Opium The Best Remedy

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"The liquid laudanum [a tincture of opium in alcohol], which I have mentioned as being given in daily draughts, is prepared in the following plain manner:

Sherry Wine: two ounces
Opium: two drachms
Saffron: one drachm
Cinnamon in powder, cloves in powder, equal parts: one drachm

Mix, and put into a vapour bath, for two or three days, until the liquor become of a proper consistency. Strain, and lay by for use.

I do not profess to consider that this form of laudanum has any advantage over the solid opium in point of strength. Its merit consists in being of a more convenient form, and more uniform in the action of its doses. It can be given with wine, distilled water, or any other liquid. And here I cannot but break out in praise of the great God, the Giver of all good things who hath granted to the human race, as a comfort in their afflictions, no medicine of the value of opium, either in regard to the number of diseases that it can control, or its efficiency in extirpating them. As all forms of opium come alike from the poppy, it is an attempt upon our credulity to pretend that the virtues of narcotics in general, and of opium in particular, are due to any artificial or peculiar process on the part of the preparer. Whoever will be guided by experience, and will diligently and frequently compare the effects of the natural juice with the effect of its artificial preparations, will discover that there is no difference between them; and will be well assured that the wonderful effects of the remedy are the effects of its own natural virtue and excellence, and not due to any skill of any clever artifice whatever. So necessary an instrument is opium in the hand of a skilful man, that medicine would be a cripple without it; and whoever understands it well, will do more with it alone than he could well hope to do from any single medicine. To know it only as a means of procuring sleep, or of allaying pain, or of checking diarrhoea is to know it only by halves. Like a Delphic sword, it can be used for many purposes besides. Of cordials it is the best that has hitherto been discovered in Nature. I had nearly said it was the only one."
– Thomas Sydenham, 1666 (1).

Sydenham was the leading English physician of the 17th century and probably to the present time. He was using a well tried remedy. It had been known by then for about 4000 years, frequently mentioned by Hippocrates, and recognized in use in medieval Europe where it probably came through Arabic traders and was well established in use in Paris by the 12th century (2). Professional concerns up to the time of Sydenham were not about addiction. As can be seen from his text, they were about whether the drug was available in adequate preparations, whether there was any difference between opium and other narcotics, particularly comparing the natural juice with "its artificial preparations" (1) (all of which he thought to be about equal in effect), whether it was stimulant or restorative and invigorating, and whether it was being properly used for all the conditions in which it could be helpful. Addiction, dependence and insanity are not mentioned, although the fact that it could occasionally promote excitement ("frenzy") was known.

Only with the 19th century did opioids come to be widely seen as a problem requiring regulation, and then only in the context of the professional struggle of pharmacists and physicians to obtain for their societies the latest and best perquisites of guilds (3), ie, professional licensing. In this issue of *Pain Research & Management* we have a book review (Moulin, page 49) of a symposium volume (4) that looks at the social and scientific evolution of knowledge and practice in relation to opioids, a book that provides an important source of information on some of the vagaries of political and legal management – and mismanagement – of the control of opioids. There are reasons to think that that control not only grew out of the need by the medical profession to establish its prerogatives by serving governments, but also that it had a significant influence upon the way in which doctors came to view those who needed opioids. To this reader, the evidence suggests that as physicians became complicit with governments in controlling opioids, so those who wished for more than was felt to be justified, began to be seen as threatening the orderly functioning of the medical profession. If doctors, who were the people who knew how to control the most impressive forms of use by injection, were to give way to troublesome patients (or become like them themselves), those physicians were not merely committing individual solecisms but were also putting the whole of the profession at risk of violating its obligations and responsibilities – on which its privileges also depended.

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Years of international negotiation, discussion, worry and police investigation led to the passing of Acts in individual countries and an international convention signed in 1912 of the active involvement of the League of Nations on international regulation (3). The use of opioids became more and more limited until by the 1930s medical students were learning consistently from their teachers that even in cancer pain opioids should be used exceptionally sparingly.

In the 1960s, a reversal of direction occurred. Cicely Saunders, the founder of the Hospice movement, established the benefits of substantial doses of narcotics, when necessary, in palliative care and the treatment of advanced cancer pain, and was supported in the United Kingdom by Robert Twycross and in Montreal by Balfour Mount who developed similar centres. It was a short step, but took some while for others to go beyond the treatment of advanced cancer pain and less advanced cancer pain, to the use of substantial doses of narcotics also for chronic noncancer pain. Two centres in North America deserve particular respect for their courage in advancing the use of opioid medication: the MD Anderson Hospital in Houston where C Stratton-Hill and Frank Adams (internist and psychiatrist) pioneered the liberal use of opioids for those who needed them with acute pain and chronic noncancer pain, and Sloan-Kettering Memorial Center where Kathleen Foley and her colleagues likewise evolved a program of adequate treatment of patients with noncancer pain. Independently, Arthur Taub (5) also reported very successful use of opioids for noncancer pain. A good account of the state of events up to that point appeared in the first issue of this journal (6).

In the current issue, the article by Peter Watson and colleagues (pages 19-24) provides a useful advance in clinical information on the long-term safety and efficacy of the use of opioids for chronic noncancer pain. In this paper, Watson and colleagues describe an analysis of data from 102 patients, followed for between one and 21 years, and who were receiving treatment with opioids for noncancer pain at the Toronto General Hospital Pain Clinic and subsequently in Watson's private practice as a neurologist. This article is probably unique in the literature in regard to the range of time over which patients were safely treated and for the meticulous care provided to them, and the results speak for themselves – significant long-term relief without undue hazard.

A great deal of benefit can be derived through careful and consistent treatment, but the practitioner must be wary of oversight by regulatory authorities. There was nothing wrong with Dr Watson's practice, and he was never told why anyone should need to take a critical interest in it. As a neurologist practising with patients with chronic pain it would be expected that he would have an above average rate of prescription of these medications, but nevertheless he suffered considerable intrusion into his practice by the Ontario College of Physicians & Surgeons. Today there are changes in the atmosphere but not as much as we still could wish. A Commentary article in this issue by Mr Matthew Wilton (pages 13-18), who provides us with a medico-legal column, describes how another physician, Dr George Gale, was pilloried by the same College two years ago. Dr Gale has subsequently been more than vindicated by an appeal to the Divisional Court of Ontario in which, although the court allowed some findings of the College Disciplinary Panel to remain in being – essentially for technical reasons as Mr Wilton explains – the penalty was fully and firmly overturned. Incidentally, the College Panel was also chastised for its unfair treatment of an expert witness for Dr Gale's defence – the same Dr Watson whose work appears in this issue and who had had the temerity to speak well of Dr Gale's practice and records. It appears that, despite having produced a balanced set of evidence-based recommendations for the management of chronic noncancer pain, the College of Physicians & Surgeons of Ontario has a long way to go in establishing due process for its members, who so often think that it serves to protect their interests, whereas it inherently deprives them of due process.

Physicians often do not question the way in which their regulatory bodies operate, tending to think that they will be understanding and fair, since a College must follow a legal process after all. However, we commonly are not informed that the legal process of a regulatory College is much in the hands of colleagues who seem to make significant errors in their judgements, fail to provide all the safeguards of the regular law courts, and may be influenced, both seriously and quite frequently, by out-dated or one-sided ideas with respect to medical practice. Reform is essential.

DECLARATION OF INTEREST: Dr Merskey has served as an expert witness for colleagues on a number of occasions and has advised one College with respect to a complaint.

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