

PHYSICIAN HEALTH NEWS

The Official Newsletter of the Federation of State Physician Health Programs



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

Physician Health News is the official newsletter of the Federation of State Physician Health Programs (FSPHP) and is published by the FSPHP, with production and printing assistance from the Massachusetts Medical Society.

PUBLICATIONS COMMITTEE

Linda Bresnahan, MS (MA)
Sarah Early, Psy.D. (CO)
Scott Hambleton, MD (MS)
Carole Hoffman, PhD, LCSW, CAADC (IL)
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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, please contact Debbie Brennan.

FSPHP CONTACT INFORMATION AND MAILING ADDRESS

Debbie Brennan
FSPHP
860 Winter Street
Waltham, MA 02451-1414
Telephone: (781) 434-7343
Fax: (781) 464-4802
Email: dbrennan@mms.org
Website: www.fsphp.org

Jonathan H. Dougherty, MS, Executive Director
Federation of State Physician Health Programs, Inc.
Telephone: (518) 439-0626; Email: doughj@albmed.org

Your participation in the submission of material for future issues is vital. Please send your contributions, comments, news, and updates to:

Linda Bresnahan, MS
Physician Health Services, Inc.
Massachusetts Medical Society
860 Winter Street, Waltham, MA 02451-1414
Phone: (800) 322-2303, ext. 7342
Fax: (781) 893-5321; Email: lbresnahan@mms.org

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MESSAGE FROM THE PRESIDENT

"It is the age of foolishness, it is the age of wisdom... it is the winter of despair; it is the spring of hope"

— Charles Dickens,
A Tale of Two Cities



Warren Pendergast, MD

It has been my great privilege to serve as your FSPHP President for the last two years. Together, we have accomplished a number of great things, and have set more in motion. I'd like to highlight one of FSPHP's primary areas of work over the last year.

Specifically, your Federation has been in dialogue with the American Board of Medical Specialties (ABMS) throughout 2013 and early 2014. In February 2014, Doris Gundersen, Brad Hall, and I met with representatives of the 24 member-specialty boards that make up the ABMS. Our goal will be to further educate the boards about how our PHP members work with physicians and other professionals. We will seek to learn from the boards what their current approach is to licensees who have lost certification, and how PHPs can best help participants keep or regain their certification as they regain medical licensure and other credentials.

The ABMS is currently reviewing its Maintenance of Certification (MOC) process, and this is expected to result in

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implementation of new Standards for the ABMS Program for MOC in January 2015. The section of the Standards that most directly applies to PHP participants who have lost licensure is the first: *Professional Standing and Professionalism*. Specifically, the proposed standards encourage member boards to “establish and maintain a process that gives former diplomats an opportunity to regain Board Certification.” In other words, the standard proposes a **consistent pathway** for our participants to regain their Board certification. If adopted by the ABMS, this will represent a **huge** step forward for our participants.

It seems likely that the ABMS member boards will in turn want some degree of consistency from FSPHP members with respect to PHP compliance and advocacy letters. At our fall FSPHP Board of Directors meeting in Chicago, we encouraged ABMS representatives to think of our recovering participants as “sick” rather than “bad.” Along those lines, we will need to build credibility and trust as to what it means when a PHP states in a letter that a participant has demonstrated a return to good health and is no longer “sick.” We are also in discussions with the ABMS about the possibility of including physician health and self-care modules as part of the educational offerings by specialty boards.

This represents an incredible opportunity for FSPHP, for PHPs, and especially for our participants. I’m very excited about these developments; we’ll continue to keep FSPHP members abreast of happenings as we move forward with the ABMS.

— *Warren Pendergast, MD*

MESSAGE FROM THE EXECUTIVE DIRECTOR

There is a Leader Amongst Us

Sir Arthur Conan Doyle bestowed upon his hero, one Sherlock Holmes, a gift of uncompromising aptitude when it came to solving crimes. Even the characters within the novels themselves would marvel at his accomplishments, as noted in the story, *The Valley of Fear*, whereby it was said “Mediocrity knows nothing higher than itself, but talent instantly recognizes genius.”

What person is not in awe in the presence of greatness? To think what it would have been like to be in the garage with Steve Jobs, Steve Wozniak, and Ronald Wayne when they slapped together the first Apple computer. Or, to see Tom Clancy sit at his desk in 1982 to begin writing his first blockbuster novel, *The Hunt for Red October*. In real



Jonathan H. Dougherty, MS

time we can enjoy the fruits of their efforts and marvel at their tremendous abilities. Still, to be at the beginning of something great and to watch it grow is a gift to savor!

Each leader of the FSPHP has added their light to the sum of light in building such a tremendous organization. Yet, the Federation of 2014 is an evolved entity. There is a buzz out there. You hear it from the American Board of Medical Specialties (ABMS). You hear it from the Federation of State Medical Boards (FSMB). People who were generally regarded as individuals who might never understand physician health are now taking another look. Minds are slowly changing. Yes, there are many miles left to go but you can feel it.

Warren Pendergast, MD, wanted to make a difference when he took the helm of the presidency. He has meticulously followed the strategic plan and we are seeing the dividends. With his stewardship and the contributions of the FSPHP leadership and volunteers we have a reentry plan from the FSMB and a growing dialogue with the ABMS that, at least at the moment, has its leaders showing signs of understanding that the recertification of physicians reentering practice is fair and essential. And then there are the new member categories that will extend our family and bring in more individuals and organizations into the physician health conversation. These accomplishments were tenaciously pursued to their successful conclusions by Dr. Pendergast.

At the annual business meeting in Denver, Colorado, Dr. Doris Gundersen will add her ever-proficient abilities to the role of FSPHP President. She has already expressed her desire to continue the forward momentum that the FSPHP has enjoyed. This excites me. What wonders await us in the next two years?! Then I think of Sir Winston Churchill when he said, “Every day you may make progress. Every step may be fruitful. Yet there will stretch out before you an ever-lengthening, ever-ascending, ever-improving path. You know you will never get to the end of the journey. But this, so far from discouraging, only adds to the joy and glory of the climb.”

May you enjoy the view, Dr. Gundersen!

— *Jonathan H. Dougherty, MS*

NEW MEMBERSHIP CATEGORIES LAUNCHED

The dawning of the 2014 membership season saw the introduction of two new membership categories that had been approved by the membership during the annual business meeting in Cambridge, Massachusetts, last April. Now individuals and organizations affiliated with PHPs can enjoy limited, nonvoting membership benefits.

As stated in the bylaws, these membership categories are open to individuals (organizations) who are engaged in the education, intervention, research, peer assistance, care and treatment of physicians and/or other health care professionals with potentially impairing illness in a hospital, office, or other clinical/non-clinical setting. These categories are also open to compensated and/or non-compensated staff and oversight board or committee members of an FSPHP Organizational Member in good standing. In order to qualify for membership, applicants shall:

- 1. Attest in writing that he or she is not in conflict or competition with a state or international physician health program and that he or she supports the mission and goals of the FSPHP.**
- 2. Be sponsored for membership by a recognized state or international physician health program and shall be approved by a majority of the membership committee and two-thirds of the Board of Directors.**

Members of state licensing or disciplinary agencies are not eligible for individual membership. This is not intended to exclude alternative to discipline programs that are operated and/or overseen by the state licensing or disciplinary agency.

Individual and organizational memberships are not intended to include representatives, compensated or non-compensated staff, or oversight board or committee members of treatment facilities. No individual member can vote, attend FSPHP business meetings, hold elective office, chair committees, or represent the Federation in any venue. Individual and organizational members may be appointed to lead or chair a taskforce or act as a fully participating committee member, including ad-hoc committees appointed by the president dependent upon expertise and areas of interest. The use of Federation membership to promote a treatment facility, drug testing company, or other organization, or for financial self-interest shall be grounds for removal of membership privileges at the sole discretion of the Federation Board of Directors.

The leadership of the FSPHP and the members of the Membership Committee encourage everyone to reach out to individuals and organizations that you may be familiar with and who will benefit from having Federation membership. Template invitation letters and applications are available for your use from the FSPHP headquarters.

— *Jonathan H. Dougherty, MS*

FSPHP WELCOMES THE FOLLOWING NEW MEMBERS TO OUR ORGANIZATION

Joe Baillie
Clinical Case Manager
Physician Health Program, Medical Society of the
District of Columbia

Laura Berg
Senior Case Manager
Maryland Physician Health Program

Gary Chinman, MD
Associate Director
Physician Health Services, Inc. (Massachusetts)

Tish Conwell
Chief Administrative Officer
Professionals Resource Network, Inc. (Florida)

Olga Gay
PHP Coordinator
Kansas Medical Society Medical Advocacy Program

Rick Horak, MA, CDP
Clinical Coordinator
Washington Physician Health Program

Ms. Sarah Hutchinson
Chief Information Officer and Executive Director,
Engagement and Program Delivery
Ontario Medical Association

Gregg H. Olsen, MD
Associate Medical Director
Colorado Physician Health Program

Vince Parrish, LCSW
Development Director
Tennessee Medical Foundation — Physician Health
Program

John Reilly, MD
Vice Chairman
Physician Health Program, Medical Society of the
District of Columbia

Ruthann Rizzi, MD
Associate Director
Physician Health Services, Inc. (Massachusetts)

Katie Stuart
Compliance Monitor
Idaho Physicians Recovery Network

Laura VanCleve
Co-Chair
Iowa Board of Medicine
Iowa Physician Health Committee

continued on next page

New Members *continued*

Amy VanMaanen
Case Manager
Iowa Board of Medicine
Iowa Physician Health Committee

Mark Walter, MD
Medical Director
Wyoming Professional Assistance Program

COLORADO PHYSICIAN HEALTH PROGRAM (CPHP) WELCOMES NEW ASSOCIATE MEDICAL DIRECTOR

CPHP is thrilled to welcome a new Associate Medical Director to our program. Gregg H. Olsen, MD, joined CPHP in September 2013. Dr. Olsen specializes in adult and adolescent psychiatry and maintains a private practice in the neighboring town of Boulder, Colorado. After receiving his medical degree from the Medical College of Wisconsin, Dr. Olsen completed his Internship and Residency at the University of Colorado at Denver Department of General Psychiatry in 1995. With great connections to the Colorado medical community, including membership in the Colorado Psychiatric Association as well as many health, well-being, and physician advisory boards, Dr. Olsen is a wonderful fit with the CPHP team. CPHP prides itself on a team-based clinical approach that utilizes the individualized expertise of all our talented psychiatrists and clinicians and looks forward to Gregg Olsen's contributions to the field of physician health.

ILLINOIS PROFESSIONALS HEALTH PROGRAM WELCOMES NEW CASE MANAGER

Terry Lavery is a new case manager with the Illinois Professional Health Program and new to the FSPHP. He is a Licensed Clinical Professional Counselor (LCPC) and his caseload consists of physicians, nurses, and pharmacists. Before coming to the Illinois Professionals Health Program, he worked as a clinical case manager for the Elmhurst P.A.R.T.S. program for 11 years. His other previous experience includes working with children and adolescents in psychiatry and special education, as well as developing art therapy programs.

— *Carole Hoffman, PhD, LCSW, CAADC
Manager, Case Management Services
Illinois Professionals Health Program*

THE AGING PHYSICIAN

“And yet the wiser mind mourns less for what age takes away than what it leaves behind.”

This quote was taken from William Wordsworth's examination of mortality in his “Matthew” poems. This complex and vaguely contradictory prose is a fair metaphor for the difficulties inherent in the consideration of aging in the physician population.

A national census of actively licensed physicians found that 23 percent are 60 years of age or above. This number will grow rapidly with the graying of the baby boomer population. Additionally, physicians, like the rest of the population, are living longer. Along with the personal identity and professional satisfaction associated with practicing medicine, practical considerations influence the length of a physician's career. For example, 52 percent of physicians changed their retirement plans in response to the recent and protracted economic recession.

Aging is associated with an increased risk for developing a number of conditions that can affect cognition such as dementia, stroke, diabetes, and cardiovascular disease. Sensory and motor impairment occur with macular degeneration, orthopedic injury, and hearing loss, as well as general neurodegenerative processes. Older people are more vulnerable to the cognitive and systemic effects of acute illnesses such as infections.

The wisdom that accompanies experience is invaluable. Older physicians generally maintain the body of their medical knowledge. Decades of experience allow them to draw on thousands more patient experiences than younger physicians who have recently completed training. It is important to appreciate the difference between crystallized and fluid cognitive ability when assessing an aging physician. Crystallized cognitive ability is associated with learned and acculturated knowledge. In contrast, fluid cognitive ability involves novel or abstract problem solving. With normal aging, it is common to lose some fluid cognitive ability while crystallized cognitive ability is preserved. For this reason, an older physician may function impressively well, performing familiar procedures including complex ones. However, deficits in fluid ability may manifest when the same physician is presented a new task or one that is complicated by urgent and competing demands occurring simultaneously. For this reason, mixed age practices are ideal.

A physician's ability to deliver competent medical care can generally be determined by colleagues who work closely with the physician. However for an older physician with a smaller panel of patients who is not involved in the cross coverage of colleagues' patients, detecting cognitive impairment (which often develops insidiously)

may be delayed. Solo practice and/or working in more isolated (rural) areas can further complicate the detection of incipient health problems.

Understandably, physicians who witness the cognitive decline of an elderly colleague may hesitate to intervene, related to sympathy for that individual and/or a wish to preserve the physician's integrity. Importantly, confronting a physician who has demonstrated lapses in performance is not easy. The initial effort may be met with strong denial and resistance. For this reason, dismissing the lapses in ability or even compensating for the physician's decline are common actions taken by concerned colleagues and other members of a medical team. A 2010 *JAMA* article represented that one-third of physicians who had known a colleague was impaired (for any cause) failed to report their concerns.

Numerous studies reveal that advancing age is associated with an increased rate of discipline among physicians. However, it is unclear whether the correlation is related to the risks for complications/complaints inherent in having treated a large volume of patients over an extended period of time or age-related decline — cognitive or otherwise. Additionally, as physicians age, at least in most specialties, so do their long-term patients. Older patients tend to have multiple medical problems that are more complex — heightening the risk of error — relative to a younger demographic of patients.

Concerns regarding competency often uncover underlying cognitive disorders. A study of 267 physicians referred to a doctor-assessment center found that 24 percent of them showed some degree of cognitive difficulty requiring further neuropsychological evaluation. In contrast, a control group of 68 physicians undergoing the same cognitive screening showed no cognitive impairment. Cognitive deficits should be considered in those physicians who fail to remediate despite good effort.

Physicians belong to a safety-sensitive profession. Like pilots, physicians require similar sensory and motor skills coupled with the ability to make rapid decisions in stressful situations. The Federal Aviation Administration requires pilots to undergo medical and cognitive screening at 40 years of age and mandates retirement at 65 years of age. Air traffic controllers must step down by 55 years of age. No such mandates exist for physicians, or Supreme Court Justices for that matter! However, there is a growing trend among hospitals to pursue cognitive screening in the course of credentialing doctors over 65 years of age.

An abundance of cognitive screening instruments are available to assess basic cognitive abilities. These include the Folstein Mini-Mental Status Exam, the Montreal Cognitive Assessment, the MiniCog, and computerized

screening such as the MicroCog. However, many of the screens available (with the exception of the MicroCog) are normed for high school graduates, not physicians with baseline high intelligence in addition to 23 years of age or more of education and training. For this reason, a physician typically has more cognitive reserve relative to others. Subtle deficits may escape detection with most screens, which lack sensitivity and specificity. Other factors may confound screening results, including the expected anxiety associated with this degree of scrutiny and potential negative implications of abnormal findings. Because most cognitive disorders progress insidiously, the affected physician and his/her colleagues may not recognize deficits until they are severe and impairing.

If significant deficits are detected on a screening examination, physicians are typically referred for more comprehensive neuropsychological testing that can provide more sensitive and specific information concerning the physician's strengths and weaknesses. Importantly, reversible causes for the deficits such as obstructive sleep apnea, hypothyroidism, or B12 deficiency, to name a few, must be ruled out. Mild Cognitive Impairment (MCI) is a condition characterized by cognitive abnormalities that do not meet the full criteria to establish a diagnosis of dementia. Physicians meeting criteria for MCI may be allowed to work with certain accommodations. However, the physician would also require ongoing health monitoring due to the high likelihood of MCI progressing to full dementia. Eighty (80) percent of individuals with MCI develop dementia over a period of six years.

Medical boards, certifying bodies such as the American Board of Medical Specialties, and other credentialing entities, are beginning to explore ways to incorporate health screening into the process of maintaining licensure and demonstrating competency beyond successful performance on recertification examinations. Eventually, some health screening is likely to be required of physicians in line with other safety sensitive professions. Rather than identifying impairment through patient-driven complaints (i.e., after harm has likely occurred and when physician discipline is likely to result), a proactive confidential process should be developed to allow for the early detection of cognitive illness, expedient treatment, as well as a thoughtful fitness-for-duty evaluation. In the end, competent practice rather than age-adjusted performance needs to be the standard maintained.

A collaborative effort between cognitive specialists, physician health programs, medical boards, and certifying boards will be required to develop a thoughtful process for assuring public safety without imposing unnecessary or discriminatory restrictions on older physicians. Physicians with decades of experience and contribution deserve the same sensitivity and respect afforded their

patients as they experience health changes that may or may not allow continued clinical practice.

— **Scott Humphreys, MD,**
Associate Medical Director, CPHP

— **Doris C. Gundersen, MD, Medical Director, CPHP**

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WEST VIRGINIA MEDICAL PROFESSIONALS HEALTH PROGRAM

Making a Difference in the Lives of West Virginians

The West Virginia Medical Professionals Health Program (WVMPHP) has been operational for over six years. The WVMPHP continues to be the only physician health program designated by both Allopathic and Osteopathic Boards of Medicine. The WVMPHP recently renewed agreements with both licensure boards extending the previous two-year term agreements to five years. The WVMPHP has provided 85 educational lectures for an excess of 5,600 or more physicians and other licensed professionals since its inception.

Current support staff includes Marlene Hall, Administrator; Linda Allman, Senior Case Manager; Linda Greynolds, Compliance Monitor; and our most recent hire, Sherry Bailey, Case Manager. We welcomed Sherry to the team, February 3, 2014.

To-date, there have been 138 signed participants of whom 74 continue under active agreements impacting an excess of 30 hospitals/medical schools and many other group practices. Thirty-four (34) percent of signed participants were referred by their licensure board formally through consent order or informally through anonymous contact. Of those who have completed treatment and are under contract, resumed working, licensed, and practicing medicine safely, 89 percent have remained abstinent. The WVMPHP participants represent 18 specialties and students/residents thereof. Of the 74 under current monitoring agreements, 63 (85%) have continued their education and/or are licensed and working. Forty-three (43) of the 138 (31%) had previous issues and recurrence of their chronic medical condition further supporting the need of our physician health program and long-term guidance, assistance, and monitoring. West Virginia has created a safe-system for the ill health care professional utilizing the underlying principles of communication, collaboration, transparency, and accountability to the benefit of physicians and the public we serve.

The WVMPHP has served West Virginia beyond services to physicians, podiatrists, and physician assistants. We have a direct involvement in the Governor's Advisory Council on Substance Abuse (GACSA), providing input to legislation (Senate Bill 437, March 29, 2012) and the fulfilling of the legislative requirements. The senate bill takes various actions, including but not limited to, enhanced regulation to prevent doctor-shopping and increase accountability for those prescribing and dispensing prescription drugs. Recommendations by the council included monitoring and enforcement of options to prevent doctor-shopping and increasing accountability related to prescribing and dispensing prescription drugs. The WVMPHP continues to be actively involved in the implementation process. The WVMPHP also collaborates with other areas of organized medicine (and outside of medicine) within the state, providing assistance and guidance in a multitude of ways.

In September 2013, the WVMPHP partnering with the WV State Medical Association, WV Society of Addiction Medicine, WV Osteopathic Medical Association, both Allopathic and Osteopathic Licensure Boards, and the Bureau for Behavioral Health and Health Facilities (BBHFF) held a licensure board and an AMA CME-accredited event, "Appalachian Addiction and Prescription Drug Abuse Conference: A Paradigm for the Epidemic." Topics covered included prescription drug abuse, proper prescribing, addiction, treatment, recovery, comorbid issues, etc. Thanks to the speakers, many of which were from our membership, the conference was an overwhelming success. Planning for the 2014 event is underway.

Most recently, the WVMPHP in collaboration with WVU Healthcare and the WV Department of Health and Human Resources — supported by Substance Abuse and Mental Health Services Administration (SAMHSA) grant funds administered through the BBHFF — produced the *Clinicians Pocket Guide for Drugs, Alcohol and Tobacco Screening, Brief Intervention, Referral and Treatment*. This six-fold guide for treatment professionals contains a wealth of information regarding alcoholism and drug addiction. Ultimately, the guide was distributed to all licensed physicians, physician assistants and podiatrists throughout WV; each licensee received a copy of this *Clinicians Pocket Guide* in their mailbox.

Specifically the guide focuses on tobacco, alcohol, prescription medication, and illicit drugs among various populations from adolescence to the elderly and even programs for pregnant mothers. Components of screening, intervention, patient tools (including assessment, urine toxicology, and opioid conversions), and a section on commonly abused substances other than alcohol, nicotine, and caffeine are included. There is a wealth of other useful information for physicians and other health care providers, including treatment resources. The guide can be accessed from our website, www.wvmphp.org.

As you can see, WV Medical Professionals Health Program is not only fulfilling its mission but also has activities benefiting West Virginians well beyond the scope of the WVMPHP — *making a difference in the lives of West Virginians*.

— *P. Bradley Hall, MD, DBAM, FSAM*
Executive Medical Director, WVMPHP

REFLECTIONS OF A RELATIVELY NEW FIRE MARSHAL

Perspective of a New PHP Director

At the end of last year, I had lunch with Jim Sabin, MD, a friend and mentor who has made a name for himself exploring and writing about the ethics of managed care. Jim was extremely interested in learning about the unique world of physician health. Our world is an unfamiliar one to most doctors I know, and Jim, a seasoned and savvy semi-retired psychiatrist, was no exception. By the time I finished my salad, I had managed to give Jim a view of the incredible landscape that I parachuted into back in March 2013.

Jim made the following memorable comment: “Steve, you’re like the fire marshal. When there’s a fire involving a doctor, you hear about it. Because of your position, you’re able to

connect the dots and to see patterns. You must have a pretty good idea as to what is ailing the medical profession.”

Here in Massachusetts, our PHP is pretty much open to all comers. Some physicians self-refer; most are referred by their employer, an attorney, or the Board of Medicine. In addition to working with physicians who suffer from substance use disorders, we see doctors with the full gamut of psychiatric conditions, disruptive behavior, stress, burnout, cognitive challenges, medical problems — you name it. As a relatively new fire marshal, I’ve been trying to make sense of the smoke and flames that permeate my office on a daily basis. What are the commonalities?

What links most referrals is deficient self-care? In other words, physicians who come our way are not taking good care of themselves. In conjunction with the poor self-care of specific individuals, few medical environments do a good job encouraging or promoting the self-care of physicians. In this era of increasing demands and decreasing reimbursement, taking shortcuts in the care of ourselves is perilous. Problems go from bad to worse. That’s why many of the fires that this fire marshal is seeing are in the 5- to 10-alarm range. I have yet to see a physician at PHS whose difficulties were short-lived. Virtually every tragic case is the culmination of months and years of minimization and neglect. Most of the time, the physician, and the system, are in collusion. *If we tough it out and look the other way, maybe we’ll all get through this.* A dangerous mindset, if ever there was one.

Dr. Don Berwick, past president and CEO of the Institute for Healthcare Improvement, has written that “Every system is perfectly designed to achieve exactly the results it gets.” Recent surveys that demonstrate the high prevalence of physician burnout across all medical specialties make it abundantly clear that we find ourselves embedded in a system that can be harmful to the health of large numbers of physicians. As fire marshals, it is incumbent upon us to develop and implement strategies that help to fireproof doctors and other health care workers. *Carpe diem!*

— *Steve Adelman, MD*
Physician Health Services, Inc., of Massachusetts



Steve Adelman, MD

TEXAS MEDICAL ASSOCIATION

New Committee on Physician Health and Wellness

In May 2013, the Texas Medical Association House of Delegates approved a new name and amended charges for the committee that directs physician health activities in Texas. The Committee on Physician Health and Wellness (PHW), formerly the Committee on Physician Health and Rehabilitation, charge from the House is:

“It shall be the duty of this committee to promote healthy lifestyles in Texas physicians and to identify, strongly

urge evaluation and treatment of, and review rehabilitation to physicians with potentially impairing conditions and impairments. ...The committee shall provide responsible advocacy and support, provide education on physician and wellness topics, and promote prevention of potentially impairing conditions.” TMA Constitution and Bylaws §10.621 (May 2013).

The PHW Committee conducts numerous activities to achieve its goals, including a 24-hour hotline to receive calls about physicians who may need medical care or professional counseling; a statewide drug-screen program; continuing medical education programs; and brochures, white papers, and other publications. The PHW Committee analyzes concerns brought to its attention, arranges interventions when appropriate, refers for evaluation, and monitors. The Committee also administers the Physician Health and Rehabilitation (PHR) Assistance Fund, a 501(c)(3) entity that provides financial assistance, in the form of loans, to physicians who cannot afford treatment for depression, substance use disorders, or other problems. Funds can also be used for short-term living expenses.

The functions of the PHW Committee are three-fold:

- Promote physician health and well-being
- Ensure safe patient care by identifying physicians with potentially impairing conditions
- Advocate for the physician while maintaining confidentiality and the highest ethical standards

To help deliver services to physicians, the TMA PHW Committee has appointed 15 district coordinators in the state and works closely with county medical society-based PHW Committees. Types of referrals include substance use disorders, mood disorders, sexual boundary violations, disruptive behavior, personality disorders, and cognitive disorders. In addition to providing services to physicians, the committee outreaches to medical students, resident physicians, and Alliance members (spouses of physicians). The committee collaborates with hospitals, medical schools, treatment facilities, professional liability insurance carriers, and other entities to provide superior service to physicians and to enrich its activities.

In 1976, the TMA House of Delegates established the Impaired Physicians Committee. The name was changed to Committee on Physician Health and Rehabilitation in May 1978. Throughout the years, the PHW Committee’s commitment to the health, well-being, and effectiveness of Texas physicians has contributed to the health and welfare of all Texas citizens.

— *Linda Kuhn, PHW
Program Manager, Texas Medical Association
Committee on Physician Health and Wellness
401 West 15th Street
Austin TX 78701-1680
Phone: (512) 370-1342
Fax: (512) 370-1347
linda.kuhn@texmed.org*

PENNSYLVANIA PHYSICIANS’ HEALTH PROGRAMS NOW OFFER INTERVENTION SERVICES

Pennsylvania PHP staff is now offering services to physicians and those who care about them. Senior Case Manager Lou Verna is certified in intervention services.

Intervention, once thought of as a confrontational tool in treating addiction, has developed into a “care-frontational” approach that demonstrates care and concern not only for the impaired individual, but also the family, friends, employers, and coworkers impacted by addiction or behavioral issues.

Intervention is a way to address enabling behaviors and empowers those held hostage by addiction or behavioral problems and the challenges they present. People learn to utilize community resources and develop strategies for taking their lives back and returning to a healthy, productive lifestyle on a daily basis.

Those impacted by addiction quite often sit by helplessly witnessing and even contributing to the dysfunction. The process of intervention will allow those impacted to take charge of the situation, freeing them from being held hostage.

The importance of recognizing, defining, developing, and implementing solutions is paramount. Early recognition cannot be stressed enough. Too often, the addictive patterns and behaviors are allowed to continue and go on unchallenged.

When determining whether an intervention is needed, some of the signs to look for are absenteeism, excessive sick leave, tardiness, and Friday/Monday absences. In addition, absences prior to and after holidays can be telling. Accident rates, poor work performances, or poor relationships or disruptive behavior in the workplace also are significant factors.

The process of coaching a team for the intervention can be initiated by a phone call to the PHP. This can be the start of a well thought out process that will help alleviate conditions and behaviors that have a far-reaching impact on the outcome.

An interview will be conducted over the phone, which will address the needs of the organization, family, employer, or coworker. The intervention process will be discussed as team members will be determined or eliminated. Those who continue to demonstrate enabling behaviors will be eliminated from the intervention team. A dialogue with concrete examples of the behaviors exhibited will be created and rehearsed. Finally a time and place will be determined for the intervention to take place and ultimately the recommendations for treatment to begin the process of resolution.

In other news, PHP would like to welcome Kendra Parry and Tiffany Condran to the Case Management team. Both Kendra and Tiffany are certified alcohol and drug counselors in the State of Pennsylvania.

UPDATE FROM THE NEVADA PROFESSIONALS ASSISTANCE PROGRAM (NPAP)

The Nevada Professionals Assistance Program (NPAP) has again had a busy year. We continue to have excellent relationships with our allopathic and osteopathic boards as well as with hospitals, groups, and other health care entities. The NPAP is proud of the level of trust such entities have with the NPAP. We are proud to serve our community with the best services available.

In 2013 the NPAP worked on officially expanding its program to other professions. We have since signed a Memorandum of Understanding with the Nevada State Bar, and have been approved as a provider for administrative evaluations and process groups for the Nevada State Board of Nursing. The NPAP looks forward to the opportunities this expansion brings to further assist Nevada professionals in need.

The NPAP's alumni population continues to grow and is bigger than ever before. The NPAP is proud of the continued success of its participants and their desire to continue with the NPAP — even after their completion.

Dr. Mansky continues to serve on the Board of Trustees for the Clark County Medical Society, the largest medical society in Nevada. His work has been instrumental in referrals to the NPAP. Dr. Mansky also remains a vital source of information about professionals and impairment to the community in both Northern and Southern Nevada and continues to provide presentations, at the request of educators, hospitals, group practices, and licensing boards in Nevada. Presentation topics have included physician impairment, physician burn-out, and professionals and addiction. Our Senior Associate Director Shauna Eger graduated in May 2013 with her masters in Health Care Administration and Policy and continues to provide the NPAP with her proficiency in the field.

In 2014, the NPAP will continue to provide outstanding services to the state of Nevada and work toward more widespread knowledge and support of not only physician impairment but also impairment among other safety sensitive professions and its impact on our community.

— *Shauna Eger*

Senior Associate Director

Nevada Professionals Assistance Program (NPAP)

9811 W. Charleston Blvd.

Ste 2-735

Las Vegas NV 89117

Phone: (702) 257-NPAP (6727)

Fax: (877) 324-7915

npap2shauna@gmail.com

PHYSICIAN HEALTH AND OTHER RELATED ORGANIZATIONS' NATIONAL MEETINGS

FSPHP Annual Meetings

April 23–26, 2014
Grand Hyatt Regency
Denver, CO

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

FSMB Annual Meetings

April 24–26, 2014
Hyatt Regency Denver at Colorado
Convention Center
Denver, CO

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

2014 AMA-CMA-BMA International Conference on Physician Health

September 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 7–11, 2014
Hyatt Regency Chicago
Chicago, IL

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 3–7, 2014
New York, NY

American Society of Addiction Medicine

April 10–13, 2014
Hilton Orlando
Orlando, FL

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

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improving relationships at work. For
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National Organization of Alternative Programs

March 24–28, 2014
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FEDERATION OF STATE PHYSICIAN HEALTH PROGRAMS, INC. FSPHP ANNUAL EDUCATION CONFERENCE AND BUSINESS MEETING

*Grand Hyatt Denver ~ Denver, Colorado
~Will coincide with FSMB Conference~*

April 23–April 26, 2014

AUDIENCE

Your audience will primarily be composed of physicians from all specialties; administrative personnel and support staff of state physician health programs; and others interested in learning more about how to identify, intervene, refer for treatment, and monitor physicians with substance use, mental disorders, and/or behavioral issues.

PROGRAM OBJECTIVES

- ▶ Describe best practices, future challenges, and benefits of utilization of performance measures by physician health programs (PHP).
- ▶ Examine the latest research on the efficacy of PHPs, the determination of risk assessment prior to PHP monitoring, and the subsequent determination of the need for PHP monitoring.
- ▶ Compare various drug- and alcohol-testing methodologies, biomarkers, frequency of testing, abnormal test results, and potential alternatives for PHPs.
- ▶ Describe various approaches to effective monitoring of cases involving boundary violations, disruptive behavior, and professional sexual misconduct.
- ▶ Evaluate the impact of the DSM-5 implementation on treatment and monitoring of health care professionals.

NEW EXPANDED POSTER SESSION ~ POSTER SESSION OBJECTIVES

- ▶ Differentiate between the relapse-prone style and the recovery-prone style of coping with problems and stuck points in recovery.
- ▶ Discuss the need to adapt programming to conform to the changing profile of the client (hospital site, clinic, individual physician, etc.) population.
- ▶ Examine the effects of aging on clinical performance.
- ▶ Identify clinician attributes and attitudes relevant to effective collaboration with physician health programs.
- ▶ Describe ways to establish healthy boundaries in professional relationships with patients both in the workplace and in the recovering community.
- ▶ Implement preventive measures that can reduce the prevalence of completed suicides among physicians.
- ▶ Apply strategies designed to bring balance in physicians' lives.

CONFERENCE SESSIONS

- ▶ Ensuring Compliance: Exploring Best Practices in Drug Testing of Health Care Professionals Monitoring Through Biomarkers
Martha E. Brown, MD, Penelope P. Ziegler, MD, Guida Brown, MS, and Douglas Lewis, D.Sc.

continued on next page

continued from previous page

- ▶ Controversies of Pain Management in Recovering Health Care Professionals
Michael P. Sprintz, DO, Andrew B. Mendenhall, MD, and Mel Pohl, MD, FASAM
Moderator: Doris Gundersen, MD
- ▶ The Development of a Quality Scorecard Instrument for Measuring Physician Health Program Effectiveness
Amanda Shaw, MPH, and Charles Meredith, MD
- ▶ Integrating Outcomes Reports into PHP Practice: Implications for Patient Safety, Quality Improvement, and Treatment Planning
Michael Groat, PhD, MS
- ▶ Are There Precursors for Substance Use Disorders in American Physicians?
Michael R. (Mick) Oreskovich, MD, FACS
- ▶ Risk Assessment and PHP Involvement with Complex Cases: A Roadmap for Success
Philip Hemphill, PhD, and Scott Hambleton, MD
- ▶ Medical Student Participation in a State PHP: The Florida Experience
Lisa J. Merlo, PhD, MPE
- ▶ The Impact of DSM-5 on Physician Health Programs
Penelope P. Ziegler, MD, and Martha E. Brown, MD
- ▶ Special Presentation — FSMB Speaker:
Common Goals of Physician Health Programs and Licensure Boards, including Promotion of Patient Safety
Jon V. Thomas, MD, MBA, Chair, FSMB Board of Directors
- ▶ Disruptive Behaviors: Varied Approaches to Remediation
Understanding the Role and Utility of a Comprehensive Clinical Assessment in the Management of Disruptive Behavior in Physicians
Michael Kaufmann, MD, Ron L. Neufeld, BSW, LADAC, Kimberly P. Brown, PhD, Betsy White Williams, PhD, MPH, and Carolyn W. Westgate, MS, LCP
- ▶ PHP Administrative Meeting:
Show Us the Money: Enhancing the Funding of Your PHP
Steven Adelman, MD
- ▶ To Monitor or Not to Monitor: That Should be the Question
Joy Albuquerque, MD, MA, FRCP, and Michael Kaufmann, MD
- ▶ Clients Speak: Results from the Colorado PHP Program Evaluation
Elizabeth Brooks, PhD, Sarah R. Early, PsyD, and Michael H. Gendel, MD
- ▶ JOINT FSPHP AND FSMB @ Hyatt Regency Denver at Colorado Convention Center
Federation of State Medical Boards: Current Issues Related to Physician Health
- ▶ Surviving Political Challenges to Your PHP: Building Stakeholder Support and Developing External Performance Measures — The Montana Experience
Physician and Professional Health Programs; Challenges and Opportunities
Michael Ramirez, MS, Gary D. Carr, MD, P. Bradley Hall, MD, and Warren Pendergast, MD

FOR MORE INFORMATION VISIT FSPHP.ORG

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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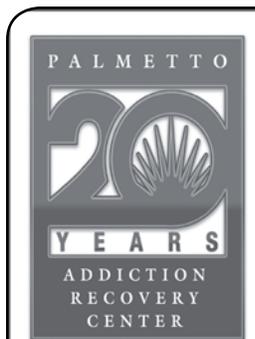
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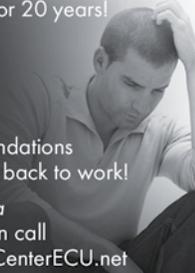
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We look forward to working with you in future editions.

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