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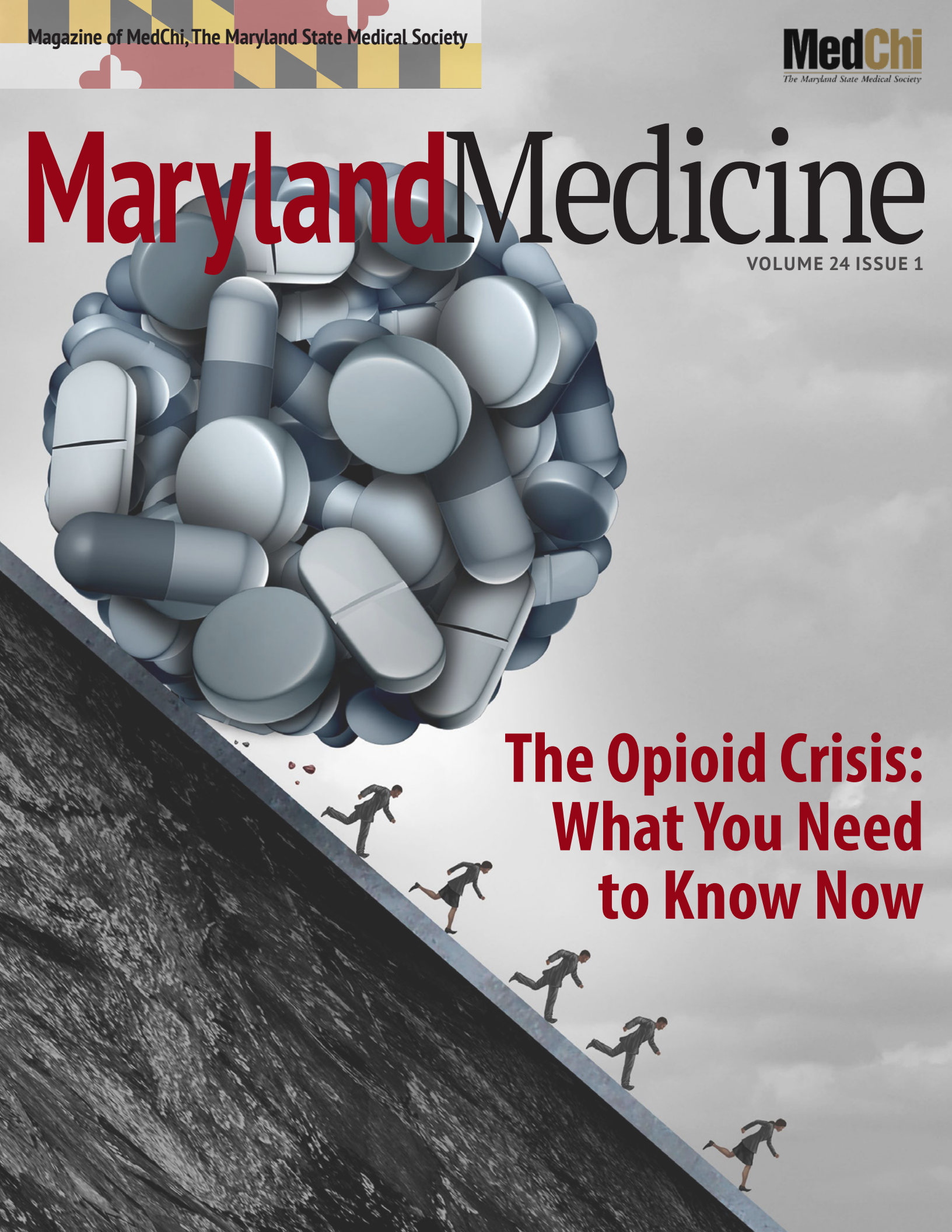

The Opioid Crisis: What You Need to Know Now

From the President...

James York, MD

As an orthopaedic surgeon, I am no stranger to prescribing opioids. In fact, orthopaedic surgeons are the third-highest physician prescribers of opioids, writing more than 6 million prescriptions a year. Because over-dispensing of opioids is a factor contributing to the ongoing opioid epidemic, researchers at Johns Hopkins surveyed orthopaedic providers to better understand what drives their prescribing practices and to identify gaps in knowledge and potentially worrisome trends. In their survey of 127 orthopaedic providers in the Baltimore area, the Johns Hopkins researchers found that respondents frequently recommended prescribing a nine-day supply of around-the-clock oxycodone doses following commonly performed orthopaedic surgeries. The researchers also found that risk factors that might normally warrant prescribing fewer opioids, such as a history of drug misuse or depression, often did not diminish hypothetical prescribing rates.

The researchers published their findings on June 22, 2019, in the *Journal of Opioid Management*. In the survey, researchers gauged responses to six scenarios routinely encountered by orthopaedic surgeons. They found that although increased experience was associated with decreased prescribing, 95 percent of respondents recommended prescribing at least fifty-five oxycodone pills following five of the six surgeries described. That amounts to a nine-day supply of medication, more than current recommendations from the Centers for Disease Control that no more than a three- to seven-day supply routinely be prescribed.

The study also found that 62 percent of respondents reported that they do not routinely use their state-sponsored electronic prescription drug-monitoring program, which can help flag when patients go "doctor shopping" for a new source of pills. Finally, 79 percent of respondents reported that they do not provide opioid disposal instructions to their patients, an alarming find as studies show that unused pills remaining in homes can potentially get into the wrong hands.

The health care system where I work, Luminis Anne Arundel Medical Center, also published the results of our multi-phased approach to reducing opioid prescribing which can be found in the *Journal of Opioid Management*, March–April 2021, pp. 169–79. Implementation of the interventions resulted in an average reduction of 15.2 MME per encounter (54.5 percent) compared to the preimplementation cohort $p < 0.001$). Pills per opioid prescription was reduced by 13.4 (29.5 percent) $p < 0.001$), and the percent of patients receiving opioids was reduced from 8.3 percent to 5.8 percent ($p < 0.001$). This multi-phased approach by Luminis offers a template that other institutions may use to reduce opioid overprescribing in practices.

Yet knowledge gaps among surgeons for prescribing still remain that need to be addressed. Evidence-based guidelines for opioid prescribing for specific procedures are also needed to keep overprescribing in check, while still adequately treating pain. MedChi recently partnered with Queen Anne's County Medical Society to address the illicit use of unused opioid medications through a wide-spread distribution of at-home drug deactivation and disposal systems and consumer education (see page 17).

From October 2021 to September 2022, there was a steady decline in the number of fatal overdoses from all substances, including fentanyl, cocaine, alcohol, opioids, heroin, methamphetamine, benzodiazepine, and phencyclidine in Maryland. The decrease in opioid-overdose fatalities is 27 percent down over the same time frame (see graphics on page 6). It's an optimistic picture, yet more work remains to be done.

Pain is the most common reason that people go to the doctor. Yet physicians and medical students have limited training in pain management and prescribing opioids. As Maryland (and indeed, our nation) suffers from an opioid epidemic, people within the medical field are reexamining what doctors are taught about pain and rethinking best practices for treating pain through opioid prescriptions.

Report from the Opioid, Pain, and Addictions Committee (OPA)

Sarah Merritt, MD, and Gary Pushkin, MD

This vital committee has evolved greatly over several years. Both the Addictions Committee and Pain Committee were established to identify issues of importance in addiction medicine and pain management. They also exist to work with MedChi to develop policies and activities that address these issues for the benefit of the health status of Maryland citizens.

The Opioid Task Force was established in 2017 while Gary Pushkin, MD, an orthopedic surgeon was MedChi President. The significant changes in opioid prescribing practices lent impetus to make a standing committee by MedChi's House of Delegates. One goal of the Opioid Committee was to provide physicians with a better understanding of how to prescribe opioids correctly and most effectively.

In 2021 the Opioid, Addictions and Pain Committees joined forces as we discovered there was a great deal of overlap in key areas as well as committee members.

The Opioid Pain and Addictions (OPA) committee is comprised of a diverse group of physicians who are in the following specialties: surgery, pain management, emergency medicine, OB/Gyn, and primary care. The OPA Committee is unique from other MedChi Committees as it also has members who are medical students, pharmacists, researchers, representatives from the Prescription Drug Monitoring Program (PDMP) within the Maryland Department of Health (MDH) and CRISP, the Board of Pharmacy, and the DEA.

A project that was initiated by the Opioid Task Force was researching best practices for opioid prescribing and making resources available on the MedChi website. These are still available at https://www.medchi.org/ending-opioid-crisis. Another major accomplishment was changing hospital electronic prescribing software to enable the ability of a prescriber to enter a dosage as opposed to the dosages automatically populating. This has helped address the issue of higher dosages prescribed than the prescriber believes are necessary and appropriate.

As the current co-chairs, we are pleased with much of the progress that has been made in educating physicians in proper opioid prescribing leading to opioid prescriptions having decreased by 44.4 percent between 2011 and 2020. However, overdose deaths continue to increase, emphasizing the importance of treatment for substance use disorders.

The focus of the OPA Committee moving forward is:

- During and now post COVID, fentanyl has saturated the illicit opioid supply. How can we better treat these patients who are exposed to fentanyl?
- In 2006 there were twenty-six fentanyl overdose deaths in the state of Maryland.*
- In 2021 there were 2,348 fentanyl deaths in the state of Maryland.*
- How can we continue to monitor and propose legislation to protect prescribers and ensure pain management care and treatment for opioid use disorder are available to Marylanders?
- How will legalized marijuana impact prescribers and Marylanders with pain and/or substance use disorders?

Sarah Merritt, MD, is ABMS Board-Certified in Anesthesiology and Pain Medicine at Lifestream Health Center and a state-appointed member of the Technical Access Committee for the Maryland State Prescription Drug Monitoring Program (PDMP). Dr. Merritt can be reached at smerritt@lifestreamhealth.com.

Gary Pushkin, MD, a former MedChi president, is a Board-Certified orthopedic surgeon at Cohen & Pushkin, MD, PA. He is active on many committees at MedChi, including Board of Trustees, House of Delegates, Bylaws and Legislative Council — among others. He can be reached at gpush4101@gmail.com or gpush@comcast.net.

Innovative Approaches to Treatment of Opioid Use Disorder in Youth

Marc Fishman, MD

Introduction

Opioid use disorder (OUD) is a catastrophic problem for youth (adolescents and young adults) and their families. Youth have prominent developmental vulnerability to substance use disorders (SUD) and their progression. MOUD treatment for youth is safe and effective, and should be the first-line standard of care. But despite the evidence, overall uptake has been severely limited. There have been substantial barriers to engagement, initiation, and retention of youth in MOUD treatment, and poorer outcomes compared to older adults. Several emerging, developmentally-informed interventions have promise for improving outcomes.

Developmental vulnerability and prevention

The vast majority of individuals with OUD across the lifespan have onset of SUD before age eighteen. Adolescence and young adulthood are dynamic periods of growth in many domains, but developmental maturation remains incomplete well into the mid twenties. Substantial developmental immaturity during these periods make youth much more vulnerable to SUD than mature adults. In this way addiction can be conceptualized of as a developmental disorder of pediatric onset.

No epidemic can be solved with treatment alone. Prevention is also necessary to stem the flow of cases. OUD should be thought of as an advanced, malignant subtype of SUD that comes with progression of the broader disorder. Young adults have had disproportionately higher rates of OUD than any other period in the lifespan. While some cases of adolescent OUD begin with medical opioid exposure and initiation, the majority of cases begin with non-medical initiation. Furthermore, whether opioid initiation is medical or non-medical, most cases of youth OUD are preceded by other SUDs. That is, problems and loss of control of other non-opioid substances (typically alcohol, cannabis and/or nicotine), are a major risk factor, if not the major risk factor, for OUD. For SUD in general and OUD in particular, as in many chronic disorders, earlier onset leads to worse outcomes, and earlier intervention leads to better outcomes. Intervention for youth SUD and substance use before it progresses to disorder, prior to opioid initiation, is itself OUD prevention, and should be a major public health priority.

Standard treatment

Although the treatment of OUD in youth is not as well studied as in mature adults, an increasing body of research supports MOUD as the standard of care. MOUD for youth is effective, life-saving, prevents relapse. And although all medications have potential side effects, there are fortunately has no additional safety concerns for adolescents and young adults based on age. MOUD is also supported by expert clinical consensus, for example endorsements by the American Academy of Pediatrics and the American Society of Addiction Medicine). Adolescents are generally treated with buprenorphine or XR-naltrexone, and only very infrequently with methadone, while young adults are also eligible for treatment in adult methadone programs.

Limited uptake of MOUD for youth may be due to problems with treatment capacity, misinformation or prejudice. Older and discredited ideas may linger, such as the notion that MOUD for youth should only be second-line after failure of non-medication treatment, or that youth MOUD should be short term only, or that antagonist treatments are intrinsically better for youth than agonists. Despite the effectiveness of MOUD for youth, and superiority over treatment without MOUD, outcomes are generally worse compared to those for older adults. Problems with medication adherence and treatment retention are prominent. The following are examples of innovative models for youth OUD treatment.

Innovative model — Youth Opioid Recovery Support

This wrap-around model attempts to address barriers to treatment engagement in the vulnerable young adult population, especially difficulties with medication adherence. The YORS model incorporates several components aimed at increasing the effective implementation of MOUD, including: home delivery of extended release relapse prevention medications (either XR-naltrexone or XR-buprenorphine), promotion of family engagement, and use of assertive outreach. By literally meeting youth and families where they are, home delivery of medication aims to engage and retain youth that may not succeed in more traditional models. The impact of family engagement is well known but has been poorly applied in treatment of young adults because of inadequate training, over-rigid concerns about confidentiality, and the developmentally normative push back by young adults against their subjective sense of family "intrusiveness." But respecting the emerging autonomy of youth and empowering families are fully compatible. Treatment proceeds best as a collaboration among the youth, the family and the treatment team, including: participation in treatment planning sessions, development of a written family treatment agreement, signing of releases for communication, coaching on effective strategies for promotion of medication adherence, and development of a "back-up plan" in the event of relapse. Assertive outreach consists of staff taking the active lead, rather than waiting passively for patients to show up, reaching out with treatment reminders, using the

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Innovative Maryland Responses to the Opioid Crisis

Marc Fishman, MD

Introduction

Opioid use disorder (OUD) continues to be a major public health crisis. Rates of opioid drug overdose deaths are rising precipitously, most of those due to the synthetic opioid fentanyl. Fentanyl analogues, manufactured in bucket labs in China and Mexico by the criminal drug cartels, have flooded many areas of the US, including Maryland, essentially replacing heroin. Fentanyl is commonly pressed into pills, and sold as counterfeit "Percocet" or other "prescription" opioids. In addition to being highly addictive, fentanyl's extremely high potency (50-100x stronger than heroin) puts even experienced opioid users at risk because they cannot estimate a safe amount to use. Fentanyl is also disguised as or added into non-opioids, for example pressed into counterfeit "Xanax" tablets, or laced into cocaine or cannabis. This means that even those intending to use non-opioid substances can unintentionally overdose on fentanyl.

Despite the bad news of growing morbidity and mortality, there is good news. One of the major initiation pathways, over-supply of opioid analgesics, has slowed substantially with more rational prescribing practices. Most importantly, there are effective treatments available for opioid use disorder. The cornerstone of treatment are three FDA-approved medications for opioid use disorder (MOUD): methadone, buprenorphine, and naltrexone. Buprenorphine is available in monthly injectable extended-release formulation and daily sublingual tablets or film. Naltrexone is available in monthly extended-release injections. Access to treatment in Maryland is increasing and we are fortunate to have better resources than many states, including a robust safety net program with broad Medicaid coverage for treatment including all the forms of MOUD. Additionally, there are several innovative projects underway across the state attempting to improve our response to the opioid crisis.

Support for primary care treatment

While specialty addiction care, including inpatient and residential, may be necessary for the most high-severity or unstable cases, there has been widespread success with moving OUD treatment into primary care, especially with buprenorphine, which is easy, safe, and effective. This increases access to treatment by increasing availability and capacity, lowering barriers to care, and decreasing stigma.

The Maryland Addiction Consultation Service (MACS), funded by the Maryland Behavioral Health Administration and administered through the University of Maryland School of Medicine, provides support to medical practices in addressing the needs of patients with substance use disorders and chronic pain. The MACS warmline provides free consultation within 24 hours from an experienced panel of on-call specialists. MACS also provides training on a wide variety of OUD and other addiction treatment topics to the community through regular live webinars and case-based ECHO conference series. Call 1.855.337.MACS (6227) for consultation or more information, or www.marylandmacs.org.

The Collaborative Opioid Prescribing (CoOp) model developed at Johns Hopkins, coordinates buprenorphine treatment between a specialty center and a PCP. This model has the initial phases of treatment implemented at the specialty Opioid Treatment Program (OTP), including assessment, medication initiation, stabilization, and counseling Once the patient is stabilized, ongoing buprenorphine prescribing and maintenance is shifted to an office-based, less intensive setting, like primary care. Concurrent counseling and monitoring continues at the specialty center as needed during a transition phase, decreasing in intensity over time. The specialty center remains actively involved and available for consultation to support the office-based prescriber, and can take the patient back for periods of exacerbation and re-stabilization, including direct dispensing of buprenorphine or switching the MOUD to methadone if needed.

Telehealth

Regulatory restrictions previously required certain in-person elements for buprenorphine treatment, but accelerated regulatory changes during the COVID state of emergency allowed the widespread uptake of telehealth buprenorphine treatment. While some patients benefit from in-person OUD management like urine drug testing or in-person group support, telehealth access has decreased barriers to care for many. Now, even though in-person care has largely resumed post-pandemic, the federal government and state have continued to allow the indefinite continuation of buprenorphine telehealth, at least on an ongoing interim basis. We are learning more about which patients are better candidates for telehealth vs in-person care, and having the choice is beneficial.

MOUD during incarceration

The intersection between addiction and involvement in the criminal justice system is well known. Individuals with OUD

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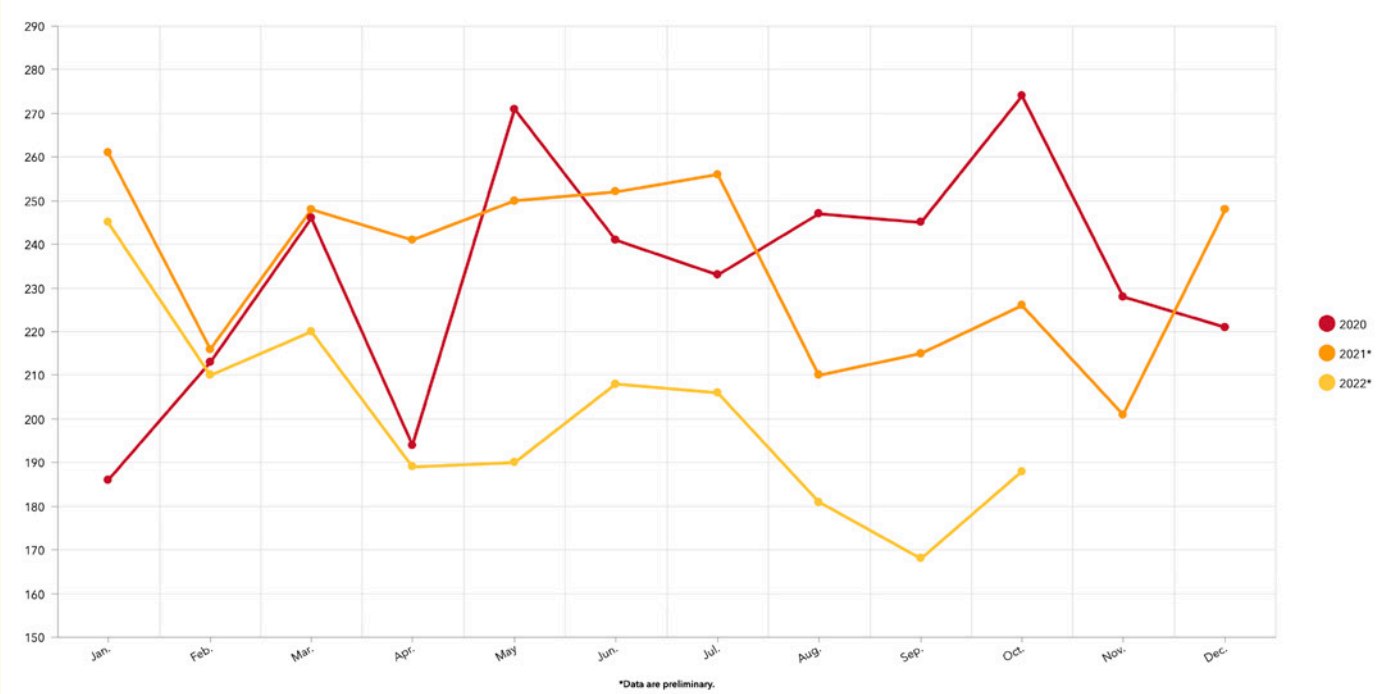
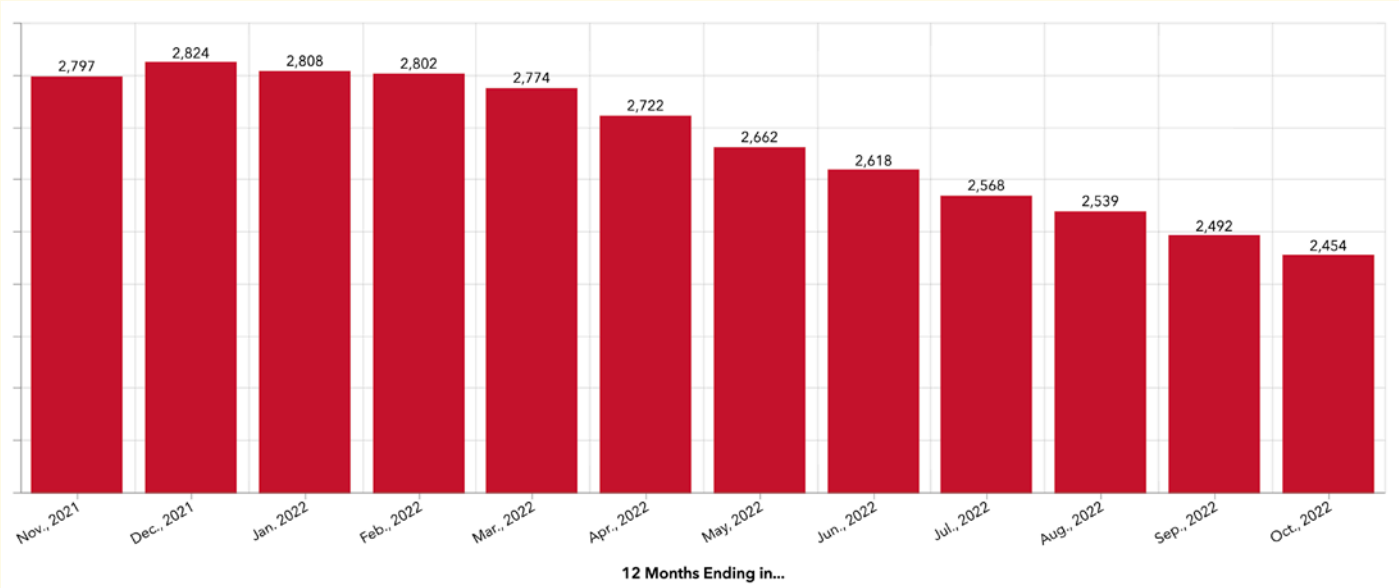
Fatal Overdoses (All Substances) | By Month (2020–2022)



Fatal Overdoses (All Substances) | Rolling 12-Month Period



Source: Maryland Overdose Data Dashboard, courtesy of Opioid Operational Command Center, data current as of 02/10/2023.
Visit: beforeitstoolate.maryland.gov/oocc-data-dashboard/.

Stigma: The Greatest Barrier to Effective Treatment of Opioid Use Disorder

Joseph A. Adams, MD, FASAM

The widespread use of ineffective treatment for opioid use disorder (OUD) is a major obstacle to addressing the opioid crisis. This is related to stigma and misunderstanding of our most effective OUD treatment: medications for OUD (or MOUD). Methadone and buprenorphine are the only treatments shown to reduce overdose deaths, and are the "gold standard" for most individuals with moderate to severe OUD.[1] There is an important but more limited role for long-acting injectable naltrexone.[1]

According to the National Institute of Drug Abuse in 2022, "methadone … and buprenorphine have proven to be life-savers … enabling [patients] to live healthy and successful lives, facilitating recovery… The efficacy of MOUD has been supported in clinical trial after clinical trial, and is considered the standard of care in treatment of OUD, whether or not it is accompanied by some form of behavioral therapy."

Although some individuals, even some with severe OUD, have achieved recovery without MOUD, this is much less common. Individuals should be able to choose among treatment options in conjunction with their health provider, and informed of likely benefits and risks. Surprisingly, ineffective treatment is all that most U.S. residential treatment programs offer for OUD, namely, psychosocial treatment only, without the option of maintenance OUD medication.[2] Also, many recovery residences limit or prohibit access to MOUD regardless of patient preference, a practice which does not meet the basic standard of care for OUD, and which is a form of discrimination that potentially violates federal law.[3] Yet, many of these recovery residences still receive quality certification from the Maryland Certification of Recovery Residences program (MCORR).

Mortality due to opioids has now impacted the general U.S. life expectancy, and opioid-involved overdose deaths have increased nine-fold increase in since 1999. Yet only about 20 percent of people with OUD are estimated to receive any type of treatment in a given year. For no other medical condition for which an effective treatment exists is that treatment used so infrequently. Stigma, a form of stereotyping and discrimination, includes self-stigma and structural stigma (e.g., excessive restrictions imposed on patients causing barriers to treatment, which result from, and also perpetuate, stigma).

MOUD stigma largely stems from conflating "addiction" with "physical dependence." Despite widespread misunderstanding that using methadone or buprenorphine is "trading one addiction for another," "addiction" is the wrong word for these medications. "Addiction" is a loss of control over something that causes harm.

Due to the slow delivery to the brain (analogous to a nicotine patch) and very long half-life, maintenance methadone and buprenorphine are not 'addicting' by the accepted definition. These medications are associated with a normal ability to drive, and in stable patients a normal ability to raise children, function in society and work in virtually any occupation. (Although it is possible to intentionally use these medications to accentuate the acute effects of other drugs such as sedatives). Studies have indicated that some patients endorse that they have diverted buprenorphine "to get high," but the meaning of this phrase is unclear and does not necessarily indicate either harm or "addiction." The goal of minimizing diversion should be balanced with providing adequate, convenient access to these lifesaving medications. Diverted medication is most commonly used to manage withdrawal symptoms or to avoid using more dangerous substances, and is more common when access to MOUD is limited.

The literature is clear that psychosocial services (counseling) alone, without MOUD, whether inpatient or outpatient, are ineffective for the overwhelming majority with moderate to severe OUD, and puts patients at significant risk of return to use or fatal overdose. The results of randomized controlled trials of the benefits of counseling as a supplement to MOUD are mixed. These services should be available and encouraged, but mandatory psychosocial services can be barrier, so they should not be a strict condition of accessing MOUD.

Even stable patients should not be encouraged to taper off of MOUD, but patients' wishes should be respected. OUD is a chronic relapsing medical condition and most patients with moderate to severe OUD benefit from long-term treatment of at least several years. Many if not most benefit from longer-term or indefinite medication treatment, although some taper off and remain stable. All studies to date of MOUD tapering and discontinuation demonstrate very high average relapse rates.

A valuable resource for providers, patients and families is www.StopStigmaNow.org, including uniquely effective videos of people on MOUD telling their stories. Providers can get advice and support from the Providers Clinical Support System (https://pcssnow.org/), the Maryland-DC Society of Addiction

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MPHP Works.

So, physicians can.

Being a physician is **stressful**. With so many patients' well-being depending on you, it's easy to feel exhausted and overwhelmed. If you experience symptoms of stress on a near-constant basis, you may be suffering from burnout, which is characterized by

- Feeling overextended
- Feeling emotionally and physically depleted, drained and used up
- Depersonalization
- A sense of reduced accomplishment in day-to-day work

Studies have shown burnout to be dangerous for both you and your patients.

Now there is help. The Maryland Physician Health Program (MPHP) assists physicians in a **private**, **confidential** setting to address issues that may potentially impact your ability to practice medicine.

MPHP assesses and refers participants to clinically appropriate treatment, helps participants develop an individualized plan, provides case management to facilitate progress with the plan, and provides advocacy on behalf of the participant when needed.
Get the help you need to keep you healthy and performing at your optimal best.
For a confidential consultation, call 800-992-7010 or 410-962-5580 or email Phpinfo@medchi.org.

Center for a Healthy Maryland
The Maryland State Medical Society Foundation

MPHP
MARYLAND PHYSICIAN HEALTH PROGRAM
Forging the path to physician wellness.

Treatment of OUD Youth, *continued from pg. 4*

patient's preferred mode of communication (typically texting), persistently until contact is made.

The preliminary effectiveness of the YORS intervention has been documented in several studies, and a larger randomized trial of YORS is underway in the Baltimore region funded by the National Institute on Drug Abuse (NIDA) under the Helping End Addition Long-term (HEAL) program.

Innovative model — CRAFT family coaching

Family involvement has been consistently supported as effective in youth SUD research. Furthermore, involvement of families (or others with close relationships) in supporting the treatment of loved ones with illness is standard and routine in every other area of health care, except addiction which is plagued by family secrecy, shame, anger and stigma. CRAFT (Community Reinforcement Approach and Family Training) is an evidence-based model that takes family involvement upstream by engaging family member(s) of a loved one with SUD in need of treatment but not yet motivated or ready for treatment. The core concept is to coach the family to use relationship and leverage more effectively to help promote treatment entry and engagement. The model was initially developed for adults (typically a spouse) but has been adapted for parents of youth.

Through a grant from SAMHSA through the MD State Opioid Response initiative, the National Center for School Mental Health at the University of MD has established free access to and training for online parent CRAFT. Highly engaging online video segments include structured suggestions for practicing skills for families with substance-involved youth. Focus areas include effective communication, positive reinforcement, natural consequences, strategies to support youth accepting treatment.

Some families may need or prefer individual coaching from a professional. Through NIDA HEAL funding, Maryland Treatment Centers has established a pilot program for free access to a specialized CRAFT therapist who can work with individual families. If and when a youth with SUD, including OUD, becomes ready to accept help, this can lead to a seamless transition to treatment, including persistent family involvement. A zoom family-to family peer group is also available, in which families can get support from each other.

Local Resources

Youth Opioid Recovery Support Study (YORS)
Kamala Malik-Kane, Kamala@marylandtreatment.org

On-line Parent CRAFT Training
https://www.cadenceonline.com/maryland/
Melissa Ambrose, mambrose@som.umaryland.edu

Therapist-Supported CRAFT Family Coaching
Luciana Lavorato, llavorato@marylandtreatment.org

Young Adult Recovery Housing
Lauren McCarthy, LMcCarthy@marylandtreatment.org

Innovative model — Youth-specific recovery housing

Unstable living situations, substance-infested environments, and difficulties with persistent engagement in treatment are barriers for recovery for many individuals with OUD. Recovery houses can provide structure and peer support in a safe and sober living environment to promote recovery. But adult recovery houses are often problematic for young adults, both because there may not be enough structure to support those with immature independent living skills, and because rigid rules for adults may not adequately accommodate developmentally-normative impulsive youth behavior leading to discharge for rule infractions. Furthermore, many recovery houses are not welcoming or supportive of MOUD. The state Behavioral Health Administration has funded two youth-specific recovery house programs, one in Baltimore City and one in Westminster, available without charge to young adults with OUD. These houses emphasize developmentally-informed program components, and support engagement in outpatient treatment including MOUD.

Conclusion

MOUD is standard of care and should be a first line component of all treatment for OUD in adolescents and young adults. While there are many barriers to optimal outcomes, an emerging set of innovative models that utilize developmentally informed approaches have promise for improving initiation, engagement, adherence, retention, and success.

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Ending the X-waiver and Expanding Care for Opioid Use Disorders

Rahul Gupta, MD, MPH, MBA, FACP

Synthetic opioids like illicit fentanyl are leading to unprecedented numbers of drug poisoning deaths in America. In Maryland alone, there were more than 2,700 deaths in 2021. It's affecting people in Baltimore, in Southern Maryland, outside the Capital Beltway (where I grew up), in Western Maryland, on the Eastern Shore, and everywhere in between. Why? Because illicit fentanyl is incredibly lethal and fewer than 10 percent of Americans who need substance use treatment can access it.

It doesn't have to be this way—and soon, it won't be. In December, President Biden expanded treatment for opioid use disorder to millions of Americans by signing the bipartisan government funding bill into law, which ended the longstanding "X-waiver" that had proven to be a substantial barrier to patients receiving treatment in the U.S. Thanks to this new law, any DEA-registered prescriber of controlled substances can now offer buprenorphine treatment to patients with opioid use disorder without additional federal approvals.

This is a game changer. As a primary care physician, I have directly encountered this barrier to care numerous times. Before I went through the process to receive an X-waiver, I had patients who needed medication for opioid use disorder, but I couldn't give them the necessary prescriptions. Instead, I had to refer them to addiction specialists, and I saw too many patients die because they couldn't or didn't go. My patients needed me to step up so I went through the process to get the X-waiver, but doing so was onerous and many physicians are not able to do the same.

Now that the X-waiver barrier is lifted, it is time for all physicians to join in treating patients for addiction. These patients are in your panels and they need you to screen for and treat their substance use disorders.

Further, we need the entire health care system to support this opportunity as well. We must ensure that pharmaceutical companies, distributors, pharmacies, and health care administrators are making treatment available, accessible, and affordable.

Finally, we must come together as a society to address the social determinants of health that could prevent patients from accessing treatment. Our patients have lives, they may have children, they need food and housing and transportation to get to their appointments. We have to meet people where they are so they can get the care they need.

It took a broadscale coalition of advocates, community leaders, and medical providers to help bring an end to the X-waiver, and it will take a large coalition of prescribers to ensure everyone who needs treatment for opioid use disorder receives it. We must spread the word to providers and patients so people know treatment is available.

To the readers of *Maryland Medicine*, I thank you for everything you are doing for Marylanders with substance use disorder, and I urge you to do even more so we can reduce these deaths and keep families whole. By ensuring more people can access treatment, you will help save lives and end this crisis.

Rahul Gupta, MD, MPH, MBA, FACP, is Director of the White House Office of National Drug Control Policy. He was recently presented with the American Medical Association's 2023 Award for Outstanding Government Service.

EDITORIAL STATEMENT

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BALTIMORE COUNTY OPIOID ACADEMIC DETAILING PROJECT

A Baltimore County Department of Health Initiative

What is Academic Detailing?

An interactive in-person healthcare practitioner educational outreach to optimize clinical decisions and improve patient care.

The Opioid Academic Detailing Project offers evidence-based information to support therapeutic decisions specific to pain management and substance use disorder. Academic detailers are trained public health professionals who offer brief visits with practitioners to discuss their needs in prescribing controlled dangerous substances, supporting patients with pain management needs, and referring or offering substance use disorder treatment. Academic detailers connect practitioners with evidence-based, clinically relevant and actionable resources offered by their local, state, and federal health agencies.

Best Available Evidence

CLOSING THE GAP

Clinicians need high quality information that is:
-Relevant to clinical problems
-Focused on real world decisions
-Customized to their clinical setting

Actual Clinical Practice

Research on Detailing

Academic Detailing has been found to improve prescribing practices

- In 2018, the CDC listed Academic Detailing as an evidence-based strategy for preventing opioid overdose (1).
- A 2013 overdose prevention intervention carried out on Staten Island used targeted educational sessions with medical providers to reduce rates of inappropriate opioid prescribing and overdose death. The intervention resulted in a 29% decrease in prescription opioid overdoses on Staten Island, even as overdose rates remained unchanged in New York City's other boroughs (2).
- A study in San Francisco found an eleven-fold increase in the rate of naloxone prescription among physicians who received a half-hour-long academic detailing session (3).

Project Goals

For the County

- Improve opioid prescribing practices
- Increase clinician use of the state's Prescription Drug Monitoring Program (PDMP)
- Prevent opioid-related overdose deaths
- Augment skillsets of the public health workforce

For clinicians

- Possess sufficient knowledge of the CDC Guidelines for Prescribing Opioids, which will allow clinicians to formulate strategies for guideline implementation into practice
- Implement current CDC opioid prescribing guidelines into clinician practices and utilize resources provided by detailers

Requests for a detailing session and support for opioid prescribing and safe drug disposal options available through the Baltimore County Department of Health. Please contact R. Adrian Boswell 410-887-8188 or rboswell@baltimorecountymd.gov for more details.

Quick Tips

Below are some key messages from our Academic Detailers

Use non-opioid treatment as the first line for acute or chronic pain management

If opioids are needed, start prescribing at the lowest effective dose

Use available PDMP data to determine if patients have previously filled prescriptions for opioids or other controlled medications

Ensure patients' safety by avoiding prescribing of opioids with other sedating drugs

Offer treatment for patients with Opioid Use Disorder (OUD)

Co-prescribe naloxone to patients at high risk of experiencing or witnessing an opioid related overdose

1. Centers for Disease Control and Prevention. Evidence-Based Strategies for Preventing Opioid Overdose: What's Working in the United States. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, 2018. Accessed September 30, 2019. from https://www.cdc.gov/drugoverdose/pdf/pubs/2018-evidence-based-strategies.pdf
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2023 LEGISLATIVE AND REGULATORY PRIORITIES

As the statewide professional association for licensed physicians, we are dedicated to our mission to serve as Maryland's foremost advocate and resource for physicians, their patients, and the public health.

Clement Banda, MD
Co-Chair, MedChi Council on Legislation

Kathleen D. Keeffe Hough, MD
Chair, MedChi Public Health Subcommittee

Anuradha Reddy, MD
Chair, MedChi Health Insurance Subcommittee

Lawrence Green, MD
Chair, MedChi Boards & Commissions Subcommittee

MedChi's Legislative Advocacy Efforts are Centered Around Four Principles

- Ensuring timely delivery of health care services and payment.
- Protecting access to physician services and the practice of medicine.
- Addressing behavioral health treatment and recovery needs.
- Strengthening public health initiatives.

Our 2023 Priorities Include:

- Streamline and reform utilization management policies (i.e., prior authorization and step therapy laws) in both the commercial market and in Medicaid to reduce administrative burdens and increase transparency.
- Ensure that the Fiscal Year 2024 Medicaid budget maintain E&M reimbursement rates to 100% of Medicare to support physician participation in the program and ensure that Medicaid patients have adequate access to physician services.
- Oppose policies that would adversely affect patient care by inappropriately expanding the scope of practice of non-physician providers, including the ability to independently diagnose, treat, prescribe medications, and/or manage medical disorders.
- Continue to support health equity initiatives that address health disparities and the social determinants of health.

Learn more about these priorities at *www.medchi.org/YourAdvocate*

MedChi is focused on improving your professional quality of life by serving as your advocate and your resource. But we can't do it without you. Together, we will improve healthcare for Maryland's physicians and patients. Visit ***www.medchi.org/Membership***.

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Innovative Maryland Responses, *continued from pg. 5*

detained in jails and prisons are particularly vulnerable. Even if they do not use actively during incarceration, most do not get treatment or gain recovery skills to prevent relapse after release. The risk of overdose death has been estimated to increase 10- to 100-fold in the weeks following release from incarceration.

Despite MOUD treatment in detention saving lives and increasing post-release treatment linkage, there is resistance to uptake. Fortunately, Maryland is reforming this historical misdirection with a law (House Bill 116) requiring treatment of OUD with MOUD in all county jails by 2023. Several jails have already implemented these programs. Last year the state issued grants to several counties to fund these initiatives. Many community treatment providers are partnering with jails to support these efforts by providing services in the jails, and linkage to care for post-release treatment. A collaboration between Carroll County Detention Center and Maryland Treatment Centers provides counseling, re-entry care-coordination services, and post-release MOUD treatment to inmates. The UMB telehealth team supports OUD treatment in jails by prescribing buprenorphine remotely in rural counties to patients who may not otherwise have access to medication providers.

Peer services

The training and deployment of peer recovery specialists, who use their personal lived experience of addiction and recovery as tools to encourage, engage and support persons with substance use disorders to seek treatment and recovery is an expanding trend. Peers have been used across MD in many specialty treatment settings, and in general medical settings such as EDs and hospital consultation services, and jails. One example of a successful initiative is the Stop, Triage, Engage, Educate and Rehabilitate (STEER) program funded by Montgomery County. STEER uses a team of peers who are on-call 24/7 to meet persons in need at a point of crisis in the community, including at the scene of an overdose or in the ED. STEER peers are sometimes able to take advantage of the "motivational moment" to link persons immediately to care. But peers more often outreach over the next days and weeks to persuade a person to enter inpatient or outpatient treatment. STEER peers also remain in contact with individuals in recovery to promote treatment retention. Previously peer services in Maryland have required grant funding or have been absorbed into providers' budgets. But starting later in 2023, Maryland is beginning fee-for-service Medicaid reimbursement for peer services in order to expand their impact.

Ongoing research

Maryland continues to be a leader in OUD treatment research. Friends Research Institute (FRI) is conducting a NIDA-funded study to further investigate MOUD transitions from incarceration, by initiating monthly injectable MOUD (randomization to XR-naltrexone vs XR-buprenorphine) in several county jails prior to release and then continuing it for 6 months in the community post-release. This project also includes a learning collaborative for jails and community provider partners to receive technical assistance and support through the implementation of the HB116 programs.

Maryland Treatment Centers is one of the multiple sites of the NIDA Clinical Trial Network's national Retention Duration Discontinuation study, which hopes to address the important questions of how can we improve long-term retention in MOUD treatment, what are optimal durations of MOUD treatment, and what are successful strategies for successfully supporting those who decide to discontinue MOUD treatment. In the retention study participants with OUD can receive free MOUD treatment and are followed for about 2 years. In the discontinuation study, participants who have already decided to stop MOUD are assigned to various methods of discontinuation, then followed closely and encouraged to resume medication at the first sign of problems. For more information: mmtcrdd@gmail.com, 443.478.3607.

Future directions include the possibility of new medication combinations in the hopes of improving MOUD treatment outcomes. Hopkins Bayview is studying the effect of the addition of treatment for sleep dysregulation added to buprenorphine, using the insomnia medication suvorexant. For more information: ahuhn1@jhu.edu. Finally, MTC is studying the addition of cannabidiol (CBD) to existing MOUDs, and in another study the possibility of combining two of the existing MOUDs — naltrexone plus buprenorphine.

Conclusions

The opioid crisis remains a devastating public health emergency, with considerable morbidity and mortality, but treatment is effective and life-saving! Providers can have substantial impact by remaining competent in treatment options for opioid and other substance use disorders. Maryland is a leader in innovative initiatives that strive to enhance outcomes. We are hopeful that these initiatives and others will make a difference, as it's always good to have more tools in the toolbox. And while there is plenty of room for improvement, one of our oldest tools — therapeutic optimism — remains one of our best.

Marc Fishman, MD, is Medical Director, Maryland Treatment Centers; Associate Professor at Johns Hopkins University Department of Psychiatry. He can be reached at Mfishman@marylandtreatment.org


AMN Healthcare
MERRITT HAWKINS
Average Wait Time in Days 2022
Average physician appointment wait times in 15 large metropolitan areas for five specialties
(family medicine, obstetrics/gynecology, orthopedic surgery, cardiology, and dermatology)
METRO AREA | ALL DAYS PER 5 SPECIALTIES | AVERAGE PER 5 SPECIALTIES
Portland 228 45.6
Boston 169 33.8
Minneapolis 154 30.8
San Diego 151 30.2
Miami 146 29.2
Philadelphia 141 28.2
Seattle 141 28.2
Denver 134 26.8
Los Angeles 111 22.2
Dallas 105 21.0
Atlanta 101 20.2
Houston 101 20.2
Detroit 94 18.8
Washington, D.C 90 18.0
New York 87 17.4
Total 130.2 26.0
Source: 2022 Survey of Physician Appointment Wait Times and Medicare and Medicaid Acceptance Rates. AMN Healthcare/Merritt Hawkins. September, 2022.
Scan to view the full report and other thought leadership resources provided by AMN Healthcare and Merritt Hawkins.
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An insider's view
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The Maryland State Medical Society Podcast

Addressing the Opioid Crisis: Implementing RX Safe-Disposal Sites Across Queen Anne's County

Olivia Altman

Like several other states with countless rural communities, Maryland suffers from opioid abuse resulting in overdose and/or death. To add insult to injury, in 2018 Maryland had the second highest opioid-involved overdose deaths in the country with 33.7 per 100,000 individuals. MedChi has partnered with Queen Anne's County Medical Society to address the illicit use of unused opioid medications. Through education and widespread distribution of at-home drug deactivation and disposal systems, the goal is to disrupt the initial use and subsequent addiction cycle that often leads to long-term adverse health effects, overdose, and death.

Prescription opioids are powerful, pain-reducing medicines that can help patients successfully manage pain when prescribed for the right conditions and when used properly. In 2017, as many as 90 percent of patients who received prescription opioids reported not finishing the bottle, potentially leaving millions of unused opioids in medicine cabinets that subsequently can get into the hands of friends and family. During that same year, 47,600 people died from overdose involving opioids.

While many local police, sheriff departments, and pharmacies are eligible to collect unused prescription drugs for disposal, only 3 percent of these agencies have volunteered to do so. Additionally, too many community members fail to take advantage of the opportunity to dispose of pills lying around their homes. As a result, there is an increased risk of someone using those pills for illicit purposes.

MedChi and Queen Anne's County Medical Society have established two main objectives:

Goal 1: The creation of an online/on demand Continuing Medical Education (CME) program on safe disposal of medicine and will provide a second course on the use of the drug monitoring program. MedChi's hope is to increase the use and general understanding of the disposal system by health care professionals.

Goal 2: The distribution of a safe medication disposal system (pouch or container) that can be used at home or in a clinical setting. This product is the safest, most effective choice used to destroy and properly dispose of unused, unwanted, and expired medications with the simple addiction of tap water. This is the only product available today that is scientifically proven to destroy prescriptions and over-the-counter medication, including addictive opioids. This at-home drug deactivation and disposal system helps prevent diversion, misuse, and abuse. Also it's plant-based packaging and non-toxic ingredients prevent harmful chemicals from entering our landfills and water supplies, making the world safer for everyone.

This program is expected to begin July 1, 2023, with the distribution of 5,000 safe disposal bags to the residents of Queen Anne's County through means of practitioners and others. The program has identified key actual measurable items to ensure the success of establishing safe disposal, CME opportunities, and the education of practitioners to ultimately reduce the harm the opioid crisis has caused to society.

Olivia Altman is a law clerk at MedChi and can be reached at oaltman@medchi.org.

***Stigma,** continued from pg. 7*

Medicine (www.md-dcsam.org or www.mddcsam.org), or from the author at joeadamsmd@gmail.com.

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Joseph A. Adams, MD, FASAM, is the Medical Director, Veni Vidi Vici Treatment Services in Bel Air, Maryland. He can be reached at joeadamsmd@gmail.com. A complete version of this article is available at: https://www.stopstigmanow.org/research-articles/.

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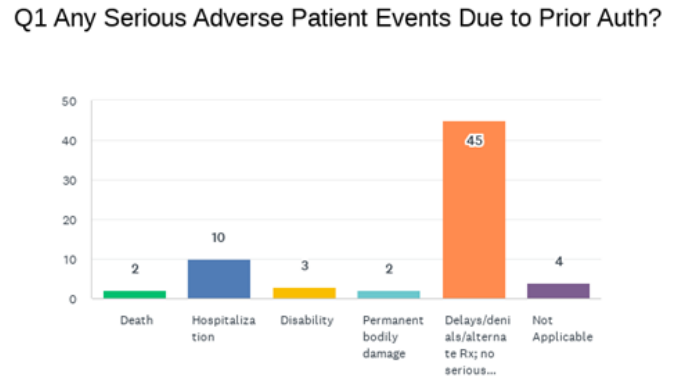
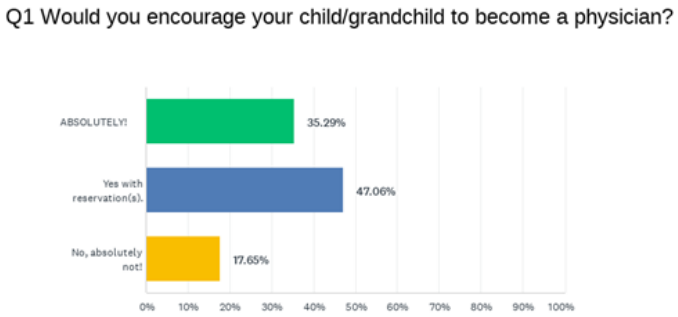
MCMS Begins 2023 with a POP!

Susan D'Antoni, FAAMSE

Montgomery County Medical Society began 2023 by initiating a new member engagement opportunity — its Physician Opinion Profile, or POP. Each week in MCMS' enews, physicians will be asked their opinion on one poignant question and then MCMS will report those results the following week. The first two questions presented interesting results, which can be seen below.





More interesting questions and answers to come throughout 2023.

MCMS has also rolled out an Early Career Success Educational Series for 2023. Using many content experts, MCMS has established a calendar of programs beginning in January and continuing through May and picking up again in September through November. Some of the topics include physician–employer contracting, compensation models, negotiation skills, payor negotiation strategies, passionate about private practice, and financial basics. These programs are developed with early career physicians in mind; however, all physician members of MedChi are able to attend at no cost. There is a fee for potential members to participate

We continue to promote the Patient Action Network to practices throughout Montgomery County. The goal is to encourage patients to become more involved in decisions that are made by legislators, payors, and regulators. It is a free subscription-based service, and it's very easy for patients to sign up. MCMS developed resources and materials for physician practices to use to promote PAN to their patients.

Legislatively speaking, MCMS is active in the 2023 Maryland Legislative Session. MCMS has invited physicians' experiences with prior authorization in a survey to capture stories. MCMS held its annual pre-legislative meeting in early January, which was an opportunity for physicians and legislators to talk about several important topics included in MedChi's Legislative Agenda. On March 1, MCMS will hold its Annual House Call on Annapolis. Moreover, MCMS has launched a membership recruitment campaign — Join the Fight Against Prior Authorization — to get physicians to "enlist" in the effort to diminish the impact of prior authorization policies on patients and on physicians and their practices.

On April 27, MCMS will host its first large-scale, in-person membership meeting since COVID began. MCMS' Annual Membership Meeting and Installation of Officers will be at the Bethesda Marriott and will include a networking reception with exhibitors and partners prior to the dinner and installation. MCMS members are invited to attend.

Susan D'Antoni, FAAMSE is CEO of Montgomery County Medical Society. She can be reached at sdantoni@montgomerymedicine.org.

BCMS Plans for Full Year of Advocacy and Engagement

Lisa B. WIlliams

Legislative Activities — From January to April of each year, Baltimore City Medical Society (BCMS) members join other MedChi members to review legislation and regulatory measures introduced in the ninety-day Maryland General Assembly. The foundation for this work, however, begins before the Assembly convenes, and is ongoing. Each year, MedChi holds two House of Delegates meetings, at which MedChi components and individual members present policy recommendations. Outcomes of the recommendations help inform an agenda for organized medicine during the Assembly.

BCMS members have long held leadership positions on MedChi's legislative council. The council convenes weekly during the Assembly to review health and medical related bills. In recent years, Ben Lowentritt, MD, co-chaired the council, while Anu Reddy, MD, continues to chair the health insurance subcommittee. Each is committed to this important work and believe physicians must have an ongoing voice in Annapolis.

BCMS member, Erica Isles, MD, who recently joined the council, shared: "As a family medicine physician, there are often regulatory, workflow issues that impact my clinical practice. I joined the council to become better informed of state policies and procedures."

In addition to council membership, BCMS physicians also serve as "physician of the day" in the Annapolis State House first-aid room. And, on February 25, BCMS members visited with legislators to share our legislative priorities.

Community Engagement — BCMS physicians have a long history of engaging with community organizations. Recently, Western High School requested physicians present during their career networking day. We appreciate the following physicians who volunteered to present to the students: Peter Beilenson, MD; Patricia Disharoon, MD; and Elana Smith, MD.

Past president, Camellus Ezeugwu, MD, continues to direct the activities of the nearly year-long community health advocates program, in conjunction with members of the Association of Black Cardiologists. Advocates have given more than fifty presentations on heart health to community and faith-based groups in the first six months of the program.

Lisa B. Williams is CEO and Executive Director of BCMS. If you are interested in BCMS advocacy and community engagement, contact Ms. Williams at info@bcmsdocs.org.

Washington County Members Gather for Nachos and Networking

Members of the Washington County Medical Society (WCMS) enjoyed dinner and camaraderie at Hagerstown's Coast Tacobar on January 5, 2023.

Left photo: Stephen Rockower, MD; Girish Reddy, MD; and Danielle Reynolds, MD. Middle photo: Mitesh Kothari, MD, President, WCMS; Gary Sherman, MD; Andrew Oh, MD, Secretary WCMS; Stephen Rockower, MD, Past-President, MedChi; and Bill Su, MD, Vice President WCMS. Right photo: Cheryl Mejia, MD, with Frank Yang, MD, and Mrs. Yang.

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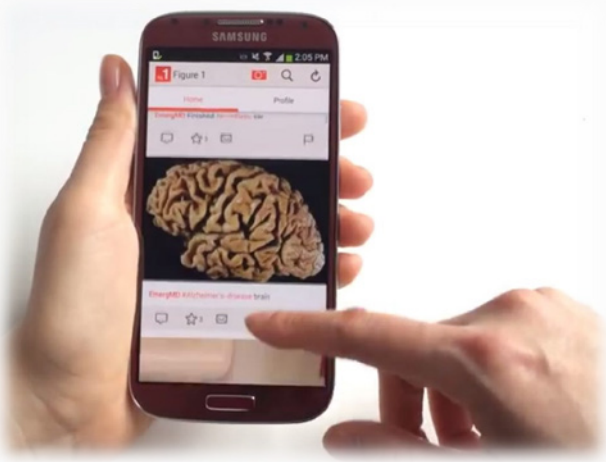

This community exists. It's called **Figure 1.**

Figure 1's mission is to democratize medical knowledge and bring **better medicine** to all patients. To date, Figure 1's global community of over 3 million members has contributed more than 100,000 real-world cases and fostered discussion on everything from rare conditions to strategies for patient care. A **safe**, secure platform with controls in place to maintain patient anonymity.

Figure 1 members have full access to an **accredited CME** Center, a hub offering free CME credits available on demand.

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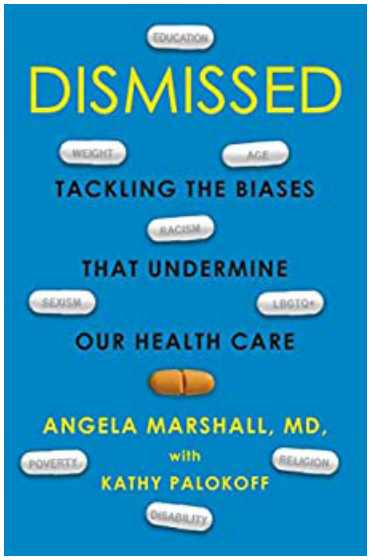
figure1

Instagram for doctors.

Dismissed: Tackling the Biases That Undermine Our Health Care, by Angela Marshall, MD, with Kathy Palokoff

Reviewed by Bruce Smoller, MD, with Stephen Rockower, MD

Our colleague, Dr. Angela Marshall, has written a book based on her experience with patients, colleagues and treating physicians which draws heavily on her identification as an African American woman. Using both knowledge and speculation about human behavior, she has crafted a readable and comprehensive compendium of bias and dismissal within and by the medical profession. The book is a comprehensive thesis on discrimination that draws from the author's own personal and professional experience and the views of patients and correspondents. Many of her conclusions should trouble the house of medicine while others — albeit a bit subjective, will provoke thought. The overall theme, that unconscious biases and unspoken feeling may lead to poorer outcomes, needs to be taken seriously.



The intent of the book is a comprehensive discussion of all the forms and targets of bias. Bias can lead to dismissal of serious purpose and thus to poor treatment, and potentially, a catastrophic outcome for the patient. Dr. Marshall takes pains to discuss the biologic, social and developmental determinants of bias in chapters such as "Our biased brain", "Dismissing Women" and The Social Determinants of Health." Her basic premise is that we are all genetically and biologically loaded to be prejudiced against "the other" and that by understanding and coming to terms with our biases, we can overcome them. For Dr. Marshall, these assumptions are not only anthropologically unnecessary but the basis of dismissal, exclusion, malpractice, and denigration. Be aware of this tendency, she states, and one can overcome a natural proclivity to deny, dismiss and dehumanize.

As a psychiatrist, I believe in suppression, unconscious bias, action derived from hidden motives, and the whole palette of emotions which inform our decisions. And I agree that being aware of this results in our becoming better thinkers and doers. Dr. Marshall's taxonomy and guide to its protean forms is thus welcome reading.

One of my concerns is that Dr. Marshall assumes that the actions that she and others in the book encounter derive solely from bias. She herself suggests other possible reasons why things go wrong, from the doctor having a bad day to her misreading of the encounter. Dr. Marshall and her contributors might well be so primed to find prejudice that they ascribe all interactions to that cause, a type of confirmation bias that slightly detracts slightly from her thesis.

The efforts to eliminate bias in order to deliver good medical care are not new. In the current climate of strained feelings, we need to balance self-awareness with the acknowledgement that sometimes what we perceive is not the objective truth. It is human nature to view a scene one (especially when we've been primed) at the expense of considering other explanations. In my medical career, I have seen more examples of objective and unbiased professional care being delivered than examples of racist or bigoted interactions. We all have biases, but most of us are aware enough to not let them seep into our professional lives. However, the presence of bias and its attendant dismissal of "the other" still exists. While we are better at identifying it, our efforts at eliminating it need to be redoubled.

Overall this book is a very good and comprehensive prescriptive, with one small cavil: on page 96 Dr. Marshall writes "Furthermore, an increase in the number of Black physicians could reduce health-care disparities, as they have been shown to exhibit less implicit racial bias." I was surprised to find this sentence in a book devoted to the idea that all humans are tribal and therefore biased towards, or wary of, "the other." To be true to the book's message, then, perhaps it should emphasize that we all need to be aware of our implicit biases and not let them affect the care we provide so we can exist in a world in which no one feels dismissed.

Dr. Marshall offers this book as a service to her physician colleagues and patients. This works much of the time, but the need to speak to several different audiences at once may be disconcerting to physicians. Dr Marshall proceeds from the point of view that a physician's knowledge of bias is as underdeveloped as anyone's, and as a result this has caused unnecessary suffering in a field so integral to the welfare of humanity.

Dismissed: Tackling the Biases That Undermine our Health Care will be available in bookstores and online on March 28, 2023.

Bruce Smoller, MD, a former MedChi president, is a psychiatrist in Montgomery County who consults for the Federal Government. He can be reached at Bruce.Smoller7@gmail.com. Stephen Rockower, MD, is a past President of MedChi. His Twitter handle is @DrBonesMD.

MedChi's Newest Physician Members

MedChi welcomes the following new members, who joined between November 21, 2022, and February 2, 2023.

Ibilola Adekunle, MD — Kaiser Permanente
Omolola O Adesina, MD — Kaiser Permanente
Seyedeh Mahsa Alaie, MD — Kaiser Permanente
Jerjis Alajaji, MD — Advanced Radiology
Jyothi Arun, MD — Kaiser Permanente
Virender Aulakh, MD — Patient First
Tasnim Azim, DO — Kaiser Permanente
Salman Aziz, MD — Emergency Service Associates, PA
Amit Babra, MD — Patient First
Anmoldeep S. Bajaj, MD — Advanced Radiology
Dana Baras, MD
Bassel Beitinjaneh, MD — Kaiser Permanente
Jessica Berger-Weiss, MD — Capital Women's Care
Arun Bhandari, MD — Chesapeake Oncology-Hematology Associates, PA
Nancy Bierman-Dear, MD — Patient First
Emilie-Petula Tibemen Biondokin, MD — Kaiser Permanente
David Bishai, MDPatient First
Ashleigh Bouchelion, MD, PhD — Capital Women's Care
Victor A Bracey, MD — Advanced Radiology
Heather Brillhart, MD, FACOG — Capital Women's Care
Kent Thomas Buxton, MD — Kaiser Permanente
Claudia I Cardenas, MD — Kaiser Permanente
Linda Anne Panicker Chacko, MD — Kaiser Permanente
Jerome Ashton Chambers, MD — Kaiser Permanente
Ravi Anant Chandra, MD — Kaiser Permanente
Aaron Michael Cheatham, MD — Kaiser Permanente
Brian Honewell Cho, MD — Rubin Institute for Advanced Orthopaedics
Jennifer Grace Chu, MD — Kaiser Permanente
Melody Pei-Shien Chung, MD — Kaiser Permanente
Spencer K Craven, MD — Chesapeake Urology
Donique Alyssa Cross, MD — Kaiser Permanente
Shamim Dada, MD — Advanced Radiology
Daoud Dajani, MD — Chesapeake Urology
Dockmias Kassahun Demeke, MD — Kaiser Permanente
Nikhil Desai, DO — Kaiser Permanente
Lulit Dessie, MD — Kaiser Permanente
Tejan Paraj Diwanji, MD — Kaiser Permanente
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Robert Dolitsky, MD — OrthoMaryland
Nathaniel Downing, MD — Emergency Service Associates, P.A.
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Uchechi C. Egbuhuzo, MD — Kaiser Permanente
Onyekachi W. Egwim, MDKaiser Permanente
Diego Escobosa, MD
Maria Ramona Evidente, MD — Kaiser Permanente
Stephen Leo Facchina, MD — Kaiser Permanente
Emily Kathryn Fay, MD — Kaiser Permanente
Jason Federline, MD — Patient First
Kelly Linette Ferguson, MD — Kaiser Permanente
Daphne Collado Ferrer, MD — Kaiser Permanente
Julie Fifer, MD — Kaiser Permanente
Ghislaine Fougy, MD — Ghislaine Fougy, MD, PA
Steven Fountain, MD — Kaiser Permanente
Christopher Gable, MD
David B. Gitlitz, MD — University of MD Vascular Center
Jeffrey Ian Glicksman, MD — Kaiser Permanente
Rinal Choksi Goel, MD — Kaiser Permanente
Mary Graham, MD — Patient First
Andrew Biskal Haddad, MD — Kaiser Permanente
Xu He, MD — Kaiser Permanente
Bridget Ivery, MD — Kaiser Permanente
Jennifer M Jagoe, MD — OB/GYN of Greater Washington
Marcus Jennings, MD — Patient First
Mamta Bhasker Jhaveri, MD — Kaiser Permanente
Michael Johnson, MD — Patient First
Chase Johnson, MD — Kaiser Permanente
Kambiz Kadkhodayan, MD
Amit S. Kalaria, MD — Advanced Radiology
Matthew A Kalman, MD — Advanced Radiology
Waynekid Kam, MD — Kaiser Permanente
Priyanka Kancherla, MD — Chesapeake Urology
Floreana Kebaish , MD — Kaiser Permanente
Elizabeth Kerness, MD — Patient First
Elizabeth Kim, MD — Advanced Radiology
Emmanuel Koli, MD — The Centers for Advanced Orthopaedics, Parkway
Myoung Kwan Kwak, MD — Kaiser Permanente
Brian G LaRocco, MD — Kaiser Permanente
David Michael Loeffler, MD — Kaiser Permanente
Nicole Lucas, MD — Emergency Service Associates, PA
Alexander Hsiao MacArthur, MD — Advanced Radiology
Yudhishtra Markan, MD — Chesapeake Oncology-Hematology Associates, PA
Patricia L McKay, MD — The Centers for Advanced Orthopaedics, Parkway
Casey McRoy, MD — Advanced Radiology
Leia M Medlock, MD — Shady Grove Women's Center
Robin Metcalfe-Klaw, MD — Perinatal Associates at GBMC
Robert Miles, MD — Patient First
Adam A Morgan, MD — Advanced Radiology
Andrew W Morton, MD — Advanced Radiology
Jefferson E Moulds, MD

Chukwuemeka U. Obidi, MD — Partners in Pediatrics and Family Health
Edward Oh, MD — Advanced Radiology
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Joseph Powers, MD — Emergency Service Associates, PA
Joseph L. Raffetto, MD — Tidal Health Cardiology
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Arshia Ashley Soleimani, MD — Chesapeake Oncology-Hematology Assoc, PA
Gayatri Sonti, DO
Sacari Thomas-Mohammed, MD — Patient First
Minh Tran, DO — Patient First
Thu N. Tran, MD — Capital Women's Care - Division 68
Raman R. Tuli, MD — Raman Tuli, MD, P.C.
Vasantha Udugampola, MD — Patient First
Hisham Valiuddin, DO
Melissa Vyfhuis, MD, PhD — Chesapeake Oncology-Hematology Associates, PA
Angele Brenda Wafo, MD — Kaiser Permanente
Veronica Son Wang, MD — Kenneth Klebanow & Associates, PA
Daniel Wang, MD — Chesapeake Urology
Samantha Ward Nealon, MD — Kaiser Permanente
Angela E. Watkins, MD — Kaiser Permanente
David Weber, MD — Patient First
Michael B. Williams, DO — Kaiser Permanente
Adrienne A. Wilson, MD — Kaiser Permanente
Michael W. Witthaus, MD — Chesapeake Urology
Henock Wolde-Semait, MD — Kaiser Permanente
Letitia J. Wright, MD — Harbor Hospital Center
Jacqueline Wulu, MD — Kaiser Permanente
Patricia Yang, MD — Kaiser Permanente
Andrew M Yang, MD — Advanced Radiology
Antora Yazdan, MD — Kaiser Permanente
Ivan N Zama, MD — Compassionate Wellness Center, LLC
Duo Zhang, MD — Kaiser Permanente
Mohammed kareem Zuaiter, MD — Kaiser Permanente

MedChi Calendar of Events

A complete list of MedChi and component events can be found at: http://www.medchi.org/Calendar-of-Events.

MARCH

12: MedChi President's Meeting
16: MedChi Board of Trustees Meeting
22: Baltimore County Medical Association Board of Governors' Meeting
23: IDEA Committee Meeting
25: Baltimore City Medical Society Presidents' Gala
27: Maryland Society of Otolaryngology Spring Meeting, "Multidisciplinary Approaches to Management of Sinonasal Inverted Papilloma"

APRIL

13: Baltimore City Medical Society Board Meeting
16: MedChi Presidents Meeting
22: MedChi Presidential Gala in Honor of James York
24: IDEA Committee Meeting
26: Baltimore County Medical Association Board of Governors' Meeting
27: Montgomery County Medical Society Installation of Officers, Bethesda Marriott on Pooks Hill
29: Baltimore City Medical Society CME Event
30: MedChi Spring House of Delegates Meeting

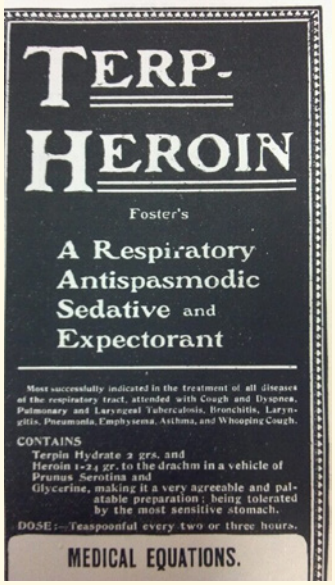
MAY

6: Baltimore County Medical Association Installation of Officers
10: Baltimore County Medical Association CME Event
11: Baltimore City Medical Society Board Meeting
12–14: Atlantic Dermatological 100th Annual Conference
14: MedChi President's Meeting
18: MedChi Board of Trustees Meeting
23: Atlantic Dermatological 100th Annual Conference

Vintage Ads From When Cocaine and Heroin Were Legal, 1880–1920

Meg Fielding

As I peruse our medical journals from the 1800s, I am often surprised at the advertisements of the era. From Burnside Dairy and Chattolanee Spring Water in Maryland's Greenspring Valley, to homes for inebriates with scenic views over New York Harbor, to tonics of every sort (many involving malt and hops), and chocolates to boost energy levels in new mothers, these ads are a fascinating view into medical "cures" of the period.



It's also shocking, looking at these ads from a 21st century perspective, to see casual advertisements for cocaine and heroin, none of which come with warnings of any sort. Even at that time, it was understood that these drugs were incredibly addictive. By the 1930s, regulations had been set. We have certificates issued to one of our physicians by the Internal Revenue Service for dispensing "opium, cocoa leaves, etc."

These ads appear in back issues of the *Maryland Medical Journal*, which may be viewed on the MedChi website. There you'll find digitized editions of the *Journal*, from 1878 to 1899.

Maryland Medicine
The Maryland State Medical Society
1211 Cathedral St., Baltimore, MD 21201

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