

PHYSICIAN HEALTH NEWS

The Official Newsletter of the Federation of State Physician Health Programs



VOLUME 17 • APRIL 2012

MESSAGE FROM THE PRESIDENT

I will be ending my presidency this April after three-and-a-half years of service. During this time, it is my pleasure to share our accomplishments. We contributed to the Federation of State Medical Boards' (FSMB) *Policy on Physician Impairment*, which not only reflects our guidelines, but also our overall approach to physician health problems (the exception being continued use of the word "impairment" in the title). We also played a substantial role in the development of physician health policies in the American Society of Addiction Medicine and the AMA. Our guidelines and discussions — both in person and over the listserv — during the past 15 years have established us as the most substantial force in physician health within our organization and in others. Considering our increasing influence and new diagnostic and treatment models in the field, it's important we review our guidelines for substance use disorders.

Our first annual meeting after the development of our bylaws consisted of about 20 representatives around a big conference table. Our annual meetings now attract attendance from a majority of our state and provincial member programs, their associates, and many others. The annual meeting has been and will continue to be a source of considerable academic and practical input into our field. The meetings generate a substantial percentage of our revenue, which gives our organization the ability to explore future development needs.

Our board discussed membership and the proposed expansion of our membership to include individual or auxiliary membership, which will allow more communication with people who have interest and input in physician health but do not qualify for state or associate membership. Although we are currently a membership organization of state PHPs, this would include academics and others who make contributions to our field. Our board will address the voting membership programs we have for state PHPs. The discussion will involve the wisdom and process of seeking membership from other programs that provide assistance to health care professionals — but not physicians. Many of these programs are now members of national associations based on employee assistance programs. We share many goals with non-PHPs, but these programs may not share our mission at all levels.



Peter Mansky, MD

Our programs address the major aspects of prevention — primary, secondary, and tertiary. These activities are being challenged, especially the safety of our participants as practitioners. Many of us have said we would rather go to a physician in our program than a random physician in the community, but we need more evidence of the quality care they are giving. We know that the recovery rate of our participants is substantial. Recovery increases the quality of their family and social lives as well as the quality of the medical care they provide others. The increased quality of family and social life — an overall life balance — spurs physicians to take better care of themselves, which inevitably leads to better care of their patients.

With more funds in reserve, increased annual meeting attendance, and the success of our program planning committee, we can fund starter research of our own. Such a project will position the FSPHP to obtain federal and special grants, as well as present an opportunity to utilize the services of a grant writer. Our research task force, under the excellent leadership of Drs. Jeffery Selzer and Michael Gendel, will likely coordinate these activities.

These are exciting times for the FSPHP. Our retreat last fall set a new mission statement along with goals and objectives. I encourage you to participate on committees, and to contact your federation board representatives and officers to express your opinion.

Thanks to all of our members whom have contributed their time and energy to help our Federation change and grow over the two and a half years of my service as president.

I look forward to seeing you at the meeting in April.
— Peter A. Mansky, MD, DLFAPA

CONTENTS

Message from the President	1
Message from the Executive Director	2
Moving Forward after the Retreat	3
FSPHP Mission Statement, Goals, and Objectives	4
Please Join Us in Welcoming Our New FSPHP Members	5
AMA Official Observer Report	6
News from State PHPs and Regions	6
The Need for Consensus and Consistency	11
Change to Joint Commission Standard	12
Review of the MPAP in Assisting Physicians for Disruptive Behavior, 1996 to Present	12
Physician Health and Other Related Organizations' National Meetings	20



Welcome to the 17th edition 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, with production and printing assistance from the Massachusetts Medical Society.

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The FSPHP is a national organization providing an exchange of information among state physician health programs to develop common objectives, goals, and standards. If you're not yet a member, please consider joining. State membership is \$400.00 per year, and individual (associate) membership is \$100.00. We sincerely hope you respond as an indication of your commitment to a stronger, more cohesive Federation of State Physician Health Programs.

For more information on each of the membership categories, please contact Vicki Grosso of the AMA at (312) 464-4574.

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Physician Health News is developed through the volunteer efforts of the Publications Committee with pro bono assistance from the Massachusetts Medical Society's Department of Premedia and Publishing Services.

MESSAGE FROM THE EXECUTIVE DIRECTOR

Strategic planning is one of the most essential, yet often neglected, obligations for any organization. Organizations that have been established for many years and have had a consistent mission can enjoy the luxury of proceeding with a modest strategic planning endeavor and selection of objectives. However,



Jonathan Dougherty, MS

that can also lull organizations into a sense of complacency, which could have dire consequences. Of recent note I am reminded of Eastman Kodak Company, once a leader in the photo imaging business and now facing bankruptcy because of its hesitation to embrace digital technology. As a membership organization, the Federation of State Physician Health Programs, Inc., may not be subject to the tectonic variances often found in the common marketplace. Later in this issue, Dr. Charles Meredith summarizes the FSPHP Board of Directors retreat in Chicago last November. He highlights that our reason for existence is to serve our member programs and advance the cause of physician health. Nevertheless, as our member organizations evolve, the Federation must be prepared to evolve alongside by facing political and economic challenges, by finding the necessary resources to meet our obligations and by embracing new technologies that will help us do our job better.

As chair of the strategic planning subcommittee and incoming FSPHP President, Dr. Warren Pendergast was mindful of the need for board members to prepare ahead of time by reviewing some of the key components of strategic planning. To that end, he recommended the board read, *The Five Most Important Questions You Will Ever Ask about Your Organization*, by the late Dr. Peter Drucker, prior to the meeting. This excellent selection not only primed the board members to discuss the necessary aspects of strategic planning, but also redirected a considerable amount of time toward the actual mechanics of the task at hand.

An honest, situational analysis is the bedrock of any strategic planning process. The board members reviewed 2008's strategic plan and examined which components of the plan were enacted versus those that weren't. The goals and objectives ensconced in the 2008 strategic plan were rated for their level of importance and likelihood of success. It was discovered that although some of the objectives had not been fully realized, there were some very important strides achieved during the previous three years. Specifically, it was important to note that many premier associations involved in recovery recognize the

FSPHP as an authority in physician health. Furthermore, your leadership has pursued liaisons with these same organizations in an ongoing basis.

Having vivid knowledge and understanding of the environment in which our members practice is perhaps the most important component of any situational analysis. From my perspective, the people who serve on the board of directors and attended the retreat are the best representation of our organization. Not only was there a plethora of geographic representation but, more importantly, a vast array of experience in physician health spanning generations. As necessary as it is for us to be able to say what we are, it is equally important to recognize what we are not. Our strategic plan will have the most success through a comprehensive understanding of what state physician health programs grapple with daily.

As we continue with the review and, ultimately, the approval of our strategic planning document, you will be able to witness the richness of the contributions made by your board of directors in mapping out the future direction of the FSPHP. What we do, for whom do we do it, and how to excel at it will be questions easily answered because of this process.

— *Jonathan H. Dougherty, MS*

MOVING FORWARD AFTER THE RETREAT

During the first week of November 2011 the board of directors of the FSPHP met in Chicago to assess the organization and map out a mission statement, goals, and objectives as the Federation continues to evolve. This was not an easy task. As a membership organization responsible to its constituents, the board of directors took great strides to find ways for the FSPHP to be more accountable to you and provide increased value to your own state's program. Keeping in mind the diversity of state physician health programs and how many of your programs are changing in light of greater needs placed upon you, the board of directors felt that it was important to craft a snapshot of the organization today and address how to successfully evolve to meet your future needs.

In addition to the board of directors, we were privileged to have Dr. Gary Carr, our immediate past president, and past board member Dr. Mick Oreskovich in attendance. Our retreat mediator was FSPHP Past President Dr. Lynn Hankes, who did a superb job keeping everyone focused on the tasks at hand and drawing ideas from participants. Although some had to attend via teleconference due to scheduling conflicts, it's important to note that most of the participants left their busy lives in physician health to be physically present at the retreat. It was refreshing

and inspiring to see the enthusiasm displayed by the Federation's leadership. The net result is a work product that still needs further refinement by the board of directors, but is a major step in setting a future direction for the FSPHP.

After many hours of intense discussion and introspection by various members of the board regarding the purpose the FSPHP serves for all of us, the following comprehensive mission statement was developed and approved during the first night of the retreat:

To support physician health programs in improving the health of medical professionals, thereby contributing to quality patient care.

One sentence can say a lot about an organization. The universal belief by your leadership is that the organization is here for you and the state physician health programs. The more that we can do to help you, the better it will be for maximizing quality patient care throughout the United States and Canada.

The second day of the retreat was spent solely on the identification of goals, objectives, and action items for the next few years. Energized by the success of the first day, multiple volunteers within the board of directors volunteered themselves over the upcoming year for various assignments intended to strengthen the Federation. One major objective discussed stems back to the 2008 strategic plan to *continue the FSPHP outreach to all identifiable organizations concerned with recovery*. Although we have made great strides in connecting with virtually every organization that has a connection with physician health, the board feels that we need to expand that outreach further.

Another obvious concern relates to funding limitations. As alluded to earlier, one of the FSPHP's many strengths is its passionate and devoted volunteer base. However, as time progresses and demands on the organization grow, increased funding to support this growth — through a more established administrative structure and engaging any future research opportunities — will need to be a priority. Otherwise, the Federation could be limited in its ongoing mission to increase its national visibility and enhance the practice of physician health throughout North America.

After the Board of Directors fine tunes the new strategic plan, please take the time to review its contents and seek out your regional directors to provide your feedback. This is an exciting time to be part of the FSPHP and we are grateful for your assistance in helping our organization grow and prosper in the years to come.

— *Charles Meredith, MD, and Jonathan Dougherty, MS*

FSPHP MISSION STATEMENT, GOALS, AND OBJECTIVES

MISSION: To support physician health programs in improving the health of medical professionals, and thereby contributing to quality patient care.

(Prepared for FSPHP Board of Directors, January 2011)

Goals and Objectives

1. Increase Funding
 - a. The FSPHP should explore research partnerships on existing outside grant opportunities and/or use of a grant-writer (Drs. Oreskovich and Selzer/ Research Committee)
 - b. Membership expansion (Retreat action: defer to the BOD).
 - c. Relationships (assignment to make contact with a goal of increased coordination and communication with outside entities, ask for suggested actions and goals vis-à-vis the entity).
 - d. Federation of State Medical Boards (FSMB): Dr. Warren Pendergast.
 - e. American Society of Addiction Medicine (ASAM): Drs. Gary Carr, Brad Hall, and Penny Zeigler.
 - f. American Medical Association (AMA): Drs. Charles Meredith and Luis Sanchez.
 - g. National Organization of Alternative Programs (NOAP): Dr. Brad Hall.
 - h. Medical Group Management Associations (MGMA): Mr. Dougherty.
 - i. Physician Insurers Association of America (PIAA): Drs. Pendergast and Zeigler, and Mr. Dougherty.
 - j. Administrators in Medicine (AIM): Dr. Hall.
 - k. American Psychiatric Association (APA): Drs. Gundersen and Zeigler.
 - l. American Academy of Addiction Psychiatrists (AAAP): Dr. Gendel.
 - m. American Board of Medical Specialties (ABMS): Dr. Pendergast.
 - n. Citizen Advocacy Center (CAC): Drs. Gundersen and Pendergast.
 - o. American Academy of Family Physicians (AAFP): Dr. Zeigler.
 - p. American Society of Anesthesiologists (ASA): Dr. Oreskovich.
 - q. American College of Surgeons (ACS): Dr. Oreskovich.
 - r. National Association Medical Staff Services (NAMSS): Dr. Hall.
 - s. American Academy of Psychiatry and the Law (AAPL) (Forensic): Dr. Sanchez.
 - t. Association for Medical Education and Research in Substance Abuse (AMERSA): Dr. Oreskovich.
2. Infrastructure and Operations
 - a. Full-time Executive Director and staff were delegated to discussion by Task Force
 - b. Revise the membership database: Mr. Dougherty.
 - c. Revise and update the FSPHP website with added functionality: Drs. Hall and Pendergast, and Mr. Dougherty with involvement of Publication Committee.
 - d. General revision and update of FSPHP bylaws: Dr. Gundersen.
 - e. Update Board and committee charges: Dr. Pendergast.
 - f. Clarify/reestablish the role of Regional Directors (underlying goal of better communication between members and BOD). Regional Director Task Force to address this issue.
 - g. Develop a leadership succession plan.
3. Services
 - a. Increase the circulation and frequency of the newsletter: Ms. Bresnahan and Mr. Dougherty.
 - b. Certify accuracy of the listserv membership: Mr. Dougherty. Consider an FSPHP moderator.
 - c. Oversee annual meeting and regional meeting finances and obligations: Drs. Gundersen and Oreskovich, Mr. Dougherty, and Ms. Bresnahan.
 - d. Crisis consultation was deferred.

4. Research

- a. The Research Committee is recommended to explore the following research topics:
 - i. Patient safety
 - ii. Cost effectiveness of programs
 - iii. Qualitative measures of success
 - iv. Physician suicide
- b. Develop Federation research database with links to website: Drs. Gendel and Selzer.
- c. Development of FSPHP guidelines for interfacing with outside research organizations

5. Guidelines

- a. The existing FSPHP guidelines are to be revised and updated.
- b. Additional components are to include the treatment of the “distressed physician” and the identification of boundary violations, both sexual and non-sexual. (Consider change in terminology to “physicians with behavioral issues”)

PLEASE JOIN US IN WELCOMING OUR NEW FSPHP MEMBERS

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AMA OFFICIAL OBSERVER REPORT

At the annual meeting of the AMA in June 2011, the following report was accepted by the delegation.

D-405.990 Educating Physicians about Physician Health Programs. (Resolution 402, A-09; Modified: CSAPH Report 2, A-11).

The report recommendations are summarized as follows:

1. Our AMA will work closely with the Federation of State Physician Health Programs to educate our members as to the availability of state physician health programs and services to continue to create opportunities to help ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory.
2. Our AMA will continue to collaborate with relevant organizations on activities that address physician health and wellness.
3. Our AMA will, in conjunction with the FSPHP, develop state and legislative guidelines addressing the design and limitation of physician health programs.

The full report can be reviewed on the AMA website.

Dr. Sonja Boone, director of physician health and health care disparities, AMA, and I are co-leading a task force to implement these recommendations. To assist with this task, the AMA is developing an advisory council to research best practices of existing physician health programs, define model programs with regard to confidentiality practices, and sustainable programs for physician health and wellness, and identify ways to best educate physicians and trainees about PHPs.

The FSPHP task force, consisting of Warren Prendergast, Mick Oreskovich, Doris Gunderson, and myself, assisted the AMA in developing this report and will continue to be involved as we work on the recommendations. We encourage any interested FSPHP members to provide their input as we continue with this task. In addition, it's probable that we will be surveying best practices of state programs as we work on developing model guidelines.

In my opinion, this is an excellent opportunity for the AMA and the Federation to develop PHP guidelines similar to what our organization established years ago — most recently in the past year by the American Society of Addiction Medicine and the Federation of State Medical Boards.

We look forward to working with you and reviewing your input on this project. — *Luis T. Sanchez, MD*



Luis T. Sanchez, MD

NEWS FROM STATE PHPS AND REGIONS

Southeast

Southeast Regional FSPHP Meets in Asheville, NC

The Southeast Regional FSPHP meeting was held Friday, September 30 through Sunday, October 1, 2011, at the Crowne Plaza Tennis and Golf Resort in Asheville, North Carolina. Friday's afternoon business meeting was followed by a dinner that was well attended by members and guests. Attendees had the opportunity to meet the new medical director of the Alabama PHP, Eric Hedberg, MD, and a representative from the group working to develop a PHP in Georgia, Steven Lynn, MD.

On Saturday, the North Carolina PHP (NCPHP) presented a mock medical board hearing with two attorneys from the North Carolina Medical Board and two private attorneys experienced in representing physicians before the medical board. Dr. Warren Pendergast, NCPHP medical director, played the part of the physician/respondent, Dr. Brett Favre. The SE FSPHP attendees served as medical board members. This presentation was an accurate representation of a real board hearing, and was both enlightening and entertaining for everyone in attendance.

After a stimulating roundtable discussion, Drs. Pendergast and Jordan of the NCPHP made a presentation, along with guest speaker, Peter Hazelrigg, Pilgrimage Professional Development Group, who has worked with NCPHP on cases involving workplace behavior issues. The presentation was entitled "Coaching for Team Success: A Model of PHP Intervention." It explored the use of a coaching approach in dealing with disruptive workplace behaviors in physicians who have not been found to have significant psychiatric disorders and/or a need for formalized treatment.

As defined by Peter Hazelrigg, executive coaching is "a targeted developmental process that assesses a participant's personality tendencies, strengths, and weaknesses, and utilizes an external partner to facilitate positive behavioral change." The goal is to increase the physician's effectiveness at work, improve stress management skills, and expand frustration tolerance. Several case examples were used to illustrate the usefulness of this approach, where the coach is viewed as an equal partner with the participant, focusing on accountability, encouragement, and support.

West Virginia Medical Professionals Health Program

The West Virginia Medical Professionals Health Program (WVMPHP) has been up and running for nearly five years and continues to be the only physician health

program recognized by the WV Board of Medicine and the WV Board of Osteopathy. Our southern office is located within the State Medical Association building in Charleston, West Virginia, with a northern office located in Bridgeport, West Virginia. The WVMPHP has provided 3 educational lectures to an excess of 200 attendees for 2012 YTD and cumulatively 62 educational lectures for more than 3600 physicians, hospitals, medical staffs, medical societies, students, and residents since its inception. Currently, funding has been largely provided through the WV Mutual Insurance Company, grants from the WV Hospital Association, licensure board's fees and support from the WV State Medical Association, pro-bono services by many individuals involved, donations, and participant fees.

To date, there have been 93 signed participants of whom 58 continue under an agreement impacting an excess of 30 hospitals/medical schools and many other group practices. Ninety (90) percent of these individuals, who have completed treatment and are under contract, resumed working, remain abstinent, licensed, and practicing medicine safely. Forty-three (43) percent of current participants were referred by their licensure board formally through consent order or informally through direct contact, 7 participants resided and practiced out of state were able to maintain their active West Virginia medical license as direct result of their participation with the WVMPHP. Participant specialties include: family practice, internal medicine, pediatrics, ophthalmology, orthopedics, obstetrics and gynecology, general surgery, neurosurgery, cardiovascular surgery, radiology, emergency medicine, endocrinology, pathology, psychiatry, cardiology, palliative medicine, medical students, and residents in training. Sixty-nine (69) of the 93 continued to work or have been returned to the active safe, monitored practice of medicine. Of the 58 under current monitoring agreements, 47 have continued to work or have been returned to work. Twenty-three (23) of the 93 (25%) had previous issues and recurrence of their chronic medical condition, further supporting the need of our physician health program and long-term guidance, assistance, and monitoring.

During initial evaluation, some were found to have some type of impairment (physical or on initial neurocognitive testing), most of which resolved with treatment. A few remain impaired and are disabled due to physical disorders detected or persistence of cognitive impairment. Many detected impairments were unrelated to their original issues leading to participation with a few individuals having residual impairment due to the "qualifying condition of participation" (mental illness or substance use disorder) or other unrelated physical disorders. These initial

and permanent impairments would not have been detected had they not sought the assistance of or been referred to the WVMPHP.

As you can see, WVMPHP is fulfilling its mission of protecting the public and providing a mechanism for the successful rehabilitation of the sick physician and return to the safe, monitored practice of medicine to the benefit of the public and physicians themselves. West Virginia has created a safe-system with the underlying principles of communication, collaboration, transparency, and accountability to the benefit of all. The continued support of organized medicine, regulatory agencies, the health care community, the FSPHP, and treatment professionals is necessary and greatly appreciated.

— *P. Bradley Hall, MD, DBAM, MROCC, BRI-1, executive medical director, WVMPHP*

Georgia: Physician Health Program Moving Forward

In November 2011, the Georgia Professional Health Program, Inc. (Georgia PHP, Inc.), was awarded 501(c)(3) status as a charitable organization. Georgia PHP, Inc., is devoted to the early identification, education, prevention, and treatment of addiction and other psychological illnesses for Georgia health care professionals. During our infancy, we will focus on the health issues of physicians. But, we've already had inquiries from other health care professions about expanding outreach to encompass other health care professionals, including PAs, nurses, psychologists, and pharmacists.

A board of directors has been appointed, lead by co-chairs, Paul Earley, MD, and Steven Lynn, MD. Various aspects of developing the organization are well underway, however, there is still much to be done.

Many of the biggest hurdles for Georgia PHP, Inc., have been overcome. However we are still awaiting the posting of the RFP by the state of Georgia. This has not slowed us down, though. Last summer, we initiated a founding member campaign and hosted a fundraising dinner event at the conclusion of the 2011 Georgia Society of Addiction Medicine (GSAM) conference in Atlanta. In collaboration with the Georgia treatment community, Georgia PHP, Inc., has raised over \$40,000. All donations are tax-deductible under Section 170 of the International Revenue Service Code for Public Charities. To help our cause and become a member, contact Robin McCown at gsam.rmccown@gmail.com, or to make a donation visit <http://tinyurl.com/GA-PHP-INC>.

In the interim, let's hope the state of Georgia releases the RFP and moves this forward to the next step!

— *Paul Earley, MD, Steven Lynn, MD, and Robin McCown*

Northeast

Northeast Regional Meeting

The Northeast Regional Meeting of the FSPHP was held on October 13, 2011, and graciously hosted by the Massachusetts Physician Health Services, Inc., (PHS) at the Massachusetts Medical Society.

Luis Sanchez, MD, current medical director of the Massachusetts PHS and past FSPHP president, opened the meeting. Attendees included representatives from Connecticut, Maine, Massachusetts, New Hampshire, New York, Pennsylvania, Rhode Island, as well as executive director of the FSPHP, Jon Dougherty, MS, of New York.

Following general introductions, the meeting began with a review of the current status of each state's program. Of concern to several programs was the perception that state licensing boards' adoption of a more punitive philosophy. The morning session concluded with review of interstate agreement requirements for each of the programs, and what would constitute appropriate information transmitted between programs under such circumstances.

The afternoon session began with a presentation by Wayne Gavryck, MD, an associate director and the MRO of the Massachusetts PHS, entitled "New Measures In Toxicology — EtG, PEth, Hair and Nail — Case Examples." A review of the nature and parameters of the testing formats (EtG, PEth) was followed by discussion of the interpretation of these relatively new testing methods.

The final discussion topic concerned the creation of a mission statement at the FSPHP Retreat. The group indicated networking, education, and collaboration as important FSPHP functions, but there was debate as to the role of "patient safety" in the mission statement, PHP programs, and FSPHP tax-exempt status.

Dr. Sanchez concluded the meeting with an update on various FSPHP issues. Following the conclusion of the formal meeting, there was a tour of the Massachusetts PHS facilities. The next Northeast Regional FSPHP meeting will be held in fall 2012 in Rhode Island.

West

Western Regional Meeting

The Nevada Professionals' Assistance Program (NPAP) generously hosted the 2011 Western Regional meeting at their office in Las Vegas, Nevada on Friday, September 23, 2011. Attendees included representatives from NPAP, the Washington Physicians Health Program, the Utah Recovery Assistance Program, the New Mexico Monitored Treatment Program, the Montana Professional

Assistance Program (MPAP), the Idaho Physician Recovery Network (IPRN), and the Texas Medical Association's Committee on Physician Health and Rehabilitation.

Representing Promises Treatment Centers, Dr. Greg Skipper started the meeting's morning session by leading a didactic and case-based discussion on the interpretation of urine and serum testing for the detection of alcohol use. Dr. Skipper shared several difficult cases he had encountered in recent years at the Alabama Physician Health Program. After soliciting challenging and complicated cases from conference attendees, he moderated an engrossing discussion regarding the management of each case. Following this, Dr. Skipper provided an extensive educational update on multiple new technologies for monitoring alcohol use, many of which are still in development.

Following a leisurely networking lunch, conference attendees reconvened as John Southworth, MD, from the IPRN presented to the group an update on the IPRN's new partnership with a large local hospital in assisting its wellness committee in monitoring the medical staff for signs of impairing conditions. At the end of the afternoon, Dr. Peter Mansky from the NPAP led an open discussion on the primary threats and problems FSPHP member programs faced throughout the region in 2011. Global concerns were primarily tenuous funding sources, unpredictable relationships with state medical boards, and negative publicity campaigns from groups such as Public Citizen.

Attendees were in agreement that the the western regional meeting had been a success. In particular, attendees noted that having a chance to solicit proactive advice and support from peers regarding current threats to their programs was of significant value, and a great benefit in general of FSPHP membership.

British Columbia

2011 was an eventful year for the Physician Health Program of British Columbia. Because it was the final year of a six-year funding commitment from the provincial government, it was a year of reflection both informally and formally. An external review by management consultants recommended that the program consider a new governance structure in 2012, thus dissolving the independent society created in 2006 and realigning itself under the administrative umbrella of the BC Medical Association. This proposal will be enacted in April 1, 2012, and is expected to result in a number of improved administrative efficiencies. However, clinical operations will continue as usual. The program's case volume rose by approximately 50 percent compared to that in 2010, and

the staff launched a new series of accredited, small group discussions called PLGINS: Peer-Led Group Interactions.

Idaho

As indicated by our consistent participation growth commissioned program audit, 2011 was a significant year for the Idaho Physician Recovery Network (IPRN). Overall growth for the IPRN was approximately 31 percent, with the majority of that growth via self-referrals. Such a large influx of new referrals is indicative of the improved visibility of the IPRN and its positive outcomes throughout the state. In part due to the IPRN's recent rapid increase, leadership commissioned Dr. Lynn Hankes to conduct an external audit of the program's policies, procedures and clinical practices. Dr. Hankes' findings were both very useful and very positive, leading program staff to look forward to 2012 with great confidence.

Montana

During the 2011 Montana Legislature, H.B. 25 passed and became law, following the governor's signature, effective April 7, 2011. This law provides parity with other medical assistance programs in dentistry, nursing, and pharmacy. It also now *requires* a medical assistance program for medicine, modifies existing peer review language for medical assistance programs, and extends the privilege to other participating health care licensees. H.B. 25 contains a "three strikes" provision with regard to three positive toxicology screens during a monitoring episode, resulting in a compulsory report to the respective licensure board and subsequent license discipline. H.B. 25 will also require an external performance audit of the program every five years for the next ten years, with interim internal audits every two and half years.

In other developments, the MPAP Board of Directors recently produced an informational video regarding the structure and function of the MPAP. Complimentary copies of the DVD were distributed to all members of the Montana Hospital Association in June 2011, and the video can be viewed on the MPAP website, www.montanaprofessionalassistance.com.

Nevada

The Nevada Professionals Assistance Program (NPAP) had a busy year in 2011. Shauna Mansky joined the program staff as assistant director in July 2010, greatly increasing NPAP's efficiency. Ms. Mansky graduated from the University of Nevada-Las Vegas in May 2010 with a bachelor's degree in Psychology and is currently working towards her master's in health care administration.

The NPAP continues to focus on cultivating its excellent relationships with Nevada's allopathic and osteopathic

boards, as well as with hospitals, groups, and other stakeholders throughout the state. NPAP maintains 1 to 2 percent participation of the 5,500 physicians in Nevada, actively monitoring physicians, dentists, PAs, podiatrists, and residents. We also expend great efforts on primary and secondary prevention activities and advocacy for program participants. Caduceus meetings for physician support are run by the NPAP in both Reno and Las Vegas, where the majority of the state's population resides.

The NPAP provides educational outreach for Nevada's dental school and two medical schools as well as annual lectures on physician impairment at local hospitals. In September 2011, the NPAP hosted a very successful western regional meeting for the FSPHP. Finally, our executive medical director, Dr. Peter Mansky, was recognized by the Nevada State Medical Association for his NPAP work with the Community Service Award at their 2011 annual meeting.

Oregon

Founded in July 2010, the Health Professionals' Services Program (HPSP) of Oregon is provided by Reliant Behavioral Health. The highlight of 2011 was further growth and infrastructure stabilization in the program's sophomore year. Currently, HPSP monitors physicians, dentists, pharmacists, and licensees in the nursing disciplines. We currently monitor 336 clients, 90 of whom are physicians, and nurses compose the largest group of monitored licensees. HPSP monitors both psychiatric conditions as well as substance dependence, although the majority of our participants are followed for substance dependence or are dual diagnosis. Revenue comes from state funding and participants' monitoring fees for physicians' mandatory non-therapy weekly group sessions and non-therapeutic individual monthly/quarterly sessions with contracted monitoring consultants.

Goals for 2012 include working with the Oregon Medical Board, the Oregon Medical Association, and other stakeholders to increase the percentage of new referrals that are self-referrals as opposed to clients mandated to HPSP by their disciplinary boards. HPSP is also working with an HPSP advisory committee, composed of representatives from the state, each participating board, and other stakeholders to advocate for more flexibility in maintaining clients' anonymity from their board, when they remain compliant with their aftercare but are not doing well clinically.

Washington

A small and independent non-profit, the Washington Physician Health Program (WPHP) had an eventful 2011. Dr. Gary Carr assumed the position of medical director, effective September 1, 2011, while Alice Paine assumed the newly created position of executive director

earlier in the year. With the assistance of WPHP staff, WPHP's outgoing director, Dr. Mick Oreskovich, published several prominent articles in the *Archives of General Surgery* on physician well-being in 2011.

The WPHP currently monitors both substance dependence and psychiatric conditions. At this time about 85 percent of monitored participants are enrolled in the program for the former, although the proportion of interventions performed primarily for psychiatric illness is steadily increasing. In late 2011, the WPHP hit a significant milestone in program growth. The WPHP signed up "client #1000," the 1000th health care professional to enroll in a monitoring contract with WPHP during the program's 25-year history. This also marked the first time that WPHP had 300 clients under contract at any one time. WPHP's number of program participants has grown annually by a rate of roughly 10 percent over the last 5 years.

Texas

The Texas Medical Association (TMA) Committee on Physician Health and Rehabilitation (PHR), Texas Osteopathic Medical Association (TOMA) PHR Committee, and Texas Physician Health Program (TXPHP) work collaboratively to provide physician health services in Texas.

The TMA and TOMA PHR committees are longtime components of their applicable medical associations. As such, these programs are funded by their applicable associations. The TXPHP, in particular, became operational in February 2010 and is administratively attached to the Texas Medical Board. Program participant fees are collected to administer the program.

All aforementioned entities share the common goal of helping physicians who may have a potentially health-impairing condition, which in turn ensures patient safety.

Alberta, Canada

Dr. Terrie Brandon is the new clinical director of the Physician and Family Support Program (PFSP) of the Alberta Medical Association. Ms. Beverly Adams, policy and program development coordinator, is a new PFSP team member as well. Dr. Brandon and Ms. Adams will run the program previously overseen by Dr. Dianne Maier, who retired in January 2012.

California

When California's Diversion Program for Physicians was closed by the Medical Board of California, several organizations mobilized under the leadership of the California Medical Association and formed California Public Protection and Physician Health, Inc. (CPPPH), with the mission to develop a comprehensive physician health program for the state.

CPPPH (or "C3PH") is an independent, non-profit public benefit corporation established in 2009 and funded by specialty societies, county medical societies, liability carriers and medical groups. It is governed by a board comprised of leaders from the California Society of Addiction Medicine, the California Psychiatric Association, the California Medical Association, and the California Hospital Association. Further details are available at www.CPPPH.org.

PENDING LEGISLATION

Throughout 2011, there was a consensus process to agree upon what authorizations should be put in place by legislation to allow for the establishment of a statewide physician health program, funded from physician license fees. The result is language for a bill agreed upon through consensus. The next step is underway: working with a legislator who will introduce the bill in the second half of the 2011–12 legislative session.

EDUCATIONAL PROGRAMS FOR PHYSICIAN HEALTH COMMITTEES

In the last half of 2011, CPPPH launched a program of education and local network building in three major areas of the state: the San Francisco Bay Area, the Sierra Sacramento Valley area, and Los Angeles County. In August, CPPPH began a series of Saturday morning workshops, offered every four months, for members of physician health committees of the hospitals and medical groups in that area with the intention of forming a network among them.

Each workshop includes a presentation on one topic — a different one for each workshop — with ample time for questions and dialogue between the presenter and participants. Each workshop also a time to share informational resources used by various committees, so that everyone can benefit from the experience of others.

By March 2012, each of the three regions will have held its third workshop, and a fourth region for medical staff health committees from all nine California medical schools will have been created.

— *James Hay, MD, chair, CPPPH*

Colorado: Educating Physicians

For the past 10 years, the Colorado Physician Health Program (CPHP) has had the opportunity to inform physicians throughout the state on physician health/self-care topics. This educational advantage has been possible through collaboration with Colorado Physician Insurance Company (COPIC). The CPHP and COPIC jointly facilitates presentations and seeks to educate physicians on the advantages of self-care throughout practice and many of the risks that they could face. These one-hour educational seminars are led by our knowledgeable CPHP medical

directors. The sessions take place at hospital/practice facilities throughout the state, and with the completion of feedback forms, attendees receive Continuing Medical Education (CME) points for their presence. Presentation topics include (and can be catered to specific audiences):

- Physician Health and CPHP services
- Physician Stress/Physician Self Care
- Professional Boundaries
- The Disruptive Physician
- Physicians in Relationships and Families
- Women in Medicine
- Substance Abuse and Addiction
- Occupational Hazards of Physicians and Medical Students
- Medical Marijuana Pros and Cons: What Doctors Need to Know

The CPHP believes that educating physicians and their staff about the occupational hazards/risks of being in medicine is greatly beneficial, and thus has sought — through partnership with COPIC — to be proactive and preventative within the realm of physician health. As exemplified with the steady increase in requested presentations each year (e.g., there were 11 completed sessions in 2010 compared to the 24 conducted in 2011), there is a burgeoning effort to thwart these risks. Within the past 10 years, the CPHP has conducted over 120 presentations with the partnership between COPIC and the CPHP. These efforts have also reminded Colorado physicians about the importance of their own health. The CPHP is informing the FSPHP about this unique collaboration as incentive to develop similar proactive ventures for physicians across the country. — *Amanda Parry, executive assistant, and Sarah Early, Psy.D., executive director of Colorado Physician Health Program*

THE NEED FOR CONSENSUS AND CONSISTENCY

Physician/Professional Health Programs (PHPs) began in the mid-70s out of growing concern for physicians with Substance Use Disorders (SUDs)(100%). Over time, PHPs also realized the need to address psychiatric issues (88%) that were potentially impairing or a risk factor for SUD relapse. Over the past decade, PHPs have been called upon to assist with disruptive behavior (78%), professional boundary issues (70%), stress associated with malpractice claims or incidents (18%), and other professionals' health issues (30%). In 1990 the FSPHP was born and the organization has since contributed significantly to the continued growth, expertise, and maturation of PHPs nationwide.

Several years ago a secure e-group was made available, allowing for rapid consultation and the sharing of collective knowledge, experiences, and wisdom.

PHPs and the FSPHP are generally well respected in the United States and abroad for their work with health care practitioners with SUDs. The FSPHP guidelines have contributed to consistency in addressing SUDs and psychiatric illness among this population. While more data is needed regarding our work with psychiatric illness, it appears that PHPs are fairly uniform in our approach. However, in terms of the treating and monitoring the other aforementioned issues, there is considerable ambiguity and difference among programs.

There are three particular areas of concern: disruptive behavior, bipolar illness, and professional boundary issues. Some programs rely on local resources for evaluation and/or treatment while others require nationally recognized programs. Some programs report monitoring individuals with these issues for one year, others for five years, and some “for life of license.” The level of “monitoring” is often quite different from state to state. Some use local monitors, while others use a 360-degree monitoring system. Some PHPs require participants without SUDs to attend their Caduceus groups, which, in my opinion, is a detriment to both. Some participants require abstinence and urine screening even without a history of SUDs. Being human, we sometimes bring our own prejudice and bias into play without researching evidence-based best practices. Other times we send these cases to our recognized/approved evaluators and then chose not to follow their recommendations. While we must acknowledge the various differences, political considerations, and challenges faced by individual state PHPs, improvement in the consistency of practices is beneficial to all.

From my years of experience working with PHPs and the FSPHP, I believe us to be a passionate and dedicated group of professionals who try to do what is best. However, the lack of uniformity when assisting practitioners with disruptive behavior, bipolar illness, and those with boundary violations does not serve us well. An impression of confusion, along with the potential for undo outside criticism, may then be extrapolated to our general level of professionalism. The three problem areas (disruptive behavior, bipolar illness, and boundary issues) are highly complex and often don't lend themselves to simple evaluation, treatment, or monitoring protocol. For instance, on what basis should a practitioner with bipolar illness be discontinued from monitoring — after one year, three years, or five years? What case-by-case variations occur and how do we approach those on a case-by-case best practices basis? How are urine toxicology screens justified for individuals with no history of a SUD? How do we justify prohibiting a “love sick” physician who crossed a physician-patient boundary years ago

but received appropriate treatment and monitoring, is remorseful, and in solid recovery from ever seeing another female patient?

I believe FSPHP members comprise the “consensus of experts” most qualified to pursue answers to these complex questions and establish best practices for addressing these categories of potential impairment. Nationally, no group possesses more knowledge about practitioners with potentially impairing illnesses. Regarding these three critical areas, however, we’re at risk and in need of significant study and an honest appraisal of our abilities and rationale. PHPs involved with these areas of impairment must help define FSPHP recommendations and determine how to do so. What questions still need to be answered? Are we ready to pursue guidelines? What is our process going forward?

If we are to enjoy the level of respect and authority in the arenas of disruptive behavior, bipolar illness, and boundary issues that we have cultivated through our work with SUD issues, we must ensure that we are promoting evidence-based best practices and exercising a certain degree of “individualized uniformity” in our collective approach. — *Gary Carr, MD*

CHANGE TO JOINT COMMISSION STANDARD

Disruptive Behavior Is Changed in the Standards

In 2009 the disruptive behavior standard (LD.03.01.01) came into effect, prompting health care organizations that have not already done so to develop professional standards (i.e., codes of conduct) in order to create a culture of safety.

The term “disruptive behavior” in two elements of performance (LD.03.01.01, EPs 4 and 5) has been revised to “behavior or behaviors that undermine a culture of safety.” It has been brought to the attention of The Joint Commission that the term “disruptive behavior” is not viewed favorably by some in health care, and that it can be ambiguous for some audiences. For example, some physicians object the notion that strong advocacy for improvements in patient care can be characterized as disruptive behavior. Also, the phrase “disruptive behavior” may be used in the context of a care environment that has become temporarily unsettled by the behavior of a patient. The term was discussed with The Joint Commission’s Accreditation Committee and its Board of Commissioners. Because of the term’s potential for ambiguity, the new wording describes the problem that the standard is trying to address more accurately. The change will be made in the update to the accreditation manuals, to be published in spring 2012.

There are two additional standards of The Joint Commission that relate to the work of our physician/practitioner health programs (PHPs). All three are described in the 2010 issue of our newsletter, still available at www.fsphp.org. The standards are:

- **Licensed Independent Practitioner (LIP) Health MS.11.01.01:** The medical staff implements a process to identify and manage matters of individual health for LIPs.
- **Conflict Management LD.02.04.01:** The organization manages conflict between leadership groups to protect the quality and safety of care.

There are no changes to these standards.

— *Linda Bresnahan*

For questions regarding changes in standards, please contact:

Maureen Carr

Project Director

Standards and Survey Methods

Division of Healthcare Quality Evaluation

The Joint Commission

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Email: Mcarr@jointcommission.org

Website: www.jointcommission.org

REVIEW OF THE MPAP IN ASSISTING PHYSICIANS FOR DISRUPTIVE BEHAVIOR, 1996 TO PRESENT

Since 1996, the Montana Professional Assistance Program (MPAP) has received a total of 48 referrals involving alleged disruptive behavior. Forty (40) of these cases were received from 12 of 16 component medical societies, while 8 referrals were received from the medical board or self-referred for consultation involving out-of-state licensure applicants.

Caseload review demonstrated referral and utilization patterns, and common sentinels that contribute to disruptive behavior reporting. Most reported cases included elements of strained relationships in the work setting, communication problems, inappropriate expressions of anger, and boundary violations. Disruptive behavior represented over 10 percent of the total referral caseload — often complex and protracted — challenging physician health resources.

The Montana Medical Board (MMB) response was shown to be measured and incremental, deferring discipline and

encouraging local resolution whenever feasible. Continuing medical education to help prevent and resolve conflict was also encouraged. MMB involvement was higher in disruptive behavior cases than in all others, yet referrals that involved the MMB had waned. Incidence of license discipline in the caseload reviewed was slightly over 10 percent, less than all other MPAP cases. All but one out-of-state application, with history of disruptive behavior, were either withdrawn or denied.

Most physicians referred for disruptive behavior did not return to work to the parent organization. Attrition rate for this group was double the population of all other physicians referred to the MPAP during the reporting period. There was greater likelihood for retention at the parent organization with internal resolution. MPAP was seen as safe harbor for distressed physicians who had been identified as demonstrating disruptive behavior, providing a source of support for them to move forward in their careers unencumbered by a report to the National Practitioner Data Bank, and without formal medical staff or medical board action.

With hospitals struggling to recruit and retain qualified physicians, it's incumbent upon leadership to develop and implement effective strategies for mitigating disruptive

physician behavior, which can have a negative impact on meeting goals and objectives of a hospital organization. There is evidence of deficits in communication skills and higher order professional judgment in many cases. Because over half of all Montana physicians are now hospital employees, there exists a need for skills and training, as well as development of protocols which instill a culture that continues to value physicians and provides physician leadership in steering the future course of hospital-based medicine. Montana hospitals have benefited directly from services provided by the MPAP in these rather difficult and challenging cases — without commensurate remuneration or financial support.

The MPAP has provided a forum to facilitate assessment and monitoring of distressed physicians for almost 20 years, preserving the physician's ability to move laterally unencumbered by formal discipline in most cases. Successful adaptation suggests encouraging hospitals to develop policies and procedures that effectively promote local resolution of cases whenever possible, and to continue service as a resource for consultation and referral for evaluation and treatment, only as needed.

— *Michael J. Ramirez, MS, CRC, clinical coordinator, Montana Professional Assistance Program, Inc.*



Guest speaker George Valliant, MD, at Annual Meeting 2011

Left to Right: Peter Mansky, MD, George Valliant, MD, Luis Sanchez, MD, Warren Pendergast, MD, Linda Bresnahan, MS, and Terrance Bedient, FACHE



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April 23–26, 2012

AUDIENCE

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PROGRAM OBJECTIVES

- ▶ Identify the prevalence of disorders that have an impact on physicians
- ▶ Recognize signs and symptoms of disorders as they present in different areas of the physician's life
- ▶ Organize and implement an appropriate intervention in clinical practice before patients are harmed by a physician who is impaired
- ▶ Assess and evaluate the severity of applicable disorders and refer for appropriate treatment
- ▶ Define components of an adequate monitoring agreement for each disorder so that relapse can be detected before patients are harmed
- ▶ Explain the circumstances under which a physician may be reported to the state medical board
- ▶ Analyze outcomes using standardized metrics

HIGHLIGHTS

- ▶ Extensive opportunity to visit a wide range of exhibitors offering services in the field
- ▶ A forum for education and exchange of information among state PHPs
- ▶ Opportunity to network with professionals from the United States, Canada, and other parts of the world dedicated to assessing, monitoring, and treating physicians with potentially impairing conditions
- ▶ FSPHP regional membership meetings
- ▶ FSPHP committee meetings

GENERAL SESSIONS

- ▶ Risk of Physician Malpractice Claims before and after Physician Health Program Intervention
— *Elizabeth Brooks, PhD, Jay Shore, MD, Doris Gundersen, MD, and Michael Gendel, MD*
- ▶ Use of the 4th/5th Step Group Process to Identify and Treat Personality/Character Issues that Present Barriers to Long-Term Recovery in Physicians
— *Kenneth Thompson, MD, Gregory Gable, Psy.D., and Scott Teitlebaum, MD*

- ▶ Proper Prescribing and Substances Abuse Identification: A Continuing Medical Education Intervention
— *William Swiggart, MS, LPC/MSHP, Charlene Dewey, MD, and Martha Brown, MD*
- ▶ Risk Factors for Relapse among Health Care Practitioners with a Substance Use Disorder:
A Follow-Up Study of Washington Physicians Health Program Clients
— *Amanda Buhl, MPH, Michael Oreskovich, MD, Charles Meredith, MD, and Gary Carr, MD*
- ▶ Committee Meetings
- ▶ The Disruptive Physician: The Development and Use of One 360 Instrument as a Monitoring Tool
— *Betsy White Williams, PhD, MPH, William Swiggart, MS, LPC/MHSP, and Michael Williams, PhD*
- ▶ Reliability and Validity of the Disruptive Behavior Instrument for Physicians with Disruptive Behavior
— *Philip Hemphill, PhD*
- ▶ Policies and Research on Identifying, Assessing, and Monitoring PHP Participants
— *Judy Rivenbark, MD, Martha Brown, MD, and Lisa Merlo, PhD, MPE*
- ▶ Understanding and Utilizing Professional Assessments — *Mary Deitch, JD, Psy.D., Ron Neufeld, and A.J. Reid Finlayson*
- ▶ Healing Shame and Restoring Trust after Betrayal — *M. Deborah Corley, PhD, and David Mitchell, MD*
- ▶ Responsibility for Addiction among Physicians with Addictive Disorders — *Michael Gendel, MD*
- ▶ Guest Speaker: Alcoholics Anonymous Effectiveness: Faith Meets Science
— *Lee Ann Kaskutas, Dr.Ph., senior scientist, Alcohol Research Group, associate adjunct professor, School of Public Health, University of California Berkeley*
- ▶ To Skype or Not to Skype That is the Question — *Ms. Jordanna Graves, MSW, RSW, and Judi Platt, RN, CARN*
- ▶ Remediation Program Success — *Jeannette Guerrasio, MD*
- ▶ Extended-Release Injectable Naltrexone (XR-NTX) in Health Care, Professionals with Opioid Dependence:
Research Findings and Practical Implications — *Paul Earley, MD, and David Gastfriend, MD*
- ▶ Mandatory Naltrexone Treatment as Component of the Monitoring Contract for Opiate-Dependent
Anesthesiologists and Pharmacists — *Lisa Merlo, PhD, MPE, Judy Rivenbark, MD, and Martha Brown, MD*
- ▶ Puzzling, Shocking, and Odd: Asperger's and the Outlier Disruptive, Behavior Case
— *Scott Stacy, Psy.D., John Whipple, MD, and Peter Graham, PhD*
- ▶ The Aging Physician, a New Challenge for Physician Health Programs
— *Betsy White Williams, PhD, MPH, William Nemeth, MD, and John Fromson, MD*
- ▶ The Prevalence of Alcohol Use Disorders among American Surgeons
— *Michael Oreskovich, MD, Amanda Buhl, MPH, Charles Meredith, MD, and Krista Kaups, MD*

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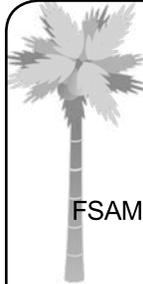


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2012 International Conference on Physician Health

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American Academy of Addiction Psychiatry

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American Medical Association House of Delegates Annual Meeting

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American Medical Association House of Delegates Interim Meeting

November 10–13, 2012
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FSPHP NEWSLETTER ADVERTISING INFORMATION AND SPECIFICATIONS

Dear prospective *Physician Health News* advertisers:

We would like to invite you and your organization to advertise your services in the future editions of *Physician Health News*. *Physician Health News* is mailed to all state programs and state licensing boards. The newsletter is also distributed widely at the FSPHP Annual Meeting. Articles and notices of interest to the physician health community, the newsletter includes planning information about the upcoming physician health meetings and conferences including FSPHP meetings.

NEW! We offer ad design and proofreading services for an additional fee. For your convenience, full ad specifications and PDF instructions can also be provided upon request.

We hope you will consider taking advantage of this once-a-year opportunity to advertise your facility, services, and contact information. Become part of a great resource for state physician health program professionals.

We look forward to working with you in future editions.

FSPHP Publication Committee

Linda Bresnahan, MS (MA)	Carole Hoffman, PhD, LCSW, CAADC (IL)
Sarah Early, PsyD (CO)	Linda Kuhn (TX)
John Fromson, MD (MA)	Charles Meredith, MD (WA)
Scott Hambleton, MD (MS)	

SPECIFICATIONS

Ad Size

3.125" w x 2.25" h

Guidelines for PDF Ads

Black and White Only

Ads should be submitted as grayscale. They will be printed in black ink only. As a convenience, we are able to turn your ad into grayscale if necessary.

Border

You do not need to include a border with your ad. We will frame your advertisement with a 1-point border during newsletter production.

Font

To reduce registration problems, type should be no smaller than 9 point. Fonts must be embedded and TrueType fonts should be avoided.

Screens

150 line screens are preferred for halftones. Halftone minimum screen tone value is 10%.

File Guidelines

All submissions should be Acrobat PDF files and should be sent at the exact size specified herein. Native files or other file formats will not be accepted.

Guidelines for Word Files

Supply Word document and high-resolution logos and graphics (if applicable). Maximum 2 passes for ad approval.

Submission

Remember to label your file with your company name (i.e., CompanyX.pdf or CompanyX.doc). This will assist us in identifying your ad. Please also double check that your ad contains the most up-to-date information.

PLEASE CONSIDER A SUBMISSION IN FUTURE ISSUES!

QUESTIONS?

Please contact Linda Bresnahan at lbresnahan@mms.org