Testimony in Opposition of House Bill 73

Chairman Huffman, Vice Chair Johnson, Ranking Member Antonio, and members of the Senate Health Committee, thank you for the opportunity to provide my personal opponent testimony on House Bill 73.

My name is Stephanie Seaman and I am a clinical pharmacist working in the Emergency Department and Medical Intensive Care Unit at a tertiary care hospital in Columbus, Ohio. I work side-by-side with physicians, nurses, respiratory therapists, dieticians, and countless other medical professionals every day to optimize patient care, including frequent use of medications for off-label indications. Pharmacists fully support the utilization of off-label medications in the appropriate patient. Often, I am the one recommending off-label use of a medication when other first-line medications have failed. I utilize my knowledge of biochemistry, pathophysiology, primary literature, and near decade of bed-side experience to make highly specialized recommendations when standard guidelines fail to address specific patient populations or situations.

A pharmacists' job is to protect patients from harm caused by medications or from the withholding of medications. Sometimes this harm comes from errors in prescribing. This can take the shape of straight-forward errors, such as prescribing a drug or dose that is inappropriate for someone with reduced renal function because their inability to clear the drug will lead to toxicity or lead to the drug becoming ineffective. Sometimes this harm is less obvious and comes from when a drug that may be helpful in one disease, such as chemotherapy in cancer, can be harmful in another. If given to the wrong patient, this can lead to unnecessary side effects or can negatively impact the patient's other disease states in a way that causes significant harm.

Medicine is nuanced and incredibly complicated, and multidisciplinary healthcare has been shown, time and time again, to improve patient outcomes. Pharmacists have been shown to reduced mortality, reduce hospital length of stay, reduce healthcare costs, reduce hospital readmissions, and provide antimicrobial stewardship that leads to decreased duration of treatment and utilization of antimicrobials, ultimately reducing development of multi-drug-resistant organisms and preserving our ability to use those antibiotics for future generations. Despite this, pharmacists often face resistance, largely from providers who trained in placed that lacked interdisciplinary care or fail to acknowledge the benefits interdisciplinary care provides. Pharmacists have a fiduciary responsibility to protect their patients, and the liability they assume gives credence to their role and is the backbone upon which they stand. This bill will make pharmacists nothing more than automated dispensing cabinets, taking away their years of experience and expertise in protecting patients from harm, and undermining multidisciplinary healthcare and all of the evidence-based benefits that go along with it. Medication effects are rarely so black-and-white as to be able to determine when a medication contraindication is "life-threatening" as opposed to simply harmful, until retrospectively evaluating an event that leads to death. This will create undue burden on the pharmacist to "prove" the critical nature of their interventions, leading to fear being the driving force behind their decision-making. Pharmacists will no longer be able to put their patients first, and the profession and their patients will suffer tremendously.

This bill not only takes away pharmacists' ability to intervene on potentially harmful prescriptions, it undermines the years of experience and specialty training inpatient physicians and other providers receive that allows them to make the most appropriate decisions regarding their patients' care. When a

patient is critically ill, their pharmacokinetics and pharmacodynamics change, the interplay between their diseases states becomes more pertinent, and multisystem organ failure and mechanical life support add further intricacies to their care. A drug that would be fine for them to take outpatient may lead to severe morbidity or mortality when they are critically ill. While their outpatient physician may provide important information to help inpatient providers determine the most optimal course of treatment, those inpatient specialists are the ones with the most expertise and knowledge to care for the patient at that particular moment in time and at that stage of illness. Allowing outpatient providers, many of whom have limited experience in critical care, to overrule the judgement of the inpatient managing physician is a dangerous precedent to set, will lead to patient harm by unqualified providers, and will contribute to the further death of the expertise and credibility of the medical field.

In the midst of severe drug shortages and growing healthcare costs, it is up to both pharmacists and physicians to responsibly assess medication utilization and reserve medications on shortage to the most critical patient populations. Pharmacy departments are forced to think on their feet, often pivoting to alternative treatment options based on the best available evidence and reserving critical supply to patients whose lives depend on it or who have contraindications to receiving the alternative. For example, in the face of a growing syphilis epidemic and a worsening shortage of long-acting penicillin-G benzathine injections (Bicillin-LA), we have turned to utilizing doxycycline, an adequate alternative treatment option for the general population, and reserving Bicillin for pregnant patients, in whom doxycycline is relatively contraindicated due to harm it can cause the fetus. House bill 73 provides no protection for these patients and could snowball into not just harm on one patient, but harm on an entire population of patients who are impacted by the individual decisions of providers allowed to overrule the judgement of entire healthcare organizations.

On top of the implications regarding patient safety and optimizing patient care, this bill creates a logistical nightmare for healthcare systems, circumvents our healthcare reimbursement structure, and creates precedent for hospitals to provide different levels of healthcare to patients who can afford to pay upfront for medical therapies, potentially undermining the federal Emergency Medical Treatment and Active Labor Act, otherwise known as EMTALA. It would allow health care organizations to make their formularies more restrictive and require patients to pay up-front for drug treatments that are not on formulary. I fear the long-term impact this could have on healthcare, particularly for indigent populations who already struggle to receive adequate treatment.

Thank you for the opportunity to provide this written testimony in opposition to House Bill 73. I appreciate your careful consideration of the dangers this bill will present to patients and to the healthcare system.

Sincerely,

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