INTRODUCTION

In November 2016, 42 Canadian health agencies released the Joint Statement of Action to Address the Opioid Crisis, meant as a landmark national document identifying specific organisational policies to address the alarming growth in opioid-related harms. In their written commitments (box 1), Health Canada, the federal health agency tasked with pharmaceutical regulation, as well as the Health Ministers of Ontario and of Newfoundland, made direct references to Suboxone, the brand name of the buprenorphine-naloxone sublingual tablet used to treat opioid use disorder (OUD), the medical diagnostic label for opioid addiction. This repeated use of the brand name in a major policy forum was coupled with wide referencing and linking to a ‘Suboxone Education Programme’ (the ‘Programme’) developed by Indivior, the corporate rights-holder for Suboxone, in Canadian regulatory, scientific and policy documents relating to the Canadian opioid crisis. This was unusual and
constitutive element. Though no clear benefits from this major regulatory policy response to that country's opioid Risk Evaluation and Mitigation Strategy (REMS) pharmaceuticals, such as toxicity or death. For example, the regulation, mitigation schemes have been increasingly for market access of Suboxone. In pharmaceutical document, reflecting Health Canada’s curious given existing regulations in Canada for health professional education that prohibit the use of brand names in accredited continuing education as a means to counter promotional bias and given the growing concern about the persistent and insidious role of industry in promoting opioid analgesics.4,5

The Suboxone Education Programme is referenced in the product monograph as part of a ‘risk mitigation programme’6 (Box 2). This monograph is a regulated document, reflecting Health Canada’s 2007 approval for market access of Suboxone. In pharmaceutical regulation, mitigation schemes have been increasingly deployed to attend to multiple perceived risks of pharmaceuticals, such as toxicity or death. For example, the opioid Risk Evaluation and Mitigation Strategy (REMS) of the US Food and Drug Administration (FDA) was a major regulatory policy response to that country’s opioid crisis of which health professions education was a central constitutive element. Though no clear benefits from this programme have been delineated,7 and despite concerns of the close involvement of industry in the development and deployment of this programme,9 Canada too has begun to implement a similar risk programme for opioid analgesics which includes components of health professions education.9

That the origin of the Programme is regulatory in nature is not surprising given that OUD is perhaps the most highly regulated area of medical practice internationally. For example, in Canada, opioid agonist therapy (OAT)—the primary medical treatment for OUD—is in part regulated at the federal level through legislation such as the Controlled Drugs and Substances Act (CDSA) which sets the parameters for the use of substances such as methadone and buprenorphine. Until recently, Canadian prescribers had to individually gain an exemption from the CDSA to prescribe methadone and sometimes buprenorphine.10 Similar federal regulatory processes are in place in other jurisdictions such as the UK, USA and Australia.11–13 While other medical therapeutics may require certain levels of training, expertise or monitoring to be used (perhaps thalidomide and isotretinoin as the most well-known examples in the USA), it is highly unusual to require exemption from federal law or approval from federal authorities. Likewise, although clinical practice guidelines are typically developed by independent scientific and clinical authorities, OAT practice guidelines are often instead determined by regional regulatory authorities—such as state or provincial health professions regulators—implying both an increased level of regulatory surveillance around this practice and more direct disciplinary consequences for not following this guidance.14

Research question
Even outside of opioid analgesics, many scholars have drawn attention to how pharmaceutical companies have appropriated medical research and education as part
METHODS
Study design and objectives
We conducted a critical discourse analysis of publicly available documents that specifically referenced or linked to the Suboxone Education Programme, including to live in-person versions of the Programme or to the online Programme accessed through the URLs suboxonecme.ca and suboxonetrainingprogram.ca. We followed a process similar to those described for other critical analyses of health policy, medical education and media coverage of the opioid crisis.

There is a plurality of approaches to critical discourse analysis, and multiple levels (micro, macro and meso) of social life, and interactions between the levels, to which it can be applied. Within this plurality, Shaw and Bailey identify three commitments common across discourse analyses. These include commitments to analysing language and interaction within their social context, to understanding knowledge as socially constructed, and to examining the social functions of discourse. In this study, using critical discourse analysis allowed us to identify and analyse the assumptions underlying the Programme that present it as a logical and integral policy intervention for addressing the opioid crisis and thus Indivior’s as an legitimate and beneficent intervenor. As a policy intervention, the Programme explicitly and implicitly describes the problem of the opioid crisis, including assumptions about OUD, OAT, and people who use drugs, while also suggesting the particular changes required to solve this problem. Our express purpose was not to identify thoughts or biases of, or assign blame to, individual policy actors. Nor were we interested in questioning the effectiveness of buprenorphine as a harm reducing pharmacological intervention for OUD, which has been well established. Instead, we were interested in tracing how an industry-developed and delivered programme became embedded in government policy, professional communications and clinical practices despite a climate in which such conflicts of interest, especially in relation to pharmaceuticals, were widely being questioned.

Data sources and sampling
One author (AS) collected documents with specific reference to the Programme through internet searches, social media references, searches of bibliographic databases of the scientific literature and discussions with key informants with extensive involvement in Canadian opioid crisis policy development. Archived web pages, using tools such as Wayback Machine, were also searched to identify any historical changes to texts and documents subsequently taken down from the web. These texts were first read in an open-ended manner to identify the most significant characteristics.

Our next step was to develop an appropriate systematic archive of documents for analysis. The content of the Programme was not specifically our primary object of interest as we were more concerned with the wide inclusion of the Programme in a variety of official documents. Furthermore, we determined such a use of the content in the online portal might be construed as a violation of Indivior’s Terms and Conditions of Use policy which restricts use of the Programme content only to the personal use of healthcare professionals. The full research team examined the already collected documents as our primary archive and then included all additional documents through a comprehensive web search in July 2020 using Google as a secondary archive (online supplemental file 1). One researcher (AS) used the search terms ‘Suboxone Education Programme’, ‘Suboxone Training Programme’, ‘suboxonecme’ and ‘suboxonetrainingprogram’ in Google. For both the primary and secondary archives, we included any documents that specifically referenced the title or URL of the Programme. Based on our familiarisation phase (see below), we also included the publicly facing portions of the online Programme portal in the primary archive. Given that this was a programme targeting Canadian healthcare professionals, we only included documents from Canadian sources.

Data collection and analysis
The full research team gathered as a multidisciplinary group of researchers with expertise in opioid crisis policy, opioid prescribing education, OUD and OAT, discourse analysis, bioethics, policy analysis, critical theory and pharmaceutical industry influence in healthcare.

Public and patient involvement
The full research team collectively participated in a familiarisation phase beginning with discussions with experts in the Canadian opioid crisis policy process. This process included people with lived experience with opioid-related harms who had subsequently been engaged with crisis policy. We also solicited feedback.
from the public, including people with lived experience, through presenting preliminary findings at a national OUD conference.

The full research team then read broadly about Suboxone as a pharmaceutical agent including the history of its development and clinical applications, its regulatory approval processes, its role in opioid crisis policy and the activities of the various companies that have held its marketing and manufacturing rights. This included reviewing information from a variety of information sources including academic journals, media reports and press releases, legal documents, lobby records, conference proceedings, meeting minutes, clinical practice guidelines and policy documents.

Three researchers (AS, MS and QG) then constructed a semistructured data extraction instrument (online supplemental file 2) based on congruent approaches to critical analysis of policies, media and industry-authored educational materials.21 22 31 This instrument was first piloted by three researchers (MS, AS and QG) with three documents from the primary archive. The instrument and pilot results were reviewed with the full research team. Working through each document in the primary archive, investigators answered a series of open-ended questions while documenting supporting evidence from the sampled documents such as quotations or providing detailed descriptions of images, formats and layouts. Each document was analysed in duplicate (AS, QG, SS, PS), with one investigator (MS) as a consistent coder for each document. Using NVivo to store and manage the collected data, three researchers (MS, AS, QG) then led the production of narrative summaries across each question and identified preliminary themes.

These preliminary themes and the relationships between them were identified through a process of discussion and further refined with the entire research team through multiple meetings. As an example, at this preliminary stage of analysis, the team identified key discursive distinctions between documents issued by different kinds of groups suggesting the importance of analysing the document archive by the kind of group. Two researchers (AS, QG) used these refined themes to guide coding of the secondary archive. On completion of this second round of coding, narrative summaries were created (by AS) for each code and discussed with the larger research team to identify the primary discourses of interest. As one example, at this stage of analysis the team identified discursive associations between the Programme and other educational programmes. One researcher (AS) conducted a final search in May 2021 to identify any additional new documents (primary archive) against which our findings were further reflected through discussion with the full research team. At this stage of analysis, as an example, the team identified specific instantiations of the surveillance of healthcare professionals. We used the Standards for Reporting Qualitative Research checklist for reporting this research.

RESULTS
We included 69 documents and identified four distinct kinds of sources (table 1):

1. Regulatory bodies such as provincial professional colleges outlining policies and guidelines for OAT prescribing (n=19; medicine n=10, nursing n=5, pharmacy n=3, joint medical and pharmacy n=1).
2. Clinical and scientific opinion leaders characterising the appropriate use of OAT in contemporary clinical and social contexts (n=18) through presentations, primers, peer-reviewed articles and information sheets.
3. Documents from regional health authorities, professional associations and educational institutions (n=28) usually in the form of newsletters, information sheets, proceedings and meeting minutes.
4. Documents from industry itself (n=4) including webpages, promotional posters and a Programme handbook.

Only nine (14%) of non-industry documents identified (either in the main text or references) the drug’s manufacturer, Indivior as the Programme developer. Likewise, across all types of documents, the majority (44 documents or 68%) referred to the brand name Suboxone independently of references to the title of the Programme, typically without use of the registered trademark and frequently without identifying the scientific name buprenorphine/naloxone (online supplemental file 1).

In analysing the documents, we identified a multitude of risks that the Programme was characterised as addressing, including the overprescribing of opioid analogues, the presence of toxic street drug supplies, and the greater relative risk of full opioid agonists such as methadone. To address these risk-problems, the Programme facilitated two important functions: the surveillance of healthcare providers and the prescribing of Suboxone. This status as a solution to these risk-problems was bolstered by the Programme’s association with regulatory, epidemiological and professional educational authorities which also obscured its industry origins.

Justifying the programme: a multiplicity of risk-problems
Defining health problems as ‘risks’ implies a need for intervention—a key role of contemporary health services is to mitigate the variety of primarily human-made risks that societies face.32 Thus examining the kinds of risks identified in documents that reference the Programme as an intervention can provide important insights into the roles that the Programme, especially a Programme that was developed as part of a Health Canada regulated risk management programme, is expected to fulfill. Throughout the archive, rather than a single, specific risk that the Programme was characterised as addressing, a multitude of risks includingiatrogenic, environmental and pharmacological were described.

If the opioid crisis was referenced in the regulatory documents, it was typically associated with the overuse of opioid analgesic medications (table 2). By identifying this as a problem of specifically prescribed opioids, risk in
these documents was implicitly focused on the prescription process and the behaviour of healthcare professionals. This justifies interventions that may change and surveil their knowledge and behaviour and thus mitigate iatrogenic risk.

References to the opioid epidemic were quite distinct in the clinical and scientific documents. There was much less emphasis on inappropriate prescribing and much more so on harms from a toxic street drug supply—namely the nature of the risk at hand was characterised more as an environmental one rather than an iatrogenic one (table 2). Discussions of opioid-related harms in these documents were much more centred on the specific issue of OUD rather than the much more vague problem of ‘opioid dependence’ of the regulator documents.

The clinical and scientific documents, similarly with the industry documents, identified a third pharmacological risk-problem that the Programme could address. Suboxone was repeatedly characterised as safer (‘less risky’) and equally efficacious compared with methadone. Suboxone was described as a ‘partial’ agonist with a ‘ceiling’ effect, both words meant to contrast with the ‘full’ agonist effect (and thus dangerous overdose potential) of methadone (table 2). Striking visual comparisons were made between the two medications, such as one from an educational presentation to healthcare professionals that depicted methadone as a sleek sports car ‘going 180 km per hour’ but buprenorphine as a cartoonish family car ‘going 50 km per hour.’ This distinction in terms of safety and risk of buprenorphine vs methadone was extensively elaborated in other documents, which in turn argued that because of these characteristic differences, buprenorphine should be considered first line therapy for the treatment of OUD over methadone and is particularly suited for use in primary care settings.

**Programme function: the moral imperatives to surveil and to prescribe**

The programme fulfilled two functions which were emphasised as moral imperatives to address the risks identified above: the surveillance of healthcare professionals and the facilitation of Suboxone prescribing (table 2). In the regulatory documents, education was cast as a regulatory requirement for OAT prescribing—that prescribers would not be granted prescriptive authority for buprenorphine/naloxone and could face punitive consequences if they did prescribe without first undertaking the recommended education, which typically included the Programme. Enforcement of such policies required mechanisms to report and track Programme participation. The Privacy Policy of the Programme, issued by Indivior, reflected this surveillance imperative, describing a variety of reasons for collecting personal information about health professional participants. This imperative recalled one component of the risk management programme from the product monograph which specified the maintenance of ‘a list of Suboxone Education Programme trained physicians’ (box 2). It also recalled

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**Table 1** Document archive by source, type, industry and brand reference, and authorship

| Document source (total no) | Geographic distribution by province (no) | Document types | No identified programme as industry developed | No referenced suboxone independent of programme | Named authorship |
|----------------------------|-----------------------------------------|----------------|---------------------------------------------|---------------------------------------------|-----------------|
| Regulatory bodies (19)     | MB, SK (3 ea); AB, NL, PE (2 ea); BC, NB, NS, NT, NU, ON, QC, YT (1 ea) | Information notices (10); Practice guidelines (6); Newsletters (3) | Main text: 2 (10%) References: 1 (5%) | 15 (79%) | 0 (0%) |
| Clinical and scientific opinion leaders (18) | ON (6); National (5); BC (4); AB, MB, QC (1 ea) | Professional presentations (10); Clinical Primers (3); Peer-reviewed scientific articles (2); Information sheets (2); Book chapter (1); Policy recommendations (1) | Main text: 2 (11%) References: 1 (6%) | 13 (72%) | 14 (78%) |
| Health authorities, professional associations, and educational institutions (28) | ON (8); National (5); BC, NL (4 ea); AB (3); SK (2); QC, YT (1 ea) | Newsletter (6); Info sheet or handbook (6); Programme description (4); Report (3); News notice, news release or programme promotion (3); Proceedings (2); Presentation (1); Meeting minutes (1); Training link (1) | Main text: 3 (11%) References: 0 (0%) | 16 (57%) | 14 (50%) |
| Industry (4) | National (2); AB, ON (1 ea) | Posters (2); Publicly available portions of suboxonemc.ca (1); Publicly available programme handbook (1) | Main text: 4 (100%) | N/A | 0 (0%) |

AB, Alberta; BC, British Columbia; MB, Manitoba; NB, New Brunswick; NL, Newfoundland and Labrador; NS, Nova Scotia; NT, Northwest Territories; NU, Nunavut; ON, Ontario; PE, Prince Edward Island; QC, Quebec; SK, Saskatchewan; YT, Yukon.
a ‘DoctorLocator’ initiative outlined in a regulatory newsletter that intended to collect information about all ‘trained’ prescribers and make this available to the public (table 2).
health professionals surveilling each other. For example, in one guideline for pharmacists and pharmacy technicians, the document began with extensive descriptions of the regulatory requirements for prescribers (eg, physicians and nurse practitioners) and began its guidance for drug dispensing with a short description of training requirements and then stated:

On receiving a new patient, pharmacists are required to confirm that the prescription is written by a valid prescriber who meets the legislative requirements for the medication assisted treatment prescribed to the patient (see previous section). The pharmacist must screen and assess the appropriateness of the treatment at the dose prescribed.33 (emphasis added)

Second, in identifying Suboxone as a potential corrective to previous opioid analgesic overprescribing—and identifying education as the means through which to begin doing this appropriately by improving knowledge, skills and behaviour—the regulatory documents also cast education as a moral imperative to address previous iatrogenic harms. The clinical and scientific documents also consistently reiterated this message of the Programme as a facilitator of prescribing by identifying that participation in the Programme was either required or useful for Suboxone prescribing. The moral imperative in these clinical and scientific documents, however, was to facilitate the prescribing of Suboxone as a corrective against growing harms from OUD (table 2). Suboxone was thus cast as a safe and effective therapeutic that was being underused by health systems given the scale of the opioid crisis. The Programme, then, could help remedy this by changing health professional behaviour and better meeting population health needs for the drug.

Bolstering the programme: associating with institutional medical authority

The credibility of the programme as a solution for these risk-problems was bolstered by the programme’s association with institutional medical authority—either regulatory, epidemiological or professional (table 2). Throughout the archive, the Programme was identified alongside other non-industry, accredited educational programmes as among the available and, in the case of the regulatory documents, authorised, programmes of record. Medicine holds much social power because of the collective value we place on health, science and expertise.34 By identifying the programme as a useful resource alongside other accredited non-industry programmes, these documents lent their authority to the programme by association. The repetition of text and images between the industry and non-industry documents emphasised this association. Likewise, the obfuscation of document authorship in regulatory and industry documents (table 1) further emphasised institutional authority without individual accountability for the content of the documents and its implications, including the legitimisation of industry as a risk mitigator.

The references to the programme throughout the archive documents can best be summarised by characterising the Programme as a ‘useful resource’. For example, most of the professional association documents were newsletters—some were focused on general business matters while others focused specifically on substance use. The majority of these documents listed helpful resources for addiction treatment and include a reference to the programme or hyperlink to the programme website as one such resource (table 2). Through these kinds of references, the health authorities, professional associations and educational institutions projected a professional authority and credibility through everyday communication. In the few cases where specific authors were identified in the regulatory documents, they were typically high-ranking and/or credentialed organisational executives (eg, college CEOs) or officials (eg, college registrars).

There were no individual named authors of the industry documents. In these documents, we noted the use of terms and phrases that draw on the authority of accreditation in continuing education, though there was no evidence that the Programme was fact accredited. In the two programme posters the term ‘Planning Committee’ recalled the planning processes of accredited continuing medical education—though nowhere on the posters was there an official statement of accreditation. Likewise, the posters included six specific ‘learning objectives’ that are phrased exactly as learning objectives might be for accredited continuing medical education. An archived page of the suboxone.ca Privacy Policy specifically mentions that personal information of programme participants may be ‘collected, used and disclosed … to Health Canada, the College of Family Physicians of Canada (CFPC) and/or other professional associations for accreditation purposes’.35 This recalls an earlier Quebec regulatory document from 2009 which identified that the programme was accredited for up to 6 hours of continuing medical education credit by the CFPC.36 This accreditation statement is no longer present on more current versions of the Programme Privacy Policy.

The industry handbook did appeal to professional authority by listing highly credentialed health professionals (physicians and a pharmacist) at the outset of the document as having contributed to ‘the initial draft of this programme’. The posters promoting live versions of the programme follow this appeal to professional authority exactly—they list the same group of health professionals (and their credentials) as the ‘Planning Committee’ for the programme. Both imply a kind of authoritative production of the programme without relying explicitly on authorship and the accountability that that entails.

DISCUSSION

The use of education programmes by the pharmaceutical industry to drive profit-making through the
overprescribing of opioid analgesics and other pharma-
cotoxicities has been widely discussed and well estab-
lished.\(^{17} 37 38\) To our knowledge, this is the first empirical
study examining industry involvement in health profes-
sions education for opioid agonist therapies like buprenor-
phine. This is highly relevant given both the importance
that agonists have been given as opioid crisis interven-
tions\(^{39}\) and also the abuses of regulatory processes that
Indivior has engaged in to maximise its profit-making
including ‘securing potentially undeserved orphan drug
status for its buprenorphine products, manipulating the
availability of such products, filing questionable citizen
petitions and engaging in abuses of the FDA REMS plan
to attenuate safety risks associated with buprenorphine
products.’\(^{40}\) This analysis comprehensively covered 69
distinct documents over 13 years from every Canadian
province and territory and included representation from
medicine, nursing, pharmacy as well as a wide range of
health institutions.

Continuing education for health professionals about
opioid analgesics has often been explicitly promotional,
delivered by company representatives or funded by
‘unrestricted’ grants that blur the distinction between
education and marketing.\(^{17} 41\) In this case, we identi-
cified a different process that was premised on the notion
of ‘risk.’ The identification and mitigation of risk is a
central, moral concern of contemporary, professionalised
health systems and social services in general.\(^{42} 43\) These
risks can be multifarious, ranging from environmental
to behavioural to psychological.\(^{44} 45\) with the process of
selecting and locating the relevant risks being subject to
the input and assessments of interests with various levels
of influence.\(^{46}\) In the case of strategies to facilitate the
use of opioid agonist treatments, we see the primary risks
framed as unruity opioid prescribers in need of surveil-
lance, and unpredictable and dangerous drug supplies,
in the form of methadone and street drugs. Here, various
kinds of medical institutions (regulatory, epidemiologi-
ical and professional) construct ‘risk’ in overlapping and
complex ways,\(^{47}\) with the result that a branded, industry
developed and delivered education programme presents
as an effective and normalised ‘risk mitigation’ strategy.
By extension, the manufacturer, Indivior, gains purchase
as a legitimate and beneficent risk-mitigator in the Cana-
dian opioid crisis and the brand name Suboxone becomes
normalised in everyday discourse relating to the opioid
crisis and treatment of OUD.

This process resonates squarely with the industry
promotion strategy for other pharmaceuticals. In an anal-
ysis of Zyprexa and Prozac, other ‘blockbuster’ psychoph-
armaceuticals (defined as pharmaceuticals with more
than US$1 billion in annual sales),\(^{48} 49\) Applbaum states,
‘getting to yes is the means whereby pharmaceutical
corporations fuse divergent positions of market inter-
mediaries under the banner of a more abstract, univocal
and often ethical purpose, drawing even on the energy of
those intermediaries to construct a single directed force
projecting them towards company objectives’.\(^{16}\) Indeed,
even the basic messaging around Suboxone identified
here follows almost exactly that of Prozac, which included
focusing on primary care professionals as market agents,
identifying substantial population harms related to
depression (such as suicide risk), and inspiring primary
care professionals with confidence in the product based
on its improved side effect profile and lower overdose risk
compared with earlier, off-patent antidepressants.\(^{16}\) In
this case, the toxic street drug supply and the documented
lethality of methadone play the threatening roles that
suicide and tricyclic antidepressants played for Prozac.
Importantly, this analysis does not question important
pharmacological differences between buprenorphine
and methadone or other opioids, but identifies specific
and contingent discursive productions of buprenorphine
against these other substances. It is possible to imagine
other ways to discuss buprenorphine to identify its utility
that do not involve comparisons to the risks of metha-
done and street opioids, just as we might imagine ways
to discuss the utility of selective serotonin reuptake inhibi-
tors without specific mention of the risks related to tricy-
clic antidepressants.

This kind of co-opting of the medical infrastructure
by industry through an education programme appears
novel, though the process very much recalls tactics used
in other areas of healthcare.\(^{50}\) Similar to how others
identified a kind of ‘ghost authorship’\(^{15} 51\) that facilitates
the promotion of industry messaging through medical
research, we saw a parallel kind of authorship vacuum
among these policy and training documents, including
specifically in the regulatory and industry documents.
This absence both elides individual responsibility for
industry promotion on the part of regulatory and some-
times professional leaders and also gives space for industry
to gain credibility on the shoulders of medical institu-
tional authority. It may also indicate a larger, concerted
strategy by Indivior to promote its product by using not
just medical education but also other means such as
government lobbying.\(^{52}\) Future scholarship should focus
on identifying, comparing, and analysing these additional
processes of Suboxone promotion.

Much of the existing scholarship around the processes
of industry influence on medical care has been based
on analysis of publicly available litigation.\(^{16} 17\) A new
generation of scholarship may be forthcoming given
the substantial and ongoing opioid-related litigation
in the USA and Canada.\(^{53}\) For this analysis, additional
future research should focus on the original regulatory
decisions for Suboxone’s 2007 approval which could
provide more insight into the nature of the ‘risk’ that
the Suboxone Education Programme was intended to
address and the process of delegating risk mitigation
from the public, federal drug regulator to the pharma-
ceutical industry. This could yield important knowledge
similar to the analysis of the public hearings for the regu-
latory approval for Thalidomide by the FDA in 2008.\(^{16}\)
Fortunately, Health Canada has committed to transpar-
ency as a drug regulator and documents relating to this

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Sud A, et al. BMJ Open 2022;12:e059561. doi:10.1136/bmjopen-2021-059561
decision may be forthcoming (personal communication, Health Canada).

The moral imperative to intervene on the specific conglomeration of risks relating to the opioid crisis overrode other moral imperatives of avoiding industry involvement in medical education and risks attendant with this involvement. As has been identified in other scholarship, this indicates a relative absence and weakness of educational authorities in the Canadian medical landscape. At the same time, the only document in our collected archive which overtly identified the Programme as industry sponsored, and possibly the need for a non-industry alternative, was from a medical educational institution. This suggests that strengthening the independent authority of medical educational institutions within the larger medical landscape may help mitigate the influence of the pharmaceutical industry in determining priority health challenges and the appropriate means for intervention.

This moral imperative to intervene is strengthened by the systemic marginalisation and manufactured vulnerabilities of people who use opioids. Namely, intervention—irrespective of the risks of industry involvement—may be deemed as required since the populations that may most benefit have historically been denied access to appropriate harm-reducing services and therapies. Thus, we see a normalisation of industry promotion of harm reduction interventions such as increasing naloxone uptake and reducing opioid-related stigma. Likewise, clinicians, researchers and policy-makers remain open to industry involvement in activities promoting the use of buprenorphine-naloxone in response to the steep and inevitable rises in opioid overdoses during the pandemic. A similar dynamic around industry involvement in harm reduction can be seen in other fields. As one example, the tobacco control community is currently polarised in relation to the promotion of e-cigarettes to reduce the harms of tobacco smoking and potential partnerships with tobacco or e-cigarette companies in achieving this goal.

There are important limitations to this analysis. The first is that our strategy for building the study archive selected only publicly available documents. Analysis of privately held documents such as minutes of lobbying meetings may identify new and different discursive constructions of the Programme that could influence the overall analysis. Likewise, this study does not account for the reach and impact of the various documents included for analysis. Discursive constructions in narrowly circulated meeting minutes from a small province or territory can hold as much weight in this analysis as widely disseminated policy documents from prominent medical institutions. These limitations could potentially be mitigated both by requesting additional documents through Access to Information Act requests and through formal interviews with key informants involved in the policy discussions around OUD care and opioid crisis responses in Canada. Both these activities present important avenues for future work that were beyond the scope of this study. Finally, this analysis was not able to examine the content of the Suboxone Education Programme itself. While other documents provided some insight into this programme content (eg, by referencing content from the programme), this was not sufficient to conduct a fulsome analysis of programme content.

CONCLUSIONS

In this analysis, we identified how the seemingly benign characterisation of a multitude of risks related to the Canadian opioid crisis opened the door for an industry developed and delivered education programme to become a legitimate and even morally appropriate solution for addressing these risks. Institutions from across the medical landscape lent their authority to this programme, overriding any concerns relating to conflicts of interest between industry and population health. This was despite explicit and persistent concerns around the role of industry in promoting the overprescribing of opioid analgesics, which was a crucial contributor to the opioid crisis and the related risks that this industry programme was meant to mitigate.

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