Federation of State Physician Health Programs
Better Together

Fall 2026 • Volume 2

Physician Health News

The Official Newsletter of the Federation of State Physician Health Programs







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Welcome to the 33rd edition, Volume 2 of *Physician Health News*. We hope you will find this an informative forum for all aspects of physician health and well-being. *Physician Health News* is the official newsletter of the Federation of State Physician Health Programs (FSPHP) and is published by the FSPHP.

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

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President's Message

Edwin Kim, MD, FAPA, MRO



It is an honor to address you for the first time in this medium as President. Stepping into this role, I am struck not only by the momentum our organization has built but also by the incredibly personal nature of the work we do every day.

I begin my term at a time of significant progress for the FSPHP, following the launch of standards like the PEER™ and ETA™ programs, and advancement of safe haven and confidentiality initiatives to strengthen our states' work with healthcare professionals. Every standard we raise ensures that when an individual is in need, they are met with confidentiality, compassion, and unparalleled expertise.

The sequelae of stigma surrounding mental illness and substance-related disorders in our profession remains a profound and unnecessary threat. In our modern healthcare system, there is no reasonable justification to allow our safety-sensitive occupation professionals to continue neglecting their health and well-being, let alone out of fear. This is why we must fiercely advance the mission of healthcare professional health. Safeguarding our colleagues, our medical system, and patients require more than just awareness; it demands a system of intervention that provides scaffolding for a culture where health is the priority.

My vision for the coming years is to deepen our impact by focusing on advocacy and education. We must continue being a leading voice in legislative halls, championing policies that protect those who seek help and the programs in which they receive assistance. We must ensure that organized medicine, state licensing boards, and employers understand their critical role in this effort. Equally important, we must reach the next generation of physicians early. No medical student or resident should ever have to wonder how a Physician and/or Health Professional Program (PHP) can support them and their colleagues.

We are bound together by a shared commitment to heal the healers, saving not just their careers but also their lives. I am incredibly proud to serve as your President alongside such a dedicated community, and I look forward to the deeply meaningful work ahead of us.

Edwin Kim, MD, FAPA, MRO
Federation of State Physician Health Programs, President



FSPHP President Dr. Edwin Kim addresses attendees from the podium at the 2026 FSPHP Annual Education Conference in Baltimore.

Helpful FSPHP Resources

Insights
https://www.fsphp.org/fsphp-insights

Featured Articles, Podcasts, and Videos about PHPs
https://www.fsphp.org/featured-articles-podcasts-and-videos-about-phps

PHP Member Policy Library
https://fsphp.memberclicks.net/member-policy-library

Job Opportunities
https://www.fsphp.org/job-opportunities

FSPHP Event
https://www.fsphp.org/events

State Program Videos
https://www.fsphp.org/state-program-videos

Map of FSPHP Regions
https://www.fsphp.org/assets/docs/RegionMap.pdf

FSPHP Update from the Executive Director

Linda Bresnahan, MS



Better Together: Strength in Numbers

I'd like to echo Dr. Kim's call to keep up FSPHP's momentum and deepen PHP impact through advocacy and education. Here is where our work stands after the past year, and where staying aligned will take us next.

Our strategy has three parts:

- Raise awareness through education, advocacy, and policy.
- Increase accountability, consistency, and excellence through PEER™ and ETA™.
- Drive impact by growing membership and funding support for FSPHP and Physician and Health Professional Programs (PHPs).

The Year at a Glance

- 25 presentations nationwide
- 2 new publications
- 4 states supported through advocacy and consultation
- 8 PHPs have completed PEER™
- 6 ETA™ accredited programs
- 6 PHPs enrolled in the Research Information System
- 339 members, up more than 9%

Raising Awareness

Education

FSPHP leadership delivered 25 presentations nationwide between September 2025 and October 2026 to medical boards, medical societies, health systems, and national partners. View all FSPHP presentations.

At the 2026 International Conference on Physician Health, our PHP Connect session brought together programs from Canada, the U.S., and Spain.

Recent presentations:

- American Medical Association (AMA) Alliance Physician Family Wellness Series, October 15, 2026. "The Sick Physician: How Physician Health Programs Heal Doctors and Their Families," Linda Bresnahan, MS, FSPHP Executive Director and CEO, and Chris Bundy, MD, MPH, FAPA, FASAM, FSPHP Chief Medical Officer
- National Association Medical Staff Services (NAMSS) 50th Annual Conference, October 18–21, 2026, New Orleans, LA. "Bridging Credentialing Risk Gaps with Health Verification by State Professional Health Programs," Linda Bresnahan, MS, FSPHP Executive Director and CEO, and Edwin Kim, MD, FAPA, MRO, FSPHP President

FSPHP has launched its own Online Learning Center.

New

Telling Our Story

The FSPHP Video: Trusted Help for Healthcare Professionals brings together stories and shared messaging from FSPHP and state PHPs. It is changing how people understand the compassionate, life-changing work of PHPs. Our webinars carry that message further and give members material to reuse in their own states.

Publications

- "Stigma, Shame, and Recovery in Physician Health Programs," *The Carlat Addiction Treatment Report* (July 2026).
- "Physician Wellness Programs and Physician Health Programs: A Powerful Partnership," in *A Step-by-Step Guide to Develop Medical Society Physician Wellness Programs, Tool Kit*, Second Edition (July 2026).

Partnerships and Collaborations

- Dr. Lorna Breen Foundation. Our partnership adds a strong national voice for changing intrusive licensure and credentialing questions. It also supports our own goals: confidentiality protections for PHP records and an early, safe path to a PHP before a health condition affects safe practice. FSPHP serves on the Foundation's ALL IN coalition and its workgroups.
- The Physicians Foundation funds three major FSPHP initiatives: reduced PEER™ fees for up to 15 PHPs, our webinar, "When Physicians Become Patients: Providing Care for General Medical, Mental Health, and Substance Use Disorders," and the Research Information System.

- The Federation of State Medical Boards (FSMB) Foundation supported our PHP National Survey, our joint education session, and other projects.
- FSMB Education Modules. The FSMB's Educational Modules on Medical Regulation: Protecting Patients, Supporting Physicians and Advancing Trust are now available on demand. Module 6 features FSPHP Chief Medical Officer Dr. Chris Bundy as a subject matter expert on physician well-being and the role of PHPs in safe medical practice. Access the modules.
- The Accreditation Council for Graduate Medical Education (ACGME). FSPHP content is featured in ACGME's Well-Being in GME resources (see "Mental Health Services and Suicide Prevention"), including "Improving Access to Mental Health Care in Graduate Medical Education" and "Physician Health Programs (PHPs): Support for Clinicians, Safety for Patients." View the resources.
- International Doctors in Alcoholics Anonymous (IDAA). In the IDAA webinar "Healing the Healers: Q&A with FSPHP and IDAA about Physician Health Programs," Dr. Chris Bundy and Linda Bresnahan answered key questions about PHP operations and standards. They also described current FSPHP initiatives and invited feedback to strengthen transparency, accountability, and resources across the healthcare community.

Policy and Advocacy

State Advocacy

- **California (AB 408):** FSPHP has been keeping an eye out for next steps toward the developing of a PHP. The bill sponsored by the Medical Board of California (AB408) that was introduced into the 2025–2026 legislature did not advance. We await next steps to learn of ways to support the process!
- **Wisconsin:** We are supporting the Wisconsin Medical Association in developing a PHP.
- **Nebraska:** We are working with the Nebraska Medical Association as it develops its Professional Health Program.
- **South Dakota:** We are consulting with the South Dakota Medical Board, using the PEER™ framework and stakeholder interviews, to make recommendations on its monitoring program.

National Policy

- **Triad of confidentiality:** Our Safe Haven work covers three protections: fair licensure health questions, confidential PHP records, and immunity protections similar to peer review. The work continues with a state-by-state review, papers, and presentations. It includes a state legislation lookup table developed with the FSMB.
- **PHP Guidelines:** An update is underway.
- **RFP guidance:** Now in development. Some states must use a Request for Proposal (RFP), a formal competitive bidding process, to choose a PHP. The guidance will help states design RFPs that reflect the clinical and regulatory realities of PHP work, so PHPs aren't treated as interchangeable vendors.

Accountability, Consistency, and Excellence

Performance Enhancement and Effectiveness Review (PEER™)

Eight member programs have completed a PEER™ review. They report that the process strengthened their policies and built credibility with their regulatory partners. Congratulations to:

- Alabama Professionals Health Program
- Colorado Physician Health Program
- Community Bridges, Inc. Professionals Medical Monitoring Program (Arizona)
- Georgia Professionals Health Program
- North Carolina Professionals Health Program
- Pennsylvania Physicians' Health Program
- Pu'ulu Lapa'au: Hawaii Program for Healthcare Professionals
- Utah Professionals Health Program

Ways to Stay Involved

- PEER™ Open Forum: Hear from participating PHPs about how PEER™ affected their programs. Watch the recording.
- Open Forum Leadership Series: Now in its second year, with quarterly peer support meetings for PHP leaders.

FSPHP Evaluation and Treatment Accreditation™ (FSPHP-ETA™)

Six Programs Have Earned FSPHP-ETA™ Accreditation

- All Points North Lodge
- Bradford Health Services
- Pavillon International
- Positive Sobriety Institute
- UF Health Florida Recovery Center
- Palmetto Addiction Recovery Center

We invite more programs to take part. Each PHP that completes a PEER™ review and each treatment program that earns ETA™ accreditation strengthens the case for all of us. Learn more about PEER™ and Learn more about ETA™.

Driving Impact

Research

- **PHP National Survey:** We have presented the findings, which give us the clearest picture yet of the national PHP landscape. One key finding is that PHPs help an estimated 10,000 physicians each year. Three papers are in progress: the national PHP landscape, PHP substance use disorder **monitoring practices, and PHP behavioral health monitoring practices**.
- Research Information System (RIS): The RIS is a national initiative to strengthen PHPs through secure, data-driven insights and ethical research. Six PHPs have enrolled. A signed legal opinion confirms that properly de-identified data can be shared for research, and our IRB has determined that the project is not human subjects research. When we can show who our programs serve and how participants do, we are better placed to secure future funding and raise the profile of PHP work. Please join us and help build that evidence. Learn more about the RIS.

Membership Growth

Membership grew more than 9% from 2025 to 2026, from 310 to 339 members. A larger membership gives us a stronger collective voice, more resources to share, and more credibility with policymakers. Growth was especially strong in our Associate, Industry Partner, and Individual categories. Interested in joining, or know someone who should be part of this work? Learn more about FSPHP membership categories.

Governance

Bylaws updates are underway to restructure the FSPHP Board. The changes aim to bring in broader expertise while keeping a physician majority, and they will set term limits to encourage fresh perspectives and ongoing leadership renewal. Members will review the full proposal and vote at the FSPHP Annual Member Business Meeting in spring 2027.

Better Together

None of this would happen without you. Thank you, our members, for coming together this year to grow awareness, advocate for the profession, and, most importantly, provide life- and career-saving support to physicians and healthcare professionals. Our committee members, volunteers, and member programs give their time and expertise generously, and it shows in everything we accomplish. Thank you for reminding us, again and again, that we are better together.

Linda Bresnahan, MS
Chief Executive Officer and Executive Director

NOW AVAILABLE ON DEMAND FSPHP Webinar that Changes How to Care for Physician Patients



A physician-patient brings medical knowledge, professional identity, and hidden vulnerabilities to every clinical encounter—and most clinicians were never trained for it.

FSPHP's on-demand webinar *When Physicians Become Patients: Providing Care for General Medical, Mental Health, and Substance Use Disorders* is designed to close that gap.

Led by five physician health experts—Drs. Paul Earley, Michael Baron, Alexis Polles, Chris Bundy, and Lisa Merlo—this two-hour program gives you the framework, language, and clinical tools to navigate one of medicine's complex dynamics.

This program will equip you to:

- **Navigate the unique ethical and interpersonal dynamics of the physician-patient relationship**
- **Recognize over-identification, self-diagnosis behaviors, and power differentials before they undermine care**
- **Address mental health and substance use concerns with sensitivity—and without derailing the relationship**
- **Know exactly when and how to involve a PHP—and make that conversation go well**
- **Earn 2 CME credits and walk away with tools you can use in your next clinical encounter**

We extend our sincere thanks to The Physicians Foundation, whose generous support makes this webinar possible.

Learn more and register at the FSPHP Online Learning Center.

Meet Our Latest PEER™ Program Completers!



Congratulations to all of the FSPHP Performance Enhancement and Effectiveness Review (PEER™) program completers! We are excited to recognize their achievement and celebrate their decision to participate in this important process.

Utah Professionals Health Program
Review date: August 5, 2024

Pennsylvania Physicians' Health Program (PA PHP)
Review date: August 9, 2024

Community Bridges, Inc. Professionals Medical Monitoring Program (Arizona)
Review dates: August 2 and 5, 2024

Colorado Physician Health Program
Review date: December 9, 2025

Pu'ulu Lapa'au: Hawaii Program for Healthcare Professionals
Review date: February 3, 2026

Georgia Professionals Health Program
Review date: May 27, 2026

Alabama Professionals Health Program
Review date: June 30, 2026

North Carolina Professionals Health Program
Review Date: August 4, 2026

The PEER™ program is a structured review process designed to empower Physician Health Programs (PHPs) and other safety-sensitive professional health programs to use the FSPHP PHP Guidelines as a practical tool for identifying opportunities to optimize performance and effectiveness in alignment with best practices among PHPs. It utilizes a comprehensive set of PEER™ assessment criteria, metrics, and assessment method specifications that align with the FSPHP PHP Guidelines developed through a robust consensus-building process utilizing a diverse group of subject matter experts.

DISCOUNTS STILL AVAILABLE!

Thanks to a generous grant from The Physicians Foundation, 10 PHPs can join the FSPHP Performance Enhancement and Effectiveness Review™ (PEER™) program at a discounted rate:

- ~~$2,500 off for the first 5 applicants~~ **ALL SPOTS FILLED**
- $1,500 off for the next 5 applicants
- $1,000 off for the final 5 applicants

Discounts awarded on a first-come, first-served basis upon submission of the PEER™ application.

Learn more and apply today.

Request a meeting to discuss the PEER™ Program.

Member News and Updates

NEW HAMPSHIRE

Beyond Coping—Building Emotional Awareness into Professional Health

Andrew W. Seefeld, MD, FACEP, FASAM, Associate Medical Director, New Hampshire Professionals Health Program



Andrew W. Seefeld, MD, FACEP, FASAM

Health professionals become remarkably skilled at functioning under pressure. We learn to compartmentalize, tolerate uncertainty, set aside our own needs, and continue performing despite fatigue, fear, grief, or distress. These abilities are often essential to our professional roles. They can also make it difficult to recognize what is happening beneath our professional exteriors.

At the New Hampshire Professionals Health Program, we have been exploring how education around emotional awareness, resilience, and recovery can complement the traditional work of a professional health program.

Over the past several years, I have developed and facilitated educational programming for NHPHP participants focused on emotional regulation, learned patterns of coping, and relief-seeking in response to distress. The purpose is to help participants understand their internal experiences and develop greater choice in how they respond.

Part of this work examines how earlier life experiences can shape patterns that persist into professional life. Strategies such as perfectionism, people-pleasing, over-functioning, intellectualization, and emotional detachment can be remarkably effective. They may help us succeed, care for others under difficult circumstances, and continue functioning under pressure.

But these strategies can also come at a cost. The patterns that allow us to keep functioning can make it harder to recognize or remain connected to what we are experiencing internally. The difficulty may emerge not in our ability to perform but in how we have learned to manage what we feel. Relief may be found through substances, behaviors, overwork, avoidance, or other ways of escaping distress. For some health professionals, the consequences of these coping patterns, rather than a lack of resilience, eventually bring them into contact with a professional health program.

Within recovery, this perspective creates an opportunity to look beyond abstinence alone. Abstinence is critically important, but recovery can also involve understanding the emotional experiences and learned patterns that contribute to relief-seeking. The goal is not simply to remove a behavior that provided relief but also to develop healthier ways of responding to the distress beneath it.

More recently, this work has focused on remaining present with difficult internal experiences rather than immediately trying to change, suppress, escape, or solve them. Participants learn to notice when they have internally disengaged and practice returning to what they are feeling without judgment. This is not about enduring more. It is about increasing our capacity to remain connected to ourselves and others when discomfort arises.

Through repeated offerings at the NHPHP, one lesson has become clear: many of the health professionals we serve do not lack resilience. They may have developed an extraordinary capacity to endure. The challenge is that endurance and other protective strategies can become primary ways of managing distress.

Professional health programs are uniquely positioned to help participants explore these patterns while maintaining monitoring, accountability, treatment, and abstinence when indicated.

The goal is not to teach health professionals to tolerate more.

It is to help them become more aware of what they are experiencing, understand how they have learned to respond to it, and develop greater freedom in what they do next.

NORTH DAKOTA

North Dakota Expands Eligibility to Dentists and Veterinary Professionals

Maggie Seamands, RN, Executive Director, North Dakota Professional Health Program

The North Dakota Professionals Health Program (NDPHP) is pleased to announce that enrollment is now available

for eligible dentists and veterinary professionals across North Dakota. This expansion reflects NDPHP's ongoing commitment to supporting the health, well-being, and professional success of healthcare professionals throughout the state.

By extending eligibility to these professions, NDPHP is broadening access to the confidential support, advocacy, and monitoring services that have long been a cornerstone of the program. Dentists and veterinary professionals can now benefit from the same trusted resources designed to promote personal wellness, professional accountability, and safe practice.

NDPHP is proud to welcome these professionals into the program and looks forward to supporting an even broader community of healthcare providers across North Dakota.

ONTARIO (CANADA)

Physician Health in Practice

Jon Novick, MD, Medical Director, OMA Physician Health Program

Laura Mattila, MA, MBA, Executive Director, OMA Physician Health Program



Jon Novick, MD



Laura Mattila, MA, MBA

It is critically important that physicians understand the unique features of physician-patients and learner-patients in their practices. This is especially true when physician- and learner-patients are managing an illness that requires specialized attention, or when they are involved with their jurisdiction's physician health program. In addition, physician leaders benefit from information about the range of needs and options to best support

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GET IN TOUCH!

their teams, which may include doctors or learners who are patients themselves, and doctors or learners who are caring for other doctors or learners.

Through feedback and consultation with Ontario (Canada) physicians, the OMA Physician Health Program (OMA-PHP) confirmed this need for added support and information for physician treaters and leaders. Many physicians have reported feeling less prepared to assess, support, and manage the unique clinical, ethical, regulatory, and workplace considerations that can arise when caring for physician colleagues.

To address these gaps and support treaters, leaders, and colleagues, the OMA-PHP developed a five-module course: *"Physician health in practice: Treating, supporting, and advocating for physicians."* The course provides practical, evidence-informed guidance that can be applied across a range of health-related and supportive encounters, physician-to-physician.

The five self-contained modules may be completed in any order, allowing engagement with the content most relevant to one's practice. The modules cover topics on physicians treating physicians, physician mental health and impairment, substance use in physicians, occupational planning (return to work), and the role of Physician Health Programs for treaters and leaders.

Each individual module is accredited for 1.0 Mainpro+ Certified Activity credits through the College of Family Physicians of Canada and 1.0 MOC Section 1 credits through the Royal College of Physicians and Surgeons of Canada. The course was made possible through the generous support from the Canadian Medical Association, MD Financial Management, and Scotiabank.

More information about the course can be found on the Ontario Medical Association's Physician Health Program website.

This course was developed by

Jon Novick, MD, Medical Director, OMA-PHP

Laura Mattila, MA, MBA, Executive Director, OMA-PHP

Lisa Lefebvre, MD, Associate Medical Director, OMA-PHP

Danijela Ninkovic, RN, MHM, Manager Clinical Services, OMA-PHP

Joy Albuquerque, MD, Past Medical Director, OMA-PHP

TENNESSEE

TENNESSEE MEDICAL FOUNDATION
PHYSICIAN'S HEALTH PROGRAM

"And the Survey Says…"—Study Ranks Our Most Helpful Services

Michael J. Baron, MD, MPH, DFASAM, FAPA, Medical Director, Tennessee Medical Foundation



Michael J. Baron, MD, MPH, DFASAM, FAPA

Background: By now you have seen our impressive participant outcome data that includes an 87% monitoring completion rate with an 11% return-to-use rate. Our TMF outcome study results align with national Physician Health Program (PHP) outcome data and tell us that the PHP model provides the most effective substance use disorder treatment. Studies also show that PHP participant graduates are healthier and safer than the general physician population.

Given this excellent outcome data, we wanted to know what our participants perceive as the most supportive services the TMF provides to help maintain their recovery. To answer that, we did a deep dive using a survey study to rank our services in order of impact.

Method: The TMF sent paper surveys by USPS to our Caduceus (TMF support group) facilitators to distribute to group members, including current PHP participants and graduates. An electronic version was also sent by email to members of our telehealth Caduceus group. Both paper and electronic surveys were optional and anonymous, resulting in a strong 68% completion rate. For multiple reasons, we wanted to focus the survey on those with at least two years of recovery, so the survey asked for sobriety month and year. Our final study group was 84 participants (N = 84) with two years or more of TMF recovery support.

Findings: All our services were perceived as helpful by our survey participants. The services listed below are in descending order of their perceived value at maintaining recovery:

1. **Advocacy:** Perceived as the most helpful service that we provide. This is a testament to the strength and reputation of the Tennessee Medical Foundation.
2. **Caduceus Meetings:** No surprise—the Caduceus group meeting is the safest recovery-based meeting around. It is a hybrid of a process group and 12-step meeting where discussion of any subject is allowed, including patient complications, divorce, malpractice, relapse, employment, etc.

3. **Connections:** This also makes sense as physicians are very isolated. Addiction only adds to the isolation as most physicians use substances alone. A participant may belong to a multi-specialty group or large institution, but those connections are superficial and employment-based. Forming deep and meaningful connections are part of the recovery process and a measure of spiritual growth. The TMF provides an avenue to make those important connections.
4. **Accountability:** This is quite a shocker, at least to me. Physicians in general do not like having "big brother" or the TMF looking over their shoulder. So, for accountability to be ranked as the fourth most helpful service was a big surprise. Accountability is the force that gets one through cravings, stress, or when accidental access happens. It's the one aspect or ingredient I point to when asked about our "secret sauce."

The remainder of the TMF Perceived Helpful Services surveyed were ranked in this order:

5. Case management
6. 12-Step recovery process
7. Intake process
8. Referral process
9. Monitoring contract

All TMF services surveyed were rated as valuable, with the top four emerging as the most impactful.

Conclusion: The TMF provides services that support our participants' recovery, with advocacy, Caduceus meetings, connections, and accountability, found to be the most helpful by our experienced PHP participants. The survey data was instrumental in our understanding of how TMF services are seen as vital support by those in recovery. We hope to fine tune our monitoring agreements to best incorporate this survey data.

Looking Ahead: To be able to publish our data, we applied for approval by the institutional review board (IRB). Because of an IRB requirement, we were obliged to repeat the participant survey study. The TMF continuously wants to know what we do that supports recovery so we can do it better; we also want to know what is not helpful to our participants' recovery. We will share results of the new participant survey as appropriate in a future article.

New TMF Leadership and Regional Representatives Announced

The TMF is pleased to announce new executive leadership and the addition of two distinguished medical professionals to its Board of Directors.

Dr. Eric W. Berg, III, of Clarksville is the new Board President, succeeding Dr. Clay Runnels, who transitions to the role of Immediate Past President. Joining the executive committee as Vice President is Dr. W. Reeves Johnson, Jr., of Knoxville. Additionally, the TMF welcomes Dr. Phyllis E. Miller (Chattanooga) and Dr. Amanda U. von Horn (Nashville) as new regional representatives.

"Our Board is the cornerstone of our mission to support Tennessee's health professionals in times of crisis," said Jennifer Rainwater, TMF Executive Director. *"The combined expertise of Drs. Berg, Johnson, Miller, and von Horn, along with the rest of our excellent Board, ensures we remain a robust lifeline for those battling substance use disorders and mental health challenges."*

NEW LEADERS 2026–2027

President: Eric W. Berg, III, MD, FCAP, FASCP



Eric W. Berg, III, MD, FCAP, FASCP

A graduate of the TMF PHP and a retired U.S. Army Colonel, Dr. Berg formerly served as Chief of Anatomic Pathology at Blanchfield Army Community Hospital. His distinguished career includes work with the Armed Forces Medical Examiner System during national crises, including the 9/11 Pentagon response and the Space Shuttle Columbia recovery.

Vice President: W. Reeves Johnson, Jr., MD, FAAFP



W. Reeves Johnson, Jr., MD, FAAFP

A former president of the Tennessee Board of Medical Examiners and member of the TN Medical Cannabis Commission, Dr. Johnson practiced family medicine in Knoxville for over 34 years before retiring from active clinical practice in 2023. He is a strong advocate for physician well-being at the local, state, and national levels.

Immediate Past President: Clay W. Runnels, MD



Clay W. Runnels, MD

Serving as Chief Physician Executive of Ballad Health in Johnson City, TN, Dr. Runnels is an ABEM-certified emergency physician. While serving in various leadership positions, he helped spearhead award-winning projects that include initiatives to reduce time to treatment for oncology patients and to streamline physician credentialing.

Southeast TN Representative: Phyllis E. Miller, MD

The first woman to lead the Tennessee Medical Association and the Chattanooga-Hamilton County Medical Society, Dr. Miller was recently honored as a "Champion of Healthcare" by the Chattanooga Times Free Press.



Phyllis E. Miller, MD

Middle TN Representative: Amanda U. von Horn, MD

Dr. von Horn is the Director of the Division Addiction Psychiatry at Vanderbilt University Medical Center in Nashville. She brings specialized expertise in addiction medicine and previously served on the board of Massachusetts Physician Health Services.



Amanda U. von Horn, MD

Lee McLellan of Pinnacle Financial Partners in Nashville remains Board Treasurer. Meanwhile, Dr. John Woods (Burns) continues Chair and Dr. Tim Davis (Chattanooga) remains Co-Chair of the Physician Health Quality Improvement Committee (PHQIC), which provides clinical oversight for the Professionals Health Program.

To see the full roster of TMF volunteer leaders, please visit e-tmf.org/leadership.

WASHINGTON

Washington Physicians Health Program Publishes Its 2025 Annual Report



The Washington Physicians Health Program (WPHP) has released its 2025 Annual Report celebrating the organization's accomplishments, measurable impact, and vital work to support and advocate for healthcare professionals. The report also provides a comprehensive look at WPHP's program outcomes and major milestones and highlights outreach and educational efforts. View the report.

Continuing Education Credit Available for WPHP's Overview and Impairment Presentation

Continuing education credit is now offered for WPHP's one-hour educational video presentation, "WPHP Overview & Impairment." In this session, Chris Bundy, MD, MPH, Executive Medical Director of WPHP, provides an overview of WPHP and the services it offers to support the healthcare community across Washington state. Dr. Bundy also explores impairment—how it is defined, how it presents, and how to address it effectively. This presentation is accredited for 1 *AMA PRA Category 1 Credit(s)*™ and is available free of charge on WPHP's website. Other health professionals may also be eligible for CME credit through continuing education partner CineMed. Please see WPHP's website for details.

WISCONSIN

FSPHP Continues to Partner with Wisconsin Medical Society in the Development of a Model PHP

FSPHP continues to partner with the Wisconsin Medical Society in the development of a model physician health program designed to support Wisconsin healthcare professionals.

As part of this ongoing initiative, Kelley Long, MBA, consultant to FSPHP and current Board Member, Chris Bundy, MD, MPH, CMO to FSPHP, and Linda Bresnahan, Executive Director and CEO of FSPHP, have provided guidance and consultative support throughout the program's development. In July, Dr. Chris Bundy participated in a stakeholder meeting in Madison, Wisconsin, contributing his expertise in clinician well-being and physician health program development.



Jim Lorence and Dr. Chris Bundy in Madison, WI.



Dr. Michael Stadler, Dr. Chris Bundy, and Dr. Stefanie Simmons at stakeholder meeting in Madison, WI.

Supported by the Advancing a Healthier Wisconsin Endowment (AHW) and led by Jim Lorence, Chief Value and Engagement Officer of the Wisconsin Medical Society, this collaborative initiative brings together healthcare leaders and stakeholders from medicine, nursing, pharmacy, dentistry, and other healthcare disciplines. The goal is to strengthen clinician well-being resources and establish a sustainable support infrastructure for healthcare professionals throughout the state.

Since the project's inception, FSPHP has served as a key consulting partner, providing expertise in physician health program development, governance, operations, and national best practices. We are proud to collaborate with the Wisconsin Medical Society and its partners on this important effort to advance clinician well-being, professional resilience, and the long-term sustainability of Wisconsin's healthcare workforce.

Join FSPHP and the Funding Development Committee for the 6th Annual Rally-by-Region Campaign!

FSPHP ANNUAL GIVING

Together, we are working toward our goal of raising $14,0000—$3,500 per region by December 31, 2026.

At a time when physician burnout, mental health conditions, and substance use disorders continue to affect the healthcare workforce, your generosity helps sustain a national framework for accountability, consistency, and excellence. Every donation is appreciated and useful, and each gift helps strengthen the national infrastructure that supports PHPs and the healthcare professionals they serve.

Organizations contributing $5,000, $10,000, or $15,000 are invited to participate in FSPHP's Strategic Partnership Collaborative, which convenes virtually twice each year to connect around our mission, activities, and shared goals for advancing physician health. Please consider making a contribution today at https://www.fsphp.org/donate.

Visit the Rally-by-Region 2026 webpage to track fundraising progress, see how your region is performing, and help us reach our goal.

CLICK HERE TO DONATE!



Dr. Chris Bundy participated in a stakeholder meeting in Madison, Wisconsin, contributing his expertise in clinician well-being and physician health program development.

Welcome Our Newest FSPHP Members!

We're thrilled to introduce the newest additions to the FSPHP community who have joined us since the Spring 2026 issue. Their presence strengthens our shared mission and brings fresh energy to our work. Let's give them a warm welcome as they embark on this journey with us!

State Voting Member

Jay Piland, MD
Medical Director, Health Professionals' Foundation of Louisiana

Associate Members

Kori Akamine-Kajihiro
Director of Operations, Pu'ulu Lapa'au: Hawaii Program for Healthcare Professionals

Valerie Jama, Esq.
Legal Counsel, Ohio Professionals Health Program

Ailyne Juarez, LMHC, LPC-S, NCC
Clinical Coordinator, Washington Physicians Health Program

Frederick Moeller, MD
Executive Director and Medical Director, Virginia Health Practitioners' Monitoring Program/ Virginia Commonwealth University

Heather Nordeen, LMHC
Clinical Coordinator, Washington Physicians Health Program

Makala Pittman
Program Manager, Oklahoma Health Professionals Program

Salma Rashwan
Quality Assurance Assistant, Washington Physicians Health Program

Sara Shelton
Senior Case Manager, Georgia Professional Health Program

Leah Sundquist
Clinical Liaison, Washington Physicians Health Program

Jason Thompson, MHA, MBA, MSSW
Case Director, North Carolina Professionals Health Program

Individual Members

Damian McHugh, MD, FACEP
Associate CMO, Clinician Burnout Foundation

Michael Miller, MD, DFASAM, DLFAPA
Medical Director: Plan/Design/Build, Wisconsin Healthcare Professional Services Program

Byamah Brian Mutamba, MMED (Psych), MPH, PhD
Senior Consultant Psychiatrist, Butabika National Referral Mental Hospital; Technical Director, YouBelong Uganda

Kenneth Zoucha, MD
Associate Professor Psychiatry/Pediatrics and Program Director for Addiction Medicine Fellowship University of Nebraska Medical Center

Industry Partner Individual Members

Peter Graham, PhD
Director/President/Co-Owner, Acumen Assessments/ Acumen Institute

Thomas Joles, MD
Founder, Insight Health Solutions

Erica Larson, DO
Insight Health Solutions

Jonathan Lee, MD, DFASAM
Medical Director, Farley Center

Jeremy Mirabile, MD, FASAM, ABPM-ADM
Recovery Keys

Malcolm Spica, PhD
Clinical Neuropsychologist, Tennessee Neuropsychology

Rachel Waters, LMHC
Director of Professional Services, UF Health Florida Recovery Center

Michael Wilkerson, MD
Medical Director, Pavillon Treatment Center

Scott Wolf, DO, MPH, FACP
Physician Executive, Certified Executive Coach

Organizational Member

Lynne McCullough, MD
Interim Executive Medical Director Physician Health & Wellness, UCLA

It's Time to Renew Your FSPHP Membership for 2027

The 2027 FSPHP Membership Renewal Period is Now Open!

Renewal notices and invoices were distributed beginning **October 1**, and we hope you'll continue your membership with FSPHP as we work together to advance physician and health professional well-being nationwide.

Your membership supports FSPHP's mission, strengthens our professional community, and helps drive important initiatives in education, research, accreditation, and advocacy.

Special Membership Promotions

Join Now and Receive the Rest of 2026 Free!

New members who join FSPHP for the 2027 membership year will receive membership benefits for the remainder of **2026 at no additional cost**.

This is a great opportunity to become part of a growing network of professionals dedicated to supporting the health and well-being of physicians and other healthcare professionals.

Complimentary Associate Membership for Renewing State PHPs

To encourage engagement and welcome new participants to the FSPHP community, each qualifying State PHP that renews for 2027 is eligible* to receive **one complimentary Associate Membership**. This free membership may be assigned to a **staff member, committee member, or board member** affiliated with your PHP who is joining FSPHP as a ***first-time member***.

**Eligibility Requirements*

State PHPs with Nine or Fewer Members

If your **State Voting Member** and **all current Associate Members** renew for 2027, your program qualifies for **one complimentary new Associate Membership**.

Example: If your State PHP has three Associate Members and all three, along with the State Voting Member, renew for 2027, your program may add one new Associate Member at no cost.

State PHPs with Ten or More Members

If your program has **10 or more total members**, and the **State Voting Member plus at least nine Associate Members** renew for 2027, your program qualifies for **one complimentary new Associate Membership**.

Example: If your State PHP has 15 members, and the State Voting Member and at least nine Associate Members renew for 2027, your program may add one new Associate Member free of charge.

Important Notes

- Limit **one complimentary Associate Membership per qualifying State PHP**.
- The complimentary membership must be used for a ***new, first-time*** **FSPHP member**.
- All eligibility requirements must be met during the 2027 renewal period of October–December 2026.

For questions regarding membership renewal or eligibility, please contact savage@fsphp.org.

Invitation to Nominate: FSPHP Board of Directors 2027–2029

Imagine if the next chapter of physician and health professional well-being was written with your input!

The Federation of State Physician Health Programs (FSPHP) is currently seeking committed and visionary members to serve on our Board of Directors for the 2027–2029 term.

This is a meaningful opportunity to help shape the strategic direction of FSPHP and contribute to our mission of supporting Physician and Health Professional Programs nationwide. If you're passionate about the health of medical professionals and ready to lead, we encourage you to consider submitting a nomination.

The following Board of Directors positions will be on the ballot for the 2027–2029 term:

- Secretary
- Treasurer
- Director at Large
- Public Member
- Central Region Director
- Northeast Region Director
- Southeast Region Director
- Western Region Director

Nomination submissions are due December 31, 2026.

Nomination Criteria

- Experience with a wide range of physician health issues
- Experience as an FSPHP committee chair or committee member
- Expected to continue as an FSPHP member throughout the two-year term
- Willingness to assist in governing the FSPHP in its mission with duty and loyalty
- Ability to oversee the FSPHP's financial integrity
- Participate in eight to twelve Board of Directors meetings a year and in the Annual Membership Meeting
- Participate in subcommittees, retreats, or special projects as requested with travel
- Familiarity with the FSPHP bylaws and policies

How to Nominate

- Complete the FSPHP 2027 Nominee Form
- Provide supporting documents: a statement of interest, biography, headshot, and any other relevant documents.

We look forward to your interest in serving the FSPHP!

Visit the 2027 FSPHP Call for Nominations webpage for full details and to access the FSPHP 2027 Nominee Form.



2026 Annual Education Conference Presentation Summaries

PRE-CONFERENCE FORUM

Pharmacy Health Programs: Models, Funding, and Impact

Becky Carlson, LMHC

Nancy K. Hooper, D.Ph.

Edwin Kim, MD, MRO, FAPA



Becky Carlson, LMHC



Nancy K. Hooper, D.Ph.



Edwin Kim, MD, MRO, FAPA

FSPHP marked a significant milestone at its 2026 Annual Conference with the inaugural pre-conference forum dedicated to Pharmacy Health Programs (PHPs). Titled *"Pharmacy Health Programs: Models, Funding, and Impact,"* the session brought together national leaders, including Becky Carlson, LMHC (Iowa Professional Health Program), Edwin Kim, MD, FAPA (Pennsylvania Pharmacists' Health Program), and Nancy Hooper, DPh (Tennessee Pharmacy Recovery Network), to highlight the growing role of recovery and monitoring programs for pharmacy professionals and their alignment with physician health program principles.

A central theme across all presentations was the shared mission of supporting pharmacists, pharmacy technicians, and student pharmacists affected by substance use disorders, mental health conditions, and other potentially impairing illnesses, while ensuring patient safety. Despite differences in structure, funding, and regulatory relationships, each program emphasized early identification, intervention, treatment, monitoring, and advocacy as essential components of successful recovery-oriented systems.

Becky Carlson described Iowa's Professional Health Program (IPHP) as a confidential, supportive monitoring process that emphasizes early diagnosis, treatment, accountability, and safe return to practice whenever possible. Operating within Iowa's licensing framework, the program balances participant support with public protection while fostering strong relationships with boards, employers, and educational institutions.

Edwin Kim outlined Pennsylvania's dual-system model, where the Pennsylvania Pharmacists' Health Program (PharmHP) works collaboratively with the Commonwealth's Professional Health Monitoring Program (PHMP). The PharmHP provides peer assistance, advocacy, and case coordination, while PHMP administers both alternative-to-discipline and disciplinary monitoring pathways on behalf of licensing boards. This partnership promotes early intervention through confidential channels while maintaining regulatory oversight when necessary.

Nancy Hooper highlighted Tennessee's Pharmacy Recovery Network (TPRN), a program grounded in strong statutory protections, peer support, and collaboration with the Tennessee Board of Pharmacy. A distinguishing feature of TPRN is its statewide network of volunteer pharmacist advocates, who provide mentorship, accountability, and lived-experience guidance. Tennessee's model demonstrates the value of peer engagement in supporting long-term recovery and successful reintegration into professional practice.

Presenters also explored funding mechanisms, operational structures, and program outcomes. Pennsylvania's program is funded by participant fees, state contracts, and fundraising support; Iowa's program is funded through licensing fees; and Tennessee utilizes grant funding and Board support. Program data demonstrated strong participant engagement, favorable completion rates, and low levels of non-compliance, while highlighting ongoing collaboration with licensing boards, employers, and colleges of pharmacy.

Common challenges included the cost of treatment and monitoring, barriers faced by students and trainees, rural access to services, diversion cases, evolving cannabis policies, and supporting solo practitioners. Despite these challenges, presenters emphasized that confidential, recovery-focused monitoring programs provide meaningful pathways to rehabilitation while protecting the public.

The forum underscored the growing alignment between pharmacy and physician health programs and highlighted opportunities for continued collaboration, shared best practices, and the expansion of recovery support services nationwide. The session concluded with a clear message: compassionate intervention, rigorous monitoring, and strong peer support remain the foundation of successful professional health programs and safer healthcare systems.

Advancing Accountability, Consistency, and Excellence in PHP Monitoring Practices

Christopher Bundy, MD, MPH, FAPA, FASAM

Michael Gendel, MD

Paul Earley, MD, DFASAM

Sandra Frazier, MD, FASAM



Christopher Bundy, MD, MPH, FAPA, FASAM



Michael Gendel, MD



Paul Earley, MD, DFASAM



Sandra Frazier, MD, FASAM

"Advancing Accountability, Consistency, and Excellence in PHP Monitoring Practices" was an interactive panel presented on April 30, 2026, at the Federation of State Physician Health Programs (FSPHP) 2026 Education Conference and Annual Membership Meeting. Dr. Chris Bundy, Executive Medical Director of the Washington Physicians Health Program and FSPHP's Chief Medical Officer, moderated, joined by three PHP leaders: Dr. Michael Gendel, Medical Director Emeritus of the Colorado Physician Health Program and an FSPHP past president; Dr. Paul Earley, Medical Director Emeritus of the Georgia Professionals Health Program and an FSPHP past president; and Dr. Sandra Frazier, Medical Director of the Alabama Professionals Health Program and Co-Chair of FSPHP's Medical Student and Resident Committee.

The session opened from a practical concern: how consistently do Physician Health Programs (PHPs) monitor those in their care? The panel focused on the two parameters where programs diverge most—how often participants undergo toxicology testing and how long their health support (or "monitoring") agreements last. Preliminary FSPHP National Survey data showed the spread: in Year 1 of a substance use disorder agreement, programs averaged 41 random urine tests but ranged from 12 to 104, and agreement durations varied just as widely by diagnosis, participant type, and condition.

Not all variation is a problem, the panel argued; an early task was separating the kind worth keeping from the kind worth questioning. Warranted variation reflects legitimate differences in participant risk, diagnosis, practice setting, and state legal environments, while unwarranted variation stems from program culture, legacy habits, risk tolerance, and resource constraints. Drawing on health-services research, they argued that unwarranted variation quietly erodes reliability, fairness, and trust, while alignment to shared standards improves consistency and outcomes without sacrificing clinical judgment.

Two frameworks structured the discussion. The first set standardization against individualization, framed not as an either/or choice but as a tension to manage well. The second centered on procedural justice: reducing unwarranted variation advances its core features—minimizing undue burden, ensuring fair assessment, preserving voice and appeal, tailoring consistently, and infringing as little as possible—the qualities that give monitoring legitimacy and earn participants' trust.

Panelists offered their own testing and agreement-duration practices as quick case examples, and audience-response polling gauged the room: 93% agreed or strongly agreed that more specific national toxicology guidelines were needed and 92% said their programs would adopt them. Two open forums then debated what such a guideline might contain—frequencies, tapering, responses to non-negative results—whether agreement lengths for mild SUD and non-SUD conditions should be more uniform, and the barriers to harmonizing them: statutes, contracts, capacity, and culture.

Attendees left with a clearer sense of where their practices stood relative to peers, but the larger purpose was forward-looking: to bring considerations to the surface that could shape consensus-based recommendations for greater accountability, consistency, and excellence across PHPs. Throughout, the discussion stayed anchored to existing guidance, including *FSPHP's 2019 PHP Guidelines*, FSMB policy, and ASAM's drug-testing consensus.

Balancing Safety, Recovery, and Professional Identity: Contemporary Approaches to Physician Mental Health Assessment and Monitoring

Daryl Shorter, MD

Alton Bozeman, PsyD



Daryl Shorter, MD



Alton Bozeman, PsyD

Physician health programs today operate at a demanding intersection: evolving clinical evidence, shifting ethical standards, and the complicated lived experience of physicians navigating recovery. This session took that intersection head-on, offering attendees both technical grounding in assessment practice and a broader challenge to rethink what these evaluations are ultimately for.

The first half of the session focused on the importance of identifying and using valid psychological and psychiatric measures in the assessment of physicians. Presenters made the case that instrument selection is not a procedural detail but a foundational one. Measures used with physician populations must be appropriate to that population, defensible in how their results are interpreted, and applied in the service of accurate diagnostic assessment, thoughtful risk stratification, and sound impairment evaluation. Where tools are poorly matched or over-interpreted, the consequences fall on real careers and real patients alike. Attendees were walked through updates in diagnostic assessment tools and current thinking on how evidence-informed approaches are reshaping evaluation practice.

The second half turned to the restricted scope of the typical fitness-for-duty evaluation—and argued that this restriction is a missed opportunity. Presenters observed that these evaluations are conventionally framed around a single question: does this physician pose a risk to the public? That question matters, but it is not the only one worth asking.

The core message was a call to go further. Providers were encouraged to look beyond the traditional protection-of-the-public scope and to also attend directly to the well-being and improvement of the physician being evaluated. In concrete terms, that means treating symptom reduction, sustained sobriety, and reduction in physician suicide as legitimate goals of the evaluative and monitoring process—not incidental byproducts of it. An evaluation designed only to gatekeep tells you less, and helps less, than one designed to also inform a recovery pathway.

Threading through both halves was the persistent tension among public safety, physician well-being, and fairness in professional oversight. Presenters did not resolve that tension so much as insist that it be held honestly. They examined the ethics and practical utility of fitness-for-duty assessments, the limitations of the frameworks currently in wide use, and the downstream effects these evaluations have on a physician's recovery and reintegration into practice. Discussion also touched on recent developments in treatment planning and longitudinal monitoring, and what those developments suggest about designing oversight that supports rather than merely constrains.

Participants left with a sharper understanding of emerging guidelines in this space, a more critical read on where existing evaluative models fall short, and practical strategies for supporting long-term recovery and continued professional functioning without compromising accountability or public protection. For anyone whose work involves evaluating, treating, or monitoring physicians, the session offered a useful reframe: rigorous assessment and genuine support for the physician are not competing aims, and the strongest programs are built to serve both.



Dr. Shorter presents at the FSPHP 2026 Annual Education Conference.

Best Practices in Suicide Prevention and Postvention for PHPs

Emily King, PA-C

Lisa Merlo, PhD, MPE

Laura Moss, MD

Natalie Lyons, BS



Emily King, PA-C



Lisa Merlo, PhD, MPE



Laura Moss, MD



Natalie Lyons, BS

Many studies (though not all) suggest that physicians are at higher risk of death by suicide than are members of the general public, due in part to occupational factors. Psychiatric disorders and substance use are also known to increase risk of suicidal ideation, attempts, and completions throughout the population. Thus, individuals referred to physician health programs (PHPs) may be at particularly high risk of suicide, suggesting that PHPs have a role to play in prevention. This session presented results from a recent 10-item online national survey of PHP suicide screening and postvention practices obtained from 42 programs, highlighting areas of consistent practice and opportunities for further development. Next, suicide risk mitigation criteria in the FSPHP PEER™ assessment were presented, including the use of standardized suicide risk screening and a postvention process. Program representatives of PHPs of varying sizes (small, medium, and large PHPs) and structures (i.e., different staffing models and participant populations) made up the panel that shared examples of suicide prevention/postvention practices. Panelists shared how, when, and how often participants are screened for suicide, while highlighting variations in safety planning and staff training across programs. The session also tackled tough questions regarding how to support internal staff and participants' support systems when an unexpected death or suicide occurs. Both presenters and audience members contributed a range of resources, policies, and actionable practices that attendees can implement in their own programs.

Drugs, Lies & Docs: A Doctor's Memoir of Addiction, Recovery, along with the Risks and Safety of Storytelling in Physician Health

I. Michael Kaufmann, MD

Jon Novick, MD



I. Michael Kaufmann, MD



Jon Novick, MD

This fireside chat session was led by a former PHP medical director and physician who has published a first-person memoir of addiction and recovery, offering a rare inside view of impairment, treatment, and sustained recovery. In conversation with a PHP medical director and audience members, this session examined how recovery narratives can teach, reduce stigma, and build connection while also exploring storytelling risks, ethical guardrails—particularly AA's emphasis on anonymity, relapse risk after public disclosure, and the distinct considerations for current versus completed PHP participants, informed consent, privacy, and emotional and other forms of safety. The shame related to active addiction and relapse vanishes in the presence of witnesses, forgiveness, and love.



Dr. Jon Novik, Dr. I. Michael Kaufmann, and Dr. Michael Baron

Facilitating Enduring Recovery: Evidence-Based Decisions on Monitoring, Milestones, Mutual Help, and Recovery Capital

John Kelly, PhD



John Kelly, PhD

The presentation to FSPHP by Dr. John F. Kelly reviewed advances in addiction and recovery science, including recovery milestones, and their implications for facilitating stable, enduring recovery. The central premise was that while addiction treatment has become increasingly effective at addressing acute stabilization needs, achieving resilient long-term recovery requires sustained attention to monitoring, recovery support services, mutual-help participation, and the accumulation of recovery capital.

Dr. Kelly began with an overview of the past 50 years regarding how addiction care has evolved, incorporating advances in neurobiology, pharmacotherapy, behavioral intervention, harm reduction, and digital health. At the same time, he described how knowledge has grown regarding how severe substance use disorder is often a chronic condition characterized by long-term vulnerability to disorder recurrence. Although most individuals with substance use disorder (SUD) ultimately achieve sustained remission, the process can take many years and often involves multiple attempts and episodes of treatment or recovery support. Dr. Kelly noted that this prolonged trajectory highlights opportunities for earlier intervention as well as ongoing recovery mentoring and continued monitoring to accelerate progress toward stable recovery.

A major theme was the importance of moving beyond an acute care model. Using a "burning building" analogy, Kelly distinguished putting out the fire—treating the acute pathology—from preventing re-ignition, importantly by providing access to the "building materials," "scaffolding," and "building permits" necessary to construct a sustainable life in recovery. These additional materials constitute "recovery capital": the individual, social, financial, cultural, and environmental resources that support long-term remission. Recovery support services—including mutual-help organizations, peer recovery services, recovery residences, recovery community centers, and long-term clinically-delivered recovery management models—can help individuals acquire and maintain these resources.

Evidence regarding mutual-help organizations was also reviewed. Alcoholics Anonymous and Twelve-Step Facilitation have strong empirical support for increasing rates of abstinence and remission relative to other interventions, as well as substantially reducing healthcare utilization and costs. However, AA or other 12-step programs are not right for everyone; an expanding menu of evidence-informed mutual-help options (e.g., SMART Recovery, LifeRing, Women for Sobriety) may increase broader recovery services engagement and retention. Importantly, Kelly described how mutual-help organization participation appears to work generally by mobilizing multiple mechanisms simultaneously—including through changing social networks, abstinence self-efficacy, coping, motivation, spirituality, craving, and negative affect—and that different individuals may benefit from these resources differently depending on their recovery stage, addiction severity, gender, life stage, and life context. Women, for example, appear to benefit the most from AA in terms of preventing relapse through AA's ability to boost women's confidence in coping with negative affect without the using alcohol, whereas for men, AA helped reduce relapse risk the most by boosting men's ability to cope with high-risk alcohol-laden social situations without drinking.

Dr. Kelly's presentation also emphasized the fact that recovery is complex and dynamic. Recovery milestones, while still preliminary, distinguish initial (0–3 months), early (4–12 months), sustained (1–5 years), and stable (5+ years) recovery, with changing levels of resilience and developmental tasks apparent across these phases. Even after years of sustained remission, relapse remains possible but diminishes in probability on average. His recent research on long-term SUD relapse (after years or decades of sustained remission) suggests that destabilization may develop gradually over many months through accumulating psychological, social, recovery service, and biological change. Some warning signs emerge as much as a year before relapse (e.g., decreased recovery vigilance/de-prioritization of recovery, social isolation), suggesting opportunities for proactive detection and intervention through using warning sign checklists, such as the one emanating from Dr. Kelly's long-term relapse research.

The research summarized by Dr. Kelly provided a strong rationale for long-term recovery monitoring, including the physician health program model. Rather than viewing monitoring merely as surveillance, it can function as an active recovery management intervention: regularly assessing risk, identifying emerging changes, reinforcing successful recovery practices, mobilizing recovery capital, and rapidly intensifying support when needed. The overarching implication is that enduring recovery is best facilitated through individualized, stage-sensitive, longitudinal care—based on continual inquiry as to who needs which recovery supports, at what point, for how long, and at what intensity.

From Research to Relevance: The Most Important Research Publications of the Last Two Years and Why They Matter

Pamela Rowland, PhD

Jon Novick, MDCM, FRCPC



Pamela Rowland, PhD



Jon Novick, MDCM, FRCPC

This session brought the FSPHP Research Committee together with attendees to review the physician health literature published over the past two years. Candidate articles were nominated by the broader FSPHP community, and Research Committee presenters selected the publications they judged most important, interesting, and relevant to the field.

Presenters walked through each selected article and, rather than stopping at the findings, focused on the "so what", how the research speaks to the administrative and clinical realities of PHPs, and to the clinicians and institutions that support physician health. Discussion was interactive throughout, with presenters facilitating audience questions, reactions, and examples from attendees' own programs.

What Attendees Took Away

Participants left the session able to:

- Cite the most significant physician health research published in the last two years
- Discuss why these publications matter to PHP administrative and clinical practice and to the individuals and institutions supporting that work
- Identify and integrate the findings most applicable to their own program

Article Summaries

Surgeons are a vital source of human capital for many hospital systems, providing significant revenue that supports increasingly complex healthcare infrastructures. Yet, the United States surgeon workforce is both aging and declining in size. Concurrently, concerns about surgeon burnout have intensified as more physicians move into employment models that offer limited autonomy over staffing, scheduling, and clinical practice. These two papers explore key issues related to surgeon health and well-being in this changing professional environment.

The Ageing Surgeon: Unmasking Impairment

Mick O'Connor and Bill Madden

***Journal of Law and Medicine*, June 2025, Volume 32, Issue 1**

In 2023, the Medical Board of Australia (MBA) observed an increase in complaints involving late-career surgeons and sought feedback from the broader medical community. It is important to note that Australia differs from the United States in several respects, including its medical education pathway, in which an undergraduate degree is not required before entry into medical school, and its very stringent age discrimination laws.

Stakeholder responses reflected a range of perspectives. Suggestions included mandatory health assessments every three years for physicians aged 70+ years, annual health assessments for those aged 80+, formal fitness-to-practice evaluations conducted by occupational health physicians for practitioners over age 70, and maintenance of the current system of annual self-reporting.

The authors provide a thoughtful discussion of the evidence regarding age-related decline and its potential impact on surgical competence. In parallel, both the American College of Surgeons and the European Union Aviation Safety Agency have supported both arguments for age-based assessments, while acknowledging the inherent challenges of reliably measuring clinical judgment and decision-making. The MBA appears to favor a compromise approach that aligns with practices used in other safety-sensitive professions, such as commercial aviation, air traffic control, and motor vehicle operation, where age may trigger additional health or competency evaluations rather than automatic restrictions on practice.

Mortality Among Surgeons in the United States

Vishal R. Patel, MD, MPH; Stephen A. Stearns, MD; Michael Liu, MD, MPhil; Thomas C. Tsai, MD, MPH; Anupam B. Jena, MD, PhD

***JAMA Surgery*, September 2025, Volume 160, Number 9**

The authors used newly available 2023 National Vital Statistics System population-based data to examine mortality rates and causes of death among surgeons. Mortality rate ratios were calculated to quantify differences in mortality between surgeons and several comparison groups, including non-surgeon physicians, lawyers, engineers, scientists, and the general working population.

Among surgeons, the leading causes of death were neoplasms (#1), heart disease (#2), unintentional injuries (#3), and motor vehicle collisions (MVCs) (#4). Although these conditions contribute substantially to mortality across all occupational groups, deaths due to MVCs appeared disproportionately higher among surgeons. We also

question whether some deaths categorized as "unintentional injuries," including drug overdoses, falls, firearm injuries, and drownings, may in fact represent misclassified suicides, particularly given that suicide was reported as the fifth leading cause of death among surgeons. Additionally, it is unclear whether age distributions were comparable across all adult occupational groups included in the analysis.

The National Vital Statistics System captures all registered deaths and classifies causes of death using ICD-10 codes. Occupational information, however, is reported by the decedent's informant. As a result, some individuals may have been identified as "surgeon" despite not having completed medical school, surgery residency training, or the American Board of Surgery Certification process. For example, medical students, residents, or fellows may have been categorized as "surgeon" based upon informant reporting, introducing the potential for occupational misclassification.

National Incidence of Physician Suicide and Associated Features

MakhijaH et al. *JAMA Psychiatry* (2025)

Physicians and medical learners experience high rates of mental health symptoms and conditions (including depression, substance use, and burnout), and rates of physician suicide have been variably reported to be elevated compared to the general, non-physician population. To further elaborate whether physician in the US have a higher rate of suicide than the general population, Makhija et al conducted a retrospective cohort study using data from the national violent death reporting system from 2017 to 2021. With physician occupation as the "exposure" they determined the suicide incidence rate radios and odds rations and concluded that female physicians had higher rates of suicide than those in the general population. In additions, they noted that prior to suicide, physicians had higher odds of depressed mood, job problems, a history of mental health problems, left a suicide note, and had criminal or non-criminal legal problems. In addition, they had higher odds of using poisoning and sharp instruments as primary methods. Limitations of the study included incomplete jurisdiction wide reporting to the database used, underreporting of physician as occupation, and the use of death investigation as the indenter for cases. In addition, the general and physician population numbers used in the calculations, as well as the data managed by the CDC (restricted)were not made available to the reader.

Causes of Death Among US Medical Residents

Yaghmour NA et al. *JAMA Open* (2025)

In their cross-sectional study of medical resident decedents in the 2015–2021 period, the authors calculated the causes of death and compared the findings with those from their initial study of medical resident decedents in the 2000–2014 period. There were no significant differences across cause of death categories when comparing the two cohorts, However, the authors found that suicide and neoplastic disease remain the top two causes of death among US Medical Residents, with suicide being the most prevalent cause of death for residents from 2015–2021.

Unlike the general population, deaths by suicide in the resident population showed a temporal trend, being more frequent in the first and fourth academic quarters of the first year. When they looked at specialty-specific causes of death using internal medicine residents as the reference group, pathology residents had the highest IRR for suicide, psychiatry residents had the highest IRR for neoplastic disease, and anesthesiology residents had the highest IRR for death by accidental poisoning.

The Triad of Confidentiality: Protecting Professionals Through PHPs and LAPs

Edwin Kim, MD, MRO, FAPA

Jonathan Lee, MD, DFASAM

Penelope Ziegler, MD

J.E. "Buddy" Stockwell III, JD, CCI

Dr. Edwin Kim introduced the "Triad of Confidentiality"—regulatory, records, and application protections—as three essential pillars that enable healthcare professionals to seek help without fear of punitive consequences.
When codified, these safeguards support confidential referrals, protect sensitive records, and modernize disclosure requirements—reducing stigma while promoting early intervention and patient safety.

J.E. "Buddy" Stockwell III, JD, highlighted parallels in Lawyer Assistance Programs, where near-absolute confidentiality drives engagement but requires careful balancing against public protection. Dr. Jonathan Lee emphasized the heightened privacy standards of 42 CFR Part 2, particularly with 2026 updates affecting consent and data sharing in substance use disorder treatment.

Dr. Penny Ziegler concluded with operational insights, noting the



Edwin Kim, MD, MRO, FAPA



Jonathan Lee, MD, DFASAM



Penelope Ziegler, MD



J.E. "Buddy" Stockwell III, JD, CCI

critical role of data security, toxicology monitoring, and third-party administration in maintaining trust.

The session called for greater national consistency and alignment, reinforcing confidentiality as a key driver of recovery, engagement, and patient safety across professional health systems.

WORKSHOPS

Beyond Boundary Violations: Evaluating Problematic Sexual Behaviors in Physicians and Monitoring Professional Sexual Misconduct

Reid Finlayson, MD

Charles P. Samenow, MD, MPH

Sally Moody, LCSW

Lacey Herrington, PhD



Reid Finlayson, MD



Charles P. Samenow, MD, MPH



Sally Moody, LCSW



Lacey Herrington, PhD

Dr. Finlayson discussed professional sexual misconduct as a serious breach of professional boundaries that can have significant consequences for patients, physicians, and healthcare organizations. He reviewed available research on the prevalence and characteristics of PSM, highlighted the substantial legal and institutional impact of misconduct cases, and outlined key components of a comprehensive fitness-for-duty evaluation. Topics included assessment of psychiatric and substance use disorders, the use of collateral information, consideration of rehabilitative potential, and strategies for conducting thorough and trauma-informed evaluations. He also described a framework for evaluating allegations within the broader organizational and professional context.

Dr. Samenow focused on the assessment of problematic sexual behavior and the importance of distinguishing between normative sexual behaviors and behaviors that may warrant clinical concern. He discussed the complexity of evaluating sexual behaviors, emphasizing consideration of consent, honesty, responsibility, developmental history, trauma, shame, and other contributing factors. His presentation highlighted the need for careful, individualized assessment and awareness of potential bias when evaluating sexual behavior.

The Pine Grove team addressed the monitoring and management of physicians following allegations or findings of professional sexual misconduct. They reviewed a range of boundary-related behaviors and discussed factors that may influence risk assessment, treatment planning, and monitoring intensity. The presenters described a variety of monitoring tools and supports, including therapy, specialized treatment groups, workplace oversight measures, and other accountability strategies.

Throughout the session, case examples were used to illustrate the challenges involved in evaluating and monitoring professional sexual misconduct and to encourage discussion regarding appropriate intervention, treatment, and long-term monitoring strategies. The presentation underscored the importance of consistent evaluation processes, individualized treatment planning, and ongoing efforts to protect patient safety while supporting physician rehabilitation when appropriate.

Difficult Cases, Part II: A Workshop on Neuropsychological and Psychological Evaluation in Making Return-to-Work Recommendations

Betsy Williams, PhD, MPH, FSACME

Benjamin R. Phalin, PhD

Amanda Janner, PsyD



Betsy Williams, PhD, MPH, FSACME



Benjamin R. Phalin, PhD



Amanda Janner, PsyD

This workshop introduced a practical, clinically grounded framework for interpreting neuropsychological and psychological findings in physicians referred to Physician Health Programs (PHPs). Using the metaphor of "the projector, the lens, and the image," the model helps clarify how different underlying mechanisms can produce similar observable behaviors.

In this framework, neurocognitive functioning represents the projector—including attention, processing speed, memory, and executive abilities that determine capacity for safe and effective practice. Psychological and characterological factors—such as mood, personality traits, coping style, and stress reactivity—serve as lenses that shape or distort how



Dr. Betsy Williams leads educational workshop at the FSPHP 2026 Annual Education Conference.

cognitive abilities are expressed. The resulting image on the screen reflects real-world behavior, including treatment adherence, workplace performance, and interpersonal functioning.

A key takeaway is that similar patterns of "noncompliance" or performance difficulty may arise from distinct causes. Some physicians demonstrate primary neurocognitive limitations despite intact motivation, while others show intact cognition, but behavior shaped by personality, psychosocial/situational stressors, or emotional factors. A third group presents with combined vulnerabilities and elevated risk. Differentiating these pathways has direct implications for PHP decision-making, including appropriate use of structure, monitoring, and treatment recommendations.

The workshop emphasized the complementary roles of neuropsychological testing (to assess cognitive capacity) and psychological testing (to understand emotional and personality influences on performance). The importance of the use of appropriate norms and consideration of professional role demands were discussed. Participants were also introduced to a brief decision-making heuristic focused on the effects of external structure and stress on functioning.

Overall, the framework provides PHPs with a shared, non-judgmental language for linking assessment findings to real-world performance, supporting more precise, capacity-informed, and risk-sensitive decisions regarding fitness for practice.

BREAKOUT SESSIONS

Clinical Care and Best Practices for Health, Accountability, and Verification Track

Disruptive Behavior in Physicians: More Than Meets the Eye

Sarah Early, PsyD

Amanda Kimmel, MPA

Lori Crane, PhD

Disruptive behavior in medical settings—including bullying, humiliation, discriminatory comments, and physical aggression—contributes to medical errors, reduced patient and team satisfaction, turnover, and staffing shortages. Nearly 100% of clinicians and other healthcare workers witness disruptive behavior regularly. Contributors include worksite factors (e.g., stress, overwork, organizational power, and interpersonal conflict), personal factors (e.g., communication skills, personality traits, psychological/psychiatric problems, and physical health), and external factors (e.g., relationships, family health, bereavement, and financial stress).



Sarah Early, PsyDMPH, FSACME



Amanda Kimmel, MPA



Lori Crane, PhD

At the Colorado Physician Health Program (CPHP), behavioral concerns are the primary reason for referral in approximately 20% of new cases. To better understand this issue, CPHP studied 308 physicians, physician assistants, anesthesiology assistants, and trainees referred for disruptive behavior between 2015 and 2022.

All participants referred for disruptive behavior receive a psychiatric evaluation by a CPHP psychiatrist, collection of collateral information as needed, and ongoing monitoring when indicated. Each participant is assigned a licensed clinician (LCSW, LPC) who oversees their case and is their primary contact. Study data came from CPHP's electronic records and medical director review, which verified diagnoses and identified personality disorder symptoms and situational stressors.

Nearly three-quarters of participants were male and referred mandatorily. Almost half practiced in a hospital. The most frequent specialties were internal medicine, anesthesiology, surgery, and orthopedics/sports medicine. One-third received a psychiatric diagnosis, most commonly major depressive disorder (13%), anxiety (8%), ADHD (7%), and adjustment disorder (6%). Coaching was the most common treatment recommendation (50%), followed by therapy (30%), psychiatric treatment (17%), and education (14%). Third-party evaluations were recommended for 18%, and included behavioral evaluations, medical specialist evaluations, or psychological/neuropsychological testing.

More than half experienced situational stress, most often workplace stress (38%). Women were more likely than men to report workplace stress (46% vs. 34%). Medical directors rated stress based on the number and severity of stressors present. Higher stress scores were associated with having a psychiatric diagnosis but were not associated with specialty, practice setting, gender, or age.

Twenty-six percent of participants had symptoms of a personality disorder. These individuals were more often men and experiencing work stress. They were not more likely to receive a psychiatric diagnosis or a treatment recommendation, but they were twice as likely to be referred for a third-party evaluation.

Nearly all participants (95%) completed participation successfully, with 58% completing within one year. Mandatory referrals and psychiatric diagnoses required longer engagement.

Disruptive behavior often reflects deeper conditions or stressors that demand targeted resources. Effective interventions begin with a comprehensive evaluation that looks beyond surface behaviors to the full context of providers' lives and the systems in which they practice. Multiple underlying conditions may require multifaceted, personalized strategies. These findings can help PHPs more effectively address this common phenomenon.

Empathy in the Face of Chaos: Clinical Strategies for Cluster B Engagement

Amanda Janner, PsyD



Amanda Janner, PsyD

This session presented an attachment-informed, trauma-informed, and neurobiological framework for understanding and treating individuals with Cluster B personality disorders, including borderline, narcissistic, antisocial, and histrionic personality disorders. The presentation emphasized that behaviors often perceived as manipulative, attention-seeking, or treatment-interfering are more accurately conceptualized as manifestations of emotional dysregulation, attachment insecurity, impaired mentalization, and maladaptive coping strategies arising from the interaction of developmental adversity, trauma, and biological vulnerability. Core features across Cluster B presentations include affective instability, impulsivity, identity disturbance, interpersonal dysfunction, and heightened sensitivity to perceived rejection or abandonment.

The presenter reviewed the developmental and neurobiological underpinnings of these disorders, highlighting the role of insecure attachment, adverse childhood experiences, limbic hyperreactivity, diminished prefrontal regulatory capacity, reward system dysregulation, and stress response sensitization. These factors contribute to difficulties with emotion regulation, self-concept, and interpersonal functioning and help explain the intensity and persistence of many Cluster B symptoms. A major focus of the presentation was the challenge of maintaining empathy in the face of complex interpersonal dynamics. Rather than attributing empathic failures solely to clinician bias, the presentation described how countertransference, attribution errors, threat-related neurobiological responses, moral injury, burnout, systemic pressures, and diagnostic stigma can impair reflective functioning. Clinicians were encouraged to recognize these reactions as predictable aspects of working with personality pathology and to use them as sources of clinical information rather than allowing them to shape treatment decisions.

The concept of mentalization, the capacity to understand behavior in terms of underlying thoughts, feelings, intentions, and motivations, was identified as a central construct. In individuals with Cluster B pathology, mentalization may deteriorate during periods of interpersonal stress, contributing to emotional escalation, impulsivity, polarized thinking, and relational instability. Maintaining a stance of curiosity, humility, and reflective inquiry was presented as essential to

preserving therapeutic effectiveness. The presentation further emphasized the importance of the therapeutic alliance as a key predictor of treatment engagement and outcome. Effective clinical work requires a balance of empathic validation, consistent boundaries, transparency, collaboration, and timely repair of alliance ruptures. Diagnosis-specific considerations were discussed for each Cluster B disorder, with attention to common interpersonal challenges and strategies for maintaining engagement. Evidence-based interventions reviewed included Dialectical behavior therapy (DBT), mentalization-based treatment (MBT), schema therapy, and acceptance and commitment therapy (ACT). Across these approaches, common therapeutic mechanisms include improving emotion regulation, strengthening reflective capacity, enhancing interpersonal functioning, and promoting more adaptive responses to distress. The presentation concluded that optimal care for individuals with Cluster B pathology requires a shift from moralistic interpretations of behavior toward developmental and functional formulations. By integrating attachment theory, trauma-informed principles, neurobiological understanding, and evidence-based interventions, clinicians can strengthen therapeutic relationships, improve treatment outcomes, and sustain empathy in challenging clinical encounters.

From Rock Bottom to the Nation's Highest Dental Office: A Story of Recovery, Purpose, and Profession

Brett H. Kessler, DDS



Brett H. Kessler, DDS

I entered dental school with a substance abuse problem and graduated with a worse one. My bottom came in October 1998, and the choice I faced was simple and stark: live or die. I chose to live. Michigan's Health and Wellbeing Program directed me to treatment, and over the next 27 years I found that every achievement in my professional life traces directly back to that decision.

The talk I gave at the 2026 FSPHP Education Conference followed that arc. I shared the practical reality of what it took to rebuild a career in dentistry after treatment, including the unexpected consequence of seeking help. When I answered Colorado's licensure questions truthfully, I was placed on probation. I did not understand at the time that monitoring was classified as a disciplinary action. A chance encounter with the president of the Colorado State Board of Dental Examiners led to my release from that contract and, more importantly, an invitation to help change the laws that created the problem in the first place. That experience launched my advocacy work and ultimately my path through organized dentistry to the presidency of the American Dental Association.

The central argument I made to the audience is this: punitive licensure environments suppress disclosure and prevent professionals from seeking help. When we shift the model from punishment to support, recovery rates move from three to six percent to seventy-five to eighty percent. That is the lever state associations and PHP programs can use to make the case for investment and policy reform. Every state dental board and dental association should understand that number.

I also spoke about the holistic nature of the wellness challenge our professions face. The ADA's own data shows 83 percent of dental members exhibit signs of clinical burnout. Fifty-six percent report extreme stress. Substance use is one symptom of a much broader crisis. Physical wellness, mental wellness, emotional health, spiritual purpose, and social connection all require attention. Recovery programs that address only substance use miss the full picture.

The program I completed in Colorado, with its monitoring requirements, peer accountability, and practice oversight, made me a better dentist and a better leader. The same tools that kept me sober, daily mindfulness practice, journaling, intentional vision-setting, and genuine accountability, are the tools that allowed me to serve 160,000 colleagues as their national leader.

The work of state physician and dentist health programs is not administrative. It is lifesaving. The opportunity these programs create is the opportunity to live a full life in service to others. I am evidence of what that looks like when the system works. The goal is to make the system work for far more people than it currently does.

Lessons from the Frontlines—Supporting Medical Professionals After Disasters

Philip Hemphill, PhD, LCSW



Philip Hemphill, PhD, LCSW

During catastrophic events, physicians and other healthcare professionals face a profound paradox: they must deliver lifesaving care to their communities while coping with their own devastation and loss. As the 20th anniversary of Hurricanes Katrina and Rita approached, I revisited raw data collected from professionals who attended our stress management and trauma-processing workshops during the year after the disasters. We used these historical findings to describe the psychological crisis and identify essential strategies

for supporting medical professionals through present-day crises.

Quantitative data revealed the hidden psychological toll of disasters on healthcare professionals and other frontline responders. In a post-disaster survey of 440 professionals using the World Health Organization Self-Report Questionnaire (SRQ-29) PTSD screening tool, 72% screened positive for psychotic symptoms—understood here as severe trauma, dissociation, and extreme sleep deprivation rather than organic psychosis—and 54% screened positive for PTSD. In addition, 34% screened positive for significant anxiety and depressive symptoms, while 22% screened positive for psychoactive substance use, underscoring the link between severe stress and vulnerability to self-medication after a disaster.

Importantly, the mental health effects are not temporary. Longitudinal analyses show a "Double Peak" pattern: distress rises sharply after a disaster, gradually subsides, and resurges about 10 years later. Although acute post-traumatic stress symptoms declined steadily over the decade, the prevalence of serious mental illness (SMI) among survivors doubled to 12% at the 10-year mark. We used several anecdotal scenarios to illustrate these findings.

The presentation's latest evidence-based intervention was the S-C-E-C-H framework, designed to reduce acute distress and prevent chronic systemic illness. The model recommends the following immediate and mid-term interventions:

- **Safety:** Provide physical security, clear information, and predictable surroundings to reduce hypervigilance
- **Calming:** Normalize intense psychological reactions and promote stabilization through rest and self-soothing techniques
- **Efficacy:** Assign manageable tasks that help professionals regain personal control, empowerment, and a sense of collective action
- **Connectedness:** Counter isolation by reuniting people and strengthening community and cultural ties
- **Hope:** Help individuals set achievable short-term goals and reframe the traumatic event to find meaning and positive change

Finally, the presentation emphasized a decades-long approach to disaster management. Clinical leaders should not equate the resolution of acute PTSD symptoms with a provider's full return to baseline. Protecting the medical workforce and other professionals requires sustained, long-term follow-up, including standardized health assessments, centralized tracking, and collaborative care. This focus encouraged all health systems to prepare now to support the long-term psychological resilience of their clinical staff during a systemic crisis.

Monitoring and Accountability Guidance for Safety-Sensitive Workers—Optimizing Flexibility, Standards, and Safety

Jenny Melamed, MBChB, BSc

E. Máire Durnin-Goodman, MD, PhD, MSc



Jenny Melamed, MBChB, BSc



E. Máire Durnin-Goodman, MD, PhD, MSc

Our presentation addressed the development of our recently published paper. We began this work because, despite decades of successful physician health monitoring programs, there are currently no standardized Canadian guidelines that extend these principles to other safety-sensitive and decision-critical occupations. Our objective was to provide a practical clinical framework that balances worker recovery, workplace safety, accountability, and human rights.

We emphasize that monitoring cannot be a "one-size-fits-all" process. Rather, it must be individualized according to the severity and chronicity of the substance use disorder, the worker's recovery history, the specific substance involved, and the degree of occupational risk. While research supporting standardized testing paradigms remains limited, extensive clinical experience demonstrates that individualized monitoring programs produce the most meaningful outcomes. We therefore advocate for flexible monitoring protocols that are guided by clinical judgment while remaining structured enough to provide consistency and accountability.

We also highlight important differences between the Canadian and American approaches to workplace drug and alcohol testing. Unlike the United States, where random testing is widely accepted in safety-sensitive industries, Canadian law generally permits testing only where there is reasonable cause, following a workplace incident, or as part of a return-to-work agreement for an employee with a substance dependence disability. These legal differences mean that Canadian monitoring programs must be carefully designed to comply with privacy legislation, human rights principles, and established legal precedents while still protecting public safety.

Effective monitoring depends on far more than simply ordering drug tests. Successful programs require a comprehensive monitoring agreement that clearly defines the responsibilities of the monitor, medical review officer,

treating clinicians, workplace liaison, and the worker themselves. Recovery support, medication oversight, communication pathways, and accountability mechanisms are equally important components of an effective monitoring program. Our recommendations emphasize that biological testing should be individualized, truly random, and clinically meaningful. Monitoring should generally be most intensive during the first two years of recovery, when relapse risk is highest, with practical testing frequencies of approximately 24 to 36 random tests annually. We also conclude that no single biological matrix is sufficient for all situations. Instead, testing strategies should consider the detection characteristics of urine, oral fluid, blood, breath alcohol testing, PEth, hair, and nail testing, using combinations of these modalities when clinically appropriate to maximize detection while minimizing unnecessary intrusion.

Finally, we emphasize that monitoring is fundamentally an ethical process. Every monitoring program must strike an appropriate balance between protecting public safety and respecting the rights, dignity, privacy, and confidentiality of the individual worker. We believe these objectives are not mutually exclusive. Well-designed monitoring programs can successfully support recovery, facilitate safe return to work, and reduce occupational risk while maintaining fairness and proportionality. In conclusion, our key message is that Canada would benefit from a consistent, evidence-informed framework for monitoring safety-sensitive workers with substance use disorders. We believe the guidance we present offers a practical foundation for clinicians, employers, regulators, and monitoring agencies to implement individualized, accountable, and ethically sound monitoring programs. Future research should focus on refining these recommendations, evaluating outcomes, and establishing optimal monitoring practices across a broad range of safety-sensitive occupations.

Neurodivergence in Medicine

Michael Seely, PsyD

Alex Latham, PsyD

Josh Hypse, PsyD



Michael Seely, PsyD



Alex Latham, PsyD

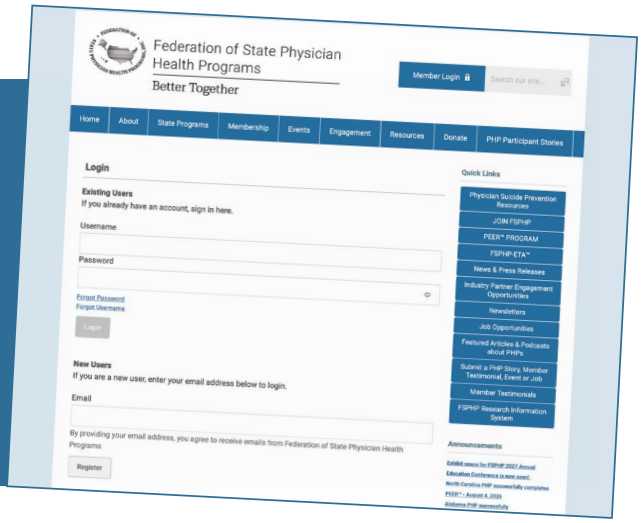


Josh Hypse, PsyD

Acumen Assessments has noted a rising number of fitness-for-duty evaluation referrals for safety-sensitive professionals diagnosed with neurodivergent conditions. Peer groups often perceive these individuals as rigid, entitled, or difficult, creating significant hurdles during training and clinical practice. Furthermore, neurodivergent physicians are frequently misdiagnosed with personality disorders, which severely complicates the development of effective remediation plans (Stacy, Whipple, and Graham, 2012). To address this, Acumen Assessments delivered a presentation exploring how autism spectrum disorder manifests in physicians. The session featured real-world examples and outlined the population's unique challenges, including rigid problem-solving, a strict reliance on routine, and social deficits that are easily misconstrued as narcissism. Ultimately, the presentation highlighted how Physician Health Programs (PHPs) and providers can support these professionals more effectively. By understanding these unique challenges and implementing reasonable accommodations, PHPs can help neurodivergent professionals thrive and leverage their distinct, highly beneficial skill sets in the workplace.

We'd Love to Hear From You!

Have a question, need support, or want to explore how we can work together? Click here to submit the FSPHP Contact Us Form and our team will get back to you as soon as possible. We are here to support your inquiries and explore meaningful ways to work together in advancing physician health and well-being.



Practical Considerations for Use of Medication for Addiction Treatment (MAT) Among Health Professionals from Different Specialties

Lisa Merlo, PhD, MPE

Abby Migliore, MSN, MBA, RN

Shannon Opie, DNP, APRN, ANP-BC, CARN-AP

Michael Sorna, MD, MSA, FASAM

John C. Tanner, D.O., DFASAM, DABAM, FAOAAM, CCFC



Lisa Merlo, PhD, MPE



Abby Migliore, MSN, MBA, RN



Shannon Opie, DNP, APRN, ANP-BC, CARN-AP



Michael Sorna, MD, MSA, FASAM



John C. Tanner, D.O., DFASAM, DABAM, FAOAAM, CCFC

Within the general population, the use of medication for addiction treatment (MAT) is common, particularly for individuals with opioid use disorder (OUD); however, the appropriate role of MAT in the treatment of nurses and other safety-sensitive healthcare professionals remains unclear. This session reviewed common practices in monitoring nurses with SUDs and/or pain disorders in the State of Florida. Data were drawn from a chart review study including 102 cases referred to the Intervention Project for Nurses (IPN), the state-approved monitoring program for nurses with potentially impairing conditions. The overwhelming majority of nurses in the sample had a diagnosis of moderate/severe OUD, almost half had a diagnosis of moderate/severe alcohol use disorder, and some had additional SUD diagnoses. Nurses in the sample were more likely to be male and Caucasian than the general population of nurses within the state.

The majority utilized opioid antagonist medication (injectable or oral naltrexone); however, about 13% utilized a partial agonist or agonist medication at some point during monitoring. Most participants completed a course of MAT with a single medication. Others attempted multiple forms of MAT and/or discontinued prematurely. Generally, similar results were observed with different forms of MAT or no MAT, though long-acting injectable naltrexone demonstrated better results than oral naltrexone. Most nurses returned to work in nursing after a delay. Longer monitoring and participation in 12-step groups were associated with better outcomes, whereas higher psychiatric co-morbidity was associated with worse outcomes. Almost half graduated monitoring successfully, without any documented lapse/relapse, and about 70% eventually had a successful outcome.

A lively panel discussion followed, with presenters representing both IPN and the Professionals Resource Network, Inc (PRN), Florida's physician health program. Panelists described their respective programs' approaches to monitoring individuals with OUD and/or pain disorders, highlighting practical considerations based on profession-specific challenges and requirements.

You Do What? Small but Mighty Physician Health Programs

Molly Dagon, LCSW

Jennifer Jackson-Harr MSW, LCSW

April Mallory, LCSW

Tina Simpson, MD

Molly Rossignol, DO

Felix Vanderlick



Molly Dagon, LCSW



Jennifer Jackson-Harr MSW, LCSW



April Mallory, LCSW



Tina Simpson, MD

A panel of leaders from four small or medium PHPs presented, *"You do what? Small but mighty physician health programs"*, which focused on challenges and creative solutions found in lower-resourced programs. The representatives from these programs discussed fostering relationships with regulatory boards, funding budgets of $300K–$1M, and issues in monitoring 50–200 participants with staff of 3–5 FTEs.

Dr. Simpson shared that Kentucky's boards hear issues with KPHF participants in an executive session, allowing KPHF to advocate privately and reduce the stigma of mental health conditions and substance use disorders in healthcare professionals. Dr. Rossignol and Mr. Vanderlick provided explanations of two budget models that are dependent

on state/regulatory board support rather than on participants paying fees to the monitoring agency or other fundraising.



Molly Rossignol, DO

Dr. Simpson explained how a small staff can distribute the responsibilities of monitoring without case management and discussed how to maximize tools of the third-party administrator. Dr. Rossignol addressed challenges of toxicology testing in a rural setting with limited collection sites. Mr. Vanderlick described the process of protecting the PHP staff via qualified immunity.



Felix Vanderlick

Molly Dagon and Jennifer Jackson-Harr spoke about keeping up with the administrative and clinical tasks with an extremely small team. The future of the organization, in the midst of substantial changes in the host agency, was also explored.

According to polling results, the session was attended by representatives from small programs. Over half of respondents indicated that they work in programs that supervise only a few professions and do not have a full-time medical director. Many are not members of the FSPHP and others indicated that they look to the FSPHP for support, connection to colleagues, and best practices. There was a Q&A session that included discourse about participant non-compliance and privacy, a variety of initial intake processes, and advocacy from community leaders to assist with funding.



Jim Lorence of Wisconsin and Dr. Geri Young of Hawaii at the Welcome Opening Remarks—FSPHP 2026 Annual Education Conference.

Program Operations, Technology, Collaboration, and Sustainability Track

Beyond Compliance: Strategies to Deepen and Sustain Recovery Engagement for the Monitored Health Professional

Christopher Bundy, MD, MPH, FAPA, FASAM

Michelle Van Alst

Melissa Warner, MD

Jeffrey Wesolowski, MD, MHSA

Courtney Strong, MA, LMHC, SUDP



Christopher Bundy, MD, MPH, FAPA, FASAM



Michelle Van Alst



Melissa Warner, MD



Jeffrey Wesolowski, MD, MHSA



Courtney Strong, MA, LMHC, SUDP

"Beyond Compliance: Strategies to Deepen and Sustain Recovery Engagement for the Monitored Health Professional" was an interactive panel presented on April 30, 2026, at the Federation of State Physician Health Programs (FSPHP) 2026 Education Conference and Annual Membership Meeting. Dr. Chris Bundy of the Washington Physicians Health Program (WPHP) moderated, joined by WPHP Clinical Director Courtney Strong and three leaders from IDAA (formerly International Doctors in Alcoholics Anonymous): Executive Director Michelle Van Alst, board chair and Farley Center physician Dr. Melissa Warner, and board member and radiologist Dr. Jeffrey Wesolowski.

The session opened from a clinical concern: many physician health programs and treatment centers were reporting a troubling decline in sustained recovery engagement among participants. The panel framed this through a central distinction between compliance, which is externally motivated and oriented around avoiding consequences and meeting requirements, and commitment, which is internally motivated and oriented around building recovery capital and personal well-being. The

presenters argued that durable recovery depended on moving participants from the former toward the latter.

A substantial portion of the talk examined whether recovery engagement was, in fact, declining and why. The panel drew on Robert Putnam's "Bowling Alone" thesis about decades of falling civic participation, which noted that AA membership had declined from its 1992 peak, and explored the role of the post-pandemic explosion in virtual meetings. Citing Zemore and colleagues' 2025 longitudinal PAL Study, they presented evidence that online-only mutual-help attendance was associated with poorer outcomes than in-person or hybrid participation, with the effect moderated by depth of involvement. At the same time, they acknowledged that virtual meetings were more accessible and more inclusive of women, BIPOC, LGBTQ, and younger participants than the older, less diverse in-person 12-step population.

The panel then positioned IDAA as a practical resource and trusted partner for PHPs and treatment providers. Van Alst described IDAA as a confidential, peer-professional recovery network for healthcare professionals and their families, outlining its meetings, helpline, annual conference, peer directory, eligibility, modest dues structure, and value across the treatment-to-aftercare-to-reentry continuum. Wesolowski shared lived experience, Warner addressed the role of primary treatment in building commitment, and Strong described how WPHP operationalized the IDAA connection through clinical prompts at key junctures (pre-enrollment reluctance, family engagement, return-to-work, isolation, shame, relapse) and a multi-channel communications strategy.

Two audience-response questions and a closing open forum invited attendees to reflect on engagement trends, the importance of profession-specific peer connection, and how PHPs could better link participants to recovery resources during both primary treatment and continuing care. The session's overarching aim was to equip providers with knowledge, resources, and collaborative models that reinforced recovery continuity while safeguarding professional well-being and patient safety.

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POSTERS

Listening for Impact: Participant and Stakeholder Feedback from the Washington Physicians Health Program

Christopher Bundy, MD, MPH, FAPA, FASAM



Christopher Bundy, MD, MPH, FAPA, FASAM

"Listening for Impact: Participant and Stakeholder Feedback from the Washington Physicians Health Program" was a poster presented at the Federation of State Physician Health Programs (FSPHP) 2026 Education Conference and Annual Membership Meeting. It was authored by a Washington Physicians Health Program (WPHP) team: Executive Medical Director Dr. Chris Bundy, Communications Manager Vanessa Bloy, Communications Coordinator Allison Yang, and Data Analyst Julien Rouvere.

The poster made the case for treating participant and stakeholder feedback as core program infrastructure. WPHP conducts comprehensive annual and exit surveys to measure both outcomes and experience on the premise that transparent, structured feedback builds credibility, guides quality improvement, and strengthens trust—and that disseminating evidence of program benefits can, in turn, raise awareness, confidence, and utilization of its services.

Surveys are administered through a secure online platform that aggregates responses anonymously, with email reminders sent until target response rates are reached. Annual surveys run from October through December, while exit surveys are collected continuously as participants discharge. In 2025, 56% of participants (130/234) completed the annual participant survey and 22% of stakeholders (146/672) completed the stakeholder survey, while 59% (164/276) of those discharging between January 2021 and December 2025 completed an exit survey.

The participant findings were strong. Current participants reported lower burnout than national U.S. health-professional benchmarks, and those leaving the program described meaningful gains: 73% said the condition that brought them to WPHP was much better and another 16% somewhat better, while 76% reported improved overall health. Notably, 88% said thoughts of hopelessness, suicide, or suicidal behavior had resolved or greatly decreased during participation. Eighty-five percent called the program helpful—including 16% who described it as

lifesaving—89% valued its advocacy, 90% felt treated with courtesy and respect, and 78% would refer a colleague.

Stakeholder confidence tracked closely with familiarity. Among those reporting a strong understanding of WPHP's services, 86% would refer a colleague, 82% trusted its fitness-for-duty endorsements, 80% believed participants were treated with care and compassion, and 90% saw WPHP as a valuable community resource. The team read these results as evidence that WPHP is balancing its dual mandate of participant advocacy and public protection, and that structured accountability paired with therapeutic oversight supports psychological stabilization and a return to professional functioning.

The broader argument was that systematic outcome and experience measurement is not mere administration but a mechanism for quality improvement and stakeholder engagement, and that the variability in stakeholder understanding points to clear opportunities for targeted outreach. The authors were candid about limitations: the low stakeholder response rate (22%) raises the possibility of response bias, the data are self-reported and cross-sectional, and survivorship among successful completers may skew exit results favorably.

Monitoring Outcomes of Substance Use Disorder Among Healthcare Professionals in Utah: A Retrospective Study of the Utah Professionals Health Program

Mubo Olufemi, MSc



Mubo Olufemi, MSc

Substance use disorders among healthcare professionals can have profound consequences for both patient safety and workforce stability. Physician Health Programs (PHPs) provide confidential, structured monitoring that supports recovery while facilitating a safe return to clinical practice. Although the effectiveness of PHPs has been well documented among physicians, considerably less is known about outcomes in the broader healthcare workforce. This study evaluated long-term monitoring outcomes among participants enrolled in the Utah Professionals Health Program (UPHP), a state program that serves a diverse range of licensed healthcare professionals.

The study reviewed records from 183 UPHP participants enrolled between 2013 and 2024. Nurses comprised the largest professional group (60.6%), followed by physicians (18.0%), with the remaining participants including pharmacists, dentists, and other licensed healthcare professionals. This predominantly non-physician cohort distinguishes the study from most published PHP outcome research and provides valuable insight into recovery among healthcare professionals who have historically been underrepresented in the literature. UPHP participants typically undergo comprehensive evaluation, individualized treatment recommendations, random toxicology testing, psychotherapy, mutual support participation, and ongoing monitoring, usually over a five-year period. The primary outcome was return to use during monitoring, identified through verified toxicology testing or self-report. Additional outcomes included monitoring status, licensure, employment, and program completion. Overall, 48.6% of participants experienced at least one return-to-use episode during monitoring, with approximately one-third of these events occurring during the first year. Despite this early vulnerability, long-term outcomes were encouraging. Among participants with five years of follow-up, 81.4% successfully completed monitoring, approximately three-quarters retained active professional licensure, and more than half were documented as working full-time in healthcare.

Several factors were associated with return to use. Older age at enrollment was associated with lower odds of return to use (OR = 0.93 per year, $p = .039$), whereas a longer duration of substance use before program entry was associated with higher odds (OR = 1.14 per year, $p = .004$). Participants with a documented history of injury or chronic pain were also more likely to experience return to use (OR = 0.23, $p = .017$), suggesting that integrated pain management and addiction treatment may be particularly important for this subgroup. Professional discipline, however, was not significantly associated with return to use after adjustment for other factors.

This study is one of the few long-term evaluations of a Physician Health Program serving a predominantly non-physician population. The findings reinforce the value of structured monitoring in supporting recovery and return to practice while identifying the first year of monitoring as a particularly vulnerable period. They also underscore the importance of profession-sensitive care, early intervention, and continued research involving nurses and other healthcare professionals to strengthen recovery outcomes across the healthcare workforce.

Patterns of Substance Use and Psychological Distress Among the Future Medical Workforce

Lisa Merlo, PhD, MPE

Cristiana N.P Araujo, PhD

Molly O'Neill, BS

Claudia Messina



Lisa Merlo, PhD, MPE



Cristiana N.P Araujo, PhD



Molly O'Neill, BS



Claudia Messina

Previous research among medical students in the Millennial generation demonstrated high rates of psychological distress, accompanied by concerning levels of hazardous alcohol use, cannabis use, and misuse of prescription stimulants. The current population of medical learners is now comprised primarily of students representing Generation Z, who appear at greater risk of mental health concerns globally. In order to explore patterns of mental health and substance use in the current generation of medical learners, an anonymous survey was conducted among medical and PA students across all 9 institutions with medical schools in the State of Florida. This included 8 allopathic medical schools, 2 osteopathic medical schools, and 4 PA schools.

Results demonstrated that Florida medical and PA students continue to display high rates of burnout (about half report at least one symptom) and distress. A small but significant minority of students also reported passive suicidal ideation during professional school. In addition, about 1 in 5 medical students and 1 in 10 PA students reported increasing alcohol consumption since beginning professional school, with nearly half of medical and PA students endorsing at least moderate risk of alcohol use disorder on the AUDIT-C. About 15% of students reported using cannabis during professional school, though a lower percentage screened positive for cannabis use disorder on the CUDIT-SF. Importantly, nearly one-half of medical students and one-quarter of PA students reported concern that seeking mental health treatment would harm their career.

Despite years of student wellness reform efforts, Florida medical learners report concerning levels of substance use and distress, mirroring national and international trends in medical education. This raises concerns about future and current risk. Stigma likely remains a critical barrier to mental healthcare. Medical schools and PHPs should partner to enhance prevention efforts and facilitate early intervention.

Practicing Recovery: Participant Experiences and Everyday Care in a Physician Health Program

Chloe Bennink, *PhD Candidate*



Chloe Bennink, PhD Candidate

This poster presentation shared early findings from an ongoing hospital ethnography at a physician health program (PHP)-approved treatment center specializing in the care of healthcare professionals. Drawing on observational fieldwork, interviews, and policy analysis, the study examines how monitored professionals and those who care for them experience and coordinate evaluation, treatment, monitoring, and return to work. A central finding is that evaluation, treatment, and monitoring are not experienced as separate stages. Evaluation shapes treatment recommendations, treatment anticipates monitoring requirements, and monitoring expectations influences how recovery, discharge, and return to work are discussed from the beginning. Recovery is therefore produced across interconnected clinical, administrative, and regulatory settings. The findings also highlight the pivotal role of evaluation quality. Evaluations do more than establish diagnoses. They inform decisions about level of care, fitness to practice, monitoring, and access to recovery resources. When evaluations are incomplete, poorly matched to the presenting concern, or insufficiently informative, the consequences may include delayed treatment, additional expense, more time away from work, and difficulty identifying an appropriate care pathway.

Another important theme is the interpretive and coordinative work performed by clinicians, PHP staff, evaluators, and other professionals. Monitored professionals must navigate treatment recommendations, releases of information, testing requirements, contracts, workplace restrictions, licensing concerns, and state-specific PHP structures. Helping individuals understand how these elements fit together is not merely an administrative task. Clear explanation and coordination can shape whether care feels coherent, fair, and navigable. External pressures, including medical board involvement, employment restrictions, financial strain, and uncertainty about future practice, also enter directly into the treatment experience. Recovery for monitored professionals involves not only addressing substance use

or mental health concerns but also negotiating changes in identity, responsibility, livelihood, and professional possibility.

Finally, trust emerged as a central condition of effective care. Many professionals initially encounter PHP involvement through fear, uncertainty, resentment, or an expectation of punishment. Over time, some come to understand oversight as a source of accountability, advocacy, and support. This shift is not automatic. It depends on clear communication, consistency across institutions, relational care, and credible opportunities to understand how PHPs work to support both professional recovery and patient safety. Overall, the study complements outcome-based research by showing how the PHP model becomes workable in everyday practice. Its early findings suggest that evaluation quality, communication, coordination, and trust are central to whether recovery and monitoring are experienced as coherent, supportive, and sustainable.

Supporting Pediatricians: Opportunities for Remediation through Compliance with American Board of Pediatrics Policy

Suzanne K. Woods, MD

Ronan E. Walker



Suzanne K. Woods, MD



Ronan E. Walker

This poster presented the American Board of Pediatrics' (ABP) approach to supporting pediatricians facing medical licensure restrictions due to chemical dependency, with a focus on remediation and maintaining professional standards. The ABP enforces strict policies regarding professional conduct, licensure, and certification eligibility. Physicians are required to report any license restrictions—such as revocation, suspension, probation, or imposed conditions—to the ABP, as these may impact their certification status.

Program Implementation

In 2021, the ABP launched a pilot Physician Health Program (PHP) Compliance Reporting Program. This initiative targets pediatricians with non-clinical licensure restrictions related to chemical dependency who are actively participating in a state medical board-approved monitoring program. The program's core procedures include:

- Quarterly submission of compliance documentation from the physician's monitoring program
- ABP review of submitted materials, which must demonstrate ongoing practice monitoring, attendance at required meetings, negative screening results, and completion of educational requirements
- Reporting compliance status to the ABP Credentials Committee
- Continuation in the program until the physician's license restriction period concludes

Outcomes and Impact

Since its inception, 40 pediatricians have participated in the program. The outcomes are as follows:

- 25 have successfully graduated from the program, having completed all requirements
- 13 remain compliant and are continuing in the program
- 2 were found non-compliant and faced disciplinary action

The program allows physicians to continue participating in certification activities during their rehabilitation, supporting their recovery while upholding high standards of professionalism and public safety. The high compliance and graduation rates indicate that structured oversight, clear expectations, and compassionate support can lead to positive outcomes for physicians undergoing remediation.

Significance

The ABP's Chemical Use and Dependency Policy, along with the PHP Compliance Reporting Program, provides a model for balancing accountability with support. It demonstrates that certifying boards can maintain public trust and professional standards while offering a pathway to recovery for physicians. The program's success suggests it could serve as a template for other medical boards seeking to address similar challenges.

REFERENCES

- ABP Honor Code and Professionalism Policies
- ABP Chemical Use and Dependency Policy
- ABP Licensure Policy
- Literature on physician health program outcomes

Survey on Physician Health Program (PHP) Relationships with Medical Schools and Residency Programs

Kay O'Shea, CADC, MAC, CTP

Sandra Frazier, MD, FASAM



Kay O'Shea, CADC, MAC, CTP



Sandra Frazier, MD, FASAM

The Survey on Physician Health Program (PHP) Relationships with Medical Schools and Residency Programs was conducted by the FSPHP Medical Student and Residency Committee in 2025 to learn about member programs' engagement with medical schools, residency programs, and wellness programs. The outcome of the survey was presented as a poster presentation in order to share effective practices among members, find areas of alignment, and identify opportunities for improvement among PHP's relationships with medical student and residency programs.

Findings

- All PHPs provide referrals to treatment and evaluators
- Non-compliance reporting varies for medical school students and residents: medical board reporting is more common for residents (70%) than medical students (14%)
- PHPs identified challenges including:
  - Lack of financial aid to assist with treatment costs
  - State regulation not permitting PHPs to receive referrals for medical students
  - National accreditation and credentialing policies that discourage early PHP involvement by requiring programs to handle issues internally without PHP referral
- Concerns/issues included: funding strategies, collaboration with national medical school credentialing organizations, differences in leverage between students and residents, increasing awareness and minimizing fear, and ensuring recommendations are scalable

Recommendations

- Standardization of referral processes and ensuring guidelines are scalable and adaptable by state
- Advocacy to embed education about PHPs into training standards, address referral limitations, and reduce policies that inadvertently delay or prevent referrals
- Funding strategies to assist with treatment costs
- Education about PHPs, partnerships, and clarifying roles of PHPs and wellness programs with a focus on increasing trust
- Outreach strategies to increase awareness with an emphasis on providing support for medical students

The FSPHP Medical Student and Residency Committee will use the results from the survey to develop a repository on the FSPHP website to aid PHPs in their relationships with medical schools and residency programs.

The Provider Health Introduction: Piloting an Upstream Provider Health Model Across the Training Continuum

Joyce Davidson, PhD, LCSW

Quinn Montgomery, LPC

Caroline Young, LPC

Hannah Adkins, LCSW



Joyce Davidson, PhD, LCSW



Quinn Montgomery, LPC



Caroline Young, LPC



Hannah Adkins, LCSW

In Spring 2025, CPHP initiated the Provider Health Introduction (PHI) Program Pilot as an upstream initiative to engage medical trainees and help them better understand how their own well-being can influence the quality and safety of their patient care, with an emphasis on self-awareness, professional identity development, and proactive support-seeking. PHI addresses the reality that healthcare trainees experience high rates of anxiety, depression, and burnout, yet many do not connect with supports until concerns affect their academic/professional performance. PHI was developed to provide earlier support, before distress progresses to impairment or other consequences. Our poster presentation reviewed the first year of the pilot program, and we are currently working toward publishing our findings.

PHI provides healthcare trainees with a voluntary and confidential introduction to provider health. Participants complete the PHQ-9, GAD-7, and Well-Being Index and then meet individually with one of

CPHP's master-level clinicians. During the consultation, the clinician reviews the participant's screening results, explains the distinction between illness and impairment, discusses professional responsibilities related to health and patient safety, and helps the participant develop an individualized self-care plan. Participants also learn how to access support for themselves and how to respond if they are concerned about a peer.

The pilot included 178 physician assistant students across five cohorts and three academic institutions. Of the students referred, 74% completed the screening tools, 71% scheduled a PHI appointment, and 65% completed the individual consultation. Fourteen students, or 8% of those referred, transitioned to CPHP's traditional services for additional support.

Pre- and post-survey results showed meaningful improvements across all learning areas. Understanding of the difference between illness and impairment increased from 62% to 90%. The percentage of students who knew what to do if they became impaired increased from 65% to 90%, while knowledge of how to respond to an impaired peer increased from 40% to over 80% across cohorts. Preparedness to access resources increased from 61% to 92%.

CPHP, through the PHI program, sought to increase students' openness to seeking support, clearly explain confidentiality, and build trust for future outreach. Participants valued having their experiences validated and normalized, and many requested additional opportunities to develop practical well-being skills. Scheduling individual consultations was sometimes challenging, suggesting that future versions should combine group-based skills workshops with continued access to individual support.

Overall, the PHI pilot showed that confidential, preventive PHP engagement can be successfully incorporated into healthcare education. The model strengthens professional health literacy, supports earlier identification of distress, and helps trainees view help-seeking as part of professional responsibility rather than as a disciplinary process. CPHP is currently working to invite medical schools to pilot the PHI program with a group-based model and plans to eventually adapt the PHI model to residents and practicing providers across Colorado.

Understanding Financial Barriers in Physician Health Programs: Insights from Participant Perspectives

Mubo Olufemi, MSc



Mubo Olufemi, MSc

Physician Health Programs (PHPs) provide an essential pathway for healthcare professionals with substance use disorders to obtain treatment, demonstrate sustained recovery, and safely return to practice. Although these programs have well-established recovery outcomes, relatively little research has examined the financial burden experienced by participants themselves. This study is among the first to evaluate those experiences across multiple state PHPs.

A cross-sectional survey of 80 healthcare professionals who completed PHP monitoring in Utah, Colorado, and Florida examined direct out-of-pocket costs, lost wages, insurance coverage, funding sources, and perceptions of financial strain. Participants reported a median out-of-pocket cost of $20,000 and median wage losses of $25,000. Most relied primarily on personal funds to pay for program-related expenses, while insurance coverage for evaluation, treatment, and monitoring costs was often limited. Toxicology testing was identified as the most significant financial burden by more than 80% of respondents. Nearly three-quarters of participants reported that PHP participation increased their financial burden, and more than one-third indicated that financial concerns delayed seeking help. Despite these challenges, most participants viewed their participation as worthwhile, believing that the benefits of treatment and monitoring outweighed the costs. Notably, two-thirds also reported that their overall financial health had improved by the completion of monitoring, suggesting that the long-term professional and personal benefits of recovery may offset some of the initial financial hardship.

Participants suggested several approaches to reduce financial burden, including expanding insurance coverage for evidence-based treatment, reducing the cost or frequency of toxicology testing where appropriate, increasing access to telehealth, and offering payment plans or other financial assistance. Together, these findings highlight the need for more flexible and equitable monitoring models that continue to protect public safety while improving the accessibility and affordability of Physician Health Programs.

Working with Litigious Clientele

Josh Hypse, PsyD

Michael Seely, PsyD



Michael Seely, PsyD



Josh Hypse, PsyD

Acumen Assessments found itself working with an increasing number of litigious individuals who tend to adopt a combative demeanor, often with little regard for accountability or regulatory authority. When speaking with our colleagues throughout the country, we realized that we are not alone in this experience. Never before have physician health programs, state medical boards, and assessment and treatment facilities encountered such a challenging population. Rather than address the issues that have generated scrutiny, litigious individuals tend to seek out fault in the organizations trying to assist them with remediation.

The looming threat of litigation creates an additional challenge and unwarranted distress when already employed in a demanding field. Research indicates that going through litigation creates an increased risk of burnout, mood disorders, physical distress, strained relationships, and substance abuse (Blake Harris Law, 2025). We have found that identifying the warning signs (making litigious statements, looking for fault in the evaluation process, submitting an abundance of their own collateral materials, insisting the report is complete before having a chance to speak with collateral sources, refusing to sign releases of information, etc.) that accompany this subset of individuals early into the relationship is crucial. We have also found the importance of adhering to a structured framework, in addition to other effective strategies (consulting with others, thorough documentation, strict adherence to ethical guidelines, making no shortcuts, being more selective when deciding who to work with), can be the most successful means of mitigating risk and potential retribution. Engaging in self-care is also paramount when working with this subset of individuals.

FSPHP and FSMB 2026 Joint Session—*Strengthening Physician Health Programs: Insights from Experience and New National Data*

AVAILABLE ON THE FSPHP ONLINE LEARNING CENTER

At a powerful joint session in Baltimore on May 1, leaders from the Federation of State Physician Health Programs (FSPHP) and the Federation of State Medical Boards (FSMB) came together to spotlight the future of physician health programs nationwide.

The session unveiled key insights from a recent national survey, revealing emerging trends in program scope, organizational and funding models, and referral pathways—while also identifying what sets the strongest, most effective programs apart.

SESSION PRESENTERS



George M. Abraham, MD, MPH, MACP, FIDSA, FRCP (Lon.)
Chair, Federation of State Medical Boards



Michael Baron, MD, MPH, DFASAM, FAPA
FSPHP Immediate Past President
Medical Director, Tennessee Medical Foundation Physician's Health Program



Edwin Kim, MD, FAPA, MRO
FSPHP President
Medical Director, Pennsylvania Physician Health Program



Lisa Merlo, PhD, MPE
FSPHP Research Committee Co-Chair
Professor of Psychiatry, University of Florida; Director of Research, Professionals Resource Network, Inc, Professionals Resource Network (Florida); University of Florida

Access the recording on the FSPHP Online Learning Center.

Upcoming Events

FSPHP 2027 ANNUAL EDUCATION CONFERENCE

Leading the Way: The Future of Professional Health Programs

April 14–16, 2027 | Oklahoma City, OK



Join us in Oklahoma City on April 14–16, 2027, for the premier educational event for physicians, healthcare professionals across all specialties, and individuals dedicated to advancing health, well-being, and professional sustainability.

The FSPHP Annual Education Conference brings together approximately 300 attendees, including Physician and Professional Health Program (PHP) leaders, staff, and nationally recognized experts involved in the evaluation, treatment, and support of health professionals. The conference offers exceptional opportunities for networking, education, collaboration, and the exchange of best practices in professional health and wellness.

It is the most valued professional development training for your PHP staff and treatment professionals.

The FSPHP Annual Education Conference is designed for:

- Physicians of all specialties
- Physician assistants
- Clinical coordinators
- Nurses
- Dentists
- Psychologists
- Attorneys
- Physical therapists
- Case managers
- Licensed social workers
- Toxicologists
- Scientific researchers

Experience the energy of Oklahoma City, a welcoming destination known for its revitalized downtown, scenic canal district, and thriving food and cultural scene. From the Oklahoma City Convention Center, where FSPHP 2027 will be held, to nearby entertainment, dining, and outdoor spaces, the setting offers the perfect blend of inspiration, connection, and discovery—making FSPHP 2027 an event you won't want to miss.

Be sure to bookmark the FSPHP 2027 Annual Education webpage and visit regularly for conference updates, program announcements, registration information, and important event details as they become available.

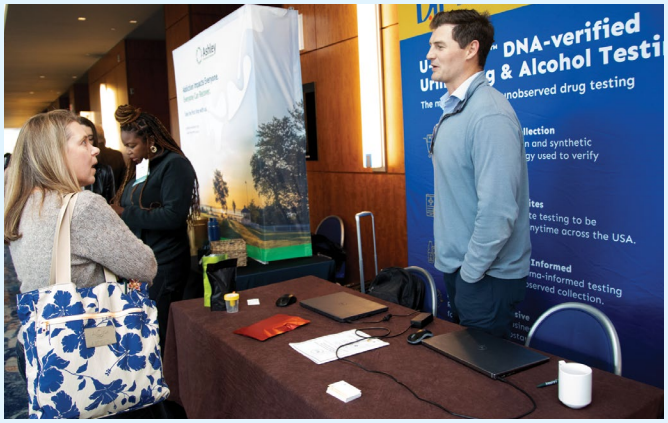
Schedule at a Glance

Hotel and Travel Info





Exhibit, Engage, and Expand Your Impact at FSPHP 2027





Join over 300 leaders in state physician and professional health programs from across the U.S., Canada, and beyond—including program administrators, care providers, and allied health professionals—all dedicated to the well-being of healthcare professionals.

As an exhibitor, you'll gain exclusive access to this highly engaged audience and:

- **Connect** with attendees during dedicated exhibit hours and meals in a spacious exhibit hall.
- **Showcase** your commitment to healthcare professional wellness including mental health and substance use recovery.
- **Stand out** in the mobile app with your logo, description, contact info, links, and one-on-one messaging.
- **Attend** key educational sessions and deepen your understanding of professional health programs and treatment of healthcare professionals.
- **Network** with attendees before, during, and after the event.
- **Amplify** your presence with pre-designed social media content to promote your booth.



Click to download the 2027 Exhibitor Brochure or visit the FSPHP 2027 Annual Education Conference webpage for more information.

Your exhibitor package includes conference registrations (based on exhibitor level) and access to all sessions and events.

EXHIBITOR INFORMATION SESSIONS

Learn more about FSPHP, our conference, and the reasons you should join us.

Click here to register for one or both Information Sessions.

- December 11, 2026 at 1:00 p.m.–2:30 p.m. ET
- January 29, 2027 at 1:00 p.m–2:30 p.m. EST



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- **Opportunity for two representatives to participate in relevant portions of the meeting**
- **A brief speaking opportunity to address attendees directly**

Click here to reserve a Regional Member Meeting Sponsorship.

Questions? Contact: ssavage@fsphp.org

Volunteer Opportunity: Facilitate a 2027 FSPHP Open Forum Leadership Series Meeting

Call for Facilitators: 2027 Open Forum Leadership Series

FSPHP is seeking volunteers to facilitate next year's Open Forum Leadership Series meetings—a valuable space for members to connect, share insights, and strengthen our community.

Facilitators must be a State, Associate, or International Member and part of their PHP's leadership team (executives, directors, department heads).

Interested in supporting peer engagement? Email ssavage@fsphp.org.

FSPHP-ETA™ Accreditation Insights & Info Session



Tuesday, November 3, 2026; 3:00 PM–4:00 PM ET

Does your evaluation or treatment program specialize in the care of healthcare professionals, or would you like to learn more about accreditation for this specialized care?

The FSPHP Evaluation and Treatment Accreditation™ (FSPHP-ETA™) program recognizes evaluation and treatment services with demonstrated expertise in caring for medical students, residents, physicians, and other healthcare professionals in safety-sensitive occupational roles.

This interactive webinar will feature programs that have completed FSPHP-ETA™ accreditation, along with the subject matter experts who participate in the review process. The session will highlight why organizations chose to participate, what the process was like, and the value accreditation brings to programs and to the field.

This session will be particularly valuable for:

- Evaluation and treatment program leaders, clinical directors, and administrators
- Organizations considering FSPHP-ETA™ accreditation
- Programs that are preparing for or are early in the accreditation process
- Programs developing or expanding a healthcare professional track within their evaluation and treatment services
- Multidisciplinary teams involved in the evaluation, treatment, or monitoring of healthcare professionals
- Current or prospective FSPHP-ETA™ Subject Matter Experts
- Individuals and organizations interested in advancing quality, consistency, and best practices in care for this population

Participants will discuss:

- Why they chose to pursue FSPHP-ETA™ accreditation
- What the process was like from preparation through review
- How the experience informed program development and quality improvement
- How Subject Matter Experts approach evaluations
- Key takeaways, surprises, and lessons lear ned
- Responses to participant questions

Learn more and register for the Info Session!

- Learn more about the FSPHP-ETA™ Program.
- Request a call to discuss the FSPHP ETA™ Program.
- FSPHP-ETA™ Frequently Asked Questions.

VIRTUAL FSPHP MEMBER-ONLY EVENTS

Regional Member Meetings Open to All FSPHP Members!

FSPHP Regional Member Meetings provide a valuable platform for members to come together, share experiences, and collaborate on developing best practices.

Southeast Region Member Meeting

Date: Monday, November 23, 2026

Central Region Member Meeting

Date: Monday, November 30, 2026

Northeast Region Member Meeting

Date: Thursday, December 3, 2026

Western Region Member Meeting

Date: Tuesday, December 15, 2026

Click here for more information, see meeting agendas, and to register.

If you are not able to attend your region's meeting, please feel free to register and attend the Regional Member Meeting that best fits your schedule.

FSPHP Membership Information Session

Wednesday, November 18, 2026
11:00 AM–12:30 PM EST

Join the FSPHP Board of Directors for this complimentary session designed to help you connect with fellow members and learn more about FSPHP.

Audience: Open to all FSPHP members—both new and existing.

Click here to register.

FSPHP Open Forum Leadership Series

Friday, November 20, 2026
12:00–1:00 p.m. EST

Facilitator: Susan K. Blank, MD, LFAPA, DFASAM, Medical Director, Georgia Professional Health Program



Susan K. Blank, MD, LFAPA, DFASAM

Join fellow FSPHP PHP leaders for informal, Zoom-based conversations designed to foster collaboration, share innovative ideas, and discuss emerging issues impacting physician and professional health programs. There are no formal agendas, presentations, or meeting minutes—just candid dialogue, peer connection, and the exchange of valuable insights and experiences.

Audience: Open to PHP members serving in leadership roles, including executives, medical directors, program directors, CEOs, and department leaders.

Click here to register.

FSPHP New Member Meeting

Wednesday, February 17, 2027
12:00 PM–1:30 PM EST

A welcoming space to connect, collaborate, and help shape the future of physician health.

Audience: Open to all FSPHP members—both new and existing.

Click here to register.

FSPHP Annual Member Business Meeting

Thursday, May 20, 2027
1:00 PM–3:00 PM ET

This important meeting will include a review of organizational priorities, a treasurer's report, recognition of new members, committee updates, and the announcement of 2027 ballot results.

Audience: Open to all State-Voting, Associate, International, and Honorary Members.

Learn more and register.

Thank You for Joining Us in Baltimore—Highlights from the FSPHP 2026 Annual Education Conference


















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Moments from the President's Reception for Speakers and New Attendees













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We extend our heartfelt gratitude to the generous donors who donated from April 1, 2026 through September 30, 2026. Your contributions fuel our work and strengthen our mission every day.

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