

PHYSICIAN HEALTH NEWS

The Official Newsletter of the Federation of State Physician Health Programs

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Welcome to the 16th edition of *Physician Health News*. We hope you will find this an informative forum for all aspects of physician health and well-being.

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

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The FSPHP is a national organization providing an exchange of information among state physician health programs to develop common objectives, goals, and standards.

If you're not yet a member, please consider joining. State membership is \$400.00 per year, and individual (associate) membership is \$100.00. We sincerely hope you respond as an indication of your commitment to a stronger, more cohesive Federation of State Physician Health Programs. For more information on each of the membership categories, please contact Vickie Grosso of the AMA at (312) 464-4574.

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Message from the President



Peter Mansky, MD

We live in a time when state physician health programs (PHPs) are being challenged and have experienced turnover. On the other side of the equation, we can be grateful and proud of our gains in the past two decades.

In 1992, when I first became the medical director of the New York Physician Health Program, there were no principles or clinical guidelines to follow except those of good addiction or other psychiatric treatment. Very little in the medical literature specifically addressed physician health programs. Conversations with colleagues David Canavan, David Dodd, Bill Farley, Doug Talbott, Marty Doot, Gerry Summer, Roger Goetz, Lynn Hankes helped, but it was clear that we needed more interchange and opportunities to discuss our dilemmas and triumphs.

There were some discussions during American Society of Addiction Medicine (ASAM) meetings, but it became evident that the best place to discuss issues concerning state physician health programs was the FSPHP. In 1994, a group of us representing state physician health programs met in Tennessee to refine the FSPHP bylaws. Our first national meeting consisted of about 15 to 20 attendees sitting around a table in a small conference room. It was modest, but it was a start.

We now have 10 times the attendance, meet in a larger area, and have support from the vendors we interact with daily. But we're still a membership organization of state PHPs with associate members currently involved in the programs. We've lost invaluable members from our federation because they've left their state PHPs, retired, or left the field. Although Gary Carr, Susan McCall, Mick Oreskovich, Lynn Hankes, Ray Pomm, and James Jennings have left their state PHPs, other members, such as Penny Ziegler, have returned. Returning members, new members, and an excellent executive director have given the FSPHP new life.

Although our current members are all representatives from state PHPs, the board of directors asked the membership committee to recommend conditions and guidelines for individuals not presently associated with a state PHP to become members. On the basis of the committee's

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report, the board has now directed the bylaw committee to draft language for an individual membership category for individuals who are not associated with state PHPs. While these members would not have a role in the governance of our federation, they would have other privileges. Considerations include granting access to our members-only website when it launches, which will include an area for posting questions. They would get the FSPHP newsletter and be able to attend our annual national meetings as well as area meetings, perhaps with a discount. Consideration for them to serve as consultants to our committees, but not as regular committee members, is under review. The current thought is to limit the number of consultants on any committee. Members in the new category would not have access to the listserv.

The individual membership category would include interested individuals, clinical members of rehabs or other clinical programs, as well as individuals who run other types of monitoring programs. All members in this category would be vetted and approved by the FSPHP Board of Directors. The cost of their membership would be the same as associate membership. This would allow talented individuals to interact with our regular membership and bring considerable new revenues to our federation.

I want to thank the membership committee for their work in the development of an individual membership category. Comments and suggestions concerning the new category are welcome. For more information, please contact representatives in your area who are on the FSPHP board.

Peter Mansky, MD

Message from the Executive Director

Evolution

“Evolution is the only science in which multiplication and division mean the same thing.”

I’m going to wear my medical society hat for a second. The changing face of medicine is creating a great deal of angst amongst physicians and those of us who serve you.

It’s no surprise that we’re creatures of habit and when the course is unclear, we get that uneasy feeling in the

pits of our stomachs. I speak for myself by saying that even when I logically conclude that change is good, the process of getting from here to there can still be uncomfortable.

Medical societies have endured a decline in membership for years because the “value proposition” traditionally associated with medical societies hasn’t resonated with the younger, more diverse audience. As described by Steve Smith, CAE, Jim Swartwout, and Barbara Greenan in the American Association of Medical Society Executives’ *AAMSE Trends Report*, “A successful medical society must do more than simply provide resources, programs, services, and representation through advocacy in order to attract and retain members. Decisions to join or renew are increasingly based upon whether the membership experience offers considerable value, unique access, and sustainable support.” I think the good news is that medical societies have begun to take advantage of technological tools to successfully transition into diverse, modern, and tech-savvy organizations where value is again being measured and memberships will stabilize. Growth must now be an objective.

As a professional association, the FSPHP, representing state physician health programs (PHPs), shares much of a medical society’s DNA — the value proposition is readily identified. In my two years with the organization, I have never heard anyone remark, “I see no value in membership.” In fact, the opposite has been the case. A key question has been to what extent we can exploit the value proposition to further enhance the science of physician health *and* help generate very badly needed revenue for the FSPHP. Your membership committee has been wrestling with that objective for two years now. It is not an easy task, for it involves meeting the objectives of membership expansion without changing the scope and character of the FSPHP. The fact that we represent state physician health programs numerically limits the number of members we can have as we are currently constituted. But service to your programs is what we’re all about, and nothing we do must ever adversely affect that.

Our members and the intellectual hardware they provide to the organization are assets that many ancillary professionals in the physician health world cherish greatly. Conceptually, it appears possible that we could meet our objectives while, at the same time, share knowledge throughout the health care system. By using the Internet and listserv networking, we can stimulate an online forum for the physician health community, thereby expanding the knowledge of physician health while staying true to our mission. On the flip side, we would be building



Jonathan Dougherty

alliances with allied professionals who would better understand what challenges state PHPs face. Going back to the value proposition, we would be providing measurable value, unique access, and sustainable support.

I am highly confident that your leadership will value any thoughts you may have on how the FSPHP can evolve to better address the needs of state PHPs. As we continue to explore other avenues for membership, please share with your regional directors any ideas you may have about where you would like to see the FSPHP progress in the coming years.

Jonathan H. Dougherty, MS

AMA Official Observer Status

Model Physician Health Program Act

In the last FSPHP *Physician Health News* update in April 2010, I summarized the status of the AMA's Model Physician Health Program Act of 1985 and the new resolution to update the act. The resolution was first introduced in June 2009 at the AMA annual meeting in Chicago. It was then further discussed at the annual meeting in 2010, with the determination that a revised model act report would be presented at the AMA Interim Meeting in San Diego in November 2010. Our FSPHP was asked to collaborate with the AMA's Physician Health and Health Care Disparities Department to update the document.

A federation taskforce consisting of Warren Pendergast, Doris Gundersen, Mick Oreskovich, and me took on the task of drafting a revision of the act and providing it to the AMA for inclusion. Throughout the course of last fall, we studiously worked on this project. We saw it as a great opportunity to incorporate all the principles and values that we in the federation know so well. We developed definitions of key terms, included a historical background of physician health programs (PHPs), provided key concepts from the federation's guidelines for PHPs, and described future goals for the development of physician health within the AMA. Our draft was accepted by the AMA group working on the report, incorporated into their report, and then provided to the AMA's Council on Science and Public Health, which reviewed, accepted, and presented the completed report to the delegates in San Diego last November.

I was present and involved in the reference committee where the report was presented and comments and questions were raised. The ensuing discussion was positive: interest in ensuring that physician mental health issues, not just substance use disorders, were included in PHPs; inclusion of medical students; and addressing

the increasing problem with physician behavior and workplace conflict, disruptive concerns we all know too well. These points led to revisions to the report, which was presented the next day to the House of Delegates for debate and approval. House debate was vigorous and interesting, focusing on disruptive physician behavior, its definition, how and by whom it should be assessed, and other related concerns. Although overall I found the discussion positive and with wide support of state PHPs and our missions, it was clear to me that the AMA was not ready to accept a revised model act with only a limited discussion of physician behaviors. The report was therefore sent back to the AMA's physician health group for further revision. Sonja Boone, MD, the director of the department, will assist me in modifying the report, which will be presented again to the House of Delegates at the annual meeting in June.

Federation of State Medical Boards (FSMB) and American Society of Addiction Medicine (ASAM)

At the San Diego interim meeting, I spoke with FSMB President Freda Bush, MD, incoming President Janelle Rhyne, MD, MA, MACP, and former ASAM President Michael Miller, MD, about their interests in updating their respective physician health policies and aligning the principles and concepts. As it turns out, the FSPHP is actively involved in these projects. Brad Hall, Warren Pendergast, Judy Rivenback, and Gary Carr are active members of a FSMB workgroup formed to update the 1995 policy on impaired physicians. James Bolton, PhD, of the FSMB chairs the group. The ASAM committee charged with drafting revisions includes Brad Hall, Gary Carr, Lynn Hankes, and Paul Earley. They have drafted 11 new policies for submission to the ASAM board of directors at their annual meeting in April 2011. Our hope is that we can assist in developing updated physician health policies that will be comparable and consistent with those of the AMA, ASAM, and the FSMB.

Another important aspect of the official observer work is to be able to meet with AMA delegates and members and the organizations they represent. I continue to be encouraged and impressed by the widespread interest in all aspects of physician health and wellness and the work that we do. Many state delegates have spoken proudly of their state PHP, directors, and staff. I feel rewarded that I can comfortably acknowledge my collegial relationship with each of you.

I welcome any comments, feedback, or suggestions, and I look forward to seeing each of you in April in Seattle.

Luis T. Sanchez, MD

AMG Names Gordon Medical Director of Illinois Professionals Health Program



Cynthia Gordon, MD, JD, Medical Director, Illinois Professionals Health Program Advocate Medical Group

Advocate Medical Group (AMG) is very pleased to announce that Cynthia Gordon, MD, JD, has accepted the role of medical director of the Illinois Professionals Health Program (IPHP) effective immediately. Dr. Gordon has been acting as interim director since August 2010, when Dr. Stafford Henry stepped down.

A graduate of Grinnell College in Iowa and DePaul University College of Law, Dr. Gordon

received her medical degree from Rush Medical School of Chicago, and in 2009, completed her psychiatry residency at Lutheran General Hospital in Park Ridge, Illinois. She currently specializes in general psychiatry with a focus on addictions and psychotherapy and serves as the medical director of the Advocate Addiction Treatment Program (AATP).

“We are delighted that Dr. Gordon has accepted this important position at IPHP,” said Kevin McCune, MD, AMG’s vice president of medical management and chief medical officer. “She has done an exceptional job as interim director and we couldn’t be happier to have her in this role full time. This is a wonderful program for our professional community, and Cynthia will be a wonderful leader.”

The IPHP was founded by a group of concerned physicians who were committed to supporting and aiding other health care professionals in difficult, challenging, and unanticipated situations. Today, the goal is to assist, guide, and advocate for participants so they can attain and maintain overall wellness while safely practicing their chosen profession.

The IPHP has no disciplinary role or authority. Its activities are solely related to advocacy, education, wellness, and support.

For more information, call (847) 795-2810.

Illinois Professionals Health Program
701 Lee Street, Suite 100
Des Plaines, Illinois 60016-4545

Please join us in congratulating Dr. Gordon on her new role!

FSPHP Past President Elected Trustee to AA



John Fromson, MD

John Fromson, MD, FSPHP past president, founding director, and current board member of Physician Health Services in Massachusetts, was elected class A trustee of the General Service Board of Alcoholics Anonymous, Inc. (AA). Founded in 1935, AA is a fellowship of more than 2,000,000 recovering alcoholics in the United States, Canada, and around the world who meet in 115,000 local groups to share their experiences, strength, and hope in an effort to help themselves and others recover from alcoholism.

What Has Happened in California since the Diversion Program Closed?

The Medical Board of California voted in July 2007 to end its 27-year-old diversion program by July 2008. In September 2007, the California Medical Association (CMA) convened a workgroup of interested stakeholders that included the California Society of Addiction Medicine (CSAM), the California Psychiatric Association (CPA), the California Hospital Association (CHA), and others in order to create a legislatively authorized, independent nonprofit entity to reestablish a physician health program for the state. We’ve been working on this for over three years and are reminded that nothing is easy in a state as large and diverse as California.

In both 2008 and 2009, a bill to create a new Physician Health Program (PHP) was introduced into the state Legislature. The first bill passed both houses with wide margins, but the governor vetoed it. The second bill didn’t advance past the first house because the governor had yet to change his mind. California now has a new governor, Legislature, and significantly changed medical board. Meanwhile, in late 2009, we created a new independent nonprofit 501(c)(3) corporation called California Public Protection and Physician Health, Inc. (CPPPH). It has a small, dedicated board drawn from the workgroup, brand new Executive Director Sandra Bressler, a top-notch clinical advisory committee, and \$100,000 in the bank to underwrite the costs of starting the new organization. Funding is comprised of donations from all sectors of the medical community: specialty and county medical societies, the CMA, the CHA, and a California liability carrier.

While CPPPH becomes established operationally, our funding and coalition partners are pursuing new legislative language in an effort to secure authority to receive funds from California physician-licensure fees and to get legislative recognition for the creation of a new and hopefully improved statewide program.

The new program designed by CPPPH will serve as the central coordinating entity to provide physicians and other consumers (hospitals, well-being committees, treatment providers, and hopefully some day the medical board itself) with evaluation tools, service referral options, individual case consultations, information about credible educational and treatment resources, monitoring programs, and testing services.

Private monitoring organizations emerged when the diversion program closed, and they continue to provide some of the services today. However, these programs are not readily known to the broader community of those in need, coordinated with each other, or widely accessible. Therefore, there's significant concern that physicians who need ongoing support and monitoring continue to practice without such aid and supervision. These are the needs CPPPH proposes to address.

CPPPH will design a full-spectrum PHP, with the help of existing programs and providers, that will also include a wellness component and educational and support services to assist those responsible for assuring quality patient care. Our efforts will proceed in stages. Parallel with the legislative effort, we are working to expand our well-being network with consultation services for all who need them; to identify standards and guidelines for all elements of a PHP; and to create a stable, solid, and sustainable organization capable of assuming responsibility for a robust statewide legislatively mandated physician health program. With the continued hard work of our staff, board, and workgroup, and with the continued support of the medical community, our state agencies, and our governing bodies, we *will* get there by 2013.

We welcome your comments. Contact us at CPPPHInc@gmail.com.

James Hay, MD, chair of the board, California Public Protection and Physician Health, Inc.

Physician Health Services in Texas

Texas Medical Association Committee on Physician Health and Rehabilitation

The Texas Medical Association (TMA) Committee on Physician Health and Rehabilitation (PHR), established in 1976, is available to all physicians, residents, and medical students in Texas. Under the direction of B. Dean McDaniel, DO, chair, the committee helps to ensure safe patient care by promoting the health and well-being of Texas physicians, ensuring safe patient care through identification of physicians whose practice is compromised, and providing responsible advocacy for the physician while maintaining confidentiality and the highest ethical standards. As advocates, the committee arranges for intervention, refers for evaluation and treatment, and monitors physicians upon return from treatment. There are no participant fees for PHR services; however, physicians are responsible for individual treatment and drug test expenses.

Issues addressed by the TMA PHR Committee include stress and burnout, substance use disorders (SUD), psychiatric problems, disruptive behavior, sexual misconduct and boundary issues, physical and cognitive impairment, aging and retirement, and physical illness. The committee partners with county medical society PHR programs throughout the state to arrange interventions (when appropriate) and offer suggestions of facilities that have met established TMA PHR Committee criteria for evaluation and treatment. Similarly, it collaborates with hospital-based physician health and wellness committees in the state. The TMA committee appointed 15 district coordinators to oversee physician health activities in their respective districts and respond to referrals when local PHR services are not available. Anyone can report a concern about a physician, resident, or medical student in need of medical care or professional counseling by calling the committee's 24-hour hotline at (800) 880-1640 or (512) 370-1640.

The TMA PHR Committee also provides several other services to the community:

- The committee educates physicians and their spouses, medical students, health care entities, and others regarding health conditions that may compromise the quality of care provided to patients.
- The committee encourages physicians to focus on developing healthy lifestyles, avoiding substance use disorders (SUDs) and behavioral disturbances, and seeking early care for themselves or colleagues who experience preventable and unpreventable serious illness.

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- The committee manages a statewide random urine drug screen program for physicians in recovery.
- The committee also operates a loan fund for physicians who cannot afford treatment for depression, substance use disorders, or other problems, or whose families need assistance with short-term living expenses while the physician receives treatment.

Texas Physician Health Program

Statute 292 established the Texas Physician Health Program (TXPHP) during the 2009 legislative session. It helps impaired physicians, physician assistants, acupuncturists, and surgical assistants through a monitored recovery program. The TXPHP accepts referrals from a wide variety of sources:

- Self-referrals or referrals from an individual
- PHR committees
- Physician assistant organizations
- State PHPs
- State acupuncture programs
- Any hospital or hospital system licensed in Texas
- Residency programs
- The Texas Medical Board (TMB)
- The physician assistant board
- The acupuncture board

The cost to the participant for enrollment in the TXPHP is \$1,200 per year, which does not include evaluation/treatment fees, continuing care, and other monitoring expenses.

Set up as a separate board administratively attached to the TMB, the mission of the TXPHP is to protect the health of Texans and promote medical excellence by serving physicians, physician assistants, acupuncturists, and surgical assistants affected by substance use disorders (SUDs) and physical or psychiatric conditions that may impair their ability to practice. The TMB helps the TXPHP with processing payments, setting up computers, and other administrative functions.

On November 19, 2010, the TMB published a proposed rule concerning the TXPHP and rehabilitation orders (34 Tex. Reg. 8091) in order to implement

S. 292. The rule established the requirements for eligibility, referrals, drug testing, and fees for participants in the program. Individuals who have or may have mental or physical impairment or an SUD are potentially eligible to participate in the TXPHP. The TMB may publicly refer an applicant to the TXPHP after a contested case hearing or through an agreed order.

An 11-member governing board, appointed by the president of the TMB, is responsible for the oversight of the TXPHP and has established policy and procedures for the operation and administration of the program. As of September 2010, the program had received 279 referrals. Of those, 208 were physicians, and 178 had agreed to treatment and monitoring and paid the fee. The TXPHP is reviewing the remaining referrals to determine whether the practitioners involved qualify for services under the program. As of last August, about 20 percent of the referrals were unresolved and sent back to the TMB.

Physicians still need to inform the TMB about any conditions that could impair them when they renew or apply for their medical license. Once the TMB has that information, it can consider whether the impairment falls within the scope of the TXPHP. The license application requires physicians to report any arrests (even if they were not convicted) and to disclose any physical, mental, or neurological condition in the past five years that impaired their behavior, judgment, or ability to function in school, work, or other important life activities. Physicians who face felony charges as a result of their actions, injure a patient while impaired, or have sex with a patient or patient's family member cannot participate in the TXPHP and are dealt with by the TMB.

At this time, the TXPHP is functioning solely on revenues generated by participant fees. With the assistance of the TMB, the TXPHP is considering whether grants from outside sources of funding are a possibility. Due to legislative budget cuts, implementation of the five-year incremental increase could be jeopardized, with funds downsized to the initial year's budget. Such budget cuts would be disastrous to the TXPHP, as it would revert to having 1.5 FTE staff for the program.

Summary

Physicians needing help can turn to the TMA PHR Committee, their local county medical society PHR committee, or the TXPHP for assistance.

While the TXPHP is the newest health and rehabilitation offering for impaired physicians and other health professionals licensed by the TMB, the TMA PHR Committee continues to oversee statewide physician health activities, respond to hotline calls, offer educational programs, administer the Physician Health and Rehabilitation Assistance Fund, and provide applicable, timely resources to specific audiences. The committee is also collaborating with the TXPHP to support the implementation of its responsibilities.

TMA Committee on Physician Health and Rehabilitation

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Texas Physician Health Program

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The Georgia Physician Health Program: History and Future Direction

Georgia is among the last states in the country to institute an independent, statewide physician health program (PHP). It would be incorrect to assume that there is no statewide interest or expertise regarding physician health, as Georgia is the home of three nationally known programs for addiction treatment. Despite this fact, the sad truth is that we've lagged behind almost every other state in institutionalizing an independent, PHP-based monitoring and continuing care program to ensure long-term recovery from addiction and other psychiatric illness.

Under Georgia law, there is a system for managing addicted physicians and physicians who suffer from potentially impairing illness. The Unprofessional Conduct Rule 360-3.02(20) states that if a physician seeks treatment for any psychiatric or substance use disorder in an organized setting, his or her provider and the physician in treatment must report to the Georgia Composite Medical Board (GCMB) within 30 days. If they fail to do so, they are sanctioned heavily. Thus, many of Georgia's physicians remain "underground;" their illness often longstanding and debilitating by the time they arrive for treatment.

In large part, the lack of a PHP comes from a perceived lack of need. Every treatment program in Georgia that treats health care professionals provides

continuing care that's similar to other states' PHP programs. All of the programs do a fine job in providing the service, but this distributed system results in each of the physician treatment programs individually interfacing with the medical board in Georgia. The GCMB, due to changing composition and its need to be familiar with multiple providers, has taken upon itself the role of determining the quality and appropriateness of each of the providers and their recommended treatment plans.

Once a physician comes before the board, they act in one of two ways: issuing a private consent order (in theory, nondiscoverable, but in practice, known to many parties) or a public consent order. Physicians who obtain a private consent order are obligated by many third-party payers to report any past illness (often detected by carefully worded provider applications that demand the disclosure of private orders). In such cases, even when the majority of such illnesses were not impairing, providers have been denied hospital privileges, managed care and insurance reimbursement, provider network affiliation, and been given financial contracts with discriminatory pay. The situation for physicians issued a public consent order is, in a word, *dire*. Physicians who divert medications prior to treatment, have been subject to public notice of their illness (such as a DUI reported in a newspaper), or have a single positive urine screen while under private consent are commonly issued a public consent order. Our physicians under public consent are denied medical privileges and excluded from insurance panels, applications for recertification in a specialty are denied and, incredibly, we have witnessed physicians' specialty board certification expunged subsequent to a public consent order.

A group of us has been working for almost a decade to enact change. In large part, our early efforts were fruitless. However, in the summer of 2008, Steven Lynn, MD worked with the Georgia Psychiatric Physicians Association (GPPA) and their legislative committee to gather support for legislative change. A bill was written and proposed, only to die in the Georgia house. In 2009, the Georgia psychiatric and addiction communities and interested attorneys gathered to form the Georgia PHP Initiative Committee. The platform of a Georgia PHP was presented to the GCMB, the Medical Association of Georgia, MAG Mutual (the largest malpractice carrier in Georgia), and several large hospital systems in the state. Georgia American Society of Addiction Medicine (ASAM) held a conference

*The Georgia Physician Health Program:
History and Future Direction
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focused on physician health in the summer of 2009. Most parties agreed, in principle, with the concept of a PHP — we emphasized that all of our adjoining states had PHPs and we were the laggards. Our committee called on the expertise of many of the FSPHP members across the country to guide us in our efforts.

Thanks to the committed efforts of the GPPA's legislative affairs consultant Lasa Joiner and a former medical director of the GCMB, Jim McNatt, MD, S. 252 passed the House Health and Human Services Committee on March 31, 2010. Although the legal protection of a PHP was defined in this bill, no funding was provided. The final bill passed the Georgia Senate on April 21, 2010, and the bill was signed into law on May 28, 2010.

Several groups have shown an interest in developing a PHP here in Georgia. Our group, comprised of all the current treatment centers and many of the physicians treating psychiatric and addiction diseases in Georgia, formed the Georgia Physicians Health Program, Inc. The Georgia PHP is a not-for-profit organization with an application pending for 501(c)(3) status. We continue to lobby with interested bodies and agencies for a balanced, measured, and effective PHP in our state. As anyone can imagine, funding is the single biggest stumbling block. Currently our plans are to become funded by moderate participant fees and to look to hospitals, organizations, and malpractice carriers for assistance.

The GCMB has responded to the law by drafting a proposed set of rules for the PHP. Our current challenge is to work in concert with the GCMB to ensure that proposed rules change the tone and harsh consequences that physicians in our state suffer if they become ill. This point in the evolution of the Georgia PHP is critical in shaping the direction of physician health in our state. We welcome the invaluable guidance, support, and supervision of the FSPHP in this monumental joint effort!

*Paul Earley, MD, Steven Lynn, MD, Frances Cullen,
and Robin McCown*

An Update from Wisconsin

Wisconsin has an admirable legacy in physician health. The Statewide Impaired Physician Program (SIPP), later renamed the Statewide Physician Health Program (SPHP), was started over 30 years ago by the Wisconsin Medical Society (WMS) through the vision of society President Gerald Kempthorne, MD, and Roland Herrington, MD, the SIPP's first medical director, under the auspices of the WMS's Commission on Mediation and Peer Review. They also established the unique Coordinating Council on Physician Impairment (CCPI), with three members each from the Medical Examining Board (MEB) and the SIPP. The CCPI linked the MEB and SPHP to coordinate and strengthen monitoring activities and balance concerns and interests between the SPHP and Wisconsin's licensing and disciplinary body. The CCPI met quarterly and reviewed cases, without divulging the identity of program participants, to assess the appropriateness of referring program participants from one entity to the other to ensure appropriate compliance with treatment and the protection of patients. The state Department of Regulation and Licensing (DRL) later established the Impaired Professional Procedure (IPP), a diversion program for licensed professionals operated by the state but modeled after the successful SIPP.

Despite a rich history of providing compassionate assistance to physicians, the SPHP had several flaws that impacted its sustainability. The SPHP never had a broad funding platform (e.g., community grants, state funding through licensing fees, and participant fees), relying instead on the WMS for nearly all of its funding. The SPHP also lacked adequate staffing, relying heavily on a single employee who retired after nearly 50 years with the WMS, with much of that time spent working with the SPHP. There was no succession plan for grooming or hiring someone with the education and experience — and passion — required for such program. The SPHP suffered a decline in enrollment, which might have been due in part to limited program resources.

The WMS Board of Directors voted to terminate the SPHP in 2007. Since then, physicians have had no program to advocate for them other than the IPP of the DRL.

Recently, the IPP was renamed the Professionals Assistance Program and provided with additional staff. But there's hope that Wisconsin will establish a Tennessee- or Colorado-type model for physician health — independent of, but supported by, the MEB/DRL and funded through a broad revenue stream.

The WMS has supported Wisconsin reentering the FSPHP. The new state contact for the FSPHP is Michael Miller, MD, a former member of the SPHP and the CCPI. Rogers Memorial Hospital (a non-profit specialty hospital, the state's largest resource for psychiatric care, and home of the Herrington Recovery Center) offered to establish an administrative framework through which a new professionals' health program can be established and operated. It will require diligence to develop political consensus among various entities and to draft and adopt legislation to provide for a formal relationship between the DRL and the new PHP, as well as funding via licensure fees for professionals (which could include attorneys as well as health care professionals). Rogers' commitment to the cause and the compelling need to support licensed professionals in Wisconsin with health problems through a service autonomous from government will hopefully result in the speedy reestablishment of a Wisconsin PHP.

*Michael M. Miller, MD, FASAM, FAPA
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Vice Speaker, Wisconsin Medical Society
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Risks to Professional Health Programs

While professional health programs (PHPs) have documented outstanding success (Dominio, McLellan, Kaufmann, et al.) in working with professionals with potentially impairing illness, there are significant risks to even the best PHPs. Generally, threats to PHPs are both political and philosophical — based on a lack of understanding regarding potentially impairing illness such as addiction and the added layer of protection PHPs provide. Unfortunately, some detractors don't understand the facts, and all too often, the sensation-driven media is eager to stoke the flames.

One obvious threat we've all seen is the public groups who seem to believe that professionals with addictive illness are just incompetent, "bad people" who are out there injuring patients. Despite the lack of evidence supporting their concerns, they believe such professionals should be identified, publically disciplined, and preferably removed from the profession. We've seen that mindset at times from public citizen groups and during unfortunate occurrences like those recently played out in California.

A subtler yet no less dangerous threat can be seen within states and often results from the organizational infrastructure of the PHP. Vulnerability comes with personality/philosophy changes, which occur each time there are changes in key positions within state regulatory or professional organizations.

While PHPs do outstanding work, we have to be intellectually honest. We know that there are variations in the effectiveness of PHPs. The quality of PHP-provided services can be related to a number of factors including, but not limited to, qualifications and experience of professional staff within the PHP, degree of dedication to the work, infrastructure inefficiencies, lack of financial stability, and other issues. When we hold all PHPs up as "excellent," we risk diminishing the reputation of individual programs and the FSPHP. Professional associations and regulatory entities have firsthand experience with individual programs and are aware of potential deficiencies. I've recently been in dialogue with some of these boards and this is what was reported to me.

I have heard many stakeholders discuss the need for PHPs to be certified by an independent quality assurance entity. This would provide PHPs, which have already undergone a degree of scrutiny by an impartial evaluator, with the added credibility of having successfully met a set of criteria utilized during the review. A certification process would indicate the PHP possesses a baseline level of competence, service, and accountability. This proposal brings up a multitude of issues in need of addressing: Who would do the certification? If it were the FSPHP, what resources would be required and what legal risks would be assumed? Would the role of the FSPHP, currently a membership organization, change? Would there be impediments to the collegiality between state PHPs and/or between PHPs and the FSPHP? Who would fund the review and how? What would it cost a PHP to undergo periodic certification? How might the varied populations PHPs serve

*Risks to Professional Health Programs**continued from page 9*

impact certification requirements? How do the differing levels of service provided factor in?

If certification were considered, legitimacy would be essential and several factors would impact the PHP receiving the stamp of approval. These factors might include, but are not limited to, the following:

- Does the PHP have adequately trained, experienced, and competent professional staff to provide the services it offers?
- Does the PHP have stable, ongoing funding?
- Does the PHP have acceptable outcomes data?
- How does the PHP measure participant satisfaction and make improvements based on those measurements?
- Does the PHP professional and administrative staff, as well as its board of directors, avoid conflicts of interest? Conflicts of interest can be financial but, just as importantly, they can be structural boundary conflicts. We must insure that the PHP structure ensures a clear separation of duties and responsibilities between the PHP, the professional association, and the regulatory entity. Substantive involvement in more than one of these entities is inappropriate. Under the best circumstances, it creates the appearance of impropriety and can be counter-productive to the PHP's mission.
- Does the PHP have a dedicated, representative board of directors who are personally invested in the PHP services and operations?
- Does the PHP have an anonymous track and safe harbor?
- Are PHP administrative matters maintained within the PHP staff such that PHP participant confidentiality is ensured?
- Does the PHP comply with FSPHP guidelines?
- Does the PHP provide earned advocacy for participants who remain compliant?
- Does the PHP demonstrate that public safety is a key part of its mission and operation?

Recent studies have been strongly supportive of the work done by PHPs. More research is indicated to clearly demonstrate public safety and to educate the PHPs on the critical elements that lead to success. Uninformed critics will remain, but their unfounded fears and claims can be countered with fact.

Although most PHPs began in the 1970s through medical associations, over time, the majority have become independent entities. Medical associations and PHPs began to encounter political and boundary issues, not to mention associated liability, which most medical associations want to avoid, realizing their needs can be met contractually.

A particularly serious threat to some PHPs that may appear unassuming at first warrants careful consideration. Some PHPs exist within a professional association or board as subsidiaries without their own representative boards of directors committed solely to the effectiveness and viability of the PHP. Fortunately, more than 70 percent of PHPs do have their own dedicated board. The remaining percent who don't are mostly respected programs that, on the surface, enjoy support and stability. Unfortunately, that support and stability can change rapidly.

Regulatory entities and professional associations are dynamic political entities. What would happen to your PHP if certain personalities rose to key leadership positions in your state? We have seen PHPs severely damaged or even destroyed in a number of states when one key person with a different view or a new agenda assumes a leadership role. PHPs should be positioned to weather the storms of change, which occur in a landscape fraught with variations in political and organizational climate.

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PA PHP Executive Director Retires



Greg Gable, PhD

The Pennsylvania Physicians' Health Program (PHP) is sad to announce the retirement of Dr. Greg Gable in February of this year. The impact of his influence on the Pennsylvania PHP cannot be overstated. Dr. Gable's presence and directorship has been the one constant in the Pennsylvania PHP since the program's inception.

Dr. Gable was hired as an assistant director in 1987, with the official designation of the Pennsylvania PHP in affiliation with the Pennsylvania Medical Society. He collaborated with the original medical directors to establish the PHP-monitoring protocol — the basic structure of which continues to be used today. In 1997, Dr. Gable was instrumental in negotiating a memorandum of understanding with the Commonwealth of Pennsylvania to undertake monitoring impaired physicians who had been sanctioned by the state board. During this time, Dr. Gable was also involved in contracting with the Pennsylvania Dental Association to monitor dentists, as well as physicians.

In 2000, Dr. Gable initiated and created what he considers to be his crowning achievement: the establishment of the Pennsylvania PHP endowment campaign. To date, the endowment stands at over \$3.6 million, providing significant independent funding for PHP operations. In subsequent years, Dr. Gable worked with the medical directors to refine the PHP-monitoring protocol, as well as to develop PHP policies for working with disruptive, boundary violation, cognitive, and psychiatric issues. More recently, Dr. Gable was a member on the FSPHP Board of Directors.

The Pennsylvania PHP staff would like to acknowledge Dr. Gable's efforts to improve the PHP while maintaining participant confidentiality, commitment to physician health, and maintenance program autonomy from political, business, and regulatory concerns. His knowledge, guidance, and leadership will be greatly missed.

In addition, the FSPHP would like to acknowledge Dr. Gable's dedication and contributions to the work of the FSPHP organization through his membership and leadership on the Board of Directors.



The FSPHP Northeast Regional Meeting was hosted by the Committee for Physician Health of the Medical Society of the State of New York in Albany.

Back Row: Karen Clancy, assistant director (NY), Susan Hill, assistant director (NY), Nicole Langlais, assistant director (NY), Gregory Gable, PhD, former assistant director (PA), Luis Sanchez, MD, director (MA), Terrance Bedient, FACHE, vice president (NY). **Middle Row:** Joann Winglosky, administrative assistant, Pamela Granda, assistant director, Debra Grossbaum, Esq., general counsel (MA), John Martynk, MD, director (PA), Toni Maki, administrative assistant, Jonathan Dougherty, MS, executive director, FSPHP.

Sitting: Janice Catuccio, administrative assistant, Linda Bresnahan, MS, director of operations (MA), Jeffrey Selzer, MD, FASAM, medical director (NY).

2011 FSPHP ANNUAL MEETING AND CONFERENCE

Leading the Way for the Healthy Healer: Strategies for Success

April 26–29, Seattle Westin Hotel and Conference Center, Seattle, Washington

Event will coincide with AIM and FSMB conferences. Watch for updates at www.fsphp.org.

Highlights

- Extensive opportunity to visit a wide range of exhibitors offering services in the field
- A forum for education and exchange of information among state physician health programs
- Opportunity to network with professionals from the United States, Canada, and other parts of the world dedicated to assessing, monitoring, and treating physicians with potentially impairing conditions
- FSPHP regional membership meetings
- FSPHP committee meetings
- PHP Administrators' Breakfast (PHP Management: Boards, Human Resources, and Public Relations — Sarah Early, PsyD, and Linda Bresnahan, MS)
- Spiritual Evolution: George Vaillant, MD, keynote speaker
- North of 49, Keeping the Igloo Warm: A Canadian Approach to a Healthier Medical Workplace — Ian Bennett, MB, BS, and Marc Cherniwchan, MD
- Special Workshop — Drug Testing: Development of Best Practices — Greg Skipper, MD, and Michael Kaufmann, MD
- The Meaning and Value of Reflective Practices: A Preliminary Psycho-Educational Intervention for Burnout Prevention — Andrew Clarke, MD, DOHS, Sandra Roman, MD, CCFP, and Claire Sauve, MA



Seattle Westin Hotel and Conference Center, Seattle, Washington

- Colorado Physician Health Program Experience with Medical Practice Act Sunset Process — Michael Gendel, MD, Doris Gundersen, MD, and Sarah Early, PsyD
- Do State Medical Board Applications Violate the Americans with Disabilities Act? — Robin Schroeder, MD, Chantal Brazeau, MD, and Freda Zackin, Esq.
- FSPHP 2011 Annual Business Meeting (open to FSPHP members)
- Life Balance in Medical Practice and Training — Lee Lipsenthal, MD
- Use of Neuropsychological Assessment Instruments to Facilitate Case Management Decisions in a Physician Health Program — Greg Gable, PsyD, John Martyniuk, PhD, MD, and Christopher Royer, PsyD
- FSMB/FSPHP Joint Session Luncheon (open to FSPHP members), Sheraton Seattle Hotel, 1400 6th Avenue, Seattle, WA 98101

Plan to Attend or Exhibit!

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

For more information, visit www.fsphp.org.

WE WANT YOUR BUSINESS!

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

Thank you for your assistance!

SAVE THE DATE

FSPHP NORTHEAST REGION MEMBER MEETING

Thursday, October 13, 2011

A meeting for education and exchange of information among state physician health program professionals

CARING FOR THE CAREGIVERS VIII PHYSICIANS TODAY: MEETING CHANGES AND CHALLENGES

Friday, October 14, 2011

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



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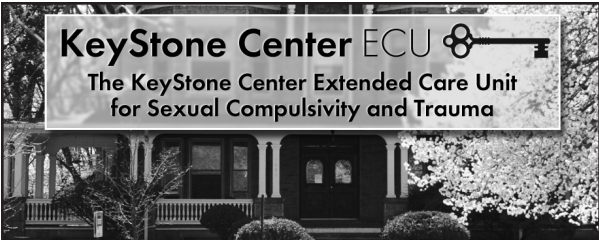
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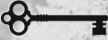
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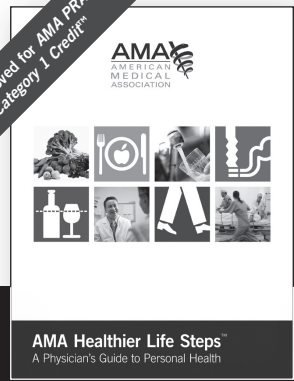
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Physician Health and Other Related Organizations' National Meetings

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April 26–29, 2011
Westin Hotel, Seattle, Washington

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April 26–28, 2012
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Seattle, Washington

2011 Canadian Medical Association Conference on Physician Health

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2012 International Conference on Physician Health

October 25–27, 2012
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American Academy of Addiction Psychiatry

December 8–11, 2011
Scottsdale Resort and Conference Center,
Scottsdale, Arizona

AMA House of Delegates Annual Meeting

June 18–22, 2011
Chicago, Illinois

AMA House of Delegates Interim Meeting

November 12–15, 2011
New Orleans, Louisiana

American Psychiatric Association Annual Meetings

May 14–19, 2011
Honolulu, Hawaii

American Society of Addiction Medicine

April 14–17, 2011
Washington, D.C.
April 19–22, 2012
Atlanta, Georgia
April 25–28, 2013
Chicago, Illinois
April 10–13, 2014
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August 3–7, 2011
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We would like to invite you and your organization to advertise your services in the future editions of *Physician Health News*. *Physician Health News* is mailed to all state programs and state licensing boards. The newsletter is also distributed widely at the FSPHP Annual Meeting. Articles and notices of interest to the physician health community, the newsletter includes planning information about the upcoming physician health meetings and conferences including FSPHP meetings.

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We look forward to working with you in future editions.

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