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Morphine kills the pain, not the patient

Just over 20 years ago, John Morgan,¹ an American pharmacologist, coined the term opiophobia to describe the analgesic-prescribing habits of physicians he had studied. Then, in 1987, WHO published its analgesic ladder,² which identified morphine as the most effective analgesic for cancer pain and effectively made a nation's per-capita consumption of morphine a proxy for the extent to which its citizens have access to pain relief and palliative care. Global morphine consumption has risen from 3.3 tonnes in 1985, before WHO's intervention, to 28.7 tonnes in 2004.³

However, underneath this change in prescribing practice, professional and public anxieties about the effects of morphine continue to hinder adequate access to analgesia. The best-known fact about morphine among the public and physicians is that it can be addictive (in fact the risk of iatrogenic addiction is under 0.01%⁴). For physicians, the second best-known fact is that morphine can precipitate respiratory depression. As a consequence, if offered enough confidentiality, clinicians can readily be found who will confess to having shortened the life of their patients to achieve pain control.⁵ Harold Shipman's use of morphine as his murder instrument has further increased disquiet among UK medical professionals and laity. Therefore, that the media take it as an accepted fact that everyday medical practice for pain control entails the use of increasing morphine doses until the patient dies as a result is unsurprising.⁶ This is a taint to which physicians specialising in pain management and, particularly, palliative care have been obliged to become accustomed.

The recent study from the US National Hospice Outcomes Project, which compared opioid use and survival at the end of life, is thus welcome,⁷ as it represents the largest and most sophisticated examination of the issue to date. In 725 hospice inpatients with end-stage cancer, lung disease, or heart

disease who were followed up until death, length of stay was positively correlated with the maximum daily opioid dose received, even when that dose exceeded 1.8 g a day—around 15 times the average for such patients in the UK and Japan.^{8,9} Neither absolute nor percentage change in dose was linked with survival. In fact, multivariate analysis found no combination of factors capable of explaining more than 8% of the variation in survival time, which suggests an overwhelming influence of the individual's disease severity.

A systematic review of previous (albeit smaller) studies, from palliative-care services in various countries, found no significant difference in survival according to either absolute morphine dose or change in morphine dose.¹⁰ These results are consistent with widespread clinical experience with morphine for analgesia. Only the opioid-naïve patient is at significant risk of respiratory depression.¹¹ A patient with moderate-to-severe chronic pain, whether malignant in origin or not, who is given the incremental dose-titration practised in pain and

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Opium poppy

palliative care centres is not at such risk. A physician who truly is killing his or her patient in the name of pain relief is not merciful, just incompetent.

What renders the situation frustrating is that the perception otherwise is so hard to shift. This problem matters because underprescribing of opioids remains a major barrier to effective pain control.¹² Furthermore, if ineffective pain management is still an issue in high-income countries, it is nearly universal in low-income countries where access to morphine is limited or absent, but where most people dying from cancer or AIDS reside.¹³ Governmental fears of illicit trafficking of morphine are part of the problem, but so are medical anxieties about adverse effects. The opiophobia that disallows all opioid drugs can change specifically into morphine phobia, with the result that only expensive alternative opioids, albeit with the same potential side-effects,¹⁴ are allowed. Either way, the poor get nothing. Yet morphine, properly used, is safe, and 10 mg should not cost more than one US cent.

As Portenoy and colleagues⁷ remark, “the timing of death in...far advanced illness involves a complex interplay of variables, and opioid therapy should not be the focus of future research of this type...Physicians should be encouraged to use opioids effectively to relieve suffering at the end of life.” Let’s move on, everyone.

Give a drug a good name

“Dear doctor...I note your patient has been taking chlorampicillin for several months. I found no infection and have asked her to stop taking it.” The doctor who dictated this letter confused chlorampicillin with chlorambucil. Drug names are not always easy to differentiate, and serious errors can occur.¹ However, the naming of medicines is not straightforward.

There are several national and international naming schemes. The best known are the British Approved Name (BAN), dénomination commune française (DCF), Japanese Accepted Name for Pharmaceuticals (JAN), and US Adopted Name (USAN). National schemes require manufacturers to use the approved name. In many countries, the approved name has to be used on prescriptions and labels of dispensed medicines.

National bodies such as the British Pharmacopoeia Commission and the USAN Council contribute to WHO’s panel of international nomenclature experts on

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I declare that I have no conflict of interest.

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recommended International Non-proprietary Names (rINNs).^{2,3} Occasionally, an objection is raised to a name and if agreement cannot be reached, the name remains a proposed INN (pINN). For example, amantadine was proposed in 1965,⁴ but it has not become a rINN because an objection remains on file. In practice, this is not problematic because amantadine is the BAN, DCF, JAN, and USAN.

Although close involvement of national bodies in the coining of INNs has aided international standardisation, approved names sometimes differ between countries. To harmonise names in Europe, the Council of the European Communities requires the so-called common name on medicine labels.⁵ According to directive (92/27/EEC), the common name means the rINN or, if one does not exist, the usual common name.

In the UK, after a faltering start, the few BANs that were not rINNs were changed except, for good reasons,⁵