009

⁵ Gomes T et al, Trends in opioid use and dosing among socio-economically disadvantaged patients, Open Medicine, January 25, 2011; 5 (1): 13-22

Among patients prescribed high or very high doses of opioids in 2004, 19 per cent of deaths during the next two years were related to the medications. The number of people dying was 10 times higher than in the general population within two years. The deaths occurred at an average age of 46.

As the study's lead author, Tara Gomes, an epidemiologist at the Institute for Clinical Evaluative Sciences in Toronto, said in a CBC News interview on the day of the report's release: "In some cases, doctors don't properly understand the risks of the drugs that they're prescribing. A bigger concern is patients who shop around looking for multiple prescriptions."

RECENT PROVINCIAL POLICY DEVELOPMENTS

In May 2010, the Ministry of Health and Long-Term Care developed a strategy to improve Ontario's ability to identify and reduce abuse, addiction and diversion of narcotics and other controlled substances while ensuring their appropriate use for legitimate medical purposes.

The aims of the narcotics strategy include a commitment to:

1. Provide access to narcotics and other monitored drugs when they are medically appropriate to treat pain.
2. Reduce the abuse and misuse of narcotics and other monitored drugs, including reducing the diversion of narcotics and other monitored drugs from medically appropriate use.
3. Support treatment for and reduce narcotic-related addictions and reduce narcotics-related deaths.

Then, on November 29, 2010, Bill 101 – An Act to provide for monitoring the prescribing and dispensing of certain controlled substances, received Royal Assent. The act is commonly known as the Narcotics Safety and Awareness Act.

Ontario has launched a strategy to address abuse of prescription narcotics and other controlled substances, and to ensure their safe and appropriate use by those who require pain management medication.

There are five key elements to this strategy:

1. Narcotics tracking system

- The new legislation enables the province to collect and analyze information on all prescription narcotics and other controlled substances dispensed in Ontario.
- This database will allow for monitoring and analysis of this information for the purpose of flagging problematic patterns in use, prescribing and dispensing.
- In instances of inappropriate or excessive prescribing or dispensing, responses could include educational support and resources, reporting to the appropriate regulatory college and in extreme circumstances, law enforcement.

2. Partnering with the health care sector to educate on appropriate prescribing

- Working with the medical regulatory colleges to develop educational and training initiatives on pain management and appropriate prescribing practices.
- Supporting awareness of the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain, recently released by the National Opioid Use Guideline Group.
- Providing awareness of resources currently available, such as the Centre for Addiction and Mental Health's Addiction Clinical Consultation Service (ACCS), which provides health professionals with advice and support related to the management of addiction problems, drug interactions and related counselling.

3. Partnering with the health care sector to educate on appropriate dispensing

- Working with the pharmacy regulatory colleges to develop educational and training initiatives on appropriate dispensing practices.
- Continuing regular inspections of pharmacies that dispense a high rate of narcotics.
- Supporting a program for the safe disposal of pain medications to ensure their proper disposal and to reduce the diversion of narcotics to inappropriate uses.

4. Educate to prevent excessive use of prescription narcotics

- Providing more education to patients who require pain management medication about the safe and appropriate use of prescription narcotics and other controlled substances.
- Raising awareness of the risks associated with the use of prescription narcotics and other controlled substances when not prescribed by a doctor -- especially among young people.

5. Addiction Treatment

- Focus on treating patients with addiction.
- Investigate additional options for treating and supporting those addicted to prescription narcotics and controlled substances.
- Develop educational workshops on the treatment of narcotics dependence.

Implications for Prescribers

Under the legislation, key requirements include requiring prescribers to record specified information on prescriptions for monitored drugs and ensure that any identification requirements set out in the regulations are met prior to dispensing a drug.

Plus the Act allows for the appointment of inspectors who may, without a warrant or notice, enter the place of practice of a prescriber and conduct inspections to determine their compliance with the Act.

Penalty for an individual found guilty of an offence under the Act is a fine of up to \$50,000 or imprisonment for a term of not more than 12 months, or both. A corporation found guilty of an offence under the Act is liable on conviction to a fine of up to \$200,000.

Tab A



2ND SESSION, 39TH LEGISLATURE, ONTARIO
59 ELIZABETH II, 2010

2^e SESSION, 39^e LÉGISLATURE, ONTARIO
59 ELIZABETH II, 2010

Bill 101

*(Chapter 22
Statutes of Ontario, 2010)*

**An Act to provide for
monitoring the prescribing
and dispensing of
certain controlled substances**

The Hon. D. Matthews
Minister of Health and Long-Term Care

1st Reading	September 15, 2010
2nd Reading	October 5, 2010
3rd Reading	November 29, 2010
Royal Assent	November 29, 2010

Projet de loi 101

*(Chapitre 22
Lois de l'Ontario de 2010)*

**Loi prévoyant
la surveillance des activités liées
à la prescription et à la préparation
de certaines substances désignées**

L'honorable D. Matthews
Ministre de la Santé et des Soins de longue durée

1 ^{re} lecture	15 septembre 2010
2 ^e lecture	5 octobre 2010
3 ^e lecture	29 novembre 2010
Sanction royale	29 novembre 2010



EXPLANATORY NOTE

This Explanatory Note was written as a reader's aid to Bill 101 and does not form part of the law. Bill 101 has been enacted as Chapter 22 of the Statutes of Ontario, 2010.

The Bill enacts the *Narcotics Safety and Awareness Act, 2010*.

The Act seeks to improve the health and safety of Ontarians by permitting the monitoring, analyzing and reporting of information, including personal information, related to the prescribing and dispensing of monitored drugs in order to:

1. Contribute to and promote appropriate prescribing and dispensing practices for monitored drugs in order to support access to monitored drugs for medically appropriate treatment, including treatment for pain and addiction.
2. Identify and reduce the abuse, misuse and diversion of monitored drugs.
3. Reduce the risk of addiction and death resulting from the abuse or misuse of monitored drugs.

A monitored drug is a controlled substance as defined in the *Controlled Drugs and Substances Act* (Canada), unless the controlled substance has been excluded by the regulations under the *Narcotics Safety and Awareness Act, 2010*. Additional drugs may be specified as monitored drugs by the regulations.

Subject to any conditions provided for in the regulations, the Minister and the executive officer, who is also the executive officer under the *Ontario Drug Benefit Act*, may collect, directly or indirectly, and use personal information for the purpose of the Act.

The Minister and the executive officer may disclose personal information if the disclosure is permitted by the Act, the *Freedom of Information and Protection of Privacy Act*, or by the *Personal Health Information Protection Act, 2004*. Specifically, if the conditions set out under the Act are met, the Minister and the executive officer may disclose personal information to prescribers, dispensers and operators of pharmacies. The Minister must ensure that a notice regarding the Minister's and the executive officer's collection, use and disclosure of personal information under the Act is made available to prescribers, dispensers, operators of pharmacies and the public.

The Act requires prescribers to record specified information on prescriptions for monitored drugs. Dispensers are required to keep a record of specified information with respect to prescriptions for monitored drugs and to ensure that any identity verification requirements set out in the regulations are met prior to dispensing a monitored drug. If directed by the Minister or the executive officer, prescribers, dispensers and operators of pharmacies are required to disclose certain information, including personal information, to the Minister or the executive officer for the purpose of the Act.

The Act authorizes the Minister to appoint inspectors. The inspectors may conduct inspections, examine and make copies of relevant documents or other things, and question persons about

NOTE EXPLICATIVE

La note explicative, rédigée à titre de service aux lecteurs du projet de loi 101, ne fait pas partie de la loi. Le projet de loi 101 a été édicté et constitue maintenant le chapitre 22 des Lois de l'Ontario de 2010.

Le projet de loi édicte la *Loi de 2010 sur la sécurité et la sensibilisation en matière de stupéfiants*.

La Loi vise à améliorer la santé et la sécurité des Ontariens et Ontariennes en permettant la surveillance, l'analyse et la communication de renseignements, notamment de renseignements personnels, relatifs à la prescription et à la préparation de médicaments contrôlés aux fins suivantes :

1. Contribuer à l'adoption de pratiques appropriées en ce qui a trait à la prescription et à la préparation de médicaments contrôlés et en faire la promotion pour favoriser l'accès à des médicaments contrôlés à des fins de traitement médical approprié, y compris le traitement de la douleur et de la dépendance.
2. Déceler et réduire l'abus qui se fait des médicaments contrôlés, leur mauvaise utilisation et leur détournement.
3. Réduire le risque de dépendance et de décès résultant de l'abus qui se fait des médicaments contrôlés ou de leur mauvaise utilisation.

Un médicament contrôlé est une substance désignée au sens de la *Loi réglementant certaines drogues et autres substances* (Canada), sauf si des règlements pris en vertu de la *Loi de 2010 sur la sécurité et la sensibilisation en matière de stupéfiants* l'excluent. Les règlements peuvent préciser d'autres médicaments à titre de médicaments contrôlés.

Sous réserve des conditions prévues dans les règlements, le ministre et l'administrateur, qui est également l'administrateur visé par la *Loi sur le régime de médicaments de l'Ontario*, peuvent recueillir, directement ou indirectement, et utiliser des renseignements personnels pour l'application de la Loi.

Le ministre et l'administrateur peuvent divulguer des renseignements personnels si la divulgation est autorisée par la Loi, la *Loi sur l'accès à l'information et la protection de la vie privée* ou la *Loi de 2004 sur la protection des renseignements personnels sur la santé*. En particulier, si les conditions énoncées dans la Loi sont respectées, ils peuvent en divulguer aux personnes autorisées à prescrire des médicaments, aux préposés à la préparation et aux exploitants d'une pharmacie. Le ministre doit veiller à ce qu'un avis soit mis à la disposition des personnes autorisées à prescrire des médicaments, des préposés à la préparation, des exploitants d'une pharmacie et du public relativement à la collecte, à l'utilisation et à la divulgation de renseignements personnels par le ministre et l'administrateur en vertu de la Loi.

La Loi exige des personnes autorisées à prescrire des médicaments qu'elles consignent des renseignements précis sur les ordonnances pour des médicaments contrôlés. Les préposés à la préparation sont tenus de garder un dossier de renseignements précis en ce qui concerne les ordonnances pour des médicaments contrôlés et de s'assurer que les exigences liées à la vérification de l'identité prévues dans les règlements sont respectées avant de préparer un médicament contrôlé. Si le ministre ou l'administrateur l'ordonne, les personnes autorisées à prescrire des médicaments, les préposés à la préparation et les exploitants d'une pharmacie sont tenus de lui divulguer certains renseignements, y compris des renseignements personnels, pour l'application de la Loi.

La Loi autorise le ministre à nommer des inspecteurs, lesquels peuvent mener des inspections, examiner des documents pertinents ou toute autre chose et en faire des copies et interroger des

matters relevant to the inspection. It is an offence to obstruct or interfere with an inspector conducting an inspection or to provide false or misleading information.

The Act provides that certain contraventions of the Act are offences and establishes penalties to which persons are subject on conviction.

The Act provides for legal immunity for the Minister, the executive officer, or any person employed or retained by the Crown, as well as for prescribers, dispensers and operators of pharmacies concerning any act done in good faith in the performance or intended performance of a power, duty or function, or for any alleged neglect or default in the execution in good faith of the person's power, duty or function under the Act. The Act also provides for a consultation process before making certain regulations.

personnes sur des questions se rapportant à l'inspection. Constitue une infraction le fait de gêner ou d'entraver le travail d'un inspecteur qui mène une inspection ou de lui fournir des renseignements faux ou trompeurs.

La Loi prévoit que certaines contraventions à la Loi constituent des infractions et établit des peines dont des personnes sont passibles sur déclaration de culpabilité.

La Loi prévoit une immunité juridique pour le ministre, l'administrateur ou toute personne employée par la Couronne ou dont cette dernière retient les services, ainsi que pour les personnes autorisées à prescrire des médicaments, les préposés à la préparation et les exploitants d'une pharmacie, pour un acte accompli de bonne foi dans l'exercice effectif ou censé tel des pouvoirs ou des fonctions que leur attribue la Loi ou pour toute négligence ou tout manquement qu'ils auraient commis dans l'exercice de bonne foi de tels pouvoirs ou fonctions. La Loi prévoit aussi la tenue de consultations préalablement à la prise de certains règlements.

**An Act to provide for
monitoring the prescribing
and dispensing of
certain controlled substances**

**Loi prévoyant
la surveillance des activités liées
à la prescription et à la préparation
de certaines substances désignées**

Preamble

The health and safety of Ontarians is important to the people of Ontario and their government. Ontario has the highest per capita use of narcotics and other controlled substances in Canada, some of which is unwarranted and is adversely affecting the health and safety of Ontarians. Ontario has seen a significant increase in narcotics-related deaths and in the need for addiction treatment services. Public and private spending on narcotics and other controlled substances has increased out of proportion to that which is medically required.

In May 2010, the Government of Ontario developed a strategy to address the health and safety concerns related to the use of narcotics and other controlled substances, including a commitment to:

1. Provide for access to narcotics and other monitored drugs when they are medically appropriate to treat pain.
2. Reduce the abuse and misuse of narcotics and other monitored drugs, including reducing the diversion of narcotics and other monitored drugs from medically appropriate use.
3. Support treatment for and reduce narcotics-related addictions and reduce narcotics-related deaths.

Monitoring the prescribing and dispensing of narcotics and other monitored drugs is a key tool in the government's strategy. The ability to collect, analyze and report on the prescribing and dispensing of narcotics and other monitored drugs will contribute to appropriate prescribing and dispensing practices and help identify and address systemic challenges that may lead to addiction and death.

Therefore, Her Majesty, by and with the advice and consent of the Legislative Assembly of the Province of Ontario, enacts as follows:

Préambule

La population ontarienne et le gouvernement de la province accordent de l'importance à la santé et à la sécurité des Ontariens et Ontariennes. L'Ontario est l'endroit au Canada où le taux d'emploi de stupéfiants et d'autres substances désignées par habitant est le plus élevé. Cet emploi n'est pas toujours justifié et a des répercussions néfastes sur la santé et la sécurité de la population. Le taux de décès liés à l'emploi de stupéfiants de même que le besoin de services de traitement de la toxicomanie ont considérablement augmenté en Ontario. Les dépenses publiques et privées affectées aux stupéfiants et à d'autres substances désignées ont connu une croissance démesurée par rapport aux exigences médicales.

En mai 2010, le gouvernement de l'Ontario a élaboré une stratégie pour répondre aux préoccupations relatives à la santé et à la sécurité liées à l'emploi de stupéfiants et d'autres substances désignées, et a pris notamment les engagements suivants :

1. Prévoir l'accès aux stupéfiants et à d'autres médicaments contrôlés lorsque ceux-ci sont appropriés sur le plan médical pour traiter la douleur.
2. Réduire l'abus qui se fait des stupéfiants et d'autres médicaments contrôlés et leur mauvaise utilisation, y compris réduire le détournement de stupéfiants et d'autres médicaments contrôlés de leur emploi approprié sur le plan médical.
3. Appuyer le traitement des dépendances liées aux stupéfiants, réduire ce genre de dépendance et abaisser le taux de décès liés à l'emploi de stupéfiants.

La surveillance des activités liées à la prescription et à la préparation de stupéfiants et d'autres médicaments contrôlés est un outil clé de la stratégie du gouvernement. La capacité à recueillir et à analyser des données relativement à la prescription et à la préparation de stupéfiants et d'autres médicaments contrôlés et à faire rapport à ce sujet contribuera à l'adoption de pratiques appropriées en ce qui a trait à la prescription et à la préparation et permettra de reconnaître et de relever les défis systémiques pouvant mener à la dépendance et à la mort.

Pour ces motifs, Sa Majesté, sur l'avis et avec le consentement de l'Assemblée législative de la province de l'Ontario, édicte :

Purpose

1. The purpose of this Act is to seek to improve the health and safety of Ontarians by permitting the monitoring, analyzing and reporting of information, including personal information, related to the prescribing and dispensing of monitored drugs, in order to,

- (a) contribute to and promote appropriate prescribing and dispensing practices for monitored drugs in order to support access to monitored drugs for medically appropriate treatment, including treatment for pain and addiction;
- (b) identify and reduce the abuse, misuse and diversion of monitored drugs; and
- (c) reduce the risk of addiction and death resulting from the abuse or misuse of monitored drugs.

Definitions

2. In this Act,

“dispenser” means a person authorized, under a health profession Act as defined in the *Regulated Health Professions Act, 1991*, to dispense drugs; (“préposé à la préparation”)

“Minister” means the Minister of Health and Long-Term Care; (“ministre”)

“monitored drug” means,

- (a) a controlled substance as defined in the *Controlled Drugs and Substances Act* (Canada), unless the controlled substance has been excluded by the regulations under this Act, and
- (b) any other drug designated by the regulations; (“médicament contrôlé”)

“operator of a pharmacy” means,

- (a) the holder of a certificate of accreditation for the operation of a pharmacy under section 139 of the *Drug and Pharmacies Regulation Act*, or
- (b) the operator of a pharmacy operated in or by a hospital to which the *Public Hospitals Act* applies; (“exploitant d’une pharmacie”)

“personal information” means personal information as defined in the *Freedom of Information and Protection of Privacy Act* and includes personal health information as defined in the *Personal Health Information Protection Act, 2004*; (“renseignements personnels”)

“prescriber” means a person authorized under a health profession Act, as defined in the *Regulated Health Professions Act, 1991*, to prescribe drugs; (“personne autorisée à prescrire des médicaments”)

“prescription” means a direction from a prescriber directing the dispensing of a monitored drug for a person. (“ordonnance”)

Objet

1. L’objet de la présente loi est de viser à améliorer la santé et la sécurité des Ontariens et Ontariennes en permettant la surveillance, l’analyse et la communication de renseignements, notamment de renseignements personnels, relatifs à la prescription et à la préparation de médicaments contrôlés aux fins suivantes :

- a) contribuer à l’adoption de pratiques appropriées en ce qui a trait à la prescription et à la préparation de médicaments contrôlés et en faire la promotion pour favoriser l’accès à des médicaments contrôlés à des fins de traitement médical approprié, y compris le traitement de la douleur et de la dépendance;
- b) identifier et réduire l’abus qui se fait des médicaments contrôlés, leur mauvaise utilisation et leur détournement;
- c) réduire le risque de dépendance et de décès résultant de l’abus qui se fait des médicaments contrôlés ou de leur mauvaise utilisation.

Définitions

2. Les définitions qui suivent s’appliquent à la présente loi.

«exploitant d’une pharmacie» S’entend :

- a) soit du titulaire d’un certificat d’agrément pour l’exploitation d’une pharmacie visé à l’article 139 de la *Loi sur la réglementation des médicaments et des pharmacies*;
- b) soit de l’exploitant d’une pharmacie exploitée au sein d’un hôpital auquel s’applique la *Loi sur les hôpitaux publics* ou par un tel hôpital. («operator of a pharmacy»)

«médicament contrôlé» S’entend de ce qui suit :

- a) une substance désignée au sens de la *Loi réglementant certaines drogues et autres substances* (Canada), sauf si les règlements pris en vertu de la présente loi l’excluent;
- b) tout autre médicament désigné par les règlements. («monitored drug»)

«ministre» Le ministre de la Santé et des Soins de longue durée. («Minister»)

«ordonnance» Directive d’une personne autorisée à prescrire des médicaments qui ordonne la préparation d’un médicament contrôlé pour une personne. («prescription»)

«personne autorisée à prescrire des médicaments» Quiconque est autorisé en vertu d’une loi sur une profession de la santé, au sens de la *Loi de 1991 sur les professions de la santé réglementées*, à prescrire des médicaments. («prescriber»)

«préposé à la préparation» Quiconque est autorisé, en vertu d’une loi sur une profession de la santé au sens de la *Loi de 1991 sur les professions de la santé réglementées*, à préparer des médicaments. («dispenser»)

Application

3. This Act does not apply to any person provided for in the regulations.

POWERS AND FUNCTIONS OF THE EXECUTIVE OFFICER**Executive officer**

4. (1) The executive officer under the *Ontario Drug Benefit Act* is the executive officer for the purpose of this Act.

Powers and functions of executive officer

(2) The executive officer may exercise the following powers and perform the following functions under this Act:

1. Monitoring and analyzing information, including personal information, related to the prescribing and dispensing of monitored drugs.
2. Collecting, using and disclosing information collected under this Act in accordance with this Act, and co-operating with other organizations, including colleges under the *Regulated Health Professions Act, 1991*, to achieve the purposes of this Act.
3. Recommending drugs to be included in or excluded from the definition of “monitored drug”.
4. Reporting to the public on any matter related to this Act as the executive officer considers appropriate.
5. Exercising any other power or performing any other function provided for in this Act or the regulations.

**COLLECTION, USE AND DISCLOSURE
OF PERSONAL INFORMATION****Collection by Minister or executive officer**

5. (1) The Minister or the executive officer may directly or indirectly collect personal information, subject to any conditions provided for in the regulations, for the purpose of this Act.

Use by Minister or executive officer

(2) The Minister or the executive officer may use personal information, subject to any conditions provided for in the regulations, for the purpose of this Act.

Disclosure by Minister or executive officer

(3) The Minister or the executive officer may disclose personal information, subject to any conditions provided for in the regulations, if the disclosure is permitted by this Act.

«renseignements personnels» S’entend au sens de la *Loi sur l'accès à l'information et la protection de la vie privée*. S’entend en outre de renseignements personnels sur la santé au sens de la *Loi de 2004 sur la protection des renseignements personnels sur la santé*. («personal information»)

Non-application

3. La présente loi ne s’applique pas aux personnes prévues dans les règlements.

POUVOIRS ET FONCTIONS DE L’ADMINISTRATEUR**Administrateur**

4. (1) L’administrateur visé par la *Loi sur le régime de médicaments de l’Ontario* est l’administrateur pour l’application de la présente loi.

Pouvoirs et fonctions de l’administrateur

(2) L’administrateur peut exercer les fonctions et les pouvoirs suivants que lui attribue la présente loi :

1. Surveiller et analyser des renseignements, notamment des renseignements personnels, relatifs à la prescription et à la préparation de médicaments contrôlés.
2. Recueillir, utiliser et divulguer conformément à la présente loi des renseignements recueillis en application de celle-ci et collaborer avec d’autres organismes, y compris des ordres visés par la *Loi de 1991 sur les professions de la santé réglementées*, pour atteindre les objets de la présente loi.
3. Recommander des médicaments à faire figurer dans la définition de «médicament contrôlé» ou à exclure de celle-ci.
4. Signaler au public toute question qu’il estime appropriée relativement à la présente loi.
5. Exercer les autres fonctions ou pouvoirs prévus dans la présente loi ou dans les règlements.

**COLLECTE, UTILISATION ET DIVULGATION
DE RENSEIGNEMENTS PERSONNELS****Collecte par le ministre ou l’administrateur**

5. (1) Le ministre ou l’administrateur peut, directement ou indirectement, recueillir des renseignements personnels, sous réserve des conditions prévues dans les règlements pour l’application de la présente loi.

Utilisation par le ministre ou l’administrateur

(2) Le ministre ou l’administrateur peut utiliser des renseignements personnels, sous réserve des conditions prévues dans les règlements pour l’application de la présente loi.

Divulgation par le ministre ou l’administrateur

(3) Le ministre ou l’administrateur peut divulguer des renseignements personnels, sous réserve des conditions prévues dans les règlements, si la divulgation est autorisée par la présente loi.

Same

(4) The Minister or the executive officer may disclose personal information if the disclosure is permitted by the *Freedom of Information and Protection of Privacy Act* or the *Personal Health Information Protection Act, 2004*.

Disclosure to prescriber, dispenser or operator of a pharmacy

(5) The Minister or the executive officer may disclose personal information respecting a person who has been prescribed a monitored drug to,

- (a) a prescriber, if the prescriber has prescribed a monitored drug to the person;
- (b) a dispenser, if the dispenser is determining whether to dispense a monitored drug to the person or has dispensed a monitored drug to the person; or
- (c) an operator of a pharmacy, if a dispenser employed or retained by the pharmacy has dispensed a monitored drug to the person through the pharmacy.

Disclosure, prescriber considering prescription

(6) The Minister or the executive officer may disclose to a prescriber personal information respecting a person, if the prescriber is determining whether to prescribe a monitored drug to the person.

Notice

6. In addition to any notice requirements imposed under the *Freedom of Information and Protection of Privacy Act* or the *Personal Health Information Protection Act, 2004*, the Minister shall ensure that a notice is made available to prescribers, dispensers, operators of pharmacies and the public in respect of the Minister's or the executive officer's collection, use and disclosure of personal information under this Act.

Collection by prescriber or dispenser

7. For the purpose of complying with section 10 or 11, a prescriber or dispenser may collect the information, including personal information, required by those sections.

Disclosure by prescriber, dispenser or operator of a pharmacy

8. (1) If directed by the Minister or the executive officer, a prescriber, dispenser or operator of a pharmacy shall disclose the following information to the Minister or the executive officer for the purpose of this Act:

- 1. The information, including personal information, required under subsection 10 (1) or 11 (1).

Idem

(4) Le ministre ou l'administrateur peut divulguer des renseignements personnels si la divulgation est autorisée par la *Loi sur l'accès à l'information et la protection de la vie privée* ou la *Loi de 2004 sur la protection des renseignements personnels sur la santé*.

Divulgence à la personne autorisée à prescrire des médicaments, au préposé à la préparation ou à l'exploitant d'une pharmacie

(5) Le ministre ou l'administrateur peut divulguer des renseignements personnels concernant une personne qui s'est vu prescrire un médicament contrôlé à l'une des personnes suivantes :

- a) la personne autorisée à prescrire des médicaments, si elle a prescrit un médicament contrôlé pour la personne;
- b) le préposé à la préparation des médicaments, s'il détermine s'il y a lieu de préparer un médicament contrôlé pour la personne ou s'il a préparé un médicament contrôlé pour elle;
- c) l'exploitant d'une pharmacie, si le préposé à la préparation des médicaments qu'emploie la pharmacie ou dont celle-ci retient les services a préparé un médicament contrôlé pour la personne par l'intermédiaire de la pharmacie.

Divulgence à la personne autorisée à prescrire des médicaments

(6) Le ministre ou l'administrateur peut divulguer des renseignements personnels concernant quiconque à la personne autorisée à prescrire des médicaments pour lui permettre de déterminer s'il y a lieu de prescrire un médicament contrôlé pour lui.

Avis

6. Outre les exigences en matière d'avis imposées aux termes de la *Loi sur l'accès à l'information et la protection de la vie privée* ou de la *Loi de 2004 sur la protection des renseignements personnels sur la santé*, le ministre veille à ce qu'un avis soit mis à la disposition des personnes autorisées à prescrire des médicaments, des préposés à la préparation, des exploitants d'une pharmacie et du public relativement à la collecte, à l'utilisation et à la divulgation de renseignements personnels, en vertu de la présente loi, par le ministre ou l'administrateur.

Collecte de renseignements

7. Afin de se conformer à l'article 10 ou 11, la personne autorisée à prescrire des médicaments ou le préposé à la préparation peut recueillir les renseignements, y compris les renseignements personnels, qu'exigent ces articles.

Divulgence : personne autorisée à prescrire des médicaments, préposé à la préparation ou exploitant d'une pharmacie

8. (1) Si le ministre ou l'administrateur le lui ordonne, la personne autorisée à prescrire des médicaments, le préposé à la préparation ou l'exploitant d'une pharmacie lui divulgue les renseignements suivants pour l'application de la présente loi :

- 1. Les renseignements, y compris les renseignements personnels, qu'exige le paragraphe 10 (1) ou 11 (1).

2. Any information, including personal information, required by the regulations.

Time, form and manner of disclosure

(2) A prescriber, dispenser or operator of a pharmacy shall disclose the information in subsection (1) at the time and in the form and manner that the Minister or the executive officer directs.

Minister or executive officer may direct

(3) The Minister's or the executive officer's direction to disclose information under this section may be made by any means he or she considers appropriate.

False information, etc.

9. No person shall provide the Minister or the executive officer with information that the person knows to be false or misleading.

PRESCRIBERS AND DISPENSERS

Prescription information

10. (1) A prescriber who prescribes a monitored drug shall record the following information on the prescription:

1. The registration number on the certificate of registration issued to the prescriber by the College, as defined in the *Regulated Health Professions Act, 1991*, of which he or she is a member.
2. The name of the person for whom the monitored drug is prescribed.
3. The name, strength (where applicable) and quantity of the monitored drug.
4. The directions for use of the monitored drug.
5. The name and address of the prescriber.
6. The date on which the monitored drug is prescribed.
7. Any other information, including personal information, required by the regulations.

No limitation

(2) Nothing in this section limits or replaces the application of any other Act with respect to the information a prescriber must record on a prescription.

Dispensing information

11. (1) A dispenser who dispenses a monitored drug shall keep a record of the following information with respect to the prescription:

1. The information required under section 10.
2. The address, date of birth and gender of the person for whom the monitored drug is prescribed.

2. Les renseignements, notamment les renseignements personnels, qu'exigent les règlements.

Délai, forme et mode de divulgation

(2) La personne autorisée à prescrire des médicaments, le préposé à la préparation ou l'exploitant d'une pharmacie divulgue les renseignements prévus au paragraphe (1) dans le délai, sous la forme et de la manière que précise le ministre ou l'administrateur.

Ordre du ministre ou de l'administrateur

(3) L'ordre émanant du ministre ou de l'administrateur en vue de la divulgation de renseignements en application du présent article peut être donné par tout moyen qu'il estime approprié.

Faux renseignements

9. Nul ne doit fournir au ministre ou à l'administrateur des renseignements qu'il sait faux ou trompeurs.

**PERSONNES AUTORISÉES À PRESCRIRE
DES MÉDICAMENTS ET PRÉPOSÉS À LA PRÉPARATION**

Renseignements : prescription

10. (1) La personne autorisée à prescrire des médicaments qui prescrit un médicament contrôlé consigne les renseignements suivants sur l'ordonnance :

1. Le numéro d'inscription figurant sur le certificat d'inscription qui lui a été délivré par l'ordre, au sens de la *Loi de 1991 sur les professions de la santé réglementées*, dont elle est membre.
2. Le nom de la personne à qui est prescrit le médicament contrôlé.
3. Le nom, la concentration (s'il y a lieu) et la quantité du médicament contrôlé.
4. Le mode d'emploi du médicament contrôlé.
5. Le nom et l'adresse de la personne autorisée à prescrire des médicaments.
6. La date à laquelle le médicament contrôlé est prescrit.
7. Les autres renseignements, notamment les renseignements personnels, qu'exigent les règlements.

Aucune restriction

(2) Le présent article n'a pas pour effet de restreindre ou de remplacer l'application de toute autre loi en ce qui concerne les renseignements que la personne autorisée à prescrire des médicaments doit consigner sur une ordonnance.

Renseignements : préparation

11. (1) Le préposé à la préparation qui prépare un médicament contrôlé garde un dossier des renseignements suivants en ce qui concerne l'ordonnance :

1. Les renseignements qu'exige l'article 10.
2. L'adresse, la date de naissance et le sexe de la personne à qui est prescrit le médicament contrôlé.

3. The drug identification number.
4. The quantity of the monitored drug dispensed.
5. The length of therapy, in number of days, of the monitored drug.
6. The date on which the monitored drug is dispensed.
7. The prescription number.
8. Any other information, including personal information, required by the regulations.

Identity verification

(2) A dispenser shall ensure that any identity verification requirements that are required by the regulations are met before dispensing a monitored drug.

False information, etc.

(3) No person shall provide a dispenser with information that the person knows to be false or misleading.

Records

(4) A dispenser shall retain any records required under subsection (1) or (2) for not less than two years.

No limitation

(5) Nothing in this section limits or replaces the application of the *Drug and Pharmacies Regulation Act* or any other Act with respect to any information that a dispenser must ensure is recorded on a prescription or of which a dispenser must keep a record.

Operator of a pharmacy

12. The operator of a pharmacy shall ensure that every dispenser employed or retained by the pharmacy complies with the provisions of this Act.

INSPECTION

Inspectors

13. (1) The Minister may appoint inspectors for the purpose of this Act.

Inspection

(2) An inspector may, without a warrant and without notice, at any reasonable time, enter a place of practice of a prescriber or dispenser that is not a dwelling and conduct inspections for the purpose of determining compliance with the requirements under this Act.

Identification

(3) An inspector conducting an inspection shall produce, on request, evidence of his or her appointment.

Confidentiality

(4) An inspector appointed under subsection (1) shall preserve secrecy with respect to all personal information that comes to his or her knowledge in the course of conducting an inspection, and the inspector shall not commu-

3. Le numéro d'identification du médicament.
4. La quantité préparée du médicament contrôlé.
5. La durée du traitement, en nombre de jours, du médicament contrôlé.
6. La date de préparation du médicament contrôlé.
7. Le numéro de l'ordonnance.
8. Les autres renseignements, notamment les renseignements personnels, qu'exigent les règlements.

Vérification de l'identité

(2) Avant de préparer un médicament contrôlé, le préposé à la préparation veille à ce que soient respectées les exigences liées à la vérification de l'identité imposées par les règlements.

Faux renseignements

(3) Nul ne doit fournir à un préposé à la préparation des renseignements qu'il sait faux ou trompeurs.

Dossiers

(4) Le préposé à la préparation conserve tout dossier qu'exige le paragraphe (1) ou (2) pendant au moins deux ans.

Aucune restriction

(5) Le présent article n'a pas pour effet de restreindre ou de remplacer l'application de la *Loi sur la réglementation des médicaments et des pharmacies* ou de toute autre loi en ce qui concerne les renseignements que le préposé à la préparation doit faire consigner sur une ordonnance ou dont il doit garder un dossier.

Exploitant d'une pharmacie

12. L'exploitant d'une pharmacie veille à ce que tout préposé à la préparation qu'emploie la pharmacie ou dont elle retient les services se conforme aux dispositions de la présente loi.

INSPECTION

Inspecteurs

13. (1) Le ministre peut nommer des inspecteurs pour l'application de la présente loi.

Inspection

(2) Un inspecteur peut, sans mandat ni préavis, pénétrer à toute heure raisonnable dans le lieu d'exercice d'une personne autorisée à prescrire des médicaments ou d'un préposé à la préparation dès lors que le lieu n'est pas utilisé comme logement, et y mener des inspections afin d'établir si les exigences de la présente loi sont respectées.

Identification

(3) L'inspecteur qui mène une inspection produit, sur demande, une preuve de sa nomination.

Confidentialité

(4) L'inspecteur nommé en vertu du paragraphe (1) est tenu au secret à l'égard de tous les renseignements personnels dont il prend connaissance pendant qu'il mène une inspection et ne doit rien en divulguer à qui que ce

nicate any personal information to any other person except as may be required in connection with the administration of this Act or as may be permitted by the *Freedom of Information and Protection of Privacy Act* or the *Personal Health Information Protection Act, 2004*.

Powers of inspector

- (5) An inspector conducting an inspection may,
- (a) examine and make copies of a document or other thing that is relevant to the inspection;
 - (b) search for or demand the production for inspection of a document or other thing that is relevant to the inspection;
 - (c) remove a document or other thing that is relevant to the inspection for the purpose of making a copy; and
 - (d) question a person on matters relevant to the inspection.

Document to be provided in readable format

(6) An inspector that requires a document or other thing relevant to the inspection is entitled to receive it in a readable format.

Return of document or other thing

(7) An inspector shall return, as promptly as reasonably possible, a document or other thing removed by the inspector conducting an inspection.

Copy admissible in evidence

(8) A copy of a document or other thing that purports to be certified by an inspector as being a true copy of the original is admissible in evidence to the same extent as the original and has the same evidentiary value as the document or other thing itself without proof of the signature or official character of the person appearing to have certified the copy.

Obstruction

(9) No person shall obstruct, hinder or interfere with or attempt to obstruct, hinder or interfere with an inspector conducting an inspection or refuse to answer questions on matters relevant to the inspection.

False information, etc.

(10) No person shall provide an inspector with information that the person knows to be false or misleading, or conceal or destroy anything that the person knows to be relevant to an inspection.

Definition

(11) In this section,

“document” means all or part of a record of information, including personal information, in any form.

OFFENCES AND PENALTIES

Offence

14. (1) A person is guilty of an offence if the person,

soit, sauf soit dans la mesure exigée dans le cadre de l'application de la présente loi, soit dans la mesure autorisée dans le cadre de la *Loi sur l'accès à l'information et la protection de la vie privée* ou la *Loi de 2004 sur la protection des renseignements personnels sur la santé*.

Pouvoirs de l'inspecteur

- (5) Dans le cadre d'une inspection, un inspecteur peut :
- a) examiner des documents ou toute autre chose se rapportant à l'inspection et en faire des copies;
 - b) effectuer une recherche de documents ou de toute autre chose se rapportant à l'inspection ou en demander formellement la production;
 - c) enlever des documents ou toute autre chose se rapportant à l'inspection pour en faire une copie;
 - d) interroger quiconque sur des questions se rapportant à l'inspection.

Document à fournir sur support lisible

(6) L'inspecteur qui exige un document ou une autre chose se rapportant à l'inspection a le droit de le recevoir sur un support lisible.

Restitution d'un document ou d'une autre chose

(7) L'inspecteur qui mène une inspection restitue un document ou une autre chose qu'il a enlevé aussi promptement que raisonnablement possible.

Copies amissibles en preuve

(8) Les copies de documents ou de toute autre chose qui se présentent comme étant certifiées conformes aux originaux par un inspecteur sont admissibles en preuve au même titre que les originaux et ont la même valeur probante que ceux-ci, sans qu'il soit nécessaire de prouver l'authenticité de la signature ou la qualité officielle de la personne qui semble les avoir certifiées.

Entrave

(9) Nul ne doit gêner ni entraver, ou tenter de gêner ou d'entraver, le travail d'un inspecteur qui mène une inspection ni refuser de répondre à des questions se rapportant à celle-ci.

Faux renseignements

(10) Nul ne doit fournir à un inspecteur des renseignements qu'il sait faux ou trompeurs ni dissimuler ou détruire quoi que ce soit qu'il sait se rapporter à une inspection.

Définition

(11) La définition qui suit s'applique au présent article.

«document» Tout ou partie d'un dossier de renseignements, notamment de renseignements personnels, se présentant sous quelque forme que ce soit.

INFRACTIONS ET PEINES

Infraction

14. (1) Est coupable d'une infraction quiconque :

- (a) fails to disclose information as directed by the Minister or the executive officer in accordance with the requirements of section 8;
- (b) fails to comply with the requirements of section 10, 11 or 12;
- (c) provides false or misleading information to the Minister, the executive officer, a dispenser or an inspector in connection with the administration of this Act or conceals or destroys anything the person knows to be relevant to an inspection contrary to the requirements of section 9 or subsection 11 (3) or 13 (10); or
- (d) obstructs, hinders or interferes with or attempts to obstruct, hinder or interfere with an inspector conducting an inspection or refuses to answer questions on matters relevant to the inspection contrary to the requirements of subsection 13 (9).

Penalty, individual

(2) An individual who is guilty of an offence under subsection (1) is liable on conviction to a fine of not more than \$50,000 or to imprisonment for a term of not more than 12 months, or to both.

Penalty, corporation

(3) A corporation that is guilty of an offence under subsection (1) is liable on conviction to a fine of not more than \$200,000.

Accused liable for acts or alleged neglect of officers, etc.

(4) In a prosecution of an offence under any provision of this Act, any act or alleged neglect or default on the part of an officer, director, partner, manager, designated manager, agent or representative of the accused, whether a corporation or not, is deemed to be the act or alleged neglect or default of the accused.

No limitation

(5) Section 76 of the *Provincial Offences Act* does not apply to a prosecution under this section.

Presiding judge

15. The Crown may, by notice to the clerk of the Ontario Court of Justice, require that a provincial judge preside over a proceeding in respect of an offence under this Act.

GENERAL

No personal liability

16. (1) No action or other proceeding shall be commenced against the Minister, the executive officer or any person employed or retained by the Crown with respect to any act done in good faith in the execution or intended execution of the person's power or function or for any alleged neglect or default in the execution in good faith of the person's power or function under this Act.

- a) ne divulgue pas des renseignements que le ministre ou l'administrateur lui ordonne de divulguer conformément aux exigences prévues à l'article 8;
- b) ne se conforme pas aux exigences prévues à l'article 10, 11 ou 12;
- c) donne des renseignements faux ou trompeurs au ministre, à l'administrateur, à un préposé à la préparation ou à un inspecteur relativement à l'application de la présente loi ou dissimule ou détruit quoi que ce soit qu'il sait se rapporter à une inspection contrairement aux exigences prévues à l'article 9 ou au paragraphe 11 (3) ou 13 (10);
- d) gêne ou entrave, ou tente de gêner ou d'entraver, le travail d'un inspecteur qui mène une inspection ou refuse de répondre à des questions sur des sujets se rapportant à l'inspection contrairement aux exigences prévues au paragraphe 13 (9).

Peine : particulier

(2) Le particulier qui est coupable d'une infraction visée au paragraphe (1) est passible, sur déclaration de culpabilité, d'une amende maximale de 50 000 \$ et d'un emprisonnement maximal de 12 mois, ou d'une seule de ces peines.

Peine : personne morale

(3) La personne morale qui est coupable d'une infraction visée au paragraphe (1) est passible, sur déclaration de culpabilité, d'une amende maximale de 200 000 \$.

Responsabilité pour les actes ou les prétendues négligences des dirigeants

(4) Dans une poursuite relative à une infraction à la présente loi, l'acte ou la prétendue négligence ou le prétendu manquement, de la part d'un dirigeant, administrateur, associé, gérant, gérant désigné, mandataire ou représentant de l'accusé, que ce dernier soit constitué en personne morale ou non, est réputé constituer l'acte ou la prétendue négligence ou le prétendu manquement de l'accusé.

Aucune restriction

(5) L'article 76 de la *Loi sur les infractions provinciales* ne s'applique pas aux poursuites intentées en vertu du présent article.

Juge qui préside

15. La Couronne peut, par avis au greffier de la Cour de justice de l'Ontario, exiger qu'un juge provincial préside une instance relative à une infraction à la présente loi.

DISPOSITIONS GÉNÉRALES

Immunité

16. (1) Sont irrecevables les actions ou autres instances introduites contre le ministre, l'administrateur ou toute personne que la Couronne emploie ou dont elle retient les services pour un acte accompli de bonne foi dans l'exercice effectif ou censé tel des pouvoirs ou des fonctions que lui attribue la présente loi ou pour toute négligence ou tout manquement qu'il aurait commis dans l'exercice de bonne foi de tels pouvoirs ou fonctions.

Crown liability

(2) Despite subsections 5 (2) and (4) of the *Proceedings Against the Crown Act*, subsection (1) does not relieve the Crown of any liability to which it would otherwise be subject.

No action or proceeding against prescriber, dispenser or operator of a pharmacy

(3) No action or other proceeding shall be commenced against an individual who is a prescriber, dispenser or operator of a pharmacy for any act done in good faith in the performance or intended performance of a power or duty or for any alleged neglect or default in the execution in good faith of the person's power or duty under this Act.

Corporation remains liable

(4) Subsection (3) does not relieve a corporation of any liability to which it would otherwise be subject in respect of a tort committed by a director, officer or employee.

Prosecution under this Act

(5) For greater clarity, nothing in this section limits the Crown's ability to prosecute an offence under this Act.

Regulations

17. (1) The Lieutenant Governor in Council may make regulations,

- (a) designating drugs to be included in or excluded from the definition of "monitored drug";
- (b) excluding a person from the application of this Act, or from one or more provisions of this Act, subject to the conditions, if any, provided for in the regulations;
- (c) for the purpose of paragraph 5 of subsection 4 (2), specifying additional powers or functions of the executive officer under this Act;
- (d) specifying requirements or conditions in respect of the collection, use or disclosure of personal information by the Minister or the executive officer under this Act;
- (e) governing the notice that is required to be made available under section 6 in respect of the collection, use and disclosure of personal information by the Minister or the executive officer;
- (f) for the purpose of paragraph 2 of subsection 8 (1), respecting any information, including personal information, that shall be disclosed to the Minister or the executive officer;
- (g) for the purpose of paragraph 7 of subsection 10 (1), specifying additional information, including per-

Responsabilité de la Couronne

(2) Malgré les paragraphes 5 (2) et (4) de la *Loi sur les instances introduites contre la Couronne*, le paragraphe (1) ne dégage pas la Couronne de la responsabilité qu'elle serait autrement tenue d'assumer.

Immunité de la personne autorisée à prescrire des médicaments, du préposé à la préparation ou de l'exploitant d'une pharmacie

(3) Sont irrecevables les actions ou autres instances introduites contre le particulier qui est une personne autorisée à prescrire des médicaments, un préposé à la préparation ou l'exploitant d'une pharmacie pour un acte accompli de bonne foi dans l'exercice effectif ou censé tel des pouvoirs ou des fonctions que lui attribue la présente loi ou pour toute négligence ou tout manquement qu'il aurait commis dans l'exercice de bonne foi de tels pouvoirs ou fonctions.

Responsabilité de la personne morale

(4) Le paragraphe (3) ne dégage pas une personne morale de la responsabilité qu'elle serait autrement tenue d'assumer à l'égard d'un délit civil commis par un administrateur, dirigeant ou employé.

Poursuite intentée en vertu de la présente loi

(5) Il est entendu que le présent article n'a pas pour effet de restreindre la possibilité pour la Couronne d'engager des poursuites en cas d'infraction à la présente loi.

Règlements

17. (1) Le lieutenant-gouverneur en conseil peut, par règlement :

- a) désigner des médicaments à faire figurer dans la définition de «médicament contrôlé» ou à exclure de celle-ci;
- b) exclure une personne du champ d'application de tout ou partie de la présente loi, sous réserve des conditions, le cas échéant, prévues dans les règlements;
- c) pour l'application de la disposition 5 du paragraphe 4 (2), préciser les pouvoirs ou fonctions supplémentaires que la présente loi attribue à l'administrateur;
- d) préciser les conditions ou exigences relatives à la collecte, à l'utilisation ou à la divulgation de renseignements personnels par le ministre ou l'administrateur aux termes de la présente loi;
- e) régir l'avis qui doit être mis à la disposition de certaines personnes conformément à l'article 6 relativement à la collecte, à l'utilisation et à la divulgation de renseignements personnels par le ministre ou l'administrateur;
- f) pour l'application de la disposition 2 du paragraphe 8 (1), traiter des renseignements, notamment des renseignements personnels, qui doivent être divulgués au ministre ou à l'administrateur;
- g) pour l'application de la disposition 7 du paragraphe 10 (1), préciser les renseignements supplémentaires

sonal information, that a prescriber must record on a prescription;

- (h) for the purpose of paragraph 8 of subsection 11 (1), specifying additional information, including personal information, that a dispenser must keep a record of with respect to a prescription;
- (i) respecting the identity verification requirements that a dispenser must ensure are met before dispensing a monitored drug under subsection 11 (2);
- (j) respecting any matter considered necessary or advisable to carry out effectively the purpose of this Act.

Public consultation before making regulations

(2) The Lieutenant Governor in Council shall not make any regulations under clause (1) (b), (d), (f), (g), (h) or (i) unless,

- (a) the Minister has published a notice of the proposed regulation on the website of the Ministry and in any other format the Minister considers advisable;
- (b) the notice complies with the requirements of this section;
- (c) the time periods specified in the notice, during which members of the public may exercise a right described in clause (3) (b) or (c), have expired; and
- (d) the Minister has considered whatever comments and submissions that members of the public have made on the proposed regulation in accordance with clause (3) (b) or (c) and has reported to the Lieutenant Governor in Council on what, if any, changes to the proposed regulation the Minister considers appropriate.

Contents of notice

(3) The notice mentioned in clause (2) (a) shall contain,

- (a) a description of the proposed regulation and the text of it;
- (b) a statement of the time period during which members of the public may submit written comments on the proposed regulation to the Minister and the manner in which and the address to which the comments must be submitted;
- (c) a description of whatever other rights, in addition to the right described in clause (b), that members of the public have to make submissions on the proposed regulation and the manner in which and the time period during which those rights must be exercised;
- (d) a statement of where and when members of the public may review written information about the proposed regulation; and
- (e) all other information that the Minister considers appropriate.

res, notamment les renseignements personnels, que la personne autorisée à prescrire des médicaments doit consigner sur une ordonnance;

- h) pour l'application de la disposition 8 du paragraphe 11 (1), préciser les renseignements supplémentaires, notamment les renseignements personnels, dont le préposé à la préparation doit tenir un dossier en ce qui concerne une ordonnance;
- i) traiter des exigences liées à la vérification de l'identité qu'un préposé à la préparation doit faire respecter avant de préparer un médicament contrôlé conformément au paragraphe 11 (2);
- j) traiter de toute question jugée nécessaire ou utile à la réalisation efficace de l'objet de la présente loi.

Consultation publique préalable à la prise de règlements

(2) Le lieutenant-gouverneur en conseil ne peut prendre un règlement en application de l'alinéa (1) b), d), f), g), h) ou i) que si les conditions suivantes sont réunies :

- a) le ministre a publié un avis du règlement proposé sur le site Web du ministère et sur tout autre support qu'il estime souhaitable;
- b) l'avis est conforme aux exigences du présent article;
- c) les délais précisés dans l'avis pendant lesquels les membres du public peuvent exercer un droit visé à l'alinéa (3) b) ou c) ont expiré;
- d) le ministre a examiné les commentaires et les observations que les membres du public ont présentés au sujet du règlement proposé conformément à l'alinéa (3) b) ou c) et a fait rapport au lieutenant-gouverneur en conseil des modifications, le cas échéant, qu'il estime approprié d'apporter au règlement proposé.

Contenu de l'avis

(3) L'avis prévu à l'alinéa (2) a) contient ce qui suit :

- a) une description et le libellé du règlement proposé;
- b) une indication du délai imparti aux membres du public pour présenter au ministre des commentaires écrits sur le règlement proposé ainsi que de la façon de les présenter et de l'adresse où ils doivent être présentés;
- c) une description de tous les autres droits, outre celui prévu à l'alinéa b), qu'ont les membres du public de présenter des observations au sujet du règlement proposé ainsi que de la façon de les exercer et du délai imparti pour ce faire;
- d) une indication de l'endroit et du moment où les membres du public peuvent examiner des renseignements écrits concernant le règlement proposé;
- e) tous les autres renseignements que le ministre estime appropriés.

Time period for comments

(4) The time period mentioned in clauses (3) (b) and (c) shall be at least 30 days after the Minister gives the notice mentioned in clause (2) (a) unless the Minister shortens the time period in accordance with subsection (5).

Shorter time period for comments

(5) The Minister may shorten the time period if, in the Minister's opinion,

- (a) the urgency of the situation requires it;
- (b) the proposed regulation clarifies the intent or operation of this Act or the regulations; or
- (c) the proposed regulation is of a minor or technical nature.

Discretion to make regulations

(6) Upon receiving the Minister's report mentioned in clause (2) (d), the Lieutenant Governor in Council, without further notice under subsection (2), may make the proposed regulation with the changes that the Lieutenant Governor in Council considers appropriate, whether or not those changes are mentioned in the Minister's report.

No review

(7) Subject to subsection (8), a court shall not review any action, decision, failure to take action or failure to make a decision by the Lieutenant Governor in Council or the Minister under subsections (2) to (6).

Exception

(8) Any person resident in Ontario may make an application for judicial review under the *Judicial Review Procedure Act* on the grounds that the Minister has not taken a step required by subsections (2) to (6).

Time for application

(9) No person shall make an application under subsection (8) with respect to a regulation later than 21 days after the day on which the Minister publishes a notice with respect to the regulation under clause (2) (a).

Commencement

18. (1) Subject to subsection (2), this Act comes into force on the day it receives Royal Assent.

Same

(2) Sections 1 to 16 come into force on a day to be named by proclamation of the Lieutenant Governor.

Short title

19. The short title of this Act is the *Narcotics Safety and Awareness Act, 2010*.

Délai de présentation des commentaires

(4) Le délai visé aux alinéas (3) b) et c) est d'au moins 30 jours après que le ministre donne l'avis prévu à l'alinéa (2) a), à moins qu'il ne le raccourcisse conformément au paragraphe (5).

Délai de présentation des commentaires raccourci

(5) Le ministre peut raccourcir le délai s'il est d'avis que, selon le cas :

- a) l'urgence de la situation l'exige;
- b) le règlement proposé précise l'objet ou l'application de la présente loi ou des règlements;
- c) le règlement proposé a une importance mineure ou est de nature technique.

Discretion relative à la prise de règlements

(6) Sur réception du rapport du ministre visé à l'alinéa (2) d), le lieutenant-gouverneur en conseil peut, sans autre avis prévu au paragraphe (2), prendre le règlement proposé après y avoir apporté les modifications qu'il estime appropriées, que celles-ci soient ou non mentionnées dans le rapport du ministre.

Aucune révision

(7) Sous réserve du paragraphe (8), un tribunal ne doit pas réviser une mesure ou une décision que prend ou ne prend pas le lieutenant-gouverneur en conseil ou le ministre en application des paragraphes (2) à (6).

Exception

(8) Tout résident de l'Ontario peut présenter une requête en révision judiciaire en vertu de la *Loi sur la procédure de révision judiciaire* pour le motif que le ministre n'a pas pris une mesure exigée par les paragraphes (2) à (6).

Délai de présentation de la requête

(9) Nul ne doit présenter une requête en vertu du paragraphe (8) à l'égard d'un règlement plus de 21 jours après la date à laquelle le ministre publie un avis à l'égard du règlement en application de l'alinéa (2) a).

Entrée en vigueur

18. (1) Sous réserve du paragraphe (2), la présente loi entre en vigueur le jour où elle reçoit la sanction royale.

Idem

(2) Les articles 1 à 16 entrent en vigueur le jour que le lieutenant-gouverneur fixe par proclamation.

Titre abrégé

19. Le titre abrégé de la présente loi est *Loi de 2010 sur la sécurité et la sensibilisation en matière de stupéfiants*.

ROLE OF THE DENTAL PROFESSION

For dentists, prescription pain relievers are an important therapeutic option in the management of persistent pain.

However, dentists face a challenge in helping their patients manage pain, especially in the management of post-operative pain following procedures like a tooth extraction or root canal therapy and in the management of pain associated with other disorders of the oral-facial complex, such as neuralgias/neuritic syndromes, temporomandibular disorders and for problems with post-operative healing or resolution of infections.

At the same time, dentists also want the opioids to be used for the right purpose and do not want to contribute to the province's opioid abuse problem.

RCDSO SYMPOSIUM

To begin the process of assisting dentists in understanding pain management, the Royal College of Dental Surgeons of Ontario convened a one-day symposium on November 17, 2010.

The purpose of the symposium was to kickstart the dialogue of how the dental community could best work with government to remedy these significant societal problems and how the College could support the profession in gaining a better understanding of pain management in the dental practice.

As this is a complex problem that will require the interprofessional collaboration of a range of health care providers to find and implement effective solutions, other colleagues from the provincial regulatory environment were invited to join us: College of Nurses of Ontario, College of Physicians and Surgeons of Ontario and the Ontario College of Pharmacists.

Since education and research will no doubt play a key role in making any necessary changes in dentistry's approach to pain management, representatives from the provincial educational institutions with dental faculties – the University of Toronto and the Schulich School of Medicine and Dentistry at the University of Western Ontario – were asked to participate.

Colleagues from the provincial and national levels of organized dentistry – the Ontario Dental Association and the Canadian Dental Association – were also invited.

In the morning, an impressive roster of speakers presented:

Opioids in Ontario: A Regulatory Perspective (Tab B)

Dr. Rocco Gerace, Registrar

College of Physicians and Surgeons of Ontario

Nature, Complexity and Challenges of Acute and Chronic Pain (Tab C)

Barry Sessle, BDS, MDS, BSc, PhD

Professor, Faculties of Dentistry and Medicine and
Canada Research Chair, University of Toronto

Appropriate Use of Opioids In The Management of Pain (Tab D)

Daniel Haas, BSc, DDS, BScD (Anesthesia), PhD (Pharmacology),
FRCD(C)

Professor and Associate Dean

Discipline of Anesthesia/ Department of Clinical Sciences

Faculty of Dentistry, University of Toronto

Use of Chronic Opioid Therapy in Dentistry (Tab E)

David Mock, DDS, PhD, FRCD(C)

Dean, Faculty of Dentistry, University of Toronto

Wasser Pain Management Centre, Mount Sinai Hospital, Toronto

Managing Pain In The High Risk Patient (Tab F)

Douglas Gourlay, MD, MSc, FRCP(C), FASAM

Resources for Dentistry (Tab G)

Thuan Dao, DMD, Dip Prosthodontics, MSc(Neuroscience), PhD (Biomedical
Science)s, FRCD(C)

Associate Professor, Prosthodontics

Department of Clinical Sciences

Faculty of Dentistry, University of Toronto

Then, in the afternoon, the participants broke up into roundtable discussion groups to address the following questions:

1. How do we improve the education of undergraduate student dentists?
2. How do we improve the continuous education of dentists in practice?
3. How do we improve the education of patients?
4. What more could we be doing about the use of technology to support patient care?
5. What more could we be doing to support interprofessional collaboration?

As each of the discussion groups reported back to the meeting as a whole, it became very clear that there is much work to be done by the College as the regulator and by the profession to ensure that we work effectively in partnership with the provincial government to protect the public. Section 5 summarizes the feedback from each of the discussion groups.

Tab B

Opioids in Ontario: A Regulatory Perspective

Royal College of Dental Surgeons of
Ontario

Rocco Gerace MD



College of Physicians and Surgeons of Ontario
QUALITY PROFESSIONALS | HEALTHY SYSTEM | PUBLIC TRUST

Overview

- Why did we engage in the opioid policy initiative?
 - Our Strategic Direction
- An opioid primer
 - What are they and what are the issues?
- What is 'the College' doing?
 - Guidelines and policy recommendations



Vision Statement

- CPD requirements
- **Quality** Every doctor every 10 yrs
- Healthy System
- National Registration
- **Public Trust** Opioid prescribing
- Communications
- The public and profession



Our Professional Obligations

To cure sometimes

To relieve often

To comfort and support always

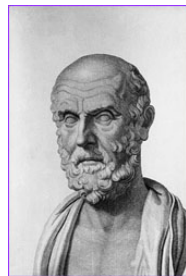


Dr Edward Trudeau



Our Professional Obligations

I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone.



Hippocrates



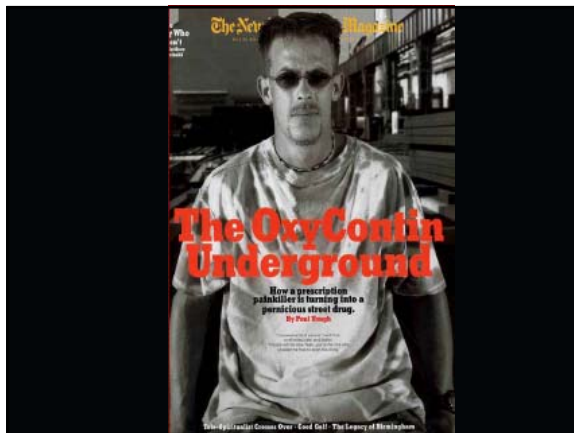
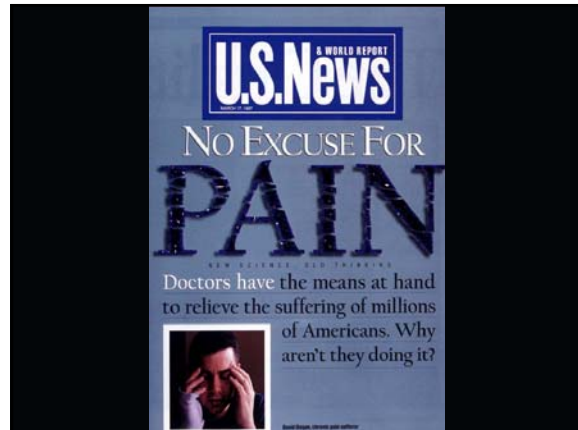
Our Professional Obligations

- Put patients first
- Treat people – NOT diseases
- Relieve pain and suffering
- 'Primum non nocere'



Overview

- Why did we engage in the opioid policy initiative?
 - Our Strategic Direction
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Case Composite

- Reports from various sources
- Concern around amount of opioids being prescribed to a single patient
- Examples:
 - A –Oxycontin 80mg 5 tablets 6x's daily + 2400 mg/day
–MS Contin 60mg 5 tablets 4x's daily
 - B –Oxycontin 40 mg tabs 36/day 1200 mg/day
–Oxycontin 80 mg tabs 36/day 4320 mg/day
- Disposition: What should we do?



So..... To Summarize

- Prescription opioid abuse – public health problem
- Matters coming to the College increasing in frequency
- Etiology multifactorial
 - Prescribing / dispensing
 - Fraudulent activity
 - Other criminal activity
 - Law enforcement frustrated



Overview


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Opioid Public Policy Initiative



Opioid Use / Abuse

Opioid Abuse




~~Trade Factor~~

Pain Management


The screenshot shows the website for the College of Physicians and Surgeons of Ontario. The URL is http://www.cpso.on.ca/. The page features a navigation menu with items like 'About Us', 'What's New', 'Doctor Search', 'Policies & Publications', 'Registration', and 'CPSO Members'. A prominent banner reads 'Quality Professionals. Health. Team. Public Trust'. Below this, there are sections for 'DOCTOR SEARCH', 'PHYSICIANS | REGISTER NOW', 'What's New' (including 'FMRAC Agreement on National Standards'), 'For the Public' (including 'Methadone Fact Sheet'), and 'For Physicians' (including 'Registration policies revised'). Two red arrows point to the 'Policies & Publications' and 'Registration' menu items.



THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

The Physicians' Prescribing Skills Course

A Focus on the Prescribing of Addictive and Psychoactive Drugs



METHADONE for pain GUIDELINES

Facilitated by the College of Physicians and Surgeons of Ontario
November 2009

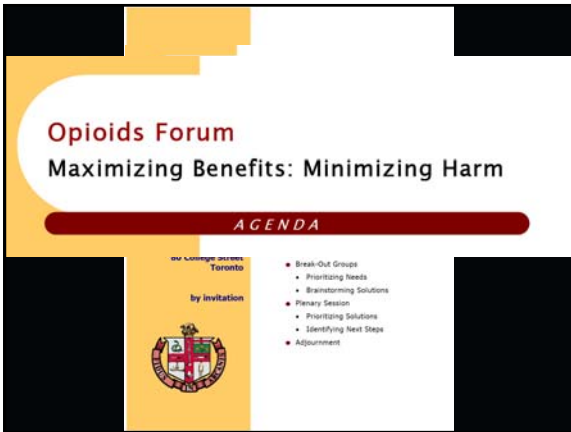
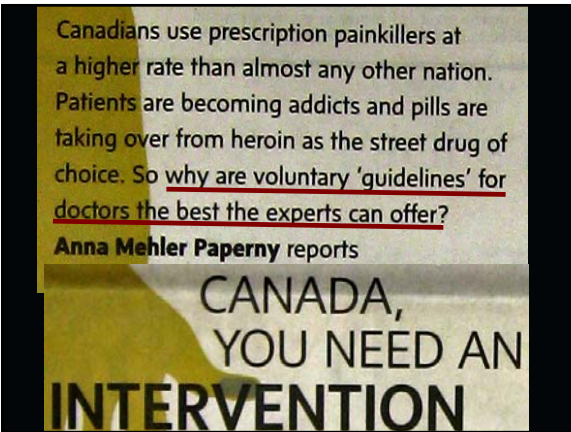
Evidence-Based Recommendations for Medical Management of Chronic Non-Malignant Pain

Reference Guide for Clinicians

Facilitated by the College of Physicians and Surgeons of Ontario
November 2009

Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain


- Multi-stakeholder group
- Under umbrella of FMRAC
- National guideline
- Knowledge transfer strategy
- Permanent home



Opioids Project

Four working groups:

- **Technology: Prescription Tracking Working Group**
- **Education Working Group**
- **Access to Health Resources**
- **Addressing Diversion**

College of Physicians and Surgeons of Ontario 

Opioids Project

Working Groups Multi-stakeholder

- Pharmacy, Nursing, Dentistry, Medicine,
 - Associations / Colleges / Academic
- Public Health
- Coroner's Office
- Ministry of Health, Health Canada
- eHealth
- Law enforcement (municipal, provincial, federal)
- Member of the Public


Support from CPSO Staff

College of Physicians and Surgeons of Ontario 

Opioids Project

Technology: Prescription Tracking Working Group


- Expand the ODB database
 - All opioid Rx's – available to all prescribers and dispensers by 2011
- Drug Information System (DIS) – all drugs and all patients – + enabling legislation
 - HCP's to have real time access
- Embed educational tools
 - Incl – Guidelines on Opioid Use

College of Physicians and Surgeons of Ontario 

Opioids Project

Education Working Group

- Academic institutions – Enhanced education for HCP's – Interprofessional training
- Enhanced CPD availability
- Educators and Regulators – develop competencies based on the 'Guideline'
- Education: public, youth, Judiciary & Crown
- First Nations

College of Physicians and Surgeons of Ontario 

Opioids Project

Access to Health Resources

- Government should prioritize - address the spectrum of issues related to opioids
- Focus on interprofessional care
- Comprehensive pain management strategy
 - specialized pain clinics – regulatory framework
- Use (and make available) all modalities for pain care
- Commit to adequate addiction treatment
- Address funding issues



Opioids Project

Addressing Diversion

- Along with the DIS – Gov't to implement a Drug Monitoring System
- Mandatory reporting of *'double doctoring'*
 - "reasonable a probable grounds to believe.."
- RHPA to require reporting from Colleges
- Police services to report members to Health Colleges
- Resources to train and to fund enforcement



Overview

- Why did we engage in the opioid policy initiative?
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- What is *'the College'* doing?
 - Guidelines and policy recommendations



Tab C

The Nature, Complexity and Challenges of Acute and Chronic Pain

Barry J. Sessle



Professor, Faculties of Dentistry and Medicine
and Canada Research Chair,
University of Toronto, Canada



Barry J. Sessle

RCD502010



OVERVIEW



- Overview of the complexity of pain and recent advances in understanding of mechanisms involved in pain and its control
- Challenges in the pain field, especially related to
 - pain awareness
 - pain education
 - access
 - research

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- Pain: An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage (IASP)

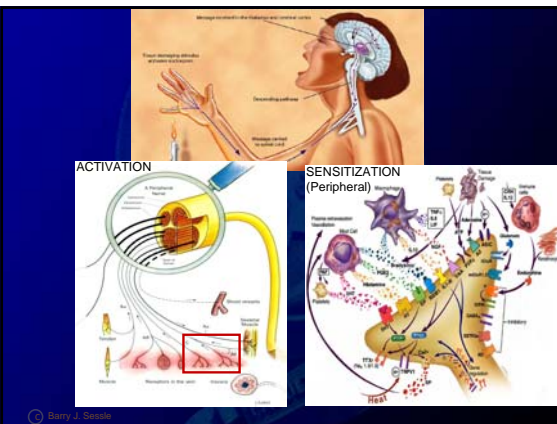
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The Multidimensionality of Pain

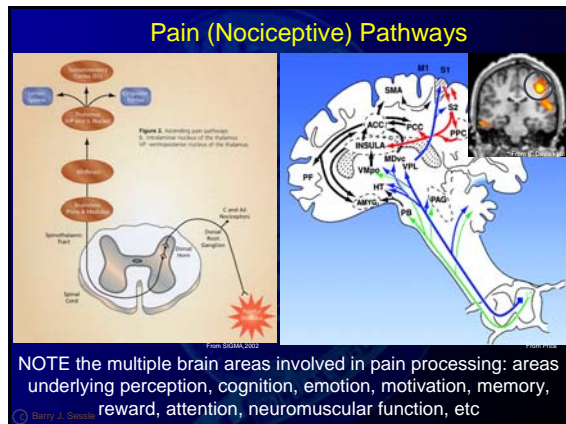


- Sensory: Perception of the spatial and temporal features of the noxious stimulus
- Cognitive: The ability to comprehend and evaluate pain and its significance; encompasses past experience, culture values, etc.
- Motivational: The “drive” to stop (or enhance) the pain
- Affective: The emotions or “feelings” associated with the pain’s unpleasantness (or pleasantness)

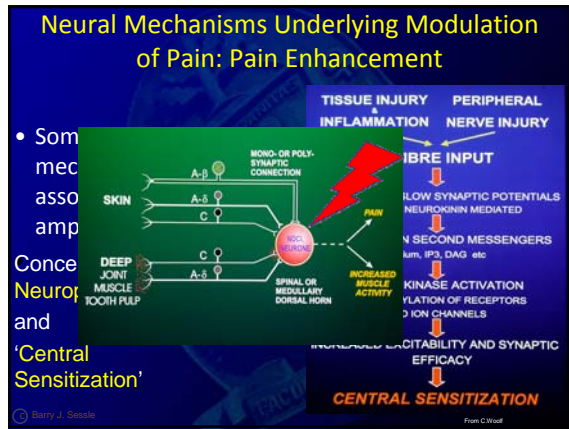
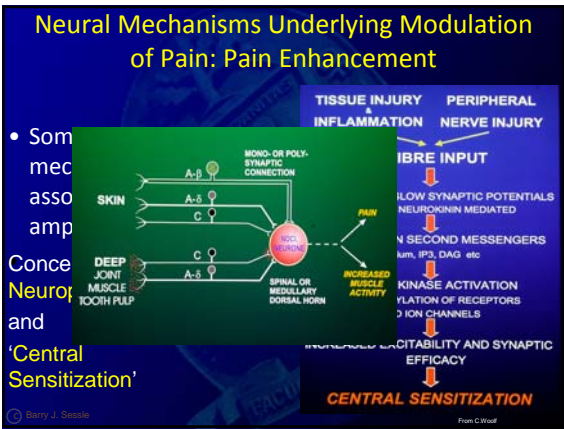
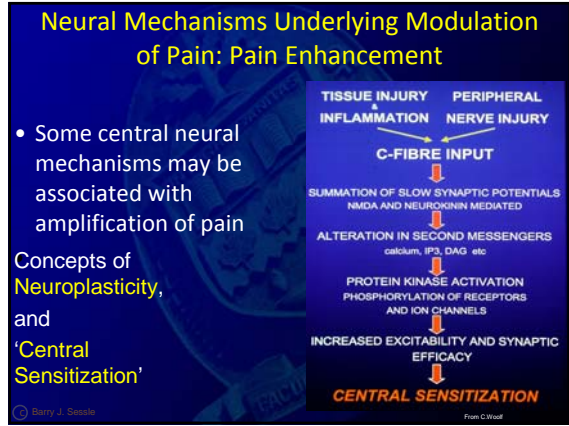
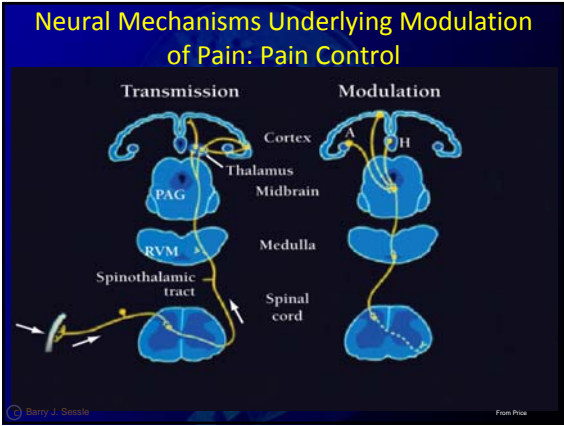
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Neural Mechanisms Underlying Modulation of Pain: Clinical Relevance

Stress, Anxiety, Depression

Placebo Analgesia

Narcotic Analgesics

Acupuncture-Induced Analgesia

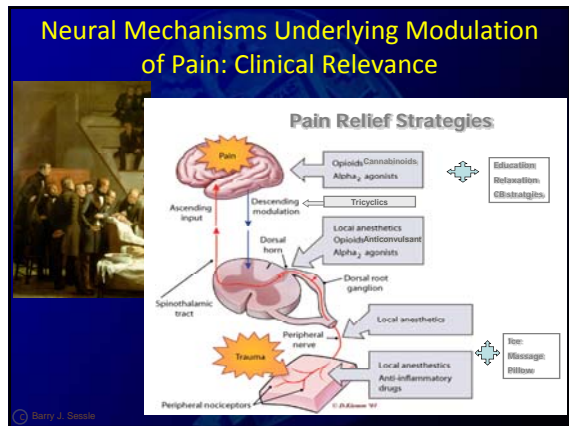
TENS-Induced Analgesia

Electronic Pain Relief

Sleep

From M. Melzack/Publishing Pharma

© Barry J. Sessle



BUT

Despite past and recent advances in pain knowledge and management, critical issues still remain :

- Pain awareness
- Pain education
- Access to care
- Pain research resources and funding

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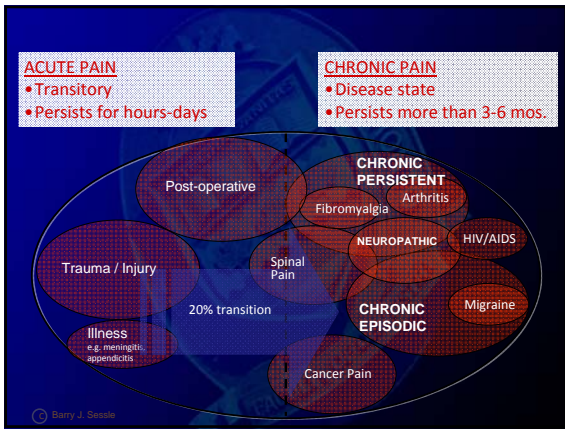
- **Pain awareness**
- Pain education
- Access to care
- Pain research resources and funding

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Some Facts about Pain, especially Chronic Pain

- Multidimensional
- A disease in its own right
- A component of many other diseases/disorders
- High prevalence
- Huge socioeconomic costs
- Most chronic pain conditions cannot be cured, and only managed at best

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- 18-20% of Canadian adults suffer from moderate to severe chronic pain daily or most days of the week*
- The prevalence of pain increases with age (17→33%)*

Source: Breivik, H, Collett, B, Ventafridda, V, Cohen, R, Gallacher, D. (2006) Survey of chronic pain in Europe: Prevalence, daily life, and treatment. *European Journal of Pain*, 10, 287-333.

* Moulin et al, 2003; Boulanger et al, 2007; CPS Nanos Survey, 2008

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- Some of most common pains occur in oral-facial region
 e.g. 10-15% prevalence of toothache or TMD

Toothache Headache Temporomandibular Disorders (TMD)

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Chronic Pain Costs :

Personal costs to Canadians

- Reduced quality of life (> 50%)
- Negative impact on relationships
- Job loss or reduced job responsibilities (>50%)
- Pain not effectively managed (>60%)
- Reduction in self-esteem
- Increased rates of depression
- Twice the average likelihood of suicide while awaiting treatment

Costs to Canadian economy

- Estimated at >\$6B/year (in direct healthcare costs)
- As much as cardiovascular disease or cancer
- Twice as much as depression
- Lost productivity and lost tax revenues

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* Moulin et al, 2003; Boulanger et al, 2007; CPS Ninos Survey, 2008

- Pain awareness
- **Pain education**
- Access to care
- Pain research resources and funding

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Knowledge Transfer and Application

- Undertreatment of pain
 - eg cancer pain
 - HIV / AIDS pain
 - cardiac surgery pain
 - neonatal pain

(Breitbart, 1997; Bernabei et al, 1998; Pargson & Hailey, 1999; Finley & McGrath, 2001; Watt-Watson et al, 2001; Stankiewicz et al, 2005; Boulanger et al, 2007; Joranson et al, 2007)

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Knowledge Transfer and Application

- Misdiagnosis; Under/Overtreatment of pain
 - eg trigeminal neuralgia / atypical facial pain / TMD



(Loeser, 1989; Okeson, 1996; Mohl, JOP, 1999; Stohler & Zarb, JOP 1999; Sharav, 2004)

Clearly, a problem exists in knowledge transfer and in its application for effective pain management

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Pain Curriculum

- Pain integral component of dental, medical etc practice
- High prevalence of pain conditions
- Huge socioeconomic costs of pain
- Changing demographics suggest future increases

Yet, pain is minor component of curriculum

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Insufficient pain education of health professional students & graduates

A 2007 CPS Survey of Pain Curricula in Health Professional Faculties in Canada *

Formal pain content in curriculum

	Total Hours (mean)	Range
Dentistry	15	0 - 24
Medicine	16	0-38
Nursing	31	0-109
Occupational Therapy	28	0-48
Pharmacy	13	2-33
Physical Therapy	41	18-69
Veterinary Medicine	87	27-200

*Watt-Watson et al, 2009

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Clearly, a problem exists in educating students about pain

- Pain awareness
- Pain education
- **Access to care**
- Pain research resources and funding

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- Access to timely and appropriate care for pain is unacceptably long
- Relatively few pain clinics, especially those providing multidisciplinary care
- Limited geographic distribution of pain clinics (>80% urban)
- Limited number of healthcare professionals with sufficient knowledge or training about pain
- Limited treatment options for many chronic pain conditions
- Limited cost coverage/availability of some management approaches, eg 3rd party, provincial drug schedules, etc
- Abuse/Misuse of pain medications by a small few; runs the risk of the creation of further barriers to access for the many with legitimate needs

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CPS Survey, Lynch et al, 2007, 2008; Peng et al, 2007

- Pain awareness
- Pain education
- Access to care
- **Pain research resources and funding**

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- Although Canada is a world leader in many pain-related basic science and clinical fields, relatively low proportion of pain researchers compared to other health science fields
- Funding for pain research in Canada (and USA) is also disproportionately low, thus limiting rapid advances in improved understanding of pain

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Figure 2) Distribution of pain research funding by province from 2003 to 2008. PEI Prince Edward Island

For last 5 years, average pain research funding : \$17M/yr in Canada
 < 1% of total CIHR funding*
 < 0.25% total health research funding in Canada
 For comparison, Cancer research funding is \$390M/year in Canada

Barry J. Sessle * In USA, pain research funding is also < 1% of total NIH funding Lynch et al 2009

- Although Canada is a world leader in many pain-related basic science and clinical fields, relatively low proportion of pain researchers compared to other health science fields
- Funding for pain research in Canada (and USA) is also disproportionately low , thus limiting rapid advances in improved understanding of pain
- The limited human resources and funds applied for pain research are disproportionately low considering the enormity of chronic pain and its socioeconomic impact in Canada, compared to other less common conditions (eg, cancer, heart disease, epilepsy, arthritis, HIV/AIDS,etc)

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SUMMARY

1. There have been considerable recent advances in our understanding of pain, and the mechanisms involved in its processing and control.
2. Nonetheless, crucial issues still exist.
3. Most crucial is the need to :
 - (i) enhance pain awareness and education, e.g. increasing pain curricular time and ensuring knowledge transfer and application, by more effective interactions between pain clinicians/researchers and the public, government/policy makers, media, and patient advocacy groups, etc.
 - (ii) improve access to pain care, e.g. ensuring sufficient number of accessible pain clinics offering timely and appropriate multidisciplinary care, accreditation, etc, but at the same time putting in safeguards to prevent abuse of pain medications.
 - (iii) increase pain research resources to improve our understanding of pain, e.g. emphasis on increasing human resources and funding levels, on inter- /multi-disciplinary and translational research, etc.

Barry J. Seaside

THANK YOU!



Barry J. Seaside



Tab D

APPROPRIATE USE OF OPIOIDS IN THE MANAGEMENT OF PAIN

Daniel Haas
Faculty of Dentistry
University of Toronto

WHY IS THIS AN ISSUE?

- Over-prescribing
 - Ontario 2008 Oxycontin Rx:
 - 2X national average
 - Ontario deaths due to oxycodone
 - ↑ 5-fold from 1999-2004
 - Diversion of prescribed opioids



WHY IS THIS AN ISSUE?

- Under-prescribing
 - Practitioner fear of causing addiction can lead to avoidance of appropriate use of opioids to manage pain



GOALS

- Lessen inappropriate opioid Rx
 - Non-medical use
 - Abuse
- Do not reduce availability of opioids for appropriate Rx



Analgesics For Acute Post-Operative Dental Pain

- Acetaminophen
- Nonsteroidal antiinflammatory drugs (NSAIDs)
- Opioid analgesics



Acute Post-Operative Dental Pain

3 possible target sites for drugs

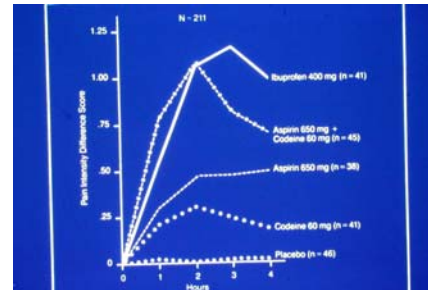
- Periphery (NSAIDs)
- Nerve conduction from site to brain
- Receptors in CNS



Third Molar Removal Model



CLINICAL TRIALS



What is being Rx?

- Evidence shows efficacy of NSAIDs alone
- Yet, 85% of oral surgeons “almost always” Rx an opioid following third molar surgery (Moore et al, 2006)
- 20 was the median # of pills dispensed (range of 8 – 40)



Opioids For Acute Post-Operative Dental Pain

- Codeine
 - Normally the first choice
 - In combination with a non-opioid
 - Either as separate Rx or pre-formed combinations
- Oxycodone
 - Normally reserved for severe pain
- Hydromorphone
 - Rarely recommended
 - May be legitimately Rx for short-term (1 – 2 days) management of refractory pain

Acute Post-Operative Dental Pain

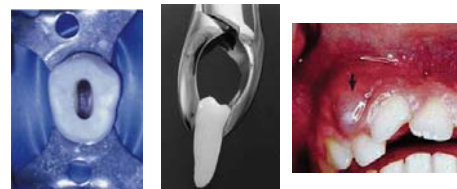
Opioids usually NOT recommended:

- CR-oxycodone (Oxycontin)
- Morphine
- Meperidine
- Pentazocine
- Propoxyphene
- Tramadol

GENERAL GUIDELINES

Eliminate the source of pain

- Whenever possible



GENERAL GUIDELINES

Maximize the non-opioid before adding an opioid

- Therapeutic dose, e.g.:
 - ibuprofen 600mg
 - acetaminophen 1,000mg
- Combination analgesics are not formulated supporting this principle
 - e.g. Tylenol 3: acetaminophen 300mg with codeine 30mg

GENERAL GUIDELINES

Individualize analgesic regimens

- Dependent on
 - medical history
 - allergy
 - patient's pain threshold
 - cause of pain

Optimize dose and frequency

- rule out compliance issues before considering a switch

GENERAL GUIDELINES

For NSAIDs consider:

- loading dose
- pre-op dose
- QID instead of prn for days 1 - 3

GENERAL GUIDELINES

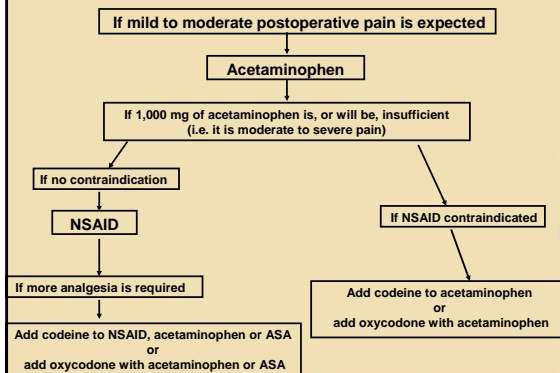
In the elderly:

- ↓ dose
- ↓ duration

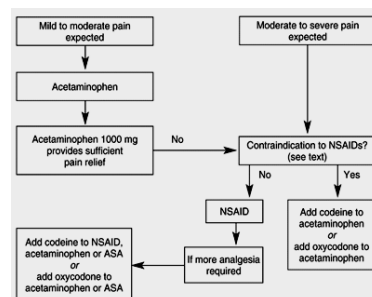
Avoid prolonged use

- if possible
- typical prescribing 3 to 5 days

ALGORITHM FOR ANALGESIC USE



CPS Clin-Info



Tab E

The Use of Chronic Opioid Therapy in Dentistry

In a symposium on:
The Management of Pain in Dental Practice
RCDSO, Nov. 17, 2010

David Mock, DDS, PhD, FRCD(C)
Faculty of Dentistry, University of Toronto
Wasser Pain Management Centre, Mount Sinai Hospital

1

Massachusetts Board of Registration in Dentistry Advisory on the Management of Pain March 11, 2009

"For purposes of this Advisory, the inappropriate management of pain includes non-treatment, under-treatment, over-treatment and the continued use of ineffective treatment. The Board encourages dentists to view pain management as a part of quality dentistry practice for all patients experiencing pain within the maxillofacial area. All dentists should become knowledgeable about assessing and diagnosing patients' pain and effective methods of pain management."

"The dentist is also responsible and accountable for acquiring and maintaining the knowledge, skills and abilities necessary to practice in accordance with accepted standards of care for pain management."

2

DIAGNOSIS BEFORE TREATMENT

- Observe Patient
 - Starts as the patient enters the room
 - Signs of apparent distress
 - Interactions with people accompanying patient
 - Patient's affect

3

HISTORY

- Most important part of the examination by far!
- Onset, related trauma/treatment, nature of symptoms, related symptoms, triggers, modifiers etc...
- Effect of pain on activities, relationships

4

MEDICAL HISTORY

- Routine medical history **PLUS**
 - Question about other pain disorders, possible contributing disorders, sleep history
 - Review history of medications, particularly related to presenting complaint, other prescribers etc..
 - Review social history
 - Relationships
 - Non-medical/recreational use of drugs or alcohol
 - Consider assessment of abuse susceptibility
 - Consider urine testing
- Generally, if you don't have a direction by the end of this — you won't*

5

CLINICAL EXAMINATION

- Should be thorough, not just localized by suspicions derived from the history
- Include intra-oral and extra-oral examination of head and neck
- Record negatives for future reference

6

SPECIAL INVESTIGATION

- ❑ Pulp testing – as indicated, manual and mechanical
- ❑ Imaging – as indicated by history and examination
- ❑ Blood work/serology – as indicated by history and examination

7

CONSULTATION

Remember that “if all you have is a hammer – everything is not a nail”

8

Consider:

- ❑ Dental Specialties – where indicated for further investigation or confirmation
- ❑ Neurologist – if a central lesion or a neurological disorder is being considered
- ❑ Pain Specialist (often an anaesthesiologist or neurologist)
 - ❑ if chronic opioid therapy or complex multidrug therapy is being considered or if a generalized pain disorder is indicated
- ❑ Rheumatologist – if a systemic disorder is considered
- ❑ Psychologist or Psychiatrist – if indicated

9

COLLABORATIONS

- ❑ For management, besides the health care personnel already consulted
- ❑ Physiotherapy, Occupational therapy, Acupuncture, Sleep clinic
- ❑ Communicate with other clinicians (including the family dentist and physician)

10

DRUG THERAPY

- ❑ Consider non-opioid medication first
 - ❑ OTC, anti-inflammatory, anticonvulsant, antidepressant
- ❑ Never use short acting opioid for chronic pain disorder except for breakthrough (and monitor)
- ❑ Start at lowest possible dose, increase as indicated and constantly review to reduce, monitor for signs of abuse, side effects
- ❑ Consider combining opioid and/or non-opioid medication and/or non-pharmacologic tx
 - ❑ Example – CBT has been shown to be not only effective on its own but as an adjunct to drug therapy, often reducing dosage
- ❑ Discuss with patient - contract

11

EXERCISE CAUTION WHEN:

- ❑ The patient requests a particular drug
- ❑ The patient repeatedly “loses” the prescription/medication
- ❑ The patient asks you to renew a prescription originally written by another practitioner
- ❑ The dosage is increasing beyond a level of comfort

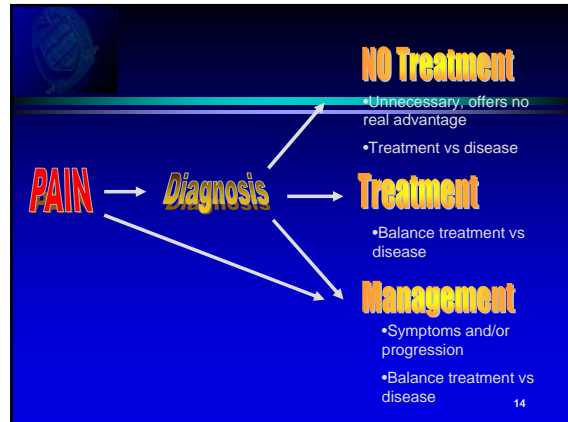
12

Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain

Published by the
National Opioid Use Guideline Group (NOUGG)
April 30 2010

<http://nationalpaincentre.mcmaster.ca/opioid/>

13



14

IN CONCLUSION:

- ❑ The dental practitioner must be able to diagnose and treat OFP
- ❑ It is our responsibility to manage pain in this region
- ❑ Statistics have shown that these OFP patients often go years and incur great expense and disability when untreated
- ❑ The dentist is the health care provider who is best trained to administer treatment for these patients
- ❑ the proper, controlled use of opioid therapy can be a safe and effective therapeutic tool.

15

Tab F

Managing Pain in the high risk patient

Royal College of Dental Surgeons, Ontario
The Management of Pain in Dental Practice
2010

Douglas Gourlay MD, MSc, FRCPC, FASAM
Four Season Hotel, Toronto

Disclosures

- No conflicts to declare

5/10/2011

Wasser Pain Center, Toronto,
Ontario

2

Objectives

- Examine the problem
 - Basic Definitions
 - Pain and Addiction Continuum
- Boundary Setting in chronic pain
- Risk Assessment
 - Signs you might be in trouble
- Exit Strategies

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Ontario

3

The Problem

- Pain and Addiction CAN coexist
- Addiction in General Population
 - Varies 3 – 16% prevalence
 - Varies with the drug, gender, economic status, race, age...
- Addiction in the Chronic Pain Population
 - We really have no idea
 - We use the same terms, with different meaning
- Lack of precision in definitions around abuse/dependency/addiction

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4

Definitions

- **Addiction:** Addiction is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving. (LCPA)

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Definitions

- **Physical Dependence:** Physical dependence is a state of adaptation that often includes tolerance and is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist. (LCPA)

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Definitions

- **Tolerance:** Tolerance is a state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug's effects over time.
- Tolerance develops at different rates, in different people, to different effects

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7

Definitions

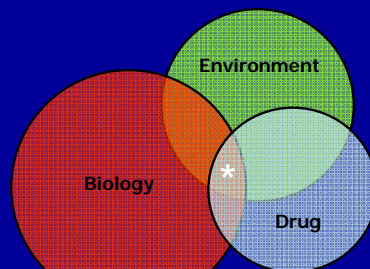
- **Pseudoaddiction:** Iatrogenic, maladaptive behavior resulting from inadequate pain control
- Not to be used "instead of" addiction
- Unwise to diagnose in patient with history of addictive disorder, even in other substance

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8

Addiction *

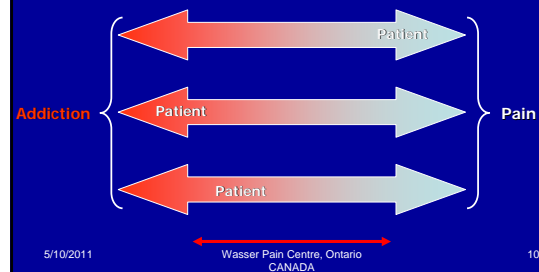


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Pain-Addiction Continuum



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Diagnosis of Addiction in Chronic Pain

- When the drug is both the problem AND the solution in the patient at the same time i.e. problematic opioid use
 - DSM-IV is inadequate
 - Addiction is "diagnosis made prospectively, over time"
 - Pseudo addiction is "diagnosed retrospectively"
 - Careful limits and boundary setting will help to make the diagnosis

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Boundary Setting

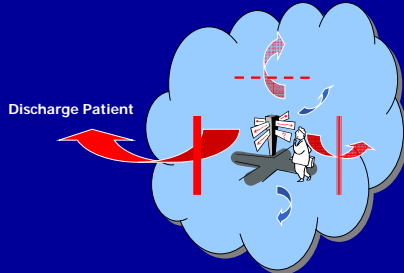
- 90%+ of patients don't need strict boundary setting
 - Most patients have their own internal set
- For remaining ~10%, strict boundary setting is essential
- Treatment Agreements, Urine Testing, interval / contingency dispensing

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Boundaries – Identification and Enforcement

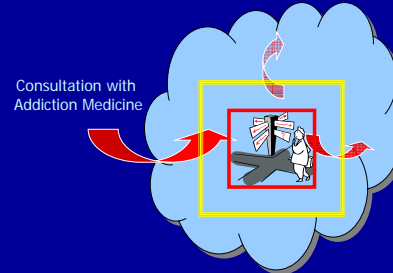


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Boundaries – Identification and Enforcement



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Aberrant Behavior

- The differential diagnosis of aberrant behavior is long
 - Co-morbid psychopathology
 - “chemical coping”
 - Pseudoaddiction
 - Substance misuse/addiction
 - Criminal intent/behavior ie Diversion

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Aberrant Behavior

- Aberrant behavior is easier to identify than it is to interpret it's meaning
 - It is also a late and relatively unreliable marker of addiction/misuse
 - Must have a plan in place to clinically address such behavior –never ignore it; don't fail to document it
- **Diagnosis of addiction is made prospectively, over time**

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To Treat or Not to Treat Acute Pain?

- The answer to this question is “Yes”
 - Acute pain needs to be treated
 - Especially if you might play a part in creating it! ☺
- But Chronic Pain is different
 - Chronic pain is NOT just a bunch of acute days “strung together”
 - **Beware the endless opioid script**
 - **Beware stories involving Elvis or Aliens to explain lost/stolen opioid scripts ☹**

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The Management of chronic pain with opioids

- “Do I have the experience AND the resources to provide safe and effective chronic care this patient”
 - The management of acute pain in the opioid naïve patient is vastly different than in an opioid experience/dependent patient
 - “Avoid an opioid debt”
 - Patients on methadone are challenging
 - The acute setting is rarely the time for chronic change

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Identifying the high risk patient

- With few exceptions, anyone on chronic opioid therapy is high(er) risk
 - Doesn't mean you can't/shouldn't manage their acute pain but be careful
 - Anyone prescribing opioids MUST have a strategy to assess and manage risk, especially if they plan to use them chronically
 - This strategy should include an exit plan

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Risk Assessment

- Variety of tools that can be self administered
 - Opioid Risk Tool (ORT@ Lynn Webster et al)
 - SOAPP
 - Screener and Opioid Assessment for People in Pain (Jamison et al)
 - Gives 'predictive' information about future risk
 - COMM
 - Concurrent Opioid Misuse Measure
 - Current Information

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Who is at risk?

- "If you have a pulse, you have a risk"
 - The real question isn't "Is there risk?", the question is "What's the risk?" and how best can it be managed?
 - Before you write for any controlled substance you must have:
 - A **diagnosis** for which opioids would be helpful?
 - A reasonable **assessment of risk**
 - An **Exit Strategy** in place *prior* to writing any Rx
 - Know who to refer the patient you think might be in trouble
 - Every health professional should know where to get help!

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What to do to remain part of the solution?

- Don't write Rx's for:
 - Family / Friends / Your Self
 - If any of the above need opioids, refer them on to someone who can objectively manage their care
- Avoid a patient's previous "drug of choice"
 - NSAIDs are usually more effective in dental pain
 - "offer a **diagnostic** block"
- For opioid dependent patients, speak to their usual provider – communication!

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Signs there may be trouble

- Feeling uncomfortable writing a script
 - Pressure from a patient is a bad sign for a good outcome
- Recurrent scripts beyond the expected period of analgesic need
 - Acknowledge your limitations and refer sooner than later
- Someone else is concerned
 - Your staff? / the pharmacist / "next of kin"

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Exit Strategies

- Abandoning the molecule does not mean abandoning the patient!
 - It is important to have a 3rd party in the room
 - Document the encounter carefully
 - If there are any threats, notify appropriate authority ie Malpractice Insurer, Regulatory Body, (?Police)
 - Violence or intimidation terminates the doctor-patient relationship
 - Stay on message / don't get distracted
 - Most common reason for d/c opioids is "safety"

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Summary

- By recognizing that pain and addiction can coexist, risk can be more effectively managed
 - If simple measures are not effective, call for help
 - Surprisingly, intractable pain can be a function of opioid use, rather than in spite of it

Resources

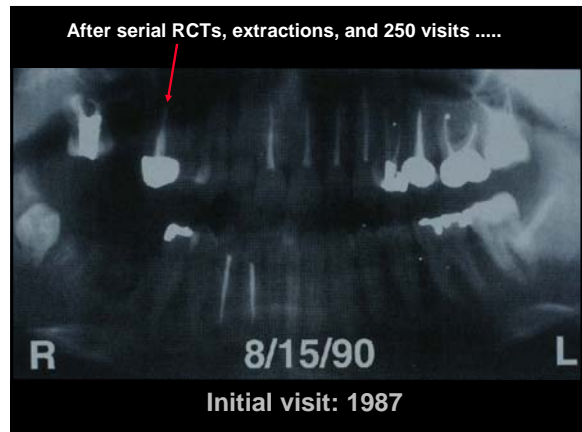
- Addiction Clinical Consultation Service
 - Aka ACCS @ 1-888-720-2227
 - For any health professional who suspects or knows that their patients is suffering from a drug or alcohol related problem
- www.emergingsolutionsinpain.com
- www.quantiaMD.com
 - Podcast CME see Gourlay / Heit on "Common Threads in Pain and Addiction"

Tab G

The Management of Pain in Dental Practice
 RCDSO November 17 2010

Resources for Dentistry

Thuan Dao, DMD, Dip Prosthodontics, MSc, PhD, FRCD(C)
 Faculty of Dentistry
 University of Toronto, Canada



Chronic Orofacial Pain: A Long-Term Follow-up Study

First visit – Previous Tx:
 33/45 patients had 150 RCTs and surgeries

Nine to 19 years later.....
 14/45 had further 100 extractions
 Permanent pain relief: 3 patients

Allerbring & Haegerstam, 2004



Management of Chronic Orofacial Pain: A Survey of General Dentists in German University Hospitals

Stefan Witz MD¹, Richard K. Ellerkmann MD², Marcus Buecheler MD³, Christian Pulsenen PhD², Joachim Nadstawek PhD², Hans-Christian Wartenberg MD²

Article first published online: 2 MAR 2010
 DOI: 10.1111/j.1526-4637.2010.00805.x
 Wiley Periodicals, Inc.

Most common diagnoses

- Atypical odontalgia
- TMD (myofascial)
- TMD (disc disp.)
- Atypical facial pain
- Trigeminal neuralgia
- Migraine surgeries
- Cluster Headache

Most common Txs

- Tx of malocclusion
- Physiotherapy
- Analgesics
- Sympat. blockades
- Surgical procedures
- Max. orthog.
- Other surgeries

Misdiagnosis



Multiple failed dental treatments

A survey of prelicensure pain curricula in health science faculties in Canadian universities

Watt-Watson et al, Pain Res Manage 2009; 14(6):439-444

TABLE 2
Average total hours for designated mandatory formal content by discipline*

Faculty or department	Site responses, n	Total hours, mean \pm SD	Range	Mean student, n*
Dentistry	5	15 \pm 10	0-24	47
Medicine	9	16 \pm 11	0-38	133
Nursing	9	31 \pm 42	0-109	133
Occupational therapy	3	28 \pm 25	0-48	47
Pharmacy	5	13 \pm 13	2-33	123
Physical therapy	7	41 \pm 16	18-69	55
Veterinary medicine	4	87 \pm 98	27-200	66

Can J Anesth/Can Anesth (2010) 57:539-548
DOI 10.1007/s12630-010-9305-5

REPORTS OF ORIGINAL INVESTIGATIONS

The Canadian STOP-PAIN project – Part 1: Who are the patients on the waitlists of multidisciplinary pain treatment facilities?

Le projet canadien STOP-PAIN – 1^{ère} partie : Qui sont les patients sur les listes d'attente pour les établissements pluridisciplinaires de traitement de la douleur?

Manon Choinière, PhD • Dominique Dion, MD • Philip Peng, MBBS • Robert Banner, MD • Pamela M. Barton, MD • Aline Boulanger, MD • Alexander J. Clark, MD • Allan S. Gordon, MD • Denise N. Guerriere, PhD • Marie-Claude Guerin, PhD • Howard M. Intrator, MD • Sandra M. Lefort, PhD • Mary E. Lynch, MD • Dwight E. Moulis, MD • May Ong-Lam, MD • Mélanie Racine, PhD(c) • Saifee Rashid, MB • Yoram Shtr, MD • Paul Tannen, PhD • Mark Ware, MBBS

The Canadian STOP-PAIN project – Part 1: Who are the patients on the waitlists of multidisciplinary pain treatment facilities?

Table 6 Types of health care professionals patients consulted for pain since its onset

Health care disciplines	%	n
MEDICAL DISCIPLINES		
Family practitioner	96.7	704
Orthopedic surgeon	46.6	339
Neurologist	43.3	315
Physiatrist	31.7	231
Anesthesiologist	30.6	222
Neurosurgeon	27.0	196
Dentist	28.6	208
Psychiatrist	31.0	226
Rheumatologist	28.0	204
Gynecologist	12.8	93
At least one other medical discipline	10.4	76

Since the onset of pain, patients reported having consulted an average of 7.4 (\pm 3.6) different types of health care professionals

A survey of prelicensure pain curricula in health science faculties in Canadian universities

Judy Watt-Watson RN PhD¹, M McGillion RN PhD¹, J Hunter BScPT PhD¹, M Choiniere PhD², AJ Clark MD FRCP³, A Dewar RN PhD², C Johnston RN PhD³, M Lynch MD FRCP³, P Morley-Foster MD FRCP³, D Moulis MD FRCP³, N Thie DDS MSc⁴, CL von Baeyer PhD PhD⁵, K Webber RN MN⁶

J Watt-Watson, M McGillion, J Hunter, et al. A survey of prelicensure pain curricula in health science faculties in Canadian universities. Pain Res Manage 2009;14(6):439-444. Un sondage des programmes sur la douleur avant l'obtention du permis d'exercer de

Prelicensure pain education is a critical step in ensuring that health care practitioners entering the workforce are competent in pain management.

However, only one-third of this sample could identify designated pain content hours in their prelicensure health science curricula.

Suggested strategies for changing clinical practices

- 1 Implement designated mandatory formal prelicensure pain courses
- 2 Train more clinical investigators / pain specialists with scientific interest in mechanisms and treatment of chronic orofacial pain

Clinical practice guideline: a tool to improve quality of health care

“Systematically developed statements to assist practitioners and patients decisions about appropriate health care for specific clinical circumstances”

Canadian Medical Association, 2007

Adaptation and development of CPGs Canadian Medical Association 2007

A CPG has the potential to play an important role when:

- 1 There is uncertainty or difference of opinion about what care should be provided, as evidence by wide variation in practice and outcome.
- 2 There is proven treatment for a condition and mortality/morbidity can be reduced.
- 3 There is a need to bring together scientific knowledge and expertise on a subject.
- 4 There are iatrogenic diseases or interventions carrying significant risks or costs.

Clin Oral Invest (2010) 14:137–144
DOI 10.1007/s00784-009-0282-4

ORIGINAL ARTICLE

A survey on German dentists regarding the management of craniomandibular disorders

Michelle Alicia Ommerborn · Carolin Kollmann · Jörg Handschel · Rita Antonia Depprich · Hermann Lang · Wolfgang Hans-Michael Raab

Table 4 Average percentage of patients treated by specialists with the following most frequent therapies for CMDs

	Minimum	Maximum	P value
Occlusal splints (n = 123)	35.9% (orthodontists)	81.4% (periodontists)	<0.01
Physiotherapy (n = 123)	3.3% (prosthodontists)	75.0% (endodontists)	n. s.
Occlusal equilibration (n = 123)	2.1% (orthodontists)	35.0% (specialists in preventive and restorative dentistry)	<0.001
Prosthetic reconstruction (n = 123)	1.4% (orthodontists)	19.7% (implantologists)	<0.001
Orthodontics (n = 124)	0.5% (maxillofacial surgeons)	28.8% (orthodontists)	<0.01
Relaxation techniques (n = 124)	6.8% (orthodontists)	45.0% (endodontists)	<0.05
Thermal packs (n = 126)	2.1% (periodontists)	40.0% (specialists in preventive and restorative dentistry)	n. s.
Medications (n = 126)	0.4% (periodontists)	35.0% (specialists in preventive and restorative dentistry)	<0.05
Diet counselling (n = 126)	0.4% (oral surgeons)	15.8% (maxillofacial surgeons)	n. s.
Psychotherapy (n = 125)	0.3% (prosthodontists)	8.6% (oral surgeons)	n. s.
Miscellaneous (n = 127)	0.1% (periodontists)	20.0% (endodontists)	n. s.

GUIDELINES

February 2006
Revised July 2009

DIAGNOSIS & MANAGEMENT OF TEMPOROMANDIBULAR DISORDERS & RELATED MUSCULOSKELETAL DISORDERS

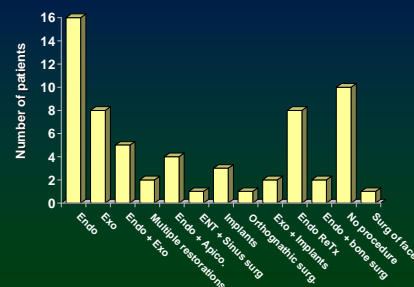
*Replaces those originally issued in November 1995 and reprinted in August 2002

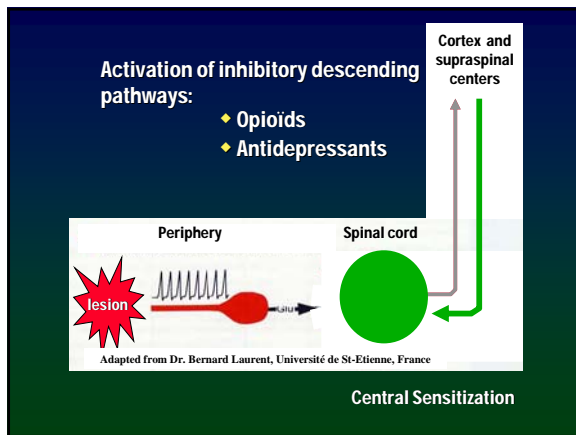
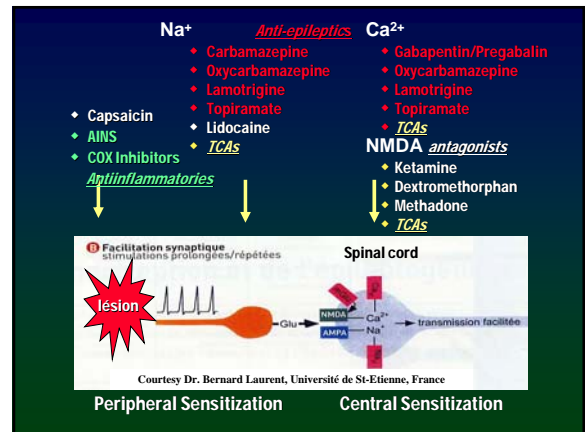
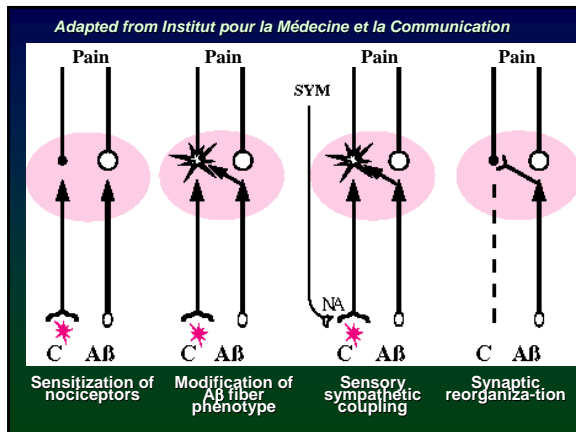


Marbach & Raphael, 2000

Atypical Odontalgia Type of Intervention

Ram et al, JADA, 2009





NNT: Number Needed to Treat

(Number of patients we need to treat with a medication, to obtain one patient with at least 50% pain relief)

The smaller the NNT, the better the medication

IASP

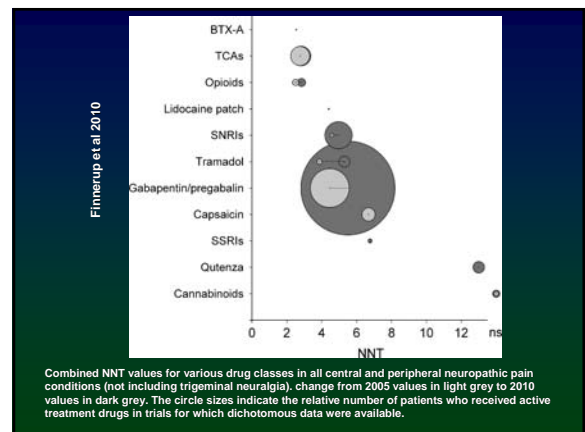
PAIN[®] 150 (2010) 573-581

PAIN[®]

www.iasp.com/locate/pain

The evidence for pharmacological treatment of neuropathic pain

Nanna Brix Finnerup^a*, Søren Hein Sindrup^b, Troels Staehelin Jensen^a



Towards better control of chronic pain

The Lancet, May 2010

... guidelines can and should change the treatment of chronic pain in three ways:

- 1 To inculcate a culture of research by identifying knowledge gap.
- 2 To standardize practice so that clinical trials can answer these questions
- 3 To assess the guidelines' goals by regularly measuring outcomes in a validated way.

Treatment for neuropathic pain – An overview of recent guidelines

adapted from *O'Connor & Dworkin, 2009*

Medication NNH/NNT	NeuPSIG (2007)	CPS (2007)	EFNS (2006)
TCAs	1 st line	1 st line	1 st line for PPN, PHN, CP
Gabapentin Pregabalin	1 st line	1 st line	1 st line for PPN, PHN, CP
SSNRIs	1 st line	2 nd line	2 nd line for PPN
Topical Lidocaine	1 st line for localized peripheral NP	2 nd line for localized peripheral NP	1 st line for PHN if small area of pain/allodynia
Opioids	2 nd line exc. in selected circumstances	3 rd line	2 nd -3 rd line for PPN, PHN, CP
Tramadol	2 nd line exc. in selected circumstances	3 rd line	2 nd -3 rd line for PPN, PHN
Carbamazepine/ Oxyc.			1 st line for Trigeminal Neuralgia

Treatment for neuropathic pain – An overview of recent guidelines

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Opioids	2 nd line exc. in selected circumstances	3 rd line	3 rd line for PPN, 2 nd line for PHN, 2 nd -3 rd for CP
Tramadol	2 nd line exc. in selected circumstances	3 rd line	2 nd -3 rd line for PPN, PHN
Carbamazepine/ Oxyc.			1 st line for Trigeminal Neuralgia

EFNS* guidelines on pharmacological treatment of neuropathic pain 2010 revision

Attal et al Eur J Neurol

Medication NNH/NNT	EFNS (2006)	EFNS (2010)
SSNRIs	2 nd line for PPN	1 st line for PPN
Opioids	2 nd -3 rd line for PPN, 2 nd line for PHN	3 rd line for PPN, 2 nd line for PHN, 2 nd -3 rd for CP

2006: "opioids have been found efficacious in several class I trials... but should only be proposed 2nd to 3rd line in chronic non-cancer pain."

2010 - For PPN: "3rd line therapy includes strong opioids because of concerns regarding their long-term safety including addiction potential and misuse, which warrants further RCTs"

*: European Federation of Neurological Societies

Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain

Part A: Executive Summary and Background
Part B: Recommendations for Practice

PART A

— Executive Summary and Background —

Published by the
National Opioid Use Guideline Group (NOUGG)
a collaboration of:

Federation of Medical Regulatory Authorities of Canada
College of Physicians & Surgeons of British Columbia
College of Physicians & Surgeons of Alberta
College of Physicians and Surgeons of Saskatchewan
College of Physicians & Surgeons of Manitoba
College of Physicians and Surgeons of Ontario
Collège des médecins du Québec
College of Physicians and Surgeons of New Brunswick
College of Physicians and Surgeons of Nova Scotia
College of Physicians and Surgeons of Prince Edward Island
College of Physicians and Surgeons of Newfoundland and Labrador
Government of Nunavut
Yukon Medical Council

Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain

Part A: Executive Summary and Background
Part B: Recommendations for Practice

PART A

Concerns regarding Patient & Public Safety Risks from Opioid Misuse

- In Ontario, oxycodone prescriptions rose 850% from 1991 to 2007
- The increase in opioid prescribing has been accompanied by simultaneous increases in abuse, serious injuries, and overdose deaths among individuals taking these drugs.
- From 1991 to 2004 in Ontario, the mortality rate due to unintentional opioid overdose increased from 13.7/million to 27.2/million/year, more than double the mortality rate from HIV (12/million)

CMAJ REVIEW

Opioids for chronic noncancer pain: a new Canadian practice guideline

Andrea D. Furlan MD PhD, Rhoda Reardon Dip(P&OT), Clarence Weppler BSc Pharm, for the National Opioid Use Guideline Group (NOUGG) CMJA June 15 2010

Key points

- In patients with chronic noncancer pain, opioids may be effective and should be considered.
- Opioid therapy should begin with a setting of realistic goals with the patient, a monitored trial of dosage titration, and follow-up to ensure opioid effectiveness.
- Prescribers and dispensers can minimize potential harms associated with opioid use by assessing risks, educating patients, monitoring use over time, and reducing or stopping opioids when indicated.
- Good communication and collaboration between health care providers and patients, across clinical disciplines, and between primary care and specialty care, is important when treating patients with chronic noncancer pain.

CMAJ REVIEW

Opioids for chronic noncancer pain: a new Canadian practice guideline

Andrea D. Furlan MD PhD, Rhoda Reardon Dip(P&OT), Clarence Weppler BSc Pharm, for the National Opioid Use Guideline Group (NOUGG) CMJA June 15 2010

Deciding to initiate opioid therapy

1. Comprehensive assessment
2. Screening for addiction risk
3. Urine screening for drugs
4. Opioid efficacy
5. Risks, adverse effects and complications
6. Benzodiazepine tapering

Conducting a trial of opioid therapy

7. Titration and driving
8. Stepped selection of an opioid
9. Optimal dose
10. Watchful dose
11. Risk of misuse

CMAJ REVIEW

Opioids for chronic noncancer pain: a new Canadian practice guideline

Andrea D. Furlan MD PhD, Rhoda Reardon Dip(P&OT), Clarence Weppler BSc Pharm, for the National Opioid Use Guideline Group (NOUGG) CMJA June 15 2010

Monitoring long-term opioid therapy

12. Monitoring
13. Switching or discontinuing opioids
14. Driving and opioid therapy
15. Revisiting steps of trial therapy
16. Collaborative care

Treating specific populations with long-term opioid therapy

17. Elderly patients
18. Adolescent patients
19. Pregnant patients
20. Comorbid psychiatric diagnosis

CMAJ REVIEW

Opioids for chronic noncancer pain: a new Canadian practice guideline

Andrea D. Furlan MD PhD, Rhoda Reardon Dip(P&OT), Clarence Weppler BSc Pharm, for the National Opioid Use Guideline Group (NOUGG) CMJA June 15 2010

Managing opioid misuse and addiction in patients with chronic pain

21. Options for addiction treatment
22. Prescription fraud
23. Unacceptable behaviour by patients
24. Acute care prescription of opioids

Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain

Part A: Executive Summary and Background
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PART B

— Recommendations for Practice —

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- College of Physicians and Surgeons of Ontario
- Collège des médecins du Québec
- College of Physicians and Surgeons of New Brunswick
- College of Physicians and Surgeons of Nova Scotia
- College of Physicians and Surgeons of Prince Edward Island
- College of Physicians and Surgeons of Newfoundland and Labrador
- Government of Nunavut
- Yukon Medical Council

April 30 2010 Version 5.6
<http://www.nougg.ca/website>

Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain

Part A: Executive Summary and Background
Part B: Recommendations for Practice

PART B

— Recommendations for Practice —

Examples of CNCP conditions for which opioids were shown to be effective in placebo-controlled trials*		Examples of CNCP conditions that have NOT been studied in placebo-controlled trials
Tramadol only	Weak or strong opioid	
Fibromyalgia	<ul style="list-style-type: none"> • Diabetic neuropathy • Peripheral neuropathy • Postherpetic neuralgia • Phantom limb pain • Spinal cord injury with pain below the level of injury • Lumbar radiculopathy • Osteoarthritis • Rheumatoid arthritis • Low-back pain • Neck pain 	<ul style="list-style-type: none"> • Headache • Irritable bowel syndrome • Biliary pain • Temporomandibular joint dysfunction • Atypical facial pain • Non-cardiac chest pain • Lyme disease • Whiplash • Repetitive strain injury

*A limitation of these trials was that the duration of opioid therapy was a maximum of three months.

What we still don't know about treating chronic noncancer pain with opioids

Chou R. CMAJ 2010

- In the Canadian guidelines, just 3 of 24 recommendations were classified as based on RCTs. Nineteen recommendations were based solely or partially on consensus opinions.
- In the US guidelines, 21 of 25 recommendations were viewed as supported by only low quality evidence.
- In other words, the developers of the guidelines found that what we know about opioids is dwarfed by what we do not know.

Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain

Part A: Executive Summary and Background
Part B: Recommendations for Practice

PART A

— Executive Summary and Background —

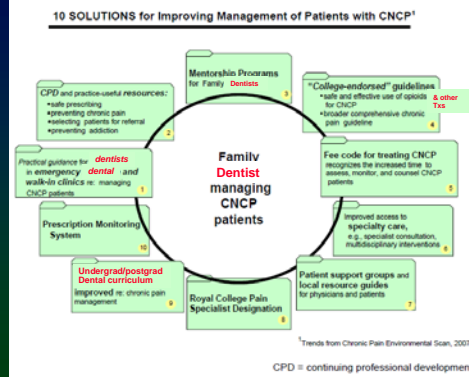
Guidelines are necessary but not sufficient for changes

CPG implementation strategies CMA 2007

Focus of strategy: Practitioners

- Educational meetings
- Educational materials
- Web-based education
- Educational outreach/academic detailing
- Audit and feedback; individual/associations
- Reminders: verbally, paper, computer...
- Local opinion leaders
- Patient-mediated interventions
- Practice tools, e.g. flow charts

Figure A-8.1.10 Solutions to Improving Management of CNCP



UofT Centre for the Study of Pain Interfaculty Pain Curriculum

- Dentistry
- Medicine
- Nursing
- Occupational Therapy
- Pharmacy
- Physiotherapy

Schedule			
PAIN: PUTTING THE PERSON AT THE CENTRE			
UofT CENTRE FOR THE STUDY OF PAIN INTERFACULTY PAIN CURRICULUM			
March 23 - 26, 2009 See manual for room locations			
MONDAY	TUESDAY	WEDNESDAY	THURSDAY
0900 Introduction J. Hunter		Lessons, Challenges and New Opportunities	
0930 Introduction to the Clinical Problem of Pain R. Jaffe		Concurrent Session A (0900 - 1030) Students each choose ONE session. 1. Pharmacotherapy of Pain: The Basics. R. Jaffe	
1000 Putting the Person at the Centre: The Experience of Living with Pain- Patient Panel Moderators: J. Watt-Watson L. Alaman-Welsh T. Day	Facilitated seminar groups: CASE: Acute Pain: Assessment of a person with acute pain 0900 to 1200	2. Complementary and Alternative Pain Management Strategies. T. Day, J. Laprade 3. Common Acute Pain Challenges. T. Day, R. Goodman, M. Sirosh 4. Pain in Children and Adolescents with Arthritis. K. Whitney-Hartney, N. Lattada, L. Jasko	Facilitated seminar groups: CASE: Persistent Pain Comprehensive, evidence-based management of a person with persistent pain 0900 - 1200
1130 Overview of the Clinical Problem of Pain R. Jaffe		break (1030 - 1100)	
		Concurrent Session B (1100 - 1200) Students each choose ONE session. 5. Pharmacotherapy of Pain: Clinical Issues. R. Jaffe 6. Self-management Strategies for Chronic Pain. M. McGillivray, S. Greenwood 7. Cancer Pain: An Interprofessional Approach. Ludrachi, C. Shohetnik, R. Satalani	
1230			
1330 - 1630	Profession specific perspectives (see manual - page 8 for room numbers)	Teams meet independently CASE: Acute pain management	Teams meet independently NEW CASE: Persistent Pain - Assessment of the person with persistent pain.

*Thank you for your
kind attention*

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WHAT NEEDS TO BE DONE? THE CHALLENGES

The deliberations from each of the discussion groups at the symposium that focused on the following five key areas provide a broad and comprehensive framework for action by the regulator, dental educators and the dental community.

A. EDUCATION OF UNDERGRADUATE DENTISTS

1. Establish educational objectives so that graduating students are:
 - Able to diagnose pain disorders.
 - Able to discriminate between pain as a symptom (manifestation of an organic disease) and pain as a disease (a sensory disorder affecting the peripheral and central nervous system).
 - Understand the pharmacotherapeutics of chronic pain.
 - Understand the value of non-pharmacological pain management and the effect of psychosocial factors.
 - Understand their own professional and personal limitations in the practice of pain management and the prescription of potentially addictive medications.
 - Understand the important of interprofessional collaboration and be able to initiate appropriate referrals.

2. In order to best meet these objectives, during their course of study, dental students would need to:
 - Obtain foundational knowledge of the basic science of pain physiology.
 - Have a sound knowledge and clinical ability to diagnose and treat/manage symptomatic organic disease of the mouth and jaw.
 - Gain experience in clinical practice with chronic pain patients through the use of seminars, problem-based learning and clinics. This would require that clinical instructors be specifically trained to teach diagnosis and management of chronic pain.
 - Collaborate with the other health care providers, who through their knowledge and training, are qualified to deal with chronic pain management through the use of interprofessional teaching modules.

- Receive regular assessments of competencies expected at the various levels of teaching.
- Be encouraged to apply for hospital internships or other relevant post-graduate experience after completion of their dental degree.

B. CONTINUOUS EDUCATION OF DENTISTS IN PRACTICE

1. Increase the opportunities for dentists to access continuous education on this topic.

- Use a wide variety of continuous education delivery modes, including: webinars, magazine articles, print-based tool kits, live presentations/courses with pain management scenarios and online learning.
- This continuous education would be provided by:
 - faculties/schools of dentistry;
 - the regulator, the Royal College of Dental Surgeons of Ontario;
 - the regulator in partnership with the dental professional association, the Ontario Dental Association;
 - private continuing education course providers.

The caveat on the corporate sponsorships of CE courses/programs/lectures is the appearance or perceptions of a conflict of interest, or indeed real conflicts. This could be addressed by having unrestricted grants and corporate sponsorships noted publicly. This practice is customary in peer-reviewed journals.

2. Adapt the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain for dentistry.

- Establish a multidisciplinary working group with representation from appropriate health care regulatory bodies, professional associations and content experts.
- Link the Guidelines to regulations/standards so that they are enforceable.
- Establish reporting requirements about misuse for dentists.

3. Work collaboratively with other involved health care professionals (physicians, nurses, pharmacists) to develop educational materials, such as tool kits, and to facilitate the use of existing resources and supports, such as the Drug Information and Research Centre of the Ontario Pharmacists Association.
4. Work with the College of Pharmacists of Ontario to develop educational materials that can be delivered in a range of ways, e.g. print/web-based.
5. Acknowledge and incorporate into the strategy the importance of role models in the transfer of new information and adoption of best practices.
6. Promote the relationship between knowledgeable pain management by dentists and the satisfactory outcomes for patients: more knowledgeable dentists mean happier patients.

C. IMPROVEMENTS IN THE EDUCATION OF PATIENTS

1. Education of the dentist in the proper management of pain is the best vector for the education of patients. Dentists need to recognize that pain and addiction can coexist. All medications have risks and must be managed appropriately. In order to do that, dentists must make the right diagnosis, do a risk assessment and have treatment exit strategies.
2. Patients need assistance to understand that factors in their medical history (emotional and physical abuse/depression, etc.) strongly influence the risks when taking opioids.
3. Both patients and dentists need to understand that drugs are both the problem and solution. Due to the inherent risks of drugs, their use must be carefully managed.
4. Effective communications through the patient/dentist dialogue is an effective way to manage patient expectations.
5. Dentists need to work collaboratively with other members of the patient's health care team (physicians/pharmacists) to be able to treat the patient in a comprehensive way.

6. Both dentists and patients need to be open to the referral of the patient to another health care professional more experienced in the management of pain.

D. USE OF TECHNOLOGY TO SUPPORT PATIENT CARE

1. Computer literacy is essential and should be made a core competency for dental students and a standard of practice for dentists.
2. There should be consistency in design of computer systems for all health care practitioners, including dentists, to facilitate interprofessional integration and collaboration and to address security and privacy issues.
3. Enable e-prescribing to assist in decreasing prescription errors and increasing public safety. At the same time, encourage the use of clinical decision support tools.
4. Institute a Drug Information System (DIS) that would provide prescribers and dispensers with access to a complete history of all prescriptions for each individual patient.
5. Develop and promote online access to resources for dentists, such as prescribing guidelines and educational material for dentists and their patients.
6. Patients should have online access to their own electronic health records to help empower them to take an active role in their own care. It would also save time and improve safety in event of an emergency.
7. Take immediate steps to use technology/education as the implementation of large systemic changes may be a long time off.

E. COLLEGE SUPPORT OF INTERPROFESSIONAL COLLABORATION

1. Advocate the Ministry of Health and Long-Term Care for the establishment of appropriately resourced regional specialized pain clinics.
2. Advocate government and private insurers for financial incentives to facilitate direct referral to specialists.
3. Advocate for fee codes to allow dentists to bill for the diagnosis and management of oral-facial pain.
4. Develop case-based learning modules and webinars in collaboration with other health care regulators that focus on case studies (e.g. long-term resident with multiple needs: dental, nutritional, medical, nursing, physiotherapy, etc).
5. Support and advocate for the development of e-health systems that enable appropriate access to health information by health care professionals that includes prescription drug history.
6. Work with Ministry of Health and Long-Term Care and other health care regulatory colleges to ensure privacy issues do not create a barrier to quality, safe and effective patient care.
7. Encourage the Federation of Health Regulatory Colleges of Ontario (FHRCO) to develop annual interprofessional collaboration objectives and to report every year publicly on their accomplishment via the websites of the regulators and FHRCO.

NEXT STEPS

The symposium has raised a number of important issues that face dentistry in supporting the government's effort to identify and reduce abuse, addiction and diversion of narcotics and other controlled substances and in enhancing the profession's knowledge and ability to appropriately manage pain.

Excellent collaborative relationships are already established with our colleagues in medicine, pharmacy and nursing.

Also, in late November, the College received a letter from the Opiate Project Manager at the Centre for Addiction and Mental Health (CAMH) offering to work with the College in educating its members about how to potentially minimize some of the access to opioid prescriptions and use by youth and others who are at risk.

This letter from CAMH was in response to the one of the three educational webinars that the College produced for Ontario dentists in the fall of 2010 that profiled University of Toronto's Dr. Dan Haas speaking on acute pain control and the use of opioids in dentistry.

The College is committed to moving forward on this issue. The question now is how best to do that.

This report will be shared with the College's Quality Assurance Committee for review and recommendations over the coming months. These recommendations would then proceed to the College Council for debate and consideration for action.

WITH THANKS

The College is enormously grateful to all the participants in the November 2010 symposium, and especially to the presenters. The calibre of these presenters is without measure and this report and subsequent actions by the College are only possible because of their singular contributions.