

## **Appendix 2 (as supplied by the authors): Guideline Panel Values & Preferences Statement**

On the basis of our review of the relevant published literature, our own focus group interviews with our patient committee, and the clinical experience of our expert consultants, we have concluded that for patients living with chronic noncancer pain receiving opioid therapy, achieving pain relief is the most important consideration. We believe these results (and the subsequent importance ratings we present here) are likely to generalize to patients considering opioid therapy, and we therefore use these values in questions directed at this population.

When patients experience severe nausea, vomiting, or constipation as a result of opioid use, these adverse effects are almost as important as pain relief, and thus may be more important than small degrees of pain relief. Other opioid-related adverse events, such as sleep disturbance, personality changes, dizziness, and mental fog are less important to patients with chronic noncancer pain but are not irrelevant and thus deserve consideration in making our recommendations.

When considering less common more severe adverse events (addiction), and particularly rare but very serious adverse events (unintentional overdose requiring hospitalization, fatal unintentional overdose) we viewed societal values and preferences as very important. On the basis of decisions made regarding other drugs with severe rare side effects, and on public and policy reactions to diversion, addiction and death related to widespread opioid use by patients with chronic noncancer pain, we have concluded that society places a high value on minimizing these adverse events. As a result, we too place a high value on avoiding these adverse events, even if less frequent or rare. We consider that their avoidance may be more important than achieving modest pain reduction, particularly if that pain reduction is associated with the adverse effects noted previously.

Superficial consideration of our interviews with members of the Patient Advisory Committee suggest that these individuals place little importance on avoiding addiction or the small likelihood of accidental overdose or death. Our analysis, however, suggests that this may be a result of an attitude of “it won’t happen to me”. That conclusion is based in part on the observation that the lived experience appears to have an important framing effect on patient’s values and preferences regarding use of opioids, that serves to aligns patients’ and societies’ values over the long-term. Out of desperation for any relief from chronic pain, patients with chronic noncancer pain are often willing to trade rare but serious harms for small but important pain relief, and this may leave some patients vulnerable to short-term decisions that are inconsistent with societal values. The patients on our advisory committee who had actually suffered serious adverse events placed a much higher value on their avoidance, consistent with societal attitudes toward such events.

Finally, our focus group interviews revealed that some patients using long term opioid therapy for chronic noncancer pain were concerned about adverse consequences of opioid withdrawal that may result from efforts to wean or discontinue their opioid use. For those using high doses of opioids in whom weaning is undertaken, we continue to place a high value on societal considerations of minimizing the risk of rare serious adverse events, but we also place a high value on avoiding severe suffering, increased pain, and functional limitation that may accompany opioid reduction. We also place a high value on patient autonomy under these circumstances. Our value and preference statement applies to all recommendations.