***Patients Access to Integrative Heathcare Act of 2020***

TESTIMONY BEFORE THE MARYLAND SENATE
EDUCATION, HEALTH, AND ENVIRONMENTAL AFFAIRS COMMITTEE

Maryland Society of Integrative Medicine, Inc.
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CV in attached materials

In addition to testifying before you today we have had the privilege of meeting with the Maryland Board of Physicians ("Board"), the Department of Health and MedChi who have all made good faith efforts to understand our concerns and the operation of the bill. A few of the objections raised simply evidence the same negative reactions to integrative medicine that underlie the need for this bill, but many are legitimate questions about how the bill would operate. We hope to continue these constructive conversations, but I intend to address 6 misconceptions about the bill as best I can in the next few minutes.

1) <u>Misconception: The bill prevents proper disciplinary action against physicians misusing integrative techniques.</u>

The Board of Physicians has expressed concern that Section 1 of the bill would carve out special exemptions that would prevent the Board from taking appropriate disciplinary actions against integrative physicians. The Board is apparently reading Section 1 as if it says it may not take action IF a practitioner's practice is integrative in nature. The language is in fact that the Board may not take action BECAUSE a practice is integrative in nature. If a peer reviewer qualified by training and experience in a well-founded minority viewpoint similar to that of the respondent physician finds the respondent was in error, the Board could bring an action based on improper use of integrative methods under Section 2. This would NOT be an action taken BECAUSE the practitioner used integrative methods, but rather because a properly qualified peer reviewer found the integrative methods were not valid or used responsibly. Seeking discipline in such a case would not violate Section 1.

What the language in Section 1 would accomplish is to ensure that the Board does not discipline a physician because he or she uses integrative medicine, in other words, by imposing standards of care that are contrary to methods that have been developed by the integrative or other minority medical communities. For the Board to do that would be to take action BECAUSE the physician used integrative methods. This gives effect to our intent that the standards and evidence supporting integrative work not be ignored but applied by at least one reviewer.

The bill would also allow discipline, as has been the consistent approach in other states, where the methods used present a risk not outweighed by the potential benefits and where informed consent was not adequate.

An important instance are areas where there are unresolved differences in professional viewpoint, such as determining whether continuing symptoms in Lyme patients are a post-Lyme syndrome or result from ongoing persistent infection. We understand, for example, that Johns Hopkins and Stanford medical schools have sharp disagreements over the Lyme controversies. The Board of Physicians should not take sides in such disputes, nor discourage innovative, emerging, or established minority medical viewpoints by choosing reviewers from only one side of such disputes or where there are differences in the paradigm for care.

2) Misconception: The bill creates a separate disciplinary track for integrative medicine.

The bill does not create a different disciplinary track for integrative physicians nor treat them differently; it merely requires that, like any other physician, respondents be viewed according to the standards or evidence-base for their practice. That there is only one standard of care is in many cases a misconception that ill-fits the complexity of medicine as art and science. What the bill does is restore the concept of review by an actual peer.

Current law requires that a reviewer be board certified in the matter at hand and also have special expertise. Health Occupations § 14-401.1(e)(2). We have litigated the meaning of this language in the context of orthomolecular psychiatry, a form of integrative medicine which focuses on nutrients that affect neurologic function. We argued before the Baltimore Circuit Court that the statutory additional requirement for special expertise required a reviewer versed in orthomolecular expertise, not simply a psychiatrist, but the Court held that being boarded in psychiatry was sufficient, making a legislative fix necessary. Note that the then President of the Maryland Psychiatric Society testified at the hearing at which the charges in this case were dismissed that these charges never should have been brought because of differences in standards of care, which is exactly our point.

3) Misconception: "Integrative medicine" is not sufficiently defined.

The proposed obligation on the Board to respect standards of practice or evidence-base for integrative medicine does not turn on its definition. While we understand the nature of the concern, note as context that of the 13 states that have passed similar laws, only three attempt a definition and none of those definitions add to what is contained in SB103, these statutes merely define it in contrast to conventional methods. The field is highly varied and includes emerging therapies as evidence becomes available. While there are common elements such as an holistic approach, a focus on nutritional medicine and the evidence-based use of herbs, among other aspects, whether a practice under scrutiny clearly fits within or without an integrative model is not a legal standard that can be directly applied.

The actual issue is whether a physician's methods have a rational basis properly applied as indicated in part by professional and evidence-based support. There are a number of professional associations that teach, research and support integrative practice, noted in the attached materials, which are a place to begin but the actual question should be about the basis for a therapy that takes into account that patients should have access to different paradigms of practice.

4) Misconception: The bill is not about access but physician protection.

As an attorney representing many integrative physicians in Maryland, I frequently have to counsel physicians who ask whether they can perform certain therapies with legal safety that,

even though the learned about these therapies at established conferences there could be real disciplinary risk. We cannot go to the Board for declaratory rulings and have to base advice on dozens of cases in which physicians have been reprimanded or their licenses suspended or revoked. The chilling effect of possible board action limiting physicians ability to use innovative approaches is a major bar to access to this care and this is our central concern.

5) Misconception: Because few cases have addressed integrative medicine, it is not a significant problem.

Understanding that one of our concerns is Lyme Disease, the Board reviewed their records and found 27 of 27,000 cases reported involved Lyme Disease. Of those 27, I handled 3 cases, one leading to probation solely on record keeping because the reviewers were unable to recognize the use of pulsed antibiotics under ILADS guidelines. One of the others was dismissed on its face and one because I insisted and the Board accepted the peer review we seek be established in law. This does not often happen in other cases.

More to the point, I alone have handled over a dozen other cases and seen a dozen others in which charges were filed that raised a wide number of integrative medicine matters, aside from Lyme, and action against one doctor can affect the willingness of many other physicians to provide what they consider legitimate treatments.

6) Misconception: Integrative medicine is not evidence-based.

As we have highly qualified physicians and researchers testifying I will just make a few observations. Integrative methods have been taught for years in coursework with Category 1 CME credit at medical conferences that have been ongoing for over 40 years with thousands of participating physicians. The field has board certification in the American Board of Integrative Medicine (ABOIM), recognized by the American Board of Physician Specialties (ABPS) with over 20 fellowship programs feeding the board qualification. Integrative physicians have lead many developments in medicine, stressing the importance of diet and food beginning some 40 years ago. Immunotherapies for cancer began as an integrative medical idea that was initially scorned. Herbal and nutritional approaches can make available well-researched interventions that are effective and can be safer than pharmaceutical options that may be widely prescribed even with black box warnings. As but one resource, Harvard Medical School compiled a database of over 15,000 citations to clinical studies for natural medicines now available through a pay site at https://naturalmedicines.therapeuticresearch.com to assist doctors in making evidence-based choices. John's Hopkins has published research, for example, suggesting that garlic may be more effective against the Lyme spirochete than antibiotics. (*See* attached exhibits). There are peer-reviewed journals, medical textbooks, and other substantial resources of which a few are listed in our exhibits.

Patients who see integrative physicians have usually exhausted conventional means, particularly for chronic disease for which treatments are limited. There is also a mythology that conventional medicine is largely evidence-based, but repeated studies have found estimates more on the order of 20% are in fact evidence-based, as in the 2017 BMJ article included in our exhibits.

Additional Background

The Maryland Board of Physicians (Board) has taken the position that responsible use of such therapies may be performed with patient informed consent, but the policy does not work well in practice because 1) the Board relies on peer reviewers who are largely only versed in conventional standards of care and critique physicians based upon a lack of information and a presumption against schools of thought in which they are not trained, 2) this unfamiliarity with other protocols gives rise to critiques of diagnosis, treatment and documentation that reflect the reviewers lack of understanding, not error on the part of the respondent, and 3) the views of informed consent and scientific evidence are not consistently applied by the Board.

Patient harm is rarely alleged in these cases and the presumption that nonstandard therapies present an unreasonable risk of harm reflect untested conventional viewpoints that are often not valid. The Board often expresses concern about the avoidance of conventional treatments, but these patients have generally already exhausted conventional care before seeking out an integrative physician.

The disciplinary process is largely dictated by peer reviewer findings; the bill requires that at least one of two peer reviewers is trained in the methods at issue. If a physician is investigated for an approach that is disengaged from a respectable minority of physicians and, as a result, a peer trained in that view is legitimately unavailable, the Board may use any reviewer with some training in integrative medicine. Peer reviewers would be guided by the standard that the methods must pose no greater risk than conventional medicine not outweighed by potential benefits. If a CAM therapy that may be generally appropriate is incompetently applied, the reviewer trained in such methods would be in a position as a peer to form a proper basis for an adverse finding. Further, if it can be shown that a physician was acting in bad faith rather than a genuine healing effort, this bill would provide no protection. In any event, in order to use nonconventional approaches a physician must have documented proper informed consent by the patient.

Closing Thought

Contemplating the importance of this bill I am reminded of work I did as a clinical social worker before engaging in my 30-year legal career working with integrative physicians. I was a family therapist at a residential facility for adolescent drug offenders and the young men we worked with generally went on one of two paths; they were either identified as the sick one and went into

psychiatric inpatient care where the purpose was to "fix" the child, or they stayed with us where we identified the entire family as in need of assistance and worked to address the family dysfunction that manifested in the young man's symptoms. Hospitalization was 10 times the cost, but more to the point the life path of these young men and their families was deeply affected by this choice. Joining the parents in assigning blame to the child was not always in anyone's best interest. The manner in which we define medical problems sets the stage for how we resolve them. Fortunately, no regulator was imposing one view over the other in the name of "standard of care."

Many integrative/CAM therapies once scorned have now become accepted. There is often not one static, clear standard of care, particularly for complex, chronic diseases that are too often not well-managed with conventional care alone. Allowing functional and emerging views of medicine to be used in practice with informed patients per the standards laid out in this bill would provide a proper balance of access and safety.

Thank you for your consideration.