WRITTEN TESTIMONY REGARDING PENNSYLVANIA HOUSE BILL 1800
by Patrick J LaRiccia, MD, MSCE

Introduction

I have practiced medicine going on 33 years. Besides my medical degree I have Master's Degrees in Psychology and Clinical Epidemiology. I am Board Certified in Internal Medicine, hold Pennsylvania medical and acupuncture licenses, have staff privileges at Penn-Presbyterian Medical Center (General Medicine) and the Hospital of the University of Pennsylvania (Physical Medicine and Rehabilitation, and am the director of research at the Won Sook Chung Foundation in Moorestown, New Jersey. I am an Adjunct Scholar at the Center for Clinical Epidemiology and Biostatistics and Perlman School of Medicine of the University of Pennsylvania. I have published book chapters and medical journal articles. For my Master's thesis I conducted a randomized placebo controlled study of a food supplement.

Personal Experience with Utilization Review

I have dedicated my career to improving health care by using and researching methods of care that are effective or more effective than standard methods along with being safer and gentler. After completing my residency in internal medicine I completed two years of fellowship in Behavioral Medicine focusing on the mental techniques of hypnosis, relaxation techniques, and biofeedback applied to medical problems. Later training in acupuncture further increased successful patient outcomes. Over the course of time I became familiar with multiple forms of complementary/alternative medicine techniques. Patients came and still come to me after failing standard medical treatments. I witnessed the utilization review process wreak havoc with many patients suffering chronic pain in. Patients who were improving or being maintained by regular acupuncture treatments would have their therapy interrupted or stopped. It was a miserable experience for my patients and for me as witnessed their physical regression with its concomitant psychological pain.

In the context of chronic pain, complementary and alternative medicine techniques helped many of my patients do without/use less narcotic medication. Currently, one of the main causes of both prescription and street narcotic abuse/death is chronic pain. Yesterday March 15, the CDC published guidelines for prescribing narcotic medication in which non-pharmacological therapies were mentioned. Below is an excerpt of from the guidelines (http://www.empr.com/news/cdc-12-recommendations-for-prescribing-opioids-in-primary-care/article/483363/?DCMP=EMC-MPR_DailyDose_cp&cpn=pcp_md,pcp_all&hmSubId=&hmEmail=WV0H2X3UQ7kKxT9C3cmSu9_fndfC6gdj0&NID=1558544148&dl=0&spMailingID=13981766&spUserID=MTgxMDk3NjIzMjMwS0&spJobID=741195267&spReportId=NzQxMTk1MjY3S0)

"Based on available evidence and expert opinion, the CDC recommends the following:
1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate (recommendation**category: A, evidence type: 3**)".

Evidence Based Medicine (EBM) versus the reality of our current medical care system

The true definition of evidenced based medicine is seldom used in the medical literature, by providers, the media or insurers. Gordon Guyatt was the first person to coin the term evidence based medicine. If you carefully read the first chapter of his textbook or papers co-authored by him or his chief collaborators almost all physicians would be quite surprised. In the bible of Evidence Based Medicine authored by Guyatt and collaborators, the second chapter of the book (titled "What is Evidence Based Medicine") details the incorporation of clinical expertise, patient values, patient preferences, and patient participation in decision making starting on page 12 in the subsection titled **"Evidence is Never Enough to Drive Clinical Decision Making".**

[Guyatt G, Rennie Drummond, Meade MO, Cook DJ. Users' Guide to the Medical Literature: A Manual For Evidence-Based Clinical Practice. Chapter 2 pps. 12-18. 3rd Edition. 2015. McGraw Hill, New York]

The following are quotations and their citations from the fathers of Evidence Based Medicine reiterating the importance of clinical expertise, patient values, patient preferences and patient participation in decision making as components of Evidence Based Medicine.

"Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate use of individual patients' predicaments, rights, and preferences in making clinical decisions about their care. …….Good doctors use both individual clinical expertise and the best available external evidence, and neither alone is enough. Without clinical expertise, practice risks becoming tyrannised by evidence, for even excellent external evidence may be inapplicable to or inappropriate for an individual patient. Without current best evidence, practice risks becoming rapidly out of date, to the detriment of patients".

[Sackett DL, Rosenberg. WMC, Gray JAM, Haynes RB, Richardson WS. Evidence based medicine: what it is and what it isn't: It's about integrating individual clinical expertise and the best external evidence.BMJ 1996; 312:71-72.]

"The term evidence based medicine was developed to encourage practitioners and patients to pay due respect—no more, no less—to current best evidence in making decisions. An alternative term that some may find more appealing is research enhanced health care. Whichever term is applied, one can be confident in making better use of research evidence in clinical practice, especially if the wishes of the patient are taken into account."

[Haynes BJ, Devereaux PJ, Guyatt GH. Physicians' and patients' choices in evidence based practice; Evidence does not make decisions, people do. BMJ 2002; 324:1350.]

"As we continue our journey through the era of research informed health care, the benefits that our patients will receive, and satisfaction with our own clinical performance, will depend

increasingly on making care decisions that incorporate the clinical state and circumstances of each patient, their preferences and actions, and the best current evidence from research that pertains to the patient's problem. The nature and scope of clinical expertise must expand to balance and integrate these factors, dealing with not only the traditional focus of assessing the patient's state, but also with the pertinent research evidence, and the patient's preferences and actions, before recommending a course of action."
[Haynes BJ, Devereaux PJ, Guyatt GH. Clinical expertise in the era of evidence based medicine and patient choice (Editorial). Vox Sang 2002; 83, (Suppl. 1): 383-386.]

"Evidence-based medicine (EBM) has been defined as the judicious and systematic application of research evidence to the care of individual patients integrated with clinical judgment, expertise, and patient values and preferences".
[Scott IA, Guyatt GH. Cautionary tales in the interpretation of clinical studies involving older persons. Arch Intern Med. 2010;170(7):587-595.]

The above references make the components of Evidence Based Medicine very clear. However our current medical care system has distorted the real definition of Evidence Based Medicine with a focus on the research literature component while ignoring the clinical expertise of the provider and the values, preferences, and decision making participation of the patient. Thus Insurers, special interest groups and the media have seized upon the research literature aspect. House Bill 1800 does not in any way indicate that it is referring to the real definition of Evidence Based Medicine. It sets up a set of predetermined approved therapies and approved applications without regard for the health care provider's clinical expertise or the patient's values, preferences and decision making participation.
It is disturbing to note that most utilization review involves a health care provider interjecting their management of the patient based solely on a chart review. If the patient's care is compromised by this interjection the reviewing health care provider is not liable. In the everyday practice of medicine outside of worker's compensation medicine, if a health care provider makes a management decision that results in harm to a patient never examined by that provider that provider is then medically liable for that harm. As noted above I have witnessed utilization review adversely affecting the medical outcomes of patients. If patients are making progress or their medical status is prevented from deteriorating by a therapeutic process should not the person or organization interjecting a different course of action without examining the patient incur some liability if the patient's condition worsens?
I think that the agenda behind House Bill 1800 is to prevent utilization abuse. However, for the sake of patient care some other method must be agreed upon. I feel that House Bill 1800 will result in **utilization review abuse.** A new or revised bill needs to be crafted that will use the real definition of Evidence Based Medicine to improve medical outcomes while reducing or preventing utilization abuse.
Feel free to contact me if you have questions.

Individualized process patient values and preferences and providers expertise
Excerpts from texts and papers
House Bill 1800 doesn't use this definition
House Bill will create a list which will at times adversely affect the care of the patient by terminating their treatment as I have witnessed.
What is needed is a method to verify if the patient is improving or is being maintained by their current treatment regime. If

CAM, EBM
Commentary on House Bill 1800

The popular and biomedical literature often overlook the fact that the definition of evidence based medicine (EBM) includes patient preferences and expert opinion, in addition to knowledge of the medical literature.[10-14]

10. Kligler B, Weeks J. Finding a common language: Resolving the town and gown tension in moving toward evidence informed practice, Explore (NY). 2014; 10(5):275-277.

11.[Sackett DL, Rosenberg. WMC, Gray JAM, Haynes RB, Richardson WS. Evidence based medicine: what it is and what it isn't: It's about integrating individual clinical expertise and the best external evidence.BMJ 1996; 312:71-72.]
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15. Guyatt G, Rennie Drummond, Meade MO, Cook DJ. Users' Guide to the Medical Literature: A Manual For Evidence-Based Clinical Practice. Chapter 2 pps. 12-18. 3rd Edition. 2015. McGraw Hill, New York