Hi, my name is Howard Schulman, MD. I've been a general internist, adult primary care physician, in Rhode Island since 1995. I am testifying with **major concerns** about this bill H-7923.

Before I relate my concerns, I think everyone should know that, for me, prescribing narcotics on a chronic basis to patients is one of my **least** favorite things to do. Patients tell me they are in pain, and they want me to prescribe these medication's, yet I often have to tell them "no" or give them less than what they ask for.

As for this bill, I object to trying to micromanage **chronic** pain treatment by defining **acute** pain and putting in law that some type of specialist, as opposed to a primary care provider, is the only one that can determine that a patient has "chronic pain".

Most of my patients I know on a long term basis, and I know I'm probably in a better position to regulate narcotics for them.

Additionally, if you make it so **onerous** and **dangerous** for non-specialists to prescribe narcotics on a chronic basis, the chronic pain patients will **overwhelm** the pain centers, if you can find one, and we're going have a major problem.

I think the best way forward is to continue with public education and education for physicians, which is happening, as well as closer monitoring of outlier and high-rate-of-prescribing providers.

Also, and I think this is important, over the past 10 years, providers and your constituents have become much more aware of the problems caused by chronic narcotic use. Many of the patients getting narcotics on a chronic basis now are unfortunate, older "legacy" patients, for whom getting **off** narcotics is more **dangerous** than maintaining a **steady dose** and preventing dose escalation.

Particular sections I have concerns with:

21.28-1.2 sections 6 and 7. I object to defining chronic pain and then determining how and who deals with it.

21.28-3-20. I object to defining acute pain and a first prescription limited to 7 days, as not infrequently acute pain situations happen on top of chronic situations.

Instead of bothering the prescriber every year to write an additional prescription for Naloxone and hassling them with this responsibility, you should permit the pharmacies to offer Naloxone to patients getting narcotics.

Instead of putting the responsibility of checking the prescription monitoring program on the provider, the Dept of Health should take responsibility for alerting the prescriber if the patient is getting narcotics from another source or if there is a concerning change in the pattern of use. The Department of Health has all the data.

This Committee should also be aware that frequently pharmacies run out of ADD medication, in particular, which creates further confusion as far as how much has been prescribed, so providers should not be held responsible for knowing at all times how much has been dispensed.

Thank you

extra testimony:

I'm writing this because recently two physicians were disciplined by the Department of Health for prescribing narcotics. In one particular case, the physician had been prescribing the narcotics for 20 years on a stable basis but because the patient hadn't signed a "pain contract", which is a useless piece of paper, he got disciplined and written up in the online press. If the patient violates the pain contract, what am I supposed to do, sue them?

For that matter, providers cannot perform **random** drug testing, we can only do drug testing at the time of appointment, which is not only totally **useless**, but conveys to the patient that they cannot be trusted.

If the Dept of Health insists on random drug testing, perhaps they could organize a group to suddenly appear at the homes of patients who are

prescribed narcotics and ask for a urine specimen on the spot and accompany them to the bathroom to make sure they don't substitute someone else's urine, like they do in professional sports when testing for anabolic steroids, or random drug testing by employers for commercial drivers licenses.

As legislators, you have to understand that there's no test to determine if someone's in pain. Anyone on this Committee in pain or have a headache? Prove it!

It is impossible to find a pain center in RI that wants to do anything for the patient except give them highly-reimbursed spinal injections, and then refer them back to me after they've exhausted the allowed number of injections.

I appreciate a clause at the end of this bill indicating that notwithstanding anything else, a provider shall not be disciplined for using their best judgment. In my mind this clause is an admission that this bill has problems.

I object to needing to trial non narcotic pain medication before any narcotics are given out, as prior history may indicate narcotics up front are appropriate, like when I had my outpatient hernia operation, I got a few Percoset, without needing to try Tylenol first.