Testimony Given To The Colorado Senate Judiciary Committee In Opposition to SB 19-193

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April 1, 2019

Mr. Chairman and Members of the Colorado Senate Judiciary Committee:

I am speaking today in opposition to SB 19-193, CONCERNING THE CONTINUATION OF THE "COLORADO MEDICAL PRACTICE ACT". Specifically, this testimony addresses the language on page 5, line 27 of the draft bill which addresses C.R.S. §12-36-123.5, and the contents of C.R.S. §12-36-123.5 considered as a whole.

The principal points of my testimony are summarized as follows:

C.R.S. §12-36-123.5 called for the creation of one or more physician peer assistance programs in Colorado.

> *(b) (I) **As a condition of physician, physician assistant, and anesthesiologist assistant licensure and renewal** in this state, every applicant **shall pay**, pursuant to paragraph (e) of this subsection (3.5), an amount set by the board, not to exceed sixty-one dollars per year, which maximum amount may be adjusted on January 1, 2011, and annually thereafter by the board to reflect:*
>
> *(A) Changes in the United States bureau of labor statistics consumer price index for the Denver-Boulder consolidated metropolitan statistical area for all urban consumers, all goods, or its successor index;*
>
> *(B) Overall utilization of the program; and*
>
> *(C) Differences in program utilization by physicians, physician assistants, and anesthesiologist assistants.*
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> *(II) Based on differences in utilization rates between physicians, physician assistants, and anesthesiologist assistants, the board may establish different fee amounts for physicians, physician assistants, and anesthesiologist assistants.*
>
> *(III) The fee imposed pursuant to this paragraph (b) is **to support designated providers that have been selected by the board to provide assistance to physicians, physician***

assistants, and anesthesiologist assistants needing help *in dealing with physical, emotional, or psychological problems that may be detrimental to their ability to practice medicine, practice as a physician assistant, or practice as an anesthesiologist assistant, as applicable.*

(c) The board shall select ***one or more peer health assistance programs*** *as designated providers. To be eligible for designation by the board, a peer health assistance program must:*

(I) Provide for the education of physicians, physician assistants, and anesthesiologist assistants with respect to the recognition and prevention of physical, emotional, and psychological problems and provide for intervention when necessary or under circumstances that may be established by rules promulgated by the board;

(II) Offer assistance to a physician, physician assistant, or anesthesiologist assistant in identifying physical, emotional, or psychological problems;

(III) Evaluate the extent of physical, emotional, or psychological problems and refer the physician, physician assistant, or anesthesiologist assistant for appropriate treatment;

(IV) Monitor the status of a physician, physician assistant, or anesthesiologist assistant who has been referred for treatment;

(V) Provide counseling and support for the physician, physician assistant, or anesthesiologist assistant and for the family of any physician, physician assistant, or anesthesiologist assistant referred for treatment;

(VI) Agree to receive referrals from the board;

(VII) Agree to make their services available to all licensed Colorado physicians, licensed Colorado physician assistants, and licensed Colorado anesthesiologist assistants. [Emphasis added.]

Since 1986, The Colorado Physicians Health Program (CPHP) has been the sole contractor for services provided pursuant to this legislation. Not only does the enabling legislation not specifically authorize the creation of a monopoly for these services but the sole source procurement laws found in C.R.S. § 24-103-205 state:

A contract may be awarded for a supply, service, or construction item without competition when, under rules, the executive director, the chief procurement officer, the procurement official, or a designee of any such officer determines in writing that there is only one source for the required supply, service, or construction item.

And, under Procurement Rule R-24-103-205-01 the following two criteria must be met for sole source procurement:

> *There is only one good or service that can reasonably meet the need, and*
> *There is only one vendor who can provide the good or service.*

In the 33 years of operation of CPHP, only a single instance of a sole source justification is documented and no empirical justification was ever provided for the claim that there is only one vendor that can reasonably meet the need. To the contrary, peer assistance programs, or employee assistance programs (EAP's) as they are commonly called, are practically ubiquitous in Colorado.

Reading the text of C.R.S. §12-36-123.5, the basic proposition seems very straightforward. A fee will be collected from physician and other license holders at the time of initial licensure, held as custodial funds by the State of Colorado, and used ***to support designated providers that have been selected by the board to provide assistance to physicians, physician assistants, and anesthesiologist assistants needing help.*** Note that credentialing, certification of fitness, agency enforcement, and concern for the public health and safety were not legislated to become the ambit of the peer assistance program(s).

CPHP continues to be a monopoly and documentation obtained from a CORA request and other sources demonstrate that CPHP has departed from its role as a peer assistance program while under the supervision of the Colorado Medical Board. Both legislation and oversight will be required to provide a course correction.

This testimony will enlarge on the following points:

1. The Federation of State Physician Health Programs (FSPHP), a subsidiary of American Society of Addiction Medicine (ASAM - an organization of almost exclusively self-designated specialists), began a program of representing themselves as specialists to state-run physician peer assistance EAP's in the early to mid- 1990's. The

group now operates identical models in 45 of 50 states and usually funded by physician license fee surcharges.

2. State PHP's are monopolies in virtually every state despite their service lines being specified in state statutes as peer-assistance programs or EAP's. EAP's, other than for physicians, are widely available in a variety of corporations and labor organizations in every major US market.

3. The FSPHP program employs a strict adherence to 12 step clinical approaches when the vast majority of the treatment population does not have substance habituation problems at all. The claimed recovery rates are generally regarded as non-scientific self-promotion in the academic literature. (Appendix IX)

4. The FSPHP programs universally employ a network of out-of-state regional treatment centers run by other ASAM members that are residential, require cash up-front, do not accept insurance, and insist on stays of weeks to months because of the claimed special needs of physicians. Academic, university, and mainstream clinical providers are absent or under-represented in the FSPHP regional referral centers.

5. The regional referral centers have every economic incentive to over-diagnose because this behavior increases cash income and inflates recovery rates: It is easy to "cure" people who were never sick in the first place. A fundamental tenet of FSPHP is coerced treatment for physicians. The FSPHP calls it "leverage". (Appendix IX)

6. The FSPHP programs employ a variety of non-approved tests ("LDT's") that are claimed to be very sensitive and yet prove to be non-repeatable and non-specific and are nowhere else in clinical use. Some of the regional referral centers employ polygraphs as part of their diagnostic pathways.

7. The FSPHP model has an enormous potential to be used to punish or silence physicians under the guide guise of offering help. The "weapon-ization" of psychiatry has a dark history in the 20th and 21st centuries. (Appendix IX)

8. Physicians concerned about a colleague's health believe that PHP referrals are the least helpful choice. A physician health program in Michigan is the target of a class action lawsuit. A physician health program in North Carolina was the subject of a scathing state auditor's report (Appendix VIII). The medical literature contains numerous entries that describe the ethical, legal, and medical shortcomings of these programs.

9. The early history of PHP model programs (e.g. Talbott Recovery Center) were marred by multiple incidents of abuse and suicide. PHP's represent themselves as sources of assistance to physicians but their documented procedures, history of medical board interactions and dependency, and details of the consent they seek demonstrate that they are "wolves in sheep's clothing."

10. The biggest issue with FSPHP programs may be the missed opportunities to intervene helpfully in the face of widespread depression and suicidality among physicians that seems to have a secular upward trend. Since 1999, U.S. age-adjusted, gender-specific suicide rates have increased 33% overall while the rest of the developed world has experienced a downward trend in rates. In the U.S., male physicians have a relative risk of suicide mortality 170-200% of the general male population rate and female physicians have a rate 360-400% of the general female population rate. No argument is made for the proposition that EAP's should not be serving this urgent physician need but the last things physicians who understand PHP's would do is to refer a colleague to one.

11. Forensic and clinical encounters with treatment "providers" and treatment "monitors" in PHP's inter-twine clinical and forensic

encounters in a way no other forensic specialties do. Most forensic specialty physicians (and psychologists) have a strict code of ethics that enjoins them from this sort of behavior. FSPHP models provide "fitness for duty" assessments all the time without having ANY knowledge about a physician's work environment or need for employer accommodation. They are not any resources in PHP's to deal with somatic causes of impairment. PHP's have no occupational medicine expertise despite practicing very high-stakes occupational medicine. (Appendix VI)

12. PHP's virtually always have de facto monopolies in the state in which they operate. State medical boards can assign sanctions to licensed physicians unavailable under their medical practice acts by referring to PHP's problematic physicians who have been neither unsafe nor impaired but merely problematic.

13. PHP's consider themselves something other than state actors so they are free to act without accountability or due process. State medical boards must provide at least a semblance of due process and have a convenient avenue of extra-agency controls and sanctions by dint of the availability of PHP's. PHP's can deliver sanctions within hours or days without oversight, ombudsmen, documentation, or hearings. (Appendix VIII)

14. The FSPHP model grew out of physician peer assistance programs largely operated by the medical societies. In almost every state these informal arrangements became state monopolies and moved these activities from professional control to state monopolies in the absence of legislation that permitted this change to a monopoly. This is an anti-trust violation that jeopardizes the physician and physician assistant members of the Colorado Medical Board as they have no state immunity to federal anti-trust actions.

15. The FSPHP has served as a model "morality car wash" for substance-abusing physicians who wish to salvage their clinical practices by proclaiming that medical substance abuse is rampant and

is the fundamental problem in US medicine. Their salvation is spreading the blame to others and evangelizing 12 step interventions. Incitement of these "moral panics" serves a small group of physicians who adopted this scheme.

16. The solution is to call for statutory change that strictly separates clinical and forensic practice in PHP's, dis-allows monopolies or related party transactions between PHP's and medical boards or PHP regional specialty centers, and employs the ADA model for proving unfitness in a current worker in a field. The ADA standards for unfitness present a very high bar for persons with a disability currently working in a job and include legal terms of art such as "direct threat", "objective evidence", and "business necessity".

17. Peer assistance programs funded by physicians and other licensees should have no function other than assisting physicians, physicians assistants, and anesthesiologist assistants. They were never intended to assist medical boards or regulators. The bidding processes for state PHP's needs to be carefully scrutinized in each state. Forensic panels that assess individual physicians' fitness for duty serve a public safety function and should be supported by general tax revenues.

----------end of spoken testimony----------

I - The emergence of ASAM and FSPHP as thought leaders and controlling organizations in state physician health programs

Physician Health Programs and Professional Health Programs (PHPs) were started in the 1970s as "impaired physician" programs and existed in every state by 1980. The designations were changed to Physician Health Programs (PHPs) to focus on wellness rather than impairment. The expressed organizational goal of these efforts was to help sick doctors and protect the public. They were originally funded by medical societies and staffed by volunteer physicians. In the 45 states that have PHP's following

the FSPHP model, ASAM physicians widely populate the staff of these programs.

In 1986 group of physicians "in recovery" started calling themselves "experts" in addiction medicine. In contrast, Addiction Psychiatry is a recognized subspecialty in addiction medicine that requires a 4 year psychiatry residency and 1 year of fellowship at an accredited training program. ABAM certification requires only an MD and board certification in any specialty. ASAM/ABAM "Board Certification" not recognized by American Board of Medical Specialties. The number of physicians in US board certified in Addiction Psychiatry is about 1000 while the number of physicians in US "board certified" by ASAM is over 4000

The majority of these physicians are "recovered" addicts and alcoholics who had licenses revoked. They were able to regain their licenses by convincing State Medical Boards that they were recovered, reformed, and redeemed and that there was an overwhelming societal need for addiction medicine doctors. With medical licenses restored they became "certified" in addiction medicine. In large numbers they joined PHP programs funded by State Medical Societies and staffed by volunteer physicians. They also staffed 12-step inpatient drug rehabilitation programs as Medical Directors.

The State PHPs were vulnerable to influence because unlike employee assistance programs established in other sectors they were not subject to oversight by organizations representing very many physicians. In organized labor arrangement, EAP's are usually the joint product of labor and management negotiation. This was not the history of the dissemination of the FSPHP model.

Physicians removed from PHPs were threatened with swift and certain consequences if they violated confidentiality agreements or "peer review" protection enabled by the passage of the Health Care Quality Improvement Act (HCQIA) of 1986. Most effective, however, was the implied and unspoken threat that if they did not do as they asked they could end up being monitored indefinitely for having been witness to ethical violations and possible criminal activity.

The State PHPs taken over by the ASAM physicians are under the umbrella organization FSPHP. The ASAM staffed treatment centers are also under an umbrella organization: NAATP and are in every instance operated as small LLC's by a conservative subset of ASAM physicians who call themselves "Like-Minded Docs".

II - State PHP's are monopolies in all but one state where they follow the FSPHP model

It is a legitimate question to ask how employee assistance programs for physicians were transformed into today's FSPHP. The question can be answered in the case of Colorado.

CPHP is in its 33rd year of operation and it has never had a marketplace competitor. The state procurement history can be traced back as far as 2004. In 2014, a documented sole source contract justification was written that has no reference to the unique aspects of CPHP and no mention of the abundance of private and commercial employee assistance programs in Colorado. C.R.S. §12-36-123.5 did not authorize creation of a monopoly but years of interaction with the Colorado Medical Board and DORA, that oversee the CPHP contract and licenses the CPHP staff have transformed an EAP into a regulatory arm of DORA.

The latest published RFP for Colorado physician peer assistance services, RFP SJAA 2019-101, describes some of the mechanisms that have worked to constrain competition in this marketplace for physician peer assistance services in which physicians have a role as both consumers and providers. (Appendix II, III, IV)

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STATE OF COLORADO

Department of Regulatory Agencies (DORA), Executive Office
Division of Professions and Occupations (DPO)

REQUEST FOR PROPOSAL (RFP) SUBMITTAL COVER SHEET

Publish Date:	November 9, 2018	RFP Number:	RFP SIAA 2019-101

Subject to the specifications, terms and conditions herein stipulated, attached, or linked, proposals will be accepted at the address below prior to the date and time listed. Offers are now being accepted for:

Physicians', Physician Assistants', and Anesthesiologist Assistants' Peer Health Assistance Program ("Program"), as defined in section 12-36-123.5, C.R.S

Submit All Proposals to:	Department of Regulatory Agencies, Procurement Office 1560 Broadway, Suite 110 Denver, CO 80202	**Purchasing Agent and Telephone No.:**	John P. Weber, CPPO, C.P.M.
Deadline for Submission of Proposal:	January 3, 2019, 3:00 PM MST	**IMPORTANT:** This completed and signed RFP Submittal Cover Sheet MUST accompany proposals submitted. Proposals must be delivered "sealed" with RFP Number, and Opening Date and Time on outside of envelope. Be advised that telegraphic or electronic offers cannot be accepted.	
# of Copies to be Submitted:	One (1) Original Plus five (5) Hard Copies Required and 1 Electronic Copy on CD or flash drive is desired*		

IDENTIFICATION OF OFFEROR(S) *(Legibly Complete the Following Information):*

OFFEROR(S)/COMPANY NAME:

STREET ADDRESS:

CITY/STATE/ZIP:

PHONE: FAX:

E-MAIL ADDRESS: WEBSITE ADDRESS:

AUTHORIZED SIGNATURE: _____
(one copy must include an original signature)

PRINTED NAME AND TITLE:

FEIN OR CORE SUBSCRIBER NUMBER AS REGISTERED ON CORE:

CONTACT NAME FOR CLARIFICATIONS: PHONE:

MODIFICATIONS RECEIVED: PAYMENT TERMS (Not Less Than NET 45):

F.O.B.: Destination, Prepaid & Allowed LEAD TIME/DELIVERY ARO: See Contract Requirements

In submitting this coversheet, you are verifying receipt of the original CORE notice and attachments. Where modifications are issued, you need to additionally acknowledge receipt of the number of modifications above where indicated. Offeror(s) are responsible for reading the entire RFP document before submitting a proposal.

COMPLETE AND RETURN THIS PAGE WITH YOUR RESPONSE

RFP-SJAA 2019-101 on page 6, section 1.1.16 titled Number of Awards specifies that one contract for physician peer assistance services will be awarded. In Section 1.1.19, it is specified that a process audit may be required as frequently as every three years under the terms of the RFP. (CPHP has never undergone a process audit.) On page 9 of the RFP, C.R.S. §12-36-123.5 is cited and the text stating that, "The Board is authorized to disburse moneys…from the "Fund" to **one or more** peer health assistance programs…' (emphasis added).

Section 3.0 of RFP-SJAA 2019-101, Statement of Work and Proposal Requirements, lists stringent requirements for the type of evaluation to be performed including provisions for emergency assessments, performance of an "evaluation that is sufficient to determine the extent of the Recipient's physical, emotional, psychiatric psychological, drug abuse, or alcohol abuse problems", "of whether the Recipient is addicted to or dependent on alcohol or habit-forming drugs, or is a habitual user dependent upon, or addicted to any controlled substance…", and which "must include a comprehensive biopsychosocial evaluation".

Section 3.2.2.4 of the RFP specifies that the successful bidder ("Offeror") will conduct a criminal background screen on anyone seeking peer assistance services as a Recipient prior to the initial appointment and to obtain authorization to release information that is legally adequate to permit Contractor to provide the State with records in connection with an investigation, disciplinary action, or other purpose authorized by statute, or each Recipient's records, including records received from other sources in the Contractor's custody. Evaluation *shall not* be conducted without signed authorization/release to the State. Moreover, in Section 3.8.2. , peer assistance program records become the property of the State of Colorado: "All material related to Recipients known to the State and generated by Contractor in conjunction with an awarded Contract is the property of the State and may not be released to the Recipient without written authorization from the State. In no event shall the material be released to the Recipient prior to the Board taking action."

Section 3.2.5 states, "Recipients who require evaluation outside the scope of practice of Offeror, known as Third Party Evaluations, shall be referred to appropriate, licensed, board certified, specialized professionals for a specialized examination to supplement the biopsychosocial evaluation conducted by Offeror." In Section 3.2.8, the following appears: "If at the conclusion of the evaluation, the awarded Offeror has determined the Recipient is not safe to practice, the State shall be notified. The Recipient shall be asked to sign a cease practice agreement between the Contractor and Recipient, which shall be enforced by notification to employer and the State. An appointment shall be scheduled to review and sign a Monitoring Agreement between the Contractor and Recipient. In the event a determination cannot be made of whether the Recipient is safe to practice, the Recipient shall be directed to cease practice, including a cease practice agreement, until a determination can be made. The agreement shall be enforced through notification to the State and notification to the Recipient's employer or practice supervisor"

The Successful Offeror is required to comply with HIPAA in Section 3.6.4 and to comply with the Americans with Disabilities Act of 1990 in Section 3.5.3 The State of Colorado is further intertwined with the daily operations of CPHP or its successor by the provisions of Section 3.5.4 that requires that all publications and forms of the peer assistance program be subject to State approval. Finally, the Successful Offeror agrees to provide testimony in contested cases if requested by the State without compensation.

In the event that RFP-SJAA 2019-101 selects a new contractor, Section 3.10.2.1 denies the payment of transition costs and has the effect of erecting a barrier to new competitors.

Interestingly, CPHP responded to RFP-SJAA 2019-101 (Appendix IV)and was told it was a "non-responsive bidder." The RFP, the notification correspondence, and further communication about this bid determination are appended to this testimony. The February 1, 2019 letter from Colorado DPA deemed the CPHP bid as non-responsive because of a question about ownership of the products produced by CPHP pursuant to the contract and because of the requirement that the bidder agree to release

all medical records, including those from outside sources, to the State of Colorado per RFP section 3.2.6

DORA has been the subject of a CORA inquiry regarding CPHP sole source authorization and compliance with Colorado Open Meetings in drafting the RFP requirements including sole-sourcing. That correspondence is appended. (Appendix V)

The basic concern about the operation of CPHP is that DORA and CMB influence have transformed it into what amounts to a state agency rather than a contractor. As a state agency, it has the basic obligations of due process in dealing with disputes with recipients of its services. Those obligations can be distilled down to the obligations to hold a hearing and the obligation to give notice of that hearing. Moreover, if CPHP is a state actor in all but name and takes actions under color of state authority to deprive persons of civil rights, it is susceptible to claims under 42 U.S.C. § 1983.

CPHP is free to select "acceptable" third-party providers, including out-of-state regional referral centers without specifying any criteria as to what it considers acceptable. The influence of ASAM and FSPHP makes it a matter of legitimate concern whether it considers only "like-minded docs" to be acceptable. As far back as 2004, the RFP's for physician peer assistance services have sought only a single vendor. The State of Colorado authorized CPHP as a sole source in 2014 and RFP's have shown a steady increase in DORA performance demands so much so that CPHP cannot make a credible claim to be anything other than a state actor.

However, as recently as 2015, CPHP, represented by the Colorado Attorney General, claimed that it was not susceptible to CORA inquiries that cover both public and quasi-public entities in Colorado. A legal framework for testing what comprises such a Colorado entity has emerged from the Colorado Court of Appeals in *Denver Post Corporation v. Stapleton Development Corporation* 99CA1260. CPHP meets all the test requirements specified in this decision. It is noteworthy that CPHP is such an exception. Another quasi-public agency in Colorado that deals with complex medico-

legal issues, Pinnacol Assurance, is required to hold public board meetings and respond to CORA requests.

Sovereign immunity does not apply to CPHP and DORA does not indemnify CPHP for its possible errors of omission of commission. The physician members of CPHP are not only bound by the contract of CPHP with the State of Colorado but they are also regulated by the same statutes, regulations, and rules as every other Colorado physician. The current arrangement has benefits for both the Colorado medical board and the peer assistance program: CPHP is free to designate certain third party providers as acceptable without accountability or objective standards while the State of Colorado would have no legal basis for designating a third party of their choice to be the final word on the "fitness for duty" of a particular physician. The Colorado Medical Board gets the advantages of a private actor to act as a conduit for protected health information that is at once diagnosing physician, treating physician, and forensic physician in a way that the State of Colorado could not do itself. Questions about the mishandling of protected health information on the part of CPHP, and any damages arising from misuse or unauthorized disclosure, fall on CPHP for which the State of Colorado takes no responsibility. CPHP may be able to hope it can rely on the bid solicitations and contracts with the State of Colorado in order to deflect claims but there is no certainty about the effectiveness of such legal defenses. Indeed, the increasingly risky demands from DORA, as manifested in the 2004 to 2019 peer assistance program RFP's statements of work and proposal requirements, could only arise in an environment in which an FSPHP-modelled program has nowhere else to vend its services and in which DORA absolves itself of any misdeeds of the physician peer assistance program.

III- The CPHP Model For Handling Protected Health Information

CPHP reserves to itself the power to determine which third party health providers will receive its referrals and, in turn, those third parties must agree to turn over their medical records not only to CPHP but also to the State of Colorado where they are beyond the reach of the evaluated physician. However, CPHP has a general duty and a contractual duty to

abide by HIPAA as do any third party vendors. Therein, a significant conflict arises. If a fundamental characteristic of the acceptability of a third-party healthcare provider to CPHP is that they make their authorizations for medical records release "transitive" to the State of Colorado then those vendors must run the risk of their protected health information release authorizations being held to be coerced, unconscionable, or otherwise invalid. While these vendors may choose to make transitive their medical record releases, they will discover that the liability for improper medical records releases is intransitive.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") sets in federal statutes the Privacy Rule (Appendix VII) in an attempt to standardize the balance between the privacy rights of patients and the business necessities of healthcare providers. The Privacy Rule applies to all the enumerated types of personally-identifiable health information with psychotherapy notes receiving an elevated level of statutory protection. In general, the Privacy Rule requires patient permission that may be obtained by asking the individual outright, or by circumstances that clearly give the individual the opportunity to agree, acquiesce, or object. When CPHP mandates that a recipient of services be evaluated and treated by an "acceptable third party" who will only see patients who agree to transitive medical records releases of all data, including psychotherapy notes, or else face sanction, that release is coerced. Moreover, an incidental or occasional vendor of third party consultative services to CPHP (paid for by the evaluated physician) would have legitimate grounds for believing that the circumstances of such a record release are improper and violate the terms of a physician-patient relationship or are unethical, improper, or illegal in some other fashion. It is very likely that mainstream third party healthcare providers would consider that disclosure of protected health information to CPHP outright negligent under the terms of the most recent bid solicitation for Colorado physician peer assistance services.

IV-The Clinical-Forensic Divide in Physician Peer Assistance Programs

The physicians in the employ of CPHP are bound by the same norms as every other Colorado physician. I believe that the canonical documents are those that describe the shared conception of the physician-patient relationship that the Colorado Medical Board promotes as normative. This view, expressed in CMB Rule 40.3, underwent an important change in August 2015. The versions in effect before and after 2015 are presented here:

40-3 Policy Statement Regarding the Physician/Patient Relationship
Date Issued:
11/13/97
Date(s) Revised:
7/1/10
Purpose:
To clarify the Colorado Medical Board's position concerning the physician/patient relationship
POLICY: The following statement reflects the policy of the Colorado Medical Board regarding the physicians it licenses.

A Colorado physician has both medical-legal and ethical obligations to his or her patients. These are well established in both law and professional tradition. The prevailing model of medical practice, as it is implemented by some plans, may result in an inappropriate restriction of the physician's ability to practice quality medicine. This may create negative consequences for the public. It is incumbent that physicians take those actions they consider necessary to assure that the procedures in question do not adversely affect the care that they render to their patients

Without regard to whether an act or failure to act is entirely determined by a physician, or is the result of a contractual or other relationship with a health care entity, the relationship between a physician and a patient must be based on trust and must be considered inviolable. Included among the elements of such a relationship of trust are:

- Open and honest communication between the physician and patient, including disclosure of all information necessary for the patient to be an informed participant in his or her care.
- Commitment of the physician to be an advocate for the patient and for what is best for the patient, without regard to the physician's personal interests.
- Provision by the physician of that care which is necessary and appropriate for the condition of the patient and neither more or less.
- Avoidance of any conflict of interest or inappropriate relationships outside of the therapeutic relationship.

The relationship between a physician and a patient is fundamental, and is not to be constrained or adversely affected by any considerations other than what is best for the patient. The existence of other considerations, including financial or contractual concerns is and must be secondary to the fundamental relationship.

Any act or failure by a physician that violates the trust upon which the relationship is based may place the physician at risk of being found in violation of the Medical Practice Act.

40-3 Policy Statement Regarding the Provider/Patient Relationship
Date Issued: 11/13/97
Date(s) Revised: 7/1/10; 8/20/15
Purpose: To clarify the Colorado Medical Board's definition of, and position concerning the provider/patient relationship
POLICY: The Colorado Medical Board ("Board") adopts the following policy regarding the provider patient relationship:
The Board defines "Provider" to include licensees regulated by the Board and the "Provider-Patient Relationship" as the mutual understanding, between a provider and patient, of the shared responsibility for the patient's healthcare. This relationship is established when:

A. The provider agrees to undertake diagnosis and treatment of The patient, and the patient, or a medical proxy for the patient, agrees to be treated- whether or not there has been an in-person encounter between the patient and the provider; and,

B. The provider:

i. Verifies and authenticates the patient's identity and location;

ii. Discloses his or her identity and applicable credential(s) to the patient; and,

iii. Obtains appropriate informed consent after any relevant disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telehealth technologies.

A "Provider-Patient Relationship" has not been established when either the identity of the provider is unknown to the patient or the identity of the patient is not known to the provider.

Further, the Board finds the relationship between a provider and a patient is fundamental, and is not to be constrained or adversely affected by any considerations other than what is best for the patient. The existence of other considerations, including financial or contractual concerns is, and must be, secondary to the fundamental relationship. Prevailing models of medical practice may result in an inappropriate restriction of the provider's' ability to practice quality medicine, creating negative consequences for the patient. It is the expectation of the Board that providers take those actions they consider necessary to assure that the procedures in question do not adversely affect the care that they render to their patients.

The first version of the CMB norms for a physician-patient relationship embodied in Rule 40.3 declare a positive duty of patient advocacy on the physician. The later version no longer expresses such a view and disconnects failure to advocate from any CMB sanctions.

A simpler version of these norms, now being re-discovered, was stated by Dr. Francis Peabody and reads, "the secret of the care of the patient is in caring for the patient". Peabody, Francis (1927). "The care of the patient". JAMA. 88 (12): 877–882

One might ask about encounters with a physician that are intended to establish facts or findings rather than to treat the patient. Modern societies have needs for this type of encounter and special norms needed to be developed that govern this type of encounter. As a group, these are considered **forensic** encounters and different rules have been adopted by the organizations that speak for physicians who do this type of work.

A succinct example is published by the American Board of Independent Medical Examiners (ABIME):

Guidelines of Conduct

Each physician certified by the American Board of Independent Medical Examiners (ABIME) is expected to comply with these guidelines of conduct. Accordingly, each physician should:

1. be honest in all communications;
2. respect the rights of the examinee and other participants, and treat these individuals with dignity and respect;
3. at the examination:
    a. introduce him/herself to the examinee as the examining physician;
    b. advise the examinee they are seeing him/her for an independent medical examination, and the information provided will be used in assessment and presented in a report;
    c. provide the examinee with the name of the party requesting the examination;
    d. advise the examinee that no treating physician-patient relationship will be established;
    e. explain the examination process;
    f. provide adequate draping and privacy if the examinee needs to remove clothing for the examination;

g. refrain from derogatory comments; and
h. close the examination by telling the examinee that the examination is over and ask if there is further information the examinee would like to add;

4. reach conclusions that are based on facts and sound medical knowledge, and for which the independent medical examiner has adequate qualifications to address;
5. be prepared to address conflict in a professional and constructive manner;
6. never accept a fee for services which is dependent upon writing a report favorable to the referral service;
7. and maintain confidentiality consistent with the applicable legal jurisdiction. [emphasis added]

A simple summary of these rules is that a forensic examiner has the duties to disclose the non-existence of a patient-physician relationship and to avoid injuring the patient. Similar versions of these rules are published by the American College of Physicians, The American College of Occupational and Environmental Medicine, The International Commission on Occupational Health, and the American Psychological Association. All are appended. (Appendix VI)

The basic thrust is that both forensic and clinical encounters can be conducted under generally-accepted non-overlapping rules. A clinical encounter or relationship and a forensic encounter or relationship are fundamentally different and impose different obligations on the examiner.

Understandably, patients will usually assume that a physician encounter is bound by the usual expectations of a physician-patient relationship. This is the default. That is the principal reason that the obligation to disclose that the nature of an encounter is limited to forensic examination only applies in certain circumstances. The default expectation is almost always correct for patient-physician encounters.

The duty to avoid injury is common to both sets of rules; although, a physician and patient can jointly agree to undertake a course of diagnosis or treatment that poses patient risks if the stakes warrant while invasion or risk are generally avoided in forensic examinations. The duty to be honest is shared. The rules of disclosure and the rules to be a patient advocate could not be more different. This leads to the generalization that a

physician cannot have both a forensic and a clinical relationship with the same patient.

The CPHP scope of services provided to Recipients involve diagnosis, treatment, and referral for treatment. This is a clinical scope of services. But CPHP also performs "fitness for duty" examinations that have the force of regulation and take into account the general public welfare. This is clearly a forensic examination and determination. A physician cannot be intermittently forensic and clinical with the same patient and the duty to warn applies to forensic encounters. CPHP does not recognize the existence of this "separation of powers" and is intrinsically structured to violate these norms.

V-The Americans with Disabilities Act of 1990 and PHP assessments of Fitness For Duty

About one half of the US physician population is formally-designated as employees. As much as another quarter has working relationships that amount to "functional employment".

The Americans with Disabilities Act of 1990 (ADA) is generally regarded as having the intention of including persons with disabilities in the mainstream of society. It is prominent among US 20th century statutes that sought the expansion and definition of basic civil rights.

There are types of mandates in the ADA: employment, public entities, and public accommodations. After nearly three decades, the case law is extensive. Unsettled areas include the range of its applicability to state actors and regulatory agencies with a licensing function. That said, it is noteworthy that CPHP maintains that it is not a state actor.

While volumes have been written on ADA case law and applications to a variety of circumstances, the focus in this testimony is the consensus rules

that apply to mandated medical examinations for persons currently in the employ of an individual or corporation.

CPHP documents attached to the appendices and the RFP's for PHP services describe various mechanisms by which a physician may be referred to CPHP. The referral itself is not appealable. However, the ADA rules on mandated medical examinations of current employees are substantially different.

Under the ADA, an employer may require an employee to undergo a medical examination (and/or inquiry) if it is job-related and consistent with a business necessity. 42 U.S.C. § 12112(d)(4); 29 C.F.R. § 1630.14(c) and under case law if he or she is thought to pose a "direct threat" Sands v. Runyan (2nd Cir. 1997)1997 U.S. App. LEXIS 32228. According to the Interpretive Guidance issued by the Equal Employment Opportunities Commission (EEOC), this regulation permits employers to require a fitness for duty exam when there is a need to determine whether an employee is still able to perform the essential functions of his or her job. 29 C.F.R. Pt. 1630, App. In order to legally require an employee to submit to a fitness for duty examination, the employer must have a reasonable belief, based on objective evidence, that either 1) the employee's ability to perform his or her essential job functions is impaired by a medical condition or 2) the employee poses a direct threat to safety of others due to a medical condition.

According to the Ninth Circuit Court of Appeals, "when health problems have had a substantial and injurious impact on an employee's job performance, the employer can require the employee to undergo a physical examination designed to determine his or her ability to work, even if the examination might disclose whether the employee is disabled or the extent of any disability." Yin v. California (9th Cir. 1996) 95 F.3d 864.

The Sixth Circuit Court of Appeals has more recently stated the test this way: "for an employer's request for an exam to be upheld, there must be significant evidence that could cause a reasonable person to inquire as to

whether an employee is still capable of performing his job." Sullivan v. River Valley School District (6th Cir. 1999) 197 F.3d 804.

In limited circumstances, the law may even mandate fitness for duty examinations. Indeed, the EEOC's Interpretive Guidance recognizes that the ADA permits periodic physicals to determine fitness for duty or other medical monitoring if such physicals or monitoring are required by medical standards or requirements established by federal, state, or local law. The following are some examples of instances when fitness for duty examinations are required: OSHA requires that employees exposed to certain hazardous substances be periodically monitored (29 C.F.R. § 1910.1001(d)(e)); OSHA requires that employees who wear respirators must undergo a medical examination to ensure that the employee may safely wear a respirator (29 C.F.R. § 1910.134(e)); mandated drug testing for employees who operate commercial vehicles. See, e.g., 49 CFR Part 383.

In general, an employer is only permitted to receive information about an examined employee's ability to perform the essential functions of the job, with or without reasonable accommodations. Further disclosure is not permitted.

Notably, state laws can amplify and extend the ADA rules on employment. California's Confidentiality of Medical Information Act (CMIA), California Civil Code § 56.10, et seq., is the most prominent example and California is the largest state to lack an FSPHP model physician peer assistance program.

Unless a health care professional is regularly called upon to treat a specific group of employees (e.g., a police department may regularly send officers to a particular physician for fitness for duty examinations), he or she may not have the requisite knowledge of a position to know what the essential functions of the job are, let alone make a determination that an employee can or cannot perform those functions. The solution to this problem is simple. Nothing in law prohibits an employer from providing a health care provider with a detailed job description, or even an opportunity to visit the

job site to see how the job is performed. Work site visits are considered occupational medicine "best practices" but are not included in the CPHP scope of services.

Employers of physicians are not obligated to use CPHP services in order to make fitness for duty determinations. In almost every instance, employer-mandated fitness for duty examinations are paid for by the employer. Physicians subjected to such examinations by their employers are in a position to object that the records of such an examination be made property of the State of Colorado as well as on other grounds. CPHP cannot claim a monopoly on the provision of physician fitness for duty examinations in Colorado and other policies or requirements to the contrary are likely to be found violations of ADA.

VI-Marketing Trends in AA/NA/12 Step Programs

The 12-step programs proposed by Ruth Fox MD in the 1930's have fierce proponents and fierce detractors. The objective evidence for the efficacy of these programs is small in proportion to the widespread support for these programs. This testimony will steer clear of that controversy except to say that 12 step programs do not have a monopoly in the diagnosis or treatment of addictions, substance use disorders, or "process addictions".

More than one model of reasonable diagnosis, classification, and treatment of these disorders is accepted by the medical community and the Colorado Medical Board has no basis in fact for offering only a single model.

VII-The Role of Coercion in Treatment

PHP's in the FSPHP model universally claim that they have great success rates because of their access to "leverage" with state medical boards. The claims of high success rates have been criticized in the medical literature and the terms of the recent RFP's for physician peer assistance services offered by the State of Colorado show that the threat of disclosure to the Colorado Medical Board is a "moot point". Full disclosure to the

Colorado Medical Board by CPHP can be made in any circumstances deemed appropriate by CPHP in perpetuity.

Coercion in psychiatric diagnosis and treatment is also questionable on professional ethical grounds. The American Psychological Association (APA) in Ethical Principles Of Psychologists And Code Of Conduct (appended) discusses the mandatory nature of informed consent for treatment, the duty to report limits of confidentiality, and a duty to not torture among scores of other ethical constraints.

VIII-PHP's, Medical Boards, and Anti-Trust Injuries

Traditionally, state medical boards have been understood to enjoy immunity from antitrust claims under doctrine derived from Parker v. Brown, 317 U.S. 341 (1943). This immunity, as applied to private entities operating under color of state authority, was limited in California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97 (1980) unless there was a showing that their conduct is (1) taken pursuant to a "clearly articulated and affirmatively expressed . . . state policy" and (2) "'actively supervised' by the State itself." This immunity limitation was extended to state professional licensing agencies in North Carolina State Board of Dental Examiners v. FTC, 135 S. Ct. 1101 (2015) when the Supreme Court held that in order to obtain antitrust immunity, a state agency must be actively supervised by the state if "a controlling number of [its] decision-makers are active market participants in the occupation the board regulates." In summary, a regulatory agency board that restricts entry into a market and is comprised of active market participants in said market must be subject to active state supervision in the performance of their official duties or else be liable to claims they acted to restrict competition in an illegal fashion.

The Colorado Medical Practice Act states that the composition of the Board of Medicine requires that a majority of members be actively-licensed. C.R.S. §12-36-123.5 creates a physician peer assistance program in Colorado supported by money collected from licensed physicians and

others and held as "custodial funds". Colorado physicians are deprived of choice of peer assistance program providers by the actions of the physician members of the Colorado Medical Board in awarding only a single contract just as they are deprived of the right to compete in the provision of these services supported by collected custodial funds. The Colorado Medical Board illegally restrains competition under the Sherman Act (15 U.S.C. sec 1-38) in a medical sector by of their administration of C.R.S. §12-36-123.5.

Of note, this claim is supported by documentation alone. Colorado state claims of immunity for physician medical board members do not supersede federal anti-trust statute and such an understanding of the current state of affairs is a legitimate concern for physicians who may wish to serve on the Colorado Medical Board.

IX-Negligent Referral

In light of the extensive criticisms of FSPHP-modelled physician peer assistance programs in the academic medical literature (appended) and medical press, a physician who refers a colleague to CPHP may still be susceptible to claims of negligent referral even if the act stems from good intentions.

X-Scope of PHP Practice Competency

Apart from administrative personnel, the staff of CPHP is comprised of persons with training in psychiatry and psychology. However, the scope of services in the bid solicitations for peer assistance services and fitness for duty examiners calls for competence in a wide variety of medical disciplines that are nowhere represented in the current CPHP staff. As constituted, CPHP is unable to address the vast majority of somatic causes of impairment and does not even have formal expertise in occupational medicine.

XI-The "Safe Harbor" Illusion and Truth in Advertising For PHP's

The progression in the language of the RFP's for physician peer assistance services shows that the notion that CPHP provides a "safe harbor" for

physicians seeking help without interacting with the Colorado Medical Board is unsupported by the facts. Any record created by CPHP can become the property of the State of Colorado and the decision to make such a record state property in an unreviewable decision of CPHP alone.

Any claims about the helpfulness of CPHP (Appendix I) must be tempered by a disclosure of these basic facts of CPHP's mandates under contract.

XII-Adverse Outcomes Related to PHP's- The Limits of the Data

The early days of PHP's were associated with scandals regarding physician suicides. The Talbott Recovery Center in Georgia was associated with a cluster of suicides reported in the lay press.

> "At least 20 doctors, nurses and other health professionals who have gone through the Ridgeview Institute's nationally acclaimed treatment program over the past 12 years have killed themselves since leaving the hospital."
> — Atlanta Journal Constitution

However, commonly-accepted standards for medical case series or epidemiology-based risk assessments are lacking in the reports of the association of state PHP programs with physician suicide. So far, little beyond anecdotes exist and reporting bias and misclassification errors are impossible to assess.

A personal communication was directed to Pam Wible MD (idealmedicalcare.org) about any apparent association of PHP involvement in her series of nearly 1300 physician suicides. At least for CPHP, no conclusions could be drawn. Point 10 of the spoken testimony section (*vide supra*) emphasizes that the principal adverse health effects of PHP's on physician may result from missed opportunities rather than from commission.

Disclaimer: The facts and opinions in this testimony should not be construed to constitute legal advice or legal opinion.