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Editorial

Physician Health Programs (PHPs): a Flawed System in Need of Reform

Lawrence R. Huntoon, M.D., Ph.D.

Shortly after entering a PHP/treatment center, one is confronted with the realization that the only thing missing is an orange jumpsuit. Polygraphy, excessive and unwarranted testing, false diagnoses to justify prolonged expensive treatments, no ability to contest diagnoses or recommended treatments, and no escape are all emblematic of a highly flawed system. And, the physician inmate is forced to pay for all of this abuse while not being able to work and earn a living. Under these extreme conditions, some have chosen suicide.

In a post by Pamela Wible, "America's Leading Voice on Doctor Suicide," she writes:

> [Some] claim that doctors are sometimes falsely accused and getting help that they don't need. They say the result drains their savings, endangers their licenses, and has even led some young doctors to take their own lives.[1]

The stark reality soon sets in that the participant is essentially owned by the PHP and will be owned by the PHP for years to come under threat of being reported to the medical board for non-compliance, with subsequent loss of medical license.

The serious flaws in the PHP system are well-known to those who have had the misfortune of being sentenced to a PHP to "do their time." However, as most physicians never have contact with a PHP, the flaws are largely unknown and perhaps not considered relevant to their day-to-day lives. After all, they are not alcoholics, drug abusers, or sex addicts; it will never affect *them*.

False Diagnoses Used to Justify Prolonged Unwarranted Treatment

The use of false diagnoses by PHPs is not surprising given the current environment in medicine today. False diagnoses are not exclusive to PHPs. Due to the prevalent third-party-payor system, false diagnoses have become widespread and commonplace. The third-party-payment system, which includes Medicare, Medicaid, and private insurers, is vulnerable to, if not inviting of, false diagnoses so as to secure coverage and payment. A recent story in *AAPS News* noted:

> In a settlement with Texas officials, Texas Children's Hospital (TCH) has agreed to open the country's first Detransition Clinic, pay $10 million, and fire five physicians over its secretive illegal "transition" procedures. The hospital was allegedly falsifying medical records with fake diagnoses to collect Medicaid payments.[2]

A recent article in *The Epoch Times* revealed just how lucrative false diagnoses can be for Medicare Advantage Plans.

> At some point, according to the Department of Justice, insurance companies began to inflate patients' risk scores by sifting through patient data to add diagnoses that, in many cases, no doctor ever indicated. The companies were paid more as a result, regardless of whether the beneficiaries ever sought treatment for the condition or even knew they had it…. Yet even when those added diagnoses were found to be inaccurate, some of the companies never removed them from the patients' charts—and never returned the money they had been overpaid for providing care…. An audit of 97 beneficiaries who were rated as high risk of stroke found that none of the diagnosis codes submitted were supported by physician medical records. That cost taxpayers $462 million in overpayments, a May report from the Inspector General stated….[3]

Moreover, physicians were incentivized and allegedly went along with this scheme.

> Kaiser Permanente, a large healthcare corporation that includes a health insurer, hospitals, and physician practices, allegedly pushed doctors to add diagnoses to patient charts. Over a 10-year period, the company mined personal medical data to identify potential conditions for which patients hadn't yet been diagnosed, the Department of Justice

alleged. The company allegedly linked physician and facility bonuses to risk adjustment goals.[3]

PHPs have taken the false diagnosis scheme to the extreme, with the difference being instead of bilking taxpayers out of money, they wrongfully extract large sums of money from PHP participants who have been given erroneous diagnoses.

Physicians who are referred to a PHP are coerced to agree to false diagnoses and submit to expensive treatment or face loss of their medical license if they do not submit. Physician whistleblower and long-time advocate for PHP reform, Dr. Kernan Manion, describes the Catch-22 situation:

> Manion says in his lawsuit that doctors who are reported to physician health programs face a "Catch 22;" if they challenge a program determination that they are alcoholic, addicted, or mentally ill, they are assumed to be "in denial" and told their license will be revoked since they are failing to cooperate with assessment. However, if they agree to assessment (even if only to avoid automatic license revocation) they are generally forced to sign five-year contracts that commit them to highly burdensome and expensive treatment and monitoring programs.[4]

Once a false diagnosis is made, the PHP sticks with it despite strong evidence that the diagnosis is completely false. If the physician victim complains, severe punishment is certain to follow. The *BMJ* article went on to explain:

> Despite a comprehensive psychologic evaluation that found Manion had no mental impairment, the state demanded that he have another assessment and possible treatment at an out-of-state facility. He declined, saying he was denied due process rights. The state then told him that because he had not complied with the program requirements he had to inactivate his license immediately and resign his position or face felony charges for practicing without a license.[4]

Well-qualified physicians have noted that diagnoses provided by PHPs are often at marked variance with independent physician assessments, and the Federation of State Physician Health Programs (FSPHP) seems unconcerned about this discrepancy.

> Jesse O. Cavenar, Jr., emeritus professor and vice chair of the department of psychiatry at Duke University, told *The BMJ* that he grew concerned about the state's program after he and several other psychiatrists found that its diagnoses were at "marked variance" with their own assessments. Cavenar, who has never been the object of an investigation or medical board action, has become a fierce advocate for reform. He believes Manion and other doctors have been unfairly treated and that the state's program and medical board, as well as the Federation of State Physician Health Programs, have been unresponsive to concerns he and his colleagues have raised.[4]

False diagnoses provided by PHPs based solely on the finding of low-level alcohol metabolites are unfortunately all too common. A former associate director of the Massachusetts's PHP, Dr. J. Wesley Boyd, stated:

> I have known some PHPs to report low-level positive drug tests to their boards even when these tests might indicate incidental exposure to a substance instead of intentional use or relapse. (For example, a physician who uses ethanol-based hand sanitizer repeatedly over the course of the day might have a low-level positive test the following day for metabolites of ethanol.)[5]
>
> We have seen low-level positive EtG [ethyl glucuronide] in individuals who have done nothing more than use alcohol hand wash, rinse their mouths with alcohol-based mouthwash, or used asthma inhalers with ethanol propellants. (We have also seen positive morphine tests in individuals who had consumed only poppy seed bagels or crackers.) Because of its extreme sensitivity, the Substance Abuse and Mental Health Services Administration has issued an advisory cautioning that EtG testing be used for clinical purposes only and not used solely as the basis of reports in forensic programs (Center for Substance Abuse Treatment, 2006).[6]

The Farmer case (*John Mitchell Farmer, M.D., vs. Baptist Health Medical Group, Inc.*)[7] is an example of how a false diagnosis by a PHP can cause devastating harm to the physician, leading to years of stressful litigation in an attempt to get justice.

At the time, Dr. Farmer was a family medicine resident in Kentucky. He had just finished treating a child who had ADHD (Attention Deficit Hyperactivity Disorder) when the mother of the child asked to speak with the practice manager. As noted in the court document:

> She [practice manager] testified the complaining mother informed her that Dr. Farmer was perhaps "on something," that he was rubbing his nose a lot, and shifting his weight from side to side. Crick [practice manager] testified she did not credit the mother's complaint as anything to be worried about, as the behavior described by her was normal for Dr. Farmer. Dr. Farmer has been diagnosed and treated for attention deficit hyperactivity disorder (ADHD) since 2005.[7, p 3]

Dr. Farmer had been diagnosed with Mild Alcohol Use Disorder based solely on a positive alcohol metabolite test. There was no evidence that Dr. Farmer was in any way impaired. The Kentucky Supreme Court stated:

> The record makes it clear that a PEth test [phosphatidylethanol] is a blood test for alcohol markers and can generally determine whether alcohol has been ingested in the last two to three weeks….[7, p 10]
>
> Thus the PEth test cannot tell whether Dr. Farmer was in fact impaired on November 4, 2019 [date the initial complaint was made]. At this point in our recitation, it is necessary to detail that there is no evidence in the record whatsoever that Dr. Farmer was ever impaired by drugs or alcohol while at work, or that his alcohol consumption, to the extent it exists, ever interfered with his ability to practice medicine. After KPHF [Kentucky Physicians Health Foundation] received these test results, Dr. Farmer was sent to a third-party treatment center, called MARR Addiction Treatment Center. MARR produced a report, which the trial court did not allow Baptist Health to discover from the KPHF, diagnosing Dr. Farmer with Alcohol Use Disorder (AUD)-Mild.[7, pp 10-11]

As pointed out in the recitation of the facts by the Kentucky Supreme Court, the PHP diagnosis of mild alcohol use disorder did not comport with the DSM-5 [Diagnostic and Statistical Manual of Mental Disorders] standard which is only warranted "when a person reports experiencing two symptoms at least ONCE in the past year."[7, p 11]

In June 2026, the Kentucky Supreme Court reversed the decision of the Court of Appeals, which had reversed the jury verdict in favor of Dr. Farmer. The Court reinstated the jury award of $3.7 million in favor of Dr. Farmer.[7]

It is also noted that at times, a PHP may attempt to nullify or actually nullify a legitimate diagnosis so as to support a false diagnosis in order to justify further expensive treatment. In particular, PHPs have an entrenched skepticism concerning the diagnosis of ADHD, with a bias toward viewing all referred physicians as having an underlying addiction. A PHP may conclude that ADHD is merely being used as an excuse to obtain stimulant medication. In some cases, a PHP may

even go so far as to overrule the participant's treating physician, who vigorously objects to PHP proposed "treatment" as unwarranted and harmful (personal communication). Apparently, for some PHPs a strong profit motive trumps the edict of "first do no harm."

Excessive, Unwarranted Testing/Treatment

Driven by false diagnoses, conflicts of interest, and profiteering, excessive, unwarranted, and expensive treatment and monitoring are often the result. Also, by ignoring the critical difference between illness and impairment, PHPs seek to treat referred physicians simply based on the fact they have an illness or diagnosis. A diagnosis or illness, however, cannot be equated with impairment. Impairment, as the name implies, indicates that there is an inability to adequately perform certain activities. This problem was highlighted in a review article:

> A substantial problem driving unnecessary mandated treatment is that many programs do not seem to be distinguishing doctors who are ill from those who are impaired—something that is central to treatment, according to the Federation of State Physician Health Programs, the American Society of Medicine, and the American Psychiatric Association. Conflating illness with impairment results in far more doctors being subject to investigations and treatment than might otherwise be the case.
>
> The federation defines impairment as "the inability to practice medicine with reasonable skill and safety." It states, "Physician illness and impairment exist on a continuum, with illness typically predating impairment, often by many years. This is a critically important distinction. Illness is the existence of a disease. Impairment is a functional classification….
>
> Despite the distinction, the federation notes that "in some jurisdictions the regulatory process addresses all ill physicians as if they were impaired." Critics say many doctors have indeed been caught up in mandated programs even though they were not impaired.[4]

The review article went on to review the case of Dr. Susan Haney, who was an emergency physician in Oregon. Dr. Haney suffered from intermittent depression, which did not interfere with her ability to practice medicine. When she voluntarily sought help for her depression, she was advised that she would need to inactivate her medical license while she was undergoing evaluation. The fact that she had depression was taken as evidence of impairment. Dr. Haney subsequently sued the Oregon Board of Medical Examiners.[4]

A class action lawsuit filed recently in U.S. District Court in Montana (*Chris Thacker, M.D. et a; v. Maximus, Inc. and DOES 1-50*), alleged similar problems.[8] At the time, Maximus was the contracted administrator for the Montana Medical Assistance Program. According to the complaint, it was alleged:

> Maximus arbitrarily prolonged participation, potentially for financial gain, and without regard to participant well-being or evidence-based clinical practices.
>
> Maximus breached these duties by requiring excessive testing, potentially for financial gain, which are not tailored to individual clinical assessments. Upon information and belief, Maximus received substantial profits from its toxicology testing requirements by requiring excessive testing, contraindicated by clinical recommendations and professional standards, and by charging grossly excessive fees. The excessive toxicology testing harms participants financially and emotionally.[8]

Lack of Due Process

In addition to the widespread use of false diagnoses by PHPs, the most serious flaw is the lack of impartial, objective due process. A lawsuit to address this flaw is often the only viable remedy, and as is the case with all lawsuits, the outcome is uncertain.

A former PHP associate director writes:

> Formally appealing these decisions can be difficult or actually impossible. In my state, Massachusetts, appealing a PHP recommendation requires filing a lawsuit in the state court system, which can cost thousands of dollars in legal fees and take months or years to adjudicate. In many states, there is no avenue of appeal at all. Consider the case of North Carolina. After receiving several complaints from physicians, the state auditor's office, for which I served as a consultant, audited the North Carolina Physicians Health Program (NCPHP) and found that it lacked objective, impartial due process procedures for physicians who disputed its conclusions. The auditor's office stated that "the lack of objective and independent due process procedures could prevent physicians from successfully defending themselves against potentially erroneous accusations and evaluations."[5]

The North Carolina state auditor did not mince words in describing this serious flaw:

> State auditor Beth Wood told *The BMJ* that holes in the 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….The doctors concerned were not allowed to be present and were not allowed to see the programs' medical reports on them….The lack of transparency and failure to honor due process provide fertile ground for abuse in which anonymous accusers can retaliate against whistleblowers or make accusations based on personal animosities or bias.[4]

The problem of lack of due process is compounded by the effects that conflicts of interest have on evaluation and treatment.

> Physicians who might object to the conclusions and recommendations of PHPs in many states do not have the ability to appeal and lack due process. Additionally, given that many of the evaluation and treatment centers to which PHPs refer their clients also sponsor meetings of PHPs, there is a significant potential for conflict of interest…. Physicians generally have little recourse but to comply with PHP recommendations, given that state boards of medicine usually mandate full compliance with PHP recommendations if a physician hopes to continue working, and there are often no effective avenues of appeal of mandates by the board of medicine or recommendations of PHPs.[9]

Incredibly, some have argued that coercion and lack of due process are justified because of allegedly high PHP treatment success rates.

> Physician health programs report high rates of success in their work with physicians—generally in the 75% or 80% range—rates that are far higher than those seen in other populations (DuPont et al., 2009). Some argue that these high rates of success justify any coercion employed by PHPs or lack of appeals process (Gitlow, 2012).[9]

The specific findings of the North Carolina state audit regarding lack of due process are worth reviewing as it highlights just how egregious the violation of due process has become.

> The Program did not have objective, impartial due process procedures for physicians who disputed the Program's evaluations and directives.
>
> Additionally, the Program did not have due process procedures independent of the Medical Board so that physicians could challenge Program evaluations and

directives without risk of being identified to the licensing board.

The Program lacked objective, independent due process procedures for three reasons.

First, objectivity was compromised because Program procedures allowed the CEO/Medical Director and the Clinical Director excessive influence over the process by which physician participant complaints were reviewed. The CEO/Medical Director and the Clinical Director are allowed to make the initial assessment of physicians and to make recommendations for a comprehensive assessment at a treatment center. If a physician disagreed with the initial or comprehensive assessment, the physician was required to submit a complaint in writing to the CEO/Medical Director and the Clinical Director. The CEO/Medical Director and the Clinical Director would then present the complaint to the Program's Compliance Committee, without the physician's attendance. As members of the Program's Compliance Committee, the CEO/Medical Director and the Clinical Director also participated in deciding the merits of the complaint.

Second, objectivity was compromised because Program procedures did not give physicians the ability to effectively represent themselves when disputing evaluations. The Program's policies did not allow physicians to have access to their evaluations and case records that the Program maintained. The Program's policies did not outline any required communication between the Program and the physicians. And physicians were not allowed to attend the Program's Compliance Committee meeting when the CEO/Medical Director and the Clinical Director presented the physician's complaints.

[This process is the very definition of a Star Chamber proceeding.]

Third, independence was compromised because Medical Board members participated as members of the Program's Compliance Committee….

State law requires due process procedures for peer review activities such as those performed by the Physicians Health Program. Specifically, North Carolina General Statute 90-21.22(a) and (b) state:

- Peer review activities "shall include programs for impaired physicians and impaired physician assistants"
- "Peer review agreements **shall** include provisions **assuring due process**" [Emphasis added].

Additionally, the agreement between the Medical Board and Physicians Health Program requires due process procedures for the Physicians Health Program. Specifically, section five of the Memorandum of Understanding between the Medical Board and the Program states,

"Any action taken by NCPHP under this Memorandum with respect to an impaired practitioner will in all respects comply with all of such practitioner's due process rights enumerated in Article 1, Chapter 90 of the General Statutes of North Carolina and all relevant due process rights contained in the Administrative Procedures Act, Chapter 150B of the General Statutes of North Carolina."[10]

The audit made it clear that due process for the North Carolina PHP was a complete farce. The PHP was perfectly content with the "fox guarding the chicken coop" approach administered via a Star Chamber proceeding.

The lack of objective and independent due process procedures could prevent physicians from successfully defending themselves against potentially erroneous accusations and evaluations. If a physician is required to enroll in comprehensive evaluations and treatment based on erroneous accusations and initial evaluations, the physician could experience undue and unnecessary financial, reputational, and family hardships.[10]

Based on a state audit conducted by the state of Montana which was published in 2025, the Montana PHP also uses the "fox guarding the chicken coop" approach to due process and appeals.

We found the current vendor [that operates the PHP in Montana] lacks a formalized appeals or internal review process for participants beyond escalating those cases for further review within the new vendor's staff hierarchy.[11]

Following a very critical review by the Montana Legislative Audit Committee, the vendor administering the Montana PHP, Maximus, decided to leave the state. An article in the *Montana Free Press* reported:

The planned departure of Maximus, Inc., was announced by Sarah Swanson, the commissioner of the Department of Labor and Industry, during a Monday morning meeting of a public advisory group tasked with reviewing the assistance program for more than 60,000 licensees.[12]

In Montana, the Department of Labor and Industry (DLI) administers the Montana Medical Assistance Program, with day-to-day operations performed by a vendor under contract with the state. It covers licensees under four state licensure boards: medicine, dentistry, nursing, and pharmacy.[11]

As reported by the *Montana Free Press*:

The Medical Assistance Program Advisory Council was formed after a critical audit by nonpartisan legislative staff in August and media reporting about participant discontent, including one nurse's suicide in January reported by Montana Free Press.[13] Late last month, a group of nurses and one doctor filed a class-action lawsuit against Maximus in federal court,[8] alleging the company prioritized profits over participant well-being, among other things.[12]

The advisory council had recommended extension of Maximus's contract for one year, but Maximus decided to exit the contract effective Jan 31, 2026.[12]

Undisclosed Bidirectional Conflicts of Interest

Lacking any meaningful independent oversight, PHPs have adopted bidirectional conflicts of interest which are not disclosed to participants. A former PHP associate director described the situation:

There are often significant financial ties in both directions between PHPs and the evaluation and treatment centers they use. Many of these centers are more or less dependent on such PHP referrals for their own viability and are often principal sponsors of state, regional, or national meetings of PHPs. Such relationships between the PHPs and the evaluation and treatment centers create financial incentives for each to act in ways that favor the other's interests.[5]

The North Carolina PHP audit noted the blatant conflict of interest created by the fact that treatment centers provide both evaluation and treatment. The audit stated:

The Program allowed treatment centers to have a potential conflict of interest in evaluation results because treatment centers provided both evaluations and treatment. The Program makes referrals to approximately 19 treatment centers. Each of the treatment centers provided evaluations as well as treatment programs.[10]

The Federation of State Physician Health Programs guidelines specifically prohibit this conflict of interest.

The Federation of State Physician Health Programs established guidelines that prohibit treatment centers from having conflicts of interests related to the evaluations they perform. Specifically, the "Physician Health Program

Guidelines" state,

- "There should be no actual or perceived conflicts of interest between the evaluator and the referent or patient."
- "No secondary gain should accrue to the evaluator dependent on evaluation findings/outcome."
- "An evaluator should not be in a treatment relationship with the professional being evaluated."[10]

And, because evaluation and treatment centers are financially dependent on PHP referrals, it strongly influences the diagnoses and recommendations it provides. A review article noted:

> If in its referral of a physician, the PHP highlights a physician as particularly problematic, the evaluation center might—whether consciously or otherwise—tailor its diagnoses and recommendations in a way that will support the PHP's impression of that physician.[6]

The article also noted that a conflict of interest often exists between the PHP and the licensing board, noting that a majority of PHPs in the nation receive substantial funding from state licensing boards. PHPs are thus incentivized to act in ways that satisfy the board. One PHP that ran afoul of the licensing board in California (California Physician Advocacy Group) was shut down.[6]

To the PHP, the fact that the Federation of State Physician Health Programs have guidelines that prohibit conflicts of interest did not deter the PHP from adopting them.[10]

> The Federation of State Physician Health Programs established guidelines that prohibit conflicts of interest. Specifically, the "Physician Health Program Guidelines" state, "Due diligence must be taken to avoid acceptance of funds from sources that create a conflict of interest." The guidelines further state, "Physician Health Programs must not have any conflict of interest or business association with programs utilized for referrals."[10]
>
> The appearance of a conflict of interest caused some physicians to question the objectivity of Program referrals. Physicians questioned whether referrals were based on physician needs or the Program's financial relationship with the treatment center.[10]

The audit also found that the PHP paid scholarships to treatment centers, thus creating yet another conflict of interest.

> The Program also created the appearance of a conflict of interest by paying scholarships directly to treatment centers…. The direct payments created a business association between the Program and the treatment centers.[10]

Lack of Any Meaningful Independent Oversight

PHPs typically operate without any genuine oversight, to the detriment of referred physicians. One article noted:

> Ultimately PHPs have tremendous power over physicians who have been referred to them and are rarely subject to any genuine oversight. In some states, the medical society or board of medicine is charged with overseeing PHPs. However, the reality as I [former PHP associate director, Dr. J. Wesley Boyd] know from my personal experience and research, is that they often receive very little external scrutiny. Indeed, PHPs are often given a free pass because they are seen from without as benevolent in nature. Many physicians I've heard from feel exactly the opposite about PHPs after they've been forced into them.[14]

The North Carolina PHP audit noted that neither the medical board nor the medical society provided oversight of the PHP.

> The Medical Board did not conduct periodic evaluations of the Physicians Health Program to ensure compliance with state laws, written agreements, and best practices. In accordance with *North Carolina General Statute* 90-21.22(a), the Medical Board entered into an agreement to outsource Program administration to the North Carolina Physicians Health Program, Inc. The Medical Board received periodic reports from the Program, but it did not conduct periodic evaluations of Program activities.[10]

Clearly, the North Carolina Medical Board was accepting of the "fox guarding the chicken coop" approach.

> The Medical Society did not use its appointees on the Program's Board of Directors to provide adequate oversight of the Program's operations. The Program is administered by a Medical Society affiliate (North Carolina Physicians Health Program, Inc.). The Medical Society appointed five members to the Program's 15-member Board of Directors, but the Medical Society did not take an active role in overseeing Program activities.
>
> For example, the Medical Society did not use its appointees on the Program's Board of Directors to require audits or evaluations of Program performance. As a result, the Medical Society did not identify concerns with the Program's due process procedures.[10]

One of the recommendations provided by the Montana PHP audit was that the Department of Labor and Industry should improve its oversight of the program vendor.[11]

PHP—a "Profits First" Model

Complaints about exorbitant costs by PHP/treatment centers are universal. An article published in 2025 reported that out-of-pocket costs can range from $250,000 to $321,000.[15] Another article noted that high costs associated with 90-day length of stay treatment "can be prohibitive, especially for physicians in training and for those who are not working."[6] The 2025 article noted that nurses may be affected as well.

Another nurse told *CalMatters* that she paid more than $8,000 in drug testing fees and thousands more for medical and psychological evaluations. Posters on Reddit called the company's practices "draconian" and a "racket," with one nurse alleging to have paid Maximus $26,000 in fees.[15]

An article authored by a former PHP associate director, J. Wesley Boyd, M.D., Ph.D., indicated that long treatment stays were often dictated by profit motive rather than need.

> If substance abuse is suspected—and sometimes even if it's not—the evaluation center will often recommend up to 90 days of inpatient treatment, which can cost as much as $50,000 [2016 dollars] or more. Many of these evaluation centers also offer treatment. Like the initial evaluation, this is usually not covered by insurance, generally because coverage for substance abuse and mental health services tends to be poor. But another reason insurers might state is the relative lack of scientific evidence to support this length of treatment [90 days as opposed to 30 days].[14]
>
> Injecting the profit motive into a situation where folks generally have no choice but to comply with any and every recommendation you make if they want to be able to continue practicing is a recipe for abusive practices, said Boyd.[15]

A class-action lawsuit filed in U.S. District Court in Montana in 2025 highlighted allegations that the PHP prioritized profits over participant well-being.

> Plaintiffs allege Maximus placed profit ahead of participant safety and recovery, imposed requirements untethered to evidence-based standards, obstructed access to records and clinical information, and interfered with

class members' ability to work—causing Class Members substantial harm….

Upon information and belief, Maximus received substantial profits from its toxicology testing requirements by requiring excessive testing, contraindicated by clinical recommendations and professional standards, and by charging grossly excessive fees….

Maximus' inflated and excessive testing charges are in stark contrast to toxicology testing fees paid by the state government in other substance use treatment programs like drug treatment courts….

Maximus exploits participants by charging fees that are excessive, unexplained, and failing to act in the participants' best interests and that avoid financial conflicts of interest….

Maximus prioritized financial gain over participant well-being….[8]

Unethical Conduct

Taken together, coercion, making false diagnoses to justify prolonged, expensive, unwarranted treatment and monitoring so as to enhance profits, depriving physicians of due process and adopting blatant conflicts of interest, are emblematic of unethical conduct.

Consent-for-treatment forms physicians are coerced to sign under threat of being reported as non-compliant to the medical board are unethical and not voluntary. Moreover, PHPs that collect data about participants and publish outcomes data without true voluntary consent violate the Nuremberg Code of Medical Ethics.[6]

Equating illness with impairment for the purpose of requiring treatment/monitoring is wrong and unethical.

Interfering with and/or overruling the treatment and recommendations of the participant's private treating practitioner is wrong and goes against the edict of "first do no harm."

Noteworthy is the Montana PHP audit which found that the state contract required the PHP to follow "strict ethical standards," but the Legislative Audit Committee "could not verify whether the new vendor has internal ethics policies to meet contract requirements."[11]

North Carolina PHP Performance Audit

The North Carolina Office of the State Auditor evaluated the performance of the North Carolina Physicians Health Program for a 10-year period ending on Dec 31, 2012. Fieldwork was conducted from April 2013 to December 2013. The results of the audit were published in April 2014.[10]

"The North Carolina Physicians Health Program (Program) was created in accordance with North Carolina General Statute 90-21.22." [10] Longtime advocate for PHP reform and fairness for physicians, J. Wesley Boyd, M.D., Ph.D., served as an expert consultant to assist the state auditor.[14]

The audit was initiated to address the concerns of several physicians that complained that:

> The Program abused its authority by intimidating some physicians into unnecessarily enrolling in alcohol and chemical dependency treatment programs. These physicians also questioned the quality of the evaluations and treatment they received and alleged a conflict of interest between the Program and treatment centers. Additionally, physicians were concerned about the predominant use of out-of-state treatment centers.[10]

Key findings included:

- The audit found no indications of abuse by the Program; however abuse could occur and not be detected because the Program lacks objective, impartial due process procedures for physicians who dispute its evaluations and directives.
- Abuse could occur and not be detected because the Program gave the CEO/Medical Director and the Clinical Director excessive influence over the process for reviewing physician complaints, and physicians were not allowed to effectively represent themselves when disputing evaluations.
- Abuse could occur and not be detected because the North Carolina Medical Board did not periodically evaluate the Program, and the North Carolina Medical Society did not provide adequate oversight.
- The Program created the appearance of conflicts of interest by allowing treatment centers that receive Program referrals to fund its retreats, paying scholarships for physicians who could not afford treatment directly to treatment centers, and allowing the centers to provide both patient evaluations and treatments.
- Program procedures did not ensure that physicians received quality evaluations and treatment because the Program had no documented criteria for selecting treatment centers and did not adequately monitor them.
- The Program's predominant use of out-of-state treatment centers created an undue burden on physicians.[10]

Key Recommendations included:

- The Program should ensure physicians have access to objective, independent due process procedures.
- The Medical Board and Medical Society should develop and implement plans for better oversight of the Program.
- The Program should not allow treatment centers to fund its retreats and should stop paying scholarships to centers.
- The Program should make it clear in writing that the physician may choose separate evaluation and treatment providers.
- The Program should continue its efforts to identify qualified in-state treatment centers.[10]

The North Carolina Chair of the Physicians Health Program [NCPHP] responded to the audit by stating:

> NCPHP notes the OSA [Office of State Auditor] expert review of 110 files led to a finding of "no indications of abuse" with "sufficient, appropriate evidence to support the referral to a treatment center" for each referral.[10]

Likewise, the Executive Director of the North Carolina Medical Board (NCMB) similarly responded by stating:

> The NCMB is gratified that the OSA found "no indications of abuse by the [NCPHP]" and that the OSA, with the assistance of two independent experts, found NCPHP had "sufficient, appropriate evidence to support the referral to a treatment center" in each of the 110 participant cases it reviewed.[10]

The state auditor, however, was quick to point out the gross misrepresentations by the North Carolina PHP and Medical Board. An article published in *The BMJ* reported:

> But state auditor Wood says that [responses of NCPHP and NCMB] is a misrepresentation of the findings. She told *The BMJ* that although the state investigators were unable to confirm specific instances of abuse, the program's processes were "so opaque" that it would be impossible to detect abuses that might have occurred, "and nobody would ever know it except the doctors who were abused." The report further specified that abuses could be undetected because "the program lacks objective, impartial due process procedures for physicians who dispute its evaluations and directives."[4]

North Carolina Physicians Health Program Follow-Up Audit—2019

A follow-up audit conducted by the North Carolina State Auditor in 2019 found that many important improvements were made based on the recommendations in the 2014 audit.[16]

With regard to implementing independent and objective due process procedures, the follow-up audit found:

> The Program developed and implemented policies and procedures to improve the intake and management process for the physicians who are referred to the Program. Collectively, procedures ensure that physicians have access to independent and objective due process procedures and maintain their anonymity from the Medical Board. Specifically, the Program:
>
> - Separated the duties of the Chief Executive Officer and Medical Director
> - Adjusted the roles and responsibilities of the Compliance Committee. The Compliance Committee serves as reviewer of all the Program's evaluations and directives. However, it does not evaluate disputes from physicians.
> - Formed an Independent Review Committee to evaluate physician disputes of the Program's evaluations or directives
> - Created policies and procedures that allow physicians to:
>   - Access their evaluations and case records maintained by the Program
>   - Effectively represent themselves when disputing recommendations
>   - Attend the Program's Review Committee meeting when the physician's complaints are presented.
>
> Auditors reviewed case files for 67 out of 332 (20%) cases managed by the Program during the two-year period ending December 31, 2017. Each case file contained sufficient, appropriate evidence that supports that independent and objective due process procedures have been implemented.[16]

Although it was not stated in the follow-up report how the Independent Review Committee is funded, a further improvement could be made by requiring that the funding come entirely from licensure fees so as to avoid any conflict/influence by being paid by the PHP. In hospital peer review hearings, for instance, an independent hearing officer is appointed to preside over the hearing, but in anticipation of further lucrative business in the future, the hearing officer may be influenced to make rulings in favor of the hospital where possible.

The Program also implemented policies and procedures to eliminate conflicts of interest. Specifically, the Program:

- Did not accept contributions from treatment centers that receive referrals to fund the Program's biennial retreats
- Did not pay scholarships directly to treatment centers
- Allowed physicians to select the treatment center. For those physicians in which an evaluation resulted in a recommendation for treatment, the Program allowed physicians to select the treatment center from a list of treatment providers. This was documented in writing and co-signed by the physician.[16]

It is noted that although the physician is allowed to select the treatment center, the PHP maintains complete control over the "list" of treatment centers provided to the physician. This differs from the 2014 recommendations which stated: "The Program should make it clear in writing that the physician may choose separate evaluation and treatment providers."[10] Separate evaluation and treatment providers would imply providers that are not part of the PHP or its "preferred" treatment centers.

The Program also made improvements with respect to selection and monitoring of treatment centers. Specifically, the Program improved the:

- **Selection of Qualified Treatment Centers**. Program executives network at professional conferences and events to identify treatment centers. The Program joined a consortium of other state programs to identify and evaluate treatment centers. The Program requires each potential treatment center to receive an initial comprehensive evaluation to ensure that each meets quality standards applicable to safety-sensitive workers.
- **Systematic Monitoring of Treatment Centers**. Treatment centers that receive referrals from the Program are periodically evaluated according to an established schedule. Program policies and procedures require treatment centers, that have been approved for Program referrals through an initial evaluation, to be evaluated at least once every three years.
- **Identification of In-State Options**. The Program has added two in-state treatment centers to meet the needs of the physicians. Additionally, the Program continues to network with medical professionals to identify any new treatment centers in North Carolina.

The use of the term *safety-sensitive workers* in the follow-up audit is problematic given the fact that it is often used by PHPs to skirt compliance with the Americans with Disabilities Act.[17] Also, an independent evaluation of quality and periodic monitoring would be preferable to PHP industry insiders doing these assessments.

The Program also made improvements to oversight of the program. Specifically, the Program implemented:

- **Tri-annual performance audits**. The Program hired independent consultants to conduct tri-annual performance audits of Program operations and to identify areas of improvement for the Program. The first audit was completed in April 2017. Results of the audit were provided and discussed with the Program's Board of Directors, the Medical Board and the Medical Society.
- **Regular reporting and communication requirements**. The Program provided regular operational reports to the Medical Board and Medical Society. The Medical Board receives a Compliance Committee report every other month, and a Financial Performance, and Quality Assurance report twice a year. The Medical Society receives a report of the Program Financial and Performance Measures on an annual basis.
- **Ongoing reviews of physician evaluations**. The Program's evaluations of physicians and Program directives are reviewed by the Compliance Committee. New case files and existing case files in which new information has been uncovered are reviewed during bi-monthly Compliance Committee meetings.

The North Carolina audits no doubt sent shock waves throughout the PHP world and have apparently left other PHPs scrambling for ways to avoid a North Carolina type audit. One article reported:

> In response to criticism and, more importantly, in order to stave off a North Carolina-style audit, several state PHPs have hired one individual to "audit" their programs, but the "auditor" that they hired is a PHP insider (a former director of a state PHP and also past president of the national federation of PHPs), not someone actually from without.[14]

Recommendations for PHP Reform

Although the changes made to the North Carolina PHP program are not perfect, they nonetheless represent meaningful improvements. The recommendations made in the 2014 North

Carolina audit should serve as a template for other PHPs to follow.

Like hospitals that are required to renew full accreditation by the Joint Commission every three years and are subject to unannounced on-site surveys every 24 to 36 months, [18] all PHP/Treatment Centers should be subject to the same type of accreditation. Accreditation of residential rehabilitation/recovery centers is already available via the Joint Commission. Accreditation either by the Joint Commission or by the Commission on Accreditation of Rehabilitation Facilities (CARF) should be required by state statute or contract.

CARF may be particularly appropriate for inpatient programs for substance use disorder, mental health problems and intensive outpatient treatment centers.[19]

> CARF specializes in rehabilitation and behavioral health and is often perceived as more person-centered in its emphasis. Standards lean heavily toward individualized treatment planning, outcomes measurement, and community integration. The survey is consultative in tone—surveyors are often willing to suggest improvements rather than just identify findings.[19]

State audits should be performed routinely every five years.

Physicians should be allowed to select licensed, qualified practitioners (physicians, psychologists, therapists) of their choosing as an alternative to a PHP-preferred (and conflicted) treatment centers. One article noted: "Some doctors say they should have the right to seek other forms of treatment with strong scientific evidence of success."[4]

A former associate director of a PHP program noted:

> As a clinician, by the way, I have never seen any four-day evaluation produce anything substantively different than I could glean after meeting with a client for one to two hours, obtaining a urine and/or hair sample for drug testing, speaking with people who know and work with the individual, and then conferring with my own colleagues if needed.[14]

At a minimum:

- "Physician health programs should not take any steps that could interfere with a contracting physician's right to the best medical care, including, for example, contacting his treating physicians to discuss the difficulties of monitoring while under legitimate, warranted treatment with opioid medication."[6]
- All conflicts of interest must be eliminated.
- Independent, objective due process procedures must be implemented.
- Polygraph testing should not be allowed.

Research allegedly supporting claims that physicians treated outside of the PHP model have less successful outcomes[20] needs to be scrutinized for scientific validity and ethics. Did research comply with Institutional Review Board (IRB) requirements and the Nuremberg Code of Medical Ethics (voluntary, non-coerced consent)? Was research conducted in accordance with the scientific method?

Conclusions

One thing that was demonstrated in North Carolina is that complaints to the state legislative body from a relatively small number of physicians can lead to reform. State audits could also lead to beneficial legislative reforms. Physicians who raise concerns also need to be protected from retaliation by the PHP.

Unless and until necessary reforms are implemented, PHPs, with the exception of the North Carolina PHP, should be referred to using a more accurate and appropriate name— Genuinely Unethical Life-draining Agencies of Abuse and Greed (GULAG).

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