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 **against** this bill S-3259.

If this bill passes it will create a lot of very upset patients and upset physicians and APP's who will have even more bureaucratic tasks. I can reassure the members of this Committee and the Board of Licensure that providers have gotten the message that narcotics are addictive and that it is very easy to get in trouble with our licensing board if we give out too many.

However, I have a problem with needing to get a so-call pain specialist to certify that a particular person has "chronic pain". I'd like to remind everyone here that dealing with pain situations is very difficult for a number of reasons, and that there is no fool-proof test you can do to determine if a patient is having pain, especially if the patient isn't cooperative or is trying to impress you that they are.

Additionally, there really aren't any pain clinics in Rhode Island. I get asked about this occasionally. There may be something at St Annes in Fall River. The pain clinics I'm aware of are mostly interested in performing highly reimbursed injections, not medically managing pain.

Also, because word has gotten out about how addictive narcotics are, the number of patients getting hooked chronically on narcotics has markedly decreased over the past 10 years, in my experience, but there remains a number of so-called "legacy" patients, often older patients who are on narcotics' for whom it is often better to continue narcotics while resisting dose escalation, similar to maintaining a person on Suboxone or methadone, which are narcotics.

Also, instead of creating yet another bureaucratic job for providers, writing naloxone prescriptions every time we prescribe a narcotic, why don't you permit the dispensing pharmacist to automatically give the patient naloxone, without creating more work for the provider?

I object to this bill legally interfering with our treatment of patients by insisting that non-narcotics have to be tried in every situation before a narcotic is given out, and making us document that we spoke with them about the addictive potential of narcotics.

Also, instead of putting the onus on the provider to check the drug monitoring program every three months, why doesn't the Dept of Health notify providers if a patient on chronic narcotics has a change in their prescribing or they get narcotics from another provider? They have the information, why don't they take advantage of it instead of creating another hassle for providers? For our group of 23 providers, it would cost $13,000 initially and $5,000 per year just to have the narcotic website integrated into our electronic medical record.

I think the information on the website is very useful as a resource, but creating a "gatcha" situation where if the provider doesn't check it every single time, especially in low risk, well-defined situations, is a burden.

I would suggest strongly that the Department of Health continue to focus on outlier providers who prescribe more narcotics than their peers, and also to continue public education on the danger of narcotic addiction.

Most physicians and APP's would be extremely happy not to have to deal with chronic pain situations, but the fact is these situations exist and we, in large part the primary care providers, are stuck with it.

The great majority of providers are intelligent and try to do the right thing, despite a healthcare system that is broken. Please don't make it worse.