Comments on WSMA Resolution B-2 (A-19) “An Ethical and Effective Physician Health Program for Washington” submitted by Louise B Andrew MD JD

**Summary of Comments**

* WPHP and WMC operate closely in tandem both contractually, and under State Law
* Comprehensive statistics on WPHP should be readily available and easily retrievable
* Compliance with evidence based standards and Federal law by WPHP in dealing with Washington physicians should be a Given, yet it is not
* Currently publicly available standards DO NOT comply
* Recently promulgated internal FSPHP PEER “Guidelines” may not comply with ADA and were arrived at by interested parties to maintain the status quo
* WA Physicians should not be destituted by unnecessarily restrictive out-of-state inpatient evaluation or treatment, or removed from practice unnecessarily
* An effective appeal process from erroneous diagnosis must exist
* Physicians do NOT actually occupy “safety sensitive” positions under law. This is a false construct being repeatedly used by individuals and organizations such as FSPHP/ASAM that wish to promote drug testing in the workplace without cause.
* A fundamental right to due process should not be abridged by PHP coercive contracting with naïve participants who are led to believe that their best interests are being protected. Physician employers should provide details of malpractice liability coverage to all employed physicians; Liability insurers should offer protection from indirect licensure actions triggered by PHP reporting; and physicians without such current coverage should be educated about the benefits of securing such coverage

**Conclusion: The Resolution Asks Only that Current WPHP Policies be Transparent and Compliant with anti Discrimination Law; that Physicians are not Financially Vanquished or forced into non Evidence-Based Treatment for diagnoses that may be in error without the possibility of meaningful review and appeal; and that Physicians be Advised to Determine in Advance whether their Liability Insurers provide for Protection against Indirect Licensure Deprivation without Due Process**

* Washington physicians deserve to know how effective the PHP which they finance with licensure fees actually is, by virtue of easily accessible, accurate and comprehensive statistics including suicides. They deserve transparency in PHP processes and outcomes, so as to be assured that the agency which they are supporting via licensure surcharges operates ethically.

* Washington physicians enrolled in their PHP are entitled to receive due process as well as agency treatment that is in compliance with the ADA and other federal laws, and to diagnostic and treatment services that comport with current verifiable, evidence-based standards, and not merely to self serving internally created “guidelines” promulgated by organizations with ties to the $34B drug treatment and $12B drug testing industry. Currently available evidence suggests that they are receiving neither. Proposed policies reportedly will continue the status quo.

* Washington physicians deserve to have legal representation before entering into a process that can deprive them of licensure if they are wrongly diagnosed, refuse to participate in non standard care or unnecessarily restrictive treatments and/or unjustifiably prolonged monitoring mandated by the WPHP, sometimes for conditions that they do not actually have, as well as access to a timely mechanism for impartial review and appeal. Employed physicians should be educated to inform themselves about their existing liability insurance coverage (as is their right) against various types of practice related liability, and advised to consider the desirability of obtaining additional coverage if necessary for licensure defense against adverse regulatory actions.

**While Separate, WPHP and WMC are Close Partners**

The Reference Committee should not be sidetracked by the common confusion among physician licensees about the complicated relationship between a physician health program (PHP---here WPHP) and its corresponding medical licensure board (MLB---here WMC). These two agencies, while distinct, are mutually symbiotic in nearly every state. The MLB divests itself of the messy business of dealing with potentially “sick doctors”, by deferring management of physicians with potential health related concerns (who have not been reported to the MLB for conduct that could affect patient safety) exclusively to the PHP for triage and control of assessment and treatment/monitoring, and then allowing the PHP to independently continue to assess, direct treatment and monitor without reporting the individual physician back to the MLB if (and only if) physician compliance with PHP “recommendations” is absolute. In return, MLBs discipline those whom the PHP deems to be non-compliant, in the only way it can without having to perform anew the work of its delegatee PHP, usually by taking adverse licensure action.

The PHP uses this threat of reporting “noncompliance” to the MLB and the likelihood of subsequent adverse licensure action quite effectively to compel absolute adherence to their terms, a system called “contingency management”, that was adopted directly from the criminal justice system. Contracts of adhesion are extracted from naïve participants early in the process, conditioned on threat of MLB reporting and likely licensure action, creating an impression that there has been voluntary consent to the release of protected health information both to the PHP, and subsequently to the MLB if there is deemed “non-compliance” (in **any** respect) with the demands of the PHP. However, consent extracted under such duress is not indeed voluntary.

The result of this relationship is that the MLB doesn’t have to get bogged down in medical decision-making, and the PHP can claim to be supportive and “non punitive” in its actions. It is in fact a contractually negotiated and regulatorily enshrined ***quid pro quo*** between the MLB and the PHP. Physicians who become caught up in the system without legal advice as to the rights they are relinquishing or the financial, social and practical costs they are entering into by becoming PHP participants, have despaired to the point of suicide.

**Statistics on WPHP Should be Readily Available and Easily Retrievable**

The resolution calls for independent tracking of Washington Physician

Health Program enrollee physicians for 10 years, to provide numeric data on how many are alive and actively practicing, to document honest and non-coercive feedback from physician clients, and to specifically enumerate physician suicides among participants.

The current director of the WPHP has stated that these statistics are readily available from the DOH. However, one of makers of the resolution has found that despite the requirements of the WA Public Records Act that there is a cost associated with the release of such statistics by the Medical Commission, and that there is a several month delay in releasing same. Given that the WPHP is 70% financed from physician licensure fees, statistics relating to its purported effectiveness and safety should be available as soon as they are received by the DOH from the PHP, at the very least to licensed physicians and to news media and other patients WA physicians serve, upon request, and at minimal or no charge since they can readily be transmitted electronically. Given that the statistics are already compiled as a DOH imposed contractual obligation of the WPHP, there is absolutely no excuse for a delay in their release. Mere assertions about the remarkable purported effectiveness and safety of the program, by anyone, absent statistics, are fairly unconvincing.

The 2005 published WA study referenced as evidence of the program’s effectiveness solely pertains to participants in the 1990s with (hopefully verified) SUD. Most of the other cited research from a single dataset generated by DuPont, McLellan, Skipper, and other proponents of the ASAM “Blueprint for Recovery” (promulgated by those who profit continuously from extensive drug testing espoused by that Blueprint) is not statistically valid because there was no clear verification of the existence of SUD in enrollees, no control group, the study used sobriety as the only endpoint, and did not account for the numbers of physician enrollees who dropped out, were lost to suicide, or simply lost to follow-up. The WPHP, like many other PHPs, has vastly broadened its target market to include many other conditions besides SUD, so “relapse rates” from SUD as reported in the now nearly 20 yr old WPHP study are only tangentially relevant. Reportable statistics from the present day WPHP should also include data regarding the frequency with which appeals of PHP findings are made and the outcomes of such appeals, **especially** in cases of alleged misdiagnosis.

**Compliance with Evidence Based Standards and Federal Law by WPHP in dealing with Washington physicians should be a Given, yet, it is not**

**Currently Publicly Available Standards DO NOT comply**

The resolution further calls for the WSMA to advocate for the establishment of national standards for PHP treatment including ADA compliance in evaluation, diagnosis, and management. The Federation of State Medical Boards (FSMB, the trade association representing state medical licensure boards) has, with very substantial consultation and input if not ghostwriting from the Federation of State Physician Health Programs (FSPHP, the trade association representing state physician health programs), based largely on FSPHP 2005 Guidelines, adopted an Impairment Policy (<http://bit.ly/FSMBImpairmentPolicy>) in 2011 that pertains to evaluation, diagnosis and management of physicians who are alleged to have what is loosely called “potential for impairment”. This policy does NOT establish a national standard for PHP management, let alone treatment. Further, the FSMB Impairment policy makes no mention of the ADA except in two unattached references; and the Nondiscrimination Statement referenced in the policy tellingly omits any mention of disability. This ends-driven and highly flawed policy contains many questionable provisions.

Among these, the policy states

“A PHP should be empowered to conduct an intervention based on ***clinical reasons suggestive of potential impairment***.”

Despite using the term frequently, nowhere does the policy define “potential impairment”. The policy continues,

“Unlike the board, which must build a case capable of withstanding legal challenge, a PHP can quickly intervene based on a reasonable concern.”

But nowhere does it define “reasons suggestive of potential impairment” or “reasonable concern”.

As another example, one highly questionable definition of “relapse” contained in the policy (Section III Item 9 p 9) is

“behavior having the potential to impact public safety: Level 1 Relapse: Behavior **without chemical use** that is ***suggestive of impending Relapse***.”

Under this definition, a physician who has been regarded by the PHP as having a substance use problem (without necessarily meeting DSM criteria for an SUD diagnosis, but simply labeled as having subjective “potential impairment”) can be reported to the licensing authority for “substantive non compliance” for NON substance use, NOT otherwise defined, that is somehow deemed to be **“*suggestive of impending relapse*”**. This has, according to some participants, included such behaviors as drinking ginger ale from a champagne glass, or not complying with any one of a number of other monitoring and reporting obligations (such as AA meeting attendance and frequent random witnessed drug and alcohol testing by a person not suffering from a Substance Use Disorder) imposed on a licensee who has been labeled as being “potentially impaired” by purported substance use without meeting established medical criteria.

Following guidelines promulgated by FSPHP/ASAM, PHPs randomly test all participants for substances including alcohol, actively promote lifelong abstinence in all participants, and may frequently mandate monitoring when only legal substances are detected or when NO substances are detected, but the participant is deemed to have a condition such as anxiety or depression in which, according to the PHP, any substance use “might prove detrimental” to recovery. Such monitoring typically lasts for 2-5 years, is costly, inconvenient, and embarrassing. It also prohibits travel.

The FSMB Impairment policy has been deemed by one national legal authority on the ADA to show a complete lack of awareness of the ADA, let alone compliance with this federal law plainly applicable to both PHPs and MLBs as public accommodations (Title III) and/or state agencies (Title II) and possibly also as employers (Title I). (<http://bit.ly/PHPsMLBsDisregardADA>)

**Recently Promulgated FSPHP “Guidelines” may not comply with ADA and were composed by Interested Parties in order to maintain the Status Quo**

The FSPHP itself has as yet made freely available for inspection no such national standards. They are however promulgating newly minted “Physician Health Program Guidelines” to members, to be used in FSPHP performed “peer review” of PHP operations, almost certainly in response to a 2015 audit of the North Carolina PHP that showed potential for widespread abuse of participants through complete lack of due process protections. The NC auditor was quoted as stating that the “holes in [that] program were so big you could drive a truck through them.” She said doctors could find it difficult, if not impossible, to defend themselves against an incorrect assessment because they were not allowed to appeal a diagnosis or assessment to the medical board. (“Physician Health Programs Under Fire” BMJ 2016;353:i3568) WA state, emulating NC, denies physicians copies of their PHP generated medical and monitoring records with which participants might wish to mount an appeal against erroneous findings or conclusions contained therein.

PHP proponents and leaders have proudly proclaimed in numerous publications that there is a tremendous advantage to MLBs’ delegation of “potentially impaired” physicians to PHPs in that “PHPs are not constrained by due process and other legal impediments to action… However, in most cases, physicians comply with PHP recommendations to avoid the risk of formal notification of the board.” (Skipper G, DuPont R. Chapter The Physician Health Program: a replicable model of sustained recovery management. In: Kelly J, White W, eds. Addiction Recovery Management: Theory, Research and Practice; Current Clinical Psychiatry; Humana Press; 2011:283.)

It is this very lack of due process inherent in PHP operations in the absence of legal representation that the third Resolved attempts to help Washington physicians to address. It seems clear from numerous reports that a complete lack of due process prevails in most PHPs, due to naïve faith by entrants that the PHP system is supportive and protective, coupled with a complete lack of oversight (by anyone) of diagnostic processes employed by exclusive PHP- designated facilities. This is a recipe in WA, for the potential abuses that were described in the NC audit.

The FSPHP promulgated peer review process (PEER) that is poised for implementation in 2020 (likely to be first implemented in Washington) is not freely available from FSPHP as of this comment. If anyone is pointing to this internally generated review process as evidence of “national standards” for PHPs, then the policy should certainly be freely available for critical review. Almost certainly generated by PHP and FSPHP/ASAM operatives, without any evidence suggesting meaningful legal review by any disinterested third party, preliminary analysis is that, like the 2011 FSMB Impairment Policy, the PEER document/process is completely devoid of any evidence of awareness of, or compliance with, the ADA and other applicable antidiscrimination laws. See, e.g. http://bit.ly/PEERviolatesADA

**WA Physicians should not be Bankrupted or Removed from Practice Unnecessarily**

The resolution also calls for the WSMA to advocate for PHP policies supporting that treatment recommendations must be timely, and not cost-prohibitive. PHP proponents and leaders have published that direct costs for PHP directed treatment can average between $250-$312K, (DuPont R, Merlo L. Judges Journal 2018;57(1:32-35)), costs that are almost never covered by participating physicians’ health insurance policies because the medical criteria for diagnosis of purportedly impairing conditions (frequently SUD) are often not met. To bill insurance for drug rehabilitation or mental health treatment in the absence of criteria for diagnosis would constitute healthcare fraud, which is conveniently avoided by demands for cash payment up front by “preferred centers” that are the exclusive evaluators for WPHP. These are all out-of state, because of the unsupported claim by the PHP that “multidisciplinary” evaluation is required of physician clients whose intellectual capabilities would exceed the ability of any instate provider(s) to accurately assess physician patients.

And these estimates, of course, are only direct costs. Lost work productivity during mandated out-of-state inpatient treatment programs typically lasting for 90 days add substantially to the real costs to individuals. This does not even begin to address the issue of advocacy costs, societal and familial costs, lost opportunity costs, travel and inconvenience for testing and restriction of travel for testing, re-entry costs, and the ultimate costs of reinstating board certifications if removed by reason of encumbered licensure.

**An Effective Appeal Process from Erroneous Diagnosis Must Exist**

The resolution also calls for a mechanism for meaningful appeal of PHP decisions. Such a mechanism may be on the horizon, if the WPHP has followed or does follow the lead of the NC PHP in creating a review mechanism. If such exists in WPHP, it has not been publicized, and will not be known until and unless the WPHP undergoes a publicly disclosed “PEER” evaluation, AND if the PEER policy contains any such provision. Participants must of course be informed of the existence and mechanics of such an appeal mechanism if it is to have any meaning. And even if an INTERNAL review mechanism exists, there is still great potential for bias when there is no disinterested external party or authority involved in the appeal mechanism, and no opportunity for aggrieved participants to submit an independent fitness for duty evaluation by qualified individuals who have no connection to the PHP, as is currently the case in Washington. Furthermore, WPHP participants are denied access to their own evaluation, treatment and monitoring records, which makes challenge of erroneous information and diagnoses exceedingly difficult or impossible, even if an appeals process exists.

**Liability Insurers should offer protection from Indirect Licensure Actions Triggered by PHP reporting of conditions that may not be Exist, or be accurate; Employed physicians are entitled to details about their Liability coverage and have the opportunity to purchase additional coverage if regulatory action coverage is omitted.**

Last, the resolution directs that the WSMA educate physicians that their malpractice insurance may not cover defense against regulatory actions, and encourages them to be informed about coverage for such actions, especially if they are employed. Physicians have a right to know the extent of their liability coverage BEFORE it is needed, and physician employers have no basis for denying physicians knowledge of or access to their policies. Physicians whose insurers do NOT routinely provide such coverage have the option of seeking additional coverage for regulatory actions or changing employers or insurers to those who do cover such contingencies. Regrettably, reports suggest that most employed physicians, and notably trainees, are blissfully unaware of their potential for disciplinary action until after it is threatened, and need to be informed regarding obtaining legal defense resources in the event they are referred for involuntary PHP treatment, for the protection of their civil, due process, and antidiscrimination rights.

Individual liability policies often contain provisions or riders covering professional licensure defense in disciplinary proceedings that are not criminal in nature. Many of these however deny coverage for what are deemed to be non-disciplinary proceedings. Defense of license in cases of purported “substantive noncompliance” with PHP recommendations lies in a gray area because physicians can avoid disciplinary action by complying with all recommendations of a contingency contract with the PHP. However, if a contingency contract has been imposed following a flawed diagnostic process, or treatments are mandated that are not governed by evidence based medicine or recognized standard of care criteria for diagnosis, then physicians should have the right to contest the terms with the imposing agency at any point that they realize that they may have been diagnosed, treated, or reported erroneously.

When a physician’s income stream has been interrupted by unnecessary and/or unduly prolonged out of state inpatient rehabilitation or intensive outpatient treatment, they are typically still paying for (or have already paid) malpractice premiums covering a practice that is not even contemporaneously subjecting them or their insurer to liability. It is eminently reasonable that liability carriers should assist physicians to obtain legal representation in order to defend their licenses against disciplinary action that will almost certainly result in the event of reporting of purported noncompliance to the license authority by a PHP that is operating outside of standards of care or defensibility or in contravention of antidiscrimination laws.

**Inaccurate Testimony Proffered in Opposition to the Resolution**

The AMA resolution A19-321 that is so roundly praised in the online Reference Committee as indicative of AMA’s support of PHPs is merely a rehash of a 2009 resolution with the onsite addition of two provisions: first, that the AMA will “continue to work with and support FSPHP efforts already underway to design and implement the physician health program review process…” (the PEER Guidelines document upon which the program is premised was not included in the AMA resolution), and will help FSPHP to obtain even more “seed money” on top of the $65K it has already amassed to foster implementation of this PEER program. This is NOT in fact a formal endorsement of the specifics of the PEER program itself, as has been implied. That Resolved was added on as an un-backgrounded amendment during HOD testimony. There has been no formal analysis of the guidelines by the AMA (this would almost certainly expose the ADA noncompliance).

The second provision is that the AMA will work with FSPHP and other stakeholders on issues of affordability, cost effectiveness, and diversity of treatment options. This latter is not further defined, but it presumably means that AMA should work to ensure that physicians are not destituted by PHP mandated treatment programs that are not covered by medical insurance because participants do not meet relevant diagnostic criteria to justify insurance coverage. It also presumably means that PHPs should not continue to promote or exclusively mandate faith based abstinence only (e.g. 12 Step) programs for physicians with bona fide substance use disorders. In contradistinction to the statement in the Online Ref Committee

“WPHP supports MAT and PHPs were among the earliest adopters of MAT for health pros with OUD. WPHP considers abstinence to include appropriate use of prescribed medications, including MAT/OAT. For opioid use disorder, MAT plus psychosocial interventions is the ‘gold standard’ and this is what WPHP participants receive”,

there has been nothing published by the WPHP or FSPHP in support of MAT for physicians, and several recent publications and broadcasts, including quotes from the WPHP Director at NPR on 9/6/19

“…he points out, the in-patient, non-medication treatment model has been proven to work with many health professionals across several decades, and he worries that changing it could open PHPs up to unnecessary risk.

"Our tendency is to err on the side of caution," Bundy says, "especially when implementing therapies that have the potential to impair somebody's ability to practice safely. Despite the fact that there are many who would like us all to believe that the jury is in [on medications like buprenorphine], more remains unknown than known, especially when it comes to how to appropriately use these medications in safety-sensitive professionals." That includes some other professions, such as pilots, he says — not just health workers. “

(see http://bit.ly/PHPsprohibitMAT ) indicate that use of MAT by physicians in PHPs is generally prohibited based upon liability concerns held by the PHP. Further, there is no evidence that WPHP actually allows for MAT for physicians. The existence or extent of MAT use among physician participants is something that should be included in statistical reporting by the PHP.

**Physicians do NOT occupy a “Safety-Sensitive” Profession**

The current WPHP director in his online Ref commentary backtracks somewhat from his NPR statements saying “WPHP has no prohibition on OAT, though it requires a careful R/B/A analysis given the safety sensitive nature of our work.” Both here and in the NPR commentary he applies the term “safety-sensitive” professionals to physicians. ASAM and FSPHP both proclaim that this purported “safety sensitive” work justifies more draconian treatment of physicians than is afforded to normal citizens (for example, 90 days inpatient when 28 days inpatient or outpatient is the standard of care).

The FSPHP and ASAM both make very liberal use of the false descriptor “safety-sensitive” profession regarding healthcare professionals in every single recent publication, presumably in an attempt to make this a part of the common vernacular and thereby to justify the VERY disparate, extraordinarily prolonged and intensive treatment of physicians who are regarded as disabled (by PHPs), and discriminated against under the ADA, relative to treatment given to other citizens, even airline pilots.

There is no legally cognizable definition of physicians as occupying “safety sensitive” positions. That designation has been applied to airline pilots and federal employees such as nuclear technicians but NOT, for example, even to municipal bus drivers. The ***de novo*** designation of physicians as “safety-sensitive” workers came directly from the American Society of Addictions Medicine, a trade association that is largely composed of those with financial or occupational ties to the drug treatment industry. (ASAM is a progenitor of FSPHP, and leadership of the two organizations is inextricably intertwined. The current president of FSPHP is concurrently president of ASAM).

Even the SAMHSA (federal Substance Abuse and Mental Health Services Administration) does not include physicians in its list of “safety-sensitive” occupations. Under the ADA, the only thing that would allow discrimination (for example drug testing without cause, or extraordinarily restrictive or unusually prolonged ---typically 90 day---inpatient treatment requirements) against physicians based on safety considerations, is evidence of something called “Direct Threat”. Under federal law (ADA), “Direct Threat” can NOT be established by alleging “potentially impairing conditions”. Merely repeatedly claiming that members of a given profession as occupying a “safety sensitive” position in order to discriminate against them certainly does not pass legal muster.

**To Reiterate, Resolution B-2 (A-19) asks only that current WPHP policies be transparent and compliant with anti-discrimination law; that physicians are not Fidestituted or forced into non evidence-based treatment for diagnoses that may be in error, without the possibility of meaningful review and appeal; and that physicians be advised to determine in advance whether their liability insurers provide for protection against indirect licensure deprivation without due process**

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Respectfully Submitted,

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