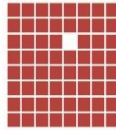




1211 Cathedral Street
Baltimore, MD 21201-5585
410-539-0872
e-mail: mdacep@aol.com
www.mdacep.org



Maryland Chapter
AMERICAN COLLEGE OF
EMERGENCY PHYSICIANS



MACHC
Mid-Atlantic Association of
Community Health Centers

The Maryland State Medical Society
1211 Cathedral Street
Baltimore, MD 21201-5516
410.539.0872
Fax: 410.547.0915
1.800.492.1056
www.medchi.org

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



Maryland Chapter

TO: The Honorable Shane E. Pendergrass, Chair
Members, House Health and Government Operations Committee

FROM: Pamela Metz Kasemeyer
J. Steven Wise
Danna L. Kauffman

DATE: March 7, 2017

RE: **OPPOSE UNLESS AMENDED** – House Bill 1432 – *Health Care Providers – Prescription Opioids – Limits on Prescribing (the Prescriber Limits Act of 2017)*

The Maryland State Medical Society, the Maryland Chapter of the American College of Emergency Physicians, the Mid-Atlantic Association of Community Health Centers, and the Maryland Chapter of the American Academy of Pediatrics submit this letter of **opposition** for House Bill 1432, **unless amended**.

House Bill 1432 prohibits a health care provider, on the initial consultation or treatment for pain, from prescribing a patient more than a 7-day supply of an opioid. An exemption is provided if the opioid is prescribed to treat a substance-related disorder, pain associated with a cancer diagnosis, or pain associated with end-of-life, hospice, or palliative care. A provider who has been found to violate the opioid prescribing limitation may be subject to disciplinary action by the appropriate health occupations board. The bill is obviously intended to address the growing incidences of substance abuse, addiction, and overdose associated with opioids. However, while well-intentioned, the effort to legislate clinical practice in statute will not result in the desired objectives and will create significant barriers to the ability of providers to appropriately address the health care needs of their patients.

Recently issued Centers for Disease Control and Prevention (CDC) guidelines for prescribing opioids for chronic pain provide recommendations for the prescribing of opioid pain medication by primary care clinicians for chronic pain in outpatient settings outside of active cancer treatment, palliative care, and end-of-life care. They offer ways providers can effectively communicate with patients, promote the safe use of opioids to manage pain, and reduce the risks of addiction and overdose as well as intervene if problems arise. However, a critical statement included in the guidelines states: *“Clinical decision making should be based on a relationship between the clinician and patient, and an understanding of the patient’s clinical situation, functioning, and life context.”*

While there are typical patients, common clinical scenarios, and best practices, codifying medical care in law as proposed by House Bill 1432 fails to recognize that the appropriate response to medical needs is never 100% consistent. Patients present with a host of different factors that alter their response to pain and different medications, influence their risks for misuse, addiction, and overdose, and impact their expectations of care. Clinical decision making needs to account for all of these and the limited “one size fits all” requirements of this legislation would prevent physicians and other health care providers from appropriately addressing the unique

needs of their patients.

The CDC guidelines themselves reinforce the need for flexibility in clinical decision-making. The guidelines state: *“The recommendations in the guideline are voluntary, rather than prescriptive standards. They are based on emerging evidence, including observational studies or randomized clinical trials with notable limitations. Clinicians should consider the circumstances and unique needs of each patient when providing care.”*

Further, the CDC guidelines recognize other guidelines that may be more appropriate for the clinical setting or health care needs of the patient. *“The recommendations are not intended to provide guidance on use of opioids as part of medication-assisted treatment for opioid use disorder. Some of the recommendations might be relevant for acute care settings or other specialists, such as emergency physicians or dentists, but use in these settings or by other specialists is not the focus of this guideline. Readers are referred to other sources for prescribing recommendations within acute care settings and in dental practice, such as the American College of Emergency Physicians’ guideline for prescribing of opioids in the emergency department; the American Society of Anesthesiologists’ guideline for acute pain management in the perioperative setting; the Washington Agency Medical Directors’ Group Interagency Guideline on Prescribing Opioids for Pain, Part II: Prescribing Opioids in the Acute and Subacute Phase; and the Pennsylvania Guidelines on the Use of Opioids in Dental Practice. In addition, given the challenges of managing the painful complications of sickle cell disease, readers are referred to the NIH National Heart, Lung, and Blood Institute’s Evidence Based Management of Sickle Cell Disease Expert Panel Report for management of sickle cell disease.”*

The above-named organizations clearly recognize the notable intent of the sponsor to address the growing incidences of substance abuse, addiction, and overdose and to focus that effort on our youth to prevent addiction and overdose. However, codification of clinical practice will not achieve that objective and could alternatively result in poor health outcomes and ineffective management of medical care needs for the very individuals intended to be protected. Providers should practice in accordance with nationally recognized clinical guidelines. Guidelines are frameworks for care, not mandates for clinical practice, and recognize the importance of clinical flexibility, judgement, and the need to be responsive to individual patient circumstances. The legislation should be amended to delete the specific clinical mandate and substitute language that recognizes practice in accordance with clinical guidelines, as well as noted exceptions, such as cancer, hospice, palliative care or other end-of-life services. Without such amendment, an unfavorable report is requested on House Bill 1432.

For more information call:

Pamela Metz Kasemeyer

J. Steven Wise

Danna L. Kauffman

410-244-7000