PROP
Physicians for Responsible Opioid Prescribing

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April 23, 2018

By Email

The Hon. Michael C. Burgess, M.D.
Chair, Subcommittee on Health

The Hon. Susan W. Brooks
Member, Subcommittee on Health

c/o Zack Dareshori, Legislative Clerk
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515
Email: zack.dareshori@mail.house.gov

Re: Additional Questions for the Record

Dear Chairman Burgess:

Thank you for the opportunity to supplement my testimony at the recent hearing entitled "Combatting the Opioid Crisis: Helping Communities Balance Enforcement and Patient Safety." Your and Congresswoman Brooks's follow-up questions raise critically important issues that I am pleased to address.

Enclosed please find my additional testimony for the hearing record in response to your questions. As requested, I have sent a Word version of the document to the e-mail address provided in your letter. Please note that because you and Congresswoman Brooks posed the same questions, I am providing a combined response.

Please do not hesitate to contact me with further questions. Your subcommittee's focus on these issues is essential to bringing the country's opioid addiction epidemic under control.

Sincerely,

Andrew Kolodny, M.D.

Director, Opioid Policy Research Collaborative
Co-Founder, Physicians for Responsible Opioid Prescribing

Enclosure

Supplemental Testimony of Dr. Andrew Kolodny

Responding to Additional Questions for the Record From

Congressman Michael C. Burgess and Congresswoman Susan W. Brooks

1. **Could you discuss your insight on how you arrived at your conclusion that requiring physicians additional CME on opioids would contribute to resolving the public health crisis before us today?**

Our opioid addiction epidemic – now the worst drug epidemic in U.S. history – was caused by a significant change in the way the medical community prescribes opioid analgesics.

Specifically, in the mid-1990s, we began prescribing opioids at increasingly higher rates, and we began prescribing these medicines for more conditions. No longer were opioid medications reserved for short-term, painful conditions like pain after major surgery or to ease suffering at the end of life. Physicians began prescribing opioid medications for common moderately painful conditions such as low-back pain, arthritis and fibromyalgia.

Opioid medications are highly addictive. Consequently, as the number of prescriptions for opioid medications skyrocketed, we saw parallel increases in the number of people suffering from opioid addiction, opioid overdoses, and deaths.

I do not blame doctors for overprescribing. We became more aggressive in our use of opioids because we were responding to a multi-faceted marketing campaign. Enlightened medical providers, we were told, should not allow patients to suffer needlessly. We should recognize pain as a "fifth vital sign" and think of opioids as a "gift from mother nature" to deliver compassionate care. The campaign exaggerated the benefits of opioids and minimized the risks of long-term use, especially the risk of addiction.

We might have been less gullible if we had only heard these messages from advertisements or pharmaceutical sales reps. But we also heard these messages from physicians eminent in the field of pain medicine, from the Joint Commission, and even from state medical boards. Only now is the public learning about the role opioid manufacturers played in coopting these authorities in their campaign to increase opioid prescribing.

I firmly agree that doctors are necessary allies. If we want to bring our country's opioid addiction epidemic under control, we need them to prescribe opioids more cautiously. That requires prescribers to better understand the risks and benefits of opioid medications. Indeed, for precisely this reason, I joined with leading experts in field of pain management and addiction in 2010 to create Physicians for Responsible Opioid Prescribing (PROP) – an organization devoted to correcting the widespread misconceptions about opioid medications.

While I firmly believe that the medical community needs better education about the risks and benefits of opioid medications, I share your concerns about the current mandatory Continuing Medical Education (CME) strategies being pursued in several states. I, too, have spoken to physicians who are frustrated with these programs. The problem with these programs, however, can be fixed.

First, prescribers should have the right to opt-out of mandatory CMEs that are not relevant to their practices. Medical professionals are busy, and our priority should be caring for patients. Clinicians who intend to limit their prescribing to 3 days or less should be permitted to opt out.

The vast majority of clinicians only prescribe opioids for acute pain, conditions that typically require 3 days or less of opioid use. Accordingly, the ability of such medical providers to "opt-out" will alleviate complaints that mandatory CMEs impose "undue" burdens. It will also ensure that the education is reaching clinicians who prescribe opioids to patients likely to become physiologically dependent (physiological dependence starts setting in after 5 days of opioid use).

Second, the content of mandatory CMEs should be scrutinized to ensure that medical professionals are receiving accurate, up-to-date information about the risks and benefits of opioid medications. The content of any CMEs should be free of industry bias, and the faculty should be independent as well.

If these modest steps are taken, I am confident that mandatory CMEs will not create a barrier to the compassionate treatment of patients with chronic pain. To the contrary, it will help ensure that physicians are caring for patients with chronic pain responsibly and not putting patients at risk of opioid addiction based upon the outdated and inaccurate information that fueled a public health catastrophe.

2. **Do you think there would be a better way to address your concerns regarding the overprescribing of opioids other than potentially burdening well-intentioned doctors further?**

For the reasons explained above, I believe that mandatory Continuing Medical Education (CME) is a necessary intervention to bring the opioid addiction epidemic under control, and I am confident that mandatory CMEs will not burden doctors unnecessarily – especially if those who intend to prescribe these medications only for 3 days or less are allowed to opt out.

Your concern for well-intentioned doctors, however, raises another issue. It is important to recognize the role that well-intentioned doctors have played in the opioid addiction crisis. The medical community overprescribed opioid medications not because we were indifferent or set out to harm patients. Rather, the manufacturers of opioid medications targeted well-intentioned doctors and persuaded the medical community that we were allowing pain patients to suffer needlessly and opioids were the answer. As a result, millions of pain patients became addicted to opioids – often by using opioid medications exactly as prescribed.

I admire your desire to see that well-intentioned doctors are not unduly burdened, but there is a more pressing target for those concerns: the extensive and unnecessary burdens on the prescription of buprenorphine (Suboxone).

Buprenorphine is the first-line treatment for opioid addiction. With the help of this medication, many people who are addicted to opioids can once again lead fully productive lives. Unfortunately millions of people who could benefit from buprenorphine do not have access to this medication because there are numerous barriers to treatment. For example, a doctor who wants to prescribe buprenophine must take an 8-hour training course, and after completing the course, that doctor is capped in terms of the number of patients he or she can treat.

It makes no sense to require doctors to take a full day of additional training to prescribe a medicine to *treat* opioid addiction when no extra training is required for physicians who want to *prescribe* opioids like OxyContin that are far more addictive and potentially dangerous.. It is similarly incongruous to cap the number of patients that a doctor can treat with Buprenorphine when no limits exist on the number of patients who may be prescribed opioids or the amount or dosage of opioids patients can receive.

Thank you again for the opportunity to testify and for your leadership on this critically important issue.