

Letters

In Memoriam

To the Editor:

I am a friend and colleague of the late William L. “Bill” Marcus, J.D., and I want to pay tribute to Bill and his contributions to the field of pain management. I have known Bill since the mid-1980s when we worked together to establish the National Association of State Controlled Substances Authorities, of which he became president. At that time, Bill’s professional legal career concentrated on the regulation of controlled substances for the California Board of Pharmacy. His activities subsequently broadened and ultimately led to providing much-needed leadership in California and throughout the United States to achieve more “balanced” drug control policies so that health professionals and patients have adequate access to controlled pain medicines.

Bill’s passing is a tragic loss for the pain management field, as well as a sad personal loss for all of us at the Pain and Policy Studies Group (PPSG). His contributions are numerous, so I will mention several that I believe are most exemplary of his dedication to people in pain.

- In the late 1980s, Bill served as an official advisor to a drafting committee of the National Conference of Commissioners on Uniform State Laws to prepare a new Uniform Controlled Substances Act for the States. He advocated for including a provision recognizing that controlled substances are necessary for the relief of pain, including chronic pain, which had been left out of the previous UCSA.
- In 1993, Bill proposed and then helped organize the “State of California Governor’s Summit on Effective Pain Management: Removing Impediments to Appropriate

Prescribing.” This first-of-its-kind meeting was held in 1994 and was instrumental in bringing about the successful transition of the controversial triplicate prescription program to a less invasive and more useful electronic prescription-monitoring program.

- Since its inception, Bill was actively involved in a nationwide America on Line discussion about regulatory issues, providing patients and health care professionals with greatly needed precise information about legal aspects of prescribing. He always advocated for fairness, objectivity and balance. There are many who will miss the prompt, forthright, and engaging contributions from “BILLNOPAIN.”
- In the late 1990s, Bill served as a peer-reviewer for the PPSG’s development of a method to evaluate and grade state laws and regulatory policies affecting pain management. The evaluation led to the identification of a number of barriers to pain management in state policies including in California.
- In 2004, Bill was recruited by the Federation of State Medical Boards of the United States to serve on the faculty for a series of regional workshops in the United States for state medical board members about regulatory barriers to pain management.
- As a result of these workshops, Bill became a member of California’s Task Force on Pain Management Laws that was established to address the numerous regulatory barriers to pain relief that had been identified in California law. With Bill’s advice and counsel, legislation to remove these provisions was adopted by the California Legislature and signed by the Governor.
- Most recently, Bill was an advisor to a Balanced Pain Policy Initiative sponsored by the Center for Practical Bioethics, and

a consultant for the PPSG project to identify the origins of barriers in state statutes and regulations.

I could recount more of Bill's contributions, but even a complete listing would not reveal the kind of person he was. Bill was one of the most thoughtful and rigorously analytical people I have known. He was sincerely committed to fairness and he had a sense of humor that was more than special. He cared deeply about his family and friends. The field of pain management and people with pain will miss him dearly.

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Re: Benchmarking the Use of Opioids

To the Editor:

We were interested in the use of the oral morphine equivalent (OME) in Wilcock and Chauhan's recent benchmarking of the use of opioids in the last days of life.¹ In previous studies looking at dosing of opioids, the OME has been quoted to incorporate all opioids using generally accepted standard conversion ratios.²

We completed a retrospective study of 451 case notes from consecutive inpatient deaths to identify two groups of 50 patients who had received either oral oxycodone or oral morphine on a regular basis during their last admission. The maximum dose prescribed during this admission was documented and the medians calculated (Table 1).

The effect of including oxycodone to the calculation is to increase the median OME dose by 33%. Variables that might account for this include overenthusiastic switching to oxycodone, a lower potency for oxycodone than that usually used, and altered metabolism of oxycodone in some patients. Like our data,

Table 1
Maximum Doses of Opioids During Final Admission

	Oral Morphine Maximum 24-hour Dose (mgs)	OME for Morphine Plus Oxycodone (mgs)
Median	60	80
Range	8–600	8–1,440
Mean	102	189
SD	121	255

those from Hughes and Robson³ also showed a marked difference between the median dose of morphine used (140 mg) and the median dose of all opioids (240 mg) using OMEs. When comparing the doses of opioids using OMEs, the use of alternative opioids may render analysis between different units/countries less useful. The use of OMEs are perhaps less useful than the median doses of specific opioids and routes.

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References

1. Wilcock A, Chauhan A. Benchmarking the use of opioids in the last days of life. *J Pain Symptom Manage* 2007;34:1–3.
2. Twycross R, Wilcock A, Charlesworth S, Dickman A. *Palliative care formulary*. Oxford: Radcliffe Medical Press, 2002.
3. Robson P, Hughes A. Opioid dose requirements. *Palliat Med* 2003;17:380.

Authors' Response

To the Editor:

We appreciate the opportunity to comment on the letter of Drs. Challand and Frew. We