

PHYSICIAN HEALTH NEWS

The Official Newsletter of the Federation of State Physician Health Programs



Welcome to the 28th edition, Volume 2 of *Physician Health News*. We hope you will find this an informative forum for all aspects of physician health and well-being. *Physician Health News* is the official newsletter of the Federation of State Physician Health Programs (FSPHP) and is published by the FSPHP.

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The FSPHP is a national organization providing an exchange of information among state physician health programs (PHPs) to develop common objectives, goals, and standards. If you're not a member yet, please consider joining. State, Associate, International, Individual, and Organizational membership categories are available. Please visit www.fsphp.org/join-now to join today.

We sincerely hope you respond as an indication of your commitment to a stronger, more cohesive FSPHP. For more information on each of the membership categories, including new categories for organizational and individual members, please see our website or contact Linda Bresnahan.

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Physician Health News is developed through the volunteer efforts of the Publications Committee with assistance from Misty Horten (design and layout) and Christine Clark (copyediting and proofreading).

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PRESIDENT'S MESSAGE

Uneasy Lies the Head

**Christopher Bundy, MD, MPH,
FASAM**



**Christopher Bundy, MD,
MPH, FASAM**

This past May I marked my seventh year with the Washington Physicians Health Program, five as its Executive Medical Director. While I am not the most senior member of our Federation, somewhere along the line I seem to have graduated from my FSPHP residency. One of the things I have noticed lately is the many new PHP medical directors among our ranks, many of whom I have had the pleasure of getting to know better this year. It has reminded me of just how challenging PHP work can be, especially in the beginning.

What we do is complex, high stakes, and can lead to intense interactions with participants, stakeholders, and even each other. New PHP directors may be hired for their enthusiasm, skill, innovation, and leadership, yet they find themselves in ecosystems that are risk averse and change resistant. These cultures may be biased toward the comfort of the familiar and reluctant to embrace the lifeblood of the new leader. The many masters to whom they are accountable need data and reports and presentations to reassure that all continues to be well and that improvements are continuously under way. No matter how skilled or experienced, new PHP directors often find themselves careening through foreign lands, steep learning curves ahead, competence and confidence in the rear view.

Rather than be daunted, I encourage new PHP leaders to take this opportunity to listen and learn. At the start, it is less important that you know or do anything and more important to understand the conceptual, historical, and sometimes political underpinnings of your PHP's extant practices. New ideas are necessary and important to advance our work, but they need to be tempered by a healthy respect for established methodology that may have been born of experience and hard lessons. Cultivating relationships, developing trust, and being very curious about the new world you inhabit can pave the way for receptivity to new ideas, always remembering that sometimes it is more important to be persuaded than to persuade.

PHP leaders give selflessly, often at considerable personal cost, in service to our nation's healers. I want you to know that your sacrifice is acknowledged and appreciated. It has not been easy for any of us over the last 18 months and I admire your perseverance and

fortitude. I also want to give special encouragement and support to those of you who are newer PHP directors. We are here to help you meet your challenges and experience the rewards that accumulate over time with each seed of recovered life you sow.

In Shakespeare's play, *King Henry IV*, the title character exclaims, "Deny it to a king? Then happy low, lie down! Uneasy lies the head that wears a crown." While PHP directors know little of the autocracy the metaphor suggests, we do know the strains of passion, duty, and diligence. The requirements of our position include suiting up each day to do battle against cunning, baffling, and powerful illnesses whose weapons include fear, shame, stigma, and denial. Without help, it can be too much for us.

A wise person once told me that sharing halves worry and doubles joy. The FSPHP is a fine example of that proverb. Through my FSPHP work, I have received far more in support, encouragement, and wisdom than I ever invested. FSPHP has made me a better PHP director, made my job easier, and given me friendships that will last a lifetime.

The gifts of the Federation are no more apparent than in the fall edition of *Physician Health News*. Here, we celebrate the bounty of our Annual Conference and the crucible of sharing it represents. In these pages, you will find ideas, innovations, and people to inspire and sustain you. And, should you be a new and perhaps uneasy crown bearer, I hope this issue reminds you that, as a member of this Federation, you need never be alone! ■

EXECUTIVE DIRECTOR'S MESSAGE

Message from the Executive Director

Linda Bresnahan, MS

Important Organization Updates



Linda R. Bresnahan, MS

- **FSPHP President Honored as WSMA's Unsung Hero:**

We celebrate Dr. Chris Bundy, FSPHP President, for being acknowledged as a national leader and for his service to the physician community in Washington. The Washington State Medical Association (WSMA) honored Dr. Chris Bundy with the much-deserved distinction of being named WSMA's 2021 Presidents Unsung Hero!

- **FSPHP Applies for Its First HRSA Grant:** FSPHP applied for its first grant when the U.S. Department of Health and Human Services, Health Resources and

Services Administration released its first-ever notice of a funding opportunity for health and public safety workforce resilience training. The purpose of this program is to provide support to entities, including associations, to establish, enhance, or expand evidence-informed or evidenced-based programs or protocols to promote resilience, mental health, and wellness among the health workforce. Whether awarded the funding or not, the FSPHP felt an obligation to pursue this opportunity, because of its alignment to our mission, the experience gained, and the opportunity to use the grant writing process to clarify FSPHP's strategic priorities. One inspiring aspect of the application process was FSPHP's receipt of letters of support for this grant application from the American Medical Association, the Federation of State Medical Boards, the American Psychiatric Association, the American Foundation of Suicide Prevention, and the American Board of Medical Specialties.

- **FSPHP Board of Directors Strategy Session:** The FSPHP Board of Directors met for two days virtually to discuss FSPHP strategic goals and commit to plans to support our member Physician Health Programs. The Board identified and committed to goals to support PHPs with how to help the profession during continued trying times and with how to prepare our PHPs for Performance Enhancement and Effectiveness Reviews.™ There were two themes throughout the meeting: (1) to be mindful of our resources and bandwidth and (2) to enhance ways we serve our membership by providing resources to programs such as education, networking, and sharing of sample policies to help PHPs be successful with a future PEER™ experience.
- **FSPHP Seeking Membership and Annual Meeting Coordinator:** Sandra Savage reduced her hours with FSPHP starting October 25, 2021. We are currently looking to fill a remote part-time position with someone who has the ability to shift to full time. The position requires strong healthcare association management and meeting planning skills, particularly in utilizing a membership database and/or website software such as MemberClicks. Interested applicants can apply here: <https://www.indeed.com/company/Federation-of-State-Physician-Health-Programs/jobs/Membership-Annual-Meeting-Coordinator-54a66bb8df32b579?fccid=d506d64ef740033a&vjs=3>. In the meantime, starting on October 20, Beth Maher, Associate Director from Riggs Enterprise, will be on board with Sandra and me to support our needs. She has worked for the American Society of Transplantation (AST) and has strong association management skills, including

administrative, membership, committee, and high-level project experience.

Highlights of Our Work in Progress

- **FSPHP Refreshed Values:** At the request of the FSPHP Board, the FSPHP Public Policy Committee refreshed the FSPHP Value Statements. Preview them here: <https://www.fspHP.org/mission-vision-and-values>.
- **Fund Development Committee:** Thank you to all who have donated so far to FSPHP's **Rally by Region** campaign. The Committee and FSPHP Board have set a goal to rally together and raise **\$10,000!**
- **PEER™ and ETA™—Preparing for Pilots:** The Accreditation Review Council, the Performance Enhancement and Effectiveness Review™ Committee, and the Evaluation and Treatment Accreditation™ Committee have completed some significant milestones with the development of criteria, metrics, and identifying subject matter expertise qualifications. Soon, FSPHP in partnership with Metacred will begin recruiting subject matter experts. Both programs will be piloting in 2022.
- **Networking and Engagement:** This fall, the FSPHP supported the Northeast and Western Regional Membership Meetings. All members are welcome to join the Central and Southeast meetings to occur in November 2021.
- **2022 FSPHP Annual Education and Membership Meeting—Embracing Inclusivity and Confronting Stigma with Professionals Health Programs' Best Practices:** Your Program Planning Committee is working hard to bring us together in person April 26–28, 2022, in New Orleans! We are excited to be together again and to create more engagement and networking than ever before with our meeting occurring at the same hotel and time frame as the Federation of State Medical Boards.
- **Welcome New FSPHP Members:** Our membership is growing with our largest membership to date! We encourage you all to reach out to our many new members, new to FSPHP, and many new to their Physician Health Programs! A complete list follows in this issue.
- **Leadership:** The FSPHP Nominating Committee Process begins in early November 2021 with the call for nominations for future leadership of the FSPHP <https://fspHP.memberclicks.net/nomination2022>. Please get involved with FSPHP by serving on a

continued on page 4

Executive Director's Message

continued from page 3

committee, chairing a committee, and preparing for a future leadership role on the FSPHP Board of Directors.

- **Research Committee:** The FSPHP Research Committee has updated a prior PHP survey. Please be on the lookout to complete this important survey. The results will be provided to all PHPs to share examples of services and methods of all PHPs. In addition, the research committee partnered with the Massachusetts Medical Society Benevolent Fund to study resources available to address the financial need of PHP participants. More will follow on the results. In addition, the FSPHP-NIDA Imaging Biomarker Addiction Treatment Outcome Study is under way. Information on how to share news of this study with your PHP participants is available here: <https://www.fspHP.org/fspHP-nida-study>.
- **Medical Student and Resident Committee:** Plans are under way to launch a survey of medical schools to inform us all of the scope of services for medical students at risk of substance use disorders and mental illness and to learn more about how PHPs work with their medical schools in their state.
- **Task Force to Support Safe Haven:** This task force will be launched to support PHPs interested in reducing barriers to help-seeking that may discourage health professionals from obtaining appropriate support and/or treatment when their well-being is at risk. Please let FSPHP know how this task force can help your PHP. The task force can share examples of licensure questions and legislation reform with PHPs and medical boards that support ADA compliance, protect the privacy of health information, and permit non-reporting of health conditions that are (or have been) appropriately addressed and do not pose risk to the public.
- **Complimentary On-Demand Physician Suicide Awareness and Prevention Program Launched:** Physician Suicide Prevention: Listening to the Voices of Experience is a complimentary two-hour, on-demand education program brought to you by the FSPHP, in collaboration with American Foundation for Suicide Prevention. CME is available for a \$50 fee. We encourage you to share this resource widely and on your own PHP website: [Click here for more information](#).
- **MAT Advisory Panel:** A position statement, *Safety Considerations for Medication Treatment of Opioid Use Disorders in Monitored Health Professionals*, continues to be in development. FSPHP sent the

statement to external reviewers in August 2021 and is reviewing the comments and integrating feedback. A final draft is anticipated in January 2022 for the Public Policy Committee review and then will be sent to the Board of Directors.

In closing, thank you for all you do! Our FSPHP members make this progress possible. Your commitment to the health of physicians and healthcare professionals in your state is vital. If you would like to get involved in any of our FSPHP initiatives, please join a committee! Information on the committees and our "committee service interest form" can be found on our website here: [Committee Interest Form](#). ■

CALL FOR NOMINATIONS FOR FSPHP BOARD OF DIRECTORS FOR 2022–2024 TERM

The FSPHP Nominating Committee is seeking candidates interested in openings in leadership on the Board of Directors. The Nominating Committee is tasked with distributing its recommendations for positions by ballot in February 2022. The following Board of Director positions have reached their two-year term and will be on the ballot for the 2022–2024 term:

- President-Elect
- Central Region Director — two open positions
- Northeast Region Director
- Southeast Region Director
- Western Region Director

All current members of the board in these positions are eligible to be candidates on the ballot for another term. <https://fspHP.memberclicks.net/nomination2022> ■

FSPHP WELCOMES NEW MEMBERS

The following new members have joined FSPHP since the Spring 2021 issue was published. Please join us in welcoming our new members!

State Voting Members

Douglas Olson, MD
Medical Director, HAVEN Connecticut

Associate Members

Mark Joseph Albanese, MD
Medical Director, Physician Health Services,
Massachusetts Medical Society

Andrew Ridley Beierschmitt, MSW, LICSW
Clinical Coordinator,
Washington Physicians Health Program

Anthony Cloy, MD
Medical Director, Mississippi Physician Health
Program

Katelyn Dalton
Case Manager, Healthcare Professionals' Foundation
of Louisiana

Brandi Dedmore
Administrative Assistant, Montana Professional
Assistance Program, Inc.

Missy Edwards
Toxicology and Scheduling Coordinator, Kentucky
Physicians Health Foundation

Gia Go
Administrative Assistant, Washington Physicians
Health Program

Mark Goldberg, MD
Board of Directors, Florida Professionals
Resource Network

Richard Montminy, MD, MPH
Clinical Coordinator, Washington Physicians
Health Program

Ryan Owsley, MD
President/CEO, Comprehensive Dermatology of
Idaho, PLLC

Glenn Pransky, MD
Chair, PHS Board of Directors, Massachusetts Physician
Health Services

Amy Sanford
Clinical Coordinator, Montana Professional
Assistance Program

Tammy Schlingmann
Kansas Medical Society — Professionals'
Health Program

David Tolentino, DO
Chair of Board, North Carolina Professionals
Health Program

Richard Whitney, MD, FASAM
Medical Director, Ohio Physicians Health Program

Individual Members

Candace Backer, LCSW
Director, Continuing the Care

Jen Brandt, LISW-S, PhD
Director Wellbeing, Diversity, and Inclusion Initiatives,
American Veterinary Medical Association

Robyn Hacker, PhD, LP, LAC
Clinical Manager, Colorado Lawyer Assistance
Program

Lindsey Hanlon, MS, CPH
Program Coordinator, LifeBridge Nebraska

Yvette Hourigan, Esq., CEAP
Executive Director, Kentucky Lawyer Assistance Program

Amy Kingery, MBA, LCSW, LAC
Assistant Director, Colorado Lawyer Assistance Program

Sarah Myers, Esq., LAC, LMFT
Executive Director, Colorado Lawyer Assistance Program

Amy Reynoldson, BS
Executive Vice President, Nebraska Medical Association

Philip Richmond, DVM
Chair, Professional Wellness & Wellbeing Committee,
Florida Veterinary Medical Association

Tish Vincent, LMSW, Esq
Chair of ABA Commission on Lawyer Assistance
Programs, American Bar Association

Industry Partner Individual Members

Elizabeth Bradshaw, MBA
National Marketing Coordinator, Santé Center
for Healing

Steven Wolt
CEO, Veritus

International Members

Chantale Brien, MD
Director of Intervention and Prevention, QPHP

Dijana Jovic, BEc, PMP
Manager, Operations, Ontario Medical Association

Organizational Members

Ray Glendrange, MD
Chair, Riverside County Medical Association Physician
Well-Being Committee

Timothy Kolb, DVM
Director, American Association of Veterinary
State Boards ■

IT'S RENEWAL TIME

The FSPHP membership renewal period began on October 1. We hope that you will renew your FSPHP membership for 2022. The involvement of every FSPHP member is important and very much appreciated.

FSPHP 2022 Membership Dues

\$1,575—State Voting
\$210—Associate
\$790*—International
\$160—Individual
\$160—Industry Partner Individual
\$420—Organizational

**The first two international members are \$790 within the same program, and others are \$210.*

We look forward to continuing your membership and growing the FSPHP membership and its associated benefits. We ask you to share information about FSPHP membership with your staff, board members, and committee members who would benefit from an FSPHP membership.

Please share these helpful links with those who may be interested in the benefits of FSPHP membership:

[Benefits of Membership](#)
[Classes of Membership](#)
[Map of FSPHP Regions](#)
[FSPHP Member Testimonials](#)
[Join Now](#)

Special Membership Dues Promotions: Two Free Months for New Members

Starting October 1, 2021, any new member who joins FSPHP for the 2022 calendar year will receive the remainder of 2021 at no additional cost. Please share this information with anyone considering membership or who you feel might benefit by becoming an FSPHP member. Please email lbresnahan@fsphp.org with any questions. ■

JOIN US IN OUR RALLY BY REGION FUNDRAISER

This year, the FSPHP leadership, inspired by the FSPHP Fund Development Committee, has launched an FSPHP **RALLY BY REGION**. Our goal is to rally together and raise **\$10,000**! We are hoping to do this by encouraging each of the four regions to independently raise **\$2,500** from both members and nonmembers between **August 20–November 30, 2021**. Your donations will ensure that FSPHP remains the trusted national voice for addressing issues that affect physician health and patient safety.

In addition, your contributions will allow FSPHP to continue the implementation of new initiatives, uphold an environment of subject matter experts, sharing and networking, and establishing best practices to assist PHPs in their quest to protect the public.

FSPHP will acknowledge your region when you reach the **\$2,500** goal.

Let the fun begin! [Click here to donate](#).*

To those [who donated already in 2021](#), we thank you wholeheartedly for your invaluable support!

**You will be prompted to enter your FSPHP username and password to proceed. New users will be prompted to create a username and password. ■*

THANK YOU TO OUR 2021 DONORS

The following have donated between March 9, 2021–October 15, 2021

Ally of Hope (\$2,500–\$4,999)

Monica Faria, MD, FASAM
Washington Physicians Health Program

Advocate (\$1,000–\$2,499)

P. Bradley Hall, MD, DABAM, FASAM
Professionals Resource Network

Caregiver (\$500–\$999)

Chris Bundy, MD, MPH, FASAM
Paul H. Earley, MD, DFASAM
Foundation of the Pennsylvania Medical Society
Mark Goldberg, MD
Doris Gundersen, MD—*In honor of all the physicians on the front line during this protracted and devastating pandemic*
Art Hengerer, MD, FACS
Missy Henke, MD
Robin McCown
Dr. Jenny Melamed and Dr. Maire Durnin-Goodman
Ohio Physicians Health Program
Glenn Pransky, MD
Michael Wilkerson, MD

Friend (\$1–\$499)

Suzanne Alunni-Kinkle, MSN, RN, CARN
Michael Baron, MD, MPH, DFASAM
Andrew Beierschmitt, MSW, LICSW
Kathleen Boyd, MSW, LICSW
Christopher Bundy MD, MPH, FASAM
Alexander Chaikin, MD
Anthony Cloy, MD
Paula Colescott, MD
Cypress Path
Paul Earley, MD, DFASAM

Mary Fahey, LCSW
 Monica Faria, MD, FASAM
 Dianne Gay
 Ray Glendrange, MD
 Angela Graham, MPA
 David Granovetter, MD
 Mary Lynn Griffin, MA, LMHC, LPCC
 Marlene Hall
 P. Bradley Hall, MD, DABAM, FASAM
 Scott Hambleton MD, DFASAM
 Art Hengerer, MD, FACS
 Amanda Kimmel, MPA
 Terry Lavery, MA, LCPC
 Bara Litman-Pike, PsyD
 Kelley Long, MBA
 Robyn Madden, JD
 Katie McQueen, MD
 Lisa Merlo, PhD, MPE
 Richard Montminy, MD, MPH
 Kay O'Shea, CADC, CCP
 Alexandria Polles, MD
 Michael Ramirez, MSn
 Amy Ressler, LCSW
 Jon Shapiro, MD, DABAM—*On behalf of the Babette Zemel Fund, in honor of presidents, past and current*
 Lindsay Shea, BA, SUDP, RYT
 Michael Vaughan
 Heather Wilson, MSW, CFRE, CAE
 Tracy Zemansky, PhD

Thank You to Our Regional Member Meeting Educational Grant Sponsors

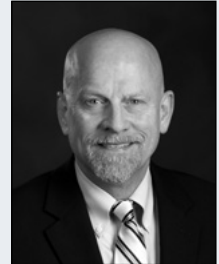


DONOR SPOTLIGHT

AN INTERVIEW WITH SCOTT HAMBLETON, MD, DFASAM

FSPHP President-Elect

I became involved with FSPHP in 2007, when I was undertaking a fellowship in addiction medicine. Since then, I have attended all but two of the annual conferences. After I became the Medical Director of the Mississippi Physician Health Program (PHP), I became more active in FSPHP and quickly realized the benefit of volunteering on committees and the board. I currently serve as the President-Elect.



Scott Hambleton, MD, DFASAM

Making a personal contribution to the FSPHP *Partnering to Advance PHPs Campaign* is imperative to me, both professionally and personally. I wholeheartedly believe in the mission, and the services provided are remarkable. Not to mention, my affiliation with the FSPHP family has been one of the most gratifying aspects of my entire career as a physician. I consider these colleagues to be part of my family. The leadership and dedication of the staff and board are exceptional, and their willingness to help each other is touching and humbling. They are some of the most gifted, intelligent, and compassionate people I have ever met. My involvement has also enabled me to be more effective in working with professionals with a potentially impairing illness. The return on investment from my donation is tremendous. After all, this is my life and career, and staying involved, both programmatically and as a donor, is immensely gratifying! ■





SAVE THE DATE

FSPHP 2022 ANNUAL EDUCATION CONFERENCE

April 26–28, 2022

Embracing Inclusivity and Confronting Stigma with Professional Health Programs' Best Practices

Conference Objectives

- Review existing evidence-informed strategies that promote cultures of wellness through the assessment and mitigation of mental health stigma, bias, and discrimination in the healthcare ecosystem.
- Examine policies or practices of PHPs, evaluation and treatment providers, employers, educators, and regulatory or credentialing entities that encourage (or impede) early identification, access to resources, and effective interventions for healthcare professionals at risk of burnout, mental illness, and/or substance use disorders.
- Describe education and advocacy efforts that use destigmatization strategies to promote health professional wellness, access to support, and effective treatment. Identify best practices for identifying, referring, and monitoring substance use and mental health disorders in healthcare professionals. Such practices include mitigating stigma, internal/implicit bias, and discrimination.

This activity has been preapproved for the following accreditations:

- AMA PRA Category 1 Credits™ for Physicians
- ANCC CE for Nurses
- ACPE CE for Pharmacists
- PA CE for Psychologists
- ASWB ACE for Social Workers



We hope you will join us ***in-person*** for our annual conference, which will focus on two themes, inclusivity and destigmatization for healthcare professionals, as we deliver PHP best practices. Presentations will focus on overcoming these barriers, while addressing the evaluation, treatment, and monitoring of illness and conditions relevant to our work. This includes the stigma that accompanies mental health and substance use disorders in healthcare professionals.

Book Your Hotel Room Early

Rooms may sell out.

New Orleans Marriott
555 Canal Street
New Orleans, Louisiana 70130

FSPHP has reserved a block of rooms at the New Orleans Marriott for a discounted rate of \$249 per night. This special rate is available until 7:00 PM CST on Monday, April 4, 2022, or until the room block sells out. Its recommended you arrive on Monday, April 25th, 2022. To attend FSMB and FSPHP Joint Education Session Stay thru Saturday, April 30, 2022.

Click here to book your room <https://book.passkey.com/event/50230716/owner/6139/home>.

2021 VIRTUAL EDUCATION CONFERENCE LECTURE SUMMARIES

PRE-CONFERENCE WORKSHOPS

**INTRODUCTION
TO MOTIVATIONAL
INTERVIEWING FOR
PHYSICIAN HEALTH
PROGRAM STAFF****Lisa J. Merlo, PhD, MPE****Lisa Merlo, PhD, MPE**

Motivational interviewing (MI) is a counseling method that has been used successfully across a multitude of settings to assist those attempting behavior change. It involves a collaborative process of guiding individuals toward healthy behavior by eliciting and strengthening their personal motivation for change. Of note, MI has been successfully applied in contexts ranging from healthcare to probation offices. Use of MI-consistent communication/counseling has been associated with improved adherence, decreased resistance, better engagement, decreased provider burnout, and improved satisfaction with care.

The Professionals Resource Network, Inc., Florida's physician health program, provided training in motivational interviewing to the PHP staff and monitoring group facilitators. The trainings were conducted by a member of the Motivational Interviewing Network of Trainers with significant experience/expertise in the field of professional health monitoring. Multiple half-day workshops were spaced to allow time for practice between sessions. Satisfaction surveys indicated that the trainings were well received, and PHP staff noted that the training contributed to improved participant interactions.

During a workshop presented at the FSPHP 2021 Annual Meeting, attendees were introduced to the theory and practice of MI through experiential learning. Specifically, we demonstrated how the use of MI strategies with PHP participants can help to improve participant engagement and motivation to complete monitoring agreement requirements. Strategies to manage conflict and "resistance" were highlighted. All individuals working in the field of physician health and professional health monitoring are encouraged to incorporate motivational interviewing strategies into their work to improve participant rapport and maximize the effectiveness of their efforts. ■

**DRUG TESTING IN PHPS: THE NEXUS
BETWEEN TOXICOLOGICAL POSSIBILITY
AND CLINICAL PROBABILITY****Gary Reisfield, MD; Scott Teitelbaum, MD; and Joe Jones, PhD, NRCC-TC****Gary Reisfield, MD****Scott Teitelbaum, MD****Joseph Jones, PhD,
NRCC-TC**

The forensic drug-testing laboratory is the most objective source of data for professional health program (PHP) monitoring and evaluation processes but, ironically, the meaning of drug test results is often fraught with uncertainty. In recent years, several factors, including the rapid evolution of analytical techniques, the validation of procedures for an ever-expanding array of drugs and metabolites, and analyses involving newer biological matrices have contributed to this uncertainty, creating a growing chasm between the meaning of test results that we understand to be toxicologically possible and those for which we can assign legitimate medical explanations.

This presentation focused on the uncertainty that exists at the intersection between toxicological possibility and clinical probability. It explicated the sources of uncertainty in drug testing and proposed specific evaluator-, laboratory-, and PHP-level practices that can reduce epistemological uncertainty, thus permitting evaluators to make the most effective use of existing knowledge and to recognize and negotiate the irreducible uncertainties.

Evaluators drive the drug-testing process, selecting analytes, interpreting test results, and integrating results with other sources of information to formulate diagnoses and make appropriate monitoring and treatment recommendations. The process should involve the expert (and critical) acquisition of a thorough and

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Drug Testing in PHPs: The Nexus Between Toxicological Possibility and Clinical Probability

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granular drug use (and drug exposure) history, an appropriate client- and context-specific selection of analytes and matrices, and correct test interpretation—a process that requires MRO-level knowledge and the ability to identify and interpret the extant literature (and/or access to expert human resources, including clinician colleagues and laboratory professionals).

PHPs can contribute to an effective drug-testing process by maximizing data capture at the time of initial client telephonic and email contacts; by facilitating timely evaluations; by employing, in appropriate circumstances, pre-evaluation drug and alcohol testing; by optimizing the content of written and oral communications with clients regarding prohibited products; and by making explicit to clients what may—and what may not—constitute legitimate medical explanations for positive drug test results.

Laboratories can enhance their value by establishing validated procedures and providing timely results for a continually evolving array of relevant analytes; by offering analysis of all common biological matrices; and by providing quality consultative services to their evaluator-clients.

The quality of PHP-facilitated evaluations is optimized when PHPs, evaluators, and laboratory professionals perform their functions expertly and integrate their expertise seamlessly. ■

GENERAL SESSIONS

COVID-19 PUT NEW EMPHASIS ON NEED FOR PHYSICIAN BURNOUT SOLUTIONS

Michael Tutty, PhD (Summary writing by Sara Berg)

The COVID-19 pandemic has highlighted the negative impact of physician burnout. Now it's time to make organizations more resilient.

Burnout typically falls as a person completes higher education. But that isn't the case for doctors because having a medical degree is a predictor for physician burnout. And while the national physician burnout rate is going in the right direction—dropping from 54.4 percent in 2014 to 43.9 percent in 2017—it



Michael Tutty, PhD

remains higher than the general working population, according to a presentation at the 2021 Federation of State Physician Health Programs' virtual education conference and annual business meeting.

That's because there is something unique about medicine that contributes to increased levels of exhaustion and depersonalization. It's the burden of the EHR and the amount of "pajama time," or work after work, that contribute to physician burnout.

To that end, solving physician burnout must go beyond individual solutions to improve resiliency. Instead, the broken healthcare system needs to be fixed. Here's how.

Physicians Need More Control

Without fixing the system that plagues doctors, many have chosen to cut the number of hours worked each week. While this drop in hours can improve burnout, medicine is facing a physician shortage. But leaving the workforce or cutting back hours is not going to solve the bigger problem.

For example, if a physician's workplace is causing burnout, she will experience lack of autonomy and control. In other words, the doctor may often feel like she doesn't have a say in her work. And, while telling them to practice yoga may help on an individual level, it does not fix the system—it is just a Band-Aid.

The problems at the institutional and health-system levels must be fixed. But that doesn't mean individuals don't need mental health support or assistance. That's where physician health programs are key to providing the confidential support they need.

COVID-19's Financial Burden

There are two physician populations during the pandemic: those who were in early hot spots and those who did not see surges in COVID-19 cases until later. For physicians in early COVID-19 hot spots, they were working a tremendous number of hours. They were also stressed about the early shortage of personal protective equipment, contracting SARS-CoV-2 and being unsure about the best course of treatment for patients with COVID-19. It all added up.

Physicians who did not see early surges like those in New York or Washington still experienced high stress because they had already cut back their elective procedures in preparation. In turn, patient volumes and revenues went down, health systems experienced furloughs, and small practices struggled to meet payroll.

Achieve Organizational Resiliency

Even though nearly 30 percent of all physicians experienced high stress related to COVID-19 and 29 percent had substantial levels of work overload, 46 percent of doctors had an enhanced sense of meaning and purpose during the pandemic. In fact, more than half felt valued by their organization.

Despite it being a crisis, organizations dove deeper into the core values of being a health professional and caring for people when they are sick. This is where building a resilient organization before, during, and after a crisis is key.

The AMA offers several resources for raising awareness around physician burnout, creating a resilient organization, supporting physicians and other health professionals during a crisis, and learning from a crisis to be an even more resilient and effective organization in the future. ■

HOW COVID-19 HAS IMPACTED THE PERSONAL COMPLEXITY AND MENTAL HEALTH OF THE HEALTHCARE PROFESSIONAL

Arthur Hengerer, MD

The advent of the pandemic changed the focus from the intensity of burnout being based on the issue of one's resilience as a healthcare professional to the concepts of moral distress and injury, tied to problems in the work environment and culture. These issues were exacerbated in many facilities and systems due to lack of preparedness and the intensity of disease and death workers faced. The significance of loneliness and need for gratitude were highlighted as important in maintaining personal wellness.

- The pandemic affected professionals differently based on their specialties and work locations, as well as their pre-COVID psychopathology. It was realized that everyone's resilience and performance capacity are not the same and stress was placed on the importance of recognizing when an HCP is needing help or needs time away.
- This leaves all of us with varying responses in terms of distress reactions, psychiatric disorders, and health-risk behaviors.



Art Hengerer, MD

- Dealing with the issue of stigma to normalize seeking help is a sign of strength, not weakness, and encourages staff to feel comfortable finding support.
- Realizing that the pandemic's duration is still undefined, the disillusionment phase is going to continue for an extended time before we can all plan for a complete recovery phase.
- The importance of leadership responsibilities and actions is accented as all levels of the organization take on increased preparedness and actions in these times to make healthcare workers feel supported, feel safe, and have hope.
- Highlighting the national efforts that are now being carried out to address burnout and the impact of COVID-19 included the following:
 - The National Academy of Medicine "Action Collaborative" on clinician well-being and resilience that has three working groups on national strategy, COVID-19, and implementation has officially launched its work.
 - Guidelines created by the FSMB for state medical boards to change application questions on mental health to only list current impairment as reportable to encourage seeking care.
 - Programs and steps being taken by the PHPs in anticipation of increased needs of mental health care and addiction treatment and monitoring. Some of these efforts include peer-to-peer programs, development of playbooks and toolkits for programs, new monitoring methods, sharing of data metrics, and research collaboration.
 - Systems will need to transition from their financial survival mode to again place a focus on their staff wellness and culture issues. This will be helped by having new data that were missing before the pandemic response. Many of the deficiencies discovered in the systems will require long-term reflection to find solutions.
 - The issues of racial disparity in healthcare as well as issues of diversity and inclusion will also need extensive investigation and need solutions.

The nation's health systems and society have an opportunity to work on a new social contract of what they want for the future. No matter what, some level of communication between hospital systems and all the various recipients in the new normal will evolve in time. ■

HOW WILL THE TRAUMAS OF COVID-19 AFFECT US IN THE LONG TERM?

Initial Results from a Longitudinal Study of Healthcare Workers and First Responders



Rebecca C. Hendrickson, MD, PhD
Hendrickson, MD, PhD

Collaborators: Roisín A. Slevin, BS; Katherine D. Hoerster, PhD, MPH; Bernard P. Chang, MD, PhD; Ellen Sano, DO, MPH; Catherine McCall, MD; Ronald G. Thomas, PhD; and Murray A. Raskind, MD

High rates of psychiatric symptoms in healthcare workers working during the COVID-19 pandemic have been identified in multiple contexts. We describe the results of a longitudinal study of healthcare workers (HCW) and first responders (FR) working during the COVID-19 pandemic, focusing in particular on which aspects of COVID-19–related occupational stressors are most associated with psychiatric symptom burden and suicidal thoughts, and the impacts of COVID-19–related stressors on workplace functional impairment or retention.

Study respondents include 510 participants, age 19–72 years (mean 41 ± 11). Among all respondents, a majority reported psychiatric symptoms in the clinical range (37% for PTSD, 74% for depression, 75% for anxiety, 34% for insomnia), and symptom burden was strongly associated with intensity of exposure to COVID-19–related occupational stressors (Pearson's $R=.53$ for PTSD, $R=.46$ for depression, $R=.43$ for anxiety, $R=.40$ for insomnia, all $p<2.2 \times 10^{-16}$). Fifty-four percent of healthcare workers and 41 percent of first responders reported that their likelihood of remaining in their current field had been somewhat or significantly decreased by their experiences working during the pandemic; elevated likelihood of leaving one's current field was most strongly related to intensity of exposure to COVID-19–related occupational stressors for healthcare workers ($R=.23$, $p<2 \times 10^{-4}$). Twenty-two percent of healthcare workers and 14 percent of first responders reported trouble completing work-related tasks, while 13 percent of healthcare workers and 19 percent of first responders reported thoughts of being better off dead or of hurting themselves in the past two weeks; ratings in both areas were significantly related to intensity of exposure to COVID-19–related stressors (Spearman's $R=.28$, $p=4.9 \times 10^{-9}$ and $R=.25$, $p=2.6 \times 10^{-6}$, respectively).

A factor analysis of our 13-item rating scale of exposure to COVID-19–related occupational stressors identified three factors, which weighted items assessing (1) total

volume of COVID-19–related care delivered ("volume" factor), (2) being asked to take unnecessary risks or being unsupported by one's workplace, or care delivered being futile or inadequate ("demoralization" factor), and (3) perceived risk of oneself or family contracting COVID-19 ("risk" factor). Although all three factors were significantly related to psychiatric symptom burden, the demoralization factor was the most strongly related to all symptom clusters. Only the demoralization factor was significantly related to reporting an increased likelihood of leaving one's current field or trouble completing work-related tasks; both the demoralization and volume factors were significantly related to thoughts of suicide or self-harm. These relationships were present even when personal history of COVID-19 infection, age, and prior history of traumatic stress were taken into account.

Longitudinal data revealed a decrease in perceived risk for participants who had been vaccinated, but minimal impact of vaccination on demoralization or on psychiatric symptom burden. For individual participants, hyperarousal and intrusive symptom clusters at the time of baseline assessment were the strongest predictors of elevated PTSD symptoms two to three months later.

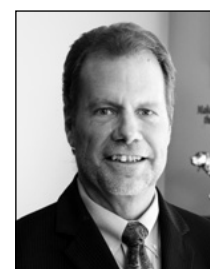
Conclusions: COVID-19–related occupational stressors are strongly associated with psychiatric symptom burden, decreased professional retention, decreased occupational functioning, and increased thoughts of suicide or self-harm in HCW/FR. PTSD symptoms are particularly strongly associated with negative occupational outcomes. ■

HOW TO ESTABLISH TRUST AND CREDIBILITY WITH YOUR STATE MEDICAL BOARD

Michael Baron, MD, MPH, DFASAM; Lynn Hanks, MD; P. Bradley Hall, MD, DFASAM, DABAM; Reeves Johnson, MD; and Scott Hambleton, MD, DFASAM

Summary by Michael Baron, MD, MPH, DFASAM

"It's all about relationships." If you've ever spoken with Dr. Brad Hall, who is one of our panelists, you've probably heard that quote. Nowhere is that truer than in the relationship between the State Medical Board and the



P. Bradley Hall, MD, DFASAM, DABAM



Michael J. Baron, MD, MPH, DFASAM

State Physician Health Program. It is all about the relationships.

Dr. Baron has been fortunate enough to have participated in this relationship from both sides, first as a regulator on the Tennessee Board of Medical Examiners where he served for seven years and then subsequently, as the Medical Director of the Tennessee Medical Foundation – Physician’s Health Program for the last four years. He has experienced a good relationship from both sides. But he knows there are many programs where problems exist with trust and credibility.

The missions of Medical Boards and Physician Health Programs complement each other to protect the citizens of the state by ensuring physicians are healthy. Physician Health Programs are reparative and are all about compliance and advocacy. Medical Directors and other employees of Physician Health Programs are hired based on their training and experience, and they do not have an expiration date.

In the presentation, you heard from Drs. Baron (PHP), Hanks (PHP), Hambleton (PHP), Hall (PHP), and Johnson (SMB) about the importance that relationship building plays in the success of Physician Health Programs. State Medical Board members who do not know you certainly will not trust you. Most State Medical Board members go through an educational component about administrative law theories and practice, usually during the first year of their appointment. It is also critical that they are educated about the Physician Health Program, about monitoring and compliance, about addiction and behavioral health, and about success and recidivism rates as most State Medical Board members are not trained or experienced in behavioral health and addiction. More times than not, they haven’t a clue.

The relationship between the Medical Board and the Physician Health Program is in many ways symbiotic. Each needs to do their job and be able to interact, communicate, and trust that the other is doing their job for the common goal of protecting the citizens of the state by ensuring physicians are healthy. Many participants think that the State Medical Board is the enemy because they are punitive and have the power to suspend or even revoke a medical license. What you will hear in the next hour is that the real enemy is not having trust and credibility between the State Medical Board and the Physician Health Program. Trust and credibility are paramount to being able to successfully advocate for your compliant participants.

Summary by Lynn Hanks, MD, FASAM

Trust is assured reliance on the character, ability, strength, or truth of someone or something. Credibility is the quality or power of inspiring belief. The success of your PHP is directly proportional to the level of trust and credibility you have with your regulatory boards.



Lynn Hanks, MD

The missions of Boards and PHPs are similar, but different. Protecting the public is primary with Boards, but secondary for PHPs, whose major focus is facilitating the rehabilitation of medical professionals with health conditions that potentially compromise public safety.

If your PHP does not have Medical Board trust or credibility, or if your PHP is a relatively new program, or if you are the new director of the PHP, here is a practical tool you can implement to cement a firm and favorable Medical Board relationship.

Establish a **Liaison Committee** consisting of yourself and a member of your Board, plus at least two members of the Medical Board: its Executive Director and its Medical Director. It is also helpful to include the Chief Investigator. This Liaison Committee initially meets informally each month just to have a bilateral exchange of information and to discuss mutual concerns. Meeting frequency will decrease over time and eventually disappear as trust is built. Keep an arm’s length between your PHP and the Medical Board. Avoid the perception by your participants or referring sources as “being in bed” with the Medical Board as Boards are largely perceived as punitive rather than rehabilitative.

Also, attend all Board meetings, not just those involving one of your PHP participants. Go to adjudication and compliance hearings, business sessions, and workshops. You will learn how Boards differ from PHPs and how they operate within their legal constraints.

Constant communication with the Medical Board is critical. Educate Board members about the disease concept. Emphasize that your participants are sick—not bad. Make the distinction that having a disease does not constitute impairment. Categorically state that treatment works, monitoring is critical, and your PHP is not the “fox guarding the hen house!”

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How To Establish Trust and Credibility with Your State Medical Board

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In addition, submit timely reports to the Medical Board and develop rapport with the Chief Investigator. Suggest that Medical Board members attend our annual FSPHP meeting, which is usually held in conjunction with the annual FSMB meeting. To enhance transparency and accountability, invite the Medical Board to audit your PHP annually. Last, and most important, do not, under any circumstances, misrepresent your PHP as being the Medical Board!

Periodically remind the Medical Board that your PHP can do what the Board can't, namely, early detection of potentially impaired professionals, immediate intervention, appropriate triage, facilitating an independent evaluation, referring to treatment, managing reentry to practice, and monitoring closely.

These tools work and are very effective in inspiring belief in your Medical Board and convincing it that you will perform commensurate with its expectations. Continuously preach the three Ps, namely, that your PHP and your Medical Board are **Partners in Protecting the Public!**

PHP and State Medical Board (SMB) Collaboration

Summary from Reeves Johnson, MD

From the Federation of State Medical Board (FSMB) paper on Mental Health Disclosures on Licensing Applications:

In 2011, the FSMB adopted a policy to include PHPs in their effort to protect the public regarding physician impairment. FSPHP policy states that in the early stages of illness, there may not be impairment and that is when the PHP needs to be involved. However, if impairment exists, PHPs can work with SMBs by providing treatment and monitoring. SMBs need to work with PHPs so as not to impede treatment that can be delayed from fear of discipline. This can lead to impairment, which is desired to be avoided. One way this can be done is through "safe haven" nonreporting, which can encourage self-reporting and allow earlier treatment and in turn reduce impairment, which better protects the public.



Reeves Johnson, MD

PHPs need to inform their SMBs that even though PHPs initially dealt with alcohol and other addictions, they now deal with other mental and physical health issues in addition to monitoring, which also protects the public. Physicians who have recovered from an SUD and have long-term monitoring have a higher recovery rate than the general population. Those completing a PHP have a lower malpractice risk than those not completing one. In addition, in 2018, the FSMB adopted a Policy on Physician Wellness and Burnout that focuses on impairment rather than illness. PHPs should work with SMBs to understand why this is important and help implement changes to application questions.

Below are my recommendations to PHPs:

- Be visible—Attend SMB, FSMB, State Medical Association, and malpractice insurance company meetings.
- Be available—Make sure the SMB is aware you are willing and able to help. Develop a relationship with the state's Board of Investigation (BIV).
- Be successful—Inform SMBs of the above and PHPs success rate, recovery rate, relapse rate, and participant satisfaction.
- Be credible—Do not "bad mouth" the SMB, that is, make the SMB the "bad guy," yet explain how they work together. Explain actions, especially those that are suspect or not consistent with previous ones. Give specific recommendations and the reasons for them.
- Be helpful—Offer to serve on BME Committees, Work Groups, Task Forces, and so forth.

In Tennessee, our SMB enjoys a successful and mutually beneficial relationship with our PHP due to the above recommendations. They have a strong relationship with our state medical association and the major malpractice carrier in Tennessee. They come to all the BME meetings and provide immediate access to applicants needing their services, and they also provide information regarding issues involving mental health. They have a high success rate. They serve on state committees and BME task forces and provide helpful information during discussions of relevant issues. Finally, and perhaps most important, they show a genuine desire to help the BME to fulfill its mission. ■

CONTROLLING THE MESSAGE: COMMUNICATIONS STRATEGIES FOR PHPS

How to Reach Your Audience and Stakeholders Through Planned Messaging

Andrew Laing and Neal Browne, Agency 33

WHY CONTROL YOUR MESSAGE? Because if you don't somebody else will!

Big Media is Big Business that earns Big Money (billions). Knowing that will help you understand your best strategy, based on the patterns that media demonstrate.

NEWS?

While news is advertised as journalism, it might or might not be. Why?

1. **Money** plays a huge, indirect influence in what is chosen and how it's presented and, conversely, what's left out, because grabbing and keeping an audience are directly how media stay in business.
2. The media depend on viewers/readers/listeners for **ratings** on which they sell advertising—from which they get money to keep their doors open. Small audiences and low ratings mean meager money, layoffs, and shutdowns.
3. In addition, **personal factors** such as bias, affiliation, and personal viewpoints affect what's chosen, what's left out, and the tone used. Though rarely admitted, it's all about what attracts and keeps an audience. Nothing "boring" is allowed. They are under pressure to deliver a "winning show" or "winning product."

YOUR STRATEGY?

While it might seem difficult to insert your message, you cannot afford to be silent. It can make you appear uncaring, guilty, or in hiding. Therefore, never answer "no comment." That is a comment and a huge no-no. Plus, if you don't speak for yourself, someone else



Andrew Laing



Neal Browne

will—sometimes adversely. *You* must build and protect your reputation.

You must think like a reporter/producer/writer. Help give them what *they* want. What is that? A captivating story that's relevant, informative, and timely, and one that appeals to their audience.

TAKING INITIATIVE

It's your form of public relations—help them by providing great material and information and building trust and relationships with reporters.

How?

1. Social media, a powerful website, blogs, news releases, podcasts, articles, and video productions all capitalize on relevant news topics.
2. Get to know them as well as you know your material. Build quality relationships.
3. Get your own sound bites together. Form your top five to six messages into powerful, short messages no more than fifteen to twenty seconds each and repeat them frequently.

(For example: What does a PHP do?)

"A PHP focuses on three major elements—all with confidentiality: Rescue, Restore, and Reenter. We rescue physicians who are burned out, help restore them to a healthy state, and prepare them to reenter their practice at full capacity."

4. Conversely, focus on your best defense. Think how you would answer if things went bad and your PHP is implicated. Do that prep before it happens. This will help ready you for "crisis communications" and so-called "ambush interviews" when a news reporter or crew approaches you unexpectedly.
5. Need help? Call HQ and ask. Also, for your own prep, read Bill Schley's book, *The Microscript Rules*, on how to make sound bites memorable and effective.

While there are no guarantees, practicing these tips will help serve you well. ■

BREAKOUT SESSIONS

SLEEP APNEA IN ADDICTED HEALTHCARE PROFESSIONALS: UNDERSTANDING THE IMPORTANCE OF DIAGNOSING AND TREATING SLEEP APNEA WITH RESPECT TO OCCUPATIONAL SAFETY AND RELAPSE RISKS

Brad Sokal, PhD, and Michael Wilkerson, MD.

Sleep disorders may be five to ten times more likely in persons with substance use disorders (SUDs). One of these disorders, obstructive sleep apnea (OSA), is a potentially serious condition that is characterized by pauses in breathing that disrupt normal sleep architecture and leads to daytime sleepiness and neuropsychological deficits (e.g., attention and executive skills). OSA has been an overlooked explanation of neuropsychological deficits among healthcare professionals with SUDs, and furthermore, sleep disturbances in general may be significant predictors of relapse.

The purpose of this presentation has been to explore the prevalence of sleep disorders among a sample of healthcare professionals, relationship to neuropsychological deficits, strategies for intervention for OSA, and positive outcomes concurrent with treatment of comorbid OSA at one evaluation and addiction treatment facility. The results from the Pittsburgh Sleep Quality Index (PSQI) and an overnight polysomnography (sleep study), as well as neuropsychological tests from pre- to post-treatment with a continuous positive airway pressure (CPAP) have been presented. Among 480 healthcare professionals receiving residential addiction treatment in one residential addiction treatment facility from January 2018 to August 2019, approximately 86 (18%) had been referred for an overnight polysomnography. Reasons for referral were based on a positive PSQI score, comorbid health concerns, risk factors for OSA, excessive daytime sleep, neuropsychological deficits, and occupational impairments. The demographics and other findings of the patient sample of Healthcare Professionals (N=480) were as follows: Nurses (36%), Medical Doctors (25%), and



Brad Sokal, PhD



Michael Wilkerson, MD

Other Medical Professionals (39%); the average age was 40; and 41 percent of the healthcare professionals were females. Over eight-tenths (84%) had screened positive for sleep disturbances on the PSQI. Of the 86 healthcare professionals referred for a sleep study, 69 (80%) were positive for moderate-to-severe sleep apnea. Significant improvements in neuropsychological test scores pre- to post-treatment with CPAP from two representative case examples were discussed. In one representative patient with a severe alcohol use disorder, the patient earned a PSQI score of 18 (severe), showed cognitive deficits in attention and executive skills, was diagnosed with severe sleep apnea from a sleep study, complied with CPAP for at least two weeks, and showed improvement in neurocognitive functioning at follow-up. The conclusions from the presentation were as follows: Addressing sleep disorders among healthcare professionals with mild neurocognitive deficits has been neglected but poses promising solutions. Neurocognitive sequelae of other sleep disorders, such as insomnia and restless legs, had been discussed, as well as the difficulties of using prescribed buprenorphine and methadone, both of which likely play a causal role in sleep apnea, in healthcare professionals recovering from addictive disorders. Furthermore, recent evidence that sleep apnea may be an independent risk factor for hospitalization with COVID-19 was reviewed. ■

RECOVERY FOR CHILDREN OF ADDICTED HEALTHCARE PROFESSIONALS THROUGH IDAA: THE JERRY MOE PROGRAM

Penelope Ziegler, MD, and Jerry Moe, MA

At the 2021 FSPHP Annual Conference, a workshop was presented by Penny Ziegler, MD, Medical Director Emerita of the Florida Professionals Recovery Network, and Jerry Moe, National Director of Children's Programming, Hazelden Betty Ford Foundation, focusing on the programs offered for children of addicted healthcare professionals through IDAA (International Doctors in Alcoholics Anonymous). IDAA, a worldwide fellowship of healthcare professionals, families, and significant others striving to



Jerry Moe, MA



Penny Ziegler, MD

help one another attain and maintain recovery from addiction, currently has over 5,000 members including physicians, dentists, veterinarians, psychologists, pharmacists, podiatrists, chiropractors, other doctoral-level healthcare providers, advanced registered nurse practitioners, certified registered nurse anesthetists, and physician assistants.

The workshop began with a brief review of IDAA's history as a noncompulsory recovery organization started in 1949 by physicians and dentists who had found sobriety in Alcoholics Anonymous. It is not affiliated with any licensing boards, monitoring programs, or other disciplinary systems. Now functioning as a 501[c][3] organization, it holds annual meetings at locations in the United States or Canada. It also offers local and regional meetings, email meetings, and virtual meetings for recovering healthcare professionals and their loved ones all around the world. As part of its annual conference, IDAA has offered recovery-oriented programming for the children of members. This has included The Jerry Moe Programs for kids ages seven to twelve; IDAA Teens; IDAA Twenties; and IDAA Al-Anon for spouses, adult children, and all concerned others.

The **Jerry Moe Program**, offered at the IDAA Annual Meeting since 1992, was developed from the children's programming originated at the Betty Ford Center (now Hazelden Betty Ford). It is open to children and grandchildren of IDAA members ages seven to twelve. It utilizes a variety of experiential techniques and therapeutic play designed to facilitate recovery from the impact of the family disease. During the workshop, Jerry Moe utilized children's artwork and stories to illustrate the goals and achievements of the three-day program. He spoke about how the children developed an understanding of the disease, learned to separate the disease from the person who has the disease, and how treatment and recovery help people to change and grow while not using substances and practicing an ongoing recovery program. The long-term goal is changing the family legacy.

Penny Ziegler then described the IDAA Teens three-day professionally facilitated program and the newer IDAA Twenties self-facilitated group (started by graduates of the IDAA Teens Program). She stressed IDAA's focus on recovery for all family members and the central role of Al-Anon in the organization from its earliest days. Some attendees described the important impact of the IDAA children's programming as a component of their own families' recovery. ■

PREPARING FOR PEER: HOW SOFT IS YOUR UNDERBELLY?

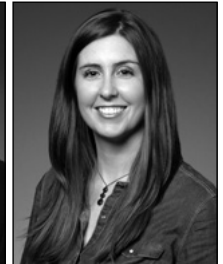
Presenters: Laura Moss, MD; Chris Bundy, MD, MPH; and Shea Scheuler, LMFTA, SUDP



Laura Moss, MD



**Christopher Bundy,
MD, MPH, FASAM**



**Shea Scheuler, MA,
LMFTA, SUDP**

In this presentation, WPHP shared how it is preparing for PEER as well as our apprehension about having our vulnerabilities (our soft underbellies) exposed during the PEER process. PEER is rolling out at a very opportune time for WPHP. WPHP has spent the last few years cleaning house. In the process we have revealed opportunities for improvement. Inefficient workflows, outdated office and technology systems, underpowered quality and performance management processes, and outdated policies and procedures are among the items that we have identified for repair and redesign. And while we have done much to improve in these areas, there is still so much left to do. The prospect of outside review through the PEER process has provided us with the motivation (aka fear) to stay on task and prioritize our improvement activities. In an interactive format, WPHP shared the experience, tools, and processes that have helped improve program operations and clinical quality. We also revealed our concerns about where we may fall short when it comes to PEER evaluation (vulnerabilities). Learners had the opportunity, through live polling and discussion, to share their own concerns and apprehensions about program assessment, collaborate on practical strategies and tools for common improvement challenges, and, ultimately, inspire and encourage engagement in the processes that will improve accountability, consistency, and excellence in their own programs. ■

IMPROVING SELF-AWARENESS TO SUPPORT CASE MANAGEMENT STRATEGIES AMONG PHPS: THE BENEFITS OF MINDFULNESS AND PERSONALITY AWARENESS

Gregory Gable, PsyD; Kathy Moore, LPC; and Maggie Tipton, PsyD



Greg Gable, PsyD Kathy Moore, LPC Maggie Miller Tipton, PsyD

The work of Physician Health Programs (PHP) and case managers is not without its successes and challenges. The successes can be invigorating and the challenges depleting. Our responsibility to ourselves and our participants is filling our resilience tank to support engagement and provide quality services. Behavioral and neuroscientific findings suggest mindfulness meditation enhances self-regulation to create space for self-awareness and self-reflection. Studies have shown yoga nidra and mindfulness meditation positively impact structures involved in self-awareness, including increases in dopaminergic tone, growth in paralimbic structures, and reduced amygdala size. There are several different meditation and mindfulness options, so it is important for individuals to find the best fit for them. Caron Treatment Centers embarked on an eight-week clinical supervision process, which included clinical, psychology, and spiritual staff, within our Healthcare Professionals (HCP) program where mindfulness and Enneagram were implemented, specifically using a book entitled *The Essential Enneagram: The Definitive Personality Test and Self-Discovery Guide*, written by David Daniels and Virginia Price. The Enneagram uses ancient wisdom to help inform a process of self-understanding and growth that is very compatible with 12-Step recovery. The Enneagram identifies nine main personality styles. Most people, upon reflection, can identify one of the nine types that represents their “go-to” emotional response set. Enneagram exploration is a self-directed tool to help individuals recognize their type. Enneagram emphasizes light and dark sides of personality, focusing on movement from deformative to formative

patterns. Our use of the Enneagram materials in group supervision began with each staff member identifying their main response pattern, and we then focused on The Four A's of Enneagram, including awareness, acceptance, action, and adherence. Supervision remained focused on work-related issues even though participants made connections to areas of strength and growth in their personal lives. The goal of this process was to understand our patterns of reactivity, improve communication, reduce conflict, and find common ground amongst all personality types. After the eight weeks, the cohort reported increased self-awareness, reduction in countertransference, better team cohesion, and better communication with the use of a “common” language for both staff and patients who were using Enneagram as a part of their treatment program to improve personality awareness and growth. The above process was completed in supervision, but this work can be done in a variety of ways: individually, among a small group of interested participants, or throughout an organization. ■

IMPLEMENTATION OF A STRUCTURED SUICIDE RISK-ASSESSMENT PROTOCOL FOR PHP REFERRALS AND PARTICIPANTS

Lisa Merlo, PhD, MPE, Alexis Polles, MD, and Kim Simon, MPPA



Lisa Merlo, PhD, MPE Alexis Polles, MD Kim Simon, MPPA

Physician suicide is a serious concern, with an estimated 300–400 physicians dying by suicide in the United States each year. As attention to this problem has increased, various factors have been hypothesized that contribute, including the following: physician depression, burnout, substance use disorders; the rigorous and often unsupportive nature of medical school, residency, and clinical practice; and, surprisingly, the practices of physician health programs, which are perceived as “intrusive/punitive” by some.

In fact, physician health programs (PHPs) were developed to support and advocate for physicians who are struggling with potentially impairing conditions

(such as substance use disorders and other psychiatric conditions), in order to help them maintain their license and career. A secondary and equally important mission of PHPs is to protect the public by evaluating and monitoring physicians to ensure that they are able to practice with reasonable safety. In many cases, physicians may need to temporarily withdraw from practice in order to obtain treatment and establish stable recovery. This phase of PHP involvement may represent a particularly high-risk period for physicians, as they are often concerned about losing their reputation, career, ability to practice, financial stability, and so forth. Indeed, vocal opponents of the PHP model have suggested that PHP intervention may lead to physician suicide. Unfortunately, there are no known data to demonstrate whether rates of suicidal ideation, attempts, or completions are higher among physicians participating in PHPs compared to the general population of physicians. Despite this, clinical experience confirms that many newly referred physicians experience significant distress, which may put them at increased risk. As organizations dedicated to physician health and well-being, PHPs have an obligation to try to minimize the risk of suicide among their participants. One important component of suicide prevention is careful and consistent screening.

As a result, the Professionals Resource Network, Inc. (Florida's PHP) recently implemented a protocol to include structured suicide risk-assessment screening throughout the case management process. All referrals receive screening with the Columbia-Suicide Severity Rating Scale (C-SSRS) at intake, upon signing their contract, after one month of monitoring, and annually thereafter. They are also screened if the need arises to have them refrain from practice during monitoring, as well as upon exit from the PHP. Implementation of this protocol required significant preparation. The process of implementation included consultation with the contracting authority regarding appropriateness of the effort, consultation with legal representation regarding risks, selection of the suicide risk-screening measure, introduction of the initiative to staff, structured assessment of staff comfort/concerns, training sessions for staff to establish competence/confidence/comfort with the suicide risk-assessment protocol, and feedback following training. Early results from the first year of implementation demonstrate that the initiative has been successful. Staff comfort, confidence, and competence all increased significantly over time and the screening has been well received by PHP participants. Further, the screening has led to identification of individuals experiencing suicidal ideation, providing the PHP staff the opportunity to intervene and connect them with appropriate

resources. We recommend that all PHPs consider implementing a similar protocol to serve their participants/clients and guard against the tragedy of physician suicide. ■

HOW LEADERS CAN USE COACHING SKILLS TO TAKE CARE OF THEIR TEAMS

**Diana Dill, EdD, and
Chris Bundy, MD, MPH, FASAM**

The well-being of an organization depends on employees' relationships with their direct supervisors. As leaders, we want to be particularly mindful of using every tool available to us to support our teams during this national time of crisis. Grief and anxiety are endemic. Remote meetings mean that every communication is intensified. Staff retention has become a serious challenge. At the same time, a functional work "family" can be an island of respite.

Clinician leaders have the power—through the supervisory style they use—to either engage and inspire people who report to them or instead—without meaning to—demoralize them. We can all remember those supervisors we've had who made us feel especially valued and the engagement it inspired in us. Multiple lines of research show that when supervisors develop, engage, inform, and care about the people who report to them, their employees work better and feel better, and their organizations benefit as well: (1) This supervisory style is *participatory management*, and (2) it is when employees are engaged as collaborators, in contrast to either an authoritative or a hands-off style of management.

Full-blown *participatory management* is complex and requires skills that not all supervisors have had the opportunity to learn. Here, we aim to simplify the process. Our read of the research literature shows us that there are four key areas where supervisors can focus their attention. Each area is so commonsensical, it's hard to appreciate that it has the powerful impact on employees that it does. Then, in order to be more



Diana Dill, EdD



**Christopher Bundy, MD,
MPH, FASAM**

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How Leaders Can Use Coaching Skills to Take Care of Their Teams

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participatory in their management style, supervisors can adopt some of the basic conversational tools that coaches use to maximize their clients' success. (3)

Emotional connection. We feel positive and cared for—emotionally connected—when our supervisor is “in sync” with us, pays full attention to us, and puts themselves in our shoes. (4) Supervisors can foster emotional connection by using a simple strategy—reflective listening, that is, mirroring the emotion and content of what their employee has said, without self-reference or judgment.

Psychological safety. When we are free to express ourselves, have new ideas, make mistakes, have doubts, and disagree, without fear of negative consequences, we feel psychologically safe at work. (5) Supervisors can demonstrate safety by letting their employee know what the rules are and what they can expect in a conversation, as well as by actively encouraging diversity of viewpoints.

Empowerment. We are empowered when our need to exercise judgment over what we do and how we do it is respected and encouraged, within the scope of our role. (6) Supervisors can empower their employee by asking them what they will do, and how, and what resources they will need, rather than telling them what to do.

Optimism. We are optimistic when we focus our attention on those aspects of an experience that bring about a positive state of mind. (7) Supervisors can direct their employees' attention toward what has worked (rather than what hasn't), what they would like to see in the future (rather than what they don't), and by doing so improve their morale.

When supervisors make their employees feel connected, safe, empowered, and hopeful, their employees will feel better and work better, and the supervisors can feel they are sharing the burden. (8)

Notes

1. For example, the Gallup Institute has showed that, across industries, when employees feel their supervisor cares for them, develops them, and recognizes work well done, they are more satisfied with their jobs, more likely to stay in their jobs, perform better, and report greater well-being. Their organizations are more profitable as well (Buckingham M and Gallup Organization, 2016: *First break all the rules: what the world's greatest managers do differently*. New York: Simon and Schuster).

Similarly, at the Mayo Clinic, physicians who report that their supervisors develop, engage, inform, and care about them are more satisfied and less burned out (Shanafelt et al., 2015, see below).

2. Shanafelt T, Gorringer G, Menaker R et al. (2015): Impact of organizational leadership on physician burnout and satisfaction. *Mayo Clin Proc*. April 2015;90(4):432–440.
3. This simplified approach to increasing participatory management can have an impact! The Atrius Health Coaching for Engagement program taught physician leaders to focus on the four key areas and use coaching skills to create the relationships they wanted with their employees. Preliminary evaluation showed greater use of participatory management, greater efficacy, and improved well-being for leaders, and improved work satisfaction for reporting clinicians (Awad K, Dill D, Schwab L, 2019: *Improving physician well-being department wide through chief leadership coaching*. Poster presented at the 2019 American Conference on Physician Health, Charlotte, NC, 2019).
4. Boyatzis R, McKee A (2005): *Resonant leadership: renewing yourself and connecting with others through mindfulness, hope, and compassion*. Boston: Harvard Business School Publishing.
5. Garvin D, Edmonson A, Gino F (2008): Is yours a learning organization? *Harvard Business Review*, March 2008.
6. Deci E, Ryan R (current): Selfdeterminationtheory.org
7. Frederickson B (2009): *Top-notch research reveals the upward spiral that will change your life*. New York: Three Rivers Press.
8. Those who were registered for the 2021 FSPHP conference can review our video presentation to watch these coaching skills demonstrated and applied to managing a difficult conversation while retaining a valued employee (Dill and Bundy: *How leaders can use participatory management skills to take care of their teams*, April 8, 2021). ■

LESSONS FROM THE PHYSICIAN HEALTH PROGRAM FOR SUBSTANCE USE DISORDER TREATMENT: IMPLEMENTING INNOVATIONS FOR AFTERCARE RECOVERY SUPPORT AND MONITORING TO ATTAIN FIVE-YEAR RECOVERY

Robert DuPont, MD, and Daniel Angres, MD

As described by Dr. Bob DuPont, physicians who are comprehensively treated and then monitored by their state Physician Health Programs (PHPs) have exceptional five-year abstinence rates as compared to the general population. In addition to specialized, intensive treatment with their peers, the PHP monitoring



Robert DuPont, MD



Dan Angres, MD

component is essential to these excellent outcomes. Those physicians enrolled in a PHP monitoring program are mandated to comply and complete their monitoring agreements and generally attain these excellent outcomes. For those patients who are not mandated to a PHP, we have attempted to improve outcomes by instituting an extended PHP-like monitoring program called Comprehensive Continuing Care (CCC).

Positive Sobriety Institute (PSI) consists of physicians and other healthcare professionals, in addition to other professionals such as attorneys, business executives, and educators. Most of these individuals are married, have supportive workplaces and families, and have an average age of 46. Their psychological profiles are also similar (for example, these individuals tend to score higher in Conscientiousness on the NEO personality inventory).

The CCC includes weekly professionally facilitated groups, random drug screens to include urine, Peth, and hair screening, Sober-Link, an expectation of outside peer support group participation (e.g., AA), and individual case management. The CCC is recommended for five years in duration.

To motivate non-physician patients, certain strategies are consciously employed—that is, sharing the better outcome data for those who have attended our continuing care (1), constant and consistent encouragement to patients and family and expectations that patients attend continuing care in the therapeutic community, making attending CCC a part of the treatment culture.

To improve retention, PSI has attempted to identify and reduce barriers to CCC participation—that is, by having reasonable compromises with attendance expectations and individualized responses to relapses/slips. With COVID, there are also telemedicine options for attendance, and this option will continue post-COVID (a hybrid approach of in-person with telemedicine attendance), which will also allow patients who are out of state to participate in CCC.

In studying outcomes, PSI clinicians have determined that motivating patients to enter CCC is easier than retaining them. Ongoing encouragement from their primary therapist in CCC during the primary treatment phase was one of most important factors in patients deciding to attend CCC. Sharing outcome data, the prospect of patients' continued contact with their treatment peers, and encouragement from their families, also contributed to greater participation. Commuting and time challenges are the two most important barriers to attendance. Expense and demands of monitoring were also a factor, which

resulted in a reduction of fees for CCC and options for telemedicine.

PSI is committed to the continuation of brainstorming ways to promote, study, and refine CCC to improve treatment outcomes in those patients who, unlike physicians, are not compelled to participate in the monitoring process.

Note

1. The Importance of Continuing Care in Substance Abuse Treatment: A Single Center Experience: Poster Session, AAAP 12/05/19, San Diego, CA, J. Werby, J. Caldeugh, D. Angres. ■

CHALLENGES IN NAVIGATING DISABILITY DISCRIMINATION AND PRIVACY LAWS IN ADDRESSING PHYSICIAN HEALTH

Richard Barton, Esq.; Rachael Harrington, Esq.; and Julian Lean, Esq.



Richard Barton, Esq. Rachael Harrington, Esq. Julian Lean, Esq.

This presentation was put on by attorneys Rick Barton, Julian Lean, and Rachael Harrington of the Procopio law firm based in San Diego, California. Rick, Julian, and Rachael's practice focuses primarily on representing hospitals, medical staffs, and physician groups throughout California in matters related to quality improvement, bylaws, policies and procedures, credentialing and privileging, regulatory agency investigations, and peer review.

Our presentation followed the increase we have seen in our own practice of physicians attempting to assert disability discrimination and privacy claims after they have been suspected of suffering from a possible impairment. We have worked with Medical Staff Physician Well-Being committees, physician leaders, and those responsible for quality oversight as they struggle with their concerns regarding these issues while attempting to fulfill critical functions necessary for the protection of patients. These concerns and lack

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Challenges in Navigating Disability Discrimination and Privacy Laws in Addressing Physician Health

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of clarity have a direct impact on the ability of physician health professionals and programs, medical staffs, physician groups, and others in their efforts to properly address physician health and possible impairment. Our presentation reviewed the fundamentals of the laws of privacy and disability discrimination as they apply in the context of addressing physician health and patient safety, including the application of the Americans with Disabilities Act. The goal of our presentation was to help provide the audience with greater clarity regarding these laws and provide practical guidance through scenarios our office has handled on behalf of healthcare institutions.

We also spent time discussing how to assess and manage impaired physicians. Through our practice representing hospital systems, medical staffs, physician groups, and physician health programs navigate the legal and procedural processes related to impaired physicians and quality of care, we have experienced an increase in cases of impaired physicians. Impairments take on a variety of forms, and every situation must take into account the legal implications arising from both federal and state law. Our approach was interactive with an emphasis on using actual situations we have encountered as well as those that have resulted in case law, which have shaped the legal environment in this arena.

Our presentation then addressed the implications of privacy protections afforded under HIPAA in assessing claims of disability and possible impairment. This included a discussion regarding the ongoing *EEOC v. Yale New Haven Hospital* litigation, before turning to a discussion regarding the current EEOC guidance on the ADA in the COVID-19 pandemic.

We concluded by presenting a series of detailed hypothetical circumstances that allowed the audience to determine the various actions that may be taken to address the concerns raised in the hypothetical.

We greatly appreciated the opportunity to present at the FSPHP 2021 Virtual Education Conference and are already looking forward to the 2022 conference. Thank you! ■

POSTERS

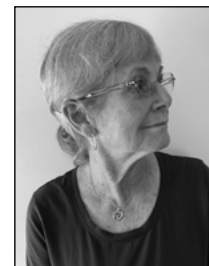
VALUE OF HEALTHCARE-PROFESSIONAL-SPECIFIC VIRTUAL TWELVE-STEP MEETINGS DURING THE COVID-19 PANDEMIC

Penelope Ziegler, MD, and Mary Raum, MD

At the 2021 FSPHP Annual Meeting, representatives from IDAA (International Doctors in Alcoholics Anonymous) presented a poster describing their research study on the development of alternative 12-Step meetings during the SARS-2-CoV pandemic. In March 2020, both local 12-Step meetings and specialized meetings for healthcare professionals (Caduceus, IDAA, etc.) were not being held due to the COVID shutdowns. In addition, IDAA was forced to cancel its 2020 annual meeting scheduled for August in Spokane.

There was an immediate need for alternative supports for healthcare professionals recovering from addiction. IDAA responded with several initiatives, including the launch of an expanded Member Portal accessed through idaa.org that provided information on worldwide virtual and in-person meetings for healthcare professionals; IDAA-sponsored, member-led virtual meetings at various times of the day via Zoom; capability for members to add local and regional meetings open to IDAA members, including special-interest groups; monthly open IDAA speaker meetings accessible to all members and guests; and the shift of all IDAA steering committee, subcommittee, and planning meetings to the Zoom platform.

Informal feedback indicated that these activities were helpful to and readily accepted by IDAA members. Therefore, it was decided to conduct a more structured survey using Survey Monkey. Penny Ziegler, MD; Mary Raum, MD; and Erin Kiesel, DO, developed, distributed, and reviewed the survey. Total responses were 223, of which 65 percent had attended an IDAA Zoom meeting. Of those, 80 percent attended one or fewer meetings weekly, while 16 percent attended



Penny Ziegler, MD



Mary Raum, MD

two or more meetings weekly. More than half of those attending had shared with the group on the virtual platform.

At the time of the survey (December 2020), 80 percent of respondents were not attending face-to-face meetings. About 60 percent of respondents were depending on virtual meetings as their primary 12-Step activity during the pandemic. In addition to sharing with all attendees at the meeting, 75 percent were using the “Chat” feature to make 1:1 contact with others at the meeting, collect phone numbers and email addresses, and so forth. About 90 percent reported no concerns about privacy or confidentiality, and none of the respondents had experienced “hacks” disrupting the meetings.

The survey asked members to characterize the meetings they were attending. About half the meetings had developed a phone and/or email list. Some meetings had created text groups or private Facebook pages. Lengths varied from one to two hours, with 60 minutes most common. Some meetings utilized opening and closing readings and prayers from AA or NA literature, while others did not. Most regular Zoom attendees felt comfortable or very comfortable connecting with persons they had met on virtual IDAA meetings, either by phone, text, or email.

It was very clear from the responses that members found Zoom meetings highly valuable. More than 90 percent of members attending virtual meetings stated that they hope to continue to include virtual meetings in their recovery programs even after the pandemic subsides and face-to-face meetings open up again. IDAA plans to continue to host virtual meetings after restrictions are lifted. The Members-Only Portal is being expanded, and members will be encouraged to continue to post both in-person and in virtual meetings, as well as continue other activities for healthcare professionals.

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TREATING TRAUMA IN PHYSICIANS WITH CO-OCCURRING SUBSTANCE USE DISORDERS

Robyn Hacker, PhD, LP, LAC, and Jason Sapp, DO



Robyn Hacker, PhD, LP



Jason Sapp, DO

Compared to U.S. lifetime prevalence rates, people with substance use disorders (SUDs) are five times more likely to meet diagnostic criteria for PTSD (Berenz & Coffey, 2012). When these disorders co-occur, patients report greater functional impairment and poorer treatment outcomes (Jacobsen, Southwick, & Kosten, 2001; McCauley et al., 2012), and rates of these diagnoses are higher among physicians than the general population (e.g., SUDs 10–12% per Flaherty & Richman, 1993; PTSD 5.2–29% depending on training level and specialty, per DeLucia et al., 2019). Research is limited on treatment specific to this intersection of disorders, but a few findings are clear: Providers should assess for trauma any time a client presents with a substance use concern; no evidence supports treating trauma without also addressing the substance use disorder simultaneously; and it can be anticipated that trauma symptoms will increase as substance use decreases.

Treatment Considerations. Assessing severity of trauma and substance use symptoms and understanding a patient’s support system and available resources are critical. This assessment determines the appropriate level of care for treatment initiation, which influences what interventions are appropriate and the progression through the phases of trauma treatment. Exploring previous experience with treatment also helps to identify potential barriers to the clinical relationship and engagement in treatment. Obtaining ROIs for all current treating providers is necessary to provide the best care.

Phase 1 Treatment: Stabilization. The initial phase of treatment needs to focus on withdrawal and stabilization of acute medical presentations through medication-supported detoxification. Deploying motivational interviewing techniques, supportive therapy, basic coping skills, and psychoeducation

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Treating Trauma in Physicians with Co-Occurring Substance Use Disorders

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facilitates the initial introduction to the importance of behavioral change concurrent to medical intervention. During this phase, medical and clinical providers also complete thorough biopsychosocial-spiritual assessments and collaborate on the initial treatment and discharge plans.

Phase 2 Treatment: Preparation. Once acute withdrawal is complete and diagnoses have been clarified, nonaddictive psychopharmacological intervention can be introduced (typically SSRIs). Some patients benefit from symptom-driven treatment, but care must be taken to not completely eradicate trauma-related symptomatology. Psychotherapeutically, treatment is focused on preparing the patient for behavioral management of their symptomatology (e.g., implementation and practice of coping skills and emotion-regulation strategies, psychoeducation on the intersect of these disorders, symptom tracking, exposure modalities) and engagement in the exposure phase of treatment. It involves increasing the patient's window of tolerance and anticipating an increase in cravings/triggers that might cause relapse.

Phase 3: Exposure. Medical intervention focuses on optimization of psychiatric and symptom management. Understanding that a symptom increase is expected is key to strategically managing medications and not responding reactively. As exposure work progresses, it may be necessary to decrease medications; it is anticipated that symptoms may increase before ultimately decreasing. Before transitioning into exposure interventions, the patient needs to demonstrate coping and emotion-regulation skills in session and describe implementation between sessions. A solid relapse-prevention plan, symptom tracking, and open discussion of triggers and cravings demonstrate readiness. Successful deployment and duration of exposure interventions is not linear and must be highly individualized. ■

UPCOMING FALL VIRTUAL REGIONAL MEMBER MEETINGS

FSPHP members are invited to attend our Virtual Regional Member Meetings this fall to share experiences, to discuss and develop best practices, and to enhance awareness of issues related to physician health and impairment.

The agenda for the FSPHP Regional Member Meetings will include portions of the meeting designed for all FSPHP Member Types and portions of the meeting for PHP Members (State, Associate, Honorary, and International Member types).

Southeast Regional Member Meeting
November 9, 2021

10:00 a.m.–3:00 p.m. Eastern

9:00 a.m.–2:00 p.m. Central

8:00 a.m.–1:00 p.m. Mountain

7:00 a.m.–12:00 p.m. Pacific

Central Regional Member Meeting
November 17, 2021

10:00 a.m.–3:00 p.m. Central

11:00 a.m.–4:00 p.m. Eastern

9:00 a.m.–2:00 p.m. Mountain

8:00 a.m.–1:00 p.m. Pacific

Members [click here](#) for more information and to register.

Eligible nonmember State PHP Staff can attend their regional meeting without membership for \$100.

State Voting Members can register their nonmember staff to attend a Regional Member Meeting for \$100 each on the online Regional Member Meeting Registration forms. For more information on the Regional Member Meetings and to register online, visit <https://www.fspdp.org/2021-regional-member-meetings>.

UPDATES FROM AROUND THE UNITED STATES

MASSACHUSETTS PHYSICIAN HEALTH SERVICES, INC. (PHS) WELCOMES NEW MEDICAL DIRECTOR

Mark Albanese, MD, is the new Medical Director of PHS. Dr. Albanese is a graduate of Weill Cornell Medical College of Cornell University and has more than thirty years of experience as a psychiatrist specializing in addiction psychiatry. He brings compassion, integrity, and administrative acumen to his understanding of physicians' challenges. He is a longtime MMS member and has also served on the PHS Clinical Advisory Committee for more than twenty years. Most recently, Dr. Albanese was Medical Director for Addictions at Cambridge Health Alliance. He is an assistant professor of psychiatry at Harvard Medical School and is board-certified in both psychiatry and addiction psychiatry. In his new role, Dr. Albanese oversees all professional, educational, assessment, and monitoring services offered by PHS to the Massachusetts medical community. As part of the leadership team, he will be an integral part of steering strategy to realize the PHS mission of improving the health, well-being, and effectiveness of physicians and medical students in MA, while supporting patient safety. ■



Mark Albanese, MD

OHIO PHYSICIANS HEALTH PROGRAM LAUNCHES PHYSICIAN WELLNESS COALITION AND VIDEO SERIES

The Ohio Physicians Health Program (OPHP), in collaboration with several statewide stakeholders, has launched the Ohio Physician's Wellness Coalition (OPWC). OPWC has identified that a multifaceted approach is necessary to address wellness and burnout among physicians. The first initiative the coalition identified was to create a Wellness Video Series. This series covers topics such as the following: *The Benefits of Counseling*, *Boundaries for the Healthcare Professional*, *The Power of Vulnerability*, and nine other videos! This series was developed by content experts and offers free CME through a partnership with Ohio State Medical Association. The OPWC aims to provide a comprehensive one-stop location for wellness resources for Ohio's physicians. OPHP wanted to share this valuable resource across the country, as this free CME wellness series is open to anyone with a medical license, in any state. To access these videos, click the link below: <https://www.ohiophysiawellness.org/physician-wellness-series>. ■

ALCOHOL DETECTION THEN AND NOW: MCLELLAN, SKIPPER, CAMPBELL, AND DUPONT'S LANDMARK BLUEPRINT STUDY VS. OREGON'S HEALTH PROFESSIONALS' SERVICES PROGRAM

Christopher Hamilton, PhD, MPA, Former Monitoring Program Director, and Lori Govar, MSW, MBA, Monitoring Director, IBH

Nineteen percent. In November of 2008, McLellan, Skipper, Campbell, and Dupont wrote that 19 percent of the physicians in their landmark "blueprint" study on Physician Health Programs (PHPs) had at least one non-negative toxicology test. Oregon's Health Professionals' Services Program (HPSP) recently found that 19 percent of physicians participating over the course of five and a half years also had at least one non-negative test.

For McLellan et al.'s study (2008), this 19 percent refers to 126 out of the 647 participating physicians who completed or were still participating in their PHP at the five-year mark. These 19 percent had at least one non-negative toxicology test. Additionally, 26 percent of those who had a non-negative test had at least one subsequent non-negative test.

For HPSP, this 19 percent refers to 38 of 199 Oregon Medical Board physicians and physician assistants participating in HPSP between January 1, 2016, and June 30, 2021. Again, these 19 percent (38) tested non-negative at least once for alcohol or other drugs. Twenty-one of the 38 individuals had two or more non-negative toxicology tests. Of these 38 individuals, 17 were terminated from the program, 17 are still participating in the program, and four participants have successfully completed HPSP.

This parallel between McLellan et al.'s study and HPSP today seems to suggest consistency, but it does not necessarily: In the years in between, technological toxicology improvements have extended the detection time for alcohol and other drugs. We will look



Lori Govar, MSW, MBA



Christopher Hamilton, PhD, MPA

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Alcohol Detection Then and Now: McLellan, Skipper, Campbell, and Dupont's Landmark Blueprint Study Vs. Oregon's Health Professionals' Services Program

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particularly at advancements in alcohol detection because 50.3 percent of the study cohort were identified with alcohol use disorder as the primary diagnosis. For HPSP, alcohol was noted as a drug of abuse in 69 percent of the physicians participating.

One significant advancement is testing for the ethyl glucuronide (EtG) and ethyl sulfate (EtS) alcohol biomarkers. This technique was being used as early as the 1990s, was still limited in the early 2000s, but then quickly gained more acceptance and use in physician health programs (Skipper, Weinmann, & Wurst, 2004). Use of EtG and EtS with appropriate cutoff levels can provide alcohol detection for up to 36 hours in the heaviest alcohol users.

An additional advancement is the use of blood tests to determine the presence of the phosphatidylethanol (PEth) alcohol biomarker. The PEth biomarker can remain in the bloodstream for up to a month in the heaviest of drinkers. A PEth result of 20 ng/ml or greater indicates moderate to heavy alcohol use. It takes time for so-called "alternative" toxicology, like blood tests, to gain a foothold in the regular PHP operations for the treatment plan of physicians. Case law reinforced the validity of PEth testing by 2016 (Ulwelling & Smith, 2018).

McLellan et al.'s study was published in 2008 but was written on data from a 1995 to 2001 cohort of 802 physicians. Thus, it seems unlikely that many of the toxicology tests in this study were testing for the EtG and EtS alcohol biomarkers or PEth. Most likely, testing was the original standard of ethanol test, which provides only a short window of detection following alcohol consumption. **These advancements in testing not only allow for better detection, but also for better deterrence.**

In contrast to their study, all of HPSP's random drug tests since the program's inception in July 2010 have included the EtG and EtS alcohol biomarkers. In addition, in 2013 HPSP began using PEth testing as an additional testing component for those diagnosed with alcohol use disorder. Looking more closely at the non-negative tests, we see that 77 percent (67 of 87) of non-negative tests were for alcohol. Further, of the 38 HPSP participants testing non-negative at least once, 18 had a positive PEth biomarker test. Four of these 18 participants had a second non-negative PEth test. Substances detected in the other 20 tests included amphetamines, marijuana, and opiates.

Although HPSP's detection tools may have been stronger than McLellan et al.'s, their study was longitudinal in design, tracking the same cohort of participants for five years, while HPSP was looking at all participants over a five-and-a-half-year period. Thus, it would be interesting to see the toxicology results if McLellan et al.'s study was repeated using a 2016–2021 multistate PHP cohort, considering most PHPs have adopted the inclusion of alcohol biomarkers in their toxicology regimens. Again, if nothing else, these expanded detection windows have the opportunity to provide a deterrent to continued alcohol consumption.

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- Ulwelling, W. E. & Smith, K. The PEth blood test in the security environment: what it is; why it is important; and interpretative guidelines. *Journal of Forensic Sciences*, 63(6), 1634–1640, 2018. ■

BRISK ACTIVITY CONTINUES FOR TENNESSEE'S MENTAL HEALTH SCREENING TOOL

Usage continues to be brisk on the Tennessee Professional Screening Questionnaire (TNPSQ), an anonymous online mental health screening tool for health professionals served by the Tennessee Medical Foundation Physician's Health Program.

Launched just before the pandemic in February 2020, first-year use of the TNPSQ was three times more than expected; to date, second-year activity is already on track to exceed last year's by nearly 65 percent.

The persistence of COVID is no doubt behind the steady activity on the site. Key issues cited by users include COVID concerns; job, financial, and relationship stress; workplace conflict; academic struggles; increasing social unrest; and gun violence. Employed health professionals and faculty comprise 72 percent of users, possibly because awareness is higher in teaching hospitals and medical schools (see figure on page 27).

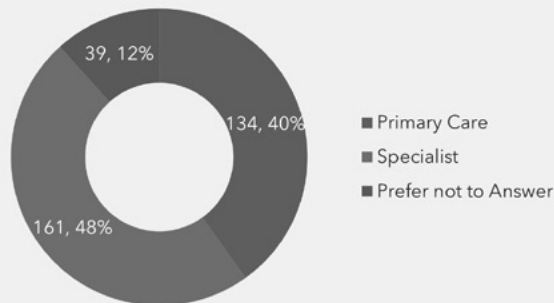
Usage Data

As of August 27, the number of screenings was 384. Results show the following:

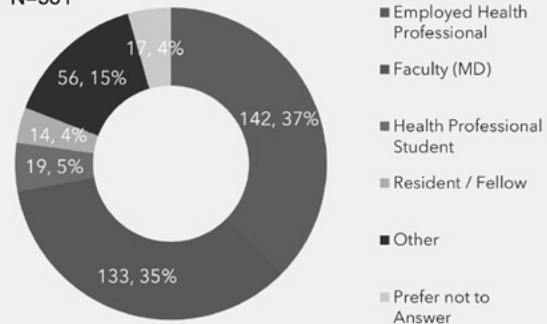
- 72 (18%) were Tier 1A (high/severe distress including suicidal thoughts/ideation).

Participant Position and Specialty

N=334



N=381



- 132 (35%) were Tier 1B (high/severe distress w/no suicidal ideation).
- 164 (43%) were Tier 2 (moderate distress).
- 16 (4%) were Tier 3 (low to no distress).
- TNPSQ counselors have responded initially to all 384.
- 281 (74%) reviewed the counselor's response.
- Of reviewers, 88 (31%) dialogued with counselors a total of 155 times.
- Of dialoguers, 49 (56%) requested an appointment or referral.
- 85% were not already receiving treatment or therapy for their mental health problem.

The TNPSQ utilizes the Interactive Screening Program, a platform developed by the American Foundation for Suicide Prevention (AFSP), and screens for mental health problems from anxiety and burnout to suicidal thoughts and intent.

Access the TNPSQ at tn.providerwellness.org. For more information, including FAQs, visit e-tmf.org/tnpsq, or contact the TMF at 615-467-6411. ■

TENNESSEE MEDICAL FOUNDATION WELCOMES DR. TAMIKO WEBB AS CASE MANAGER



Tamiko Webb, PhD

A new case manager has joined the Tennessee Medical Foundation Physician's Health Program (TMF PHP). Tamiko Webb, PhD, is working with health professionals referred by Tennessee's various licensing entities, including the Board of Medical Examiners, Board of Osteopathic Examination, and Board of Physician Assistants.

"We are so happy to have Dr. Webb on board as our new case manager handling our Board-related cases," said TMF Executive Director Jennifer Rainwater, adding, "She has a passion for helping people and a wealth of experience which make her a perfect fit for our organization. Welcome, Dr. Webb!"

Prior to joining the TMF in May, Dr. Webb served in the mental health field for over 27 years, including 19 years with the State of Tennessee, where she worked with vulnerable populations and facilitated groups on mindfulness, relapse prevention, co-occurring, anger management, and grief support. She also conducted a research study, examining *Changes in Depression*,

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Tennessee Medical Foundation Welcomes Dr. Tamiko Webb as Case Manager

continued from page 27

Cognitive Distortions, and Self-Esteem as a Function of Change in Mindfulness Among Adult Male Inmates.

"I have had the pleasure of meeting so many wonderful physicians, PAs, students, and other health professionals who continue to strive toward promoting their journey to recovery," said Dr. Webb. "The words I live by are, 'When you work in your purpose, it doesn't feel like work'; hence, working at the TMF has allowed me to further my purpose—meeting people where they are, one conversation at a time," she added.

A Michigan native, Dr. Webb earned her BS and MS in Counseling Psychology from Tennessee State University, and her PhD in Clinical Counseling, Teaching, and Supervision from Trevecca Nazarene University in Nashville, Tennessee. ■

TENNESSEE MEDICAL FOUNDATION MOURNS ONE OF ITS FOUNDERS: DR. JOHN DORIAN

Dr. John B. Dorian, one of the founders of the Tennessee Medical Foundation Physician's Health Program (TMF-PHP), died on July 2, 2021, at age 95. The TMF is deeply saddened by his loss.



**Dr. John Dorian,
1926-2021**

"When I first met Dr. Dorian and learned of his accomplishments, I was reminded of the phrase, 'Standing on the shoulders of giants,'" said TMF Medical Director Dr. Michael Baron, adding, "Without Dr. Dorian's understanding and foresight into physician health and wellness, the TMF would not exist as it does today. Thank you, Dr. Dorian."

"I never had the pleasure of meeting Dr. Dorian, but I am grateful for his sterling effort in starting the precursor of the TMF," said Board President Dr. Timothy Davis of Chattanooga. "He was forward thinking and way ahead of his time. He has positively affected thousands of lives."

As president-elect of the Tennessee Medical Association (TMA) in 1977, Dr. Dorian attended an American Medical Association (AMA) presentation on the impact of impairment on the medical profession. He returned

home and successfully proposed the TMA Board establish the Impaired Physician's Committee, which eventually became the TMF-PHP. He said he considered it one of his proudest accomplishments.

"It tackled a grave, grave problem in our profession," he told the TMF newsletter *Physician Health* in the Spring 2014 issue. Dr. Dorian lauded the lifesaving mission and work of the Foundation and its many volunteers over the decades. "It boggles the mind and instills a sense of pride and to me is a wonderful example of a professional who cares," he added.

A Memphis native, Dr. Dorian served with General George Patton's Third Army before enrolling in pre-med on the G.I. Bill at the University of Tennessee in Knoxville, followed by medical school at the University of Tennessee in Memphis. He founded Frayser Clinic and practiced there for thirty years as a family physician, and then served as assistant professor in Family Practice at UTHSC-Memphis.

In addition to serving as president of the TMA, Dr. Dorian was president of the Memphis/Shelby County Medical Society and served in several positions with the AMA, being named its Family Practitioner of the Year in 1972. He volunteered in retirement at St. Jude Children's Research Hospital and St. Vincent de Paul's soup kitchen.

Dr. Dorian is survived by his six children and their spouses, eight grandchildren, and two great-grandchildren. Memorials can be made to St. Jude Children's Research Hospital in Memphis. ■

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THE VALUE OF MEMBERSHIP!

FSPHP members have access to exclusive networking, resources, collaboration opportunities, and educational opportunities at the leading edge of physician health. In addition, the FSPHP provides education and exchange of ideas for physician health through its member email groups. Membership provides access to the members-only section of the FSPHP website. Members also have access to FSPHP policies and guidelines, leadership opportunities, new employment opportunities, and up-to-date information on the latest issues affecting physician and professional health at the state and national levels. FSPHP new members receive a discount on our annual conference and complimentary participation in FSPHP Regional Member Meetings. Visit <https://www.fsphp.org/membership> for more information on the benefits of membership.

Spread the Word and Share in the Benefits of the Strongest Membership to Date!

Our membership and our network are growing. FSPHP membership has never been larger, with approximately 270 active FSPHP members:

- 47 State Voting
- 146 Associates
- 18 International
- 15 Individuals
- 11 Industry Partner Individuals
- 5 Organizational
- 4 Honorary

New members benefit by the deep experience of our current member PHPs and, in turn, new members bring exciting ideas to our members. Our dedicated current members are a vital part of the passion and effectiveness of our overall mission: "To support Physician Health Programs in improving the health of medical professionals, thereby contributing to quality patient care," and our vision: "A society of highly effective PHPs advancing the health of the medical community and the patients they serve."

FSPHP READING CORNER

FSPHP MEMBERS PHILIP HEMPHILL, PHD, AND ALEXIS POLLES, MD, ARE PLEASED TO ANNOUNCE THE PUBLICATION OF THEIR EDITED BOOK—AVAILABLE FOR PREORDER ON AMAZON

Boundary Violations in Psychotherapy: Therapy Indiscretions, Transgressions, and Misconduct

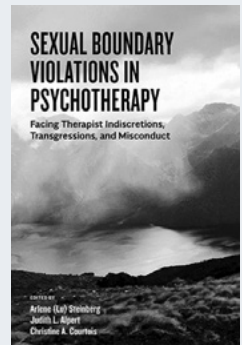
Steinberg, A., Alpert, J. L. , and Courtois, C. C. (Eds.) (July 2021), Washington, DC: American Psychological Association.

The book is different from other published books on sexual boundary violations. We seek to reach a broad audience of mental health professionals, covering topics that previously received little or no attention. We begin with a historical overview of the topic, followed by a chapter on the APA ethics code and legal statutes and one on boundary challenges. Victim/survivor clients are given center stage in this book, with consideration of why those who report are typically treated poorly, with suspicion or outright disbelief. We recommend the need for compassionate and respectful response for them as individuals and an increased understanding of the confusion/ambivalence they often express due to the betrayal trauma they experienced. We extend the concept of betrayal trauma from the individual therapist abuser to colleagues and others as bystanders and to organizations and their attempts to cover up such complaints. We suggest what might be done differently going forward to give victims the care and attention they deserve.

In another contemporary approach to the topic, we consider sexual boundary violations from various theoretical perspectives (e.g., cognitive behavioral therapy, sex therapy, gestalt therapy, feminist therapy, psychoanalytically oriented psychotherapy), and we consider boundary violations in a variety of settings (e.g., pastoral counseling, private practice, community mental health center) involving new contexts (e.g., digital and social media mechanisms) and with various populations (e.g., racial and cultural and sexually diverse dyads). The most common dyad until recently has been the older male therapist and the younger female client; however, reports of abuse by female therapists are now on the rise. The often-convoluted dynamics of such abuse, the therapist's character, and the range of serious aftereffects to the victim, therapist, and others are considered as well. Survivor stories and a detailed interview with Andrea Celenza are included.

The book contains chapters on treating previously abused clients in subsequent therapy, supervision of therapists who have engaged in sexual conduct, and the treatment of therapists who sexually offend, with an eye toward whether rehabilitation is possible. In the epilogue, major themes are identified as well as directions for prevention and intervention.

This text includes chapters by some of the major contributors to the sexual boundary violations literature (e.g., Andrea Celenza, Philip Hemphill, Mark Gold, Gary Schoener, Laura Brown, Linda Campbell, Stephen Levine, Elizabeth Goren, Sue Grand, Christine Courtois, Judith Alpert, Arline Steinberg). ■



SHARE YOUR STATE PHP EVENTS WITH FSPHP

If you are a member PHP and would like to have your event listed on the [FSPHP State PHP Events page](#), please email your complete event details to Linda Bresnahan at lbresnahan@fsphp.org. Be sure to include event name, date, location, description, contact information, and a link for more information and to register online.

PHYSICIAN HEALTH NEWS

The FSPHP produces a newsletter twice a year in Spring and again in Fall/Winter that is sent to all state programs, medical societies, licensing boards, national organizations invested in the health of the profession (such as American Foundation of Suicide Prevention, the American Medical Association, the Accreditation Council for Graduate Medical Education, the Federation of State Medical Boards, the American Board of Medical Specialty, the American Psychiatric Association, the American Osteopathic Association, Ontario Medical Association, the American College of Physicians, and the American Medical Women's Association), and other stakeholders as well.

The FSPHP requests articles (500 words or fewer) and other related information be submitted for inclusion in the FSPHP newsletter.

CALL FOR CONTENT/ NEWSLETTER SUBMISSIONS

The FSPHP wants to hear from you and invites members to submit content for inclusion in *PHN*.

This newsletter is intended to help members stay abreast of local, state, and national activities in the area of physician health. Please consider a submission to help keep all states informed of your program's activity and progress in the field of physician health.

Please send submissions by email to lbresnahan@fsphp.org.

Items that you may want to consider include the following:

- Important updates regarding your state program
- A description of initiatives or projects that have been successful, such as monitoring program changes, support group offerings, outreach and/or education programs, and so forth
- Notices regarding upcoming program changes, staff changes
- References to new articles in the field
- New research findings
- Letters and opinion pieces
- Physician health conference postings and job postings

Please limit articles to 500 words or fewer and other submissions to 200 words or fewer.

Deadline for the Spring issue: January 30, 2022

Deadline for the Fall issue: August 31, 2022

WE NEED YOUR INVOLVEMENT AND INPUT!

There are various ways to get involved in the FSPHP!

- Join us as a member: www.fsphp.org/membership
- Join a Committee: www.fsphp.org/committees
- New Activity or Project: The FSPHP Board of Directors is very interested in your ideas and suggestions, and we welcome agenda items you would like to bring before the board. But it is important to be organized in our approach to make sure ideas are fully explored and vetted. The board established a policy that members are required to submit written requests for consideration to the FSPHP Executive Director and Board of Directors. This can also be done through the work of an FSPHP Committee. This process is outlined here for our members: [FSPHP New Activity or Project Worksheet](#).

Ways to support the mission of the FSPHP:

- Join Our Mailing List
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HELPFUL FSPHP RESOURCES

- E-list Instructions
- E-list Guidelines
- New Member Guidebook
- Committee Portal Toolkit

We hope you enjoy the 2021 Fall Issue of the *Physician Health News*.