Prevalence and determinants of cannabinoid prescription for the management of chronic non-cancer pain: A postal survey of physicians

| Abstract: | Objectives: Cannabinoid prescription patterns for the management of chronic non-cancer pain (CNCP) are inadequately studied in Quebec as well as in the rest of Canada and internationally. The objectives of this study were to measure the prevalence and identify the determinants of cannabinoid prescription in the management of CNCP.

Methods: In February 2013, a postal survey was sent out to all physicians of the Abitibi-Témiscamingue region (Quebec) using a modified Dillman method. Multivariate logistic regression models were used to identify determinants of cannabinoids prescription.

Results: The response proportion was 52.2%, for a total of 166 physicians. A majority of physicians (79.2%) had not attended continuing medical education (CME) activities concerning cannabinoids in the past year. The prevalence of cannabinoid prescription for the management of CNCP was 23.0%, with 91.1% of these physicians prescribing cannabinoids to ≤5 patients. Among prescribers, 92.1% reported having prescribed nabilone, 18.4% medical marijuana, and 5.3% nabiximols. Multivariate modelling showed that physicians' comfort level with cannabinoid prescribing was the principal determinant of increased likelihood of cannabinoid prescription. Prescribers and non-prescribers reported that CME activities could increase their comfort level with cannabinoid prescribing. According to physicians, more studies are needed about the efficacy and safety of cannabinoids for the treatment of CNCP.

Conclusions: Although cannabinoids are not products of first line in the therapeutic arsenal for the treatment of CNCP, they appear to have their |

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Prevalence and determinants of cannabinoid prescription for the management of chronic non-cancer pain: A postal survey of physicians

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INTRODUCTION

Between 11 to 29% of the Canadian population is affected by chronic pain (1-4) which is known to have serious consequences for the physical functioning, mental health and quality of life of those who suffer from it (3, 5-7). This health issue also represents a significant economic burden on the healthcare system (8, 9). To date, the treatment of chronic non-cancer pain (CNCP) remains suboptimal, mainly because of a lack of recognition of the condition, not enough training for healthcare professionals, the absence of effective treatment, the lack of access to pain treatment centers and the suboptimal usage of certain drug classes (5, 8, 10-13).

Cannabinoids are a therapeutic modality for the management of CNCP that has been found effective and safe for some pain syndromes (14-17) while for others, it raises concerns (18, 19). A number of pharmaceutical products are available in Canada such as nabilone (Césamet®), nabiximols (Sativex®) and medical marijuana. However, the usage prevalence of these products for the management of pain symptoms remains low (12-15%) (20-23). This limited use among patients could be partly explained by the stigma associated with smoking marijuana which also affects the products offered in pills or vaporizer (21, 24). Using cannabis for medical purposes is one of the treatments for which users are the most stigmatized regardless of their specific health condition (25). Moreover, the situation could be explained by physicians' lack of comfort regarding these therapeutic modalities (26). As of now, very few studies have been conducted to explore physicians' prescription practices and attitudes toward the use of cannabinoids for the treatment of CNCP in Canada (27).

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It is important to better understand the cannabinoid prescription habits of physicians to inform educational programs. The specific objectives of this study were to measure the prevalence of cannabinoid prescription for the management of CNCP and identify the determinants of cannabinoid prescription. Physicians' comfort level with cannabinoid prescribing was also investigated. Considering the attention given to medical cannabis in recent medical literature and the new Canadian medical marijuana regulations (28), this is an important and timely topic.

METHODS

Study population

The present study was conducted among a convenience sample composed of the physicians who are members of the *Collège des Médecins du Québec* (CMQ) and who are practicing in one of the five main Health and Social Services Centres (HSSC) of the Abitibi-Témiscamingue region of Quebec (Canada). As of January 2013, 318 physicians (family physicians: n = 183, physicians practicing another medical speciality: n = 135) met these criteria.

Research design & Protocol

In February 2013, a cross-sectional postal survey was sent to all these physicians. The protocol was approved by the human research ethics committee of the Université du Québec en Abitibi-Témiscamingue.

Participants completed a French language paper-and-pencil self-administered questionnaires that they received by mail. A modified Dillman's Total Design Survey

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Method (29) which implies four rounds of postal mail-outs was used. In the first round, an introductory letter, the questionnaire and a pre-paid return envelop were mailed to participants. The second round involved a reminder postcard sent one week after round one. For round three, three weeks after the initial mail-out, a duplicate questionnaire as well as a pre-paid return envelop were mailed to the participants who still had not returned their questionnaire. Finally, in round four, duplicate questionnaires with a pre-paid return envelop were again mailed out, this time seven weeks after round one. Registered mail was not used for this seven-week packet contrary to what is suggested by Dillman.

According to recommendations (30-32), some additional strategies were used in order to further increase the response proportion. For instance, the cover letter had a blue handwritten signature and a direct telephone contact for the principal investigator, assurance of confidentiality was given, the correspondence was personalized, the questionnaire consisted of 12 pages colour printed pages, and finally a teaser sentence "*By opening this envelope, you will contribute to research conducted in Abitibi-Témiscamingue by researchers from here!*" was printed on the mailing envelope. No financial incentives were offered to physicians in exchange for their participation.

The first round resulted in a 15.7% response proportion (50 questionnaires), second round increased the response proportion to 31.1% (49 questionnaires), round three further increased the response proportion to 43.3% (42 questionnaires), and finally round four led to a final response proportion of 52.2% (25 questionnaires). Comparison between the characteristics of the physicians who participated in the study with those of the physicians

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who did not participate was possible since information such as such as medical speciality

and belonging Health and Social Services Center are published in CMQ's directory.

Measures

The questionnaire aimed to measure cannabinoid prescription patterns of physicians

specifically regarding CNCP (Appendix I). Its content was designed according to the

Cannabinoid Education Needs Assessment tool developed by the Canadian Consortium for

the Investigation of Cannabinoids (CCIC; www.ccic.net) that was used in previous research

(27). For the purpose of this study, relevant questions were adapted to French-Canadian

language and to the context of CNCP (double forward translation method by two

independent translators, reviewed by an expert committee who reached a consensus on any

discrepancies). Other items such as physicians' comfort level with cannabinoid prescribing

were added and the final questionnaire was pretested among a sample of adults suffering

from chronic pain.

Measures included the past-year prevalence of cannabinoid prescription, types of

cannabinoids prescribed, prescription indications, physicians' comfort level with

cannabinoid prescribing (0 to 10 scale where 0 indicates absolutely not comfortable and 10

indicates completely comfortable), characteristics of physicians' medical practice, and

factors that could increase physicians' comfort level with cannabinoid prescribing. Listed

factors (list of answer choices) were chosen according to previous literature (27) with the

option to specify other factors that could increase comfort level.

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Data Analysis

Descriptive statistics were conducted in order to describe the sample as well as the study variables. Multivariate logistic regression models were used to identify the determinants of cannabinoid prescribing for the management of CNCP (yes/no). The choice of variables to be included in the final multivariate model was based on their association with this dependant variable (all predictors with a p-value ≤0.15 in the univariate logistic regression models in addition to the number of years of practice). Because of our substantial sample size (n = 166), we are confident that the statistical power of the multivariate models was sufficient based on the following rule of thumb: sample size ÷ 20 = the number of variables that can be included in the multivariate model (33, 34). All statistical analyses were conducted with the IBM SPSS Statistics software version 19[®].

RESULTS

Prescription habits

Table 1 shows the socio-demographic characteristics of the 166 physicians who completed the questionnaire as well as those of the 152 physicians who failed to return their questionnaire. The only difference between the two groups was regarding the HSSC where they were practicing. Specifically, physicians from the HSSC Rouyn-Noranda were more likely to return their questionnaire than the other physicians. Of the non-responding physicians, six called or wrote to the researchers to discuss their reasons for not participating: not in a clinical practice (n = 1), doesn't treat chronic pain (n = 1), does not prescribe any prescription drugs (n = 3), and cannabinoids are against their values (n = 1).

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Table 2 shows the characteristics of the participating physicians (family physicians: 56%).

A majority of physicians (79.2%) had not attended any continuing medical education

(CME) activities about cannabinoids in the past year. The overall prevalence of past-year

cannabinoid prescription for all potential indications was of 27.3%. As shown in Figure 1,

the prevalence of cannabinoid prescriptions specifically for the management of CNCP in

the present sample was 23.0%; 91.1% of these physicians prescribed cannabinoids to ≤5

patients during the past year. Among those who prescribed cannabinoids for the

management of CNCP, 92.1% prescribed nabilone (Césamet®), 18.4 % prescribed medical

marijuana, and 5.3 % prescribed nabiximols (Sativex®).

When prescription prevalence was stratified by medical speciality, it was found that 34.8%

of family physicians vs. 8.2% specialists had prescribed cannabinoid for the management of

CNCP in the past year (p < 0.05).

Comfort with cannabinoid prescriptions

Figure 2 shows the degree of comfort with prescribing cannabinoids that physicians have

reported. A minority of physicians reported a comfort level superior or equal to 6 on a 10

point scale for the prescription of cannabinoids in general (17.3%) or for the management

of CNCP (19.4%).

When asked what factors could increase their comfort level with prescribing cannabinoids

for the management of CNCP (according to cannabinoid prescribers and non prescribers), a

majority of physicians mentioned attending CME activities about cannabinoids (68.4%),

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having guidelines/algorithms including cannabinoids (67.8%), and having more clinical

data and new studies (50,0%).

Determinants of cannabinoid prescriptions

Table 3 shows the different variables associated with the prescription of cannabinoid for the

management of CNCP, both in the univariate logistic regression models and in the final

multivariate model. The univariate regression models, which do not allow for the

consideration of intercorrelations between independent variables, suggest that medical

speciality (specialists vs. family physicians OR : 0.17; 95%CI : 0.07-0.43), practicing in a

hospital environment (OR : 0.35; 95%CI : 0.16-0.75), practicing in a family medicine

group/family medicine unit (OR : 3.21; 95%CI : 1.48-6.96), higher weekly caseload (OR :

1.02; 95%CI : 1.01-1.03), higher perception of CNCP prevalence in their clientele (OR :

1.03; 95%CI : 1.01-1.05), and higher degree of comfort with prescribing cannabinoids for

the management of CNCP (OR : 2.04; 95%CI : 1.64-2.54) were all associated with the

prescribing of cannabinoids for the management of CNCP (p<0.05). However, when the

intercorrelations between independent variables were considered (final multivariate model)

a higher degree of comfort with prescribing cannabinoids for the management of CNCP

(OR : 1.25; 95%CI : 1.01-1.55) was the only variable that significantly predicts the past-

year prescription of cannabinoids for the management of CNCP (controlling for the years

of practice, medical speciality, practicing environment, weekly caseload, perceptions of

CNCP prevalence in their clientele and the proportion of past-year attended CME about

cannabinoids).

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Figure 3 shows more specifically the correlation between physicians' comfort level with prescribing cannabinoids for the management of CNCP and the prevalence of prescription. Results indicate that 83% of the variance in prescription prevalence can be explained by physician's degree of comfort.

INTERPRETATION

The present results suggest that the proportion of physicians who have prescribed cannabinoid for the management of CNCP is substantial, but this therapeutic modality is prescribed to very few patients. Furthermore, the results suggest that the degree of comfort with cannabinoids is low and that the more physicians are comfortable with prescribing cannabinoid the more likely they are to prescribe cannabinoid products to their patients for the management of CNCP.

The degree of comfort of Canadian physicians regarding cannabinoid prescriptions for the management of CNCP has not been studied. The present results show that they are not comfortable prescribing cannabinoids, as roughly 80% of them reported a degree of comfort below 6 on a 0-10 scale. Furthermore, independent of years of practice, medical speciality, practice environment and the number of CME about cannabinoids attended in the past year, only the degree of comfort with prescribing cannabinoids was found to be a significant determinant of their prescription for the management of CNCP. It is suggested, based on the results of the present study, to target physicians' degree of comfort in the development of new CME activities. Other potential helping factors reported by physicians were the establishment of guidelines/algorithms for cannabinoids prescription. Chronic pain guidelines including these therapeutic agents exist (35, 36) but our findings suggest that

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these guidelines merit more dissemination. Past research has also found that having a

personal positive experience with medical or recreative marijuana could increase

physicians' degree of comfort with cannabinoids (37). This was however not assessed in the

present study.

Another important result is physicians' low estimation of CNCP prevalence. Specifically,

they estimated the prevalence of CNCP in their clientele at 10% or less while it is well

accepted that the prevalence of CNCP is around 25% for patients consulting in primary care

(38). Furthermore, a high number of the physicians had not attended a training session

about CNCP (34%) or about cannabinoids (79.2%) in the past year. Given that the literature

suggests that Canadian healthcare professionals manifest a need for better training

regarding the treatment of chronic pain (4, 39, 40), it would be beneficial to increase the

number of training opportunities.

Finally, although close to a quarter of the physicians (23,0%) reported having prescribed

cannabinoids for CNCP, most of them (91.1%) had only prescribed it to 5 or less patients in

the preceding 12 months which suggests a low usage of these products among CNCP

patients. To date, few studies of this kind have been conducted with samples of physicians.

In the only other Canadian study conducted, the prescription prevalence was of 35% for

family physicians and 33% for physicians with a different medical speciality (27). In the

present study, when the prescription prevalence is stratified by medical speciality, the

results are in line with those reported by Ziemianski et al. (27) for family physicians

(34.8%) but significantly less physicians with a different medical speciality prescribed

cannabinoids in our sample (8.2%). This difference could be explained by the fact that the

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Ziemianski et al. (27) sample was composed of physicians who participated in CME

activities about cannabinoids. Their sample may have been more representative of

physicians interested by this drug class and not necessarily representative of all physicians.

Nonetheless, increased access to CME activities about cannabinoids could help increase the

comfort of physicians with this drug class for the management of CNCP.

Limitations and Strengths

The present study has a number of significant strengths such as the usage of a standardized

data collection method, a high response proportion in the context of a physician survey, the

inclusion of numerous potential confounding variables in the data analyses, and a

satisfactory statistical power due to the sample size. However, a number of limitations must

be mentioned. First, even though the participating and non participating physicians were

similar on a large number of characteristics, more physicians from one HSSC participated

compared with the other 4 HSSC of the administrative region where the study was

conducted. Also, it is possible that non responders decided not to complete the

questionnaire because they do not prescribe cannabinoids or are not comfortable with them.

If that was to be true, the present results may present an over-estimation of cannabinoid

prescription prevalence. Finally, the present results may not be generalizable to all the

clinical contexts of Canada. However, it is probable that the specific training needs

identified by the physicians of the present study are generalizable to other physicians who

are not familiar with this drug class.

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Conclusion

The results of the present study suggest that cannabinoids are not often prescribed for the management of CNCP and that physicians are not comfortable with this drug class. This degree of discomfort could be addressed by CME activities. Future research is nonetheless needed in order to replicate the present results in different regions and to determine the objective impact on prescription of offering more CME activities about cannabinoids. Although cannabinoids are not products of first line in the therapeutic arsenal for the treatment of CNCP, they have their place in the toolbox of physicians. Researchers and educators must work with physicians for optimal and informed cannabinoid prescription and use.

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Table 1. Comparison between the characteristics of the physicians who participated in the study with those of the physicians who did not participate.

Physicians' characteristics	Participants (n=166)	Non participants (n=152)
Medical speciality – n (%)		
Family physician	93 (56.0)	87 (57.2)
Other speciality	73 (44.0)	65 (42.8)
Sexe – n (%)		
Male	77 (46.4)	81 (53.3)
Female	89 (53.6)	71 (46.7)
HSSC – n (%)		
HSSC Rouyn-Noranda	62 (37.3)	34 (22.4)
HSSC Vallée-de-l'Or	46 (27.7)	34 (22.4)
Other HSSC [a]	58 (34.9)	84 (55.3)

HSSC = Health and Social Services Centers

[a] HSSC Aurores-Boréales, HSSC Témiscamingue and HSSC Les Eskers de l'Abitibi.

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Table 2. Characteristics of participating physicians

Characteristics	n= 166
Socio-demographic characteristics	
Years of practice – n (%)	
0-5	30 (18.5)
6-10	20 (12.3)
11-20	50 (30.9)
21+	62 (38.3)
Sexe – n (%)	
Female	89 (53.6)
Male	77 (46.4)
Medical speciality – n (%)	
Family physician/General partitionner	93 (56.0)
Other medical speciality	73 (44.0)
Type of medical work environment frequented in the past year– n (%) [a]	
Hospital environment (excluding the ER)	
FMU/FMG	87 (53.4)
ER	43 (26.4)
Private medical office	35 (21.5)
Environment offering palliative care	21 (12.9)
CLSC (Local Community Services Centers)	11 (6.7)
CHSLD (Long-term care facility)	12 (7.4)
ASSSAT (Health and social services agency of the Abitibi-Témiscamingue region)	8 (4.9)
	6 (3.7)
Other	5 (3.1)
Medical practice characteristics	
Proportion of medical practice dedicated to seeing patients in the past year (%)	
Mean ± SD	82.40 ± 24.25
Median	90
Min	0
Max	100
Proportion of medical practice dedicated to seeing patients in the past year– n (%)	
<50 %	13 (8.1)
≥50 %	147 (91.9)
Number of patients seen each week within the medical practice	
Mean ± SD	58.42 ± 37.24
Median	50
Min	0
Max	250

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Prevalence of Chronic Non-Cancer Pain in your clientele (%)	
Mean ± SD	22.06 ± 17.44
Median	20.0
Min	0
Max	100
Prevalence of Chronic Non-Cancer Pain in your clientele – n (%)	
<50 %	146 (91.8)
≥50 %	13 (8.2)
Proportion of the Continuing Medical Education activities about CNCP and its treatment in the past year – n (%)	
0 %	54 (34.0)
1-10 %	71 (44.7)
11-20 %	28 (17.6)
21-30 %	4 (2.5)
31-40 %	2 (1.3)
Proportion of the Continuing Medical Education activities about cannabinoids in the past year– n (%)	
0 %	126 (79.2)
1-10 %	32 (20.1)
11-20 %	1 (0.6)

Proportion of missing data ≤ 4.2 %; CNCP = Chronic Non-Cancer Pain, FMG = Family medicine group, FMU = Family medicine unit

[a] Categories are not mutually exclusive. A physician could be working in more than one environment.

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Table 3. Physicians' characteristics and their medical practice in relation with their prevalence of cannabinoid prescriptions for the management of CNCP.

Predictors	No (n = 127)	Yes (n = 38)	p-value of the univariate logistic regression	Crude OR (95% CI)	Adjusted OR (95% CI) ***
Years of practice – n (%)					
0- 20 years (référence)	92 (62.6)	8 (57.1)		-	-
21 years and more	55 (37.4)	6 (42.9)	0.689	1.255 (0.413 - 3.807)	0.704 (0.174-2.838)
Sexe – n (%)					
Male (référence)	59 (46.5)	18 (47.4)		-	
Female	68 (53.5)	20 (52.6)	0.921	0.964 (0.466-1.993)	
Medical speciality – n (%)					
Family physicians (référence)	60 (47.2)	32 (84.2)		-	-
Other medical speciality	67 (52.8)	6 (15.8)	0.000 *	0.168 (0.066-0.429)	0.140 (0.011- 1.711)
Practice mostly in hospital environment (excluding ER) – n (%)					
No (reference)	50 (40.3)	25 (65.8)		-	-
Yes	74 (59.7)	13 (34.2)	0.007 *	0.351 (0.164-0.751)	1.898 (0.423-8.509)
Practice mostly in the ER – n (%)					
No (reference)	98 (79.0)	29 (76.3)		-	
Yes	26 (21.0)	9 (23.7)	0.722	1.170 (0.493-2.775)	
Practice mostly in a FMG/FMU – n (%)					
No (reference)	99 (79.8)	21 (55.3)		-	-
Yes	25 (20.2)	17 (44.7)	0.003 *	3.206 (1.476-6.962)	1.521 (0.395-5.856)
Practice mostly in private medical office – n (%)					
No (reference)	111 (89.5)	30 (78.9)		-	-
Yes	13 (10.5)	8 (21.1)	0.096 **	2.277 (0.864-5.998)	1.330 (0.288-6.154)

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Proportion of the medical practice dedicated to seeing patients in the past year (%) – Mean ± SD	80.29 ± 28.35	86.32 ± 14.03	0.215	1.011 (0.994-1.029)	
Number of patients seen in a week in the medical practice– Mean ± SD	52.30 ± 33.09	73.63 ± 47.28	0.005 *	1.015 (1.005-1.025)	1.006 (0.992-1.021)
Perception of CNCP prevalence in their clientele (%) – Mean ± SD	19,73 ± 15,14	28,55 ± 22,21	0,011 *	1,027 (1,006-1,049)	1,010 (0,976-1,044)
Proportion of Continuing Medical Educations activities about CNCP and its treatment in the past year, recoded – n (%)					
0 - 10% (reférence)	114 (79,2)	11 (78,6)			
11 - 40%	30 (20,8)	3 (21,4)	0,958	1,036 (0,272-3,952)	
Proportion of Continuing Medical Education activities about cannabinoids in the past year, recoded – n (%)					
0% (reférence)	116 (80,6)	10 (71.4)			
1 - 20%	28 (19,4)	4 (28.6)	0.421	1.657 (0.484-5.674)	
Degree of current comfort with prescribing cannabinoids for the management of CNCP – Mean ± SD	1.39 ± 1.85	5.92 ± 2.54	0.000 *	2.039 (1.640-2.535)	**1.252 (1.009-1.553)**

CNCP = Chronic Non-Cancer Pain, FMG = Family medicine group, FMU = Family medicine unit

* p-value < 0.05

** 0.05 ≤ p-value ≤ 0.15

*** Estimation of the adjusted OR for all predictors with a p-value ≤ 0.15 in the univariate logistic regression models. We also choose to enter the number of years of practice in the multivariate model.

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FIGURES

Figure 1. Cannabinoid prescription prevalence in the past year for a number of therapeutic indications among participating physicians.

Figure 2. Degree of current comfort of participating physicians with the prescription of cannabinoids.

Figure 3. Correlation between physicians' degree of comfort in prescribing cannabinoids for the management of CNCP and the past-year prevalence of cannabinoid prescriptions for the management of CNCP.

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Figure 1. Cannabinoid prescription prevalence in the past year for a number of therapeutic indications among participating physicians.

CNCP = Chronic Non-Cancer Pain

Proportion of missing data = 0.6 %.
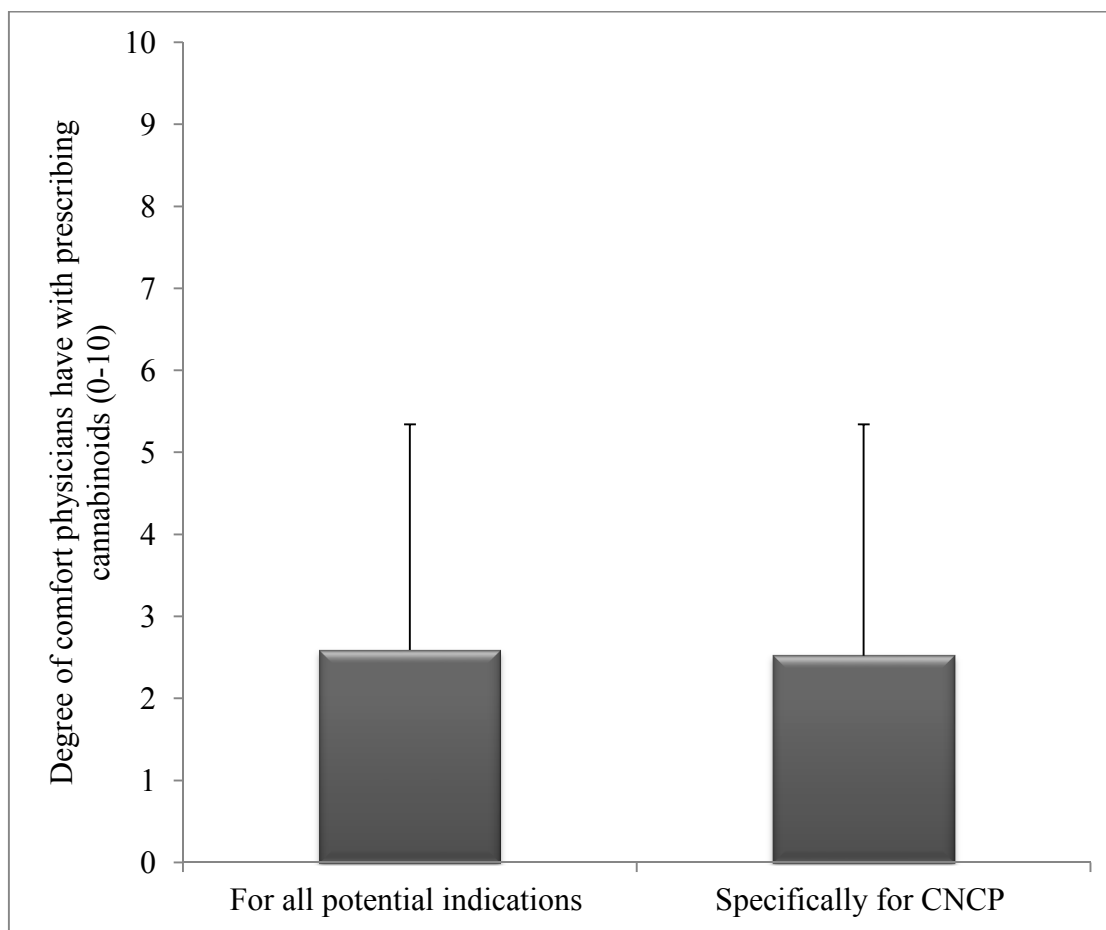
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Figure 2. Degree of current comfort of participating physicians with the prescription of cannabinoids.

CNCP = Chronic Non-Cancer Pain

Proportion of missing data = 6.0-6.6 %.

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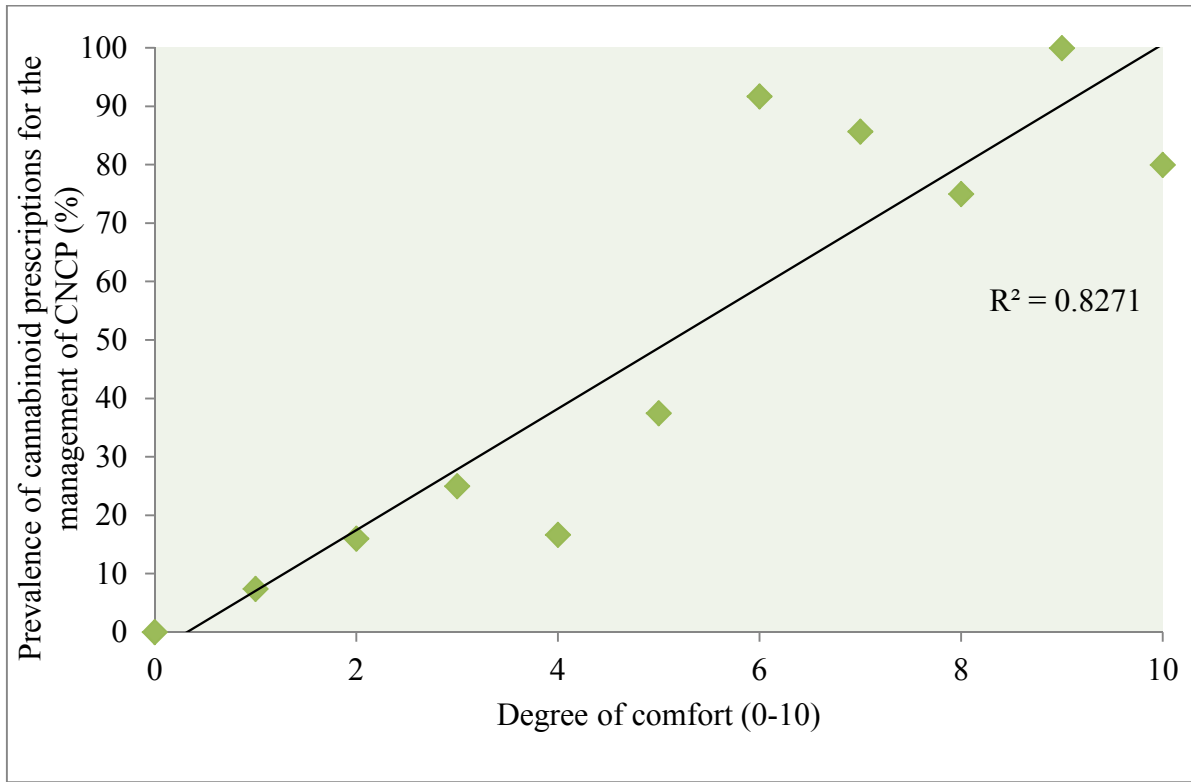
Figure 3. Correlation between physicians' degree of comfort in prescribing cannabinoids for the management of CNCP and the past-year prevalence of cannabinoid prescriptions for the management of CNCP.

Université du Québec
en Abitibi-Témiscamingue

La prescription de cannabinoïdes pour la prise en charge de la douleur chronique non cancéreuse en Abitibi-Témiscamingue

Questionnaire adressé aux médecins

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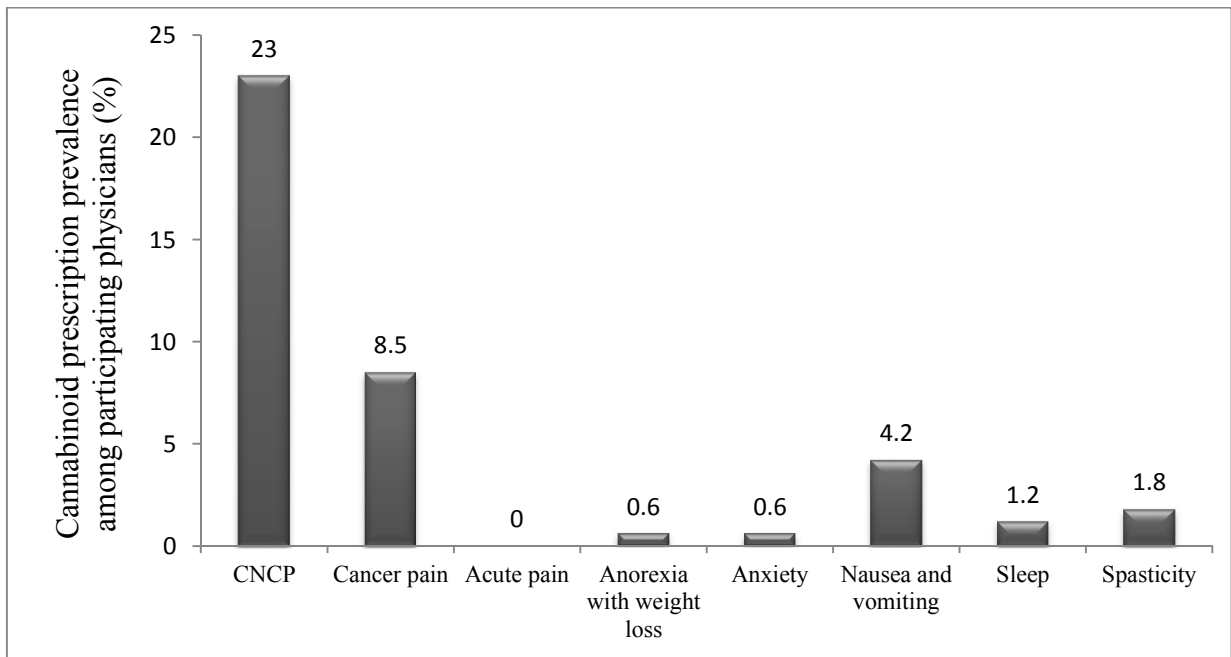42
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Préambule

La douleur chronique, qui a des répercussions importantes sur le fonctionnement physique et psychologique des personnes qui en souffrent, touche environ un adulte sur cinq au Québec. Les syndromes de douleur chronique non cancéreuse comprennent notamment la lombalgie, la cervicalgie, l'arthrite rhumatoïde, l'arthrose, les migraines, les céphalées, la fibromyalgie, le syndrome du côlon irritable, les névralgies ainsi que les douleurs chroniques post-traumatiques ou postchirurgicales.

Parmi les modalités thérapeutiques permettant une prise en charge de la douleur chronique, les cannabinoïdes naturels et synthétiques se sont avérés efficaces et sécuritaires pour certains de ces syndromes. Ces produits pharmacologiques comprennent le nabilone (Césamet®), le dronabinol (Marinol®), le THC/cannabidiol (Sativex®) et la marihuana à des fins médicales. Ceux-ci sont tous disponibles avec ordonnance au Canada.

Les questions suivantes portent sur les tendances de prescription, le degré de confort, les besoins en matière de formation et les barrières face à la prescription de cannabinoïdes. Nous vous invitons à inscrire vos réponses au meilleur de votre connaissance.

Tendances de prescription de cannabinoïdes

1. Au cours de la dernière année, avez-vous prescrit des cannabinoïdes?

☐₀ Non   ☐₁ Oui

Si oui, lesquels? *(Cochez plusieurs cases, s'il y a lieu)*

☐ Nabilone (Césamet®)

☐ Dronabinol (Marinol®)

☐ THC/cannabidiol (Sativex®)

☐ Marihuana à des fins médicale (Programme d'accès de Santé Canada)

Si oui, pour quel(s) problème(s) de santé?

(Cochez plusieurs cases, s'il y a lieu)

☐ Douleur chronique non cancéreuse

☐ Douleur chronique cancéreuse

☐ Douleur aiguë

☐ Anorexie avec perte de poids

☐ Anxiété

☐ Nausées et vomissements

☐ Sommeil

☐ Spasticité

☐ Autres (veuillez préciser) : _____

Si oui, à combien de patients (dans la dernière année)?

☐₀ 1-5   ☐₁ 6-10   ☐₂ 11-20   ☐₃ 21-50   ☐₄ >50

Si non, pourquoi?

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Degré de confort envers la prescription de cannabinoïdes

2. Actuellement, quel est votre degré de confort à prescrire des cannabinoïdes (toutes indications confondues)? *(Veuillez encercler la réponse)*

0	1	2	3	4	5	6	7	8	9	10

Inconfortable   Confortable

3. Actuellement, quel est votre degré de confort à prescrire des cannabinoïdes pour la prise en charge de la douleur chronique non cancéreuse? *(Veuillez encercler la réponse)*

0	1	2	3	4	5	6	7	8	9	10

Inconfortable   Confortable

4. Quels facteurs pourraient augmenter votre degré de confort à prescrire des cannabinoïdes pour la prise en charge de la douleur chronique non cancéreuse? *(Cochez plusieurs cases, s'il y a lieu)*

☐ Données cliniques/nouvelles études

☐ Données sur l'efficacité de ces produits

☐ Données sur l'innocuité à long terme

☐ Données sur la dépendance à long terme

☐ Lignes directrices/algorithmes qui intègrent les cannabinoïdes

☐ Nouvelles indications thérapeutiques

☐ Éducation et sensibilisation des patients

☐ Formation médicale continue

☐ Discussions entre pairs

☐ Autres (veuillez préciser) : _____

Besoins en matière de formation face à l'utilisation et à la prescription de cannabinoïdes

5. Pour chacun des thèmes ci-dessous, veuillez entourer le chiffre qui décrit le mieux votre niveau de connaissance actuel et le niveau de connaissance que vous souhaiteriez avoir :

Veuillez encercler le chiffre qui décrit le mieux votre opinion sur une échelle de 0 à 5, où 0 correspond à un niveau de connaissance nul et 5 à un excellent niveau de connaissance.

Niveau de connaissance actuel	Thèmes	Niveau de connaissance souhaité
Nul → Excellent		Nul → Excellent
0 1 2 3 4 5	Douleur chronique non cancéreuse et son traitement	0 1 2 3 4 5
0 1 2 3 4 5	Mécanismes d'action des cannabinoïdes (système endocannabinoïde)	0 1 2 3 4 5
0 1 2 3 4 5	Cannabinoïdes disponibles (molécules existantes)	0 1 2 3 4 5
0 1 2 3 4 5	Prescription efficace des cannabinoïdes (toutes indications confondues)	0 1 2 3 4 5
0 1 2 3 4 5	Prescription de cannabinoïdes pour la prise en charge de la douleur chronique non cancéreuse	0 1 2 3 4 5
0 1 2 3 4 5	Risques de l'utilisation des cannabinoïdes à long terme	0 1 2 3 4 5
0 1 2 3 4 5	Lois et règlementation entourant l'utilisation de marihuana à des fins médicales de Santé Canada	0 1 2 3 4 5
0 1 2 3 4 5	Synergie d'action entre les cannabinoïdes et les opioïdes	0 1 2 3 4 5

6. Selon votre expérience, pour quel(s) syndrome(s) de douleur chronique non cancéreuse les cannabinoïdes peuvent-ils être efficaces? *(Cochez plusieurs cases, s'il y a lieu)*

☐ Arthrite rhumatoïde   ☐ Fibromyalgie

☐ Arthrose   ☐ Lombalgie

☐ Céphalées de tension   ☐ Migraines

☐ Cervicalgie   ☐ Syndrome du côlon irritable

☐ Douleur neuropathique   ☐ Autres (veuillez préciser) : _____

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Barrières face à l'utilisation de cannabinoïdes

7. Selon vous, est-ce que les facteurs suivants sont des barrières à l'utilisation des cannabinoïdes pour la prise en charge de la douleur chronique non cancéreuse dans la pratique médicale actuelle?

Veuillez encercler le chiffre qui décrit le mieux votre opinion sur une échelle de 0 à 5, où 0 n'est pas une barrière et 5 est une barrière importante.

Barrières potentielles	Votre opinion					
	N'est pas une barrière → Est une barrière importante					
Degré d'efficacité des cannabinoïdes	0	1	2	3	4	5
Risques/Effets indésirables	0	1	2	3	4	5
Données probantes limitées	0	1	2	3	4	5
Fenêtre thérapeutique étroite	0	1	2	3	4	5
Interactions médicamenteuses	0	1	2	3	4	5
Suivi nécessaire/Monitorage	0	1	2	3	4	5
Manque de lignes directrices pour leur utilisation	0	1	2	3	4	5
N'est pas un premier choix de traitement	0	1	2	3	4	5
Les patients ont tendance à sous-rapporter leurs symptômes douloureux	0	1	2	3	4	5
Stigma social associé aux cannabinoïdes (tabous et préjugés)	0	1	2	3	4	5
Craintes des patients/de leur famille	0	1	2	3	4	5
Manque de formation des professionnels de la santé	0	1	2	3	4	5
Considérations légales	0	1	2	3	4	5
Possibilité que le patient utilise les cannabinoïdes dans un but récréatif	0	1	2	3	4	5
Possibilité de vente sur le marché noir	0	1	2	3	4	5

Autres barrières et commentaires :

_____

_____

Caractéristiques de la pratique médicale

8. Êtes-vous un homme ou une femme?

☐₀ Homme ☐₁ Femme

9. Depuis combien d'années pratiquez-vous la médecine?

☐₀ 0-5 ☐₁ 6-10 ☐₂ 11-20 ☐₃ 21+

10. Quelle est votre spécialité médicale?

☐₀ Médecin de famille/Omnipraticien ☐₁ Autre spécialité médicale

11. Au cours de la dernière année, dans quel type de milieu de pratique avez-vous passé la <u>majorité</u> de votre temps?

☐₀ Hôpital - Clinique externe

☐₁ Hôpital - Salle d'urgence

☐₂ Groupe de médecine de famille (GMF)

☐₃ Cabinet médical privé

☐₄ Milieux offrant des soins palliatifs

☐₅ CLSC - Centre local de services communautaires

☐₆ CHSLD - Centre d'hébergement et de soins de longue durée

☐₇ Agence de la santé et des services sociaux de l'Abitibi-Témiscamingue (ASSSAT)

☐₈ Autre (veuillez préciser) : _____

12. Au cours de la dernière année, quelle était la proportion de votre pratique médicale consacrée à voir des patients? *(Veuillez encercler la réponse)*

| 0 % | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 % |

13. En moyenne, combien de patients rencontrez-vous par semaine dans le cadre de votre pratique médicale?

☐ patients/semaine

☐ Aucun, car je n'effectue pas le suivi de patients

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14. Selon vous, quelle est la prévalence (%) de douleur chronique non cancéreuse au sein de votre clientèle? *(Veuillez encercler la réponse)*

0 %	10	20	30	40	50	60	70	80	90	100 %

☐ Non applicable, car je n'effectue pas le suivi de patients

15. Durant la dernière année, quelle proportion de vos activités de formation médicale continue portait sur la douleur chronique non cancéreuse et son traitement?

☐$_0$ 0 %   ☐$_1$ 1-10 %   ☐$_2$ 11-20 %   ☐$_3$ 21-30 %   ☐$_4$ 31-40 %   ☐$_5$ >40 %

16. Durant la dernière année, quelle proportion de vos activités de formation médicale continue portait sur les cannabinoïdes?

☐$_0$ 0 %   ☐$_1$ 1-10 %   ☐$_2$ 11-20 %   ☐$_3$ 21-30 %   ☐$_4$ 31-40 %   ☐$_5$ >40 %

Lorsque l'étude sera terminée, souhaiteriez-vous recevoir un résumé des résultats par courrier électronique?

☐ Non

☐ Oui : _____ @_____

Le questionnaire se termine ici

Veuillez vous assurer d'avoir répondu à toutes les questions et nous retourner le questionnaire dans l'enveloppe-réponse <u>au cours de la semaine prochaine</u> afin d'éviter que nous vous relancions inutilement.

Merci beaucoup de votre participation!