

4 March 2014

Mr. Greg Loyst
Director of the Office of Policy and Strategic Planning
Controlled Substances and Tobacco Directorate
Room 1605
1st Floor, Main Statistics Building
150 Tunney's Pasture Driveway
Ottawa, ON K1A 0K9

Sent via email: greg.loyst@hs-sc.gc.ca

Dear Mr. Loyst:

Thank you for this opportunity to comment on the *Controlled Drugs and Substances Act* (CDSA) and its regulations. In this letter, I would like to speak specifically to our perspectives addressing prescription drug abuse, prescribing medical marijuana, and the importance of harm reduction.

The College of Family Physicians of Canada (CFPC) is the voice of Family Medicine in Canada, representing over 30,000 dedicated members. The CFPC advocates on behalf of its members to ensure high quality in the delivery of care. Education is a key element of our mandate: we establish standards for the training, certification and ongoing education of family physicians; we are responsible for accrediting postgraduate family medicine training in Canada's 17 medical schools.

Family physicians are largely at the centre of prescribing. Prescriptions for the most common of drugs are usually written by us. But I would be remiss if I didn't note that prescribing decisions – whether to prescribe, what to prescribe, how much to prescribe - can be the result of complex factors. For example, how a patient reacts or doesn't react to certain medications, the patient's history, other drugs the patient is taking, considering a patient's preferences and income levels when prescribing (for example, what to do when a lower income patient does not have a drug benefit plan) and what happens when a patient is prescribed a drug in hospital and then discharged.

While there are numerous benefits to prescription medications, we are certainly aware of harms due to prescription drug misuse and abuse.

Those harms include severe allergic reactions and a variety of effects related to the known mechanism of action and effect of the drug. For some drugs, the harmful effects involve addiction, withdrawal, overdoses (intentional and unintentional) and suicide.

In a study of opioid-related deaths among Ontario Drug Benefit patients in 2006, 40% of all single-opioid deaths were due to oxycodone, followed by morphine/heroin. One study also found that in about two-thirds of opioid-related deaths in Ontario, the victim had been seen by a physician at least a month prior to death. In most cases, the coroner determined that the cause of death was accidental.

The CFPC has taken a position on oxycodone in particular. In November 2012, our Board passed the following resolution:

“The CFPC expresses profound concern that any changes that lead to an increase in the Canadian supply of sustained release oxycodone will contribute to further ongoing abuse of this drug and all of the accompanying negative health and social consequences. We call for a comprehensive approach to increase research and education initiatives surrounding appropriate and effective treatment strategies for patients who suffer from chronic pain.”

The CFPC takes its role of social accountability seriously. We know that family physicians must take steps to assist in the reduction of prescription drug abuse and misuse.

We recommend that this issue be addressed using the framework from the report: “First do no Harm: Responding to Canada’s Prescription Drug Crisis”; the CFPC was a member National Advisory Council on Prescription Drug Misuse that contributed to this report.

The CFPC is concerned with the government’s approach to prescribing medical marijuana. As our position statement on medical marijuana notes:

“The potential liability, as well as the ethical obligations, for health professionals prescribing marijuana for medical purposes appears not to have been adequately addressed. In our view, Health Canada places physicians in an unfair, untenable and to a certain extent unethical position by requiring them to prescribe cannabis in order for patients to obtain it legally. If the patient suffers a cannabis-related harm, physicians can be held liable, just as they are with other prescribed medications. Physicians cannot be expected to prescribe a drug without the safeguards in place as for other medications – solid evidence supporting the effectiveness and safety of the medication, and a clear set of indications, dosing guidelines and precautions. On the other hand, if the physician refuses to prescribe, this might damage the patient-physician relationship; some patients will blame their physician for forcing them to purchase marijuana illegally.”

We have welcomed a number of opportunities to work with Health Canada on this issue and Health Canada continues to solicit our perspectives on medical marijuana prescribing. Canadian family physicians are being faced with requests from their patients to prescribe smoked marijuana in the absence of any solid evidence for efficacy, dosing limits, and comparability with therapeutic alternatives. As the organization that these physicians look to for guidance on difficult clinical decisions, we cannot at this time, ethically recommend to our members that they prescribe medical marijuana when evidence is not present.

Finally, I would like to note the absence of a harm reduction action plan in the National Anti-Drug Strategy. The CFPC encourages Health Canada to rely on the best evidence when developing plans to address illicit drugs. Harm reduction mitigates human suffering and must not be judged ideologically or politically. For example, data indicate that at Vancouver's Insite, health care staff "fielded 497 overdose incidents, performed 3,418 clinical treatment interventions, and made 4,564 referrals to other social and health services" (Canadian Public Health association brief to the Standing Committee on Public Safety and National Security, February 2014).

The CFPC has also commented that the National Anti-Drug Strategy is concerning as it, in concert with other recently-passed laws, appears to favour enforcement over prevention, treatment and harm reduction. We encourage you to strike a balance between the three action plans present in the National Anti-Drug Strategy and we strongly urge you to add harm reduction.

The CFPC is taking a leadership role through our Patient's Medical Home. This vision for family practice advocates for a team-based, patient-centred approach. By creating multidisciplinary teams, such as family health teams and primary care networks, we are able to provide a full range of treatment options related to pain, mental illness, and addiction.

Thank you once again for this opportunity to present a family medicine perspective on the CDSA and the National Anti-Drug Strategy. The CFPC would be pleased to continue this dialogue with you at your convenience.

Sincerely,

A handwritten signature in black ink, appearing to read "Kathy Lawrence". The signature is fluid and cursive, with the first name "Kathy" written in a more stylized, looped manner.

Kathy Lawrence MD, CCFP, FCFP
President

c.c.: Dr. Francine Lemire, Executive Director & Chief Executive Officer, CFPC
Dr. Jamie Meuser, A.E.D. & Director, Continuing Professional Development, CFPC
Mr. Eric Mang, Director, Health Policy and Government Relations, CFPC