

PHYSICIAN HEALTH NEWS

The Official Newsletter of the Federation of State Physician Health Programs

Volume 15, Number 1

April 2010



Welcome to the 15th issue 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 nationwide organization whose purpose provides for an exchange of information among state physician health programs to develop common objectives, goals, and standards.

If you haven't, please consider joining the organization. State membership is \$400.00 per year, and individual (associate) membership is \$100.00 per year. We sincerely hope you will 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 American Medical Association at (312) 464-4574.

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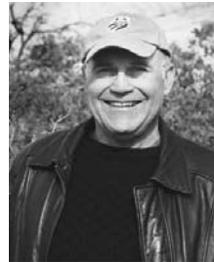
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Message from the President



Peter Mansky, MD

This is my first message to the membership since I assumed the position of president this past October. I am honored to be able to be of service to the FSPHP and to continue the tradition of the presidents I follow. I was hoping to work with Gary Carr as president for two years before assuming the presidency. This, unfortunately, was not in the cards.

Gary has left his position in Mississippi but is still active in running a medical professionals program. He has been a great source of support and information for me. His thoughts and visions for the FSPHP represent the thoughtful consideration of many years, especially from his extended tenure as president-elect. In order to have a smooth transition and continue the momentum of my predecessors, I plan to seek the advice and counsel of Gary and Luis Sanchez, as well as other officers, board members, and the membership of our organization. Please do not hesitate to contact me or your area representative with ideas, suggestions, or even critical opinions.

We have a rich background of leadership from those who have been with the FSPHP for many years and those who are new to our organization. Both have made valuable contributions, as I have experienced in conversation and on the e-group. The e-group is a valuable and rich source of information and debate. It has been an important resource for me, and I'm glad we live in the computer age, which allows for this type of communication.

This is our organization, and your participation is important. There are a number of committees listed on our website. If you see an area in which you would like to participate, please email me (NHPAF@cox.net) and/or the chair so that we can discuss your interest with you.

I look forward to seeing you at our Annual Meeting. The Program Committee and its chair, Mike Oreskovich, have planned and organized a meeting with excellent, relevant, and interesting content. We will also have a joint session with the Federation of State Medical Boards (FSMB). The meeting is a great opportunity for networking with our membership and with the exhibitors and other attendees involved in keeping the physicians in this country healthy and well.

Peter Mansky, MD



Jonathan Dougherty

Message from the Executive Director

One Year Later

I can't remember the last time I saw a comic book. In 2006, DC Comics played a cruel joke on its loyal readership by advancing the daring exploits of its various superheroes by exactly one year. They called it *One Year Later*. Imagine just how discomfoting it must have been for a loyal fan not to know what audacious escapades Superman or Wonder Woman had experienced during the course of 365 days.

On January 1, 2010, I celebrated my first full year as executive director of the FSPHP. Although I can certainly remember everything I experienced, it seems remarkable that the year went by so quickly. As I referenced in last year's message, state physician health programs were not a new concept for me at the time I started my job with the FSPHP. I have always advocated for New York state's program as one that saves lives and careers. Nevertheless, having to adjust from a policy-centric county/state medical society to the more academic-focused FSPHP took a little effort. As a result of the tremendous guidance given to me from the leadership and some rather forgiving souls, I hope that I have adequately adjusted my skills to become a meaningful contributor to the family of physician health.

The most disturbing aspect of my education these last 12 months has been witnessing the assault on physician health by individuals who ignore science in favor of sensationalism and personal career advancement. As a medical society executive, I have seen 24 years worth of "bad doctor" bashing from so-called consumer rights advocates and their allies in the trial bar, so this is nothing new. But I really could not imagine anyone taking issue with restoring the health of another human being, especially not with health care professionals that we so desperately need in our communities. Regardless, there are those who know how to play on the fears of society and find a compliant media and state legislature to advance their agendas. But through its Citizen Advocacy Center Task Force, the FSPHP is pushing back at every turn, and we're just beginning to fight!

From New Orleans to Boston, from Chicago to Coeur d'Alene, I have had the honor of getting to know many of you and appreciate what you "superheroes" do for our physicians and the patients they serve. I extend my gratitude to your leadership for their guidance, to Dr. Sanchez for my shotgun mentoring in the first half of 2009, to Linda Bresnahan and Terry Bedient for

holding up the flashcards, and to Vickie Grosso for always filling in the blanks. As we move forward under the leadership of our president, Dr. Peter Manksy, I look forward to implementing the elements of the strategic plan and advancing our financial contributors in 2010 and beyond. Let us all have a great Annual Meeting in April and a terrific 2010 for physician health!

Jonathan H. Dougherty, MS

AMA Official Observer Status

As many of you know, the FSPHP was granted official observer status with the American Medical Association (AMA) about four years ago. This allows for an individual appointed by the FSPHP to be designated to represent the organization and attend the AMA's annual and interim meetings. As president, I was initially designated by the board to be that observer, and now I have been asked to continue in that role for now by our board of directors.

This status has been very helpful in creating an awareness in the AMA, its states, members, and multiple other organizations of the importance of physician health and the role that our federation has in promoting health. At the meetings I have attended, there have been many opportunities to offer opinions about resolutions that have been promoted, meet informally with various members and organizations, and develop networking opportunities that continue throughout the year. In this status, the FSPHP does not have a vote on resolutions, but I am able to fully participate in the debate and discussions, which are recorded and noted by the AMA. Last year, Gary Carr (as our president) and I attended the meeting in Chicago, which we both found very beneficial in our roles of communicating the importance of physician health. Resolution 402 followed, which I will discuss now in more detail.

As you might also know, the FSPHP office is now placed within a newly structured department at the AMA called Physician Health and Health Care Disparities, led by Dr. Sonja Boone. The federation had an opportunity to assist in the development of this office, both at the annual meetings and with the meetings we have had with the board and the appropriate AMA staff over the last few years. We are very pleased that Dr. Boone has taken the helm, allowing us to enhance our communication with the AMA and work together on important endeavors. Along with Sonja, Vickie Grosso serves as the administrative assistant of that office, as she does with the FSPHP.

With the AMA Annual Meeting in Chicago in June of 2009, a resolution was put forward by various medical societies with the title of the "Model Physician Health Program Act." In essence, there was an interest in

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updating a previous AMA policy involving physician health programs and the need for uniformity, which was felt to be outdated. A vigorous discussion ensued at this meeting, in which Gary and I participated along with several others. The discussion was positively focused, encouraging the enhancement of physician health and the working together of the AMA with the FSPHP. This came to be known as Resolution 402, which was referred by the AMA for further discussion prior to enactment of its resolves and will be discussed at the Annual Meeting in June of 2010 in Chicago.

A summary of the resolution follows:

- The AMA recognizes the importance of the promotion of physician health in the AMA strategic plan.
- There needs to be collaboration between the FSPHP and the AMA to study the barriers for effective utilization of state PHPs and the effectiveness of their confidentiality safeguards and funding mechanisms, updating the existing AMA policy regarding physician health programs, reviewing the federation guidelines to determine their relevance to existing or future AMA policies, and working together in updating these guidelines.
- There needs to be interest to educate the AMA members as to the availability of state PHPs in order to create opportunities to help ensure that physicians and medical students are fully knowledgeable about the purpose of PHPs and the relationships that exist between them and the state licensing authority.
- There was also an interest for the AMA to clarify the confidentiality issues involved in communications between state PHPs and the licensing boards, including the applicability of 42 CFR as to the confidentiality of substance use patient records.

The AMA decided that, rather than proceeding with the study, which they felt would be beneficial, they would recommend that the resolution be referred to the Office of Physician Health and Disparities, along with the collaboration of our federation, to determine how best to proceed. In that regard, myself and other members of our board will be working with Dr. Boone and her staff to further delineate the resolves in the resolution so that the AMA can take further action, presumably authorizing the study of the AMA and PHPs.

If any of our members have an interest in further discussing this, please either let me, your regional directors, or any members of the board know.

Luis T. Sanchez, MD

State Program News

WVMPHP Update

The West Virginia Medical Professionals Health Program (WVMPHP) has been operating with active, signed participants for 26 months. The southern office is located within the state medical association building in Charleston, West Virginia, with the northern office located in Bridgeport, West Virginia. The WVMPHP has provided educational lectures to an excess of 1,500 physicians, hospitals, medical staffs, medical societies, students, and residents since its inception. Funding to date has been largely provided through the West Virginia Mutual Insurance Company, a grant from the West Virginia Hospital Association, support from the West Virginia State Medical Association, pro-bono services by many individuals involved, donations, and participant fees.

Currently, there have been 42 signed participants, most of which continue under an agreement impacting an excess of 25 hospitals where these participants have privileges. More than 95 percent of these individuals (who have completed treatment and are under contract) resumed working, remained abstinent, licensed, practiced medicine safely, and were monitored. Forty-five percent of current participants were referred by licensure boards formally through consent order or informally through direct contact. Eight participants reside and practice outside of the state and maintain active West Virginia medical licenses as a direct result of participation with the WVMPHP. Specialties include family practice; internal medicine; pediatrics; ophthalmology; orthopedics; obstetrics and gynecology; general surgery; emergency medicine; endocrinology; pathology; psychiatry; cardiology; and medical students and residents in training. Twenty-five of the 42 have been returned to the active safe, monitored practice of medicine. Thirteen of the 42 had previous issues prior to the establishment of the WVMPHP. The recurrence of their chronic medical conditions further supported the need for our physician health program and long-term guidance, assistance, and monitoring. During initial evaluation, six were found to have some degree of cognitive impairment, all of which resolved with treatment (with the exception of three). These three remain impaired and are disabled due to physical disorders detected but unrelated to their original participation diagnoses. These permanent impairments unrelated to mental illness or substance abuse would have not been discovered had they not sought the assistance and guidance of the WVMPHP.

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*State Program News**continued from page 5*

As you can see, the West Virginia Medical Professionals Health Program is fulfilling its mission of protecting the public and providing a mechanism for the successful rehabilitation of sick physicians and their return to the safe, monitored practice of medicine to the benefit of the public and physicians themselves. Currently, with the support of organized medicine, including that of the licensure boards, legislation is being considered to add a licensure fee “add-on” which would go directly toward the funding of the WVMPHP. The benefit the WVMPHP provides to the state of West Virginia has been progressively recognized and supported by all of organized medicine within the state. It is our hope to continue the development of such a worthwhile endeavor.

P. Bradley Hall, MD
Medical Director, WVMPHP
President, WVSAM
Diplomat, ABAM
AAMRO

NCPHP Schedules Biennial Conference

The North Carolina Physicians Health Program biennial conference will be held October 8 to 10, 2010, at the Caraway Conference Center near Asheboro, North Carolina. This year’s theme is “Relationships and Recovery.”

NCPHP Hires New Associate Medical Director

Michele Denker, MD, has joined the North Carolina Physicians Health Program as associate medical director. She completed medical school at the University of Buffalo School of Medicine with an internship and residency in psychiatry at the University of North Carolina at Chapel Hill. Dr. Denker also completed a fellowship in forensic psychiatry at the Federal Correctional Institute in Butner, North Carolina. She is board certified by the American Board of Psychiatry and Neurology and has maintained a private practice in North Carolina since 1993. She provides professional assessments for self-referrals and participants of our program. (See <http://www.ncphp.org/staff>.)



Dr. David Simmons at the FSPHP Northeast Regional Meeting held at the Massachusetts Medical Society in the fall of 2009. Dr. Simmons served the FSPHP on its Board of Directors prior to his retirement this past year.

Vermont Practitioner Health Program Announces Medical Director Change

Paul Harrington of the Vermont Medical Society (VMS) has announced that Dr. David Simmons has resigned as the medical director of the Vermont Practitioner Health Program (VPHP) effective immediately. Dr. Simmons was very instrumental in the educational outreach of the program, which in turn increased awareness in Vermont communities and more voluntary referrals to the program. The VMS and VPHP committee wishes Dr. Simmons all the best for his future endeavors.

Mr. Harrington is pleased to announce that Dr. Suzanne Parker has accepted and will resume her role as the medical director. Dr. Parker is a psychiatrist and is certified in addiction medicine. Her knowledge and expertise will be very valuable to the VPHP. Dr. Parker worked very hard to establish and get the VPHP off the ground. The VMS and the VPHP committees are grateful to have Dr. Parker return, especially with her commitment to physician health.

Happiness and Despair in the Practice of Medicine: Restoring Choice and Balance

Dr. A. Clark Gaither is offering his services for speaking engagements. He will provide a critical and informative look at a timely topic — physician burnout. As a past participant in the North Carolina Physician Health Program (NCPHP), past chair of the NCPHP, and current physician health program advocate, Dr. Gaither will offer keen insight into the causes, signs, and symptoms of physician burnout. Rounding out his presentation will be a discussion of the preventative or corrective measures that physicians can employ to retain or recapture personal pleasure and joy in the everyday practice of medicine.

A. Clark Gaither, MD, FAAFP, is a board certified family physician in Goldsboro, North Carolina. For further information, please contact gaither@esn.net or (919) 735-0433.

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Oregon Update: Progress? Far from Perfection

In June of 2008, one of the final acts of the Oregon legislature was to pass HB2345, which eliminates all existing Oregon professional health programs effective July 1, 2010. In place of the current programs run by the nursing, dental, pharmacy, and medical boards, HB2345 creates a new “umbrella program,” which any health regulatory board in Oregon *must* use in order to utilize a diversion program. The new program will be contracted through the Department of Human Services. A request for a proposal has recently been issued for the development of the new Health Professional Monitoring Program. The request for proposal (RFP) can be accessed by registering as a potential service provider and expressing interest in the proposal on the website of the Oregon Procurement Information Network at <http://orpin.oregon.gov>. Parties currently expressing interest include Maximus, FirstLab, and other for-profit providers.

The good news is that Oregon will retain a health professionals monitoring program. Unfortunately, it will no longer have a physician health program. I encourage FSPHP members to be vigilant regarding the vulnerability of state health professionals programs being usurped by for-profit corporations. Although these entities may offer adequate services, the potential for robust profit margins to overshadow the commitment to serving the profession and colleagues is a possibility. The goal of enhancing the recovery of program participants may not be included or foremost in the mission of regulatory programs. The Oregon RFP places a primary emphasis on compliance and performance measures. The regulatory aspects overshadow the therapeutic aspects, as vividly illustrated by replacement of health professionals program weekly “facilitated recovery support groups” with weekly “compliance consultation groups.”

On a personal note, after finding the “wisdom to know the difference” allusive for several years, following the passage of HB2345, I finally accepted what I could not change. In July of 2009, after thirteen years as a medical director, I left the Health Professionals Program. As I begin a new career in pain management, I will carry with me the gift of having been a small part of the individual recovery of many Oregon physicians and a small part of the FSPHP. I will never be able to adequately express my gratitude to each of you for the professional and personal support, mentoring, and camaraderie I have experienced as part of the FSPHP. It has been an honor to be part of an organization that lives by its values and whose membership includes such extraordinary, dedicated professionals.

Information on the RFP follows:

Opportunity #: DHS-3005-10, Addendum # 1

Original Publish Date and Time: January 25, 2010, 3:00 p.m.

Publish Date and Time: February 2, 2010, 10:19 a.m.

Closing Date and Time: March 17, 2010, 3:00 p.m.

Time Zone: Pacific Time

DHS-3005-10: DHS - AS - Office of Contracts and Procurement

Susan McCall, MD

Launch of the Physician Workplace Support Program for Ontario

The Physician Health Program of the Ontario Medical Association is pleased to announce the launch of the Physician Workplace Support Program (PWSP), a comprehensive program aimed at reducing the incidence of disruptive physician behavior in the workplace.

The program will use a systems approach focused on supporting changes in both the individual practitioner *and* the workplace. It will operate on a cost-recovery basis phased in over a three-year period and will be fully “self-supporting” by December 31, 2012. Services will focus on awareness, prevention, early intervention, case management, and organizational consulting.

The program will be launched on April 1, 2010, with an initial emphasis on the case management service, which will include case response for referred individuals and a telephone advisory service for physician leaders.

Case Response for Referred Individuals: This will be delivered in a collaborative fashion with the PWSP, the referred physician, and the hospital all agreeing to the services provided. It will consist of three phases: assessment (3 months), rehabilitation (24 months), and long-term follow-up (36 months). Each phase will be contracted separately.

Telephone Advisory Service for Physician Leaders: Physician leaders will be provided with an opportunity to subscribe to a telephone advisory service. This service will provide unlimited telephone advice for managing disruptive behavior(s) for an annual fee.

Mary Yates, MEd

Director, Physician Workplace Support Program

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Citizen Advocacy Center Meeting Held in San Francisco, June 2009

In June of 2009, several FSPHP members attended the Citizen Advocacy Center (CAC) Meeting. While we had no formal seat at the table, several cogent points were made via a roving microphone concerning the significant role physician health programs play in assisting ill physicians before impairment occurs and thereby contributing to efforts to improve public safety. The CAC is pushing very hard for all physician health programs to disclose the identities of physician clients to state medical boards. Absent such disclosure, they maintain that adequate public safety cannot be assured. FSPHP members in attendance were able to counter this position, citing the critical role that confidentiality provisions play in encouraging physicians to seek help voluntarily, and importantly, before illness severity jeopardizes patient care. Having representation from the FSPHP made a difference. By voicing our concerns and articulating counterpoints early in the morning session, the tone of the afternoon sessions proved to be less hostile, if not friendly. Based on this experience, we decided that it would be important to closely monitor the CAC's activities in the future and solicit a speaking opportunity at a future meeting.

The CAC convened a second meeting in Orlando, Florida, in the fall of 2009. Again, several FSPHP members attended and contributed to discussions. The FSPHP was invited to be a part of a speakers' panel, including Kay McMullen from the North Carolina Board of Nursing. It was moderated by David Swankin, CEO of the CAC. Warren Pendergast, MD, represented the FSPHP by addressing and reinforcing many of the points made in San Francisco. Dr. Pendergast reiterated and emphasized the following:

- The difference between point prevalence and lifetime prevalence of illness
- That addiction is only one of the conditions we monitor to ensure that physicians are not practicing while impaired. Specifically, he talked about depression and other medical/neurological illnesses that are monitored to safeguard the public.
- That PHP collaboration with licensing boards is critical in protecting the public
- That illness is not synonymous with impairment and specifically that impairment can be a point in time but is not a static condition

- That, with a confidential process, physician health programs are positioned to capture more physicians with illnesses and intervene before impairment develops

Speakers remained sensitive to citizen concerns about quality of care issues (e.g., a woman in the audience spoke about her husband who was injured by a physician) while also supporting the physician health mission. Paul Earley, MD, expressed concern that the CAC was simply measuring safety based on the amount of discipline a state applies and that discipline alone doesn't solve the problem if a physician has an untreated illness or lacks competency. He also shared information from his treatment program supporting the efficacy of treatment and the promising data regarding returning physicians to work. He invited the CAC leadership to call him at any time to obtain more information about physician treatment outcomes.

Doris Gundersen attended a dinner event at which Sidney Wolfe, MD, was recognized for his commitment to assuring public safety. Dr. Wolfe presented a series of slides illustrating a number of physicians in various states who had numerous malpractice claims and had not been on the radar of state medical boards. Dr. Gundersen challenged some of the assumptions in Dr. Wolfe's presentation, noting that not all physicians settle malpractice claims because of errors made. She cited some recent research in Colorado addressing neonatal encephalopathy. The majority of these cases has no identified etiology and are not related to medical error. Obstetricians often choose to settle these malpractice claims out of compassion for families who will inherit a lifelong burden of taking responsibility for a very impaired child. Dr. Gundersen also asked if Dr. Wolfe's organization had conducted outcome studies in states where heavy regulatory discipline was applied and whether this improved public safety made a physician a better practitioner. Dr. Gundersen also talked about the advantage physician health programs have in identifying potentially impaired or incompetent physicians early, in most cases before a regulatory board would be notified. She noted that, with early intervention and expert treatment, an opportunity for preserving a societal resource exists, especially at a time when we are anticipating physician shortages. Dr. Gundersen emphasized the following points in question-and-answer sessions:

- Punitive action does not heal ill physicians or restore competency in physicians with knowledge deficits.

- The success of state medical boards is largely measured by the number of admonishments delivered. Medical boards do not currently receive applause for referrals to physician health programs when illness is identified. Perhaps it is time to reevaluate how success in protecting the public is assessed.
- We invest a great deal in training physicians, and we should be committed to preserving this resource through rehabilitation when possible. Physician shortages also pose a danger to the public.

Dr. Martha Brown, despite a heavy fog in the air, arrived from Tampa to deliver some important points. Her message was one of “Let’s work together. We all want the same thing. Let’s ensure that physicians who are practicing are safe to do so, but let’s also be real here. Physicians are not immune to illness, and there needs to be avenues to help physicians who are ill so that they can return to practice safely.”

Another important issue raised by the CAC was that of maintenance of competence. There were people in attendance who argued that professional organizations certifying physicians in certain specialties did not do enough to assure competency. Dr. Gunderson made the argument that the majority of physicians are conscientious, if not compulsive, and pursue CME without the pressure of discipline. She further discussed the oversight physicians currently have with hospital medical executive committees, credentialing committees, and peer review processes, in addition to certification and recertification with specialty boards.

The FSPHP members attending this meeting remain in agreement that our organization needs to continue educating regulators and public safety advocates about the efficacy of our work and increase awareness about the studies demonstrating the success of our programs.

Warren Pendergast, MD, and Doris Gunderson, MD

Physician Self-Care: Physician, Please Don’t Heal Thyself

In a book entitled *The Physician as Patient* by Michael F. Myers, MD, and Glen O. Gabbard, MD, the psychology of physicians and the culture of medicine are aptly described (1). Gabbard feels that the very perfectionistic behaviors that patients often seek and the field of medicine expects can become “personally expensive.” While perfectionism may lead to comprehensive diagnostic efforts, precision in the ordering of lab tests, and thorough treatment planning — all of which serve patients well — when the same perfectionistic expectations are applied to one’s self and other nonpatient relationships, they often become maladaptive. Several investigators including Gabbard have concluded that perfectionism is a vulnerability factor for depression, burnout, anxiety, and eventual suicide.^{1,2,3}

Clinical work with physicians conducted by the Washington Physicians Health Program (WPHP) confirms the observations of others that perfectionism in physicians is often associated with the childhood belief that one was not sufficiently valued or loved by his or her parents and that, if childhood behavior and achievement becomes perfect, then the love will follow. Low self-esteem can be overcome with accolades and attention. Unfortunately, it is not uncommon that the perfect child tries to become the perfect physician. When awards are forthcoming (i.e. high school

valedictorian, summa cum laude, AOA), the only response from the perfect child is to demand even more of him- or herself. Gratification and contentment, if they occur, are short-lived and have little real value. Instead, they are replaced with the psychic torment of still trying to be good enough.

What happens then when the perfect physician finds him- or herself with a substance abuse problem, depression, or major mood liability? Is he or she able to seek help for this disorder as if it were hypertension or diabetes? Unfortunately, more often than not, the answer is no. In the experience of WPHP, the ability of the physician to see him- or herself as someone who is “ill” instead of “bad” is rare and compounded by shame and guilt that arises from the cognitive distortion of thinking “this should never have happened to me, and people have finally found out what a fraud I really am.”

In fact, when self-doubt and shame are combined with an exaggerated sense of self-responsibility and responsibility to others, it becomes difficult for a physician to give him- or herself permission to be sick at all. We readily ask our patients not to return to work because they are “too sick” to do so, but how often do we come to work minimizing our illnesses when we are ill ourselves? We compulsively search for depression in our patients while at the same time rationalizing our own depression as just being “a bad day”. How capable are

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we of concluding that our alcohol consumption has become as problematic as we have seen in our patients?

Because of the expectations of society and ourselves that we should be “different,” we are unable to accept any illnesses in ourselves which may connote any sense of loss of control. We may know that “something isn't right,” but what it is and what to do about it isn't usually within reach. We search for less egregious explanations, minimize symptoms, rationalize responses, and deny our own access to adequate care. It seems like we are not good enough to be “that sick.”

This doubt, shame, and exaggerated responsibility also predispose physicians to self-diagnosis and self-care. How can we delegate our health to someone else when we think we should have been taking better care of ourselves? If we do seek care and are appropriately treated, how often do we take medications as prescribed and complete the prescriptions? Not often. Physicians are notorious for stopping medications because of side-effects or adjusting dosages without telling treating physicians because we know better and “don't want to bother them.” So the Benadryl[®] becomes Ambien[®], the ibuprofen becomes Vicodin[®], and recurrent suicidal ideations are dismissed because “I would never do that.” The physician who treats him- or herself is considered to have “a fool for [a] patient and a charlatan for [a] doctor” and is violating both state and federal laws if diverting a controlled substance.

Physicians deserve the same quality of care that they provide to others. We have the same prevalence and incidence of disorders as our patients (however, the suicide rate is much higher than the general population). What can we do to change this paradigm?

- Acknowledge that physician health is as important as the health of patients.
- Seek adequate medical care, especially preventive care, and be compliant with all treatment recommendations.

- Take all medications exactly as prescribed.
- Avoid all self-diagnosis and especially self-treatment. It is dangerous, and we deserve better than that.
- Seek additional education and training that allows us to distinguish the differences among stress, burn-out, poor boundaries, maladaptive coping, depression, risk of suicide, substance abuse, and substance dependence.
- Become familiar with resources and the services of organizations like the WPHP (www.wphp.org) and the American Foundation for Suicide Prevention (www.afsp.org/DoctorsWithDepression.org).

Simple as it may seem, it is true that the healthier physicians are, the healthier their patients will become!

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FSPHP Solidarity in Trying Times

We in the field of professional health programs (PHPs) face many challenges at home and on the national front. Some of these threats are routine and expected. Others are more threatening and concerning. How individual state PHPs respond and how the federation works together is of critical importance.

At home, there are always the year-in and year-out conflicts that inevitably arise when dealing with physician health issues. The mission of the FSPHP, our state PHPs, and regulatory entities, while complimentary, is also often at odds. The primary focus of PHPs is “illness and health,” while many regulatory agencies have mandates to focus on misconduct issues.

Complicating this is the fact that both PHPs and state medical boards experience staff turnover from time to time which may require the time-consuming process of re-establishing working relationships. How many times do we find ourselves thinking, “Do I have to fight this same battle again?” It is probably one of our occupational hazards.

On the national scene, we have all witnessed the devastating consequences of the dissolution of the California PHP. More credit should be accorded to progressive medical boards who understand that a pathway affording early intervention, treatment, and monitoring makes much more sense for all involved and does much more to see that the public is safe.

Threats to the FSPHP and individual PHPs will continue to exist, and they are very real. Therefore, it is more important than ever that those who understand and have a passion for this work remain firmly united within the FSPHP.

How do we remain firmly united? First, remain actively involved with the FSPHP and its committees/task force efforts. Repeatedly, the FSPHP’s Board of Directors approaches a topic and asks for committee input. The FSPHP board relies on you and your committee’s opinion. Continue to actively support the federation’s annual and regional meetings. We need everyone, and the messages we take away from our meetings need to be congruent.

There are two important and current areas for consideration regarding our unity as a federation. The first is research. While each state should feel free to publish from its own data, the FSPHP’s research agenda needs to be driven through the Research Committee.

Research ideas are carefully vetted through the committee and then presented to the FSPHP Board of Directors for approval. The board always entertains such issues with state PHP interests at heart. While we might disagree with our elected leaders’ positions on particular research projects, they represent us. We elected them to take on this responsibility and to speak for us.

The second issue is purely a business concern. Most who do state PHP work do so not because it is a “job” but because it is a “calling.” Should the day come when we see state PHPs going to companies soliciting purely on a business-model, all that is best about the FSPHP could be forever lost. We will deteriorate into bidding wars, and the professionals we assist will be little more to us than the “bottom line.” State PHPs run by passionate professionals who believe in our wounded sisters and brothers are what brought us to the respected organization we are today with the buy-in and good will of state medical associations and licensing boards.

*Gary D. Carr, MD, FAAFP
Diplomate, ABAM
Past President, FSPHP*

Joint Commission Standards That PHPs May Want to Follow

There are now three standards from the Joint Commission that may impact physician/practitioner health programs (PHPs). PHPs may want to review these standards to consider education programs or methods to provide guidance to health care organizations that are seeking accreditation.

The first standard has been in existence for several years and was renumbered in January of 2009. The FSPHP was involved in providing feedback when it was created, and it relates very specifically to PHP programs. This standard opens the door for PHPs to guide health care organizations seeking accreditation with a process for referring practitioners identified with health-related concerns to PHPs. When it first came out, prior to 2009, the FSPHP sought and obtained confirmation from the Joint Commission leadership directly that PHPs could serve as a “process” to rely on to satisfy this standard. This offers PHPs an opportunity to suggest health care organizations forgo an in-house committee and rather design a recognized process of direct referral to local PHPs. The guideline follows.

continued on page 10

*Joint Commission Standards
That PHPs May Want to Follow
continued from page 9*

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.

There are a number of elements of performance.

Develop a process that includes the following:

- Education of LIPs
- Self-referral and referral by others
- Confidentiality
- Evaluation of credibility of the complaint or concern
- Referral for diagnosis and treatment
- Reporting if LIP unsafe

The second relevant standard that went into effect in 2009 relates to disruptive behavior. The disruptive behavior standard (LD.03.01.01) is 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 standard follows.

LD.03.01.01: Disruptive Behavior

Leaders create and maintain a culture of safety and quality throughout the hospital.

There are 10 elements of performance.

1. Leaders regularly evaluate the culture of safety and quality using valid and reliable tools.
2. Leaders prioritize and implement change identified by evaluation.
3. Leaders provide opportunities for all individuals who work in the hospital to participate in safety and quality initiatives.
4. The hospital has a code of conduct that defines acceptable, disruptive, and inappropriate behaviors.
5. Leaders create and implement a process for managing disruptive and inappropriate behaviors.
6. Leaders provide education that focuses on safety and quality for all individuals.
7. Leaders establish a team approach among all staff at all levels.
8. All individuals who work in the hospital, including staff and licensed independent practitioners, are able to openly discuss issues of safety and quality.

9. Literature and advisories relevant to patient safety are available to all individuals who work in the hospitals.
10. Leaders define how members of the population(s) served can help identify and manage issues of safety and quality within the hospital.

The third standard (LD.02.04.01) relates to conflict management and offers PHPs an opportunity to connect with health care leaders in their areas. It reads as follows.

LD.02.04.01: Conflict Management

The organization manages conflict between leadership groups to protect the quality and safety of care.

There are five elements of performance.

1. Senior managers and leaders of the organized medical staff work with the governing body to develop an ongoing process for managing conflict among leadership groups.
2. The governing body approves the process for managing conflict among leadership groups.
3. Individuals who help the hospital implement the process are skilled in conflict management.
Note: These individuals may be from either inside or outside the hospital.
4. The conflict management process includes the following:
 - Meeting with the involved parties as early as possible to identify the conflict
 - Gathering information regarding the conflict
 - Working with the parties to manage and, when possible, resolve the conflict
 - Protecting the safety and quality of care
5. The hospital implements the process when a conflict arises that, if not managed, could adversely affect patient safety or quality of care.

PHPs may want to develop a list of resources to offer health care organizations to help them align with these standards. Also, PHPs can offer expertise in identifying when there is to be a referral for a potential health or behavioral matter for assessment through the PHP. For further information on these standards, contact the Joint Commission (www.jointcommission.org).

WE WANT YOUR BUSINESS!

The FSPHP Board of Directors is very interested in your ideas and suggestions, and we welcome agenda items you may wish to be brought before the board. But it is important to be organized in our approach in order to make sure that ideas are fully explored and vetted. Last October, the board established a policy that members are requested to submit written requests for consideration to regional directors directly instead of to the board as a whole. This will ensure an organized chain of communication between you and your representatives.

Thank you for your assistance!

FSPHP 2010 ANNUAL MEETING AND CONFERENCE

Promoting Physician Health and Enhancing Patient Safety: The Role of PHPs

Monday to Thursday, April 19–22, 2010
Palmer House Hilton Hotel, Chicago, Illinois

Highlights include:

- Extensive opportunity to visit with a wide range of exhibitors offering services in the field
- Presentation of “Whack a Mole” by leading author David Marx, Esq.
- Prognosis for Recovery of Surgeons from Chemical Dependency: Mick Oreskovich, MD
- Luncheon address by Humayun J. Chaudhry, DO, MS, FSMB President
- Responses to the public facilitated by Frank Fortin, director of communications at the Massachusetts Medical Society, including past presidents of FSPHP Dr. Luis Sanchez and Dr. Gary Carr
- FSPHP Regional Meetings
- Exhibitor Session
- Positive Sobriety: A Manualized Approach to Addiction Treatment: Daniel Angres, MD
- Treating Physicians with Sexually Aberrant Behavior: An Integrated Good Lives Model with Behavioral Measurements: Philip C. Hemphill, PhD, LCSW
- The Differences in Keeping Both Male and Female Physicians Healthy: Sarah Early, PsyD
- Return to Anesthesiologist in OR: Mick Oreskovich, MD, and Paul Earley, MD



Palmer House Hilton Hotel
Chicago, Illinois

- Innovations in Toxicology and Testing: Panel facilitated by Greg Skipper, MD
- Disruptive Behavior Approaches: Panel coordinated by Michael Kaufmann, MD
- Joint FSPHP/FSMB Session and Luncheon, Physician Health Programs and Licensing Boards: Partners for Patient Safety
- Administrators’ Session

Plan to Attend or Exhibit!

Each year, the FSPHP holds an annual meeting attended by nearly 200 state physician health program administrators, care providers, and allied health professionals dedicated to the purposes of the FSPHP and its member state programs. This is your opportunity to network with professionals dedicated to treating dependency and mental health issues facing physicians and other care providers in the United States, Canada, and other parts of the world.

For more information, visit www.fsphp.org or contact: Vickie Grosso, FSPHP Staff Assistant
Physician Health and Health Care Disparities
American Medical Association
Phone : (312) 464-4574
Fax: (312) 464-4111
E-mail: vickie.grosso@ama-assn.org

FSPHP Committees 2009–2010

Board of Directors

President	Peter A. Mansky, MD
Interim President-Elect	Warren Pendergast, MD
Secretary	Linda R. Bresnahan, MS
Treasurer	Terrance M. Bedient, CHE
Immediate Past President	Luis T. Sanchez, MD
Director at Large	Doris Gundersen, MD
NE Regional Directors	Greg K. Gable, PsyD Vacant
SE Regional Directors	Roland Gray, MD James T. Jennings, MD
Central Regional Directors	Monica Feider, MSW, LICSW Carole Hoffman, PhD, LCSW
Western Regional Directors	Mick Oreskovich, MD Linda Kuhn
Executive Director	Jon Dougherty, MS
FSPHP Staff Assistant IV	Vickie Grosso

Task Force on Guidelines

Purpose: To develop guidelines for PHP programs and participants

Doris C. Gundersen, MD, Chair
Meena Abraham, DrPH
Terrance M. Bedient, CHE
Michael H. Gendel, MD
Brad Hall, MD
Peter Mansky, MD
Warren J. Pendergast, MD
Michael Ramirez

Nominating Committee (2009–2011)

Purpose: To nominate PHP members to the Board of Directors when terms expire or become vacant and report changes to the membership

Luis T. Sanchez, MD, Chair
Rosemary Maher, ACSW, LICSW, NE Rep
Roland W. Gray, MD, SE Rep
Michael Sucher, MD, Western Rep
Jim Wieberg, Central Rep
Terrance Bedient, FACHE (President's Appointment)

Executive Committee

Purpose: To provide oversight to the full Board of Directors

Peter A. Mansky, MD, President
Warren Pendergast, MD, President-Elect
Luis T. Sanchez, MD, Immediate Past President
Terrance M. Bedient, CHE, Treasurer
Linda R. Bresnahan, MS, Secretary
Mick Oreskovich, MD, Western Region Rep
Board-appointed EC position, vacant

Bylaws Committee

Purpose: To review bylaws changes as needed

Debra Grossbaum, Esq., Chair
Terrance Bedient, CHE
Sarah R. Early, PsyD
Monica R. Feider, MSW, LICSW
Maureen Dinnan, Esq.

Task Force on Research

Purpose: To develop, evaluate, and pursue research opportunities and funding which may be available to the FSPHP or facilitate individual program research

Michael H. Gendel, MD, Co-Chair
Mick Oreskovich, MD, Co-Chair
Linda R. Bresnahan, MS
Joan Brewster, PhD
Erica Frank, MD (Consultant)
Brad Hall, MD
Carole E. Hoffman, PhD, LCSW, CAADC
Joseph Jordan, PhD
Janet Knisely, PhD
Cynthia MacWilliam, Hons. BSc, MBA
Luis T. Sanchez, MD
Jeffery Selzer, MD
Greg E. Skipper, MD

Subcommittee of Research Steering Committee on Research (Disbanded)

Gary D. Carr, MD, Chair	Linda R. Bresnahan, MS
Michael H. Gendel, MD	Luis T. Sanchez, MD
Terrance M. Bedient, CHE	Greg E. Skipper, MD

Program Planning Committee

Purpose: To develop the agenda for the Annual Meeting

Mick Oreskovich, MD, Chair
Julie Alleman, MEd, LPC, LMFT, LAC
Candace Backer, LCSW
Terrance M. Bedient, CHE
Linda R. Bresnahan, MS
Martha Brown, MD
Doris C. Gundersen, MD
Carol E. Hoffman, PhD, LCSW, CAADC
Michael Kaufman, MD
Peter Mansky, MD
Luis T. Sanchez, MD
Greg Skipper, MD
John Southworth
Michael Sucher, MD
Bert Toews, MD

Publication Committee

Purpose: To provide oversight to the FSPHP newsletter and the website

- Linda R. Bresnahan, MS, Chair
- Sarah R. Early, PsyD
- John A. Fromson, MD
- Carole E. Hoffman, PhD, LCSW, CAADC
- Linda Kuhn
- Greg E. Skipper, MD

Public Policy Committee

Purpose: To develop policies/templates for media management assistance and assist with guidelines dissemination issues

- Herbert Rakatansky, MD, Chair
- Monica R. Feider, MSW, LICSW
- Luis T. Sanchez, MD

Finance Committee

Purpose: To provide financial oversight and budgetary requirements

- Terrance M. Bedient, FACHE, Chair
- Michael Todd

Membership Committee

Purpose: To develop membership criteria

- Scott Alberti, CCDC, III, Chair
- Monica Feider, MSW, LICSW
- Brad Hall, MD
- Michael Todd

Ethics Committee

Purpose: To address the ethics of interstate PHP competition

- | | |
|---------------------------------|---------------------|
| Warren J. Pendergast, MD, Chair | Linda Kuhn |
| Candace Backer, LCSW | Vince Parrish, LCSW |
| J. Wesley Boyd, MD, PhD | Michael Ramirez |
| Stafford Henry, MD | Carol Tavani, MD |

Past Presidents

Purpose: To provide oversight from a historical point to the federation

- Luis T. Sanchez, MD, Chair
- Gary D. Carr, MD
- Susan McCall, MD
- Michael H. Gendel, MD
- Martin C. Doot, MD (In Memoriam)
- Lynn Hanks, MD, FASAM
- John A. Fromson, MD
- David T. Dodd, MD
- Gerald L. Summer, MD (In Memoriam)
- Richard Irons, MD (In Memoriam)
- Violet Eggert, MD (In Memoriam)

Task Force on Toxicology

Purpose: To develop guidelines related to state-of-the-art toxicology testing in PHPs. Review FSPHP policy areas related to toxicology, such as a pooled purchasing power and TPA issues.

- | | |
|-------------------------|--------------------|
| Greg Skipper, MD, Chair | Brad Hall, MD |
| Fred Frick, MD | James Jennings, MD |
| Sally Garhart, MD | Michael Sucher, MD |
| Wayne Gavryck, MD | Penny Ziegler, MD |

Medical Student/Resident Committee

Purpose: To define components required to educate students and residents regarding physician health and suggest mechanisms to facilitate implementation

- | | |
|-------------------------|-----------------|
| Martha Brown, MD, Chair | Michael Ramirez |
| Michael H. Gendel, MD | |

Curriculum Committee

Purpose: To develop components necessary to provide education regarding PHPs/FSPHP. Consider tailoring by audience (public, medical staff, administration/boards, etc.).

- | | |
|----------------------------|---------------------|
| Mick Oreskovich, MD, Chair | Peter A. Mansky, MD |
| Scott Alberti, CADC, III | Jim Wieberg |
| Michael H. Gendel, MD | |

Ad Hoc Audit Committee

Purpose: To develop guidelines for audits of PHPs

- | | |
|------------------------------|-----------------------|
| Michael H. Gendel, MD, Chair | Debra Grossbaum, Esq. |
| Maureen Dinnan, Esq | Michael Kaufmann, MD |
| Sarah Early, PsyD | Charles Walton, MD |
| Doris Gundersen, MD | |

FSPHP Funding Task Force

Purpose: To develop strategies for monies so the FSPHP can be developed

- | | |
|------------------------|--------------------|
| John Southworth, Chair | Michael Sucher, MD |
| Martha Brown, MD | Carol Tavani, MD |
| Greg Gable, PsyD | Michael Todd |
| Roland Grey, MD | |

FSPHP CAC Task Force

Purpose: To provide liaison with the Citizen Advocacy Center in order to promote and protect the FSPHP mission

- Doris Gundersen, MD (Co-Chair)
- Warren Pendergast, MD (Co-Chair)
- Martha Brown, MD
- Stafford Henry, MD
- Mick Oreskovich, MD
- John Southworth
- Lynn Hanks, MD (Emeritus Member)

We are pleased to introduce our **advertisement section** of *Physician Health News*. We thank all the participating organizations for their support of the FSPHP. We hope this section is a useful resource to state physician health program professionals.

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Physician Health and Other Related Organizations' National Meetings

FSPHP Annual Meeting

April 19–22, 2010
Palmer House, Chicago, Illinois

2010 AMA/CMA/BMA International Conference on Physician Health

October 3–5, 2010
Swissotel, Chicago, Illinois

American Academy of Addiction Psychiatry

December 2–5, 2010
Boca Raton Resort & Club, Boca Raton, Florida

American Medical Association House of Delegates Annual Meeting

June 12–16, 2010
Chicago, Illinois

AMA House of Delegates Interim Meeting

November 6–9, 2010
San Diego, California

American Psychiatric Association Annual Meetings

May 22–27, 2010
New Orleans, Louisiana

May 14–19, 2011
Honolulu, Hawaii

American Society of Addiction Medicine

April 15–18, 2010
San Francisco, California

April 14–17, 2011
Washington, DC

California Society of Addiction Medicine

October 27–30, 2010
Newport Beach, California

Federation of State Medical Boards Annual Meetings

April 22–24, 2010
Chicago, Illinois

April 28–30, 2011
Seattle, Washington

International Doctors in Alcoholics Anonymous Annual Meeting

August 4–8, 2010
Buffalo, New York

August 3–7, 2011
Tucson, Arizona

FSPHP Newsletter Advertising Information and Specifications

Dear prospective *Physician Health News* advertisers:

We would like to invite you and your organization to participate by advertising your services in the 2011 edition of *Physician Health News*. *Physician Health News* is mailed to all state programs and state licensing boards. In addition to articles and notices of interest to the physician health community, the newsletter also includes planning information about the upcoming FSPHP Annual Meeting and Conference.

For the 2011 issue, all advertisements are being offered at \$300.00 per advertisement and will be the same "business card" size they've been in past issues. For your convenience, full ad specifications and payment instructions are outlined here. 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 in the 2011 edition of *Physician Health News*. Become part of a great resource for state physician health program professionals.

We look forward to working with you to make this the best edition of our newsletter yet.

FSPHP Publication Committee

Linda R. Bresnahan, MS (MA) Carole Hoffman, PhD, LCSW, CAADC (IL)
Sarah Early, PsyD (CO) Linda Kuhn (TX)
John A. Fromson, MD (MA) Greg Skipper, MD (AL)

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Double check that your ad is the correct size and contains the most up-to-date information.

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Native files or other file formats will not be accepted. Fonts must be embedded and TrueType fonts should be avoided.

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Questions? Please contact Linda Bresnahan at lbresnahan@mms.org.