To Congressional Policymakers: April 13, 2021

I am writing you in opposition of extending class wide scheduling for fentanyl analogues. As a trained and board-certified physician specializing in Emergency Medicine, Medical Toxicology, and Addiction Medicine, I am intimately familiar with the synthetic opioids like fentanyl analogues that have driven increases in overdose deaths in recent years, and not only do I treat these overdoses, but I follow patients with addiction to opioids long term both in and out of the hospital. I am also the person on the other end of the phone when people call Poison Help with concerns like drug exposures and overdose. I have seen more overdoses than I can count, most of them from fentanyl and fentanyl analogues, and this response is not going to solve the problem Americans are facing from these drugs.

Since class wide scheduling was first introduced we have only seen further increases in both overdoses and deaths from fentanyl and fentanyl analogues. 2019 and 2020 each set new records in terms of drug overdoses, and there is no indication that this trend is even slowing down relative to enactment of this policy. As drug-related harms rise unchecked in response to class wide scheduling we are actually seeing additional harms related to increased sentencing and harsher penalties for people who use drugs.

While fentanyl is the driving cause of our current overdose crisis, fentanyl analogues play a much smaller role but receive greater amounts of attention when they are discovered in testing of samples and victims, likely because they are often novel compounds that are poorly understood. Limiting our ability to research and study these drugs, and gain understanding, by making them Schedule I substances. Of the fentanyl analogues we do understand, it is apparent that many of them can have very different properties, actions and effects than standard fentanyl and so while they appear similar at a molecular level they do not always behave similarly. Some of the analogs are a direct result of the same early drug discoveries that produced fentanyl, an invaluable therapeutic medicine, and drugs like remifentanil and sufentanil are analogs that are also very valuable in medicine. Some of the analogs we know about have been discovered through illicit drug discovery, like alpha-methylfentanyl, which despite being categorized as Schedule I in the 1980s is actually less likely to cause overdose and could have valuable therapeutic uses.

Myths about fentanyl and fentanyl analogues have dominated the narrative in recent years. Despite being first discovered in the street drug supply in the late 1970s, it wasn't until the past few years that people started to believe things like it could be possible to overdose from fentanyl by touching it, by breathing it in the air, or by being near fentanyl or someone who used fentanyl. None of those things are true. These substances, as diverse as they may be, can only cause overdose when intentionally ingested. What that means is that we need to focus on protecting people who use drugs and providing resources to prevent and treat overdoses, rather than adding additional stigma to this vulnerable population.

In my personal experience in recent years I now see overdose victims not receive appropriate (and lifesaving) resuscitation because of fears about fentanyl, and particularly fears about fentanyl analogues being so much more dangerous that they get nicknames like "elephant tranquilizer." I have personally resuscitated patients who have overdosed on carfentanil without any adverse effect to myself and with standard amounts of reversal agent, naloxone (Narcan).

Over the past year of our coronavirus pandemic I have additionally seen firsthand serious shortages of drugs like fentanyl lead to adverse outcomes for patients. Fentanyl is one of the most commonly-used medications to treat people with serious respiratory disease and critical illness, in addition to its use as a pain medication. Of the many fentanyl analogues that exist and those that have yet to be discovered, there is bound to be a drug that would have therapeutic benefits in treating the sick, and to limit ourselves further when we are already seeing limitations would be unwise.

There are plenty of easy and evidence-based policy actions that can be taken to save the lives of Americans, to prevent overdoses and to reduce rates of substance use and addiction. Class wide scheduling has not accomplished any of those aims and the available scientific and medical evidence does not support extending it. I would urge you to consider facts rather than fear and not to extend this policy.

Ryan Marino MD

rtmarino@gmail.com

Assistant Professor, Departments of Emergency Medicine & Psychiatry

Case Western Reserve University School of Medicine

Medical Toxicologist

Cincinnati Children's Hospital Drug & Poison Information Center