

PHYSICIAN HEALTH NEWS

The Official Newsletter of the Federation of State Physician Health Programs



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ANNUAL MEETING 2014 REVIEW

Welcome to the 19th edition, Volume 2 of *Physician Health News*. We hope you will find this an informative forum for all aspects of physician health and well-being.

Physician Health News is the official newsletter of the Federation of State Physician Health Programs (FSPHP) and is published by the FSPHP, 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 a member yet, please consider joining. State membership is \$400 per year, and (associate) membership is \$100. 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, including new categories for organizational and individual members, please contact Debbie Brennan.

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MESSAGE FROM THE PRESIDENT

Why Focus on Physician Wellness?

"In no relationship is the physician more derelict than in his duty to himself"

—Sir William Osler



Doris Gundersen, MD

Most physicians who enter medicine are intellectually curious, enthusiastic, and industrious workers. We choose to lead a life of service with all the attendant rewards. We are afforded the privilege of taking care of patients, making a meaningful difference in the lives of others by curing illnesses or, at the very least, diminishing pain and suffering. We are members of a respected profession and, despite shrinking reimbursements, receive comfortable remuneration for the work we love to do.

Becoming a physician requires innumerable hours of training and studying to master the art. Individuals who choose medicine as a career are by definition high achievers, given the competitive nature of the entrance requirements. We put pressure on ourselves with little tolerance for error. The practice of medicine requires intense dedication and self-sacrifice. Patients are struck by serious illnesses every day, including holidays. Babies are born at unpredictable times. Suicidal patients call any and all hours of the night. Physical trauma is commonplace and infectious diseases can quickly become widespread, creating a community if not global crisis. We prepare ourselves for these scenarios and accept the fact that life will not always be easy.

However, nothing has prepared us for the challenges accompanying our evolving health care delivery system. Prior to the 1960s, medicine was primarily viewed as "a calling." There was something sacred about being a doctor. It was an honor to serve patients in an intimate way. Over the last several decades, the profession of medicine has collided with a corporate philosophy in which maximizing profits has become a high priority. There is the expectation for physicians to see "the sicker quicker." With evolving health care structures, physician autonomy

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has decreased. Physicians who encounter excessive restrictions on their decision making often report increased stress and job dissatisfaction, particularly in the absence of malpractice reform. Other sources of stress include unsettled issues regarding health care reform, arguments with insurance companies about coverage for appropriate treatment, the introduction of electronic medical records, and third party intrusions. The list goes on and on.

It is not surprising that physicians are experiencing high rates of burnout, addiction, depression, and suicide. In a 2001 Kaiser Family Foundation survey of 2,608 physicians, 87% agreed that physician morale had declined in the preceding five years (KKF.org). In a recent study of more than 4,000 medical students surveyed from seven U.S. medical schools, 50% endorsed symptoms of burnout within the preceding year. Burnout characterized by emotional exhaustion, depersonalization, and a sense of inefficacy can lead to depression. The lifetime prevalence of depression in physicians is approximately 13% for males and 19.5% for females. Of significant concern, male physicians have a suicide rate 40% higher than the general population. Female physicians have a suicide rate 130% higher than the general population. In this country, approximately 250 physicians commit suicide annually.

Historically, the house of medicine has given low priority to the health needs of its own. Implicit in traditional medical culture was the tacit assumption that professional demands would always trump a physician's personal needs. Consequently, we tend to self-diagnose and self-prescribe. We are less likely to have a relationship with a primary care physician, resulting in a fundamental risk factor for poor health. While counterintuitive, physicians tend to receive poor health care.

There is growing awareness that physician wellness is vital to patient safety and the delivery of high-quality health care. Personal well-being may actually enhance professionalism including empathy and compassion. Physicians in good health are more likely to counsel patients about healthy habits. Modeling healthy lifestyles to our patients is critical, especially considering that chronic and costly diseases such as diabetes, obesity, heart disease, and depression are at an all-time high.

When physicians are unwell, the overall performance of a health care system suffers. Sleep deprivation can be more incapacitating than a high blood alcohol concentration. Call-associated fatigue is related to increased error rates in the cognitive skill domain for surgeons. Fatigue and

sleep deprivation increase the risk of percutaneous needle sticks, near-miss incidents, medical errors, and physician motor vehicle accidents. Fatigue and sleep deprivation can lead to burnout that is associated with reduced productivity and inefficiency. Physicians who are highly unsatisfied with their work have an increased probability of changing jobs within the medical field or leaving medicine altogether, leading to increased costs for physician recruitment and retention. The cost of replacing a physician is estimated to be between \$150,000 and \$300,000. With an aging population, the cost of physician shortages is immeasurable.

Aside from the practical implications of a healthy workforce, physicians are deserving of the same sensitivity and caring they provide to their patients. A medical culture that acknowledges the human frailty of its physicians and does not punish or ostracize them for seeking help is worthy of our efforts to create. Fortunately in Colorado, the Department of Regulatory Agencies (DORA) and the Colorado Medical Board (CMB) recognize that punishing ill physicians does not make them well. Physicians who seek assistance from the Colorado Physician Health Program do not need to disclose their health condition when applying for or renewing medical licensure. This strict confidentiality has led to fewer complaint-driven referrals and more proactive self-referrals.

In contemporary quality improvement campaigns, the phrase "every patient matters" is often employed. I believe that *every physician matters!* We need one another; we are responsible for one another and our work affords us the privilege to attend to that truth every day. I would like to take this opportunity to express my enthusiasm as I embark on the presidential path of the FSPHP. I am grateful to have the support of talented members of the board of directors and hardworking committee chairs and committee members. In future publications, I plan to share more about the activities of the FSPHP and our progress in advancing the health of physicians. Stay tuned!

—*Doris C. Gundersen, MD, President,
Federation of State Physician Health Programs*

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SYNOPSIS OF ANNUAL CONFERENCE PRESENTATIONS AND POSTERS

THURSDAY, APRIL 24, 2014

THE DEVELOPMENT OF A QUALITY SCORECARD INSTRUMENT FOR MEASURING PHYSICIAN HEALTH PROGRAM EFFECTIVENESS

The Washington Physicians Health Program (WPHP) leadership was tasked with developing a scorecard instrument to measure and track program outcomes and performance. This tool was originally designed to include specific performance metrics that would assist the WPHP Board of Directors in its duty to ensure a high quality program. Ultimately this undertaking resulted in the development of two scorecards: one for use by WPHP management and one for use by the WPHP Board of Directors.

An inpatient hospital quality model and FSPHP guidelines for program quality measures were used as the foundation for the WPHP scorecard. The scorecard includes the following quality domains: patient safety, access to care, satisfaction/service, cost-effectiveness, outcomes, and outreach. Specifically, the scorecard was to incorporate the following:

- Factors that demonstrate the effectiveness of WPHP in protecting the public as they entrust their health to the state's physicians and other health professionals covered by WPHP
- Measures of a recovery experience that is accessible to all eligible to receive the service, ensures safe administration of care, and is found to be satisfactory by WPHP clients
- Measures that determine how cost-effective the program is
- Measures that show the recovery experience is successful



Charles Meredith, MD and Amanda Shaw, MPH

A variety of methods were used to develop appropriate indicators within each quality domain and to collect relevant scorecard data including survey of current clients, survey of program stakeholders, analysis of client outcomes, analysis of statewide program utilization, analysis of program cost effectiveness, and examination of program outreach efforts.

WPHP leadership encountered challenges in the development and elucidation of meaningful measures and benchmark standards given that physician health programs comprise a unique subset of the universal health care environment. These challenges included quantifying program performance and establishing valid performance indicators, obtaining consistent information, and utilizing the scorecard as a reporting tool for different audiences.

At present, the scorecard tool is used primarily for informational purposes, and it has raised awareness about certain areas where WPHP might focus more attention and fortify its efforts. The program considers the scorecard to be a flexible tool that can be modified as needed in order to be helpful for PHP performance monitoring or to meet the informational needs of different audiences. Further research into relating these preliminary efforts to quality performance measures would enable the identification of scorecard and dashboard characteristics that are most useful in supporting physician health program leadership in quality improvement activities.

—Amanda Shaw, MPH; and Charles Meredith, MD

INTEGRATING OUTCOMES REPORTS INTO PHP PRACTICE: IMPLICATIONS FOR PATIENT SAFETY, QUALITY IMPROVEMENT AND TREATMENT PLANNING

Routine assessment of psychiatric outcomes is rare, despite growing evidence that feedback to professionals in recovery and their monitoring teams improves treatment outcomes. The case of a physician who was seeking treatment for major depressive disorder, co-occurring alcohol abuse and avoidant personality traits, was reviewed. The physician was referred by his Physicians Health Program within the context of worsening depression, anxiety, suicide risk, and decline in functioning. During the course of his eight-week hospitalization, he completed standardized assessments of symptom/functioning at admission, two-week intervals, and post-discharge follow-up. The unique feature of this case is the use of real-time feedback of subsequent treatment response, including a review of changes in his sense of well-being and reported alliance with his team. Given that treatment alliance can account for up to 22% of

recovery outcome, this indicator proved especially useful. In the midst of an improving profile with decreasing symptom severity, the physician in treatment experienced a spike in distress and symptoms. This prompted his team to examine the treatment plan and to engage the patient around understanding the decline in function. This integration led to a realization of a rupture in the therapeutic alliance and a replay of his familiar pattern of conflict avoidance. The team and patient were able to learn from this rupture and his functioning again improved. This case is unique in that a research-based approach was used to diagnose psychiatric disorders, collect self-reported outcomes data, and objectively demonstrate clinical improvement within the context of repairing an alliance rupture with his treatment team and family. The use of freely available, evidence-based outcomes measures holds promise for enriching the ongoing monitoring and comprehensive assessment of physicians in recovery.

—*Michael Groat, PhD, MS*

RISK ASSESSMENT AND PHP INVOLVEMENT WITH COMPLEX CASES: A ROADMAP FOR SUCCESS

Whenever a theory appears to you as the only possible one, take this as a sign that you have neither understood the theory nor the problem which it was intended to solve.

—*Karl Popper*

The goal during this presentation was to have participants look at how they make decisions on a daily basis regarding interventions, policies, and recommendations. The 2013 ASAM Criteria book developed an excellent matrix, which provides a well-needed structure to these important decisions, for matching services to needs. However, some of these models have limitations with professional populations given the unique needs and complex cases managed by most physician health programs. Therefore, our objectives were to describe the challenges of monitoring, coordination, and advocacy for these complex cases by presenting three case studies involving boundary violations, disruptive behavior, and process addictions. We formulated an effective framework and construct for assessing risk while identifying measurements of low, moderate, and high risk factors. These are evidence-based practices derived from public health and decision-making theory.

The basis tenets of the “Theories of Risk” start with the belief that unstructured clinical judgment is the most subjective followed by guided clinical judgment and anamnestic assessment. These encompass what we, as interviewers, believe to be important based on our own individual judgment. The next component of the theory is



Philip Hemphill, PhD, Pine Grove Behavioral Health

the research-guided clinical judgment that focuses on static, dynamic, and acute risk items. These can be obtained from numerous assessment and monitoring instruments. The actuarial approach offers low, low-medium, medium-high, and high levels of riskiness that have a higher predictive quality. Finally, the clinically adjusted actuarial approach appears to be the most successful at achieving these goals as they include the objective measures, static/dynamic risk factors, and clinical opinion (e.g., attitudes about medicine, support systems, intimacy needs, compliance with monitoring or evaluation, hostility, access to resources, personality issues, and self-management).

The Risk-Need-Responsivity (Andrews & Bonta, 2010) model reviewed the ability to assess the participant’s **risk** (level of intervention/treatment required), **need** (specifically and explicitly targeted in treatment), and **responsivity** (treatment should be matched to individual characteristics of the individual). Clinically derived treatment selections are, at best, only moderately in line with the first of the RNR principles. This leads to under-treatment of some and possible over-treatment of others; as a result, some moderate-high to high-risk individuals may struggle during the monitoring process.

Consider these factors in your risk assessment when assessing participants: youth trauma, personality disorder, substance use disorder, psychiatric disorder, suicidal/homicidal ideation, relationship problems, work-related problems, prior violence, prior criminality, diversity of behavior, victim injuries, use of weapons, domestic violence, escalation, minimization/denial, response to intervention, motivation during treatment, and impulsivity/lack of control.

Also, consider this equation:

$$\text{static actuarial assessment} + \text{functional analysis} + \text{stable dynamic factors} = \text{judgment}$$

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Finally, three case examples — reviewed to illustrate the challenges, fears, successes, failures, regrets, and teaching moments — were presented followed by an honest post hoc assessment. These cases brought to life the complexity of making daily decisions such as the following: What is potential risk to patient care? When should PHP involvement begin? What amount of leverage is necessary to ensure compliance? Who will monitor if not me? Is it possible to provide advocacy for a participant who uses controlled substances? Where do you draw the line? When do the needs of the many outweigh the needs of the few? What steps can increase the likelihood of successful monitoring?

Ultimately your **professional discretion** overrides the above principles if circumstances warrant it and should always guide your informed decisions.

—*Philip Hemphill, PhD; and Scott Hambleton, MD*

MEDICAL STUDENT PARTICIPATION IN A STATE PHP: THE FLORIDA EXPERIENCE

The limited available data regarding substance use, psychiatric disorders, and burnout among medical students indicates a significant problem. In addition, recent research on participants in the Florida physician health program (PHP) suggest that most practicing physicians who are referred for monitoring began abusing substances by the time they entered medical school. When asked what they would change about their treatment experience if they could, a significant number spontaneously reported that they would have sought help sooner, rather than waiting for the disease to progress and more severe consequences to occur. Accumulating research and experience demonstrate the career- and life-saving potential of PHPs for practicing physicians, but in many cases medical students are denied access to this resource, despite potential for significant benefit.

Though less likely to seriously jeopardize patient safety due to their close supervision, medical students who suffer from substance-related or psychiatric impairment can experience significant consequences related to their training and career development. Interference with learning, academic failure, dismissal from school, difficulty starting residency, and delays in licensure are common when appropriate policies are not in place to help the student access the treatment or resources that he or she needs. In order to remedy this problem, a PHP in Florida worked for about a decade to provide statutory access to the program for the medical students at the state's nine medical schools.



Scott Hambleton, MD, Mississippi Professionals Health Program

After a group of medical school deans and representatives at the PHP convened, its members set to work advocating for student access. Working closely with state legislators for several years, the group was successful in passing legislation to include medical students in the population served by the PHP. Liaisons were appointed at each school to facilitate contact with the PHP, and each school eventually effected a standard model contract.

Since 2006, the number of medical student referrals has increased steadily, with 9 students referred in 2013 and 12 current medical student participants. Current and past medical students have reported significant benefit from their participation in the Florida PHP and overwhelming satisfaction with the program. At least a few students have decided to pursue a career in addiction medicine or psychiatry as a result of their participation in the PHP.

Current research examining medical student wellness in Florida demonstrates that more work is needed to improve awareness of the PHP and increase student access to services. A significant number of students anonymously reported concerns about their own mental health, hazardous substance use, suicidal ideation, and uncertainty about becoming a physician. The majority who indicated they would benefit from psychological resources admitted they had never used any. Future efforts should focus on encouraging wellness among medical students, decreasing stigma and perceived consequences of help-seeking, promoting early intervention, and helping students who may require financial assistance to obtain access to mental health services or PHP participation.

—*Lisa J. Merlo; Russ Jackson; and John Curran*

RESEARCH ON FITNESS FOR DUTY EVALUATIONS FOR PHYSICIANS WITH DISRUPTIVE BEHAVIOR

The Vanderbilt University Comprehensive Assessment Program has been collecting and analyzing data on over 400 physicians referred to the program over the past 12 years from 37 states and 4 Canadian provinces. The presentation for the FSPHP conference focused on the demographic characteristics, psychological testing, and evaluation results for the group referred to VCAP for disruptive behavior.

Physicians referred for disruptive behavior (N = 151) comprised 38% of all referrals to VCAP. They tended to be mostly male, white, and married. About a third were surgeons. These demographic data did not differ from physicians referred for other reasons (e.g., substance use, boundary violations, and mental health problems). About a third of the disruptive physicians were referred by a PHP and a third by the physician's hospital. The disruptive referrals had the lowest rate of Axis I diagnosis (48%) but the highest rate of Axis II personality disorder or traits (90%). Most of the physicians in this group were recommended for further treatment, including psychotherapy (65%) and/or an educational intervention (64%). A smaller percentage was recommended for a short-term intensive treatment (35%).

Physicians referred for disruptive behavior generally had valid MMPI-2 and PAI profiles. In addition, the vast majority of clinical scales on both measures were within normal limits. Test results differed between the disruptive referrals and other referral groups in that many clinical scales were significantly lower for the disruptive group (suggesting that they were less psychologically disturbed and experienced less emotional distress). However, on the PAI, physicians referred for disruptive behavior had significantly higher scores on scales that measure aggression, dominance, resistance to treatment, paranoia, and mania (including grandiosity and narcissism).

Physicians referred for disruptive behavior were much more likely to be found fit to practice (91%) as compared to other referral types (60%). Disruptive physicians who were found unfit were more likely to have scores on the MMPI-2 suggestive of honest responding (lower L scales) and a greater degree of psychological distress and anger (higher F scale and Scale 4). On the PAI, those found unfit to practice had significantly higher scores on certain scales, including those that measure somatic, depressive, paranoid, and antisocial symptoms. In addition, scales measuring stress and the perception of limited social support were higher in the unfit-to-practice group.

Within the disruptive behavior group, demographic data and psychological testing scores were compared between

physicians whose disruptive behavior was limited to verbal aggression (N = 95) to physicians who had displayed at least one act of physical aggression (N = 41). The physically aggressive group was more likely to be older and more likely to be surgeons. There were minor differences on psychological testing that required replication.

In summary, those physicians referred for disruptive behavior differ in some respects from physicians referred for other reasons. They tend to be less psychologically disturbed overall (in terms of psychological test findings and fewer Axis I diagnoses) and thus are much less likely to be found unfit to practice. However, they are more likely to be diagnosed with personality disorder traits, which typically contribute to their difficult and disruptive interactions with others and led to referral for evaluation.
—*Kimberly Brown, PhD, ABPP; and Ron Neufeld, BSW, LADAC*

THE EVALUATION AND TREATMENT OF THE DISRUPTIVE PHYSICIAN PART II: TREATMENT AND MONITORING

The relationship between the efficacy of a medical team's function and the quality of outcomes has become an area of increased focus. A critical part of this effort was the joint commission's publication of Sentinel Event Alert 40. That publication identified intimidating and disruptive behavior as a clear and present threat to patient outcomes. One approach to understanding disruptive behavior is to list specific behaviors. Hickson and Pichert (2010) offer a broader perspective. They define disruptive behavior as "any behavior that impairs the medical team's ability to achieve intended outcomes."

The etiology of disruptive behavior is complex and can include chemical dependency, mood and anxiety disorders, personality characteristics, external stressors, medical and neurological issues. Williams and colleagues assert that disruptive behavior can have both a mental health component and an intentional component (i.e., there are situations in which the disruptive behavior accomplishes certain goals within the system). They take a systems view in which it is important to understand the behavior that is exhibited, the system in which it occurs, and the response of the system. Also important in determining appropriate course of action is whether the behavior is goal directed. Thus, it is important to recognize the heterogeneous nature of the individual and the system.

Treatment and remediation can include any or all of the following modalities: medical, stabilization, psychiatric stabilization, individual therapy, group therapy, coaching,

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mentoring, remedial CME classes, residential professional program, workplace intervention, 360° surveys, and participation in the state PHP. Residential treatment programs are often the most appropriate option in situations where there is considerable evidence that the behaviors are longstanding and previous interventions (e.g., individual therapy, coaching, CME) have failed. These programs are multidisciplinary and multimodal. Important foci of these programs include assisting the provider in gaining insight into the causes and effects of the problematic behavior, assisting them in developing new skills, and helping them translate the knowledge and skills they have gained into practice.

Return-to-work concerns, which are common, include whether the physician's gains will remain, whether staff will feel safe, and whether the physician will have a "bulls eye" on their back. Ongoing feedback and reinforcement promote knowledge translation and continued demonstration of newly acquired skills in the workplace. In this regard, 360° survey data can be useful. Monitoring of compliance with all elements of the aftercare is critical as it promotes continued skill development as well as accountability.

In sum, many physicians exhibiting problematic workplace behavior have behavioral challenges that are longstanding. Elements of successful remediation include insight into factors contributing to problematic behavior and insight into the relationship between this behavior and a functioning health care system.

It is more effective to address skill deficits rather than to try to change the personality structure. Return to work is fraught, but with appropriate support most disruptive physicians can manage the transition and show significant skill improvement. Continuing feedback systems, participation in aftercare elements, monitoring and accountability are core to maintaining improvement.

—*Carolyn Westgate, MS, LCPC, Kansas Medical Advocacy Program; and Betsy White Williams, PhD, MPH, Professional Renewal Center and Rush University Medical Center*

HEALTH CARE'S RAPID CHANGES — HOW DO PHPs RESPOND: THE KANSAS PERSPECTIVE

The landscape of medicine has changed with a number of events that have impacted both providers and patients. Changes include the passage and implementation of the Affordable Care Act, aging of both patients and health care providers, as well as changes in the structure of practice and practice patterns of physicians. Thus, there has

been a shift from private practice situations to increased numbers of employed physicians, as well as more reliance on multidisciplinary teams and physician extenders. Also, there are concerns about the increasing prevalence of burnout in health care providers and about finding the best way to handle aging clinicians. These changes and issues provide both challenges and opportunities for physician health programs. To best serve the multiple stakeholders, PHPs need information about the issues of concern (e.g., substance use, aging physicians, burnout, disruptive behavior, etc.), the physicians' perceived needs, and knowledge of available resources.

Those who have leadership roles in hospitals, practices, and clinics responded to a short online survey. These respondents included physician leaders and nonphysician administrators from a variety of health care settings and practice types, including rural and urban areas. The following were collected: demographic data, prevalence of physician issues that they are aware of or have dealt with, resources they have used, and perceived gaps in knowledge or resources/services. Qualitative and quantitative analyses of the data will be conducted.

Collected data will assist with program development to accommodate for the rapid shifts in the health care industry. With the fundamental structure of the health care industry in flux, it is unlikely that the needs of our patients will remain the same in the next several years. We anticipate that this study will provide both direction and a model for future research as PHPs prepare to adapt to the rapidly changing landscape of the health care industry.

Pilot data for the study looked at burnout from larger and urban communities versus those in rural and smaller hospitals in Kansas. Our findings suggested higher rates of burnout for providers in rural and smaller hospital practices.

The survey explores 11 issues to determine the degree to which they are of concern to the organization: drugs and alcohol, disruptive behavior, sexual misconduct, burnout, professional staff health, professional staff aging, onboarding, turnover and engagement, staff integration, physician development and leadership, and professional and clinical competency. The instrument also offers respondents the opportunity to raise new issues. We also investigate each of the respondent's sense of competence with and effectiveness in reacting to the issues. The specific focus is on a hospital's needs and whether the state PHP is in a position to meet those needs.

Preliminary findings indicate that burnout and concerns about aging physicians appear to be the fastest-rising issues. Of all the issues, disruptive behavior at this point

appears to require the most time. Finally, most hospitals think of PHPs as primarily providing assistance for substance-related issues.

—*Carolyn Westgate, MS, LCPC, Kansas Medical Advocacy Program; Michael V. Williams, PhD, Wales Behavioral Assessment; and Betsy White Williams, PhD, MPH, Professional Renewal Center and Rush University Medical Center*

IMPLEMENTATION OF TOBACCO-FREE POLICY IN RESIDENTIAL ADDICTION TREATMENT PROGRAMS FOR HEALTH PROFESSIONALS

Background

Cigarette smoking is the number one preventable cause of death and is responsible for over 440,000 deaths annually in the United States; that number is over four times the rate from alcohol and illicit drugs. Smoking is more likely to kill patients with substance use disorders in recovery than the substance responsible for their admission to treatment (Hurt et al). Data suggests that continued smoking increases the risk of alcohol relapse among alcohol-dependent smokers, and smoking cessation interventions are associated with a 25% increase in the likelihood of maintaining long-term alcohol and drug abstinence (Prohaska et al). Physicians have a low smoking prevalence ranging from 13.7% in a 1999 survey (Hughes et al) to 2% in a more recent survey (Sarna et al), but the rates of tobacco use are extraordinarily high in individuals with alcohol and drug use disorders (60–95%). In the state of Washington’s physicians health program, smoking prevalence among those with substance use disorders was 49% (Domino et al); in Colorado, any tobacco use prevalence among substance use disorder participants was 58.1% (Stuyt et al). In addition, ongoing tobacco use in physician health program participants was found to be an independent risk factor for relapse to drugs and alcohol (Stuyt et al). Ongoing tobacco use negatively impacts returning physicians who are trying to prevent their patients from using tobacco (Frank et al).

Residential treatment programs have historically allowed patients to continue tobacco use during treatment for fear that smoking cessation distracts from the more salient goal of sobriety from alcohol or illicit drugs or removes an important crutch from individuals trying to maintain sobriety. Many programs worry that admission rates and successful completion rates will plummet. The Center for Dependency, Addiction and Rehabilitation (CeDAR) became a tobacco-free campus in February 2013. This study examines the smoking policies of 43 U.S. treatment facilities for health professionals and

describes how tobacco-free policies affected patient admissions, census data, and smoking behavior.

Methods

An informal phone survey was conducted to determine the tobacco-free status of treatment programs for health professionals (n = 43 facilities contacted). CeDAR’s pre-admission records were reviewed to determine who had declined admission due to the tobacco-free policy. Daily census data of patients and treatment completion rates were reviewed in the year prior to the implementation of the policy and the year following it.

Physician charts were reviewed to determine tobacco use and treatment completion rates (completion and accepting aftercare recommendations).

Results

An informal phone survey revealed that only 4 of the 43 facilities contacted had a tobacco-free policy. Those four sites included CeDAR, Pavilion, Pine Grove Behavioral Health and Addiction Services, and Sante Center for Healing.

At CeDAR, prior to the policy, 33% of smokers queried at discharge increased their use of tobacco, 34% stayed the same, 27% decreased their use, and 6% stopped using tobacco (n = 85). Among non-tobacco users at discharge (n = 86), 5% actually initiated smoking while in treatment.

There was no decline in the number of tobacco users coming into treatment. All of the tobacco users who reduced the amounts of tobacco use were nine times more likely to discontinue tobacco use after discharge (6% pre-policy and 52% post-policy).

Among physicians entering CeDAR for substance use disorder treatment (n = 39), 30% were current smokers, 20% were former smokers, and 50% were never tobacco users. Of the current tobacco users, 46% were cigarette smokers, 36% used oral tobacco, and 18% were cigar smokers.

Before the tobacco-free policy was implemented, 81% of physicians successfully completed treatment; in the year following the implementation, 87% successfully completed the program.

Conclusions

The transition to a tobacco-free policy was not associated with a decline in census or admission to treatment for patients seeking care for substance use disorder even

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among tobacco users. The policy led to better outcomes for patients and resulted in no new initiates to tobacco use while in treatment. All physician tobacco users successfully completed treatment, and there was no difference in physician and nonphysician completion rates before or after the implementation of the tobacco-free policy.

Health professionals with substance use disorders have higher rates of tobacco use and deserve treatment in tobacco-free facilities to avoid the risks of tobacco initiation, worsening use, secondhand smoke exposure, and the higher relapse rates associated with continued tobacco use. The use of tobacco should be considered comparable to the use of other substances in respect to treatment and monitoring recommendations.

—*Laura Martin, MD; Patricia Pade, MD; Yu Tack Kang, MD; and Anne Felton, RN, ND, MBA; Center for Dependency, Addiction and Rehabilitation (CeDAR) at the University of Colorado Hospital at the University of Colorado School of Medicine Departments of Psychiatry and Family Medicine*

OVERLAPPING INTERESTS AND COMPLEMENTARY RESPONSIBILITIES: PHYSICIAN HEALTH PROGRAMS AND CLINICAL COMPETENCE PROGRAMS

Physicians served by physician health programs will, at times, be required to address questions about their clinical performance and skills. Thus, these physicians may need the services of both a physician health program and a clinical competence assessment/remedial education program. There are numerous examples of such cases: the physician who suffers a stroke and who, on return to his or her practice, was found by his partners to be practicing suboptimally; the physician who wants to return to practice after a relapse resulted in a prolonged suspension of practice; and the physician who has mild cognitive decline but feels competent enough to continue practicing. What the competence assessment program and the physician health program offer to such clients are distinct, yet both are essential and complementary. The Colorado Physician Health Program (CPHP) and the Center for Personalized Education for Physicians (CPEP) have collaborated for more than 20 years in assisting physicians with these special needs. Both organizations strive to assist physicians in addressing barriers — whether they are health or performance issues — to competent and safe practice.

Case Studies

Case Study #1

A 48-year-old male nephrologist stopped practicing after being diagnosed with a brain tumor. He presented to CPHP two years later after successful surgery. After testing revealed deficiencies, CPHP recommended neurocognitive rehabilitation and engagement with CPEP prior to returning to practice. At CPEP, the physician had an educational needs assessment and entered into a supervised reentry plan to assist him in his successful transition back into practice.

Case Study #2

A 42-year-old female internist was mandatorily referred to CPHP by her workplace for issues related to poor patient care, prescribing errors, and concerns of mental health issues. CPHP referred the physician for neuropsychological testing and treatment with a psychiatrist. Deficiencies in some areas of the neuropsychological testing lead CPHP to refer the physician to CPEP to assess safety to practice. After poor results on some components of the CPEP evaluation, she engaged in a supervised learning plan, with oversight by CPEP. A question about fraudulent documentation ultimately led to a referral by the medical board to CPEP's Medical Record Keeping course and CPEP's ProBE Program for ethics remediation. CPHP provided ongoing monitoring and assessments of continued safety to practice from a health standpoint.

Case Study #3

A 35-year-old female orthopedic surgeon, out of practice due to substance abuse and previously involved with an out-of-state PHP, proactively referred to CPHP for monitoring prior to resuming practice. Initial CPHP evaluation identified substance abuse, in remission, and depression. CPHP referred to appropriate treatment providers and the physician began urine drug screens. After approximately two years of documented sobriety, the physician was referred by the medical board to CPEP to assess readiness to resume practice.

Summary

A physician's health and clinical competence are inextricably intertwined. The work of the clinical competence program and the physician health program are complementary. Collaboration of these two types of organizations is essential to optimize the quality of service provided to physicians while also protecting patient safety.

—*Sarah Early, PsyD, Executive Director, CPHP; and Elizabeth S. Grace, MD, Medical Director CPEP*

PROFESSIONAL IMPAIRMENT: LICENSURE AND DISABILITY INSURANCE

Mark F. Seltzer, Esq., presented the poster, “Professional Impairment: Licensure and Disability Insurance Issues,” designed to help guide monitors and practitioners. This presentation focused on the complex interaction between factual disability that is a result of injury or sickness — often with a psychiatric and/or addiction component — and the frequently concurrent legal issues a medical professional faces regarding their license to practice. Disability policies require that an insured physician establish that he or she is “factually disabled” and receiving appropriate care in order to be entitled to total or residual/partial benefits. On the other hand, state boards of medicine require (among other things) that in order to maintain a license, a physician should establish that he or she is “fit to practice” medicine with reasonable skill and safety to patients. While being medically “unfit to practice” from a regulatory standpoint can be consistent with the medical inability to perform the duties of a physician specialty, this is not necessarily the case from a contractual standpoint. Conversely, it is possible to be medically “fit to practice” and simultaneously eligible for benefits. Reconciling these concurrent issues is in reality not only complex but can have debilitating consequences on an insured’s claim. Often an impaired physician will have to choose between pursuing disability benefits, which will provide immediate financial security to allow him or her to obtain the treatment he or she needs, and protecting and maintaining their license to practice medicine.

The aim of this presentation was to educate conference participants on how to satisfy the contractual requirements of a disability insurance policy and maintain a disability claim, to show the role practitioners’ play in helping to protect and restore a license to practice, and to show the interaction between the disability insurance policy and the license to practice. Based in Philadelphia, Mark F. Seltzer & Associates is a nationally recognized disability insurance firm that concentrates in working with addicted and impaired professionals around the country in their disability insurance claims.

—*Mark F. Seltzer, Esq.*

RESIDENT PHYSICIAN HEALTH: THE UNIVERSITY OF ALBERTA’S INNOVATIVE APPROACH TO LEARNER ADVOCACY AND WELLNESS

The University of Alberta’s Faculty of Medicine and Dentistry adopted a unique approach to the struggling learner by creating the Office of Learner Advocacy and

Wellness (LAW). The office is a safe, inclusive, and confidential space designed to ensure that learners are able to achieve their full personal and academic potential. To avoid conflict of interest, and to better maintain learner privacy, the office does not report to the medical education offices in the faculty. It is open to all learners registered with the university and is accessed by approximately 10 percent of postgraduate learners (residents). The poster presentation reviewed the number and types of cases seen.

Key to the office’s success is its ability to advocate for learners in complex and contentious issues while maintaining collaborative relationships with their training programs. It also has a close working relationship with non-university stakeholders including Alberta’s Physician and Family Support Program, the Professional Association of Resident Physicians of Alberta, the Canadian Medical Protective Association, and the College of Physician and Surgeons of Alberta.

Other unique features include undergraduate and postgraduate resources offered in the same office, allowing for increased presence and continuity of case management from medical school to residency. The office also has an in-house psychologist with a special interest in medical learner distress, and it has close ties with other learner resources allowing for coordinated service.

Its focus is one-on-one learner case management. However, program directors and other educators can also access support and advice relating to learners in difficulty. Educational sessions are also offered and widely accessed. Topics include physician health, boundary issues, and professionalism, all with a focus on learner specific issues in these areas.

In summary, the Office of Learner Advocacy and Wellness is a unique model that advocates for and supports medical learners and provides education on related topics. The office strives to aid learners who are struggling and to be a center of excellence promoting health, resilience, and success for all medical learners.

For more information, please contact Dr. Erica Dance at erdance@ualberta.ca or (780) 492-3092.

—*Erica Dance, MD, FRCPC*

POSTER SESSION PRESENTATIONS

THE “MESSAGING” OF A PHYSICIAN HEALTH PROGRAM — A PROACTIVE STANCE OF A PHP IN THE PUBLIC EYE

Taking an active stance in messaging for a Physician Health Program (PHP) is essential in today’s medical

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field. Dr. Sarah R. Early and Ms. Amanda L. Parry described how to recognize when and how public messaging for a PHP may be effective, taught approaches to best fit the needs of specific PHPs, and explained ways to implement easy and cost-effective approaches to ensure clear, accurate, and market-conscious messaging. In the age of inescapable public accountability, transitory and transparent exchanging of information, and wavering support, PHPs can no longer fly “under the radar.” The proactive approach of the Colorado Physician Health Program (CPHP) was described. This included the revitalized public affairs operation of CPHP, development of important foundational aspects, as well as the challenges in creating a positive effective “public image” and the successes of the first year of strategic messaging. CPHP dutifully explored who was the “public” in the realm of PHPs. The program developed constituent-specific information campaigns, communicated its value-driven advantages, and dispelled commonly held myths about CPHP. After 25 years in the Colorado medical community, CPHP still encountered questions about what the program is and what it does. In response, the CPHP public affairs team emphasized the bottom line: PHPs exist to help, support, and facilitate physicians around the country with their health, and many are actively venturing into the realm of actual prevention of physician illness. The authors expressed how the program combated misconceptions, engaged new (and younger) physician populations, and revalued itself throughout the Colorado medical community. In addition, results from a survey revealed the current national PHP messaging efforts, perceptions of these programs in their home communities, and goals of their public relations team. An easy-to-follow flow chart of “messaging for a PHP” was illustrated. Lastly, Dr. Early and Ms. Parry provided the attendees concrete examples of targeted messages that showed healthy physicians and healthy patients. If any FSPHP members would like to have a copy of this poster, please feel free to request at aparry@cphp.org.

—*Sarah R. Early, PsyD, Executive Director; and Amanda L. Parry, MPA, Director of Public Affairs, Colorado Physician Health Program (CPHP)*

THE JOURNEY OF RECOVERY: STAYING ON THE RIGHT ROAD

Chip Abernathy, LPC, MAC, presented a poster presentation entitled “The Journey of Recovery: Staying on the Right Road” at the 2014 FSPHP in Denver. The presentation highlighted the six stages of recovery in Terence Gorski’s developmental model of recovery, high risk factors and trigger events for relapse, and the progression of

warning signs in the relapse process. It was noted that a key component of relapse prevention is understanding that the warning signs of relapse develop on an unconscious level, and that you will not know they are occurring unless you learn to bring the warning signs into conscious awareness.

Central to the presentation was a compare/contrast of the relapse-prone and the recovery-prone styles of coping with stuck points in the recovery process. Another significant aspect of the presentation was a look at recent membership surveys, conducted by Alcoholics Anonymous and Narcotics Anonymous, which demonstrated evidence of the long-term effectiveness of these programs in facilitating sustainable recovery from addiction. It was postulated that the combination of addiction treatment and 12-step program participation provides an excellent road to successful recovery. The presentation suggested that including relapse prevention as part of treatment may help reduce relapse rates and enhance successful treatment outcomes. This poster presentation concluded that with a desire to stop using, awareness of relapse warning signs, and application of the recovery-prone style of coping with stuck points, an individual can stop the relapse and return to stable recovery. —*Chip Abernathy, LPC, MAC*

FRIDAY, APRIL 25, 2014

ENHANCING THE FUNDING OF YOUR PHP

State Physician Health Programs (PHPs) are critically important in maintaining and improving the health of physicians who suffer from a variety of serious health conditions, including but not limited to the following: substance use disorders, mental disorders, occupational health problems (disruptive behavior), neurocognitive disorders, and stress disorders and burnout. Unfortunately, PHPs are underfunded to an extreme degree, accounting for approximately .002% of health care spending.

PHPs provide “intensive care” remediation to physicians whose lives and careers are unraveling because of their unaddressed health challenges. Poor self-care, time bankruptcy, and the “Superman/Superwoman syndrome” all contribute to the phenomenon of doctors who are putting their patients and their livelihoods ahead of their own health.

It is imperative that PHPs enhance their funding in order to meet the growing health needs of medical professionals. PHPs need to re-envision themselves as “businesses with a soul.” Without margin, there is no mission. The time to act is now. Underfunded PHPs need to be stabilized and once stabilized they need to grow. Insufficient funding is only part of the problem. PHPs need to

incorporate a new can-do, “growth mindset” to replace a fixed mindset that assumes chronic underfunding.

Enhancing a PHP’s funding should be undertaken by a responsible individual who is comfortable with spreadsheets, business, fundraising, and development. It takes some amount of investment in order to grow a PHP’s funding stream. The responsible individual needs to create organizational alignment at every level of the physician health enterprise, including the board, senior leadership, and staff.

The individual responsible for enhancing the funding of the PHP should be ethical, flexible, focused, opportunistic, and patient. He or she should develop skill at identifying and developing a variety of funding leads. PHP funding methodologies include fees to individuals; organizational subsidies; capitation-type fees, donations, or memberships from stakeholder institutions; charitable giving; and grants.

A survey of 29 physician health programs indicated the following current funding profiles:

In which state/province is your PHP located?
24 States; D.C.; 3 Provinces; the Netherlands

How many health professionals in your state have access to your PHP?
29K (300–100,000)

Approximately what percentage of health professionals who have access to your PHP are physicians?
74% (6%–100%)

What is the total number of health professionals who could be considered clients in a typical year?
327 (20–1470) – 327/29K = 1.13% penetration



Steven Adelman, MD

What is the total number of physicians who could be considered clients in a typical year?

253 (15–1350)

What is the most recent yearly expense budget of your PHP?

**\$24M/29 programs = \$816K (\$54K–\$5M)
 \$2,500/case; \$28 per professional in pool**

In your PHP’s most recent budget, what was your program’s total “above the line” revenue from all sources?

Operating Margins range from –12% to +20%

Do you have a staff member dedicated to fundraising/development/funding?

YES — 6

NO — 23

How adequate is your PHP’s funding?

VERY WELL-FUNDED — 1

WELL-FUNDED — 3

ADEQUATELY FUNDED — 10

INADEQUATELY FUNDED — 15

PHP funding sources break down as follows:

FUNDING SOURCE	% (range)	# of PHPs > 0
Licensing Board	45% (0–100%)	20
Client Fees	19% (0–100%)	15
Hospitals	7.8% (0–40%)	15
Medical Society	6.6% (0–85%)	9
Legislature	6.3% (0–73%)	3
Medical Staff Org.	5.3% (0–25%)	9
Malpractice Carrier	4.3% (0–27%)	9
Endowment Income	2.9% (0–40%)	4
Family Foundations	1.4% (0–30%)	1
Fundraisers	1.4% (0–50%)	5
PHP Grads	1.4% (0–10%)	8
Individual Nonphysicians	1.3% (0–18%)	4
Physicians (not grads)	1% (0–7%)	9
Health Plans	0.8% (0–15%)	2
Specialty Societies	0.7% (0–10%)	3
Programming	0.3% (0–2%)	5
Grants	0.1% (0–1%)	3
Employer	0.1% (0–2%)	2
Ambulatory Systems	0%	0
TOTAL	105%	

In summary, PHPs tend to be underfunded, and they utilize a wide range of funding sources. It is important to focus on the finances of PHPs in these challenging times, and new strategies and initiatives may need to be embraced in order to inspire the large and well-endowed health care industry to provide sufficient funding for physician health and well-being. —Steven Adelman, MD

CLIENTS SPEAK: RESULTS FROM THE COLORADO PHP PROGRAM EVALUATION

The implementation of program evaluations can be powerful tools for understanding and improving an organization's services. Program evaluations help to establish whether specific areas work, why they work, and what needs improvement. In addition, evaluations help demonstrate program effectiveness to funders and better manage scarce resources. To understand the impact of participation from the clients' perspective, the Colorado Physician Health Program (CPHP) surveyed current and former participants between 2012 and 2013. We examined program effectiveness in terms of satisfaction, competency and risk indicators, prevention and recovery, and general recommendations for improvement. Characteristically, respondents looked similar to the general CPHP clientele. Most presented with general mental health, substance use, and stress concerns.

Overwhelmingly, respondents reported high satisfaction and most said that they would return to the program, if necessary. Satisfaction with specific CPHP services (e.g., monitoring agreements) and personnel (e.g., clinicians) were rated highly. Many individuals reported that their participation with the organization helped them to make improvements in their professional and personal life. The majority of clients utilized external services (e.g., therapy, self-help groups, spiritual practice) in addition to CPHP assistance. At the time this survey was conducted, a substantial number (44%) of former clients continued to use external supports.

Competency and risk indicators assessed the respondent's belief about how their personal condition affected patient care, the prevalence of practice limitations and malpractice claims, and other factors that could negatively affect practice. A little over a third of respondents reported that their conditions affected their competency at work. Stress/burnout and depression/mood disorders had the greatest impact on a clients' ability to practice. Eighteen percent of respondents said they put patients at risk because of their presenting problems. Again, stress/burnout and depression/mood disorders topped this list, in addition to substance use. Nearly a quarter of respondents had a complaint filed with their medical board, with most complaints occurring prior to their involvement with CPHP. A high percentage of respondents admitted to suicidal ideation or attempts.

Nearly half of respondents believed that their presenting issues could have been recognized earlier. Fifty-five (55) percent said that they exhibited clues such as mood changes, increased comments about stress/burnout, or behavioral changes (e.g., irritability, verbal outbursts).

Respondents were less able to identify factors that could help them prevent their problem, but they rated "increased awareness of workplace stressors" and "emphasizing identifying risk factors during professional training" highest.

Finally, respondents provided a number of program recommendations. Comments included the need for these:

- Increased advocacy to remove licensing conditions for timely resolution of clinical practice
- Standard counseling about coping with a lawsuit
- Clearly conveying information about board interactions and privacy limitations
- Expanded services and more frequent appointments

In sum, the program evaluation documented high client satisfaction, the positive impact of CPHP in client's personal life and professional practice, and the value of using external supports. Further examination of various competency and risk indicators is warranted. Clients emphasized the importance of conveying information about board interactions and privacy concerns. Areas for improvement include expanding the types of services and frequency of appointments.

—*Elizabeth Brooks, PhD, Principal Researcher, CPHP; Sarah R. Early, PsyD, Executive Director, CPHP; and Michael H. Gendel, MD, Medical Director Emeritus, CPHP*

SATURDAY, APRIL 26, 2014

FSPHP AND FSMB JOINT SESSION

General Topics in Physician Health: "From Burnout to Marijuana"

Drs. Doris Gundersen, Warren Pendergast, and Mick Oreskovich participated in a panel presentation at the Federation of State Medical Board Annual Meeting in Denver, Colorado, on April 26, 2014.

Dr. Mick Oreskovich presented extensive evidence for his hypothesis that burnout is a precursor for substance use disorders and that it can be prevented. He presented data from 33 studies performed by a coalition of investigators from the Mayo Clinic, the American College of Surgeons, the American Medical Association, and the University of Washington. He demonstrated that burnout is a pervasive problem among all specialties and that there is a highly statistically and significant association of burnout with depression, thoughts of suicide, work-life imbalance, substance use disorders, and medical errors. Data

presented that demonstrated burnout is a much more pervasive problem among physicians than among their counterparts in other professions. He presented data from a study using an online individualized interactive intervention to prevent burnout and promote personal well-being among American surgeons. Finally, he described the Mayo Clinic Physician Well-being Index, which is readily available for online self-assessment.

Dr. Pendergast provided an overview of PHP operational principles and functions, including assessment, referral, monitoring, and advocacy/compliance documentation. He reviewed the various referral types, and the governance structures of PHPs. The fact that PHPs assess, refer, and monitor other types of professionals (e.g. PAs, veterinarians, nurses, and pharmacists) was highlighted, and the different funding sources for PHPs were covered. Lastly, he discussed the need for balance in addressing both patient safety requirements as well as the needs of individual licensee/patients.

Dr. Gundersen's focus was on the recent legalization of marijuana in the state of Colorado and how the Colorado Physician Health Program (CPHP) worked in concert with the Colorado Medical Board (CMB) and Attorney General's Office to develop policy in an uncharted area of medicine and law. Specifically, Dr. Gundersen described unintended consequences of the passage of Amendment 20, an amendment to the state's constitution allowing marijuana to be legalized for medicinal purposes for certain debilitating conditions. Whereas conditions such as HIV/AIDs, seizures, and cachexia accounted for only 1 to 2% of all cards issued, severe pain was identified as a qualifying condition in 94% of all cases. Over the course of two years, it was apparent that many applicants for medical marijuana cards were relatively young males, concentrated in the metro Denver area; they were presenting with severe pain, a highly subjective qualifying condition. It became obvious that marijuana was being obtained under the auspices of a debilitating condition for the purpose of recreational use. Dr. Gundersen noted that only a small number (7%) of physicians in the state were making the majority of recommendations for medical marijuana. In fact, only five doctors accounted for 50% of the recommendations made. In 2010, Senate Bill 109 was passed, tightening up regulations for physicians making recommendations for the use of medical marijuana. The bill required physicians to establish a bona fide treatment relationship with any patient issued a marijuana card (i.e., keep a medical record, assess the patient in follow up, confer with other treatment providers) and also excluded physicians with restricted medical or DEA licensure.

Dr. Gundersen discussed a collaborative process that occurred between CPHP and the CMB to address the



Warren Pendergast, MD, FSPHP Immediate Past President

issue of physicians using marijuana for medicinal purposes. CPHP educated members of the regulatory agency about the cognitive impairment associated with the use of marijuana and the inability to correlate blood or urine testing with impairment. For these reasons, CPHP created a policy stating that physicians suffering from a debilitating condition requiring treatment with marijuana will be considered unsafe to practice medicine with reasonable skill and safety.

Finally, Dr. Gundersen spoke about the successful passage of Amendment 64, a ballot initiative to legalize marijuana for general use. She noted any physician in Colorado testing positive for marijuana would undergo a comprehensive evaluation to rule in or rule out a substance use disorder. She noted that even in the absence of a formal diagnosis, physicians with detectable serum tetrahydrocannabinol (THC) would be asked to cease practicing until their serum was clear of this metabolite of marijuana. She ended her presentation by noting that approving medical treatments by ballot initiatives and state legislative actions set a dangerous precedent for public health. Dr. Gundersen also noted that since marijuana became legal in Colorado for recreational purposes, citations for driving under the influence of marijuana had increased as well as emergency room visits for bad reactions to potent forms of cannabis. She described two recent deaths in the state directly related to the consumption of edibles containing THC. She encouraged other states to follow developments in those states where marijuana has been legalized and learn from the rules and regulations being adopted.

—*Doris C. Gundersen, MD; Mick Oreskovich, MD; and Warren Pendergast, MD*



**P. Bradley Hall, MD, FSPHP President Elect; and
Michael Wilkerson, MD, Bradford Health Services**



**Warren Pendergast, MD, North Carolina Physician Health Program,
and Jon Thomas, MD, MBA, FSMB President**



Steve Millette, CeDAR/University of Colorado Hospital



Robert Albury Jr., Cumberland Heights Foundation



Betsy Mitchell, Laboratory Corporation of America Holdings



Trish Beck and David Perini, Laboratory Corporation of America Holdings



Lynn Hankes, MD, and Mick Oreskovich, MD



Cathy Stratton; Amy Tardy, PhD; and Linda Albert



Michael H. Gendel, MD, Colorado Physician Health Program



John Ordiway, MS, LPC, LAT; and
Candice Cochran, Wyoming Professionals Assistance Program, Inc.



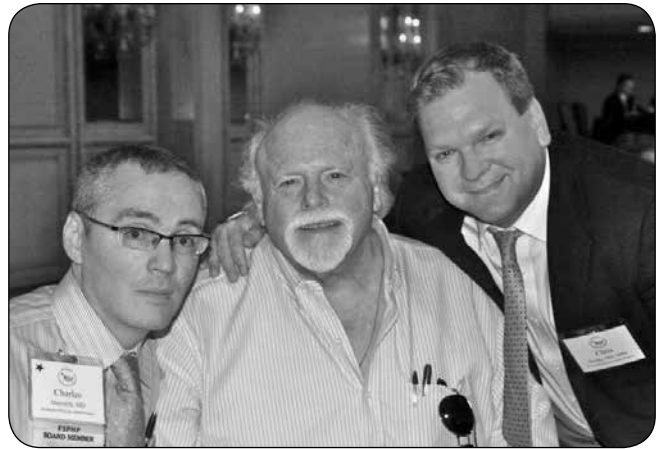
Jane and Jonathan Dougherty



Joy Albuquerque, MD, Physician Health Program,
Ontario Medical Association



Mel Pohl, MD, Las Vegas Recovery Center



Charles Meredith, MD; Scott Alberti; and Chris Bundy, MD, MPH,
Washington Physicians Health Program

SAVE THE DATE

FRIDAY, APRIL 24, 2015 — MONDAY, APRIL 27, 2015



Federation of State Physician Health Programs Annual Education Conference and Business Meeting Pursuing Physician Health Best Practices: Promotion of Accountability, Consistency and Excellence

THE WORTHINGTON RENAISSANCE FORT WORTH HOTEL
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Highlights

- General and breakout sessions each day to highlight physician health best practices for achieving accountability, consistency, and excellence
- Networking Opportunities
- Daily Peers Support Groups
- Large exhibitor space for networking in the field

Tentative Schedule Subject to Change

FRIDAY

- Board of Directors Meeting
- Registration/Exhibitors Open
- Luncheon General Sessions
- Committee Meetings
- Opening Reception

SATURDAY

- FSPHP/FSMB Joint Session
- New Member Meeting
- General Sessions
- Poster Session
- Board and Committee Chair Dinner

SUNDAY

- Administrator Topic Meeting
- General Sessions
- FSPHP Regional Meetings
- Exhibitor Session
- Annual Business Meeting

MONDAY

- General Sessions
- Adjournment

Further Details to Come...

FSPHP | 860 Winter Street Waltham, MA 02451 | Phone: (781) 434-7343 | Fax: (781) 464-4802 | Email: dbrennan@mms.org

PHYSICIAN HEALTH NEWS

The FSPHP produces a newsletter twice a year in March/April and again in July/August which is sent to all state programs, medical societies, and licensing boards. The Federation of State Physician Health Program requests articles (500 words or less) and other related information be submitted for inclusion in the FSPHP Newsletter.

SUBMISSIONS FOR NEWSLETTER:

By January 30 for the spring issue

By May 31 for the summer issue

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

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

Items that you may want to consider include:

- Important updates regarding your state program

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

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

Also, information is sent to all prospective advertisers regarding the availability of space to advertise services relevant to physician health programs. Please do not hesitate to call me at (781) 434-7342, or other members of the committee, if you should have any questions.

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 twice yearly. 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.

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.

The spring issue each year offers an advertising section.

We look forward to working with you in future editions.

FSPHP Publication Committee

Linda Bresnahan, MS (MA)	Linda Kuhn (TX)
Paul Earley, MD (AL)	Charles Meredith, MD (WA)
Sarah Early, PsyD (CO)	Warren Pendergast, MD (NC)
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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



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PHYSICIAN HEALTH AND OTHER RELATED ORGANIZATIONS NATIONAL MEETINGS

FSPHP Annual Meetings

April 24–27, 2015
Worthington Renaissance Fort
Worth Hotel
Fort Worth, TX

April 27–30, 2016
Manchester Grand Hyatt San Diego
San Diego, CA

FSMB Annual Meetings

April 23–25, 2015
Omni Fort Worth Hotel
Fort Worth, TX

April 28–30, 2016
Manchester Grand Hyatt San Diego
San Diego, CA

2014 AMA-CMA-BMA International Conference on Physician Health

Sept. 15–17, 2014
BMA House, Tavistock Square
London, UK

American Academy of Addiction Psychiatry Annual Meeting and Symposium

December 5–7, 2014
Turnberry Isle Hotel Miami
Aventura, FL

AMA House of Delegates Annual Meeting

June 6–10, 2015
Hyatt Regency Chicago
Chicago, IL

AMA House of Delegates Interim Meeting

November 8–11, 2014
Hilton Anatole
Dallas, TX

November 14–17, 2015
Atlanta Marriott Marquis
Atlanta, GA

American Psychiatric Association Annual Meeting

May 16–20, 2015
Toronto, Canada

American Society of Addiction Medicine 46th Annual Medical-Scientific Conference

April 23–26, 2015
Hilton Austin
Austin, TX

International Doctors in Alcoholics Anonymous (IDAA) Annual Meeting

July 30–August 3, 2014
JW Marriott Desert Springs
Resort and Spa
Palm Desert, CA

Northeast FSPHP Membership Meeting

October 10, 2014
Portland, ME

FSPHP Western Region Meeting In Conjunction with CSAM Review Course

September 3, 2014
Anaheim, CA