

PHYSICIAN HEALTH NEWS

The Official Newsletter of the Federation of State Physician Health Programs



20TH EDITION, VOLUME 2 • AUGUST 2015

ANNUAL MEETING 2015 REVIEW

Welcome to the 20th 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.

PUBLICATIONS COMMITTEE

Linda Bresnahan, MS (MA)
Paul Earley, MD (GA)
Sarah Early, PsyD (CO)
Scott Hambleton, MD (MS)
Carole Hoffman, PhD, LCSW, CAADC (IL)
Linda Kuhn (TX)
Warren Pendergast, MD (NC)
Cathy Stratton (ME)
Amy VanMaanen, LBSW (IA)

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.

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

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
Massachusetts Medical Society
860 Winter Street, Waltham, MA 02451-1414
Phone: (800) 322-2303, ext. 7342
Fax: (781) 464-4802; Email: lbresnahan@mms.org

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

MESSAGE FROM THE PRESIDENT

To Infinity and Beyond!

*"Coming together is a beginning;
keeping together is progress;
working together is success..."*

— Henry Ford



Doris C. Gundersen, MD

Once again, the FSPHP enjoyed a successful annual meeting in the heart of Texas. Twenty-five (25) years ago, we came together — and we have stayed together — in our commitment to assisting our colleagues move from illness to wellness. Our success is largely due to the collaborative effort of each and every one of you! This FSPHP newsletter highlights the excellent presentations given in Fort Worth, Texas.

In attending many sessions and reading about others, I was struck by the progress we have made in terms of recognizing the endemic of burnout, as well as the factors contributing to it, and remedies for treating it. We have become more sophisticated in our understanding of physician suicide and this tragic phenomenon is no longer swept under the rug. I am hopeful that current research efforts and public awareness campaigns will serve to stem the tide of premature death in physicians.

The FSPHP is taking the lead in addressing aging and cognitive impairment. We have gained an understanding that disruptive behavior generally reflects significant distress in an otherwise competent and high functioning physician. Our growing sophistication in the realm of toxicology allows us to intervene early when a physician relapses, protecting both the physician and the public from harm. We are learning that while boundary violations are serious, recidivism rates tend to be low, allowing many physicians to return to the practice of medicine safely following treatment and education.

Surveys demonstrate the need to do a better job penetrating medical schools and residency programs alike, so that we may educate our young colleagues about the occupational hazards unique to the practice of medicine and teach them the importance of self-care. Finally, we are

continued on page 3

CONTENTS

Message from the President	1
<i>Doris C. Gundersen, MD</i>	
Save the Date 2016 FSPHP Annual Conference and Business Meeting	21
Physician Health And Other Related Organizatons National Meetings	22

*Synopsis of Annual Conference Presentations and Posters***FRIDAY, APRIL 24, 2015**

THE EVOLUTION OF PHYSICIAN HEALTH PROGRAMS OVER THE LAST 25 YEARS	3
THE ASAM CRITERIA AND SAFETY SENSITIVE WORKERS	3

SATURDAY, APRIL 25, 2015

“KEEPING THE SPARK WITHOUT BURNING OUT: PATHWAYS TO PHYSICIAN WELLNESS”	4
USING INTAKE INTERVIEWS TO ENHANCE THE IDENTIFICATION OF SUICIDALITY IN PHP POPULATIONS	5
CHALLENGING TOXICOLOGY CASES IN MONITORING HEALTH CARE PROFESSIONALS	5
WHAT TO DO WITH SEXUAL BOUNDARY VIOLATIONS: HISTORY, ASSESSMENT, AND TREATMENT	6
PSYCHIATRIC AND OTHER CONDITIONS AFFECTING DISRUPTIVE BEHAVIOR	6
HEALING THE ADDICTED BRAIN — NEW, ALTERNATIVE TREATMENT OPTIONS FOR PHPS	7
PROFESSIONAL ETHICS: AVOIDING BURNOUT	7
NEUROCOGNITIVE ASSESSMENT: BEYOND THE MINI MENTAL STATUS EXAM AND THE EFFECT OF ALCOHOL AND DRUG USE ON THE STRUCTURE AND FUNCTION OF THE BRAIN	8
IMPLEMENTATION OF AN OPIOID OVERDOSE PREVENTION PROGRAM IN A TREATMENT PROGRAM FOR HEALTH CARE PROFESSIONALS	9
SUICIDE IN PHYSICIANS CHARGED WITH CRIMINAL SEXUAL BEHAVIOR, AN OPPORTUNITY TO INTERVENE?	9
STATE-TO-STATE VARIABILITY IN RE-LICENSURE RATES OF PHYSICIANS WHO ARE CHARGED WITH CRIMINAL SEXUAL MISCONDUCT: A ROLE FOR PHP?	10
DOES LACK OF ANONYMITY FOR PHP PARTICIPANTS PREVENT REFERRAL OF POTENTIALLY IMPAIRED PROVIDERS FOR INTERVENTION?	10
INTEGRATING THE VALUES-BASED MODEL WITH 12-STEP RECOVERY: HELPING PROFESSIONALS CONFRONT THE BARRIERS TO PERSONAL AND PROFESSIONAL WELL-BEING.	11

SUNDAY, APRIL 26, 2015

DEVELOPMENT AND IMPLEMENTATION OF OCCUPATIONAL HEALTH MONITORING FOR PHYSICIANS IN NEED OF PROFESSIONAL COACHING	12
ROLE OF SPIRITUALITY IN PHYSICIAN RECOVERY	13
SOUTHEAST REGIONAL FSPHP MEMBER SURVEY TO ACCESS TREATMENT PROVIDER SERVICES	13

MONDAY, APRIL 27, 2015

PROMOTION OF WELLNESS AMONG MEDICAL STUDENTS TO IMPROVE PHYSICIAN HEALTH	13
COGNITIVE DYSFUNCTION AND THE OLDER PHYSICIAN: IS YOUR ORGANIZATION READY TO MEET EMERGING DEMAND?	14
PREVENTING PHYSICIAN SUICIDE: BEST PRACTICES FOR PROMOTING HOPE AND RESILIENCE	15
DISTRESSED PHYSICIANS: A SYNTHESIS OF PHPS'S BEST PRACTICES	15
PREVALENCE OF BURNOUT AMONG PARTICIPANTS OF A STATE PHYSICIAN HEALTH PROGRAM	16
PHYSICIAN REENTRY TO PRACTICE	17
INTERSTATE MEDICAL LICENSURE COMPACT	17

continued from page 1

learning about the importance of confidentiality in attracting physicians to utilize PHPs and do so early, before impairment occurs.

While we have made significant gains in the last 25 years, we have much more to accomplish. In recent years, the FSPHP has gained credibility and status with larger and more visible organizations including the AMA, the APA, the Federation of State Medical Boards (FSMB), the American Board of Medical Specialties (ABMS), and AIM to name a few. We are no longer under the radar as media now turns to us as the experts in physician health. With credibility and status, we have a greater responsibility to ensure accountability, consistency, and excellence in the work we do. As I write this column, several FSPHP committees are hard at work in an effort to advance our cause. It is the dedication and talent every member contributes to the FSPHP that makes me proud to be a part of this incredible journey. If you haven't already, please save the dates, **April 28–May 1, 2016**, for a spectacular annual meeting in San Diego, California. See you there! — **Doris C. Gundersen, MD, President, Federation of State Physician Health Programs**

SYNOPSIS OF ANNUAL CONFERENCE PRESENTATIONS AND POSTERS

FRIDAY, APRIL 24, 2015

THE EVOLUTION OF PHYSICIAN HEALTH PROGRAMS OVER THE LAST 25 YEARS

From the FSPHP's inception in 1990, Lynn highlighted the two major contributions that occurred during each past president's tenure, such as our affiliation with the AMA and the development of the chat room. Of the 50 states and Washington, D.C., currently there are 46 members, 2 non-members, and 3 states — California, Nebraska, Wisconsin — that have no program.

He also reviewed the three major types of PHPs, different business structures, governing boards, funding sources, services provided, populations served, contract lengths, and directors' credentials.

In summary, over the past quarter century, the FSPHP now has 46 state members, 16 international members, 12 committees, 2 task forces, and an "e" group. There are



Lynn Hanks, MD, FASAM

new members categories, an administrative contract, a semi-annual newsletter, and a sophisticated annual scientific meeting.

He then stated that PHPs are currently under siege, raised some controversies and challenges, and discussed recent performance audits. He ended by surmising that this year's meeting theme of Accountability, Consistency, and Excellence, could well be the essential fabric of our next evolutionary stage. — **Lynn Hanks, MD, FASAM**

THE ASAM CRITERIA AND SAFETY SENSITIVE WORKERS

The *ASAM Criteria* is a 2013 publication of the American Society of Addiction Medicine (ASAM). It is a revision of the *ASAM Patient Placement Criteria*, Second edition, Revised (PPC-2R). This needed revision does not incorporate new criteria for levels of care or changes to the dimensions of care. The rules regarding placement in proper level of care and the continuation in such care are unchanged. Instead, this new version is much more user-friendly, helping the reader implement the criteria when determining patient placement in addiction treatment and ensuring a comprehensive treatment process. Important changes do occur in the *ASAM Criteria*, including combining adolescent and adult criteria and the addition of several new chapters.

One of the added chapters in this latest revision is specifically focused on the safety-sensitive worker (SSW). SSWs are a broad category, since almost all health care workers are defined as safety sensitive workers. All physicians who diagnose, treat, or manage medical care fall into this category. The chapter on SSWs defines what constitutes a safety sensitive worker and then goes on to:

- Describe the elements of an addiction evaluation in SSWs
- Assert that providers who treat SSWs must have expertise in the special nuances of presentation and addiction treatment in the various types of SSWs
- Describe how that expertise commonly requires centers that specialize in a specific subset of SSWs



Michael Wilkerson, MD



Paul H. Earley, MD

continued on page 4

continued from page 3

- States that such providers have the capacity to deal with the medical, social, psychological, and legal issues that are inherent in that population

The staff within specialized centers should be knowledgeable about the work environment of the SSW, especially if that environment has specific types of stressors and work-related trauma. The center must be knowledgeable as to the legal and ethical challenge of treating the specific cohort of SSWs. They must be able to work with licensing and recovery management organizations available to the specific subset of SSW they treat. In addition, staff needs to have a working knowledge of the substances commonly abused by the SSW group. Psychotherapy should be knowledgeable about and adapted to the psychological structure of the SSW. Profession-specific group therapy and relapse prevention training are prerequisites for the effective treatment of SSWs.

Centers and individuals who treat SSWs must understand subtle differences in maintaining a safe medical record with SSWs. Some agencies demand access to medical records, creating an ethical and legal dilemma to the care provider or treatment program that treats SSWs.

Safety sensitive workers may also need complex evaluations that range from diagnostic evaluations (determining psychiatric and substance use disorder diagnoses), fitness for duty (including cognitive evaluations) and competency evaluations (determine the knowledge and skill in a particular area of expertise). Such evaluations are complex and arduous, mandating that highly skilled clinicians be used; misdiagnosis can produce damage to public trust and welfare.

All practitioners and treatment centers that treat substance use disorders should purchase and study the *ASAM Criteria*. Those who treat safety sensitive workers should pay special attention to the chapter in the *ASAM Criteria* that addresses this important population. Proper implementation of this chapter should standardize and improve addiction treatment protocols. It may also help third party payers understand the importance of specialty care for our physicians and other health care providers who develop this common illness.

— *Michael Wilkerson, MD; and Paul H. Earley, MD*

SATURDAY, APRIL 25, 2015

“KEEPING THE SPARK WITHOUT BURNING OUT: PATHWAYS TO PHYSICIAN WELLNESS”

Drs. Gundersen and Gray were invited to speak at the Federation of State Medical Boards Annual Meeting. Dr. Gray shared with the audience that 86 percent of physicians were currently endorsing moderate to severe stress, primarily related to stressors such as health care reform, administrative demands, long work hours, and malpractice lawsuits. He emphasized the downstream consequences of unmanaged stress, including addiction, relationship troubles, behavioral problems, and professional consequences. Dr. Gray shared information gleaned from a Vanderbilt University School of Medicine study examining suicidal behavior among physicians referred for fitness-for-duty evaluations. He noted that of 141 physicians evaluated at the Vanderbilt Comprehensive Assessment Program, subsequent suicidal behaviors were associated with being found unfit to practice, being in solo practice and chronically using benzodiazepines (i.e., related to disinhibition). He emphasized the importance of follow-up prospective studies to be able to better identify at-risk physicians and employ preventive measures.

Dr. Gundersen educated the audience about the FSPHP's primary mission, to support physician health programs in improving the health of medical professionals and thereby contribute to quality patient care. She noted that the FSPHP provides education to state members, conducts research, develops practice guidelines and engages in ongoing consultation (nationally and internationally) to accomplish this goal. She noted that while traditionally, the practice of medicine was not considered the highest stress profession because of the autonomy physicians enjoyed, the evolving health care environment has served to restrict autonomy — leading to heightened stress among practitioners. She cited chronic stress, burnout, mental illness, addiction, poor physical health, poor work-life balance, boundary violations, and suicide as some of the common occupational hazards physicians face in the course of their careers. Dr. Gundersen emphasized the importance of educating physicians about how to maintain resilience and well-being during turbulent times.

She shared “Dimensions,” a low burden, evidence-based work and well-being toolkit for physicians that was developed through a collaboration between the University of Colorado



Doris C. Gundersen, MD



Roland W. Gray, MD

Behavioral Health and Wellness Program, the Colorado Medical Society, and the Colorado Physician Health Program in response to an April 2011 Colorado physician survey that revealed only half of physicians in the state felt that they were able to live a healthy lifestyle with regard to exercise and diet. Dr. Gundersen encouraged those in attendance to distribute this free resource widely in an effort to promote the health of all physicians. She cited the numerous studies correlating physician wellness with increased patient safety and noted that the declining wellness among the physician population was a critical concern for patient care. Finally, Dr. Gundersen spoke about the FSPHP's collaborative effort with FBC Health, a health ad agency with a long history of pro bono work, dedicated to reducing physician suicide through public service announcements and the sharing of resources for physicians in acute distress.

— *Doris C. Gundersen, MD; and Roland W. Gray, MD*

USING INTAKE INTERVIEWS TO ENHANCE THE IDENTIFICATION OF SUICIDALITY IN PHP POPULATIONS

In 2012, the Colorado Physician Health Program (CPHP) issued a survey to current and former PHP participants in an effort to better understand their needs. Nearly 30% of those responding to the survey reported that they had either thought about or attempted suicide as a student, resident, or medical provider. Because of this alarmingly high percentage of suicidal respondents, CPHP decided to conduct a retrospective review of our database in an effort to better delineate which trainees or practicing physicians were most vulnerable to attempting or completing suicide. We wanted to identify specific risk indicators and ensure that our intake interview adequately screened for suicide risk.

In reviewing CPHP participants who were monitored between 1998 and 2014, we focused on those who had endorsed suicidal ideation within 30 days of the intake interview because we thought this group would be in most need of intervention. We also wanted to identify modifiable factors to reduce the risk of suicide in this cohort of CPHP participants. As we discovered in other studies, we found that female participants were more likely to endorse suicidal ideation than male participants.

In our intake evaluation, we ask participants about specific stressors including financial, health, legal, personal, or occupational problems. We found that those reporting personal problems were five times more likely to endorse suicidal ideation, and those with financial problems were three times more likely to report recent suicidal ideation. We also found that those participants who reported histories of abuse, particularly physical abuse, were more likely to endorse recent suicidal ideation. Those participants who lacked personal

support were more likely to have experienced recent suicidal ideation. In examining this cohort of CPHP participants we also discovered that many of the predictors of suicide in the general population can be carried over to the PHP population, emphasizing the importance of keeping current with new literature on suicide.

While it is impossible to know with precision who will attempt suicide and who will not, we learned the importance of paying particular attention to “tipping points” among clients. Tipping points frequently include cumulative problems with relationships, financial hardships, public humiliation, or shame, as well as worsening medical prognosis. We saw in the results that these events are frequently reported among those who experienced suicidal thoughts within the past 30 days. Now when we identify a CPHP participant who possesses not one but numerous risk factors for suicide, we are more likely to make a mental health referral, even if the participant's presenting problem appears unrelated. Because of the small number of completed suicides (i.e., eight) in the cohort we studied, we could not analyze the data. However, CPHP hopes to collaborate with multiple PHPs in the future to conduct meta-analyses where pooled data may offer more insight into identifying high-risk physicians and offering appropriate interventions to prevent suicide. — *Doris C. Gundersen, MD*

CHALLENGING TOXICOLOGY CASES IN MONITORING HEALTH CARE PROFESSIONALS



Penny Ziegler, MD

Martha Brown, MD

Joseph Jones, NRCC-TC

During the 2015 FSPHP Annual Conference in Fort Worth, Texas, a panel discussion on challenging cases in toxicology was presented by Penny Ziegler, MD, Martha Brown, MD, and Joseph Jones, NRCC-TC. Panel members reviewed basic approaches and goals of drug testing in physician health programs. They then used cases to illustrate complicated, confusing findings with phosphatidyl ethanol (PEth) testing; EtG/EtS testing; hair and nail testing; and interpreting abnormal urine tests (diluted, over-concentrated, or with abnormally high or low creatinine levels). Audience discussion was encouraged and the panel members commented on several additional cases presented by attendees. — *Penny Ziegler, MD; Martha Brown, MD; and Joseph Jones, NRCC-TC*

WHAT TO DO WITH SEXUAL BOUNDARY VIOLATIONS: HISTORY, ASSESSMENT, AND TREATMENT

This presentation had three components: 1) a review of the publicly available data regarding physicians with a history of criminal sexual boundary violations, including available information regarding Board complaints, legal charges, return to practice, and further complaints or Board actions; 2) a review of diagnostic and treatment experience with regard to assessing, treating, and return to duty for this group of physicians; and 3) a description of currently practiced monitoring and follow-up guidelines for treatment for physicians with sexual boundary violations.

1) Of the 876 physicians who were charged with a criminal sexual offense between 1980 and 2014, 284 (33%) were licensed to practice medicine subsequently. Some of these physicians (54%) were required to have documented psychiatric treatment in order to practice. Others (30%) required specified practice conditions such as limited practice settings, chaperones, and restrictions on gender and/or age of patients for varying lengths of time.

In over 2,333 practice-years since re-licensure there were 30 incidents of subsequent disciplinary actions on the 284 physicians who were able to return to practice. Follow-up was 9 years on average with a median of 7 years and a range of 0 to 27 years. Ten (10) physicians were arrested for subsequent criminal behavior (6 were for repeat sexual crimes), there were 2 arrested for health care fraud, 1 for a narcotics violation, and 1 for building a pipe bomb, all 10 had medical licenses revoked. An additional 15 physicians were revoked for various reasons, including failure to comply with board ordered probation (9), clinic incompetence (2), and 4 lost their licenses due to change in state law prohibiting the practice of medicine by registered sex offenders.

2) In general, assessment of physicians who have boundary violations consists of a specialized professional evaluation of motivations, defense mechanisms, and the type of offense. Individual character, personality issues and specialty of practice are also considered.



James C. "Jes" Montgomery, MD



Philip Hemphill, PhD



Andrew C. Stone, MD, MPH

Treatment is based on the results of a comprehensive assessment and tailored specifically to the deficits found on evaluation. This often includes education regarding boundaries and limit setting, improving awareness of problem behaviors, and development of and operationalized empathy.

3) Monitoring of physicians who wish to resume the practice of medicine is based on the specifics of the violation and may include work site and collateral monitoring. Additional tools available include monitoring progress in a therapeutic setting, medication compliance, physiologic monitoring, and community/social monitoring.

Effective monitoring typically requires multiple disciplines and interdisciplinary coordination. Multisource feedback (MSF 360) evaluations may be useful as a monitoring tool in this population.

In summary, physicians who commit sexual boundary violations (including criminal behavior) can and do return to practice after treatment and under appropriate monitoring conditions. The recurrence rate of behaviors is low but a comprehensive assessment, treatment, and monitoring program may improve outcomes for these physicians and prevent further victims. Further research and the development of consistent policies is needed.

— James C. "Jes" Montgomery, MD; Philip Hemphill, PhD; and Andrew C. Stone, MD, MPH

PSYCHIATRIC AND OTHER CONDITIONS AFFECTING DISRUPTIVE BEHAVIOR



Lisa Merlo Greene, PhD, MPE



Martha Brown, MD



Penny Ziegler, MD

At the 2015 FSPHP Annual Conference in Fort Worth, Texas, Lisa Merlo Greene, PhD, Martha Brown, MD, and Penny Ziegler, MD, presented a Paper Session on "Psychiatric and other Conditions Affecting Disruptive Behavior." Disruptive physician behavior is a significant concern in health care settings because it compromises quality and may adversely affect patient safety. Research has demonstrated several adverse consequences to disruptive behavior, including increased medical errors and impaired staff communication. Identification, assessment, and rehabilitation of physicians who demonstrate disruptive behavior help to ensure safe and effective health care. The study presented examined the prevalence of psychiatric diagnoses among

physicians referred to a state-monitoring program due to disruptive behavior.

Methods: IRB approval was obtained and a retrospective chart review was completed for all professionals referred for monitoring due to disruptive behavior ($N = 54$). Psychiatric diagnoses were obtained from the evaluators' reports.

Results: Among professionals (53 physicians and 1 massage therapist) referred for disruptive behaviors, the majority of physicians (96.2%) were diagnosed with an Axis I and/or Axis II diagnosis. Thirteen (13) professionals had no Axis I diagnosis. Fifteen (15) professionals had no Axis II diagnosis, traits, or features noted.

Conclusions: Recognizing the link between psychiatric diagnoses and disruptive behavior may improve understanding of disruptive behavior among physicians and lead to improved efforts at prevention and intervention. It is important to consider a holistic approach when discussing disruptive behavior in professionals. This study shows that more attention to physician health and wellness could decrease disruptive behavior and its negative impact on quality and patient safety. Further discussion during the session included how to recognize early warning symptoms of potential disruptive behavior, as well the best practices used in intervention, evaluation, and treatment of these professionals. In order to decrease disruptive behavior of physicians and other health care professionals in the future, further development of prevention programs and identifying potential disruptive behaviors need to be developed, such as Grand Rounds, "hospitality training," CME activities, and attention to burnout symptoms.

— *Lisa Merlo Greene, PhD, MPE; Martha Brown, MD; and Penny Ziegler, MD*

HEALING THE ADDICTED BRAIN — NEW, ALTERNATIVE TREATMENT OPTIONS FOR PHPS

Addiction is a chronic, medical disease that affects the brain. The longer the duration of substance use, the more severe the injury. Drug and alcohol addiction injures the Cortex and Limbic systems of the brain that often lead to a number of cognitive impairments including:

- Memory loss
- Ability to handle stress
- Unbalanced demand and reward systems



Harold Urschel, MD, MMA

Some of the more observable characteristics in patients suffering from drug or alcohol addiction include:

- Unstable emotional states such as irritability and aggression
- Altered blood sugar levels and dehydration
- Memory and cognitive clouding
- Reduced pain perception
- Sleeping irregularities
- Depression, lethargy
- Seizure

Since addiction is a complex disease, treating patients effectively requires a multi-dimensional science-based approach. Such an approach typically involves a combination of intensive inpatient treatment followed by long-term multi-modality outpatient support with an emphasis on the following areas:

- Cortex Therapy Modalities
 - Individual, family, and group therapy
 - Trauma and stress management
 - Faith-based guidance and support
 - Nutrition and wellness
- Limbic Therapy Modalities
 - Dual-disorder medication
 - Anti-addiction medication

When followed correctly, a science-based approach, as outlined by the National Institute of Health, can give patients greater than a 70 percent chance for a successful outcome. Those are significantly better results compared to more traditional treatment approaches. As medical professionals, we are trained to seek out and provide the best care for our patients. We do it for other diseases such as cancer, diabetes, and stroke. Now is the time that we all come together and adopt that same approach for addiction.

— *Harold Urschel, MD, MMA*

PROFESSIONAL ETHICS: AVOIDING BURNOUT

Competence to perform their work is affected by how well physicians and other professionals take care of themselves, making self-care a matter of professional ethics. Maslach and Jackson characterize the burnout syndrome as emotional exhaustion, depersonalization, and



Chip Abernathy, LPC, MAC

continued from page 7

reduced feelings of accomplishment. In this poster presentation, a practical way to identify, avoid, and manage burnout to ensure professional competency and optimal health was presented. A patient's perspective of what burnout looks and sounds like was shown as well. A physician's ability to put forth the energy, attentiveness, and best use of their skills towards helping a patient is largely determined by what kind of shape they are in physically, mentally, and spiritually. In a busy world with constant demands by patients, spouses, children, staff, and others it is challenging to not fall into negative patterns and attitudes that prevent professionals from having a balanced, happy life. This presentation was designed to help professionals avoid burnout, and in that process enhance their enjoyment and effectiveness at work, at home and in the other important areas of their lives.

— *Chip Abernathy, LPC, MAC*

NEUROCOGNITIVE ASSESSMENT: BEYOND THE MINI MENTAL STATUS EXAM AND THE EFFECT OF ALCOHOL AND DRUG USE ON THE STRUCTURE AND FUNCTION OF THE BRAIN

The damage caused from alcohol and drug abuse is similar to a mild traumatic brain injury. The most consistent structural changes occur in the Frontal, Parietal, Limbic, and Cerebellum areas of the brain. Some of the most commonly abused drugs that damage these areas include:



Josh Masino, MD

Alcohol: Interferes with cerebral cortex, limbic system, cerebellum, medulla, and hypothalamus, disrupting a number of brain functions:

- Exaggerated emotional states
- Impaired thought processing
- Limited motor and sensing skills
- Reduced decision-making and inhibition

Marijuana: The THC in marijuana binds with the cannabinoid receptors inside the hippocampus, cerebellum and basal ganglia, creating deficiencies such as:

- Short-term memory loss
- Impaired coordination
- Learning difficulties
- Reduced problem-solving

Cocaine: Cocaine affects the ventral tegmental area (VTA) of the brain affecting dopamine transmitters which allows dopamine to build up in the synapse, creating a heightened state of euphoria and deficiencies such as:

- Paranoia
- Impaired decision-making
- Reduction in limbic system function
- Structural changes to reward systems

So, how can we screen for cognitive impairment in patients with a history of substance abuse? One widely accepted tool is the Montreal Cognitive Assessment (MoCA). The assessment is a 30-point test and takes roughly 10 minutes to administer. The assessment is endorsed by the National Institute of Health and is designed to evaluate multiple cognitive domains:

1. Memory recall
2. Visuospatial abilities
3. Executive function
4. Attention and concentration
5. Language skills

As medical professionals, what can we do when we identify patients with cognitive impairments caused by substance abuse or addiction? First, it is always a good practice to refer the patient to a neuropsychologist for an in-depth assessment of their cognitive, behavioral, and emotional functioning. Also, encourage them to get treatment from a provider that offers diagnostic and assessment services, medically supervised withdrawal stabilization (detoxification), intensive one-to-one therapy has expertise with anti-addiction and anti-craving medication and specializes in dual diagnosis.

Patients with substance abuse or addiction may look normal on the surface, but inside there could be significant cognitive impairments that are affecting their relationships, career, and health. By taking a comprehensive approach to the care we provide and helping patients understand what they need to do to recover will give them the greatest chance at a positive outcome.

— *Josh Masino, MD*

IMPLEMENTATION OF AN OPIOID OVERDOSE PREVENTION PROGRAM IN A TREATMENT PROGRAM FOR HEALTH CARE PROFESSIONALS

Submission context: In 2013, there were 43,982 drug overdose deaths in the United States. Of these deaths, 16,235 involved prescription opioids. Concurrent to the increase in drug overdose deaths in the general population, physicians have a significantly high risk of dying from suicide and each year 400 physicians are lost to suicide, often from drug overdoses. Physician with opioid use disorders can be at an increased risk for overdose death particularly if they are high dose opioid users, have co-occurring medical and psychiatric co-morbidity and are heavy drug users transitioning to relative abstinence or abstinence and have access to opioids (i.e., those individuals discharging from drug treatment program and returning to their former practice). A body of evidence and experience supports approaches to prevent opioid overdose deaths by providing education and training to patients and stakeholders on overdose risk factors, signs, and symptom antagonist to revive individuals experiencing an overdose. A number of states have passed legislation and more have pending legislation allowing prescriptions of naloxone to individuals for the purpose of overdose reversal. Residential substance abuse treatment programs treating physicians emphasize abstinence-based care for those suffering from addiction. Harm-reduction approaches have not been widely accepted in residential treatment centers even with the high risk of transitioning from high dose opioids to abstinence and a return to drug access in the workplace. The University of Colorado and the Center for Dependency, Addiction and Rehabilitation (CeDAR) is expanding the use of harm-reduction practices in residential care and paving the way for new approaches in residential settings.

Methods: This performance improvement project reports the implementation of an opioid overdose prevention program provided to patients and their family members in a residential treatment setting. Opioid dependent inpatients (N=26) along with their family members received overdose prevention training consistent with guidelines established by PrescribeToPrevent (www.prescribetoprevent.org). A pre and post training questionnaire based on a 5-point Likert scale assessing ability to recognize overdose, fear of overdose, comfort in assisting with overdose, perception of life-threatening nature of addiction and the value of overdose management was administered.



Patricia Pade, MD

Results: Pre and post scores for each Likert scale were analyzed using Student's T-tests. Significant improvements in the ability of patients and families to recognize an opioid overdose as well as in their comfort to assist with an overdose were demonstrated. There was a trend toward improvement in perceptions regarding the life-threatening nature of overdose. The pre- and post-education responses were both notably high for perceived value in learning about overdose and prevention.

Conclusions: We strongly suggest that physician health programs as well as treatment facilities institute opioid overdose prevention programs and that these trainings be provided soon after entry of opioid dependent participants into monitoring programs if state laws are supportive. Family members and stakeholders should attend the trainings and receive prescriptions or information to obtain naloxone. Such programs would provide evidence-based education for a high risk population and would help stakeholders to understand the potential severity of the disease and promote a life-saving intervention.

— Patricia Pade, MD

SUICIDE IN PHYSICIANS CHARGED WITH CRIMINAL SEXUAL BEHAVIOR, AN OPPORTUNITY TO INTERVENE?

Prevention of physician premature mortality is an important goal for physician health programs (PHPs). Having an acute disruptive life event can lead to hopelessness, depression, risk taking behavior and suicide. Recognizing arrest for criminal sexual behavior as such an event may help prevent needless violent deaths among physicians.

A systematic Internet search of public records found 876 physicians who were criminally charged for inappropriate sexual behaviors since 1980. According to newspaper accounts, 24 (2.7%) died around the time of their arrest, trial, and/or conviction. The number of physicians who died from suicide, violent accident, and/or overdose was found to be increasing from 4 prior to 2000, to 10 in the 2000s and 10 in the first four years of 2010s.

Criminal characteristics of the behavior (contact crime, non-contact crime, victim profile, and Internet-related "cyber" crime) were compared to those who did not commit suicide and found to be no different. Indeed, the criminal charges were similar to the 284 physicians who were eventually allowed to return to the licensed practice of medicine.

Timing of death was within hours to days of arrest in 12 (50%) of those who committed suicide. Eight (8) died within days of trial, sentencing, or days after release

continued from page 9

from incarceration. The remaining 4 died in the next 1 to 4 years after arrest.

This data shows the increasing rate of suicide amongst physicians who are charged with criminal sexual behavior over the last 15 years. Although rare, a significant percentage of these physicians successfully complete suicide around the acute event and/or subsequent interactions with the criminal justice system. The crimes this cohort were charged with were not different than physicians who are charged similarly who did not commit suicide. Additionally, 1/3 of the surviving physicians were able to regain license to practice medicine.

Given the relatively small window of time when these deaths occurred, it may be possible to intervene to prevent these deaths. Outreach and suicide risk assessment by a PHP may be able to intervene with physicians who are arrested for criminal behavior in attempt to prevent these premature deaths. There are many potential factors that contribute to the suicidal behavior including substance abuse and underlying mental health issues. Future study is needed to find characteristics that might be predictive of suicide among physicians charged with criminal behavior. — *James C. “Jes” Montgomery, MD; Philip Hemphill, PhD; and Andrew C. Stone, MD, MPH*

STATE-TO-STATE VARIABILITY IN RE-LICENSURE RATES OF PHYSICIANS WHO ARE CHARGED WITH CRIMINAL SEXUAL MISCONDUCT: A ROLE FOR PHP?

There are no studies looking at the rate of re-licensure and inter-state variability of re-licensure rates for physicians who have been charged and/or convicted of criminal sexual behavior. Yet, some physicians who commit such offenses do return to practice after appropriate evaluations, treatment, and restrictions. A physician health program (PHP) may have a roll to monitor these physicians as well as to advocate for physicians in recovery from these disruptive behaviors and to help protect patients from such behaviors.

We performed an exhaustive Internet search of public records, news reports, and aggregate sites to identify 876 physicians who were charged with criminal sexual behavior over the last 35 years. After losing their medical licenses as a result of criminal charges, 284 (33%) were then able to be re-licensed to practice medicine.

There was no differences in categories of criminal charges (contact versus non-contact crimes) or who these physicians offended against (patients vs. non-patients; minors vs. adults) for those re-licensed compared to those who were not licensed. Similarly no difference in

re-licensure rates was seen in Internet (cyber)-related crimes versus crimes unrelated to the Internet.

There was state-to-state variability in the rates of re-licensure, and the types and durations of sanctions for physicians who offend. With few exceptions, states with higher numbers of physicians per capita are less likely to re-license physicians charged with criminal sexual misconduct than states with lower numbers of physicians per capita.

State licensing boards seemed to vary in their requirement to involve a PHP in the absence of substance abuse or mental health disorders. Yet, more than half of those who were relicensed were required to undergo psychiatric treatment as a condition of re-licensure, perhaps suggesting a role for PHP monitoring of treatment adherence.

There are no clear guidelines for which category of offending behavior physician may benefit from PHP involvement. However, evaluation for concomitant substance use and/or mental disorders may be warranted, which will allow some offending physicians the ability to return to some kind of clinical practice. PHP's may have the expertise and referral experience to manage the mental health concerns of some offending physicians. Further study is needed to evaluate the utility of PHPs in the evaluation and ongoing management of physicians who return (or may potentially return) to clinical practice. — *James C. “Jes” Montgomery, MD; Philip Hemphill, PhD; and Andrew C. Stone, MD, MPH*

DOES LACK OF ANONYMITY FOR PHP PARTICIPANTS PREVENT REFERRAL OF POTENTIALLY IMPAIRED PROVIDERS FOR INTERVENTION?



Charles Meredith, MD



Amanda Shaw, MPH

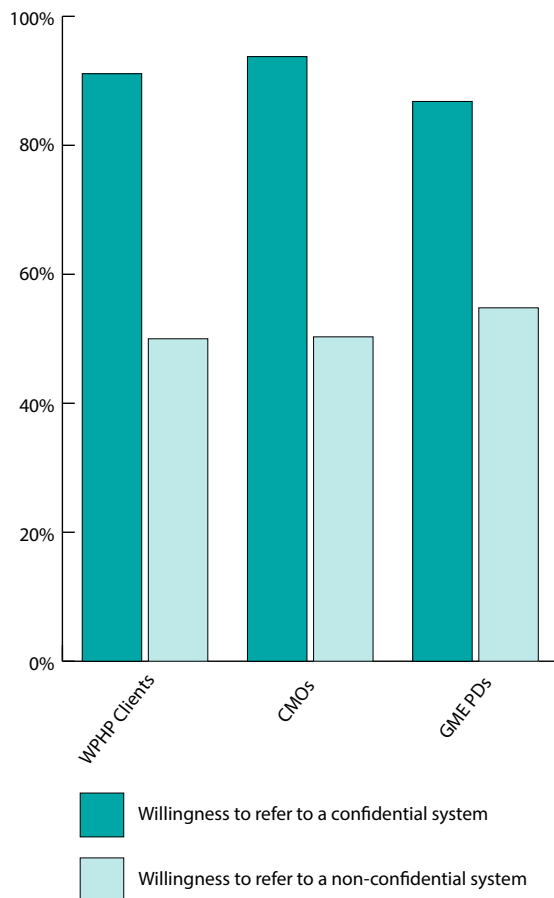


Chris Bundy, MD, MPH

Physician Health Programs (PHPs) have been established at a state level across the United States to promote early identification of and intervention on health care providers suffering from medical conditions that can cause impairment, such as uncontrolled substance use disorders. For years, proponents of PHPs have argued that these programs are most effective when they are allowed to serve as a confidential therapeutic alternative to discipline for physicians suffering from an untreated medical illness with potential for causing impairment.

Not all states permit health care providers to seek help confidentially from a PHP, which may subject an individual to public scrutiny or sanction that could end or impede their career. Subsequently, the authors attempted to test the hypothesis that physicians are much less likely to refer a distressed colleague for help if a confidential therapeutic alternative to discipline is not available.

Respondents of an anonymous quality assurance survey were asked how likely they would be to refer a potentially impaired colleague to the Washington Physicians Health Program (WPHP). They were also asked how likely they would be to proceed with making the referral if such information could not be kept confidential from the state licensing board. These questions were posed to current program participants under monitoring with the WPHP as well as to medical leaders throughout the state of Washington. Specifically, the authors queried all residency program directors around the state, as well as chief medical officers (CMOs) of large hospitals and large physician medical groups. Response rates were high (80%) for WPHP participants but low for CMOs (14%) and residency program directors (25%).



Whether a respondent was a WPHP program participant or an institutional medical leader, their answers were fairly similar. 86.8% of residency program directors, 93.75% of CMOs, and 91.1% of WPHP participants would refer a potentially impaired health care provider to WPHP if the provider's participation could remain confidential. Only

54.8% of residency program directors, 50% of CMOs and 50.3% of WPHP participants would still proceed with the referral if the provider's participation could not remain confidential from the state licensing board.

Somewhat unexpectedly, individuals in a high level position of institutional authority and responsibility were rather unlikely to refer a provider at risk for impairment for appropriate intervention — unless the medically ill provider had a reasonable chance to maintain their confidentiality from the disciplinary authority.

The authors concluded that the presence of a confidential physician health program can markedly increase the likelihood of earlier intervention and treatment for health care providers impaired by a medical illness and is a useful tool to promote public safety. — *Charles Meredith, MD; Amanda Shaw, MPH; and Chris Bundy, MD, MPH*

INTEGRATING THE VALUES-BASED MODEL WITH 12-STEP RECOVERY: HELPING PROFESSIONALS CONFRONT THE BARRIERS TO PERSONAL AND PROFESSIONAL WELL-BEING

This presentation described how the 5 Core Values of the program are integrated with the 12 steps of Recovery. Professionals entering a treatment program after experiencing significant failure in their professional and/or personal roles, due to an impairment can identify with several or all of the values that they are having serious problems upholding in their lives. Since the recovery from addiction using the 12-step recovery model has been very successful with professionals, the integration of the Values Model and 12-step recovery has organically evolved.



Beverly Watson, RN

The 5 Core Values, under the umbrella of awareness are: 1) Open, honest and direct communication; 2) Respect for self and others; 3) Responsibility for one's choices; 4) Accountability to others and willingness to hold others accountable; and 5) Inclusion of all parts of self and others. Integration is weaved continuously into the group process of the treatment milieu through a variety of means. Initially, members of the program will process their experience of attending outside 12-step evening meetings in various groups during the day. They receive feedback from other members and staff, which begins their exploration of how the values and recovery are integrated. Members are held accountable to meeting attendance and participation, ultimately resulting in interpersonal conflicts that are resolved using the values. This process is made explicit in educational and interpersonal groups focused on addiction

recovery as well as other groups. Throughout this experience, integration of 12-step recovery and the values are reinforced into the culture of the milieu. Having taken back responsibility for their own choices, restoring lost parts of self, and developing improved skills for open, honest, and direct communication, this process culminates at the end of treatment, when the member has confronted the barriers that resulted in dysfunction in one or more areas of his/her life and understands how integrating the values in an active way will support ongoing recovery. — *Beverly Watson, RN*

SUNDAY, APRIL 26, 2015

DEVELOPMENT AND IMPLEMENTATION OF OCCUPATIONAL HEALTH MONITORING FOR PHYSICIANS IN NEED OF PROFESSIONAL COACHING

In recent years, Physician Health Services of Massachusetts (PHS) recognized an increase in referrals of physicians who were experiencing significant difficulties in the workplace, but whose challenges could not necessarily be tied to clear mental health or substance use diagnoses. Some of these physicians presented with disruptive behaviors, and others manifested performance difficulties in a variety of domains, including challenges with medical records, punctuality, and time management; difficulty with work-life balance; and an inability to manage conflicts with demanding patients and colleagues. In the past, when clients presented with these types of challenges that fell outside of the typical mental health and substance use disorders, PHS recommended resources for psychoeducational courses or a referral to a professional coach. While some physicians followed these recommendations and responded well to the interventions, many more minimized their “dose” of remediation and the performance issues resurfaced.

Seeing an opportunity to more formally engage physicians with occupational challenges in a proactive remedial and preventive intervention, PHS developed its **Occupational Health Monitoring (OHM) Agreement**. This new type of monitoring agreement focused on a one-year intervention with a commitment to professional coaching. The coaching would include direct input from the workplace, with oversight provided by PHS. The four-party agreement would be signed by the physician, an organizational leader at the workplace, the professional coach, and PHS, with any breach of



Steve Adelman, MD



Debra Grossbaum, Esq.

the agreement being reported to the organizational leader, and *not* to the state licensing board. This was designed to make occupational health monitoring and the remedial coaching intervention attractive to individuals (and their organizations) with early stage occupational difficulties, and to emphasize the focus on remediation rather than discipline.

PHS launched the OHM Agreement in the fall of 2014, and shared its progress with the OHM Agreement at the April 2015 FSPHP Annual Meeting. Specifically, after approximately six months of recommending this innovative intervention, not one physician had signed the agreement. So was it a failure? Not at all. Dr. Steven Adelman shared several surprising and positive outcomes that resulted merely from having the intervention available and initiating discussion about professional coaching. Of the 11 clients for whom the OHM Agreement was recommended, three proceeded with the recommended coaching intervention on their own. One had so quickly and completely ensconced himself in a positive coaching arrangement that by the time that the formal recommendation for the OHM Agreement was made, this physician no longer needed the PHS oversight. Two others took advantage of the coaching recommendation, but, for reasons both related and unrelated to their workplace challenges no longer had work sites to support the structure of the OHM Agreement. Two of the physicians for whom the OHM Agreement was recommended were so challenged in their abilities to interact positively with others that they were not likely to have benefitted from this structured, but self-driven type of intervention. Finally, there were six physicians for whom the recommendation was made, that did not choose to proceed, but that did benefit from having had direct and ongoing conversations with their worksites about their behaviors, potential options for remediation, and future options for oversight if behaviors did not change on their own.

Also, the development of the OHM Agreement brought to the table the many benefits of professional coaching for physicians. Physicians, not unlike professional athletes, must be at the top of their game to provide optimal performance for their patients. Like athletes, they deserve the support and guidance of a professional coach to help them attain and retain this optimal performance level. Through the development of the OHM Agreement, PHS has been able to amass a cadre of skilled practitioners who can serve as professional coaches for the growing population of physicians who could benefit from this service, which resources can also be offered to self-referred practitioners who choose to proceed with this type of support even outside of the context of PHS involvement. PHS views the development of the OHM Agreement and the resulting conversations as helping to create a normative culture of coaching in medicine, hopefully bringing about more civility, productivity, and satisfaction in the profession.

— *Steve Adelman, MD; and Debra Grossbaum, Esq.*

ROLE OF SPIRITUALITY IN PHYSICIAN RECOVERY

- Physicians and patients welcome inclusion of spirituality
- Plays crucial role in the recovery process from substance use disorders (SUDs)
- Physicians with SUDs pose risk to patient safety
- If physicians experience spiritual awakening that is part of 12 Steps of AA, they are:
 - More likely to have longer periods of abstinence
 - Less likely to report having craving for alcohol
 - Improved psychosocial outcomes of treatment
- The spiritual awakening experience
 - Isn't always associated with religion or religious denominational practices
 - Is associated with physicians' unique and intense connection with the AA group's spiritual orientation
 - *John A. Fromson, MD*



John A. Fromson, MD

SOUTHEAST REGIONAL FSPHP MEMBER SURVEY TO ACCESS TREATMENT PROVIDER SERVICES

“SE Regional FSPHP Survey to Assess Treatment Provider Services” was presented by Scott Hambleton, MD, and Paul Earley, MD. The goal was to initiate discussion about consensus expectations of physician health programs (PHPs) regarding services by the facilities that evaluate and treat PHP participants. The survey results were compared to existing 2005 FSPHP Guidelines and challenges of PHPs effectively utilizing treatment provider services were discussed in the context of promoting physician health through effective monitoring. The presentation was not intended to represent treatment guidelines or best practices.

The actual survey was developed by the SE Regional Members and consisted of 51 questions administered by SurveyMonkey. All 10 SE Regional Members completed the survey, including: Alabama; Arkansas; Florida; Georgia; Kentucky; Louisiana; Mississippi; North Carolina; Tennessee; and Virginia. A maximum of two representatives from each PHP completed the survey, which consisted of three sections. The first section regarded



Scott Hambleton, MD



Paul H. Earley, MD, FASAM

substance use disorder related evaluations; the second section addressed comprehensive behavioral evaluations (psychiatric/disruptive behavior/professional sexual misconduct); the last section regarded substance use disorder treatment. The results of the survey were discussed at the SE Regional Meeting of the FSPHP on September 13, 2014.

Caveats included: small sample size; lack of clarity for some questions indicated in comments by respondents; and potential for skewed results because some states had two staff complete the survey and some had only one.

In summary, the opinion of the presenters is that the best approach for appropriate evaluation and treatment of physicians is described by the American Society of Addiction Medicine Criteria in the chapter “Safety Sensitive Occupations.” The overwhelming consensus of the respondents was that more comprehensive evaluation and treatment is considered best, whenever possible. Each PHP is unique, however, consensus of at least two thirds of respondents mirrors the FSPHP Guidelines published in 2005. Ongoing challenges for evaluation and treatment include determination of the appropriate level of forensic involvement for each case, duration and level of treatment, funding for services, as well as application of DSM V diagnostic criteria. Finally, it was unanimously agreed that updated FSPHP Guidelines are necessary. — *Scott Hambleton, MD; and Paul H. Earley, MD, FASAM*

MONDAY, APRIL 27, 2015

PROMOTION OF WELLNESS AMONG MEDICAL STUDENTS TO IMPROVE PHYSICIAN HEALTH

Almost half of U.S. medical students exhibit symptoms of burnout; in addition, anxiety, depressive symptoms, and general psychological distress are higher in medical students than age-matched peers. Anecdotal evidence suggests alcohol abuse, prescription stimulant misuse, and other drug use are also relatively common among medical students. Yet, many students report significant barriers to seeking appropriate mental health care. Students with untreated psychological and substance use disorders may be at increased risk for academic failure, medical errors, and professional dishonesty. Previous research suggests that most physicians referred to one



Lisa Merlo, PhD, MPE



Penelope Ziegler, MD

continued from page 13

state PHP for substance-related impairment already exhibited problematic substance use in medical school.

In the current study, 1,144 medical students (57.1% female) across 9 medical schools in Florida responded to an anonymous survey assessing overall wellness, coping strategies, use of resources, and perceived barriers. Results demonstrated 46.7% of students were less happy since beginning medical school, with “academic workload” and “conflicts with work-life balance” noted as top stressors. Common stress reduction methods included exercise, watching TV/movies, sleeping, listening to music, confidant, eating, and social activities (with or without alcohol). Though 70% of students felt they could benefit from psychological resources, and most were aware of counseling services available within their medical school (85.4%), university (80.5%), or local community (65.6%), only 39.2% were aware that they had access to the state PHP.

Support services were underused, with only 30.2% using medical school services, 9.5% using university services, 8.9% using community services, and 1.1% using PHP services. Most students who utilized the services described them as “very helpful”; however, “lack of time” and “difficulty scheduling around other obligations” were cited as the most significant barriers to accessing help. Barriers related to confidentiality concerns, fears of negative impact on academic record, professional career opportunities, or licensure, and cost were endorsed by about a quarter of the sample. In addition, 11.1% of students had been discouraged from seeking help due to concerns about potential negative career impact.

The plurality of medical students (47.5%) named their spouse/romantic partner as their primary support in the past 6 months, followed by parents (22.9%) and other medical students (16.4%). Notably, 5.4% of students reported having no one they turned to when support was needed. Students also provided input into how medical schools could improve medical student health and well-being, including ideas for a wellness program curriculum and modifications to the scheduling, campus environment, and quality of teaching in their medical schools.

Overall, results demonstrated that there is a significant gap between the percentage of students who feel they would benefit from mental health resources and those who actually utilize these services. Teaching and encouraging medical student self-care is an important method for promoting physician health and preventing future impairment. Medical schools, physician health programs, and licensing boards may need to work together to increase student access to mental health care in order to ensure a healthy physician workforce in the future.

— *Lisa Merlo, PhD, MPE; and Penelope Ziegler, MD*

COGNITIVE DYSFUNCTION AND THE OLDER PHYSICIAN: IS YOUR ORGANIZATION READY TO MEET EMERGING DEMAND?

The U.S. physician population is aging. Currently one in five physicians is 60 years of age or older. The Seattle Longitudinal Study is the largest and most comprehensive longitudinal cohort study measuring changes in cognitive performance over the lifespan. Observations from this study tell us that there is no uniform pattern of cognitive change over time, but that all measured domains show decline with age that becomes noticeable, on average, beginning in the sixth decade of life.

Even modest declines in physician cognitive performance may carry unacceptable risks to patient safety. This begs the question of whether physicians should be subject to mandatory retirement age and if so, at what age. However, because there is substantial inter-individual variability in cognitive decline, a mandatory retirement age for physicians would likely be arbitrary, forcing highly capable physicians out of the workforce at a time when the U.S. physician labor supply can least afford it.

Data from the Washington Physicians Health Program over the last three years reflects trends in the published literature that demonstrate critical associations between referral for impairment for any reason and subsequent findings of cognitive impairment severe enough to warrant discontinuation of clinical practice. It is estimated that 3 to 18% of practicing physicians are impaired and another 10% are incompetent. Cognitive impairment in physicians may be responsible for as many as 63% of preventable medical errors. Finally, advancing age in physicians has consistently been associated with declining performance on cognitive testing and poorer clinical outcomes.

Together, these data suggest that PHPs should consider cognitive screening as part of the initial assessment for all referrals. Such screening is likely to result in increasing need for follow-up assessment and referral to neuropsychologists with special expertise in the evaluation and norming procedures for physicians. Thus, PHPs should begin looking at their capacity to effectively manage these cases and the referral resources available.

PHP stakeholders, including health care organizations, medical executive committees, and state medical boards, are increasingly concerned about how to identify and address cognitive decline in physicians before patient safety is compromised. Mandatory age-based cognitive screening is a promising approach. Increasingly sophisticated screening tools are being developed that can reliably detect existing cognitive dysfunction and also

stratify risk for future cognitive problems in cognitively intact individuals. Risk stratification that targets interventions to vulnerable physicians while decreasing the surveillance burden on low-risk physicians may strike an acceptable balance between physician well-being and public safety.

PHPs are positioned to influence policymakers on the best methods for early identification and intervention for age-based cognitive dysfunction. In addition, PHPs may be ideally suited to provide screening, follow-up assessment, referral and advocacy for aging physicians in a confidential and dignified manner. Federation members have begun collaborative discussions aimed at developing consensus and leadership to address this important physician health issue.

— *Chris Bundy, MD, MPH; Charles Meredith, MD; and Amanda Shaw, MPH*

PREVENTING PHYSICIAN SUICIDE: BEST PRACTICES FOR PROMOTING HOPE AND RESILIENCE

The National Strategy for Suicide Prevention (2012) has called for the use of multiple access points to increase the possibility that suicidal individuals will receive help and support with their despair. The challenge of seeking help for suicidality is particularly prominent among the physician community, where concerns loom large regarding the loss of privileges, sanctions from medical boards, loss of respect, or internally felt shame around one's suicidal feelings. Preventing physician suicide involves several key elements: 1) messaging that help is available; 2) destigmatizing help with stories of physicians who have recovered from suicidal distress; and 3) creating opportunities for increased peer support around the unique stressors physicians face. Recent research on the use of peer support among distressed physicians has demonstrated the helpfulness of realizing one is not alone with suicidal despair, decreases in shame and judgments of failure, and lessened distress. Given the relative risk of suicidal despair among physicians compared to many other professions, this session addressed practical steps physician health programs can take to convey openness and receptivity to the needs of our physicians in the throes of suicidal despair. With support, renewed hope is possible. — *Michael Groat, PhD, MS*



Michael Groat, PhD, MS

DISTRESSED PHYSICIANS: A SYNTHESIS OF PHP'S BEST PRACTICES

There is increasing recognition of the importance of communication and appropriate professional comportment in the delivery of high quality medical care. Research suggests that physicians who engage in behaviors that are disruptive to the functioning of the system can have a negative impact on co-workers and patients. Leape and Fromson note that such behaviors can increase likelihood of errors, as other providers tend to avoid the problematic physician, hesitate to ask for help or clarification of orders, and hesitate to make suggestions about patient care.¹ The behavior can decrease morale and satisfaction of staff and undermine patients' confidence in the physician and institution. Disruptive behavior takes several forms, has varied causes and necessitates various management strategies. Typical behaviors include aggressive acts, yelling, demeaning comments, throwing objects, laying hands on staff and/or colleagues, as well as more passive acts such as not answering phone calls or pages or not completing charts. The diverse presentations of the behavior and varied workplace responses contribute to difficulties in appropriately managing and ultimately extinguishing problematic behaviors. Failure to consider the multi-factorial causes and manifestations of disruptive behavior contributes to ineffective approaches that do not successfully address the problem and present a high risk of relapse, thus posing a continuing threat to patient safety.²

Our review of information on fsphp.org suggests that physician health programs' responses to referrals about these problematic behaviors can generally be divided into three categories: no services provided; referrals for resources only; and direct monitoring services. Some PHPs choose a hybrid service model where they also provide group participation opportunities for "disruptive" practitioners. When programs do provide services, variability exists in the length, components, and term of the monitoring contract.

The Florida Professionals Resource Network (PRN) has adopted an approach that stresses the importance of open communication between the referring party, PRN, and the identified physician. After PRN receives a referral, the case manager completes a comprehensive intake. Crucial to the process are support and appropriate documentation from the referral. Multidisciplinary evaluations are frequently



Christina Gaudiana, LMHC



Betsy Williams, PhD, MPH

continued from page 15

requested and evaluation recommendations are staffed. A review of 25 recent PRN cases indicates that post-evaluation 42% of participants were referred to outpatient services and a monitoring contract, 33% required a professionals program followed by monitoring, 8% required no further action, and 16% were non-compliant and turned over to the Department of Health.

Critical lessons learned include the importance of 1) Support from the referral source; 2) Workplace monitor chosen by Referral Source; 3) Psychotherapist specializing in personality disorders and professionals; 4) Communication between care providers, PRN, and appropriate parties in workplace; 5) CME curriculum including skills development and system understanding³; 6) 360 surveys⁴; 7) Contract flexibility; and 8) Accountability.

In summary, physicians displaying disruptive behavior in the workplace are a heterogeneous group. Characteristics of effective treatment range from education to changes in workplace systems. Treatment optimally addresses both the cause and/or motivation of the disruptive behavior and teaches the physician new and more adaptive ways of interacting. Monitoring and accountability are important for long term-sustained changes in behavior.

— *Christina Gaudiana, LMHC; and Betsy Williams, PhD, MPH*

References

- ¹Leape LL, Fromson JA. Problem doctors: is there a system-level solution? *Ann Intern Med.* 2006;144(2):107–115.
- ²Williams BW, Williams MV. The disruptive physician: A conceptual organization. *Journal of Medical Licensure and Discipline.* 2008;94(3):12–20.
- ³Samenow CP, Swiggart W, Spickard A. A CME course aimed at addressing disruptive physician behavior. *Physician Executive.* 2008;34(1):32–40.
- ⁴Swiggart W, Williams M, Williams B, Dewey C, Ghulyan M, Walston K. Assessments of a Physician's Workplace Behavior. *Physician Executive.* 2014:28–33.

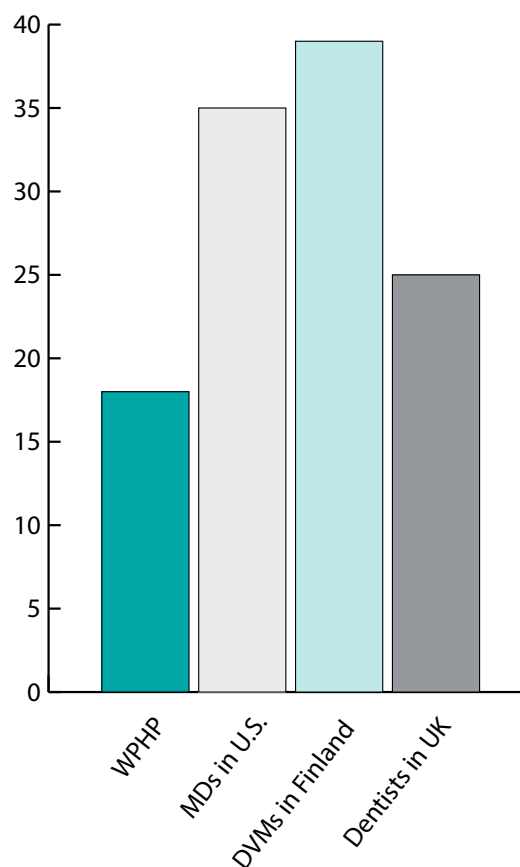
PREVALENCE OF BURNOUT AMONG PARTICIPANTS OF A STATE PHYSICIAN HEALTH PROGRAM

The phenomenon of burnout is thought to have become endemic to medicine, garnering widespread interest and media discussion. In general populations of actively practicing health care providers, the prevalence of burnout has been reported to be 40% among veterinarians, 26% among dentists, and 35–46% among physicians. The presence of prolonged burnout is correlated with increased medical error rates, a comorbid alcohol use disorder, and increased rates of suicidal ideation.

Given recent attention focused on this health issue, the authors attempted to determine the prevalence of burnout in a population of doctoral-level health care providers under active monitoring in a physician health program (PHP). The authors analyzed data from a quality assurance survey administered annually to participants in the Washington Physicians Health Program (WPHP). This brief survey instrument includes both questions from the mini Maslach Burnout Inventory, which has been validated as an accurate brief screening instrument for the presence of burnout.

Survey response rate was 72% in 2014 and comparable in 2012–2013, indicating that prevalence rates identified in this study are an accurate reflection of the incidence of burnout in a population of doctoral-level health care providers under active monitoring in a PHP. From 2012 to 2014, the prevalence of burnout in this population ranged from 15.26–19.20%, well below the prevalence rates measured in general populations of practicing dentists, physicians, and veterinarians. Prevalence rates for burnout differed little between WPHP participants in monitoring for a substance use disorder versus those in monitoring for a behavioral health disorder.

BURNOUT



In any given year from 2010 to 2015, on average 75% of program participants under active monitoring by WPHP have been allopathic or osteopathic physicians, 10% have been physician assistants, 10% have been dentists, 3–4% have been veterinarians, and 1% have been podiatrists.

The authors of this study concluded that for reasons that are unclear, participation in the monitoring and treatment process administered by a physician health program (PHP) is inversely correlated with the development of provider burnout. — *Chris Bundy, MD, MPH; Charles Meredith, MD; and Amanda Shaw, MPH*

PHYSICIAN REENTRY TO PRACTICE

The Federation of State Medical Boards (FSMB) has convened two committees — the Special Committee on Reentry to Practice (2012) and the Special Committee on Reentry for the Ill Physician (2013) — to develop recommendations and model policy regarding physician reentry to practice.



Janelle Rhyne, MD, FSMB

The Special Committee on Reentry for the Ill Physician addressed the return to practice for physicians who have a licensure restriction due to physical or psychiatric illness, including addictive disease. Specifically, the Committee drafted recommendations aimed at ensuring formerly ill physicians are capable of providing safe, effective patient care without feeling encumbered or penalized as a result of license restrictions that are interpreted negatively and impact their ability to obtain or maintain specialty certification, insurance, hospital privileges, or employment.

Highlights from the committee's report include:

- The need to clarify the distinction between illness and impairment.
- A license restriction due to medical fitness concerns is different from a license restriction containing a restricted practice clause and does not necessarily imply a lack of professionalism or that the physician is unable to practice safely.
- Physicians returning to clinical work following an illness should be considered on a case-by-case basis.
- State boards should consult physician health programs for assessment and monitoring services.

- Physicians who have been out of practice for an extended time should participate in a reentry plan.
- Language and information used in state boards' licensing and disciplinary processes should be clarified and standardized.
- Decisions about a physician's specialty certification status, insurance, hospital privileges, and employment should be based on consideration of all available information about the physician's illness and relevant state board actions.
— *Janelle Rhyne, MD, FSMB Guest Speaker*

INTERSTATE MEDICAL LICENSURE COMPACT

In September 2014, following an 18-month drafting process, final model legislative language of an Interstate Medical Licensure Compact was released to states and their respective medical boards for their formal consideration. The Interstate Medical Licensure Compact, a new expedited medical licensure pathway, is expected to streamline and simplify the licensing process, expand access to care and facilitate telemedicine, while ensuring each state's medical regulatory authority in the protection of the public.

The compact is an adjunct licensure pathway that is voluntary for both physicians and states. Physicians who meet certain eligibility criteria will be able to utilize the compact process to expeditiously obtain licensure in other Compact Member States. A Compact Commission, comprised of representatives of state medical boards participating in the compact, will administer the new licensure process.

The Interstate Medical Licensure Compact has the support of nearly 30 state medical and osteopathic boards, as well as a number of hospitals, health systems, and medical provider and specialty organizations across the nation.

As of June 30, 2015, the compact has been signed into law in nine states, including Wyoming, South Dakota, Utah, Idaho, Montana, West Virginia, Minnesota, Nevada, and Alabama, and is currently on the desk of the governors of Illinois and Iowa. The compact has been introduced in eight additional state legislatures, and is being considered on the floors and in committees in legislatures across the nation. Several additional legislative introductions and enactments are expected this year, and many more in the future.

— *Janelle Rhyne, MD, FSMB Guest Speaker*

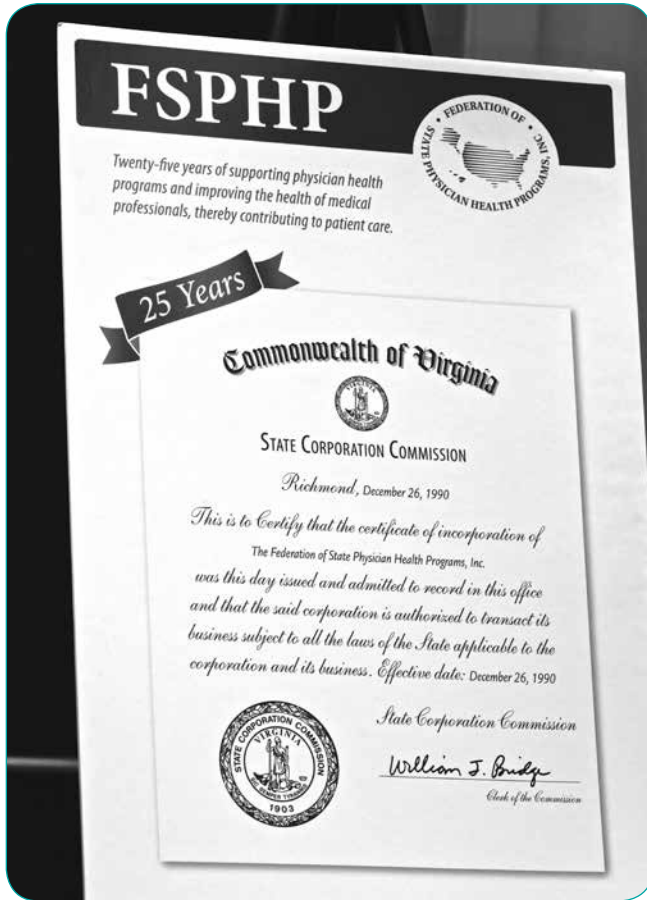
ANNUAL MEETING 2015



FSPHP Board of Directors and FSPHP Past Presidents



FSPHP Annual Meeting 2015 Attendees



FSPHP 25th Anniversary



Dr. Doris Gundersen, FSPHP President Welcome



Drs. Martha Brown and Penny Zeigler



Dr. Lynn Hanks, FSPHP Anniversary Speaker

ANNUAL MEETING 2015 (continued)



FSPHP Annual Meeting 2015 Attendees



Drs. Paul Earley, Lynn Hanks, Michael Wilkerson, and Doris Gundersen



Janelle Rhyne, MD, FSMB Guest Speaker



Drs. John Fromson, Lynn Hanks, Michael Gendel, Warren Pendergast, Doris Gundersen, and Brad Hall

SAVE THE DATE

THURSDAY, APRIL 28—SUNDAY, MAY 1, 2016



Federation of State Physician Health Programs Annual Education Conference and Business Meeting

Essentials of Physician Health Programs: Success During Challenging Times

The FSPHP is excited to announce the 2016 Federation of State Physician Health Programs Annual Education Conference and Business Meeting — *Essentials of Physician Health Programs: Success During Challenging Times* will be held in beautiful, sunny San Diego at the Manchester Grand Hyatt San Diego on Thursday, April 28—Sunday, May 1, 2016.

Our room block is now open. To make your reservation, please call (888) 591-1234 or visit <https://resweb.passkey.com/go/FSPHP2016>. Room rates are \$219 for a standard room, and our code is G-FSPH.

MANCHESTER GRAND HYATT SAN DIEGO

1 Market Place

San Diego, CA 92101

(619) 232-1234

manchestergrand.hyatt.com/en/hotel/home.html



Highlights

- General and breakout sessions each day to share physician health best practices
- Networking Opportunities
- Large exhibitor space for networking in the field
- Daily Peer Support Groups
- Tentative Schedule Subject to Change

Tentative Schedule Subject to Change

THURSDAY

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

FRIDAY

- New Member Meeting
- General Sessions
- Poster Session
- Board and Committee Chair Dinner

SATURDAY

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

SUNDAY

- 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 AND OTHER RELATED ORGANIZATIONS NATIONAL MEETINGS

FSPHP ANNUAL MEETINGS

April 28–May 1, 2016
Manchester Grand Hyatt
San Diego, CA

April 19–23, 2017
Worthington Renaissance Fort Worth
Hotel
Fort Worth, TX

FSPHP REGIONAL MEETINGS

Southeast FSPHP Membership Meeting
August 21–22, 2015
Ritz Carlton, Amelia Island, FL

Western FSPHP Membership Meeting
October 23, 2015
Hyatt Regency San Francisco Airport
San Francisco, CA

Northeast FSPHP Membership Meeting
October 29, 2015
Massachusetts Medical Society
Headquarters, Waltham, MA

FSMB ANNUAL MEETINGS

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

April 20–22, 2017
Omni Fort Worth Hotel
Fort Worth, Texas

2015 CANADIAN CONFERENCE ON PHYSICIAN HEALTH
October 16–17, 2015
Winnipeg, MB

2016 AMA-CMA-BMA INTERNATIONAL CONFERENCE ON PHYSICIAN HEALTH
September 18–20, 2016
Renaissance Boston Waterfront Hotel
Boston, MA

AMERICAN ACADEMY OF ADDICTION PSYCHIATRY ANNUAL MEETING AND SYMPOSIUM
December 3–6, 2015

Hyatt Regency Huntington Beach
Resort and Spa
Huntington Beach, CA

December 1–4, 2016
Hyatt Regency Coconut Point
Resort and Spa
Bonita Springs, FL

AMA HOUSE OF DELEGATES ANNUAL MEETING
June 11–15, 2016

Hyatt Regency Chicago
Chicago, IL

June 10–14, 2017
Hyatt Regency Chicago
Chicago, IL

June 9–13, 2018
Hyatt Regency Chicago
Chicago, IL

AMA HOUSE OF DELEGATES INTERIM MEETING

November 14–17, 2015
Atlanta Marriott Marquis
Atlanta, GA
November 12–15, 2016
Walt Disney World Swan/Dolphin
Orlando, FL

November 11–14, 2017
Hawaii Convention Center
Honolulu, HI

November 10–13, 2018
Gaylord National
National Harbor, MD

AMERICAN PSYCHIATRIC ASSOCIATION ANNUAL MEETING

May 14–18, 2016
Atlanta, GA

May 20–24, 2017
San Diego, CA

May 5–9, 2018
New York, NY

May 18–22, 2019
San Francisco, CA

AMERICAN SOCIETY OF ADDICTION MEDICINE

ASAM 47th Annual Conference
Hilton Baltimore
April 14–17, 2016
Baltimore, MD

ASAM State of the Art Course in Addiction Medicine
October 6–8, 2016
Washington Hilton
Washington, DC

ASAM 48th Annual Conference
April 6–9, 2017
Hilton New Orleans Riverside
New Orleans, LA

ASAM 49th Annual Conference
April 12–15, 2018
Hilton San Diego Bayfront
San Diego, CA

ASAM 50th Annual Conference
April 4–7, 2019
Hilton, Orlando
Orlando, FL

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.

INTERNATIONAL DOCTORS IN ALCOHOLICS ANONYMOUS (IDAA) ANNUAL MEETING

August 5–9, 2015
Norfolk Waterside Marriott
Norfolk, Virginia

2016 — New Orleans, Louisiana
2017 — Salt Lake City (Snowbird),
Utah
2018 — Reno, Nevada

CARING FOR THE CAREGIVERS X: ENHANCING THE QUALITY OF YOUR PROFESSIONAL LIFE

October 30, 2015
Jointly provided by the Massachusetts Medical Society and Physician Health Services, Inc.

This program is designed to help physicians and other health professionals develop and implement strategies to improve their own health and well-being. For more information, contact Jessica Vautour at (781) 434-7903.

MANAGING WORKPLACE CONFLICT: IMPROVING PERSONAL EFFECTIVENESS

Jointly provided by the Massachusetts Medical Society and Physician Health Services, Inc.

This program, held each spring and fall, is an educational forum for physicians to learn improved methods of relating with peers, coworkers, and patients and improving relationships at work. For more information, contact Jessica Vautour at (781) 434-7903.
November 19–20, 2015
Waltham, MA

NATIONAL ORGANIZATION OF ALTERNATIVE PROGRAM

March 15–18, 2016
West Palm Beach Marriott
West Palm Beach, FL

MEDICAL GROUP MANAGEMENT ASSOCIATION

October 11–14, 2015
Nashville, TN

AMERICAN BOARD OF MEDICAL SPECIALTIES ANNUAL CONFERENCE

September 9–11, 2015
Chicago, IL

NATIONAL ASSOCIATION OF MEDICAL STAFF SERVICES

NAMSS 39th Educational Conference and Exhibition
Washington State Convention Center
October 3–7, 2015
Seattle, WA

NAMSS 40th Educational Conference and Exhibition
Sheraton Boston Hotel
September 17–21, 2016
Boston, MA

NAMSS 41ST EDUCATIONAL CONFERENCE AND EXHIBITION

The Broadmoor
October 21–25, 2017
Colorado Springs, CO

NAMSS 42ND EDUCATIONAL CONFERENCE AND EXHIBITION

Long Beach Convention Center
September 29–October 3, 2018
Long Beach, CA

NAMSS 43RD EDUCATIONAL CONFERENCE AND EXHIBITION

Philadelphia Marriott Downtown
October 19–23, 2019
Philadelphia, PA

AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW

46th Annual Meeting
October 22–25, 2015
Marriott Harbor Beach Resort
Fort Lauderdale, FL

47th Annual Meeting
October 27–30, 2016
Hilton, Portland and Executive Tower
Portland, OR

AMERSA — ASSOCIATION FOR MEDICAL EDUCATION AND RESEARCH IN SUBSTANCE ABUSE

39th Annual National Conference
November 5–7, 2015
The Fairmont Hotel, Washington, DC, Georgetown

FSPHP E-GROUPS — PLEASE JOIN!

An extraordinarily valuable tool for our members is the FSPHP e-groups, providing a user-friendly capability to share information among our members. As you may know, we now have two e-groups.

FSPHS e-groups are a forum for discussion of issues, problems, ideas, or concerns, relevant to State PHPs.

Membership to the e-groups is only open to Federation members. Visit www.fsphp.org/FSPHPEGroupGuidelines11.14.pdf for guidelines on the use of the e-group.

For any questions concerning the two e-groups groups, please call Debbie Brennan or Jessica Vautour at (781) 434-7343. There are currently many FSPHP members who are not yet enrolled on the fsphpmembers@yahoo.com. We'd like to change this to ensure all are enrolled. Please watch for an email invitation to join this group, if you are not already on it.

fsphpmembers@yahoo.com

An information exchange venue for ALL FSPHP MEMBERSHIP CATEGORIES. This includes State, Associate, Honorary, International, Individual, and Organizational members of the Federation of State Physician Health Programs, Inc.

statePHP@yahoo.com

A group limited to the following membership categories — State, Associate, Honorary, and International categories. All State, Associate, Honorary, and International members are eligible for both groups. Please join both. — *Linda Bresnahan, MS, Executive Director FSPHP*





Federation of State Physician Health Programs
860 Winter Street
Waltham, MA 02451-1414

Non-Profit Org.
U.S. Postage
PAID
Boston, MA
Permit No. 59673

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)

Paul Earley, MD (AL)

Sarah Early, PsyD (CO)

Scott Hambleton, MD (MS)

Carole Hoffman, PhD, LCSW, CAADC (IL)

Linda Kuhn (TX)

Charles Meredith, MD (WA)

Warren Pendergast, MD (NC)

Cathy Stratton (ME)

Amy VanMaanen, LBSW (IA)

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