PHYSICIAN HEALTH NEWS

The Official Newsletter of the Federation of State Physician Health Programs

Welcome to the 26th edition, Volume 1, 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.

The FSPHP is a national organization providing an exchange of information among state physician health programs (PHPs) to develop common objectives, goals, and standards. If you're not a member yet, please consider joining. State, Associate, International, Individual, and Organizational membership categories are available.

We sincerely hope you respond as an indication of your commitment to a stronger, more cohesive FSPHP. For more information on each of the membership categories, including new categories for organizational and individual members, please see our website or contact Julie Robarge.

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

The FSPHP: Growing in Sophistication and Stature

Paul H. Earley, MD, DFASAM

Paul H. Earley, MD, DFASAM

Two thousand nineteen has started out with a bang for the Federation of State Physician Health Programs, with more active projects than any time in our history. I am sure many of our readers will be coming to our Annual Meeting to hear all about it, but I wanted to tell you more about the interlocking pieces of our biggest project to date.

continued on page 2

IN THIS ISSUE

President's Message

continued from page 1

In 2016, many of our members were talking about our standards. Driven by the natural need for continuous improvement and a smaller need to respond to incorrect and misplaced concerns, the ACE Committee took up the task to revise our 2005 Guidelines document. The result is a whopping one-hundred-page, impressive revision to the Guidelines that define best practices for PHPs and our service organizations. The project has been led by Maureen Dinnan, Esq. (Connecticut), and Doina Lupea, MD (Ontario). With contributions from innumerable content providers, editors, and fact and reference checkers this fine compendium is almost ready for prime time. It covers nearly every aspect of building and maintaining a physician's health program. In addition, it delineates quality practices by our partners who treat our participants.

But—wait there is more. The revised Guidelines will be part of a larger, two-pronged project, the FSPHP Performance Enhancement and Excellence Review (PEER™) and the Provider Accreditation (PA) process. The PEER™ uses the elements of the Guidelines to encourage PHPs to survey their services, looking for service areas that can be modified or enhanced. Once a PHP completes an internal assessment, they may choose to go the next step, to have an external reviewer take a look at PHP procedures and systems—to complete a PEER™. In this manner, each PHP can validate the excellence of their program.

We felt the PEER™ process of external review would ensure each program is up to date and continues to grow in sophistication. Many of our sister organizations agreed. When we asked other national organizations if they agreed, they validated the importance of the Physician Health Program model though very generous financial support. The Federation of State Medical Boards (FSMB), the American Medical Association (AMA), the American Psychiatric Association (APA), the Accreditation Council for Graduate Medical Education (ACGME), the American College of Physicians (ACP), the American Board of Medical Specialties (ABMS), and the American Osteopathic Association (AOA) all provided financial support to the development of this review process. The level of endorsement we received through financial contributions is currently $65,000. We have made a solid development launch toward our fundraising goals for this project. We anticipate additional sponsors to join this alliance of support. Building this program is expensive and we cannot do it without the support of organized medicine.

The second arm of our quality assurance process is the Provider Accreditation Program (PAP). This program is based upon standards defined in our new Guidelines to accredit our external providers. It is important to note that this program does not replace hospital accreditation, such as that provided by CARF or the Joint Commission. Rather, the added accreditation process by the FSPHP ensures an evaluation or treatment center understands and is ready to address and treat the special needs of healthcare providers in a safety-sensitive occupation. The PAP builds on a small existing process developed several years ago by several FSPHP member states.

The result of this enormous multi-year process will be a validation of the excellent services PHPs provide. Our research-validated excellent outcomes are well documented. However, I would predict that each program will find one or more areas that need tightening up, revision, or improvement. But this is the nature of healthcare. There is always room to improve. The FSPHP is here to shape the process of continuous improvement by every PHP and every provider we use. We are improving our services and growing in sophistication thanks to the concerted effort of our members. ■

EXECUTIVE DIRECTOR MESSAGE

Linda Bresnahan, MS, Executive Director

Linda Bresnahan, MS

It is with great pride and enthusiasm that I enter my fourth year as your executive director, while FSPHP enters its twenty-ninth year since its establishment. The vision of our founders has increasing relevance today. It is a time of great opportunity for PHPs to have a direct impact in improving the health and well-being of healthcare professionals.

It is incredibly exciting that FSPHP's dedication to its vision of creating a society of highly effective PHPs advancing the health of the medical community and the patients they serve is moving forward with increasing recognition by new FSPHP members, the healthcare community, national associations, and, most important, the participants whose lives are restored by their PHP's support.

Prior to being your executive director, I was a member for 25 of these 29 years. It has been a remarkable experience to transition from a member to your executive director. I enjoy these many conversations with members who are developing new efforts at their PHP, and they are grateful for the expertise and experience they gain from their membership with FSPHP, just as I had when I was a member. From outside our membership, I am on the receiving end of so many expressions of gratitude from leaders in national organizations who know firsthand how PHPs have transformed the life of a physician or healthcare professional in their state.

We have made tremendous progress and impact on many levels in support of our mission and vision. I want us to acknowledge the progress accomplished by our members while emphasizing that there is more to do, and there is a place for everyone in helping us build on our success. We need your help and especially your continuous feedback.

Our Progress

As a 501(c)(3) charity, the FSPHP through its Fund Development Committee's efforts has raised over $25,000 this past year for the FSPHP, and we now have seven national organizations (AMA, FSMB, APA, ACP, AOA, ACGME, and ABMS) sponsoring the development of our PEER™ and Provider Accreditation initiative. We have sustained a strong and growing membership of 46 State PHPs, bringing our total membership to 212 members. Additionally, we currently have 16 FSPHP committees with significant purpose and accomplishments that I'll highlight more in this issue and that you can learn about at www.fsphp.org/committees. We have a new FSPHP website and membership database: www.fsphp.org. With this new platform, we now have an opportunity to build more member content, such as adding PHP sample policies and best practice documents. I also am pleased to have Sandra Savage join us this past month! Her email address is ssavage@fsphp.org. Sandra and I are currently your FSPHP staff, so her email and my email address are the only two email addresses to utilize to reach FSPHP!

We Need Your Help—Please Share Your Feedback and Join Us

As we celebrate our successes, we also know that we need to stay focused on continually evaluating and reevaluating how we are doing. We are scanning the environment within which our members work to ensure that we are responsive to their needs and expectations. We continue to be focused on ensuring that facts about the effectiveness of the PHP model are not obscured by misinformation and misguided agendas that will discourage physicians from seeking care.

PHPs and the FSPHP are faced with the responsibility to continually demonstrate accountability, consistency, and excellence while sharing accurate information about what we do. Our development of Performance Enhancement and Effective Reviews™ for PHPs and Provider Accreditation for healthcare professionals is our largest and most important effort to date in this regard. With this, we need our member PHPs to join FSPHP by continuously sharing their advancements, their outcomes, and stories of success.

There is a place for everyone in helping us build on our success and momentum! Every year we ask FSPHP members to join or renew their involvement in FSPHP committees. Here is a link to a form to submit your request to be involved: www.fsphp.org/committees.

On behalf of the FSPHP, I extend our deepest appreciation and gratitude to our members, who play a role in transforming the FSPHP mission and vision into action. For those who are new to FSPHP, we invite you to join us!

Together, we are making a significant and sustainable impact in improving PHPs and therefore the health of the profession. We hope you will take a few minutes to explore our website at www.fsphp.org, and log in as a member to get to know our association better and offer ideas to build upon our member content. Please always feel free to call, write, and email me at lbresnahan@fsphp.org with your feedback about your membership association. I value and benefit from your feedback. ■

FSPHP WELCOMES SANDRA SAVAGE!

Linda Bresnahan, MS, Executive Director

Sandra Savage

Please join me in welcoming Sandra Savage to FSPHP in the role of FSPHP Membership and Meeting Coordinator. Sandra Savage comes to us from McKenna Management, where she managed several membership associations. She has a Bachelor of Arts in English from Framingham State University and over 20 years of experience working for nonprofit membership associations in the areas of event and trade show planning, marketing, and membership. I am so excited and grateful to have Sandra join us! Her primary focus includes support for our annual conference and our website, including our membership. ■

PERFORMANCE ENHANCEMENT AND EFFECTIVENESS REVIEW™ (PEER™) PROGRAM AND PROVIDER ACCREDITATION PROGRAM (PAC) DEVELOPMENT UPDATE

FSPHP's Performance Enhancement and Effectiveness Review (PEER™) program will create and manage an on-site review process of PHPs across the United States and Canada. The review will capitalize on best practices in physician health and identify areas that will benefit from improvements. The FSPHP's Provider Accreditation

continued on page 4

Performance Enhancement and Effectiveness Review™ (PEER™) Program and Provider Accreditation Program

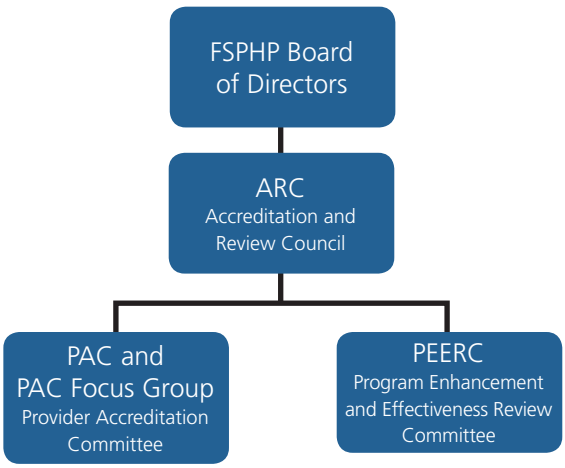
continued from page 3

is aimed at treatment providers and centers that care for healthcare professionals, again ensuring that our physicians who become ill are given the best treatment using evidence-based care designed for those in a safety-sensitive occupation.

The FSPHP is forming an alliance of national organizations to ensure the success of this important project. Our first enthusiastic support has already come from the Federation of State Medical Boards (FSMB), the American Medical Association (AMA), the American Psychiatric Association (APA), the Accreditation Council for Graduate Medical Education (ACGME), the American Board of Medical Specialties (ABMS), the American College of Physicians (ACP), and the American Osteopathic Association (AOA).

The FSPHP Board of Directors has created an oversight committee (the Accreditation and Review Council (ARC)) and two technical committees (the Provider Accreditation Committee (PAC) and the Performance Enhancement and Effectiveness Review (PEER™) Committee (PEERC)).

- The purpose of the ARC is to review the work product of the two technical committees (the PAC and the PEERC) and provide final recommendations on both committees' work product to the FSPHP Board.
- The ARC, PEERC, and PAC are each composed of a highly diverse group of stakeholders. The ARC includes FSPHP members and distinguished representatives of the ABMS, AMA, MPLA, AOA, ACP, and ACGME. The PAC includes FSPHP members and providers (potential participants in the PA program).
- The PAC organizes ad hoc focus groups to empower the full array of providers (assessment facilities, treatment centers, etc.) to engage and participate in the PA program development process.



Accreditation Review Council (ARC)

ARC Members *(50% +1 to be FSPHP members, with the others to represent external stakeholders)*

P. Bradley Hall, MD, DABAM, Co-Chair, FS.PHP Past President, WV PHP

Scott Hambleton, MD, DFASAM, Co-Chair, FSPHP Southeast Director, MS PHP

Chris Bundy, MD, MPH, FSPHP President-elect, WA PHP

Mary Ellen Caiati, MD, FSPHP Secretary, CO PHP

Paul Earley, MD, DFASAM, FSPHP President, GA PHP

Jon Shapiro, MD, DABAM, FSPHP Northeast Director, PA PHP

Michael Ramirez, MS, FSPHP Western Director, MT PHP

Michael Baron, MD, MPH, FSPHP Southeast Director, LA PHP

Michael Miller, MD, DLFAPA, DFASAM, Chair of AMA Council on Science and Public Health, *ex officio*

Robert G. Piccinini, DO, Chair of the Physician Wellness Task Force, the American Osteopathic Association, *ex officio*

Lois Snyder Sulmasy, JD, Director for Center for Ethics and Professionalism, the American College of Physicians, *ex officio*

Thomas Granatir, Senior Vice President for Policy and External Relations, American Board of Medical Specialties, *ex officio*

Mary-Lou A. Misrahy, ARM, Chair of the Board of the Medical Professional Liability Association, *ex officio*

Carol A. Bernstein, MD, Accreditation Counsel of Graduate Medical Education, *ex officio*

A representative from the Federation of State Medical Boards, *ex officio*, TBD

A representative from the American Psychiatric Association, *ex officio*, TBD

Performance Enhancement and Effectiveness Review™ (PEER™) Committee (PEERC)

The purpose of the PEERC is to develop a Performance Enhancement and Effectiveness Review™ (PEER™) program to empower PHPs and other health programs for workers in safety-sensitive occupational roles to use the new version of the FSPHP Guidelines as a practical tool for identifying opportunities to optimize performance and effectiveness in alignment with best practices.

PEERC Members

Michael Ramirez, MS, Chair
Jon Shapiro, MD, Vice Chair
Monica Faria, MD
Maureen Dinnan, Esq.
Cynthia Gordon, MD
Anne Kelley, LCSW, LCAC
Kay O'Shea, MA, CADC
Terrance Bedient, FACHE
Alexis Polles, MD
Lynn Hankes, MD
Kathleen Boyd, MSW, LICSW
Luis Sanchez, MD

Provider Accreditation Committee (PAC)

The purpose of the PAC is to develop the "Provider Accreditation" (to be named later) program that will recognize treatment centers and other providers that are qualified to specialize in the care of medical students, residents, career physicians, and other safety-sensitive professionals—and will provide a defensible basis for PHPs selecting providers that have proven their compliance with objective standards.

PAC Members

Michael Baron, MD, MPH, Chair
Joseph Jordan, PhD, Vice Chair
Peter Graham, PhD
Michael Wilkerson, MD
Gregory Gable, PsyD
Laura Martin, MD
Greg Skipper, MD
Jonathan Lee, MD
Paul Earley, MD, DFASAM
Harry Haroutunian, MD
Candace Becker, LCSW, LCAC
Sally Garhart, MD
Jon Novick, MD
John Roberts, MD
Leah Claire Bennett, PhD
Daniel Angres, MD
Penelope Ziegler, MD
Navjyot Bedi, MD
Scott Teitelbaum, MD
Reid A. J. Finlayson, MD
Robin McCown

PAC Focus Groups

The PA Committee will organize ad hoc focus groups and other activities to empower the full array of providers (assessment facilities, treatment centers, etc.) to engage and participate in the PA program development process.

PAC Focus Group Participants

Lisa Clark, RN, MSN
John Whipple,MD
Ken Chance, D. Div
Melissa Warner, MD
John Harden, LCSW, MPH
Joseph Schumacher,PhD
Joseph Garbely, DO, FASAM
Robyn Hacker,PhD
John Pustaver, Mdiv
Mark Lutz, MA, LCDCIII, ICADC
Marc Myer, MD
Kenneth Thompson, MD, DFASAM
Carrie Kappel, BS, RN, LADC
Robert Bondurant, RN, LCSW
Mary Fahey, LCSW
Brian Coon, MA, LCAS
Lacey Herrington, PhD
Betsy Williams, PhD, MPH
Sherry Young, PhD, CSAT
Joseph Nuzzo, BS
Ethan Abramowitz, Esq.
Joe Siegler, MD
Roxane Harcourt LCSW, LMFT

Next Steps for PEER™

- Draft the PEER program's eligibility requirements and review criteria and renewal requirements
- Determine the appropriate method(s), procedures, and rubrics of assessment
- Adopt policies and procedures for the PEER program
- Pilot (beta test) the PEER program
- Refine and finalize PEER program: Eligibility and renewal requirements; review criteria; assessment methods, procedures, and rubrics; and policies and procedures
- Launch the PEER program in early 2020

Next Steps for PAC

- Define the scope (including geographic scope, and type of provider) of the PA program
- Determine what characteristics and outcomes among providers are valued by those providers' various stakeholders and are measurable (defining the PA program's standards)
- Name the PA program
- Draft the PA program's eligibility requirements, accreditation criteria, and renewal requirements
- Determine the appropriate method(s), procedures, and rubrics of assessment
- Adopt policies and procedures for the PA program
- Pilot (beta test) the PA program
- Refine and finalize PA program: Eligibility and renewal requirements; accreditation criteria; assessment methods, procedures, and rubrics; and policies and procedures
- Launch the PA program ■

FSPHP WELCOMES ITS NEW MEMBERS

State Voting Members

Anand Wasudeo Mehendale, MD, Texas Professionals Health Program

Tia Cooper, MA, LAC, CACII, NCACI, South Carolina Professional Recovery Program

continued on page 6

FSPHP Welcomes Its New Members

continued from page 5

Associate Members

Beth Byarlay, MBA, North Carolina Physicians Health Program

Mark A. Hughes, MD, WV Medical Professionals Health Program

Pam Scott, PA, Medical Professionals Health Program—Board Member and Case Management Committee Member

Angela Robinson, Oklahoma Health Professionals Program

R. William Corwin, MD, Rhode Island Medical Society

Stephen W. Heimbach, MD, Oklahoma Health Professionals Program

Pam Ventgen, Alaska Physician Health Committee

Kari B. Law, M, DFASAM, FAPA, WV Medical Professionals Health Program, Case Mgmt. Committee Mbr.

Craig T Pratt, MD, DFASAM, FAPA, Ohio Physicians Health Program

Colleen M Opremcak, MD, FAPA, Ohio Physicians Health Program

WV Medical Professionals Health Program; WVU Medicine

Mike Schmit, MD, ND Professional Health Program

Individual Members

Erica Frank, MD, NextGenU, Washington

H Monica K. Guidry, LCSW, UTHealth Employee Assistance, Texas

H.P. Rode, MD, Netherlands

The Board of Directors of the WV Medical Professionals Health Program has authorized associate memberships to three of its board members and three of its case-management members in recognition of the benefit of FSPHP membership. Their experience to date has been positive, and we would highly encourage your organization to do the same.

Please consider sharing news of our available membership opportunities! ■

Dear FSPHP Supporter:

If you have not done so already, I want to ask for you to join me and our fellow donors in supporting the Federation of State Physician Health Programs (FSPHP). Please consider making a gift today!

For the past 28 years, the Federation of State Physician Health Programs (FSPHP) has provided professional education, collaboration, and advocacy to assist our member Physician Health Programs (PHPs) across the country. FSPHP strives to support physicians, and in some states other licensed healthcare professionals, who have a health condition that is affecting their ability to practice safely and effectively.

We rely on contributions to help further our mission of "supporting physician health programs and improving the health of medical professionals thereby contributing to quality patient care." While working together with individual PHPs remains essential, members and colleagues invested in the work of PHPs depend on the guidelines, standards, expertise, and program advocacy accomplished by us.

Your investment in FSPHP helps provide:

- A robust and valuable annual education meeting and newsletters to keep members abreast of critical national issues
- Expanded tools and resources for members, including policies and guidelines and individualized consultation support
- Strong advocacy with many national organizations, including the Federation of State Medical Boards (FSMB) Workgroup on Physician Wellness and Burnout, which includes a joint publication (www.fsmb.org/globalassets/advocacy/policies/policy-on-wellness-and-burnout.pdf)
- Development of a Performance Enhancement and Effectiveness Review Program (PEER) for PHPs and a review program to be utilized by treatment facilities, which increases our accountability, consistency, and excellence among PHPs nationwide

We will continue collaborating with our membership and increase engagement on a national level, but we cannot do this without your help! Your donation ensures that FSPHP continues to implement new initiatives, upholds an environment of fellowship and networking, establishes best practices, and assists PHPs in their quest to protect the public.

Please consider making a contribution. Your donation is important and will support our national efforts to advance physician health programs! Donate online at www.fsphp.org/donate or mail your donation to FSPHP Donation, 668 Main St., Suite 8, #295, Wilmington, MA 01887.

With warm regards,
Paul H. Earley, MD, DFASAM

THANK YOU TO OUR RECENT DONORS (SINCE OUR LAST ISSUE)!

2018–2019

Leader of Healing ($10,000–$24,999)
American Medical Association
Federation of State Medical Boards
American Psychiatric Association
Accreditation Council on Graduate Medical Education
American College of Physicians
American Board of Medical Specialties

Partner in Health ($5,000–$9,999)
American Osteopathic Association

Caregivers ($500–$999)
P. Bradley Hall, MD
James LeBlanc-Wilcox
Jonathan Lee MD, FASAM

Friends ($1–$499)
John Anish, MD
Mary Ellen Caiati, MD
Paula Colescott
David Goldberg, DO
Lynn Hankes, MD
John Jackson, MD
Terry Lavery, LCPC
Kelley Long
Warren Pendergast, MD
Alexis Polles, MD, PLLC
Luis Sanchez, MD
Ray Truex, MD
Jon Shapiro, MD
Penny Zeigler, MD
Tracy Zemansky, PhD

Please consider joining one of our new giving societies by donating today!

Donate online at www.fsphp.org/donate.

Federation of State Physician Health Programs 2019 Annual Appeal
Legacy of Wellness ($25,000+)
Leader of Healing ($10,000–$24,999)
Partner in Health ($5,000–$9,999)
Ally of Hope ($2,500–$4,999)
Advocate ($1,000–$2,499)
Caregiver $500–$999
Friends ($1–$499)

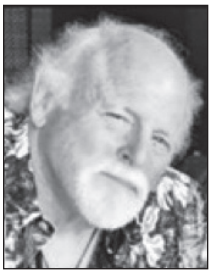
A TRIBUTE TO PETER MANSKY, MD, NEVADA, AND NEW YORK PHYSICIAN HEALTH PROGRAM


Peter Mansky, MD

January 2, 1943–
August 4, 2018

Peter Alan Mansky MD, 75, of Las Vegas, passed away Saturday, August 4, 2018, from complications of open-heart surgery. He was born January 2, 1943, to Annette and Manny Mansky in Utica, NY. Peter graduated from Cornell University and SUNY Buffalo Medical School, and then served as a lieutenant in the U.S. Navy while in the Public Health Service. He trained in psychiatry at Harvard and pursued a career as a specialist in psychopharmacology. Peter served as Medical Director of the Physician Health Program in New York and then in Nevada. He always had a special place in his heart for the FSPHP. He was involved as a founding member, served on the Board, as Treasurer, and as President from 2009–2012. Peter's professional journey as a physician touched many lives, but his family was always first in his heart. He is survived by his wife and soulmate Susan, children Shauna, Michael, and Abigail and grandchildren Kayla, Jewel, Nathaniel, Noah, and Julia. ■

A TRIBUTE TO SCOTT ALBERTI, WASHINGTON PHYSICIANS HEALTH PROGRAM



Scott Alberti

December 24, 1946–
August 3, 2018

Scott Alberti was born on December 24, 1946, in Bridgeport, CT, to Rosamond and Paul L. E. Alberti. Scott passed away on August 3, 2018. Scott was an icon in the physician health world during his 22 years as Clinical Director of the Washington Physicians Health Program. With Scott's assistance, hundreds of professionals were able to return to practice and had their lives transformed into the men and women they were meant to be. Scott considered it a great privilege to have served the FSPHP in many roles over the years and his FSPHP relationships were among his most treasured possessions. FSPHP recognized Scott's lifelong commitment and contributions to the organization when it made him its first and only non-Physician Honorary Member following his retirement from WPHP.

For those who knew him, Scott was a force of nature, possessed of an unflinching courage of his convictions, annoyingly grateful in the face of any adversity, and a dear friend who could make you feel like you were the only thing in the world that mattered to him. Like so many whose lives he touched, we share in your grief and miss him terribly. To learn more about Scott's life and connect with others in condolence, please visit Scott's obituary online at https://www.legacy.com/obituaries/seattletimes/obituary.aspx?n=scott-alberti&pid=189807830. ■

Lynn Hankes, MD and Chris Bundy, MD, MPH

RANDOMIZED CLINICAL TRIALS AND MENTAL HEALTH DISORDERS: PANACEA OR PROBLEMATIC?

Paul H. Earley, MD, DFASM, FSPHP President

A Very Brief History of Randomized Clinical Trials

The practice of medicine, like many fields of endeavor, has undergone enormous changes in our lifetime. The one-on-one relationship with a provider has been replaced by a system of specialists—my friend, who is an orthopedic surgeon, only operates on knees. Gone is the single practitioner who knows everything about you. He or she has been replaced by a vast interconnected system of medical records of dubious clarity and questionable utility.

The greatest change in the practice of medicine (and in its sister disciplines psychology and other therapeutic disciplines) has been the increasing emphasis on using research to validate the efficacy of what we do. That validation, according to its pundits, comes only from research that validates the potency and repeatability of a desired intervention. Today, if you do not have such evidence, an intervention is considered ineffective by default; your work as a practitioner is lumped into the same category as using healing crystals to cure cancer. You are not practicing "evidence-based medicine," you see.

The holy grail of evidence-based medicine is the randomized clinical trial (RCT). RCTs are rightfully accepted as having the greatest internal validity and considered to provide the highest-quality evidence to guide practice,[1] replacing case reports and series, clinical reasoning, and less rigorous clinical trials of the previous 100 years. Their use has been considered the "gold standard," reshaping medical knowledge and practice.[1] When a practitioner states they are practicing "evidence-based medicine (EBM)," their mind is most likely visualizing randomized clinical trials. Indeed EBM, or the lack thereof, is often used as a term of derision, as in, "He does not even practice evidence-based medicine" or "She cannot tell the difference between evidence-based medicine and bloodletting."

Lest I be accused—perhaps correctly—of a lunatic rant, I should state that I humbly agree with the notion that the formalization of RCTs in the 1940s was a pivotal moment in healthcare. Medicine underwent dramatic changes post-World War II, but none were as important as the codification of RCTs by epidemiologist Austin Bradford Hill.[2] RCTs improved upon case reports and series, testimonials, knowledge-based clinical reasoning, closely-held beliefs, and earlier clinical trials.

RCTs have been refined over the past 75 years, becoming the cornerstone of pharmaceutical development, an arena of medicine that has led to amazing breakthroughs in that area of medicine. They have delineated the efficacy of hundreds of new medications treating myriad conditions. The pharmaceutical industry would have never discovered safe and effective treatments for cancers, hypertension, cardiovascular disease, and stroke had it not been for rigorous RCTs. Everyone should applaud the use of RCTs in pharmaceutical research.

During this shift, statisticians became critical members of the medical research team.[1] As the team composition and methodological approach solidified into a new norm, RCTs were proclaimed the gold standard of medical knowledge,[3] lauded as "stripped clean of human bias . . . accepted as the gold standard and thus above scrutiny as a potential source of systematic error."[4] Although mathematically precise, RCTs have several central fallacies, the largest of which is the concern that the "RCT is a deductive method: If the assumptions of the test are met, a positive result implies the appropriate causal conclusion."[5]

But more is at play here, so we need to take a closer look at RCTs, distinguishing when their use is critical from when they prove problematic. A significant body of meta-research has emerged on the crest of the wave that the RCT built. If you read no further, the central theme of this inquiry is that RCTs, although amazing in limited contexts, prove especially problematic in procedural medicine and more so when the studied procedure varies in and is inherently more amorphous.

Problems with RCTs

As early as 1996, the *British Medical Journal* published an opinion piece by Nick Black, a professor of health services research. He begins by reasserting that RCTs are valuable, but only to the extent that they not crowd out other types of research. He outlines several categories of research that should continue despite medical science's enamored relationship to RCTs, and he enumerates research questions where RCTs are not the correct tool to use.[6] He states RCTs should not be used:

1. Where experimentation may be unnecessary, in situations where treatment benefits are so obvious that a trial would clearly be unethical.
2. Where experimentation may be impossible. He points out that "some people believe that any and every intervention can be subjected to a randomized trial, and that those who challenge this have simply not made sufficient effort and are methodologically incompetent."[6] An example of this would be a treatment course that has many mandatory interlocking parts where one element would render the test condition invalid.
3. Where the generalizability of the results of randomized trials is low. Here, he compares the outcome of pharmaceutical treatment (highly generalizable, not affected by the prescriber whatsoever) to surgery (where the skill of the surgeon is tantamount and more highly correlated to the outcome than the procedure performed in many cases).

Blackwood, O'Halloran, and Porter[7] bring forth additional concerns. Stating RCTs should not be used:

4. ". . . when investigators exclude participants based on certain factors (such as demographics and socioeconomic factors) there is uncertainty as to whether any benefits gained can be extrapolated to all patients seen in a daily clinical practice."[7]
5. Limitations of RCTs may become particularly acute when RCTs are used to evaluate interventions targeted at healthcare problems that have many levels of complexity.

One clear example of this phenomenon comes from the surgical literature. In the December 2018 issue of *JAMA*, Wallis states "unlike drugs that are uniform in their composition and are thus standardized at the point of licensure, procedures are delivered by physicians who need to develop technical proficiency, a process that occurs over time."[6] McCulloch et al. expand on this stating, "Operations, however, are complex procedures, and quality in performance requires frequent repetition over time. . . . During the learning curve, errors and adverse outcomes are more likely." This makes what seems at superficial glance to be a consistent intervention (e.g., an appendectomy) problematic to study and standardize. This, in turn, skews the efficacy data of any interventional study that involves multiple surgeons with different training and varying skills who are at different points in their careers.

What happens when the very act of random allocation may reduce the effectiveness of the studied intervention? This arises when the effectiveness of the intervention depends on the subject's active participation, which, in turn, depends on the subject's beliefs and preferences. Blackwood notes that, in such cases, the outcome difference between the two groups will underestimate the difference between interventions.[7] Does this sound familiar? This is especially relevant when a study compares medication treatment alone with medications plus psychotherapy.

What About Studies That Examine the Efficacy of Mental Health Interventions?

Today, the world of mental health medicine is struggling to build credibility. We have been the forgotten stepchild of healthcare for many decades. Although

continued on page 10

Randomized Clinical Trials and Mental Health Disorders: Panacea or Problematic?

continued from page 9

we deal with biology, psychology, sociology, family systems theory, evolutionary behaviors that drive tribalism and community, family and the hunger of connectedness, and yes, faith and religion, we yearn to solve the illnesses in our field "just like our sister fields in medicine." Many have swarmed to the RCT to build legitimacy despite methodological concerns.[8] More and more we adopt the language of efficacy from these fields. And none have become more common buzzwords than *evidence-based medicine*. Implied inside this moniker is its gold standard, the randomized clinical trial.

RCT research into the effectiveness of mental health interventions has as many or more unaccounted variables than surgery and proves to be at least an order of magnitude more complex than pharmaceutical trials. For example, Barber describes one of the core problems in psychotherapy research, stating RCTs ". . . have the implicit assumption that patients with the same diagnoses are similar and that they will respond to the same treatment."[9] He concludes by saying "RCTs are crucial and provide us with very important, high-quality data, but they have real limitations when applied to the study of psychotherapy."[9]

Psychotherapy is a fuzzy, even amorphous concept at best. For our purposes here, I will overgeneralize the more specific term *psychotherapy* to apply to many mental health interventions and define psychotherapy as any interaction between two or more people that has the implicit intent of improving the mental health of one or more individuals. This definition encompasses everything from individual, couples, and family therapy, manualized psychological training, educational lectures about health, and . . . wait for it . . . mutual help meetings. I am purposefully broad for a reason, even if some readers will be tempted to stop reading right here.

Psychotherapy (using this broad interpretation) is like any other procedural intervention. It relies heavily on a practitioner's skills, empathy, and adaptability to a client's struggles. This is even true if you consider the person currently speaking at an A.A. meeting as a "roaming practitioner." In this instance, sharing one's own personal journey, with deep disclosure, honest self-reflection, and (near) universal acceptance of others builds a reflexive coherent story, self-reflection, and self-acceptance in others at the meeting. Using the above definition, this too is a kind of psychotherapy.

Thus, performing RCTs on any intervention that is based solely upon the interaction between one human being and another has inherent methodological problems. Some of the inaccuracy comes from the suppleness of therapy in the hands of the experienced practitioner, who effortlessly slides from cognitive-behavioral therapy to psychodynamic formulations and behavioral controls in the course of a single session.[10] Much of the problem comes from a core truth in therapy, "High-empathy counselors appear to have higher success rates regardless of theoretical orientation."[11] Unless we are able to correctly stratify many therapists in a research trial according to myriad skills and levels of accurate empathy,[12] any RCT that uses multiple therapists or multiple interventions will tend to underestimate the efficacy of the studied intervention. A trial using one therapist conducting different interventions would fail as well; once learned at a procedural level, psychotherapists find it hard to turn off over-learned responses. And the number of participants in such a study would prevent it from gaining statistical validity.

Manualized therapy is an attempt to systematize psychotherapy, making it more repeatable and reliable. It is therefore more accessible to study using an RCT. The upside of manualized therapy is that it ensures important concepts are surfaced in sessions, hoping that all participants understand these concepts and internalize important recovery skills. In many ways, part of the A.A. experience is a loose version of manualized therapy—concepts are repeated over and over while its members describe their own real-world examples in applying these skills.

What Does This Have to Do With PHPs?

If you have stayed with me to this point, you may be left wondering why this article is here. When discussing treatment outcomes, PHPs and the FSPHP are consistently viewed with suspicion. How is it that we have an approximate 80 percent successful completion rate for substance use disorders (SUDs) at five years when the rest of the world accepts a 25 percent or lower *one-year* rate? How do our outcomes from two major sources, the Blueprint series[13] and the Washington state study[14] show such remarkable results? Despite suspicion from those outside the field, to most of us working in a PHP these data seem intrinsically

correct—our Georgia experience, although only five years old, seems to track this data nicely.

One common response from educated naysayers is, "This is because your study population is physicians." This is indeed part of, but not the entire answer. A second pushback I have heard from researchers is, "Your data is not valuable because you have not completed an RCT." Whoa there, this is not necessary or ethical. My response, from here forward will be based upon the principal of Dr. Black, that is, RCTs are not the correct tool to use ". . . where experimentation may be unnecessary, in situations where treatment benefits are so obvious that a trial would clearly be unethical."[6]

We do need to repeat and expand studies that backstop the efficacy of the PHP model of disease management for SUDs among physicians, where an initial dose of treatment is combined with long-term disease monitoring. Your research committee is hard at work on this huge project. It is also important to examine the derivative hypothesis as well, that physicians remain in remission after monitoring is discontinued. Such studies will parse the difference between monitoring as a holding tank versus monitoring as a vehicle of change. A study by Merlo et al. (presented at a past FSPHP conference and soon-to-be-submitted) seems to support this hypothesis, but additional research is needed here. Even if many physicians return to their SUD after monitoring, we still have a remarkable system, unparalleled in the addiction care industry. We are the first group of care managers to accurately regard addiction as a chronic illness that needs chronic disease management.

We all should think critically when reading RCTs that attempt to compare the relative benefit of psychosocial or psychotherapeutic interventions to medications. This is most important when a study compares medication alone with medication plus psychotherapy. If the psychotherapy arm (using my broad definition) has an effect, it may by lessened by problems inherent in procedural interventions. RCTs are well suited for medication studies but prove problematic when applied to more nuanced interventions. Combining psychosocial or psychotherapeutic interventions with medication effectiveness introduces significant methodological concerns; the effect size of behavioral interventions will be diminished when compared to that of a medication intervention. ■

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A PHP SUCCESS STORY

Paul H. Earley, MD, DFASM, FSPHP President

Please join me in sharing news of successful PHP participant stories. PHPs save lives: Everyone should rejoice in that. With careful consideration to de-identification and a strong relationship with a credible and trustworthy journalist, stories can be shared that reveal the impact of a PHP. I am grateful we were able to do that: www.marieclaire.com/health-fitness/a26443838/top-doctor-opioid-addict. ■

UPDATES FROM AROUND THE UNITED STATES

CANDACE BACKER RECOGNIZED AS A HERO FOR RECOVERY

Candace Backer, LCSW, LCAC, coordinator of ISMA's Physician Assistance Program, has been named a Hero for Recovery by Mental Health America of Indiana (MHAI). MHAI President and CEO Stephen C. McCaffrey, JD, presented the award during a ceremony at the Columbia Club in Indianapolis on December 3, 2018. Backer was honored in the Mental Health and Addiction Professional category. The awards recognize "the dedication and commitment of those that truly promote recovery of individuals in their ongoing treatment of serious and persistent mental illness and addictive disorders." ■

NC OFFICE OF THE STATE AUDITOR ISSUES POSITIVE REPORT FROM RE-AUDIT OF THE NORTH CAROLINA PHYSICIANS HEALTH PROGRAM

No new findings. Program told to "Continue with your current policies and procedures."

Raleigh, NC, March 5, 2019. The NC Office of the State Auditor (NCOSA) has completed their follow-up audit of the North Carolina Physicians Health Program (NCPHP). This nine-month process culminated in a finding that NCPHP took "appropriate corrective action to address recommendations" made in the original 2014 NCPHP Performance Audit.

The 2014 Audit reviewed 110 cases over a 10-year period. There were no findings of abuse and sufficient evidence was found to support all assessment or treatment recommendations made by NCPHP, but some process recommendations were made. These included the following improvements: increased oversight by the NC Medical Board and NC Medical Society; ensuring participants have access to additional independent and objective due process procedures; protecting against potential conflicts of interest between NCPHP and treatment centers; and operationalizing the selection and monitoring of assessment and treatment centers recommended by NCPHP.

First under the direction of Dr. Warren Pendergast, Medical Director Emeritus of NCPHP, followed by the current CEO, Joseph Jordan, PhD, the NCPHP staff worked tirelessly putting additional policies and procedures in place, ensuring that NCPHP was doing its best to protect the rights of providers while safeguarding the people of North Carolina.

"We are extremely pleased with this outcome and look at this as validation of our hard work to make a great program even better," Jordan said. "It seems clear that we have succeeded in doing so."

This follow-up Performance Audit by the NC Office of the State Auditor reviewed 20 percent of NCPHP cases from January 1, 2015, to December 31, 2017. The team of state auditors concluded that each case file reviewed contained "sufficient, appropriate evidence" that due process procedures were followed. In addition, auditors reviewed cases in which participants disputed NCPHP recommendations and found that each case file "contained sufficient, appropriate evidence that supports that independent and objective due process procedures have been implemented."

When asked about these results, Robert W. Seligson, Executive Vice President and CEO of the NC Medical Society stated: "This very positive report is proof of the incredible work that the NCPHP staff puts into ensuring this program operates with the highest integrity and improves the safety of the health system." CEO R. David Henderson of the North Carolina Medical Board said, "The latest report from the Office of the State Auditor confirms what NCMB has verified through reports and reviewing the work done by NCPHP over the last five years. NCMB concurs in the conclusion that NCPHP has implemented comprehensive protocols to ensure that participants are treated fairly."

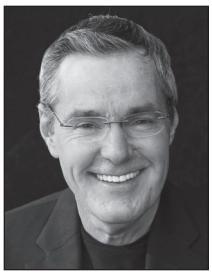
For the entire report, go to www.ncauditor.net/EPSWeb/Reports/Performance/PER-2018-8141.pdf.

About NCPHP

Since 1988, the North Carolina Physicians Health Program has been dedicated to helping medical professionals experience a lifetime of positive change and return to health. NCPHP assists with recovery from substance use disorders and other conditions such as depression, anxiety, or job-related burnout that could impair a provider's ability to safely provide care and services to their patients. NCPHP originated as a physicians health committee of the North Carolina Medical Society. Established as a formal program in 1988, NCPHP provides assistance and advocacy for licensees of the North Carolina Medical Board, the North Carolina Board of Veterinary Medicine, and the North Carolina Board of Pharmacy. From 1988 through 2018, NCPHP provided direct assistance to more than 4,200 medical professionals and indirect assistance to thousands more through educational and advisory programs. ■

THE NORTH CAROLINA PHYSICIANS HEALTH PROGRAM: MANY ITERATIONS, A SINGULAR PURPOSE

Clark Gaither, MD, FAAFP, Medical Director and MRO of the NCPHP



Clark Gaither, MD, FAAFP

The NCPHP was created in 1988 by the NC Medical Society, the NC Medical Board, and the NC state legislature to assist troubled physicians with whatever issues they are facing affecting their ability to practice safely by putting patients or themselves at risk. Since that time NCPHP has steadily grown, not only in our capacity to serve but also whom we serve and how we serve them.

At the outset, our mandate was limited to serving just those providers licensed by the NCMB. This included MDs, DOs, and PAs.

Initially, the majority of referrals came to us from the NCMB. Over the years, referrals from the NCMB have dropped to 28 percent while self-referrals have increased to 22 percent (2018). This reflects a level of trust among providers that the NCPHP has earned over the last 28 years plus encouragement by the NCMB to self-refer.

With our second iteration in 2004, the NCPHP contracted with the NC Board of Veterinary Medicine to serve troubled veterinarians and veterinary technicians as well. We offer those participants the same range of services available to physicians and PAs.

In 2011, the NCMB began licensing perfusionists and anesthesia assistants. This became our third iteration because this community of providers receives the same full range of services and resources available to all other licensees of the NCMB.

Our fourth iteration came in 2016 when the NCPHP entered into an agreement with the NC Board of Pharmacy. Troubled pharmacists and pharmacy personnel are now a part of our program too.

As part of our ongoing outreach, our staff crisscrosses the state giving talks at medical societies and medical staff meetings and to hospital boards, provider groups, and others about the services provided by the NCPHP. Educational talks are also routinely given on addiction and impairment issues in the workplace, and more recently, provider job-related burnout.

In July of 2016, I was brought on as Medical Director of the NCPHP. One of my areas of expertise is professional job-related burnout (JRB). This is one of the reasons I was brought on board by the NCPHP's CEO, Dr. Joe Jordan.

The reason JRB became a primary concern is simple. When physicians burn out they will sometimes act out with drugs, alcohol, mental health issues, or other self-destructive behaviors. The worst way a provider can act out is with suicide, which is unfortunately on the rise. What we are seeing at the NCPHP is about one-third of our referrals being directly related to JRB and another third indirectly related.

In addition to helping individual providers with JRB issues, we have now turned our attention to the organizations that employ them. In yet another iteration of what we do and who we serve, we have added consulting services for JRB mitigation, alleviation, elimination, and prevention.

continued on page 14

The North Carolina Physicians Health Program: Many Iterations, a Singular Purpose

continued from page 13

The steps taken for a JRB consultation are rather involved, but a cursory sketch of the entire process can be offered here.

Phase I:

1. Initial meeting and fact gathering with organization's administrators
2. Follow-up presentation on proposed scope of work

Phase II:

3. Administration of the Maslach Burnout Inventory (MBI) and Maslach Areas of Work-life Survey (MAWS) to targeted groups
4. Follow-up MBI and MAWS debriefing
5. Administration of the DISC Personality Profile, if applicable
6. Follow-up DISC debriefing, instruction, and workshop

Phase III:

7. Discussions on workplace changes/redesign
8. Finalization of policies, plans, and procedures to positively alter work environment from one that fosters burnout to one which fosters ENGAGEMENT—the hallmarks of which are Vigor, Dedication, Absorption
9. Implementation of policies, plans, and procedures to lessen negative impact of underlying job-employee mismatches that cause burnout

Phase IV:

10. Resurvey at a predetermined point in time with reapplication of the MBI and AWS
11. Follow-up MBI and MAWS debriefing
12. Adjust JRB elimination policies, plans, and procedures and move forward

No organization sets out with a purpose to create less than ideal or outright toxic work environments, but this where many are now entrenched. I am reminded of the quote by P&G's Arthur Jones:

"All organizations are perfectly designed to get the results they get!"

If an organization wishes to reverse a negative dynamic, then things must necessarily change in a positive direction.

All of these iterations of the NCPHP, all of these expansions of service, have caused us to grow in the most beneficial ways. All of them have complemented one another. All of them have had at their core a singular purpose—to assist troubled healthcare providers in as many ways possible. ■

OKLAHOMA HEALTH PROFESSIONALS PROGRAM—SERVING OKLAHOMA PHYSICIANS AND HEALTHCARE PROVIDERS FOR OVER 35 YEARS!

Jen Boren, Program Manager

Jen Boren

Since 1983, the Oklahoma Health Professionals Program (OHPP), Inc., has provided services to over 1,000 physicians and healthcare providers with alcohol and chemical dependence. OHPP, Inc., is an outreach program designed to support and monitor medical and allied health professionals throughout Oklahoma who are experiencing difficulty with substance abuse, as well as disruptive and boundary issues.

Because of the commitment to provide resources to professionals in need, OHPP, Inc., has expanded and now employs a Program Manager, a Compliance Coordinator, an office assistant, and three part-time Directors. Our physician leadership team includes a Director, Deputy Associate Director, and an Associate Director to administer and oversee the program.

OHPP would to introduce to you the whole team:

Robert Westcott, MD, Director

Merlin Kilbury, MD, Deputy Associate Director

Paul Cheng, MD, Associate Director

Jen Boren, Program Manager, started May 2018

Angela Robinson, Compliance Coordinator, started August 2018

Amy Hill, Office Assistant, started November 2018

Angela Robinson

Amy Hill

OHPP recently celebrated a milestone, having celebrated the thirty-fifth anniversary of the establishment of the OHPP. With this milestone and growth in staffing, the OHPP looks forward to continued program development in excellence to serve physicians and healthcare providers with potentially impairing conditions.

Testimonial

"With the guidance of OHPP, I learned how to regain the life, career, and joy that I once had prior to living in my disease. OHPP does so much more than just getting you to the right places. They teach you how to deal with your disease, day by day, and then walk with you as you recover." —Former OHPP Participant ■

OREGON HPSP SATISFACTION SURVEY

Christopher Hamilton, PhD

Christopher Hamilton, PhD

Oregon's Health Professionals' Services Program (HPSP) just wrapped up its seventeenth consecutive Satisfaction Survey. Since January 2011 and every six months thereafter, HPSP has conducted a satisfaction survey of participants, health professional associations, independent third-party evaluators and treatment providers, and workplace monitors. For this period, a 24 percent response rate was yielded of licensee participants. The survey serves as ongoing quality improvement and provides a feedback loop for participants and program stakeholders. Survey results are reviewed by the internal HPSP Policy Advisory Committee (PAC) consisting of the HPSP Medical Director, Consulting Psychiatrist, Program Director, and two licensed Agreement Monitors.

Highlights from this period:

- 100 percent of treatment providers rate their experience working with HPSP as "excellent" or "above average"
- 93 percent of licensees and 91 percent of workplace monitors rate their experience with HPSP positively
- 96 percent of licensees indicate they understood the program's statutory monitoring requirements
- 89 percent of licensees felt program requirements are clearly explained
- 95 percent of licensees stated the program provides more than "some" accountability
- 91 percent of licensees believed their Agreement Monitor is knowledgeable of their case
- 89 percent of licensees reported information is communicated clearly, professionally, and within one business day

Of key importance to the Monitoring Program's Director is feedback that HPSP treats the licensee participant with dignity and respect. For this period, 82 percent of licensees feel the program treats them with dignity and 84.5 percent of licensees feel the program teats them with respect. In previous versions of the Satisfaction Survey, licensees were asked if they had been reported noncompliant in the previous six months. The licensees in these reports that were reported noncompliant in the previous six months correlated with the licensees who did not feel they were treated with dignity and respect. Noncompliance reports to the licensee's respective boards are not an area HPSP has discretion over. As such, reports are made in 24 hours when a licensee has non-negative toxicology, misses a toxicology test, or violates other individual requirements. Although HPSP does not have discretion over these events, it is an opportunity to further educate participants on HPSP's state statutes, revised administrative rules, and program guidelines that have been approved by the participating health boards (Oregon Medical Board, Oregon Board of Pharmacy, Oregon Board of Dentistry, and Oregon State Board of Nursing).

Quality improvement and a structured feedback loop are the two goals of the biannual survey. After the survey results and open-ended comments are reviewed by the PAC, recommendations are made for changes and improvements. Examples of program improvements made over the years from licensee and stakeholder feedback include: (1) opening the office for licensees to onboard with their agreement monitor (previously telephonic) and attend annual reviews in person, (2) creating new toxicology panels at reduced cost for unemployed or underemployed licensees who are temporarily not working in a medical field, and (3) making HPSP staff available on Saturdays.

This period, nine open-ended comments from licensees ranged from "Thank you for this program!" and "This is a great program for anyone who is willing to better themselves" to comments on the other end of the spectrum from "Strongly resent everything about program" and "Punitive!!!!" Other comments provide additional information and provide an opportunity for the PAC to reflect and determine if there are better ways to structure programming that will result in improved outcomes and perception of the program.

In addition to the HPSP biannual satisfaction survey, there is also an Enrollment Survey that is targeted to

continued on page 16

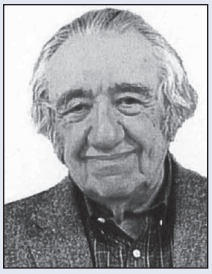
Oregon HPSP Satisfaction Survey

continued from page 15

participants once they have been in the program for three months. Data is collected monthly, reviewed internally every six months, and reported annually. An Exit Interview is also collected on an ongoing b asis, reviewed internally every six months, and reported annually. ■

HONORING HERBERT RAKATANSKY, MD

Many of you may know that Dr. Rakatansky is a fan of writing letters to editors. He did so in June of 1978 to the editor of the Rhode Island Medical Journal*, referring to an editorial by Peter Reilly, MD, on the subject of suicide in April of 1978. In May of 1978, Dr. Reilly suffered a tragic death at the age of 51. It seems fitting on this occasion to include Dr. Rakantansky's response letter entitled "Vulnerability of Physicians," as it still stands true in 2019.*



Herbert Rakatansky, MD

Editor's Mailbox

Vulnerability of Physicians
Herbert Rakatansky, MD

To the Editor:

The poignant editorial by Doctor Peter Reilly in a recent issue of the *Rhode Island Medical Journal* (61:17 1, April 1978) pointed out in a way too tragic to comprehend that physicians are as human as their patients and have similar feelings. In their professional capacity physicians are expected to disassociate themselves from and to an extent ignore their own feelings in order to make objective clinical judgements. Feelings, however, may not be ignored. They initiate and perpetuate emotional and physical states which produce the joy and satisfaction which make life worthwhile. They also produce the sadness and dissatisfaction which make life seem not worthwhile. Physicians have several impediments to expressing and dealing with feelings. By virtue of their authority, position, and the responsibility of the decisions made almost on a daily basis, normal feelings of doubt, inadequacy, anxiety, and anger may be self-interpreted as a sign of weakness.

The expression of feelings may be self-interpreted by physicians as demonstrating a lack of proficiency. Also, certain problems may afflict this group more than others. The use and abuse of medications, particularly psychoactive and narcotic medications, fall into this category. With easy access to medications physicians and members of physicians' families may rely on medications to allay the stresses of life and their feelings. Certain illnesses such as depression and alcoholism constitute another category of disease in which the physician may be peculiarly excluded from competent medical help. Organic illnesses such as myocardial infarction and even malignancy are respectable, whereas behavioral abnormalities such as depression and alcoholism are interpreted as signs of weakness.

Rhode Island is a small state. The physicians are a reasonably cohesive group in which professional and social relationships abound. There is only one major private mental health facility in the state. How can a physician who is depressed, who is drug dependent, who is alcoholic, or who has such severe anxiety as to interfere with his ability to practice or enjoy life consult a colleague with whom he may practice and socialize? Certainly outpatient psychotherapy on an individual basis is available, but many of the serious problems mentioned above require team effort and often hospitalization. Where can the troubled physician turn to ask for help easily available to the poorest welfare patient or the richest private patient?

In Rhode Island it is a difficult problem. Perhaps an organized program in cooperation with the Massachusetts Medical Society or with other agencies in Boston could provide consultation with appropriate specialists. An initial consultation with a specialist in an appropriate field and with whom there is no possibility of professional or social contact might open the door for help. Certainly, these referrals are available now, but only to those who know where to go and whom to ask. A more formal system might insure that the troubled physician in Rhode Island could obtain professional help without fear, be it real or imagined, of the loss of respect of his colleagues.

Doctor Reilly's tragedy is the tip of an iceberg. We should undertake all reasonable steps to prevent the loss of life, happiness, and productivity to which physicians may be subject as a result of their reluctance to seek help through the usual channels of entry to the medical care system.

Herbert Rakatansky, MD
Rhode Island Medical Journal (61:258-259, June 1978)

Concerned Colleagues Caring for Each Other
~ 1978–2018 ~

At the November 6, 2018, meeting of the Physician Health Committee (PHC), Dr. Herbert Rakatansky was honored by the Rhode Island Medical Society (RIMS) for his years of continuous service to the PHC and presented with a plaque of appreciation by RIMS's current president, Peter Hollmann, MD. As part of this presentation, we reviewed the RIMS's archives to extract a timeline of the evolution of the committee.

In 1976, the RIMS "Ad Hoc Committee on the Disabled Physician" made a recommendation to the RIMS Council that they form a "Physicians' Committee." Later, in February of 1978, this Ad Hoc Committee designed a "mechanism" which designated that the existing Peer Review Committee could undertake "helping disabled physicians." Eventually, after concerns about the existing mechanism were raised (and several physician suicides had occurred that year), RIMS established a standing committee known as the "Committee on the Impaired Physician." The first minutes we could find were from March of 1979 and named Herbert Rakatansky, MD, as the Chairperson. The PHC continued to evolve over the years: In 1985, we began serving dentists; in 1991, podiatrists; and in 1998, PAs were added. Each of these healthcare disciplines has a representative on the PHC. Dr. Rakatansky has presided over the PHC since its inception and has shared the company of a prestigious group of healthcare practitioners—by our count approximately 140 volunteer committee members. We honor him for his dedication and contributions as well as the many healthcare practitioners who have served on our committee over the past 40 years.

PAST AND PRESENT PHC MEMBERS

HERBERT RAKATANSKY, MD
JOSEPH CARUOLO, MD
JOHN FARLEY, MD
BRUNO FRANEK, MD
EDMOND BILLINGS, MD
HUGO TAUSSIG, MD
ROSWELL D. JOHNSON, MD
CHARLES CHARON JR., MD
THOMAS FORSYTHE, MD
BRUCE RAYMOND, MD
LOUIS VITO, MD
GEORGE TAFT, MD
LECLAIR BISSELL, MD
WILLIAM LIPPITT MAURAN, II, MD
WILMA ROSEN, MD
ROBERT E. DEFOREST, MD
BARUH MOTOLA, MD
JOSEPH DONAHUE, MD
LOUIS HAFKEN, MD
STANLEY GALE, MD
CHARLES STAUNTON, MD
ROBERT DREW, MD
LOUIS SORRENTINO, MD
CHRISTIAN HERARD, MD
MOHSENSOLTAN-HIOSSEIN, MD
JUDITH EATON, MD
M. HOWARD TRIEDMAN, MD
ANTHONY NAPOLI, MD
GEORGE CHARON, MD
RENEE GOLDA VOGEL, MD
GUIOMAR SILVEIRA, MD
PETER MATHIEU, JR., MD
JOHN FEMINO, MD
IRENA H. HORNIK, MD
LOUIS A. FUCHS, MD
SANFORD SCHATZ, MD
LUCIA FELLOWS, MD
ALAN WARTENBERG, MD
DENIS E. MOONAN JR., MD
ROBERT CHAMPAGNE, DMD
MICHAEL GOLDSTEIN, MD
J. JEFFERYS BANDOLA, MD
NICHOLAS CALIFANO, MD
JAMES MCLENNAN, MD
ROBERT SWIFT, MD
KENNETH J. MCCORMICK, DO
MALCOLM MCINNES, DDS
WILLIAM SAMUELS, MD
MICHAEL HAYDEN, DO
PATRICIA WOLD, MD
CHUCK WEITZNER, DDS
MICHELLE ASHLEY, MD
MARY ARNOLD, MD
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THE WVMPHP BEYOND SUDS

P. Bradley Hall, MD, Executive Medical Director, WVMPHP

P. Bradley Hall, MD

In the late 1970s after the AMA published a paper entitled "The Sick Physician," which recommended a proactive approach to assisting distressed physicians suffering from substance abuse or other mental health problems, physician health programs (PHP) were born. The confidential clinical approach with its associated benefit was recognized by regulatory boards. This encouraged earlier detection and referral of physicians with potentially impairing illness in addition to the benefit for patient safety. Physicians volunteer for assistance and guidance not only to avoid being reported to the regulatory board, but also to receive assistance and guidance in a confidential, professional, and respectful manner.

PHPs were not necessarily accepted by everyone. Not until 2007 did West Virginia join the other states in establishing the West Virginia Medical Professionals Program (WVMPHP) as the licensure board's recognized physician's health program. The WVMPHP continues to be the only physician health program recognized by the West Virginia Board of Medicine and the West Virginia Board of Osteopathic Medicine. The WVMPHP recently renewed agreements with both allopathic and osteopathic licensure boards for five-year terms. The WVMPHP has provided 148 educational lectures for an excess of 13,000+ physicians, hospitals, medical staffs, medical societies, students, and residents since its inception. Funding, to date, has been from a multitude of sources, primarily licensure board fees, hospital solicitations, and participant fees and remains a considerable concern for long-term viability. To date, there have been 235 signed participants, of whom 75 continue under agreements impacting hospitals/medical schools and group practices. This represents significant growth with 85 percent abstinence. The WVMPHP has provided assistance to an additional 700 "callers" on mental illness, substance use disorders, and other wellness-related issues.

Physician health programs set a new standard of care and a high level of success for the treatment of substance use disorders. The public is better served by having these confidential programs that provide early detection and careful monitoring than by exposing addicted physicians, which would delay referral and lead to higher risk of patient harm. The state regulatory boards have had the vision to do the public a great service in the support of physician health programs. Hopefully, with the continued success of the West Virginia Medical Professionals Health Program, the model can be emulated and utilized for others outside the healthcare community.

As you can see, WV Medical Professionals Health Program is fulfilling its mission of protecting the public and providing a mechanism for the successful rehabilitation of the sick physician and a return to the safe monitored practice of medicine to the benefit of the public and physicians themselves. West Virginia has created a safe system with the underlying principles of communication, collaboration, transparency, and accountability to the benefit of all. It is my hope that participation in the FSPHP's Performance Enhancement and Effectiveness Review (PEER) process will allow the WVMPHP to continue to build on its successes. Additionally, the results of such a process will likely enable the WVMPHP to further garner support from licensure boards, hospitals, medical associations, and malpractice carriers as a direct result of the PEER.

The WVMPHP has served West Virginia beyond services to physicians, podiatrists, and physician assistants. We have a direct involvement in the Governor's Advisory Council on Substance Abuse (GACSA), providing input to legislation and other relevant issues. Since September 2013, the WVMPHP partnering with the WV State Medical Association, WV Society of Addiction Medicine, WV Osteopathic Medical Association, both Allopathic and Osteopathic Licensure Boards, and the Bureau of Behavior Health and Health Facilities (BBHHF) has been holding a licensure board and AMA CME-accredited event: The "Appalachian Addiction & Prescription Drug Abuse Conference: A Paradigm for the Epidemic." Topics covered included prescription drug abuse, proper prescribing, addiction, treatment, recovery, co-morbid issues, and so forth. The 2018 Appalachian Addiction & Prescription Drug Abuse Conference, with 20 hours of CME, exceeded our expectations for continued growth, interdisciplinary education, and collaboration of multiple healthcare professional disciplines. The October 2018 conference was a success with nearly 400 participants from 11 disciplines and 39 exhibitors in attendance.

In collaboration with WVU Healthcare and the West Virginia Department of Health and Human Resources (supported by SAMSHA grant funds administered through the Bureau for Behavioral Health and Health Facilities), the WVMPHP produced the *Clinicians Pocket Guide for Drugs, Alcohol and Tobacco Screening, Brief Intervention, Referral & Treatment*. This six-fold guide for treatment professionals contains a wealth of information regarding alcoholism and drug addiction. Thousands of the guides have been distributed and continue to be requested today.

The WVMPHP has been the administrator of a Physician Education Grant with a number of goals. In collaboration with WV University, WV State Medical Association, and WV Osteopathic Medical Association, the WVMPHP has produced a three-hour web course available online for prescribers to meet the required CME proper prescribing education as part of licensure renewal for all the respective boards. There are additional other web courses that have also been produced by the WVMPHP. As part of the grant, other organizations have been supported in their educational efforts as well. The WVMPHP itself produced a web course targeting potential impairment and the PHP.

In today's changing healthcare environment, inclusive of physician employment, physician health and well-being, increased physician employment, burnout, life/work balance, barriers to assistance and guidance, suicide, and the aging physician are becoming paramount. The WVMPHP is the "ideal vehicle," building on the existing disease-management model of addressing mental illness and substance use disorders, to expand its services in providing assistance and guidance to organized medicine and the providers in best addressing these additional issues of well-being to the benefit of all. Of course, this will involve challenges and changes to the culture of medicine, processes and procedures, statutory modifications, and appropriate funding for PHP organizational infrastructure in support of these expanded services.

Onward and Forward,
P. Bradley Hall, MD, Executive Medical Director, WVMPHP ■

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WPHP SAVED MY LIFE

I wholeheartedly believe that WPHP in its entirety (the staff, the weekly group, the other participants) saved my life.

When I entered WPHP, my addiction had destroyed my health, my relationships, and my career.

Signing up with WPHP initially was a last-ditch effort to try anything to stay sober. Not only did it help me maintain sobriety, it also exceeded what I could have imagined by fostering a supportive environment where I learned to develop a lifestyle of recovery. Most importantly, WPHP gave me hope when I thought it was all lost.

In groups, I was able to meet other physicians who began in similar situations to me who were happily back at work, which gave me hope that recovery was possible. It was through numerous discussions with staff at WPHP that I discovered and started to see a potential future of my own.

Through WPHP's support and guidance, I have developed new friendships, healthy coping skills, and a structured pathway to safely return to medicine. WPHP is well-organized and well-connected and remains true to its primary goal of helping rehabilitate impaired physicians so they can successfully and healthily return to the practice of medicine.

During my time with WPHP, I found that if I was willing to put in the work to recover, WPHP was able to effectively and efficiently advocate on my behalf to help me achieve all of my goals. It has been a blessing and a true privilege to be part of WPHP and to have access to its wonderful resources. ■

LICENSURE QUESTION REFORM

Chris Bundy, MD, MPH, Executive Medical Director, Washington Physicians Health Program

Chris Bundy, MD, MPH

Danielle[1] is a third-year medical student applying for a family medicine residency. She is pretty sure that she is depressed and it seems

continued on page 20

Licensure Question Reform

continued from page 19

to be getting worse. She is good at hiding her symptoms from peers and attendings, but lately she feels so overwhelmed by the residency application process that she wonders if she might be better off dead. Danielle is thinking about seeing someone for her depression but is worried about how that will impact her ability to get a medical license in the future. She is afraid of having to disclose mental health information to the medical board but also does not want to be dishonest on her application. She thinks maybe she can wait out her depression and avoid the issue altogether.

Gabe[1] was diagnosed with a moderate alcohol use disorder in his internship year. Following treatment and monitoring by the state physician health program, Gabe has been in sustained remission for two years and is doing well in his surgical residency. He is applying for his state medical license, which asks if he has ever been diagnosed with a condition that could impair his ability to practice safely. He's not sure about the intent of the question or how he should answer.

Fear of disclosure of mental health or substance use disorder information and how that might affect licensure is a ubiquitous impediment to seeking treatment when health professionals need it, especially among medical students and residents who have never been previously licensed.[2–4] Following the suicides of two residents in New York in 2014, the American Medical Association (AMA) Council On Medical Education released its initial report, "Access to Confidential Health Services for Medical Students and Physicians," which called on medical schools and training programs to improve anonymous access to mental health and substance use disorder treatment and asked state medical boards to provide "safe-haven" provisions on licensing applications for physician health program participants. In 2016, the AMA went further and amended the report to discourage state medical boards from asking questions about past mental health diagnosis and treatment, mirroring the American Psychiatric Association Position Statement on Inquiries About Diagnosis and Treatment of Mental Disorders in Connection With Professional Credentialing and Licensing.[5] In 2018, the Federation of State Medical Boards (FSMB) followed suit and encouraged state medical boards to carefully review application questions and consider either eliminating questions specifically related to mental health and substance use disorder diagnosis or modifying such questions to address current impairment rather than broadly probing for current or past illness or treatment. In addition, the FSMB echoed the call for safe-haven provisions for physician health program participants.[7]

Following the AMA call to action for medical boards to reform their licensure questions, the Washington Physicians Health Program (WPHP) joined with the Washington Medical Commission (WMC) to undertake a review of the Washington application for medical licensure. Fortunately, Washington was among about a third of states that already had medical license application questions (MLAQ) that met the minimum criteria consistent with existing recommendations and the Americans with Disabilities Act of 1990.[4,6] However, WPHP and WMC aspired to go beyond the minimum and reform the MLAQs to reflect best practices among medical regulators nationally. As the result of this 18-month effort, four key changes to the MLAQs were implemented in December 2018 for both the initial licensure application and on the new renewal application:

- The definition of *currently* in relation to an existing health condition was modified to only include the prior six months (previously it had been within the past two years).
- Questions specifically asking about the impact of treatment or work accommodations on safety to practice were eliminated.
- Questions regarding diagnosis of paraphilias were removed.
- A safe-haven provision was added to the application instructions such that individuals known to WPHP may answer "no" to the item related to health impairment.[8]

Other state PHPs interested in similar reforms may be wondering how WPHP was effective in engaging the Washington Medical Commission on this issue. Here are a few factors that were critical to our success:

- A receptive audience: WPHP has spent 33 years cultivating our relationships with the Boards and Commissions of the licensees we serve. As a result, the Commission welcomed us raising concerns about the licensing questions.
- Formal presentation to the Policy Committee: We needed to clearly lay out the issues over about 30 minutes with evidence and expert opinion to support the recommendations (see references).
- Focus on the intent of questions: If a Board or Commission seems attached to a problematic application question, explore what the intent of the question is, whether the question accomplishes that intent and, if so, at what cost. There is little empiric support that health-related licensing questions protect the public.

- Clear recommendations: We told the Commission, as clearly as possible, what we thought they should do. This included providing model language for the application and renewal questions. This was not the time to dither, and the members were pleased that we gave them a clear starting point for their deliberations.
- Give special attention to explaining safe-haven and why it is important: It encourages potential applicants to engage with the PHP before initiating an application and reassures those who seek PHP support that they will be protected in obtaining licensure. Safe-haven is a powerful demonstration of collaborative effectiveness between PHP and its associated Medical Board.
- Appeal to goodness: Board and Commission members serve from altruistic motives, but the work can be thankless and underappreciated. This is an opportunity for members to demonstrate their clear commitment to the well-being of their peers.
- Continuing contact: It was important to continue to follow up with periodic contact as a resource and support for the Commission's process. For example, the Commission was interested to hear from another PHP about safe-haven and we were able to coordinate an exceptionally helpful and productive call with Amanda Kimmel, MPA, Director of Public Affairs at the Colorado Physician Health Program. That dialogue played an important role in helping the Commission accept the safe-haven concept (thanks Amanda!).

Tackling this barrier to wellness is a meaningful and practical action that will encourage folks like Danielle, Gabe, and countless others to obtain needed care before it's too late. It paves the way for other medical regulators across the country to follow suit in exploring opportunities to reform their MLAQs. Finally, it demonstrates how medical regulators and the PHP can work together to make progress that brings clear benefit to the profession and patients we serve. ■

Acknowledgments

WPHP is grateful to the WMC Licensing Application and Renewal Review Committee for their thoughtful efforts in bringing about these important changes. Members of the committee included Robert Small, MD (Chair), Harry Harrison, MD, Claire Trescott, MD, Jim Rooks, MD, Kim Romero (Licensing Manager), and Melanie de Leon (WMC Executive Director).

WPHP also appreciates the support and assistance of the Colorado Physician Health Program, especially Amanda Kimmel, in supporting these efforts.

References

1. Danielle and Gabe are fictional characters. Any resemblance to actual individuals is purely coincidental.
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8. Known to WPHP means the individual has informed WPHP of their behavior or condition and the individual is complying with all of WPHP's requirements for evaluation, treatment, and/or monitoring.

FEDERATION OF STATE PHYSICIAN HEALTH PROGRAMS

2019 ANNUAL EDUCATION CONFERENCE AND BUSINESS MEETING

Wednesday, April 24 to Saturday, April 27, 2019

PERPLEXING PROBLEMS AND EFFECTIVE SOLUTIONS FOR TREATING AND MONITORING HEALTHCARE PROFESSIONALS

Highlights

- Networking opportunities with leaders in the field of professional health and well-being
- Large exhibitor space with all breaks, breakfast, and food service with attendees
- Interactive general and breakout sessions each day to highlight the essentials of physician health programs
- Emphasis on panel presentations
- Poster Session Reception
- Daily Peer Support Groups and Meditation

The Worthington Renaissance Hotel, Fort Worth, TX
200 Main Street
Fort Worth, TX 76102
(817) 870-1000

Will coincide with Federation of State Medical Boards Conference

TUESDAY
4:00 p.m.–6:00 p.m. Early Exhibitor Registration
6:00 p.m. Board Meeting

WEDNESDAY
8:00 a.m.–10:00 a.m. Exhibitor Registration
9:00 a.m.–11:00 a.m. Pre-conference session
11:30 a.m. Registration and Exhibit Hall Opens
Welcome Lunch and Committee Meetings
General and Breakout Sessions
Silent Auction Dinner

THURSDAY
Morning Meditation
Morning Peer Support
New Member Meeting/PHP Peer Support Meeting
General and Breakout Sessions
Poster Session Reception
Board and Committee Chair Dinner

FRIDAY
Morning Meditation
Morning Peer Support
General and Breakout Sessions
Exhibitor Session
FSPHP Regional Member Meetings
FSPHP Annual Business Member Meeting
Social Event

SATURDAY
General and Breakout Sessions
9:45 a.m. FSMB-FSPHP Joint Session @ Omni
11:30 a.m. Final FSPHP General Session
12:30 a.m. Adjournment

Tentative schedule subject to change.

2019 FSPHP Meeting and Conference Agenda

Agenda Subject to Change
AMA PRA Category Credits ™ = *.
All session and events are open to all registered attendees unless otherwise noted.

Tuesday, April 23, 2019

4:00 p.m.–6:00 p.m	Exhibitor Check-In (Post Oak Foyer, Mezzanine Level)
6:00 p.m.–8:00 p.m.	FSPHP Board of Directors (Treaty Oak Board Room, Mezzanine Level)

Wednesday, April 24, 2019

8:00 a.m.–10:00 a.m.	Exhibitor Check-In and Setup (Post Oak Foyer, Mezzanine Level)
9:00 a.m.–11:00 a.m.	*Pre-Conference Workshop (Trinity Central, Trinity Level)
	Introduction to Motivational Interviewing *Lisa J. Merlo, PhD, MPE*
11:30 a.m.	Annual Meeting Registration (Post Oak Foyer, Mezzanine Level)
	Exhibits Hall Opens (Rio Grande, Trinity Level)
12:00 p.m.–1:30 p.m.	Silent Auction—Items Open for Bidding (Rio Grande, Trinity Level)
	Luncheon for All—Meet and Greet Exhibitors (Rio Grande, Trinity Level)
	Open Seating and Committee Meeting Tables Available (Rio Grande, Trinity Level)
12:30 p.m.–1:30 p.m.	FSPHP Committee Meetings Co-occurring with Luncheon (Luncheon Rio Grande, Trinity Level)
	Research Committee (West Fork II, Trinity Level)
	ACE Committee (Rio Grande, Trinity Level)
	Nominating Committee (Treaty Oak, Mezzanine Level)
1:30 p.m.	Welcome and Introductions (Brazos Ballroom, Mezzanine Level) *Linda Bresnahan, MS, FSPHP Executive Directort*
1:35 p.m.–2:05 p.m.	*FSPHP and Physician Health Update (Brazos Ballroom, Mezzanine Level) *Paul H. Earley, MD, DFASAM, FSPHP President*
2:05 p..m.–3:20 p.m.	*General Session I (Brazos Ballroom, Mezzanine Level) Preventing Physician Suicide: What You Can Do to Save a Life *Michael F. Myers, MD*
3:20 p.m.–3:50 p.m.	Visit Exhibitors and Break (Rio Grande, Trinity Level)
3:50 p.m.–5:00 p.m.	*General Session II (Brazos Ballroom, Mezzanine Level) Transforming Boundaries Will Transform Your Life *Sarri Gilman, LMFT*
6:00 p.m.–8:30 p.m.	Opening Night Silent Auction Dinner for All (Rio Grande, Trinity Level)
6:30 p.m.	Welcome Remarks *Paul H. Earley, MD, FSPHP President, and Martha E. Brown, MD, Program Planning Committee Chair*
	Welcome and Introductions of Exhibitors

**Reminder to all committee chairs to turn in your committee reports prior to Thursday evening's board meeting.*

continued on page 24

continued from page 23

7:45 p.m. Silent Bidding Closes and Winners Announced

Thursday, April 25, 2019

Posters Available for Viewing All Day

8:00 a.m.–9:00 a.m. Open Mutual Support Meeting (All Are Welcome) (Elm Fork I, Trinity Level)

8:00 a.m.–8:30 a.m. Meditation—Gentle Mindfulness Meditation (Elm Fork II, Trinity Level)
Facilitated by Doina Lupea, MD, MHSc

7:30 a.m.–9:30 a.m. Visit Exhibitors and Breakfast (Rio Grande, Trinity Level)

9:30 a.m.–10:45 a.m. *General Session III (Brazos Ballroom, Mezzanine Level)

Best Practices Regarding Anonymity and Confidentiality of PHP Records: 42 CFR Part 2, Peer Review and HIPAA
Stacy Cook, Esq

10:45 a.m.–11:10 a.m. Visit Exhibitors and Break (Rio Grande, Trinity Level)

11:10 a.m.–12:10 p.m. *Breakout Sessions

Breakout Session A (Brazos Ballroom, Mezzanine Level)	**Breakout Session B (West Fork I, Trinity Level)**	**Breakout Session C (Trinity Central, Trinity Level)**
Support for Healthcare Professionals with Substance Use Disorders *Penelope P. Ziegler, MD, DFASAM, Mary Raum, MD, Chris Bundy, MD, MPH, Michael McCormick, DO*	Physician Health and Fitness for Duty: An Exploration of Outcomes and Next Steps *Reid Finlayson, MD, Michael Baron, MD, MPH, Ron Neufeld, BSW, LADAC*	Challenges in Navigating Disability Discrimination and Privacy Laws in Addressing Physician Health, *Richard Barton, Esq, Natalie V. Mueller, Esq, Julian J.G. Lean, Esq, Rachael Harrington, JD*

12:15 p.m.–12:45 p.m. Breakout Sessions

New FSPHP Member Meeting (Bur Oak, Mezzanine Level)	**PHP Peer Support—A Support Group Style Meeting (Elm Fork I, Trinity Level)**
A meeting of new members to review FSPHP membership goals and meet and greet each other. *Facilitated by Paul Earley, MD, DFASAM, Chris Bundy, MD,MPH, Brad Hall, MD, DABAM, and FSPHP Board Members* ***Special thanks to the FSPHP Emerald and Diamond Exhibitors!***	PHP Directors, Case Managers, and Staff are invited to discuss stressors and strains of PHP work, including difficult conversations. *Co-Facilitated by Maureen Dinnan, Esq, and Penny Ziegler, MD*

12:15 p.m.–1:25 p.m. Luncheon and Exhibit Viewing (Rio Grande, Trinity Level)

9:45 a.m.–10:30 a.m. *General Session IV (Brazos Ballroom, Mezzanine Level)
Creating a Due Process for Clients: A Process for Addressing Participant Resistance and Complaints *Joseph Jordan, PhD, Brian Blankenship, JD*

2:30 p.m.–3:25 p.m. *Breakout Sessions

Breakout Session A (Trinity Central, Trinity Level)	Breakout Session B (West Fork I, Trinity Level)
Tips for Successful Advocacy for Modernizing State Licensing Board Questions on Mental Health *Eileen Barrett, MD, MPH, FHM*	If Rainman Were a Doctor: High-Functioning Autism Spectrum Disorder Among Physicians *Scott Humphreys, MD, and Amanda Brooks, LPC*

3:30 p.m.–4:30 p.m. *General Session V (Brazos Ballroom, Mezzanine Level)
Understanding the Importance of Accurately Diagnosing ADHD in Addicted Healthcare Professionals
Brad H. Sokal, PhD, Joseph E. Schumacker, PhD, Michael W. Wilkerson, MD, FASAM, and Don Cornelius, MD

Neurocognitive Assessment of PHP-Involved Physicians
Benjamin R. Phalin, PhD, and Scott Teitelbaum, MD

4:30 p.m.–5:15 p.m. *Breakout Sessions

Breakout Session A (Brazos Ballroom, Mezzanine Level)	Breakout Session B (Trinity Central, Trinity Level)	Breakout Session C (West Fork I, Trinity Level)
Evidence-Based Method for Assessing and Monitoring Suicide Risk in Physicians *Sally Moody, LCSW, and Lacey Herrington, PhD*	Bias in the Evaluation of Physicians: Sources and Solutions *Michael H. Gendel, MD*	Framework Data Implication in Assessment and Referral to Appropriate Treatment; Addiction and Its Complex Interaction with Mental Health and Trauma *Michel Sucher, MD, Michael Baron, MD, and Sherry Young, PhD, CSAT*

5:15 p.m.–6:15 p.m. Reception with Poster Session Presentations (Trinity Foyer, Trinity Level)

Hors d'oeuvres

Childhood Trauma and Professional Performance Issues
Betsy White-Williams, PhD, MPH, Dillon Welindt, Anna Stumps, and Michael V. Williams, PhD

The Darknet—A Virtual Abyss to Fulfill Any Desire
Anish John, MD

Science of the Heart
Stephen Loyd, MD, and David "Chip" Dodd, PhD

Physician Sexual Misconduct: Hypocritical Oaths
Renee Sorrentino, MD, and Kate Peretti, PsyD

**Posters on display all day Friday, April 26, 2019

7:00 p.m.–8:30 p.m. FSPHP Board Meeting and Committee Chairs Dinner (Pecos I, Mezzanine Level)
(Open to Board of Directors and Committee Chairs)

Friday, April 26, 2018 Posters on display all day

7:00 a.m.–8:00 a.m. Open Mutual Support Meeting (Elm Fork I, Trinity Level)
(All Are Welcome)

7:30 a.m.–8:00 a.m. Meditation —Gentle Mindfulness Meditation (Elm Fork II, Trinity Level)
Facilitated by Doina, Lupea, MD, MHSc

continued on page 26

continued from page 25

7:00 a.m.–8:30 a.m.	Breakfast and Visit Exhibitors (Rio Grande, Trinity Level)
8:30 a.m.–9:30 a.m.	*General Sessions VI(Brazos Ballroom, Mezzanine Level) Physician Well-Being Initiatives *Timothy Brigham, MDiv, PhD*
9:30 a.m.–10:30 a.m.	*General Sessions VII Brazos Ballroom, Mezzanine Level Caring for Ourselves and Each Other in the High-Stakes Universe of Physician Health *Mel Pohl, MD, DFASAM, Chris Bundy, MD, MPH, Laura Moss, MD, Doina Lupea, MD, MHSc*
10:30 a.m.–11:00 a.m.	Accountability in the 21st Century: A Canadian Experience *Doina Lupea, MD, MHSc, and Joy Albuquerque, MD, MA*
11:00 a.m.–11:30 a.m.	Visit Exhibitors and Break (Rio Grande, Trinity Level 1)
1:30 a.m.–12:15 p.m.	*Breakout Sessions

Breakout Session A (Brazos Ballroom, Mezzanine Level)	**Breakout Session B (West Fork I, Trinity Level)**	**Breakout Session C: Exhibitors (Trinity Central, Trinity Level)**
Do PHPs Use Contingency Management Theory? *Paul H. Earley, MD, DFASAM*	Eating, Drugs, and Sex: How to Evaluate and Follow Process Addictions *Fran Langdon, MD, ABAM*	Exhibitor Session Facilitated by P. Bradley Hall, MD *All exhibitors are invited to meet with members of the FSPHP Program Planning Committee for discussion and feedback*

12:15 p.m.–1:30 p.m.	Luncheon and Exhibit Viewing (Rio Grande, Trinity Level) Recognition of Emerald and Diamond Exhibitors
1:30 p.m.–2:45 p.m.	FSPHP Regional Member Meetings *(Open to FSPHP State, Associate, Honorary, International, Individual, and Organizational Members)*

Western Region (Elm Fork I, Trinity Level)	Southeast Region (Pecos II, Mezzanine Level)	Central Region P(ecos I, Mezzanine Level)	Northeast Region (Elm Fork II, Trinity Level)

2:45 p.m.–3:00 p.m.	FSPHP Members Gather for Picture (TBD) FSPHP Member Annual Business Meeting Registration (Brazos Foyer, Mezzanine Level)
3:00 p.m.–5:00 p.m.	FSPHP Annual Business Meeting Brazos Ballroom, Mezzanine Level *(Open to FSPHP State, Associate, Honorary, and International Members)*
5:00 p.m.–5:15 p.m.	FSPHP Board of Directors Meeting *(Open to FSPHP Board of Directors)* (Treaty Oak, Mezzanine Level)
6:15 p.m.	Social Event—Dinner at the Cowgirl Museum *Bus Pick-Up* (West Drive at Trinity Foyer)

A separate $75.00 pp fee applies for this event at the time of registration.

Saturday, April 27, 2019

7:30 a.m.–8:30 a.m.	Open Mutual Support Meeting (All Are Welcome) (Elm Fork I, Trinity Level)
7:30 a.m.–9:00 a.m.	Visit Exhibitors—Breakfast (Rio Grande, Trinity Level)
9:00 a.m.	Commute to FSMB Session (Trinity Foyer, Trinity Level) *Bus at West Drive/*
9:45 a.m.–11:00 a.m.	General Session VIII Joint FSMB and FSPHP Session
	The Late Career Physician: What Will Be the Impact on Patient Care? Omni Fort Worth Hotel, 1300 Houston Street, Fort Worth, Texas 76102
	Panelists: Chris Bundy, MD, President-Elect, Federation of State Physician Health Programs
	Paul Earley, MD, President, Federation of State Physician Health Programs
	Paul H. Wick, MD, Immediate Past Chair, Senior Physicians Section Governing Council, American Medical Association
	Moderator: Scott A. Steingard, DO
	Audience: FSPHP Attendees are invited to join this joint session with physician and consumer members of state medical and osteopathic boards, representatives from international medical regulatory authorities, academic and professional medical organizations, and medical school educators (approximately 450–500).
11:00 a.m.–11:30 a.m.	Travel Back to FSPHP SESSION Board Bus Outside Omni
11:30 a.m.–12:30 p.m.	*General Session IX (Brazos Ballroom, Mezzanine Level)
	State Medical Boards and PHPs Next Steps to Improve Physician Wellness *Arthur S. Hengerer, MD, Thomas Mansfield, JD, and Doris Gunderson, MD*
	Wellness and resilience continue to remain at the forefront for physicians as they strive for control of the increase in burnout in their lives. It is now evident that 90 percent of this problem is system generated. One disruptive area in the system is the regulators and the potential role they play in the stigma that prevents seeking care. The presentation will discuss steps being taken from multiple workgroup meetings involving state boards, state medical societies, and PHPs to lessen their negative effect. Included is how the PHPs are working with the other organizations to impact the process that is developing.
12:30 p.m.	Exhibitor Drawings and Closing Remarks Brazos Ballroom, Mezzanine Level *Linda Bresnahan, MS, Doris Gundersen, MD, and Martha E. Brown, MD*

ACCREDITATION STATEMENT

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education through the joint providership of the Florida Medical Association and the Federation of State Physician Health Programs. The Florida Medical Association is accredited by the ACCME to provide continuing medical education for physicians. The Florida Medical Association designates this live activity for a maximum of **15.25** *AMA PRA*

FMA Accreditation PROGRAM
How Physicians Earn Quality CME

continued on page 28

continued from page 27

Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

DISCLOSURE OF THE FLORIDA MEDICAL ASSOCIATION

It is the policy of the Florida Medical Association (FMA) to ensure independence, objectivity and scientific rigor in all approved CME content. CME faculty must present evidence-based data, clarify off-label product use and disclose all relevant financial relationships to the audience. The ideas and opinions expressed during jointly provided events do not necessarily reflect those of the FMA, and the FMA's approval of course content for *AMA PRA Category 1 Credits*™ does not constitute an endorsement of the ideas, positions or statements contained therein. Every effort has been made to ensure that all information provided by the joint provider is accurate and current. However, FMA does not accept responsibility for errors or omissions and accepts no liability for any resulting loss or damage. Attendees agree to participate in this CME activity with full knowledge and awareness that they waive any claim they may have against the FMA for injury or other damage that may result in any way from their participation in this activity.

PHYSICIAN HEALTH AND OTHER RELATED ORGANIZATIONS NATIONAL MEETINGS

FSPHP ANNUAL MEETINGS

2019 FSPHP Education Conference and Business Meeting
April 24–27, 2019
Worthington Renaissance Forth Worth Hotel
Ft. Worth, TX

2020 FSPHP Education Conference and Business Meeting
Tentative Dates: Thursday, April 30, 2020–Sunday, May 3, 2020, or Monday, April 27, 2019–Thursday, April 30, 2020

FSMB ANNUAL MEETINGS

2019—107th Annual Meeting
April 25–27, 2019
Omni Fort Worth Hotel
Fort Worth, Texas

2020—108th Annual Meeting
April 30–May 2, 2020
Grand Hyatt
Manchester, San Diego, CA

2019 AMERICAN CONFERENCE ON PHYSICIAN HEALTH (ACPH)

September 12–21, 2019
Sheraton Charlotte Hotel
Charlotte, NC
Hosted by the American Medical Association in collaboration with the Stanford University School of Medicine and the Mayo Clinic

AMERICAN ACADEMY OF ADDICTION PSYCHIATRY

30th Annual Meeting and Scientific Symposium 2019
December 5–8, 2019
Rancho Bernardo Inn
San Diego, CA 92128

AMERICAN BOARD OF MEDICAL SPECIALTIES ANNUAL CONFERENCE

ABMS Conference 2019

September 23–25, 2019
Chicago, IL

AMA HOUSE OF DELEGATES ANNUAL MEETING

June 8–12, 2019
Hyatt Regency Chicago
Chicago, IL

June 6–10, 2020
Hyatt Regency Chicago
Chicago, IL

June 6–10, 2020
Hyatt Regency Chicago
Chicago, IL

AMA HOUSE OF DELEGATES INTERIM MEETING

November 16–19, 2019
Manchester Grand Hyatt
San Diego, CA

November 14–17, 2020
Manchester Grand Hyatt
San Diego, CA

AMERICAN PSYCHIATRIC ASSOCIATION ANNUAL MEETING

May 18–22, 2019
San Francisco, CA

April 25–29, 2020
Philadelphia, PA

AMERICAN SOCIETY OF ADDICTION MEDICINE

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

ASAM 51ST Annual Conference
April 2–5, 2020
Gaylord Rockies Resort and Conference Center
Denver, CO

INTERNATIONAL DOCTORS IN ALCOHOLICS ANONYMOUS (IDAA) ANNUAL MEETING

July 21– August 4, 2019
Knoxville, TN

2020
Spokane, WA

NATIONAL ORGANIZATION OF ALTERNATIVE PROGRAMS

2020 Annual Education Conference
March 16–March 19, 2020
Albuquerque, New Mexico

AMERICAN BOARD OF MEDICAL SPECIALTIES ANNUAL CONFERENCE

ABMS Conference 2018
September 24–26, 2018
Las Vegas, NV

NATIONAL ASSOCIATION OF MEDICAL STAFF SERVICES

NAMSS 43rd Educational Conference and Exhibition
October 19–23, 2019
Philadelphia Marriott Downtown
Philadelphia, PA

NAMSS 44th Educational Conference and Exhibition
October 3–October 7, 2020
Oregon State Convention Center
Portland, Oregon

NAMSS 45th Educational Conference and Exhibition
Hyatt Regency, New Orleans
October 16–October 21, 2021
New Orleans, Louisiana

AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW

50th Annual Meeting
October 24–27, 2019
Marriott
Baltimore, MD

51st Annual Meeting
October 22–25, 2020
Chicago, IL

PHYSICIAN WELL-BEING INITIATIVES:

ACGME PHYSICIAN
Improving Well-Being
www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being

NATIONAL ACADEMY OF MEDICINE
Clinician Well-Being and Resilience
https://nam.edu/initiatives/clinician-resilience-and-well-being

INSTITUTE FOR THE ADVANCEMENT OF BEHAVIORAL HEALTH NATIONAL RX SUMMIT
April 22–25, 2019

We are pleased to present our advertising 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.

MEMBERSHIP OPPORTUNITIES

Chris Bundy, MD, MPH, Chair, FSPHP Membership Committee; and P. Bradley Hall, MD, Co-Chair, FSPHP Membership Committee

To FSPHP members:

There is significant potential for those interested in physician and professional health to join the FSPHP. The FSPHP can benefit new members. Our current member PHPs' experience can increase the effectiveness of our overall mission, "To support physician health programs in improving the health of medical professionals, thereby contributing to quality patient care," and support our vision of "a society of highly effective PHPs advancing the health of the medical community and the patients they serve."

The Board of Directors of the WV Medical Professionals Health Program has authorized associate memberships to three of its board members and three of its case management members in recognition of the benefit of FSPHP membership. Their experience to date has been positive, and I would highly encourage your organization to do the same.

Please consider sharing news of our available membership opportunities with:

- Current PHP staff, board members, and oversight committee members.

While budget considerations may limit the number of FSPHP members a PHP will fund, a designee of the PHP board or committee may be willing to fund their own membership, especially after recognizing the benefits.

- Treatment providers working with the PHP or in the field of healthcare professionals within the state
- Professional coaches of healthcare professionals in the state
- Attorneys on staff of a PHP
- Medical students or residents involved in physician wellness within their institutions
- Residents or fellows who by nature of their training may have a particular interest in physician health (psychiatrist, addiction medicine, occupational medicine, etc.)
- Academic training institutions, deans, associate deans, and attendings
- Medical and specialty societies
- Prior PHP participants working with an interest in the field

The FSPHP develops common objectives and goals in order to promote physician health and to assist state programs in their quest to protect the public through the promotion of health and well-being of medical professionals. FSPHP members have access to exclusive networking, resources, collaboration opportunities, and educational opportunities at the leading edge of physician health. In addition, the FSPHP provides education and exchange of ideas for physician health through its member listserv. Membership provides access to the members-only section of the FSPHP website, which includes a library of PowerPoint presentations shared amongst members. Members have access to FSPHP policies and guidelines, leadership opportunities, new employment opportunities, and up-to-date information on the latest issues affecting physician and professional health at the state and national levels. FSPHP new members receive a discount to our up-to-date evidence-based, informational annual conference and participation in FSPHP Regional meetings. More information on membership benefits can be accessed by going to: https://fsphp.memberclicks.net/benefits-of-membership.

The FSPHP currently has six categories of membership: State, Associate, International, Organizational, Honorary, and Individual.

Membership Categories (Criteria for membership are abbreviated here.)

State/Voting

State programs with compensated staff, and/or compensated Medical Director, and/or voluntary committee chairperson/staff

Associate*

Open to compensated staff and/or noncompensated staff and oversight board or committee members of state physician health programs

International

International programs with compensated staff, and/or compensated Medical Director, and/or voluntary committee chairperson/staff

Individual*

Open to individuals who are engaged in the education, intervention, research, peer assistance, care, and treatment of physicians and/or other healthcare professionals with potentially impairing illness in a hospital, office, or other clinical/nonclinical setting. This category is also open to compensated and/or noncompensated staff and oversight board or committee members of an FSPHP Organizational member in good standing.

Organizational*

Open to organizations who are engaged in the education, intervention, research, peer assistance, monitoring, and advocacy of physicians and/or other healthcare professionals with potentially impairing illness in a hospital, office, or other clinical/nonclinical setting. This category is open to only one (1) individual per organization, including a compensated and/or noncompensated staff and oversight board or committee member.

Honorary

Open to outstanding persons at the nomination by a state member, and elected by two-thirds of the state members present at the annual meeting

**Members of state licensing or disciplinary agencies are not eligible for membership.*

Membership applications can be accessed at: https://fsphp.memberclicks.net/index.php?option=com_mcform&view=ngforms&id=2004583#.

FSPHP E-Groups—Please Join!

The FSPHP e-groups are an extraordinarily valuable tool for our members. The e-groups provide a user-friendly capability to share information among our members. As you may know, we now have two e-groups. FSPHP e-groups are a forum for discussion of issues, problems, ideas, or concerns relevant to state PHPs. Membership in the e-groups is open only to Federation members. Visit www.fsphp.org/FSPHPEGroupGuidelines11.14.pdf for guidelines on the use of the e-groups. For any questions concerning the two e-groups, please call Sandra Savage or Linda Bresnahan at FSPHP (978) 347-0600, or email ssavage@fsphp.org or lbresnahan@fsphp.org.

Currently, many FSPHP members are not yet enrolled on the fsphpmembers@yahoogroups.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 in it. The group, fsphpmembers@yahoogroups.com, is an information exchange venue for all FSPHP membership categories. These include State, Associate, Honorary, and International for both Individual and Organizational memberships of the Federation of State Physician Health Programs, Inc. The second group, statePHP@yahoogroups.com, is limited to the following membership categories—State, Associate, Honorary, and International. All State, Associate, Honorary, and International members are eligible for both groups. We encourage you to join both groups.

The nature of messages should be consistent with each Yahoo! group ListServe purpose. The statePHP@yahoogroups.com group is for internal, anonymous, case-specific, administrative, or physician-health-program-specific discussions or questions. The fsphpmembers@yahoogroups.com group is for the wider physician health field sharing of data, information, programmatic updates, resources, and overarching field topics. Please remember to be cognizant when utilizing both of these groups.

FSPHP Newsletter—Call for Content

Dear FSPHP Members:

Please consider and submit content for future issues of the FSPHP Newsletter. The length should be 500–1,700 words, with utilization of headings, subheadings, or tags. If readers want to dive deeper, we can always include links to and/or additional materials/articles in a feature. Thank you for your hard work and dedication to physician health!

We look forward to your articles/ideas/features. Here is a suggested list of topic areas for you to consider:

- Updates in your PHP's program
  - Recent impactful news about your PHP
  - Outcomes about your PHP
  - Programming changes at your PHP
  - Anonymous testimony (or even small quotes) from participants of your program
  - Announcements of new staff or new websites
  - PHP regional conference news
  - New education programs being offered by your PHP
  - Your PHP's collaboration (or challenges and how you overcame them) with your Medical Board; collaboration with other PHPs or other societies
- Physician Health Hot Topic Features: for example, aging physician screening, burnout/stress, testing/screening of participants.

Pinnacles of Success!

We would love to feature PHP members' accomplishments, awards, or special achievements and/or any PHP program's successful accomplishments or programs as examples of pinnacles of success!

Exclusive to FSPHP members: You may submit a complimentary advertisement for any educational programs your PHP sponsors as long as the educational content is aligned with our mission. Contact Linda Bresnahan for specification requirements.

Overarching topics (not as time-sensitive or one-program-related as the aforementioned) that you have a strong knowledge of, passion for, or understanding:

- Research/data on physician health
- The Performance Enhancement Review
- Effectiveness of long-term monitoring
- Participant satisfaction measurements
- FSPHP membership growth
- Collaboration between FSPHP and the FSMB
- Collaboration between FSPHP and ASAM

Our Executive Director, Linda Bresnahan, MS, has asked that all materials be emailed directly to her at lbresnahan@FSPHP.org and notes it will be directed to the correct committee and/or channels. Any specific questions about what each article/feature/story should entail should be directed to Linda directly. Again, short or long, make sure that your PHP is featured in the upcoming Newsletter. We also accept pictures with our news/features: Send those to Linda as well.

Thank you again for all of your work in physician health in 2018!

With excitement,
FSPHP Publications Committee
Co-Chairs, Sarah Early, PsyD, and Amanda Parry

Amanda L. Kimmell, MPA
Director of Public Affairs
Colorado Physician Health Program
899 Logan Street, Suite 410
Denver, CO 80203-3156
(303) 860-0122 ext. 231
(303) 860-7426 (fax)

CPHP because . . . HEALTHY DOCTORS GIVE BETTER CARE

FSPHP Member Portal

The FSPHP website, www.fsphp.org has a member portal available to active members. Once you have successfully logged in, you will have access to update your membership profile, view a history of FSPHP important messages, and participate in our member library of presentations, renew your membership, and view additional buttons on state PHP pages available to members only. This is just the beginning of more opportunities to share resources among our members in the future.

We would also like to ask you to submit a presentation via the portal to grow this library.

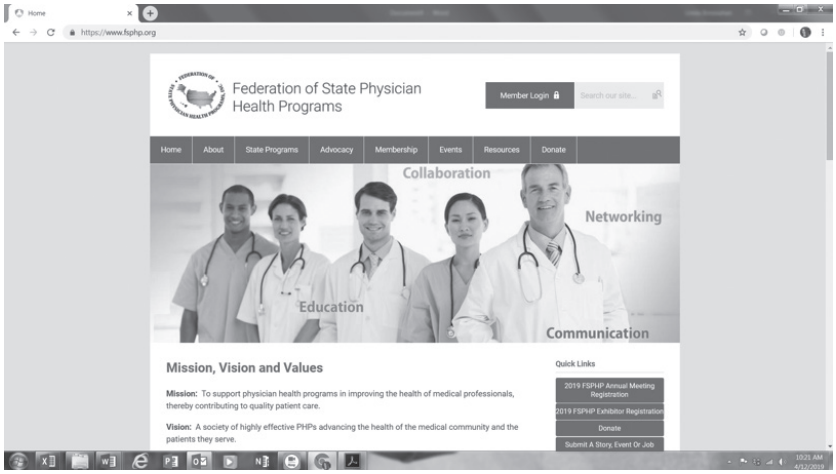
The login username is your member email address, and your password that you set.

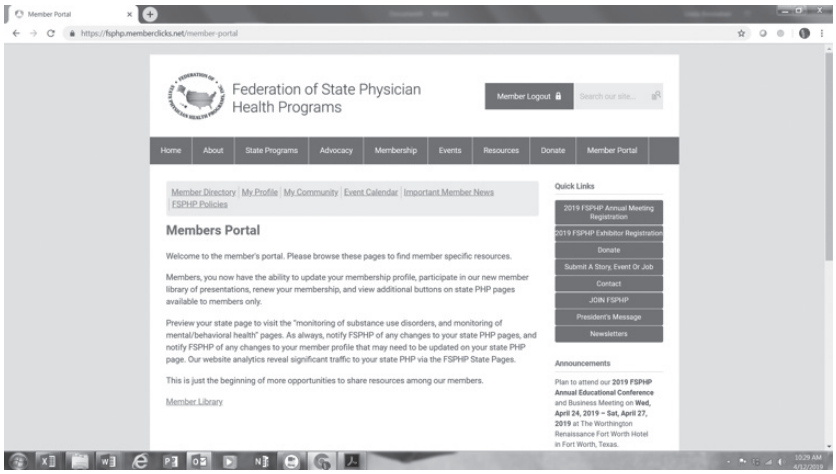
FSPHP would like to thank the Task Force on Education Materials, which was led by Dr. David Goldberg and included Tiffany Booher, MA, CADE, CIP, CCSM, Amanda Kimmel, Alexis Polles, MD, Jon A. Shapiro, MD, Michael A. Sucher, MD, and Robert Westcott, MD. This committee led the development of the guidelines for the member resource library. The guidelines allow members to submit presentations to the FSPHP for the library and users access to references for their own education and presentation needs for their PHP.

We look forward to hearing your feedback on how this portal is working for you. Please email your feedback or any questions to lbresnahan@fsphp.org and ssavage@fsphp.org.

The login username is your member email address and your password that you set. If you do not know your password, click "forgot password."

To log in as a Member: Visit www.fsphp.org and click on "MEMBER Login" on the top right corner:





FSPHP
668 Main St., Suite 8, #295
Wilmington, MA 01887

PHYSICIAN HEALTH NEWS

The FSPHP produces a newsletter twice a year in March/April and again in August/September that is sent to all state programs, medical societies, and licensing boards. The FSPHP requests articles (500 words or fewer) 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—*the summer issue is typically reserved for content related to our FSPHP annual meeting*.

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@fsphp.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, and so forth
- 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.

WE WANT YOUR INPUT!

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. You may also write directly to FSPHP Executive Director Linda Bresnahan at lbresnahan@fsphp.org. This will ensure an organized chain of communication between you and your representatives. Thank you for your assistance!