BY KENNETH A. PRICE
BARRISTER & SOLICITOR

EDITORIAL

Ken Price has practiced in a variety of areas for almost forty years. For thirty of those he has practiced tort law. He is a past president of this organization, and is a founding member of TLABC. He has worked for years providing counsel to several social and legal agencies, and has been a regular contributor to TLABC and CLE legal education programs. He has also worked to keep lawyers vigilant in their duty to represent citizens against oppression by the state.

The changing landscape of drug addiction and recreational hard-drug use in Canada has created an appalling health and social crisis, resulting in death and associated mayhem across the country. The proliferation of the use of synthetic opioids by drug addicts and recreational drug users was at first simply another way to get high. It fit with the usual menu of heroin, cocaine, and ecstasy on which addicted brains had dined for years.

> Unfortunately, the growing popularity of the "opioid high" among addicts and recreational drug users began causing problems in the supply chain. Synthetic opioids were hard to acquire, and dealers had to rely at first mainly on stolen or bootlegged pharmaceutical product. Large-scale health problems were thus avoided because of this limited availability of the drugs both on and off the streets.

Drug dealers can be inventive sorts. In their quest to increase the supply of opioids for distribution they stumbled on a little-known and little-used synthetic opioid, fentanyl. This drug had been around for several years, used mainly to treat intractable pain in cancer patients. But once drug dealers realized how fentanyl could help them in their quest to increase the availability of synthetic opioids for distribution on the street, all hell broke loose. The drug distributors began to mix fentanyl with diluted, harder-to-acquire, pharmaceutical opioids acquired on the black

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ADDRESS CHANGES & UPDATES
tla-info@tlabc.org

Letters to the Editor
editor@tlabc.org

ADVERTISING INQUIRIES
Julia Chalifoux
julia@tlabc.org

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PUBLISHER
Julia Chalifoux
julia@tlabc.org

EDITOR EMERITUS
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shawn@tlabc.org

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Julia Chalifoux

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1111 – 1100 Melville Street, Vancouver BC V6E 4A6 CANADA

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market, thereby extending the volume of the opioid cocktails for sale. Supply problem solved.

A by-product not unwelcome to the dealers was the overpowering addictive properties of the fentanyl-laced product, which made the otherwise lower-strength pharmaceutical opioids such as OxyContin very addictive even in thinly watered-down form. Fentanyl is 50 to 100 times more potent than morphine, and mixing it with small quantities of weaker opioids can result in dealers having access to virtually unlimited quantities of pills for sale.

As we now know, the incredible potency of the fentanyl has had deadly consequences. Thousands of deaths have resulted in North America this year alone, simply because of the inclusion of fentanyl in the otherwise diluted drugs being mixed with it. The drug is simply too potent in pure form, and the amount of fentanyl contained in the end-products for sale on the street is imprecise, and too often deadly to addicts and weekend users alike.

Solutions to the health and social consequences of this new reality have so far been elusive. Enforcement of drug laws against the dealers and manufacturers of the drug cocktails is difficult, as fentanyl is particularly amenable to smuggling because vast numbers of doses can be concealed or easily transported. In the meantime, governments and the health care systems, along with the medical profession have come under great pressure from the public to do something to stem the tide of carnage.

While all this chaos ensues we now have another unfortunate by-product of the crisis, people with chronic pain. The use of fentanyl and other strong opioids to treat patients in chronic pain cases is coming under scrutiny, and many factions weigh in to accuse the medical profession of being complicit in the origins of the problem because of the willy-nilly prescription of opioids to their patients. Many stakeholders clamour for stricter controls on the prescription of strong synthetic opioids. From some quarters, there are demands that the prescription of opioid medications be banned altogether, even for those who have come to rely on these drugs to control otherwise intractable pain. We are seemingly preparing to throw those innocent victims under the bus, even in cases where many of them have long been using opioids, including fentanyl, for proper and effective control of pain. The fact there is no proof whatsoever of the link between the legitimate treatment of pain and the so-called "opioid crisis" seems not to matter, either to the government or the medical regulators.

To illustrate this, we need only read the executive summary of the BC Ministry of Health's 77-page *Guideline for the Clinical Management of Opioid Use Disorder,* published earlier this year. The summary begins with the statement: "Opioid use disorder is one of the most challenging forms of addiction facing the healthcare system in British Columbia, and is a major driver of the recent surge in illicit drug overdose deaths in the province." The Guidelines purport to establish an intensive process for the reduction of opioid use. In short, the Health Ministry proposes a complex set of rules to eliminate the use of synthetic opioids

While all this may be seen as born of good intentions, it is alarming that the Guidelines presume to include in their targeted

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class of individuals not only drug addicts prone to victimization by fentanyl-laced opioids, but also people who are using opioids, including fentanyl in some cases, to control chronic pain. The Guidelines propose to restrict doctors from prescribing opioids to their patients. The Guidelines do nothing to differentiate between addicts prone to dying from fentanyl contamination and medical patients who are using strong opioids to treat pain. How is this going to help stem the "opioid crisis," apart from making innocent people suffer?

The executive summary concludes that, "through adherence to data-driven therapeutic guidelines, there is substantial potential to reduce the burden of disease and health and social service costs associated with untreated opioid use disorder." Where is there any acknowledgement of the effective role opioids play in legitimate medical treatment of pain?

The Guidelines, by implication, suggest that the medical profession is part of the problem rather than the solution here. This compounds the plight of those suffering from chronic pain, as doctors are increasingly pressured to reduce prescription of opioids. For example, the BC College of Physicians and Surgeons has adopted the US guidelines for prescribing opioids. Those guidelines warn against dosages that exceed 90 morphine milligram equivalents a day. Those limits are far below the Canadian standards that have a recommended maximum of 200 mg per day. What about the family physician who has a long-term patient who is getting significant pain relief from whatever dosage the physician prescribes? Is the doctor now expected to reduce or eliminate the prescription of opioid medications for patients who need them? What is the link between the relationship of a patient to his doctor and the drug deaths on the street? I don't see it.

But I do fear that many doctors will simply acquiesce and go along with the simplistic plan to reduce opioid use by simply refusing the prescribe the drugs, choosing to avoid all the paperwork and the distressing scrutiny from the profession's regulators and the politicians.

In 2010 the International Association for the Study of Pain (IASP) held a summit in Montreal. More than 250 pain specialists from around the world attended the conference. At the conclusion of the proceedings, the delegates to the summit published *The Declaration of Montreal, a Declaration that Access to Pain Management is a Fundamental Human Right*.

IASP concluded that pain management is inadequate in most of the world because of a number of specific problems, some of which include the following:

"1. There are major deficits in knowledge of health care professionals regarding the mechanisms and management of pain.
2. Chronic pain with or without diagnosis is highly stigmatized.
3. *There are severe restrictions on the availability of opioids and other essential medications, critical to the management of pain."* (Emphasis mine)

The IASP Declaration went on to say,

"And, recognizing the intrinsic dignity of all persons and that withholding of pain treatment is profoundly wrong, leading to unnecessary suffering which is harmful; we declare that the following human rights must be recognized throughout the world:

Article 1. The right of all people to have access to pain management without discrimination.

Article 2. The right of people in pain to acknowledgment of their pain and to be informed about how it can be assessed and managed.

Article 3. The right of all people with pain to have access to appropriate assessment and treatment of the pain by adequately trained healthcare professionals."

The Declaration went on to say that, in order to assure these rights, the following obligation, among others, endures:

"1. The obligation of government and all health care institutions . . . to establish laws, policies and systems that will help to promote, *and will certainly not inhibit*, the access of people in pain to fully adequate pain management. Failure to establish such . . . is unethical and a breach of the human rights of people harmed as a result."

The Declaration was mindful of several United Nations Declarations, starting with the 1948 Declaration of Human Rights, Article 5 of which states: "No one shall be subjected to torture or to cruel, inhuman or degrading treatment. . ."

In 1961, in response to attempts in many countries to restrict the use of narcotic pain medicines which lumped medical use of drugs under the same umbrella as illegal street narcotics, the UN Special Rapporteur on the Right to Health stated: "The failure to ensure access to controlled medicines for the relief of pain . . . threatens fundamental rights to health and to protection against cruel, inhuman and degrading treatment."

The United Nations 1961 Single Convention on Narcotic Drugs went on to declare that, "*failure to provide access to pain management violates human rights,"* and that, *"the medical use of narcotic drugs is indispensable for the relief of pain. . . and that mandating of adequate provision of narcotic drugs for medical use is essential."* (my emphasis).

We have just now begun to apply the dictates of this 50 year old declaration to the medical use of marijuana. Are we about to turn back the clock when it comes to opioid pain relief? V