



**Comment on Proposed Action 02-389P for Title 10, Subtitle 9, Pharmacy Services  
Presented on behalf of the Maryland Pain Initiative by Karen Kaiser, MS, RN, AOCN**

Columbia, Maryland 21044  
January 15, 2003

To Whom It May Concern:

As a pain management specialist with 15 years of experience, I would like to comment on the proposed action 02-389P for Title 10, Subtitle 9, Pharmacy Services (10.09.03). Recent genetic evidence has confirmed long-standing clinical observations that medication is not “one size fits all”. Genetic variations are responsible for the individual differences in medication response (Wolf, Smith, & Smith, 2000). Some individuals may be incapable of metabolizing some analgesics into active compounds and thus may never obtain pain relief from certain medications. Other individuals are fast or slow metabolizers, causing varying analgesic response as well as impacting side effect profiles and severity. Testing for the genetic polymorphisms responsible for these individual differences is not currently available except in a research environment. This means treatment, including drug selection, must be individualized for each patient based on clinical response. Preferred drug lists as recommended in the proposal limit the health care practitioner’s ability to tailor therapy and to provide effective analgesia with manageable side effects.

A recent survey of Maryland residents by the Maryland Pain Initiative and the American Pain Foundation ([www.painfoundation.org/downloads/md\\_survey\\_release.pdf](http://www.painfoundation.org/downloads/md_survey_release.pdf)) found that 66% reported they or someone in their household suffers from pain on a monthly basis. Of those people, 46% reported pain occurs daily or several times per week and 68% report the pain is moderate to severe. Numerous studies have shown that health care professionals under treat pain, causing national organizations, federal agencies, and accrediting bodies to require health care agencies to improve the management of pain (American Pain Society Subcommittee on Quality Assurance Standards, 1991; Lewin-VHI, 1993; Acute Pain Management Guideline Panel, 1992; Joint Commission on Accreditation of Healthcare Organizations 2000; Kang, 2000). Numerous health care disparity studies show minorities, the elderly, children, and females are at greater risk for under treatment of pain (Cleeland, Gonin, Baez, Loehrer & Pandya, 1997; Lewis, Lasater & Brooks, 1994, McDonald, 1994; Ng, Dimsdale, Shragg & Deutsch, 1996; Ng, Dimsdale, Rollnick, & Shapiro, 1996; Todd, Deaton. D’Adamato & Goe, 2000; Todd, Samaroo & Hoffman, 1993). System barriers, such as preferred drug lists and review processes (Ault & Hash, 2001) outlined in the proposal hamper effective pain treatment. Instituting the proposal as written in the state of Maryland is extremely likely to impede the effort to effectively manage the public health crisis of uncontrolled pain, particularly in the underserved population.

Based on the above, I strongly advise against Maryland's adoption of a preferred drug list. If the proposal goes forward as described (see [https://constmail.gov.state.md.us/comar/dsd\\_web/mdregister\\_web/2925/main\\_register.htm](https://constmail.gov.state.md.us/comar/dsd_web/mdregister_web/2925/main_register.htm)) at a minimum I highly recommend the following: a) analgesics and adjuvants (ie., medications used to treat side effects or medications that have a primary indication other than pain but are also analgesic for some painful conditions {such as antidepressants or anticonvulsants) should not be restricted and b) a pain specialist should be added to the proposed P&T committee.

As a member of the American Pain Society, American Society of Pain Management Nurses, Maryland DHMH Cancer Plan Pain Subcommittee, Maryland Pain Initiative, and a frequently called upon pain expert for the Maryland Board of Nursing, I urge you to consider the serious ramifications of proposal 10.09.03.

Sincerely,

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