Those in the healing profession have prescribed cannabis, known in the vernacular as Marijuana (MJ), for at least five millennia. MJ was prescribed in China as early as 2737 B.C. for ailments ranging from “absentmindedness” to “female weakness.” In the United States, physicians routinely prescribed MJ until the late 1930s when it seemed to fall out of favor. It was not until 1970 that the law would intervene and prescribe all use. In 1975 the Compassionate Use Program for MJ was established by the Food and Drug Administration (FDA) and reserved for patients suffering from cancer, glaucoma and multiple sclerosis. Four years later, the Controlled Substance Act was established and classified MJ as having a high abuse potential and no safe medical use. In 1986 a synthetic form of tetrahydrocannabinol (THC), the main psychoactive substance in MJ, was offered in an oral form. Marinol was placed into Schedule II by the Drug Enforcement Agency (DEA), making it accessible to patients in need and also for research purposes. However, proponents of medical MJ argue that Marinol is less effective than the natural herb and have lobbied hard to have the botanical legalized.

Research on the use of MJ for medical purposes is lacking, partly because it is currently classified as a Schedule I drug, making it virtually impossible to conduct the randomized, double-blind, placebo-controlled prospective studies that normally precede the availability of a new drug to the public. Most studies that have been done are small in number, retrospective in nature and confounded by uncontrolled variables including concomitant use of tobacco and/or co-morbid diseases.

While the Institute of Medicine stated that MJ was effective in lowering intraocular pressure

---

Testimonial from a Physician Client

Doctors do get sick. Many times they get “stuck” because they do not know how to ask for help. As physicians we are focused on the health of our patients—but in the process, we neglect our own health. This is easy to do because patients have such high expectations of us and want the absolute best care. They also expect a perfect result. When things don't go perfectly, many times patients blame us and in turn we blame ourselves. This is an uncomfortable predicament for any doctor. I want to continue my support of CPHP and The Spirit of Medicine Campaign so that doctors who get "stuck" can get the proper attention from CPHP so they can get “unstuck.”
The current economic atmosphere is profoundly different than it has ever been in the past. This is especially true for physicians. Like everyone else, we are subject to constant media coverage of the recession and its effects. All of us have patients, friends and relatives who have been hit hard financially and they realize the consequences of this uncertainty. People are making changes and the future is not as bright as it once was. In general medicine is considered to be in a “recession-proof industry”. While it is true that our incomes do not see the lows so rampant in the general business world, our financial security is threatened more directly than it has been in recent history. Our tenuous relationship with Medicare is now severely strained with cuts, refusal to pay providers, and stagnation. The ramifications of the recently passed healthcare reform bill for us are unclear. The guarantee of a certain lifestyle is now a waiving promise. It is impossible not to feel some stress and demoralization.

Most of us did not come to medicine for money. The decision to become physicians was made during a time in our lives we looked for a field that could offer intellectual challenge and allow us to care for our fellow man. As we progressed on the path to become physicians and establish ourselves in practice, our own economic realities developed.

Freshly-minted physicians face a unique matrix of financial issues. We emerge from medical training with massive student loan debt. It is a common practice for new physicians to take advantage of a “doctors mortgage.” Newly graduated from residency and anxious to get on with our lives, we bought houses with minimal or no down payment. This led many young physicians to find themselves “under water” on their mortgages. Fortunately, most physicians are able to meet their financial obligations. But uncertainty looms in the future of our profession.

Physicians in long-term practice have similar concerns. It takes years to build a successful medical clinic. The value of that clinic may make up the majority of the physician’s retirement plan. It is easy to imagine how the sweeping changes in healthcare can diminish the value of any practice. It is particularly unsettling that so many of these consequences are completely beyond our control. Most physicians are in some way dependent on Medicare. Even those doctors who do not depend on the program directly recognize Medicare as a massive pillar supporting our hospitals and clinics. It is infuriating and frightening that a huge payer of medical care can suddenly suspend payments for services already rendered. Medicare’s proposed cut of over 20% in reimbursements is a serious concern. Given the low reimbursement schedule already, many physicians are considering opting out of Medicare. Decisions such as these will have an obvious impact on the physician’s practice. More important is the impact on the physician himself. Suddenly, someone who became a physician to care for people now must make the decision to abandon a large number of his patients to protect the clinic’s solvency. We clearly were not prepared by our medical training for such wrenching decisions.

We are living in a time where our future is less certain than ever before. This is unsettling and anxiety-provoking. At CPHP we are seeing the direct impact of these changes on physicians, their families, and their health. Physicians stressed by these changes can be helped by the support of a therapeutic relationship that focuses on helping the physician better prioritize his worries and helping the physician to reframe these in order to make them more manageable. Although little can be done to change the economic atmosphere, we can control our reaction to it.

**CPHP Serves Colorado Training Programs**

The following training programs have contracted with CPHP, entitling the residents, medical students and physician assistant students access to CPHP services at no additional cost:

- **Colorado Health Foundation Transitional Year Fellowship** at Presbyterian/St. Luke’s Medical Center.
- **Denver Health Emergency Medicine Residency Program**
- **Fort Collins Family Medicine Residency Program**
- **Red Rocks Community College Physician Assistant Program**
- **Rocky Vista University College of Osteopathic Medicine**
- **Southern Colorado Family Medicine Residency Program**
- **St. Anthony Family Medicine Residency Program**
- **St. Mary’s Family Practice Residency Program**
- **St. Joseph Hospital Graduate Medical Education**
- **University of Colorado Denver Graduate Medical Education**
- **University of Colorado Denver Physician Assistant Program**
- **University of Colorado Denver School of Medicine**

CPHP is so pleased to have welcomed Rocky Vista University College of Osteopathic Medicine as its newest training program in 2009-10. If your training program is interested in establishing a contract with CPHP, please contact Sarah R. Early, PsyD, Executive Director, at 303-860-0122, ext.232. Additional information about program services is available on our website, www.cphp.org.
**Commonly Held MYTHS About CPHP**

**MYTH #1**
“CPHP is only for those with substance abuse problems.”

**REALITY**
CPHP helps medical professionals with a host of problems: family issues, work-related stress, burnout, physical conditions and emotional problems.

**MYTH #2**
“If you go to CPHP, the Board of Medical Examiners will know.”

**REALITY**
CPHP does not disclose the identity of, or information about any current or former participant without a written release of information except in rare instances.

**MYTH #3**
“CPHP is only for physicians.”

**REALITY**
CPHP serves not only physicians, but also residents, medical students, physician assistants and physician assistant students.

**MYTH #4**
“CPHP provides treatment.”

**REALITY**
CPHP conducts diagnostic evaluations of a participant and makes recommendations for treatment or other interventions (such as education). In addition, CPHP provides support services for family members. Efforts are made to refer participants to community-based treatment and/or other resources in areas in which the physician/physician assistant resides so that he/she is able to continue practicing while receiving the necessary treatment.

**MYTH #5**
“CPHP takes only mandatory referrals from the Colorado Board of Medical Examiners.”

**REALITY**
CPHP accepts referrals from a variety of sources within the medical community. This may include hospital committees, leadership in practice groups, hospitals or medical societies as well as self-referrals, and referrals by family members or practice partners. It should also be noted that the majority of cases are self-referrals.

**MYTH #6**
“Once you get involved with CPHP a significant time commitment is required.”

**REALITY**
CPHP’s diagnostic conclusions will extend so as to ensure that the client is connected in appropriate and adequate treatment. The treatment recommendations will ultimately dictate the time requirement. Once health is stabilized and ability to practice safely is confirmed, then continued involvement with CPHP may conclude.

**MYTH #7**
“CPHP is expensive—if you go there, it will cost you.”

**REALITY**
Because CPHP is funded for all Colorado licensed physicians and physician assistants, direct services are free. Residents, medical students and physician assistant students may also be eligible for free services through contracts between CPHP and various Colorado-based training programs. However, participants/their insurance are responsible for costs of any additional evaluations and treatment outside of CPHP.

**MYTH #8**
“CPHP is available only for Denver medical professionals.”

**REALITY**
CPHP serves Colorado as a whole and undertakes extensive education and outreach efforts by direct visit, consultation and presentation services to all four corners of the state of Colorado.
WHAT DO YOU EVALUATE AT CPHP?

Cae Allison, LCSW, Director of Clinical Services, states that CPHP evaluates any health issue including medical, psychiatric, emotional problems or situational stresses. A client is assigned to members of the clinical team who will manage their case during the course of their involvement with CPHP.

HOW LONG WILL THE INITIAL EVALUATION LAST?

Sally Moody, LCSW, Clinician, states that the initial appointment with CPHP will last approximately two hours. The client will be asked to complete a client questionnaire and undergo a psychiatric interview with their assigned clinical team. However, depending on the health issues that are addressed, additional evaluation by CPHP over a period of time may be recommended.

WHAT IS INVOLVED IN THE EVALUATION PROCESS?

Moody states that CPHP typically requests to speak with others who know the client, usually a professional contact and personal contact. CPHP uses these collateral interviews to help deepen our understanding of a client in various contexts.

WHAT ARE SOME OTHER THINGS I SHOULD KNOW ABOUT THE EVALUATION PROCESS?

Dwayne Spinler, LPC, Clinician, comments that CPHP assesses clients and provides professional guidance to help its clients regain their health and make the adjustments necessary to accommodate their condition. Identification is the first and often most difficult step. CPHP provides assistance that can help its clients confront and overcome problems and also offers support to families.

WHAT IS INVOLVED IN AN INITIAL CPHP EVALUATION?

Lynne Klaus, LCSW, CACIII, Clinician, indicates that typically, CPHP evaluations take place over time, in general 30-45 days, in order to gather background collateral information from colleagues, workplace, family, etc., but potentially 90 days (if an extended evaluation is warranted). CPHP is aware and understanding of the timeline often associated with residents/workplaces, such as probation or contact renewal. We are committed to working with the physician and referral party to complete these evaluations in a timely manner.

WHAT INFORMATION DO I NEED TO BRING TO MY INITIAL EVALUATION?

Klaus further states that any medical or other records pertaining to your evaluation should be gathered and presented to CPHP during your initial meeting.

WHY AM I ASSIGNED A CLINICIAN AND AN ASSOCIATE MEDICAL DIRECTOR?

Cindy Hudson, MA, CACIII, Clinician, opines that CPHP actually functions as a group collaborative model with multiple levels of input from the clinical team. However, the main point of contact for our clients will be an assigned Clinician. The Clinician will obtain all of the critical background collateral information and obtain treatment updates from treatment providers. The Clinician ensures that all case management including information gathering and any needed reports and credentialing information is completed on a timely basis.

MAY I COMMUNICATE WITH CPHP THROUGH E-MAIL OR TEXT MESSAGING?

Hudson further states that due to CPHP’s very strict levels of confidentiality, we are disallowed per CPHP policy from communicating by email or text messaging. This ensures that sensitive personal health information will remain private.

HOW IS MY CONFIDENTIALITY PROTECTED AT CPHP?

Allison emphasizes that maintaining participant confidentiality is an integral element of CPHP. She stresses that we operate under the strictest guidelines pertaining to confidentiality in medicine. CPHP has structured our confidentiality policies after 42 CFR, Part 2 guidelines. These guidelines are the strictest confidentiality guidelines that can legally be followed and are applicable for all cases.

IF I HAVE BEEN REFERRED TO CPHP BY MY WORKPLACE OR RESIDENCY PROGRAM/MEDICAL SCHOOL, WHAT INFORMATION DOES CPHP PROVIDE TO THEM?

Moody concludes that CPHP typically communicates with these referral sources and provides only the information they need, i.e., ability to practice, but does not provide specific details of a client’s circumstance. CPHP serves as a “buffer” between the information the client provides CPHP and information that the workplace receives. This way workplaces receive information necessary to assure patient safety, while a client is afforded the most privacy possible.

The CPHP Clinical Team Responds to Some Common Questions

We are so grateful to all of Colorado’s medical professionals and organizations that support CPHP’s annual Spirit of Medicine Campaign. Your renewed support of this year’s current 2009-10 campaign that concludes in October 2010 would be greatly appreciated. Your support of medical professionals saves careers, families and even lives. Thank you!
CPHP Conferences

CPHP remains committed to reaching out and serving all four corners of Colorado’s medical community by exhibiting at various medical conferences and meetings throughout the year. Attendees of the conferences and meetings recognize the organization as a valuable resource to the Colorado medical community.

CPHP Presentations

CPHP provides exceptional presentations to the medical community throughout Colorado regarding the services offered at CPHP and physician health related issues. Physicians and CPHP personnel who are experts in the field of physician health conduct these presentations. Below is a listing of presentation topics that CPHP provides. In addition, CPHP can tailor presentations to discuss the issues that are unique to any organization. Presentation topics include:

- CPHP Services and Physician Health
- Physician Stress/Physician Self Care
- Professional Boundaries
- The Disruptive Physician
- Substance Abuse and Addiction
- Women in Medicine
- Physicians in Relationships and Families
- Occupational Hazards of Physicians and Medical Students
- Physician Depression and Suicide

For additional information about CPHP presentation services or if you are interested in scheduling a presentation, please visit our website at www.cphp.org and click on presentation services. Then you may click on the Presentation Request Form icon.
Any physician making recommendations for medical MJ must hold a valid, unrestricted license to practice medicine as well as a valid, expected to cut down on the abuses reported by the Department of Public Health of some physicians making medical MJ recommendations from one of only 15 physicians and of these physicians, at least five have had disciplinary actions taken against them. SB109 is Joint Judiciary Committees that while 800 physicians have signed for patients to receive medical MJ, 75% of patients received their recom-mendation. A small scale enterprise was envisioned. Instead, storefront MJ dispensaries have sprouted like weeds (pun intended). Rumor has it that there are more MJ dispensaries in metro Denver than liquor stores and Starbucks coffee shops combined!

In reviewing medical MJ cards issued in Colorado, only 3% belong to people with cancer and only 1% for those with HIV/AIDS. Ninety percent of medical MJ cards have been issued to individuals presenting with severe chronic pain, a highly subjective qualifying condition. In 1990 and learned that just as many accidents were caused by drivers using MJ as were caused by drivers impaired with alcohol. MJ is also acutely impairs driving-related skills in a dose-related fashion. The National Transportation Safety Board studied 182 fatal truck accidents that there are more MJ dispensaries in metro Denver than liquor stores and Starbucks coffee shops combined!

(MJ) in patients suffering from glaucoma, it is estimated that a patient would need to smoke about a dozen “joints” per day for efficacy. While MJ may be successfully lowered and the risk for blindness reduced, the patient is likely to suffer side effects, including significant cognitive impairment. No study has demonstrated that MJ can lower IOP as effectively as drugs already on the market.

There is some evidence that smoked MJ relieves neuropathic pain related to HIV, but less evidence that medical MJ is helpful in controlling chronic/severe pain. Smoked MJ is also used to combat the wasting syndrome of AIDS and relieve nausea related to chemotherapy. While several reports support its efficacy, patients with these conditions are already physically compromised and unnecessary exposure to potentially dangerous substances should be avoided. MJ contains most of the hazardous substances found in tobacco smoke. It also inhibits T cell functioning and runs the risk of further compromising an immune-suppressed patient.

Those supporting the legalization of MJ tend to portray this complex alkaloid mixture of more than 400 compounds as a reasonable “natural” alternative to conventional drugs. But its organic nature does not preclude the need for scientific investigation. Despite legislation across the states relaxing laws governing the possession or use of MJ, the scientific community remains concerned about its risks. The medical literature is replete with evidence that MJ use can be complicated by abuse and dependence. Ten percent of regular MJ users become addicted to it compared with 15% with alcohol, 32% with nicotine and 26% for opiates. The number of adults with substance abuse disorders is trending upward and expected to double by the year 2020. There is concern that increasing access and availability to another addictive substance will only aggravate this trend. Of MJ confiscated in the US, the potency (percentage of THC) has increased dramatically since 1975, raising additional concerns about increased abuse potential.

The largest demographic of MJ users includes adolescent and young adult males. Colorado ranks fifth in the nation for adolescent MJ use. The younger children are when first exposed to MJ, the more likely they are to use cocaine and heroin and become dependent on drugs in adulthood. MJ poses other mental health hazards. The risk for developing psychosis is increased by 40% for those who have used cannabis. Good research shows that smoked MJ makes anxiety, depression and disorders of attention worse. University of Colorado researcher Hon Ho, MD and his associates conducted a large longitudinal study of cannabis use in adolescents. They discovered that smoked MJ is associated with the subsequent development of depression, not the reverse. Slowed cognitive processing, impaired judgment and short-term memory, impaired inhibitory control, loss of sustained concentration or vigilance, impaired visuospatial processing and perception are dose-related side effects of smoked MJ. Heavy MJ use (daily for a month) is associated with residual neuropsychological effects even after a day of supervised abstinence. It is unknown whether this is related to residual drug in the brain or frank neurotoxicity.

MJ smoke contains many of the same carcinogens and co-carcinogens found in tobacco smoke. Because inhalation is deeper and more pro-longed with MJ compared to tobacco, more tar-containing benzopyrene exposure occurs. Both acute and chronic bronchitis are associated with smoked MJ. Long-term cannabis use increases the risk for lung cancer as well as head and neck cancers. There exists scientific evidence that long-term MJ smoking alters the reproductive system. MJ use also increases heart rate. According to Harvard University researchers, the risk of a heart attack is five times higher than usual in the hour after smoking MJ.

Aside from the individual health risks associated with MJ use, it is important to consider the societal costs incurred when abusable, cognitive impairing substances are made readily available to the public. Studies employing computer controlled driving simulators reveal that cannabis acutely impairs driving-related skills in a dose-related fashion. The National Transportation Safety Board studied 182 fatal truck accidents in 1990 and learned that just as many accidents were caused by drivers using MJ as were caused by drivers impaired with alcohol. MJ is also implicated in a high percentage of workplace accidents. Drug use also contributes to crime. A large percentage of those arrested for crimes test positive for MJ. Nationwide, 40% of adult males tested positive for MJ at the time of their arrest.

Amendment 20 was meant to provide legal access to MJ for those suffering from debilitating conditions refractory to conventional treat-ments. A small scale enterprise was envisioned. Instead, storefront MJ dispensaries have sprouted like weeds (pun intended). Rumor has it that there are more MJ dispensaries in metro Denver than liquor stores and Starbucks coffee shops combined!

In reviewing medical MJ cards issued in Colorado, only 3% belong to people with cancer and only 1% for those with HIV/AIDS. Ninety percent of medical MJ cards have been issued to individuals presenting with severe chronic pain, a highly subjective qualifying condition. Of concern, 70% of medical MJ cards have been obtained by men, the majority being between the ages of 25 and 34 years, the demographic most likely to have addictions. At the time of this writing, approximately 20,000 medical MJ cards have been issued and, according to the Colorado Department of Public Health, a backlog of 50,000 existed. Either our state is experiencing an epidemic of severe pain in youthful males or Amendment 20 is being exploited, making a mockery of responsible medicine. Attorney General John Suthers testified before the Joint Judiciary Committees that while 800 physicians have signed for patients to receive medical MJ, 75% of patients received their recom-mendation from one of only 15 physicians and of these physicians, at least five have had disciplinary actions taken against them. SB109 is expected to cut down on the abuses reported by the Department of Public Health of some physicians making medical MJ recommendations in the absence of adequate evaluation or continuity of care.

Any physician making recommendations for medical MJ must hold a valid, unrestricted license to practice medicine as well as a valid, continues on page 12
Profile of Jack A. Klapper, MD
An Important Figure in CPHP’s History

A bright-eyed boy named Jack A. Klapper arrived in Denver from Kansas City, Missouri when he was in the 6th grade. He sailed through his elementary and junior high years and then landed at Denver's East High School. Upon graduation, with the full support of his parents, young Jack turned his ambitions to medical school where he aspired to become a physician. Jack enrolled in the University of Colorado Medical School where he completed his residency in both psychiatry and neurology.

Dr. Klapper became a member of the Board of Medical Examiners in the early 1980s and was also part of an important cadre of physicians in Denver who realized that physicians needed a resource in times of trouble. “After all, big companies had Employee Assistance Programs (EAPs) and it made sense for physicians to have such a structured outlet in times of difficulty,” stated Dr. Klapper.

From 1986 to 1988, Dr. Klapper was a CPHP Board Director. He fondly recalls the ongoing physician health work of Steve Dilts, MD, a primary founder of CPHP and its first Medical Director; Michael Sturges, MD, also a CPHP founder, Board Director and Associate Medical Director; Ed Casper, MD, another CPHP Board Director and Chairman of the Psychiatry Department at Denver Health; and Bruce Jensen, MD, also a CPHP Board Director. Dr. Klapper recalls Drs. Dilts, Sturges, Casper and Jensen all being at the forefront of the CPHP movement and helping many Colorado physicians who were dealing with a number of personal and medical problems.

In 1988, Dr. Klapper was in private practice and soon ascended to the presidency of the Denver Medical Society where he continued to champion the cause of CPHP. He knew that the young nonprofit start-up would be here to stay and fully supported its place in the medical community.

Dr. Klapper reiterated, “A physician health program such as CPHP became such an obvious benefit to physicians in Colorado.” He further explained that the Board of Medical Examiners is of benefit to the public, but that physicians need their own physician health resource as well. “Having healthy physicians also directly affects the public, too.”

Since the 1990s Dr. Klapper has continued to follow his passion in neurology and medical research, founding the Mile High Research Center in Denver. He and his team conduct research and currently are engaged in conducting numerous pharmaceutical trials focusing on a cure for Alzheimer’s disease.

Dr. Klapper concludes by saying how pleased he is with CPHP’s evolution and that with such good physicians and leaders as Drs. Dilts, Sturges, Casper and Jensen involved in its infancy, he fully expected the organization to become a mainstay within the medical community. “I didn’t expect anything less from CPHP and I knew it was the right organization for physicians to have in difficult times,” stated Dr. Klapper.

A portion of Dr. Klapper’s e-mail address sums up his life’s work and ongoing passion in medicine…headdoc!
Colorado Physician Health Program (CPHP) is proud to recognize the following individuals and organizations who contributed to our annual *Spirit of Medicine* Campaign during campaign year 2008-09. We are truly grateful for their generosity, which helps provide crucial support to CPHP as we strive to provide exceptional physician health care services and meet the ever-growing demand for our services throughout Colorado.

**LivingWell Giving Society**

CPHP extends special appreciation to the following members of the LivingWell Giving Society. This group of donors have pledged an annual contribution for five successive years, providing continuous funding for our work.

<table>
<thead>
<tr>
<th>Amount</th>
<th>Group</th>
<th>Names</th>
</tr>
</thead>
<tbody>
<tr>
<td>$25,000</td>
<td>Colorado Permanente Medical Group</td>
<td>-</td>
</tr>
<tr>
<td>$5,000</td>
<td>Anonymous</td>
<td>-</td>
</tr>
<tr>
<td>$1,000</td>
<td>Valley View Hospital Medical Staff</td>
<td>-</td>
</tr>
</tbody>
</table>

**Annual Donors**

<table>
<thead>
<tr>
<th>Amount</th>
<th>Group</th>
<th>Names</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,000 and above</td>
<td>Anonymous (3)</td>
<td>-</td>
</tr>
<tr>
<td>$250 — $499</td>
<td>Anonymous (3)</td>
<td>-</td>
</tr>
<tr>
<td>$250</td>
<td>David A. Grunow, Jr., MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. and Mrs. George R. Helsel</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Drs. Scott and Sarah Humphreys</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Curtis and Judy Kimball</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. Janet Legare and Dr. Vivek Balasubramanian</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>David S. Lennon, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Donna M. Nelson, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. James and Mrs. Carolyn O’Donnell</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. and Mrs. Gregg Omura</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. Debra Parsons and Dr. David Downs</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Nigel Pashley, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Perry Rasleigh, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. and Mrs. Wagner J. Schorr</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Paul D. Simmons, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Robert L. Swanson, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Steven J. Thorson, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Drs. Robert and Sara Tonsing</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Lawrence Varner, DO</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Kay Wagner, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>David S. Wahl, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Jonathan E. Walter, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Drs. Michael and Patrice Whister</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Bruce H. Wilson, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Frederick Y. Yu, Esq</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Karen Zarlengo, MD</td>
<td>-</td>
</tr>
<tr>
<td>$25,000 - $499</td>
<td>Anonymous (3)</td>
<td>-</td>
</tr>
<tr>
<td>$500 — $999</td>
<td>Anonymous (5)</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. and Mrs. James Borgstede</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Michael R. Bowen, MD and Reneal B. Dr. and Mrs. James Borgstede</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Anonymous (5)</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. and Mrs. George R. Helsel</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Drs. Scott and Sarah Humphreys</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Curtis and Judy Kimball</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. Janet Legare and Dr. Vivek Balasubramanian</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>David S. Lennon, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Donna M. Nelson, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. James and Mrs. Carolyn O’Donnell</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. and Mrs. Gregg Omura</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. Debra Parsons and Dr. David Downs</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Nigel Pashley, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Perry Rasleigh, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. and Mrs. Wagner J. Schorr</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Paul D. Simmons, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Robert L. Swanson, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Steven J. Thorson, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Drs. Robert and Sara Tonsing</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Lawrence Varner, DO</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Kay Wagner, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>David S. Wahl, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Jonathan E. Walter, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Drs. Michael and Patrice Whister</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Bruce H. Wilson, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Frederick Y. Yu, Esq</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Karen Zarlengo, MD</td>
<td>-</td>
</tr>
<tr>
<td>$100 — $249</td>
<td>Anonymous (46)</td>
<td>-</td>
</tr>
<tr>
<td>$500 — $999</td>
<td>Anonymous (5)</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. and Mrs. James Borgstede</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Michael R. Bowen, MD and Reneal B. Dr. and Mrs. James Borgstede</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Anonymous (5)</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. and Mrs. George R. Helsel</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Drs. Scott and Sarah Humphreys</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Curtis and Judy Kimball</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. Janet Legare and Dr. Vivek Balasubramanian</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>David S. Lennon, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Donna M. Nelson, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. James and Mrs. Carolyn O’Donnell</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. and Mrs. Gregg Omura</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. Debra Parsons and Dr. David Downs</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Nigel Pashley, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Perry Rasleigh, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. and Mrs. Wagner J. Schorr</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Paul D. Simmons, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Robert L. Swanson, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Steven J. Thorson, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Drs. Robert and Sara Tonsing</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Lawrence Varner, DO</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Kay Wagner, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>David S. Wahl, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Jonathan E. Walter, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Drs. Michael and Patrice Whister</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Bruce H. Wilson, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Frederick Y. Yu, Esq</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Karen Zarlengo, MD</td>
<td>-</td>
</tr>
<tr>
<td>$100 — $249</td>
<td>Anonymous (46)</td>
<td>-</td>
</tr>
<tr>
<td>$500 — $999</td>
<td>Anonymous (5)</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. and Mrs. James Borgstede</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Michael R. Bowen, MD and Reneal B. Dr. and Mrs. James Borgstede</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Anonymous (5)</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. and Mrs. George R. Helsel</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Drs. Scott and Sarah Humphreys</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Curtis and Judy Kimball</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. Janet Legare and Dr. Vivek Balasubramanian</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>David S. Lennon, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Donna M. Nelson, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. James and Mrs. Carolyn O’Donnell</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. and Mrs. Gregg Omura</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. Debra Parsons and Dr. David Downs</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Nigel Pashley, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Perry Rasleigh, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. and Mrs. Wagner J. Schorr</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Paul D. Simmons, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Robert L. Swanson, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Steven J. Thorson, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Drs. Robert and Sara Tonsing</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Lawrence Varner, DO</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Kay Wagner, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>David S. Wahl, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Jonathan E. Walter, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Drs. Michael and Patrice Whister</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Bruce H. Wilson, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Frederick Y. Yu, Esq</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Karen Zarlengo, MD</td>
<td>-</td>
</tr>
<tr>
<td>$100 — $249</td>
<td>Anonymous (46)</td>
<td>-</td>
</tr>
<tr>
<td>$500 — $999</td>
<td>Anonymous (5)</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. and Mrs. James Borgstede</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Michael R. Bowen, MD and Reneal B. Dr. and Mrs. James Borgstede</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Anonymous (5)</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. and Mrs. George R. Helsel</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Drs. Scott and Sarah Humphreys</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Curtis and Judy Kimball</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. Janet Legare and Dr. Vivek Balasubramanian</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>David S. Lennon, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Donna M. Nelson, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. James and Mrs. Carolyn O’Donnell</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. and Mrs. Gregg Omura</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. Debra Parsons and Dr. David Downs</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Nigel Pashley, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Perry Rasleigh, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Dr. and Mrs. Wagner J. Schorr</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Paul D. Simmons, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Robert L. Swanson, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Steven J. Thorson, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Drs. Robert and Sara Tonsing</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Lawrence Varner, DO</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Kay Wagner, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>David S. Wahl, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Jonathan E. Walter, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Drs. Michael and Patrice Whister</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Bruce H. Wilson, MD</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Frederick Y. Yu, Esq</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Karen Zarlengo, MD</td>
<td>-</td>
</tr>
</tbody>
</table>
**Organization Donors**

**$5,000 — and above**

- Centura Health
- Colorado Medical Foundation Trust
- St. Mary’s Hospital and Medical Center
- The Medical Center of Aurora
- Medical Staff

**$1,000 — $4,999**

- Aspen Valley Hospital
- Boulder Community Hospital
- Medical Staff
- CarePoint/Beacon Medical Services
- Craig Hospital
- Exempt Good Samaritan Medical Center
- Medical Staff
- Exempt Lutheran Medical Center
- Exempt St. Joseph Hospital Medical Staff
- Littleton Adventist Hospital
- Longmont United Hospital Medical Staff
- North Colorado MC/Medical Staff
- Foundation
- North Suburban Medical Center
- Medical Staff
- Northern Colorado Anesthesia
- Professional Consultants, LLP
- Peak One Surgery Center
- Penrose-St. Francis Hospital
- Physicians Defense Fund Trust
- Presbyterian/St. Luke’s Medical Center
- Medical Staff
- Rocky Mountain Urological Society
- Rose Medical Center Medical Staff
- Rose Medical Center
- Sky Ridge Medical Center Medical Staff
- St. Mary-Corwin Medical Center
- Medical Staff
- St. Mary-Corwin Medical Center
- St. Thomas More Hospital
- Swedish Medical Center SOC
- The Children’s Hospital Medical Staff
- University of Colorado Hospital
- Vail Valley Medical Center Medical Staff

**Up to $1,000**

- Arapahoe - Douglas - Elbert Medical Society
- Arkansas Valley Regional Medical Center
- Arkansas Valley Regional Medical Center
- Medical Staff
- Avista Adventist Hospital Medical Staff
- Avista Adventist Hospital
- Colorado Plains Medical Center
- Community Hospital Medical Staff
- (Grand Junction)
- Delta County Memorial Hospital
- Denver Health Medical Center
- Medical Staff
- Diversified Radiology of Colorado, PC
- Estes Park Medical Center Medical Staff
- Family Health West
- Gunnison Valley Hospital

Internal Medicine Associates
Kennedy, Childs & Fogg, P.C.
Lakeview Family Medicine
Lincoln Community Hospital
Medical Staff
Littleton Adventist Hospital Medical Staff
Longmont United Hospital
McConnell Siederis Fleischner
Houghtraling & Craigmile, LLC
McKee Medical Center Medical Staff
McKee Medical Center
Memorial Health System
Merry Regional Medical Center
of Durango
Montrose Memorial Hospital
Montrose Memorial Hospital
Medical Staff
National Jewish Health
Parker Adventist Hospital
Parker Adventist Hospital Medical Staff
Parkway Medical Center
Platte Valley Medical Center
Platte Valley Medical Center
Medical Staff
Porter Adventist Hospital Medical Staff
Pueblo County Medical Society
Rocky Mountain Health Plans
Rotman Eye Care, PC
Senior Care of Colorado, PC
South Denver Obstetrics and Gynecology, PC
Spalding Rehabilitation Hospital
St. Anthony Central Hospital
St. Thomas More Hospital Medical Staff
The Children’s Hospital
The Denver Institute for Psychoanalysis
The Denver Psychoanalytic Society
Yuma District Hospital

**Former CPHP Board Directors**

- Paul D. Cooper, Esq
  - Mr. Dennis J. O’Malley
  - John H. Drabing, DO
  - Samuel V. Orizio, DO
  - Ms. Carol A. Goddard
  - Stuart A. Plummer, MD
  - Robert D. Hartley, II, MD
  - Richard E. Quinn, Jr., MD
  - Ms. Bunkie Inkret
  - James H. Shore, MD
  - Ms. Patricia A. Laman
  - Leigh Truitt, MD
  - Alan Lazaroff, MD
  - Theodore R. Zerwin, MSW
  - Louise L. McDonald, MD

**The CPHP Team**

- Cat L. Allison, LCSW
  - Director of Clinical Services
- Mary Ellen Caiati, MD
  - Associate Medical Director
- Sarah R. Early, PsyD
  - Executive Director
- Michael H. Gendel, MD
  - Medical Director Emeritus
- Doris C. Gundersen, MD
  - Medical Director
- Scott Humphreys, MD
  - Associate Medical Director
- Lynne Klaus, LCSW, CACIII
  - Clinician
- Amanda L. Parry
  - Executive Assistant
- Jay H. Shore, MD
  - Associate Medical Director
- Elizabeth B. “Libby” Stuyt, MD
  - Associate Medical Director
- Todd R. Weiss
  - Development Specialist

**2008-09 CPHP Board Directors**

- James P. Borgstede, MD
  - Chair
- George D. Dikeou, Esq
  - Vice-Chair
- Stephen L. Dils, MD
  - Immediate-Past Chair
- Larry A. Schafer, MD
  - Treasurer
- Caroline M. Gellick, MD
  - Secretary
- Maureen J. Garrity, PhD
  - Director-at-Large
- Bruce H. Wilson, MD
  - Director-at-Large
- Michael V. Calvini, PA-C
  - Thomas G. Currigan
- John H. Genrich, MD, PC
  - Alfred D. Gilchrist
- Debbie Lazarus
  - Michael Michalek, MD
  - Lawrence Varner, DO

Please Note: This donor recognition list reflects gifts received at time of printing. We have made every effort to give proper recognition to those who financially supported CPHP’s mission in 2008-09. If we have made an error, we sincerely apologize. Please contact CPHP’s Development Specialist at (303) 860-0122, ext. 221, so we may correct our records.

**2010 Recognition of COPIC**

COPIC is generously sponsoring CPHP’s 2010 Annual Newsletter. COPIC has been an ardent supporter of our program since our inception in 1986. We feel very fortunate to have such strong support from a long-time ally.

We also wish to extend our appreciation to COPIC for their consistent generosity to the annual Financial Assistance Fund that directly assists physician clients in need of CPHP services who otherwise would not be able to afford such care.

THANK YOU!
I first learned about CPHP as a resident (1998-2001) so I had some previous exposure to CPHP. In 2003 I was confronted with a malpractice suit. It was a real shock and very devastating to me. As you can imagine, it was very isolating. Prior to this everything had been going really well and I was rated as one of the top physicians in our practice.

I was quite anxious and definitely not acting like myself. It seemed like a number of legal issues just kept popping up. During the malpractice suit I started practicing defensive medicine. I suppose this is a natural response. Each patient I was treating began looking like a lawsuit to me. My personal life was severely affected. My energy level for social situations was terribly depleted. I didn’t know what was coming next.

In 2005 I finally referred myself to CPHP. Once I scheduled my initial meeting with CPHP I was really looking forward to my visit. Although I must admit there was some trepidation. Perhaps even some fear. I questioned myself. Am I a bad doctor? But I soon realized my fear was irrational.

When arriving at CPHP I entered the door and was now in the waiting room. I was still a little anxious, wondering if CPHP could really even help me with legal issues and the associated stress I was dealing with. Once I met with the assigned Associate Medical Director and Clinician I felt like they really cared and understood my situation. They certainly normalized the situation. I suddenly felt like I wasn’t alone. CPHP assured me that they see this all the time. Now I felt validated and felt that I was being looked upon as a peer physician. They really treated me respectfully and it was at that moment that I knew I was in the right place!

With CPHP’s help I worked with a treatment provider, and that was very helpful. CPHP was also helpful in communicating with my workplace. Now I felt like I had a home base and that whenever I needed something I knew CPHP would be there as a resource to help me.

I still meet with CPHP at least twice a year even though it is not required. I continue to feel like it’s a place that has made me feel whole again. The monitoring was never intrusive and the process was about making me feel comfortable. So I feel like I am working on my strengths. If there are weaknesses in my situation I feel like I can work with treatment providers and this helps me to stay on top of the situation to be a better doctor.

I have communicated to other physicians about going to CPHP and let them know it is a resource to help support us and back us up during troubled times.

The group that truly represents physicians is CPHP. They allow us to be human and get the help we need.

Many of my colleagues in residency didn’t understand what CPHP was all about or how to utilize the services. However, I realized later on that many of them were able to receive help during troubling times, too.

One thing I would say to other physicians is that going through legal issues is common in our field. When it does happen, CPHP is one of the best resources to tap into.

Before coming to CPHP I felt as though I might be the worst doctor in the world. Even after all of the hard work, CPHP helped me with the situation to really identify that I am normal and that this is just a legal jungle that I have been exposed to.

This whole process has allowed me to more acutely see the human side of patients. I have a new perspective on their emotions. This has really opened my eyes and allowed me to better connect with patients.

I was experiencing some serious and complicated family problems that were spiraling out of control. This was affecting my personal and professional life in a very significant way. This was a very difficult time to be practicing.

Due to personal family problems I was experiencing, unfortunately it was affecting my career so I was mandated to seek the services provided by CPHP. I was very apprehensive about making this initial contact as this was my first encounter with CPHP. However, I called CPHP and was able to get an appointment within 30 days. Prior to meeting with CPHP I did not know anything about the organization.

It was highly disappointing to find myself under a microscope after such a long and solid career. If I were not a physician I am sure I would not have to go through this scrutiny and monitoring, although I understand the need for it. This was very hard for me to deal with. Thank goodness that I got through it.

For someone who had never had family problems or been mandated for an evaluation, the whole process was very unusual and painful, but CPHP ameliorated the discomfort as much as possible. When I spoke with the Clinician and Associate Medical Director assigned to my case I knew they were objective as they had to come to their own conclusions, but they were very kind, understanding and helpful to me.

CPHP has helped resolve my situation and all of the worries and problems have been cleared up. What a relief to not be in the spotlight now! The Clinical Team helped me in every way within their power and made this painful process more manageable and bearable. During the time I met with the Associate Medical Director and Clinician I brought up my personal issues and how my family situation affected me as a person. They kindly offered some recommendations within their treatment provider network if I decided to proceed forward…if I needed additional help.

I would absolutely recommend CPHP and their Clinical Team to other physicians and physician assistants because CPHP can exert a positive impact. They will always do their best for you and keep the process scrupulously anonymous. Given the responsi-
unrestricted DEA license. The physician must establish that a patient has a debilitating medical condition and would benefit from medical MJ. The evaluating physician should review all pertinent treatment records thoroughly, consult with other treatment providers involved in the patient’s care, obtain a thorough history and conduct a physical examination before rendering a diagnosis or treatment recommendation. A bona fide doctor-patient relationship is established in this scenario. Follow up care for monitoring the effectiveness of medical MJ and changing recommendations when indicated should occur. All of this constitutes the practice of medicine, which means that the physician must abide by the Medical Practice Act, including practicing within one’s scope of expertise, maintaining adequate malpractice coverage and engaging in continuing education to maintain one’s competency.

Physicians must consider carefully which patients are appropriate for a medical MJ trial. While remaining sensitive to the population Amendment 20 was intended to help, we must also abide by the Hippocratic Oath and protect our patients from harm. Medical MJ has not been studied the way other remedies offered to the public are. MJ purchased from dispensaries has not been formally investigated for safety and efficacy. No standardizations for therapeutic dosing have been established. The THC content in MJ can range from 1 to 10%. Consequently, MJ is dispensed in unknown, varying strengths. It is not monitored for purity. No testing for the presence of contaminants (e.g., pesticides, herbicides or molds) occurs. Importantly, unlike medications approved by the FDA, no post-marketing surveillance will be conducted to track unforeseen adverse side effects of MJ. It will not be subject to liability regulations and will be exempt from quality control standards. Despite being a Schedule I drug, MJ has bypassed the Colorado Prescription Drug Monitoring Program. For all these reasons, physicians recommending medical MJ to patients should provide careful informed consent identifying the risks, benefits and alternative treatments available. People requesting medical MJ should be screened for their vulnerability to addiction and other mental illnesses. Physicians making medical MJ recommendations should also consider the liability of such a recommendation for patients working in safety-sensitive employment (for example, the healthcare and transportation industries). Finally, it will be important for all physicians to carefully examine their motives for recommending medical MJ. It should be solely for the patient’s benefit. Financial incentives and personal political views should not influence treatment recommendations.

Of course, conflicts of interest, such as investments in dispensaries or financial kickbacks for referrals, are ethically and legally proscribed.

What is unfolding in Colorado is less about compassionate care for people with serious diseases and more about decriminalizing MJ. Those protagonists for liberalized MJ rules have strategically placed physicians smack in the middle of a political, not medical, debate. In the end, this tactical maneuver may prove to be a successful strategy for the complete legalization of MJ and other drugs, taking physicians out of the loop entirely. If not, state and federal regulators will need to ramp up efforts to ensure that the public is truly protected from indiscriminate dispensing practices and those physicians who interpret the law too loosely creating broad access to a substance with high abuse potential. Stay tuned!

(For article references, please go to the CPHP website at cphp.org.)
My commitment to our patients is to assure they receive quality patient care. This means ensuring that our physicians are safe to practice medicine. When a practitioner reports a health concern, our goal then is to see that every opportunity is at his/her disposal to address the health concerns to assure they can re-enter the workforce in a positive, capable manner. Rarely do we look at a health issue as career-ending. It is an opportunity to promote positive health, education and well-being so that the practitioner can continue to be a valued member of our Medical Staff.

The director of Medical Staff Services, upon the recommendation of the Medical Staff President and Chief Medical Officer, facilitates a referral to CPHP.

CPHP is a primary point of contact when we are faced with a physician health issue.

In our particular hospital, CPHP has helped us when physicians are dealing with alcohol/drug or psychiatric-related issues as well as other problems such as disruptive behaviors.

Our Medical Staff Bylaws encourage physicians to self-report their health problems and remind them that we promote a process of rehabilitation where confidentiality is maintained, which is key in developing a level of trust with the involved practitioner.

When behavioral issues have surfaced, CPHP’s evaluation process will help identify underlying issues or concerns that may have contributed to the behavior issues. We monitor and trend behavioral issues, as they are just one tool to help identify concerns that may need to be addressed.

It has been my experience that the majority of our practitioners work well with CPHP and they remain on Staff as a valued member after they have received CPHP’s assistance and subsequent treatment. That is why it is so important to have a good monitoring process in place to help identify an issue or concern early on.

CPHP has provided presentations to our Medical Executive Committee meeting. CPHP’s direct communication with our Medical Staff Leadership gave them the insight to help identify issues and the confidence to direct the practitioner(s) to your program. Leadership feels comfortable with the process followed by CPHP and the communication that CPHP provides to the facility.

CPHP has been a good partner to work with and they share appropriate information with the appropriate release of information. Our leadership feels confident that they can trust the recommendations of CPHP and base their decisions on information received.

We all understand how delicate and sensitive health issues are to those involved. But with CPHP at our disposal, an already tried and true entity of support, everyone feels more at ease the moment they are notified. I think that speaks volumes to the trust and support your organization has built over the years. We wouldn’t want to do our jobs without you!

Gail Winterly, CPMSM
Director, Medical Staff Services
Exempla Good Samaritan Medical Center

Testimonial From a Hospital
Our Special Appreciation to Donors of $5,000 or More to the Spirit of Medicine Campaign/Living Well Giving Society

St. Mary’s Hospital and Medical Center Receiving a Spirit of Medicine Award
Bruce Wilson, MD, Past CPHP Board Director, presenting the Spirit of Medicine award to Robert Ladenburger, then President and CEO of St. Mary’s Hospital and Medical Center in Grand Junction.

Colorado Medical Society Receiving the Spirit of Medicine Award
(L-R) Sarah Early, PsyD, CPHP Executive Director, Ben Vernon, MD, Immediate-Past President, CMS, Caroline Gellrick, MD, CPHP Board Director, Mark Laitin, MD, Current CMS President and Lynn Perry, MD, Past CMS President.

Centura Health Receiving a Spirit of Medicine Award
(L-R) Steven T. Brown III, MD, CME-Centura, CMO-St. Mary-Corwin, Pam Nicholson, VP of Advocacy, Centura, George Dikeou, Esq., CPHP Board Director, Gary Campbell, President and CEO, Centura and Sarah R. Early, PsyD, CPHP Executive Director.

Valley View Hospital Medical Staff Receiving a Spirit of Medicine/Living Well Giving Society Award
Todd Weiss, CPHP Development Specialist, presenting the Spirit of Medicine award to the Valley View Hospital Medical Staff and “Hap” Harold Young, MD, Chief of Staff.

Medical Center of Aurora Receiving a Spirit of Medicine Award
(L-R) Alan Aboaf, MD, Past President, Medical Staff at The Medical Center of Aurora, receiving the Spirit of Medicine award from Larry Varner, DO, CPHP Board Director.

St. Mary’s Hospital and Medical Center Receiving the Spirit of Medicine Award
(l-r) Dan Oberg, CPMG Chief Financial Officer, Sarah R. Early, PsyD, CPHP Executive Director, Ruby Kadota, MD, CPMG Associate Medical Director/HR, William “Bill” Wright, MD, MSPH, CPMG Executive Medical Director and President, George Dikeou, Esq., CPHP Board Director and Todd Weiss, CPHP Development Specialist.
CPHP’s Vital Mission of Research

MICHAEL H. GENDEL, MD – CPHP MEDICAL DIRECTOR EMERITUS

CPHP remains committed to conducting and supporting research in the physician health field. From the beginning, Steve Dilts, MD, our first Medical Director, confronted our field with the need for solid empirical data to guide our activities, promote physician health, and inform public policy. CPHP published about our organization and its work during the 80s in the American Journal on Addictions and in the 90s in the Journal of the American Medical Association.

Under Dr. Dilts’ leadership we organized a national physician health research conference in 1996. From this conference evolved the Physician Health Research Planning Group whose charge was to prioritize and facilitate physician health research nationally. One product of this work group, which I had the honor of chairing, was the “national database,” the health screening questionnaire which we use at CPHP and is used by many other Physician Health Programs (PHPs). This was meant to standardize the data collected about physicians so that studies could be conducted using a data set larger than any state could muster. This work group evolved into the Research Task Force of the Federation of State Physician Health Programs (FSPHP) where it now plays a vital role. CPHP also organized and hosted a recent national conference of physician health researchers to take a fresh look at the national research agenda. This conference was generously sponsored by Kaiser Permanente Colorado.

CPHP’s commitment to research has been supported by our Board of Directors and by those physicians who have contributed to our annual Spirit of Medicine campaign. Though I remain very engaged in this work, the CPHP research group is now led by Jay Shore, MD, Associate Medical Director and Elizabeth Brooks, PhD, Principal Researcher, both of whose careers are largely committed to research. Elizabeth is now working as principal investigator on many of our projects. Libby Stuyt, MD, Associate Medical Director, Doris Gunderson, MD, Medical Director and Sarah Early, PsyD, Executive Director, are also very active in the research group.


Manuscripts near completion include a retrospective study of boundary violations in the CPHP population, a description of the Colorado site’s findings in the above-captioned five-year study, and our study of randomly selected Colorado physicians concerning their patterns of self-prescribed medical care.

Other projects on the table include studying our health screening questionnaire. This is very important as it potentially opens the door to a rich source of data for us and the other PHPs using the national database. We are also looking into the feasibility of studying how CPHP intervention with ill physicians affects the quality of their medical practice.

We wish to note that all of these studies, past and proposed, utilize group data in which no individual is identifiable. No study goes forward without approval of the Institutional Review Board of the University of Colorado, Denver.

We at CPHP have also been very active in presenting our research (and learning from others’) in national and international settings. The American Medical Association (AMA) and Canadian Medical Association (CMA) jointly sponsor an international physician health research conference every two years. In 2008 the British Medical Association joined the AMA and CMA in a London conference, and our colleagues in Norway co-sponsored an event in Oslo some years ago. The FSPHP meets annually. We have been privileged to participate in all these meetings, learning about physician health problems, working to find the best ways of treating and supporting those participating in our programs, and finding ways to help all physicians cope with the stresses of our profession.

We are continuing to go green!

Many of you within the medical community have indicated a desire to receive future editions of the CPHP newsletter in an electronic format. We are so pleased to be moving in this direction to save natural resources and reduce printing and mailing costs. If you would prefer to receive future editions of the CPHP Newsletter via e-mail, please forward your name, address and email to our Development Specialist, Todd Weiss, at tweiss@cphp.org

Thank you!
CPHP Board of Directors, Medical Directors and Staff

2010-2011 BOARD of DIRECTORS

OFFICERS
James P. Borgstede, MD ........................................ Chair
George D. Dikeou, Esq. ........................................ Vice Chair
Thomas G. Currigan, Jr. ...................................... Secretary
Larry A. Schafer, MD ........................................... Treasurer
John H. Genrich, MD .................................. Director-at-Large

DIRECTORS
Maureen J. Garrity, PhD
Caroline M. Gellrick, MD
Jim E. Keller, M.P.H., PA-C
Debbie Lazarus
Michael Michalek, MD
Douglas Speedie, MD
Steven Summer
Lawrence Varner, DO

MEDICAL DIRECTOR & ASSOCIATE MEDICAL DIRECTORS
Doris C. Gundersen, MD .................. Medical Director
Michael H. Gendel, MD ................. Medical Director Emeritus
Mary Ellen Caiati, MD ................. Associate Medical Director
Scott A. Humphreys, MD .......... Associate Medical Director
Jay H. Shore, MD ................. Associate Medical Director
Elizabeth B. “Libby” Stuyt, MD .... Associate Medical Director

PROFESSIONAL & ADMINISTRATIVE STAFF
Sarah R. Early, PsyD ........ Executive Director
Cae L. Allison, LCSW .................. Director of Clinical Services
Elizabeth Brooks, PhD ........... Principal Researcher
Julie Guhl, BA ......... Receptionist/Program Assistant
Cindy Hudson, MA, CACIII ....... Clinician
Lynne Klaus, LCSW, CACIII .......... Clinician
Sally Moody, LCSW .................. Clinician
Joyce Muniz, BSB/PA ................. Compliance Coordinator
Amanda Parry, BBA .................. Executive Assistant
Denny H. Smith, CPA, MT ........ Financial Manager
Dwayne G. Spinler, MS, LPC ........ Clinician
Tracy-Sue Walters .......... Administrative/Clinical Assistant
Todd R. Weiss, BA ........ Development Specialist

All material in CPHP News is protected by copyright. Please do not reproduce or use without written permission from CPHP.