Oppose SB 332

Before the Senate Finance Committee

of the

Maryland General Assembly

Hearing on SB 332

February 15, 2024

Written Testimony in Opposition to Senate Bill 332

John M. Kelly

Bethesda, Maryland

I first want to emphasize that I do not oppose hospitals and urgent care facilities having protocols for identifying and treating sepsis nor for periodic training of such protocols. I oppose ambiguous language in the bill that could easily have unintended consequences of worsening the outcomes of sepsis treatments rather than improving them.

The protocols described in the bill would unduly constrain sepsis treatments to "generally accepted standards of care" ***only*** and, thereby, preclude more recent and effective treatments that have not yet found their way into "generally accepted standards of care".

The bill conflates the terms "evidence-based protocol" and "generally acceptable standards of care". It implies that a protocol is "evidence-based" only if it is regarded as a "generally accepted standard of care". But there are evidence-based protocols that have not been designated as "generally accepted". Therefore, the bill's requirement that the protocols be based on "generally accepted standards of care" can be easily construed as excluding safe and effective protocols that have not yet found their way into conventional definitions of "generally accepted standards of care".

It takes time for safe and effective treatments based on evidenced gathered from clinical experience to be recognized and generally accepted, but this should not exclude them from use or justify any implicit or explicit bias against their use.

The bill biases the treatment of sepsis to "generally accepted standards of care" *only*, and could easily constrain doctors from using effective, evidence-based treatments that have not yet been "generally accepted" simply due to the time it takes for any new treatment to be designated so.

These concerns are not merely hypothetical or speculative. There is convincing evidence that there is an effective and safe sepsis treatment that is far superior to generally accepted protocols but is

not yet a “generally accepted standard of care”. I urge committee member to listen to an interview with Dr. Paul Mari who is one of the persons who developed the new sepsis treatment.” (See: https://www.faim.org/interview-with-dr-paul-marik-on-vitamin-c-protocol-for-sepsis).

In a clinical trial of 150 persons, “Dr. Marik … treated patients with severe sepsis … and septic shock and only person one from that group died from the sepsis itself. Moving from a 30-50 percent mortality utilizing standard treatment protocols for sepsis to achieving a sepsis-related mortality of less than 1% using IV vitamin C / hydrocortosone / thiamine therapy in this small treatment group is nothing short of miraculous. His protocol has since been lab-tested and proven to work. It is now used regularly at Eastern Virginia Medical School to treat sepsis.” (See: Foundation Alternative and Integrative Medicine: https://www.faim.org/)

The above study raises a central questions about current protocols and the major assumption underlying the bill: What is the factual basis for the protocols and for expanding their use? Is the problem of sepsis deaths that not enough health-care facilities are following the current protocols, or is it that the current protocols are not as effective as desired and believed?

The bill implies current protocols are effective. But before the committee considers any legislation regarding such protocols – and in the spirit of the bill’s concern for “evidence-based protocols” -- the committee should find out how effective the current sepsis protocol is in preventing deaths. Then, it should compare the results with the effectiveness of recent sepsis protocols that are not yet considered “generally accepted standards of care”.

The bill continues a troubling trend of taking health care out of the hands of doctors and their patients. Traditional medicine is being turned upside down. Protocols are no longer aides to help doctors treat patients; instead, they are becoming inflexible requirements to follow. And the requirements are promulgated with insufficient regard for the physical health and medical histories of patients.

It is reasonable to be concerned that in an environment of over-reliance on established protocols, doctors would feel constrained from recommending and providing treatments based on their own training, clinical experience and, especially, knowledge of recent advances in health-care that are not yet regarded as “generally accepted”.

Doctors’ traditional role in the “patient-doctor” relationship is seriously diminished. They are becoming agents who administer “protocols” rather than doctors who make judgments about authorizing treatments in consultation with patients about the risks and benefits of health-care

interventions. On on the patient side, adequate informed consent for interventions is diminished or none is provided.