Editorials

‘Please make comfortable’:

prescribing opioids in the wake of Gosport

The latest crisis concerning UK end-of-life care arose in June 2018 with the publication of the Jones inquiry into opioid-related excess mortality at Gosport War Memorial Hospital in the 1990s.[1] Hundreds of premature deaths resulted from misuse of diamorphine and syringe drivers, which often followed the clinical instruction ‘please make comfortable’. It is hard to overstate this scandal, one of many in the NHS. The report highlights patient safety failures at multiple levels, concerns about institutional culture, insufficient challenging and investigation of poor practice, and poor support of whistleblowers. Pocock *et al*’s editorial considers whether this was the result of a rogue clinician or systemic failures, while assessing the effect on palliative care provision.[2] What merits further discussion is the complexity surrounding opioid prescribing in palliative and end-of-life care, with its repercussions on both public and political discourse in the UK and further afield.

Box 1. What actually happened in Gosport?

- Large doses of opioids, commonly diamorphine, were prescribed and administered to patients under the instruction ‘please keep comfortable’.
- Many of these patients were not experiencing pain and were admitted for rehabilitation or postoperative convalescence.
- Prescriptions were provided for administration at nurses’ discretion, with unduly wide dose ranges and high starting doses.
- The practices of prescribing and administering drugs at the hospital conflicted with national and local guidance.
- The Graseby syringe drivers used for continuous subcutaneous administration of drugs were widely used across the NHS at the time. They were subsequently withdrawn due to a patient safety alert as there were two similar-looking models that infused at different rates. Safer alternative drivers are now used.
- The doctor who instigated much of prescribing (Jane Barton) was a GP and clinical assistant in a geographically and professionally isolated hospital.
- Many failed to raise concerns over Dr Barton’s prescribing; the Jones report calls into question the responses of inter alia pharmacists, consultants, the Coroner, and even the General Medical Council.
- When concerns were raised by families and nurses, they were dismissed or inadequately investigated.

COMPLEXITY IN THE UK PALLIATIVE CARE DEBATE

Person-centred compassionate palliative care was pioneered in the UK in the 1960s by Dame Cicely Saunders, encapsulated by her quotation: ‘*You matter because you are you, and you matter to the end of your life*’.[3] However, the recent emotionally-charged debate around the now withdrawn Liverpool Care Pathway for the Dying was a painful challenge to this approach, with numerous examples of uncaring and impersonal practice.[4] The Gosport scandal provokes further challenge to this rhetoric, now with a focus on the use of strong opioids and syringe drivers. While opioids are well-recognised as highly effective in the management of nociceptive pain in advanced diseases,[5] concerns about their safety are widespread and growing among clinicians, patients, and the public.

DEALING WITH CONTRADICTION: THE INTERNATIONAL CONTEXT

‘Opiophobia’ is widespread across the world,[6] with other barriers to adequate medical use of opioids including supply chain problems and overly restrictive national policies.[7] This is despite the 1961 UN Single Convention on Narcotic Drugs, which highlights the importance of ensuring opioid availability for medical use.[8] Access to opioids in Africa is particularly problematic: the recent Lancet Commission on Pain Relief and Palliative Care reported that in Nigeria less than 1% of opioid need is met in ‘health conditions most associated with serious health-related suffering’.[9] Since oral morphine is available at very low cost, the enormity of unmet need for pain relief in Africa is arguably equally as shocking as the converse events of Gosport in the UK.

Juxtaposed is the crisis of overuse of prescription opioids in countries such as the US, where the Lancet Commission’s equivalent opioid usage is estimated to be in excess of 3000% of need in the same conditions,[9] fuelling tolerance, addiction, and excess deaths.[10]

Therefore, opioids are essential for the palliation of pain in advanced disease, and when appropriately prescribed do not hasten death nor cause addiction; outside of that context, the risks of addiction and premature death are considerable. Our role as clinicians is to ensure that only patients who need opioids receive them, but also that those who would clinically benefit do not have these essential analgesics withheld due to patient, relative, or professional anxiety — a significant concern following often alarmist and unclear coverage of Gosport.

GP RESPONSES TO THE GOSPORT SCANDAL

To ensure safe and appropriate use of opioids, GP practices can regularly review their own use of opioids and develop safe systems including processes for identifying inappropriate opioid usage and adverse events. Mortality reviews of expected and unexpected deaths are being increasingly introduced into clinical practice: the forthcoming introduction of medical referees who will independently review all deaths will help mitigate such events in the future.

When caring for patients with advanced diseases requiring opioids, good communication and information provision about these drugs is essential. Inviting questions and concerns, explaining that the problems that arose at Gosport deviated from guideline-compliant care, will help to reassure concerned patients and their families. Language and terminology needs to be used with care: is the phrase ‘please make them comfortable’ now inappropriate? The linked *BJGP* Blog: ‘Pain, Opioids, and Syringe Drivers’ has suggested questions and responses in lay language.[11]

GPs also need to ensure that they work in an open and transparent way in which they, their clinical colleagues, and the patient’s relatives are empowered to raise concerns, such as through open forums and education on the appropriate use of opioids and signs of toxicity. The challenges faced by those who tried to whistleblow about inappropriate practice in Gosport have been highlighted elsewhere.[12] The ‘health advocate’ is one of the CanMEDS roles of the physician,[13] thus GPs have a broader responsibility, beyond individual clinical care, to work to reshape the public debate concerning opioids in order to advocate for effective patient-centred care. Not for the first time, the media debate risks becoming

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sensationalist: a Sunday Times investigation appropriately highlighted the problems with Graseby syringe drivers, but misleadingly infers intravenous administration, and fails to clarify that safer pumps are now in use in the NHS.[14]

Clinicians skilled in the critique of evidence and clear communication are ideally placed to refocus this debate towards an appropriate and proportionate response. Examples of misuse of the Liverpool Care Pathway led to its withdrawal, to the detriment of palliative care provision, we have argued.[15,16] The central role of opioids in palliative care is even more crucial and must be safeguarded through education of clinical colleagues, careful usage, explanation to patients and public communication. With further investigation ongoing and potential prosecutions, the Gosport scandal will remain in the public eye. GPs need to continue to shape this agenda and protect and provide appropriate opioid usage. '*The response to poor use should be right use, not non-use.*'[15]

CONCLUSION

The debates around palliative care and opioid use are becoming increasingly salient and complex. This growing complexity in the wake of Gosport must be embraced and clearly communicated, not ignored or oversimplified. 'Balance' is needed in policy[7] but also in patient care, recognising both unmet clinical need and overuse of opioids, empowering patients and relatives to articulate their concerns. We need to continue to strive for Cicely Saunders' vision of person-centred and compassionate palliative care, and protect the critical role of opioids in enabling comfort towards the end of life.

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