more useful to regard a fax transmission as a form of telephone call, with the advantage of a readable message at both ends.

To continue the telephone-call analogy, use of the fax should pose little problem to physicians, who are well aware of legal requirements concerning prescribing over the telephone. Direct fax prescribing by physicians has many potential benefits. For instance, the original prescription remains in the prescriber's computer. Therefore, tampering with a prescription, such as changing the quantity, can be instantly verified by a conscientious pharmacist.

Computers should increasingly be found on physicians' desks. There is certainly a need for guidelines on standards and security — a debate about this need is proceeding vigorously in Britain and can be followed on the Internet. We need a much broader discussion than Capen's observations on fax machines.

Robert T.S. Frankford, MB, BS
Toronto, Ont.

[The author responds:]

Dr. Frankford is correct in pointing out that the issue of the use of fax technology in medical practice (generally and in the specific case of prescriptions) requires a much broader discussion and study than the Case File format permits. As often is the case, the development of technologies such as the fax modem outpaces the development of policies and guidelines for their use, in both practical and legal terms. However, in the interests of careful practice management, readers are directed to their respective provincial or territorial licensing bodies for the most current and appropriate information.

The College of Physician and Surgeons of Ontario stated in May 1994 that "this issue [i.e., faxing prescriptions] will require further discussion with licensing authorities in medicine and pharmacy and professional associations of physicians and pharmacists as well as with the government."

Karen Capen, MA, BCL, LLB
Ottawa, Ont.

Regulated analgesics and pain control

Drs. John F. Anderson, Kimberley L. McEwan and William P. Hrudey are to be praised for their use of an educational intervention to improve prescribing of controlled drugs, as described in their article "Effectiveness of notification and group education in modifying prescribing of regulated analgesics" (*Can Med Assoc J* 1996; 154: 31–39). We affirm the use of opioids to treat only selected patients with chronic nonmalignant pain (i.e., pain not caused by cancer), as only one facet of a comprehensive approach. However, we are concerned that Anderson and colleagues may have reinforced the established "opiophobia" of some clinicians.

The authors appear to have a strong negative view of the use of opioids to treat chronic nonmalignant pain. The evidence cited to support this view is taken from *Minnesota Medicine*, a periodical that is not held by the main medical library at the University of Calgary.

In contradistinction, there is substantial published evidence supporting the effectiveness of opioids in treating many chronic pain states, including neuropathic pain, pain due to arthritis and idiopathic pain.[1–4] Chronic pain states are a heterogeneous group of disorders, with a spectrum of nociceptive and nonnociceptive mechanisms; this heterogeneity suggests the need for trials of drugs or other therapies to sort out the many complex issues involved. A blanket statement that opioids are best avoided in the care of most patients with chronic nonmalignant pain is too proscriptive, according to current published knowledge.[5]

A second premise of this study, that "narcotics . . . are often abused by patients addicted to them," requires clarification. This coupling of addiction with patient use of opioids may be interpreted to mean that most patients who take opioids for nonmalignant pain are at a high risk of becoming addicted. The hypothesis that opioids are so compelling that they can make addicts out of nonaddicts has been strongly challenged by the results of several large surveys of patients who took opioids and were followed to assess subsequent drug abuse.[5] In contrast, addicts do seem to be at particular risk of abusing opioids, even when the drugs are administered for medical reasons. Such patients are best referred to a pain specialist before a trial of opioids.[6]

A third premise is the effect of a regulatory agency concerned with the narrow problem of drug diversion on the broader problem of pain and suffering among patients. Opioid prescription rates have fallen in regions where a drug-scheduling program was established, partly because physicians held back prescriptions, even for patients who needed opioids, because they were afraid of sanctions.[7–9] Medical licensing bodies should demonstrate sensitivity to this unwanted effect of prescription policing and should explicitly affirm the important role of each physician's own professional judgement. Blanket statements such as "narcotics are usually inappropriate for treating chronic pain" can be challenged not only for their accuracy but also for their risk of disqualifying physicians from exercising their clinical judgement in individual circumstances.[10]

Cancer pain and many other kinds of pain continue to be undertreated in Canada and elsewhere;[11–13] Canadians and others who have been dissatisfied with relief of pain have

resorted to legal action.[14,15] Are the one third of physicians in British Columbia who are not registered to prescribe regulated analgesics adequately equipped to care for patients with cancer? Have licensing bodies approached unregistered physicians to warn them of the high prevalence of undertreatment of pain?

We need a balanced approach unclouded by opiophobia, attention to the undertreatment of pain and the unjudicious use of analgesics and more widely available multidisciplinary and multimodal care.[16,17] We encourage provincial colleges of physicians and surgeons to use their triplicate prescription programs (TPPs) for such positive ends, rather than to police the profession.

Neil A. Hagen, MD, FRCPC
Associate professor
Neurology
Department of Clinical Neurosciences
University of Calgary
Calgary, Alta.
Paul Flynne, MB, ChB
Assistant registrar
College of Physicians and Surgeons of Alberta
Edmonton, Alta.
Neil Macdonald, MD, FRCPC
Director
Cancer Ethics Programme
Clinical Research Institute of Montreal
Professor of oncology
McGill University
Montreal, Que.

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[One of the authors responds:]

Drs. Hagen, Flynne and Macdonald request clarification of our statement that "narcotics . . . are often abused by patients addicted to them." This statement is not meant to imply that most patients with chronic pain will develop a substance-use disorder if they are treated with opioids. Instead, it refers to the potential for opioids to create problems for the subpopulation of patients with chronic pain who also have a substance-use disorder. In a recent Swedish study,[1] 23% (97/414) of patients with chronic pain referred for evaluation and rehabilitation met the criteria in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R)* for a diagnosis of chemical dependence. Dependence was most common among those taking analgesics, including opioids. This study provides a strong argument for screening patients with chronic pain for a substance-use disorder, for providing addiction assessment and treatment to patients with a positive screen result and for avoiding analgesics that can exacerbate substance-use disorders.

John F. Anderson, MD
Adult Clinical and Addictions Services Branch
British Columbia Ministry of Health
Victoria, BC

Our biggest concern about the modification of prescribing practices for regulated drugs is the underlying assumption that the highest prescribers of regulated drugs are practising bad medicine. This is not necessarily the case. This study has made no attempt to identify whether the prescription of a regulated drug was appropriate or inappropriate.

Among pain specialists, it is now agreed that a subgroup of patients who suffer from chronic pain can benefit from the long-term use of opioids. Benefits include improved level of functioning and better quality of life. Guidelines have been established for the prescribing of long-term opioid therapy for non-malignant pain.[1] In Canada these guidelines have been endorsed by the licensing bodies in two provinces. The guidelines clearly indicate that physicians should educate patients concerning approaches to pain management other than drug