



## ANNUAL MEETING 2013 REVIEW

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Welcome to the 18th edition of *Physician Health News*. We hope you will find this an informative forum for all aspects of physician health and well-being.

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

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The FSPHP is a national organization providing an exchange of information among state physician health programs to develop common objectives, goals, and standards. If you're not a member yet, please consider joining. State membership is \$400 per year, and individual (associate) membership is \$100. We sincerely hope you respond as an indication of your commitment to a stronger, more cohesive Federation of State Physician Health Programs.

For more information on each of the membership categories, please contact Debbie Brennan of Physician Health Services in Massachusetts at (781) 464-4802.

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

## THE BOSTON EXPERIENCE

*"Everything will be all right in the end. So if it is not all right, it is not yet the end."*

—Sonny in *The Best Exotic Marigold Hotel*



Warren Pendergast, MD,  
 President

The 2013 FSPHP conference experience was not what any of us expected, and one we will not soon forget. How often does one hear the phrases "don't forget to turn in your CME forms" and "the hotel will be on lockdown today" from the lectern of your average medical conference? My own trip to Boston began with a glimpse of Air Force One sitting on the airport tarmac as our flight landed. A fellow traveler on the plane remarked that this sight would probably be the most unusual thing we would see or experience that week. How little we knew...

As adversity so often does, the Boston marathon bombing and subsequent events brought us closer. Like Londoners during their own adversities, we "kept calm and carried on" — focused on what was in our control, despite what was unfolding literally down the street. With help and guidance from the Program Planning Committee (PPC) and stellar FSPHP staff Jon Dougherty, Jessica Vautour, and Debbie Brennan, we had one of our best conferences ever. It remains a privilege to be your Federation president, and our strong work this year in Boston did us all proud.

### Membership Categories

One notable work piece in Boston was our vote to expand FSPHP membership categories. This was the culmination of months and years of hard work by many, most recently Brad Hall and Maureen Dinnan. While the hard decisions have been made, we're still working out the details, with implementation planned for this fall. We look forward to welcoming those in pharmacy programs, dental programs, and others who do professional health work into the FSPHP fold, and we are confident that our new colleagues will bring energy and a fresh perspective to the playing field of physician health.

### The Website

As we learned again in April, it's the people that make FSPHP special. And along those lines, we need people. Specifically, I'm continuing the clarion call for volunteers to help revise our website. While we all appreciate our current FSPHP website for its simplicity and easy navigation, it's time for us to move forward into the 21st century!



View of the Charles River from the Hyatt Regency Cambridge Hotel

We need html worker bees, programming nerds aplenty, and anyone in search of some fun, learning, and service opportunities. While technical skills are certainly welcome, anyone who considers him- or herself “just knowledgeable enough to be dangerous” is invited to join the newly forming Website Task Force. If you have any questions or interest, give me or Jon D. a call or email.

### ***Coming Attractions***

The PPC, led by the intrepid Mick Oreskovich, amazing Linda Bresnahan, and your fearless President-Elect Doris Gunderson, has already begun the planning process for our 2014 meeting in Denver. We have already chosen meeting locations for 2015 (Fort Worth) and 2016 (San Diego), as well. Early planning enables us to get optimum choices and rates for hotels, and to be better stewards of FSPHP’s resources. As one of our members is fond of saying, “onward and forward!”

— *Warren Pendergast, MD*  
*North Carolina Physicians Health Program*  
*Raleigh, NC*

### **LOVELY TO SEE YOU AGAIN MY FRIEND**

No musical group could paint the mosaic of my life better than the Moody Blues. One of the earliest songs I can recall as a child was sung by them. And, certainly, one of my favorites is a Justin Hayward tune, “Lovely to See

You.” For me, it is a sentiment that’s reminiscent of Cambridge last April.

Big events excite me, especially when they involve a lot of people who are traveling from faraway places to have the opportunity to commiserate with their friends and colleagues. The FSPHP Annual Conference is a prime example of such an event:

- Planning for the conference begins almost immediately after the prior one
- Conference calls are made
- Engaging topics are covered
- Key decisions of the next conferences’ location, who the speakers will be, and what the theme of the event will be

Multiple avenues of creativity are ever present and the discourse is always very positive, pleasant, and productive. It all builds up into a massive crescendo, beginning at the end of the last Program Planning Committee call a week before the conference, when the Tri-Chairs ask, “Is there anything else?” We’re there — this is going to happen. It then ends when the luggage gets thrown into the taxi — on the way to the airport and home. And, although you may be a little tired because of the travel and the long days during the conference, there is that little anticlimactic mellowness that tells you, “Gee, that all went by so fast.” Then you realize that it may be a whole year before you see these people again.

Cambridge is an event that we have been talking about, and probably will be in our thoughts, for the rest of our lives. When mentioned to friends and family the reply is always, incredulously, “You were there!?” So then I think back to the events that occurred outside our doors and on the streets of Cambridge and wonder, *Maybe, I should have been a little more frightened, but, for some reason, I wasn't.* So then I go back to Justin Hayward for some advice. “Dark cloud of fear is blowing away. Now that you're here you're going to stay.” We were all at the event together, so I never felt alone. The sheer joy of being with all of you was sufficiently powerful, along with the excitement of seeing the conference unfold, with little room left for apprehension. We took the necessary precautions, but then we also laughed. And as inevitable problems arose, we addressed them with our trademark professionalism and camaraderie. We listened to the presentations and talked with exhibitors, but I was mindful of what the hotel staff and law enforcement were doing to protect us, so I could focus on the business at hand. I certainly hope that's a sentiment shared with all of you.

On a substantive level, a great deal was achieved during the conference. There were excellent presentations and a tremendous exchange of knowledge. The addition of two new membership categories, the result of a process that began five years ago, is a tribute to you in a couple of ways: It signifies an appropriate deliberative nature that is

commonplace amongst professionals in physician health, while also signifying your willingness to share your knowledge and expertise with those who otherwise might not have the opportunity. In the coming months your leadership will be developing guidelines and application requirements for the new categories. It will take time, but I am confident that the end result will lead to the enrichment of the FSPHP.

Just one final note: Beginning in 2012 we began the process of moving the administrative responsibilities away from the AMA in Chicago to, ultimately, the Physician Health Services people in Waltham, Massachusetts. Earlier this year, I reported this transition in my article in *Physician Health News* so I will not become redundant except to say that I had an opportunity to witness firsthand the fruits of that effort while at the annual conference. I wish to express to you that even with the difficult circumstances we all had to endure, I was amazed and greatly impressed with the creativity, competency, and efficiency displayed by Jessica Vautour and Debbie Brennan. I salute the wisdom of the Board of Directors in making this decision and I am grateful for having been given this tremendous resource. So, it's on to Denver in 2014, where I again will be able to say, “Lovely to see you again my friend! Walk along with me to the next bend!”

— *Jonathan H. Dougherty, MS*



Jonathan Dougherty, MS, FSPHP Executive Director, and Jane Dougherty, Wife, Volunteer



Linda Bresnahan, MS, FSPHP Board Secretary and PPC Co-Chair with Jessica Vautour, MM, FSPHP Staff Assistant, Tanya Roof, Helms Briscoe, and Debbie Brennan, FSPHP Staff Assistant

**FRIDAY, APRIL 19, 2013**

## **PROGRAM DEVELOPMENT: TWO KEY INITIATIVES TO STRENGTHEN PATIENT SAFETY AND CONTINUOUS QUALITY ASSURANCE**

The Colorado Physician Health Program (CPHP) was thrilled to collaborate with Patty Skolnik, founder and executive director of Citizens for Patient Safety and CPHP advisor, to educate the Federation of State Physician Health Programs (FSPHP) at their annual conference in April 2013. Sarah Early, PsyD, CPHP executive director, and Cae Allison, LCSW, CPHP clinical quality consultant, were honored to partake in this joint presentation, which highlighted the unlikely connection of a physician health program (PHP) and a public advocacy group — two groups often viewed as adversaries.

In Colorado, the partnership of the Citizens for Patient Safety and CPHP has a joint mission: transparency, prevention of harm, monitoring treatment for better health care outcomes, and appropriate and respectful intervention. A PHP with a patient safety committee garners credibility by the very fact of being scrutinized by a public advocacy group.

Ms. Skolnik discussed the untimely death of her only son, Michael, due to medical error. She shared how the tragic loss informed her efforts to promote the safe health

care of patients through advocacy, education, and systemic change. While her passion is shared decision-making, informed consent, and transparency, her dedication is fueled by a desire and promise to her son, Michael, to leave the medical profession better than he found it.

Ms. Skolnik described the innovative legislation that she ushered into being in Colorado — the Michael Skolnik Medical Transparency Acts of 2007, 2009, and 2013. The Medical Transparency Act requires all Colorado physicians, as part of licensure application, to disclose specific information that can be accessed by the public.

Ms. Skolnik explored some general misconceptions about PHPs and relayed that continuing education and outreach to the right audiences with targeted messages can help address these common misconceptions.

Dr. Early described the development and implementation strategies of the CPHP Patient Safety Committee and opined that this committee helped CPHP strengthen our message of patient safety to a broad audience. Having external as well as internal members provides unbiased points of view, as well as connections and sponsorship to offer entry into otherwise inaccessible forums. Dr. Early gave examples of the integration of the Patient Safety Committee into program delivery. She discussed the strengthening of CPHP's relationship to the Colorado Medical Board because of our dedication to patient safety and provided examples of CPHP's extensive outreach and education to other "outside

of the box” audiences such as national patient safety organizations, insurance liability groups, attorney groups, medical societies, and legislative committees.

Ms. Allison discussed CPHP’s Quality Assurance Committee and provided examples of initiatives undertaken; a client satisfaction survey (currently in progress), an internal auditing program (with descriptions of key internal auditing initiatives), and an in-depth discussion of the needs assessment outcome data.

CPHP’s presentation demonstrated how the development of two key programs illustrates best practices for a PHP and how these two committees have become institutionalized into all areas of program delivery at CPHP. These two committees have positively affected internal processes and external knowledge of how a PHP operates. CPHP’s outcome data from quality assessment provides a logical outgrowth for future areas for study and research, impacts program delivery and key decision making and provides the empirical data necessary for budget forecasting and program support.

— *Cae Allison, LCSW, and Sarah Early, PsyD*  
*Colorado Physician Health Program (CPHP)*  
*Denver, CO*

— *Patty Skolnik*  
*Citizens for Patient Safety*  
*Denver, CO*

## LONG-TERM FOLLOW-UP OF PHYSICIAN HEALTH PROGRAM PARTICIPANTS: AN ONGOING STUDY

Robert L. DuPont, MD, Scott Hambleton, MD, Lisa J. Merlo, PhD, and Gregory E. Skipper, MD, led a panel discussion on an ongoing study of physicians who successfully completed substance abuse contracts with physician health programs five years ago or longer.

The historic Blueprint Study, of which Dr. DuPont served as co-investigator, demonstrated that PHPs set the standard for long-term successful outcomes while physicians are under supervision of the program. The new follow-up study asks: How do physicians who successfully complete substance use disorder contracts describe their lives after PHP participation? What elements of the PHP experience do participants view as most helpful? What elements are viewed as least helpful?

Researchers developed an online, anonymous self-report survey to assess a variety of topics, including physicians’ opinions of the services provided by PHP care management, what elements of the PHP were most helpful and least helpful to their recovery, participation in 12-Step and other

community support programs since PHP completion, and their use of any alcohol or drugs since PHP completion.

PHPs engaged in the study identify physicians who completed contracts on or before January 1, 2007. Using scripts, the PHPs contact eligible physicians and make brief follow-up calls to confirm survey completion. PHP staff complete log sheets that track the number of physicians they attempted to contact and to provide basic demographic data about physicians who were invited but declined to participate in the study. Thus far, most physicians who have been contacted have been eager to provide feedback on their experiences.

Researchers hypothesize that the effects of the PHP care management are positive and long lasting for successful program completers — that physicians will report strongly positive experiences with the PHP care management, that most will continue to have good results long after monitoring has ended, including high rates of participation in 12-Step programs and low rates of self-reported drug and alcohol use.

Initial data collected from 77 physicians are encouraging. The large majority (97.2%) of respondents currently consider themselves to be in recovery. Many report participation in 12-Step meetings: 91.7% report meeting attendance since completing their contract and 68% report past year attendance. Attendance at 12-Step meetings and formal substance use disorder treatment were rated as the most valuable aspects of the PHP care management; whereas, the least valuable aspects include “none” (all aspects were valuable), worksite monitoring, and Caduceus meetings. This sample of successful PHP completers self-reported very low rates of substance use following contract completion: 80.6% of respondents reported no use of alcohol and 94.4% reported no use of drugs at any time since completing their PHP contracts. More data are needed to evaluate whether these results are representative of the population as a whole.

Interested PHPs are encouraged to participate in the study so that extensive data can be collected on the experiences and perceptions of successful PHP completers. These data can be used to support and inform the field of addiction medicine. This unfunded study has the potential to directly benefit all PHPs because it specifically focuses on physicians who were successful under PHP monitoring. Identifying what aspects of the PHP experience particularly helped or hindered this group has implications for all participants.

To learn more about this ongoing PHP follow-up study contact Corinne Shea at the Institute of Behavior and Health, Inc. at [corinne.shea@ibhinc.org](mailto:corinne.shea@ibhinc.org).

— *Scott Hambleton, MD; Robert L. DuPont, MD; Lisa J. Merlo, PhD, MPE; and Gregory Skipper, MD*

SATURDAY, APRIL 20, 2013

## FSPHP AND FSMB JOINT SESSION — AGING AND MISBEHAVING: TWO SPECIAL TOPICS IN PHYSICIAN HEALTH

*In this panel-style session with the Federation of State Physician Health Programs (FSPHP), participants gained an understanding of the role physician health programs play in assisting with aging and disruptive practitioners.*

On April 20, 2013, representatives from the Federation of State Physician Health Program (FSPHP) were invited to speak about “Aging and Misbehaving,” two contemporary topics of interest to our colleagues at the Federation of State Medical Boards (FSMB). Lance Talmage, MD, current chair of the FSMB, introduced Drs. Gundersen, Pendergast, and Kaufmann, panel members who addressed the challenges related to an aging physician population and complaints of disruptive behavior in medical workplaces, clinics, and hospitals alike.

Dr. Pendergast opened with an overview of physician health programs’ functions, referral types, governance, and funding services. He included statistics provided by the FSPHP member programs in these areas.

Dr. Gundersen cited a national census of actively licensed physicians that revealed 23 percent of this demographic are 60 years of age or more. She noted that, while traditionally physicians have enjoyed long careers influenced by the personal identity and professional satisfaction associated with practicing medicine, in recent times, practical considerations have influence the length of a physician’s career. With the backdrop of a recent and protracted economic recession, 52 percent of physicians changed their retirement plans. Some elected not to retire and others reentered the physician workforce for financial reasons. Dr. Gundersen observed, “With full implementation of the Affordable Care Act (ACA), the demand for physician services will grow, not diminish.”

Dr. Gundersen noted that like pilots, physicians belong to a safety-sensitive profession requiring similar sensory and motor skills coupled with the ability to make rapid decisions in stressful situations. Unlike pilots, no mandates exist for age-related medical and cognitive screening for physicians. She expressed concern that in the absence of a thoughtful and evidence-based process, some physicians may opt out of practicing medicine altogether rather than submit to mandatory cognitive testing. Dr. Gundersen noted that identifying impairment through patient driven complaints (i.e., after harm has likely occurred and when physician discipline is likely to



Warren Pendergast, MD, FSPHP President; Michael “Mick” Oreskovich, MD, PPC Co-Chair; Jeffrey Selzer, MD, NY PHP; and Michael Kauffmann, MD, Ontario PHP

result) is not the ideal standard for protecting the public. She emphasized that a proactive confidential process should be developed to allow for the early detection of cognitive illness, expedient treatment as well as a thoughtful fitness-for-duty evaluation.

Dr. Gundersen encouraged a collaborative effort between cognitive specialists, physician health programs, medical boards, and certifying boards to develop a thoughtful process for assuring public safety without imposing unnecessary or discriminatory restrictions on older physicians. “Physicians with decades of experience and contribution deserve the same sensitivity and respect afforded their patients as they experience health changes that may or may not allow continued clinical practice.”

She concluded that in the end, competent practice rather than age-adjusted performance needs to be the standard.

— *Doris C. Gundersen, MD*  
*Colorado Physician Health Program*  
*Denver, CO*

## PART II OF JOINT SESSION “MISBEHAVING”

It’s likely that (some) doctors have always been challenged with respect to maintaining respectful workplace behavior, but today it is known that physician behavior in the workplace that is disruptive to others does compromise patient safety and is much less tolerated.

In the experience of the Ontario PHP, as elsewhere, many physician leaders and workplaces struggling to address this issue turn to their local PHP for help and support. We’ve learned that using the familiar paradigm of helping a distressed, ill, or impaired physician through appropriate treatment and monitoring is insufficient in workplace disruption cases. We find that it’s better to use a systems paradigm — treating both doctor and workplace as clients, and use a staged, rational, and multilateral approach to problem-solving and behavioral rehabilitation.

We have also learned that systems and workplaces have problems that interact with the physician’s behavior, which are important issues to understand as well. To that end, we developed an approach that engages both doctor and workplace with a new, cost-recovery service called the Physician Workplace Support Program. To date, we have had over 200 inquires about our new case management service and have provided assessments for over 50 physician/workplace systems.

It is still a challenging task to provide thoughtful, thorough, palatable, and effective support for these systems, but we have observed that behavioral change and workplace support are attainable. That said, we recommend that PHPs generally use a robust approach when dealing

with this problem category to achieve the best possible results with the lowest possible burden to PHP staff and programming. — *Michael Kaufmann, MD*

## SUBSTANCE ABUSE MONITORING OF PHYSICIANS

Dr. Kaufmann presented his program’s experience with substance abuse and substance dependence monitoring. The key objectives of the talk revealed that:

- Substance abuse monitoring makes sense when it is not possible, or when there is uncertainty, regarding diagnosing substance dependence.
- Substance dependence monitoring should be reserved for individuals who have been diagnosed with substance dependence.
- It is possible to introduce low-risk use of alcohol for selected individuals diagnosed with substance abuse (not dependence) while being monitored, which increased diagnostic sensitivity for alcohol dependence and, in our experience, does not threaten patient safety.

— *Michael Kaufmann, MD; Cynthia MacWilliams, MBA; Ann Davidson, MSW; and Sherry Klein, MA; Ontario Medical Association Physician Health Program*  
*Toronto, Ontario*

## WHAT AILS PHYSICIANS TODAY

With globalization and the transitions from the old ways of doing business to the new — the 21st century poses challenges to all professions.

This is especially true of physicians in the United States, which is making momentous changes in an already complex health care system.

Given the unique nature of what physicians do, we are often under particular stress — and at great risk for increased physical and mental health issues.

For instance, studies have shown for years that physicians experience a higher rate of depression than the general public. U.S. physicians also suffer burnout more than other American workers.

At the AMA, we believe physicians need better stress-management training and more emphasis on forging a positive work-life balance and improved practice efficiency.

We know that if a physician adopts a healthier lifestyle — be it increased physical activity, eating better, losing weight, not smoking, and/or limiting alcohol intake, they will be more likely to raise these issues with patients when they are doing the history and physical.



So for the sake of ourselves and our patients, let's be good role models.

At the AMA, we've offered physicians a blueprint for this, *AMA Healthier Life Steps: A Physicians Guide to Personal Health*, a toolkit that focuses on physical health.

This AMA initiative includes a timeline for physician health screenings, plus action plans to kick-start healthier eating, increased physical activity, reduced risky drinking, and smoking cessation.

One more issue I'd like to expand on is the impact of the medical profession itself — payment and delivery systems, for instance — on physician stress.

We recently announced a new strategic focus for the organization that aims to improve health outcomes, accelerate change in medical education and to enhance professional satisfaction by helping physicians shape emerging payment and delivery systems.

In both the public and private sectors, there's a consensus that current payment and delivery models no longer meet the needs of physicians and patients.

So the AMA is analyzing the full spectrum of health care models to identify the factors most critical to physician and patient satisfaction.

In collaboration with the Rand Corporation, we're conducting in-depth field research at approximately 30 diverse physician practices in six states.

We'll leverage our findings to create tools and resources you can use to not just survive, but to thrive in the changing practice environment.

For example, we'll identify which models promote practice satisfaction and sustainability. And we'll create case studies that highlight critical factors for success, as well as any potential tradeoffs involved.

We'll use our research to advocate for changes in the larger health care environment, such as removing regulatory barriers, changing how hospitals view success, and leveling the playing field with health insurers.

In short, we're going to do everything within our power to put the joy back in medicine and help physicians do what you do best — care for patients.

— *Jeremy A. Lazarus, MD*  
*President*  
*American Medical Association*



Scott Alberti, FSPHP Membership Co-Chair; Lynn Hanks, MD, Past-President; Warren Pendergast, MD, President; and Daniel O'Neill, MD

## PHYSICIAN HEALTH SUPPORT GROUP SURVEY

This past year, the committee worked on a survey to the physician health support group attendees. In addition to the committee members, Diana Barnes Blood, LICSW, and Fredrick Arnstein, PhD, assisted in the work of this project. PHS extends a special acknowledgement to them for their work.

PHS has provided physician support groups to physicians and medical students who can benefit from such support for many years. In addition to addiction support groups, PHS has sponsored a physician health support group, which addresses difficulties in practicing medicine. Given the success of this group for the past decade, PHS conducted a survey of members and former members to more objectively determine how the group is regarded by the participants.

The survey questionnaire focused on the group process itself and its effect on the outcomes of practicing medicine, as well. In contrast to the addiction-based groups, this group is led by a facilitator who interviews prospective members and actively guides the group process. Questions were also asked regarding the role of the facilitator.

The survey results were positive and encouraging overall. A total of 72% of respondents felt quite positive about the group process and experience, while 86% rated the facilitator as helpful.

Outcomes were measured in four areas: family and friends, wellness, professional relationships, and career. A full 67% experienced positive impacts in all or some of the areas, and 26% felt there was no discernible impact.

Many comments described the supportive nature of the group, such as the strains and discouragements of practicing medicine, personal and family concerns, lawsuits, and licensing board disciplinary actions. There were many positive comments regarding the style and role of the facilitator.

In addition to the overall positive response of the group members, there were three important correlations.

- The positively viewed process of the group correlates with later positive outcomes in the four areas mentioned.
- The facilitator's role had the most positive impact on positive outcomes.
- The more sessions attended (at least eight) led to more positive opinions as to the group experience and outcomes in personal and professional lives.

PHS is thankful to the group members who participated in the survey. The results will continue to be reviewed to assist in ensuring that the support group is beneficial to physicians now and in the future.

Other areas of future interest include studying the results of PHS random drug screening and updating previously published PHS outcome studies. — *Luis T. Sanchez, MD*



Vermont PHP Representatives: Colleen Magne, Program Administrator; Suzanne Parker, MD, Medical Director; George "Skip" Linton, MD, Program Chair

## THE IMPORTANCE OF PHYSICIAN HEALTH PROGRAMS; THE WEST VIRGINIA EXPERIENCE IN THE FIRST 5 YEARS

The West Virginia Medical Professionals Health Program (WVMPHP) has been operational for five years, and graduated its first participant on November 27, 2012. The WVMPHP continues to be the only physician health program recognized by the WV Board of Medicine and the WV Board of Osteopathic Medicine. The WVMPHP has provided 74 educational lectures for an excess of 4,500+ physicians, hospitals, medical staffs, medical societies, students, and residents since its inception. Funding has been from a multitude of sources, primarily licensure board and participant fees, but remains a considerable concern for long-term viability.

To date, there have been 111-signed participants of whom 68 continue under agreements impacting hospitals/medical schools and group practices. This represents well over 100% growth rate; showing 90% abstinence. Approximately 20% of active participants are students and residents in training. Of the 43 no longer participating with the WVMPHP (111–68), 60% were for evaluation or graduated a 6- to 12-month zero tolerance diagnostic Letter of Understanding (LOU). The remainder retired, were lost to follow-up, relocated, or were disabled.

Forty-one percent (41%) of all signed participants were referred by licensure boards formally or informally. Ninety percent (90%) of all participants (111) and active participants (68) participated through a Continuing Recovery Care Agreement (CRCA) due to addictive illness. The remainder participates, as result of psychiatric illness, under a Mental Health Recovery Care Agreement (MHRCA). For those completing treatment and under contract, resumed working, remained licensed, and practicing medicine safely; 90% have remained abstinent.

Among active participants, the most common specialties are family practice 19%; emergency medicine 9%; internal medicine 9%; general surgery 9%, radiology 9% and anesthesia 7%. Eighty-two percent (82%) of current active participants have continued, or been returned, to work. Fifty percent (50%) of all participants had previous qualifying illness-related issues prior to the WVMPHP's existence; recurrence further supports the need of the WVMPHP's long-term availability, assistance, guidance, and monitoring.

During initial evaluation, some were found to have some type of impairment — most of which were resolved with treatment. Many detected impairments were unrelated to their original issues leading to participation with a few individuals having residual impairment due to the “qualifying condition of participation” (mental illness or

substance use disorder) or other unrelated physical disorders. These initial and permanent impairments may not have been detected had they not sought the assistance of or been referred to the WVMPHP.

As you can see, WV Medical Professionals Health Program is fulfilling its mission of protecting the public and providing a mechanism for the successful rehabilitation of the sick physician and return to the safe monitored practice of medicine, to the benefit of the public and physicians themselves. West Virginia has created a safe system with the underlying principles of communication, collaboration, transparency, and accountability to the benefit of all. In order for stable ongoing funding and long-term program viability, the continued support of organized medicine, regulatory agencies, the health care community, the FSPHP and treatment professionals is necessary and greatly appreciated.

— *P. Bradley Hall, MD, DABAM, FASAM*  
*Executive Medical Director, WVMPHP*  
*Bridgeport, W.VA*

## REMEDICATION OF POOR PROFESSIONAL BEHAVIORS AMONG PRACTICING PHYSICIANS

Professionalism is the cornerstone of medicine, yet some practicing physicians have lapses in their professional behavior. Physicians learn professionalism through personal values and upbringing, professional role models, through practice during residency and through formal instruction of foundational professional ethics. Data from the 2012 Medical Student Graduate Questionnaire was presented to highlight that poor professional behavior is being modeled and learned early in training. Nationally, 34% of medical students reported experiences public humiliation during medical school, 16% heard offensive sexist remarks, 9% were required to perform personal services, 2% were physically harmed, 2% threatened with physical harm, and <1% were allowed to exchange sex for grades. Approximately, half of these negative interactions came from attending physicians and half from residents who had already learned these poor behaviors as medical students.

Poor professional behaviors were categorized into aggressive, passive and passive aggressive. Aggressive behavior included angry outbursts, disrespectful language, throwing objects, intimidation behavior, physical aggression and harassment. Passive behavior include chronically late, not responding to phone calls or pages, not completing tasks, avoiding meetings, non participation, and passive aggressive behaviors include derogatory comments, complaining, blaming, and refusal to work.

Such poor professional behaviors are the cause of 50% of surgical operating room errors and 30% of obstetrics errors, and result in poor patient satisfaction, increased health care costs, decreased institutional reputation and increased staff turnover.

The audience was divided into four small groups to discuss prepared scenarios:

Dr. A — late to work, incomplete charts with concerns regarding accuracy and thoroughness; Dr. B — self-prescribing opioids and benzodiazepines, by forging partner's signature; Dr. C — angry outbursts, intimidating behavior, harming others who refuse to report the incidents; Dr. D — sexual relationships with patients. Participants in the group were asked to discuss how they would remediate the physician in their given scenario. After the small group discussions, each group presented their ideas and experiences for the general audience.

In summary, poor professional behavior is best remediated if the identification of poor professional behavior and subsequent remediation plan are just, a cause of the behavior is identified, and the remediation plan contains three elements: deliberate practice, receive feedback, and reflection in action. Techniques for remediation included referral to PHP and substance use treatment centers, interpersonal skills coaches, referenced feedback, self-assessments, root cause analysis of problems to identify triggers in environments, probation, attendance at boot camps, mock pages, role plays, and mentors. The articles Goulet *J Cont Educ Health Prof* 2007;27(1):42–48 and Papadakis *Acad Med* 2012;87(12):1694–8 were discussed.

Poor professional behaviors diminish patient care and workplace environment and spreads generationally. There are multiple techniques for remediating poor professional behavior, but must include just actions, identification of cause, and the triad of practice, feedback, and self-reflection. The early research discussed is incomplete yet serves as a catalyst for more research on remedial techniques.

More information about the remediation of all medical competencies is available in the moderator's book "Remediation of the Struggling Medical Learner."

— *Jeannette Guerrasio, MD*

*Hospital Medicine*

*Associate Professor of Medicine*

*Consultant*

*University of Colorado School of Medicine*

## EXPLORING THE RELIABILITY, FREQUENCY, AND METHODS OF DRUG TESTING: WHAT IS ENOUGH TO ENSURE COMPLIANCE?

*Dr. Greg Skipper followed Dr. Brown in discussing drug testing issues during a plenary session at the 2013 FSPHP meeting. Dr. Skipper focused on Alcohol Markers and Devices.*

A recent survey of all 46 state physician health programs regarding alcohol markers revealed that currently all programs utilize urine ethylglucuronide (EtG) testing, 85% utilize ethylsulfate testing and 76% utilize blood phosphatidylethanol (PEth) testing. The states that utilize PEth testing find it useful in identifying participants who have been drinking and mostly rely on admission of drinking following a positive PEth test to confirm drinking. Dr. Skipper emphasized that no drug test is perfect; therefore a positive test should not be solely relied upon on to confirm use. If use is denied then further evaluation and/or continued enhanced monitoring should be considered.

EtG and EtS are similar markers with similar characteristics and windows of detection. EtS is primarily of value because it is not vulnerable to degradation by bacteria and cannot be created by bacteria, as can EtG. Dr. Skipper explained that EtG or EtS can be positive from extraneous exposure to alcohol in food, hygiene products, hand gel, etc., particularly if the exposure is two to four hours prior to sample collection, because that is when EtG and EtS peak. Therefore, it's important to advise participants to particularly avoid any exposure to extraneous alcohol on the day of testing. EtG and EtS at currently used cutoffs are not particularly sensitive for detecting small amounts of drinking the next day but can be positive to tiny amounts of extraneous exposure two to four hours prior to sample collection. Dr. Skipper described one study (Wojcik and Hawthorne, 2007) that administered one to six drinks to 19 subjects and showed that all EtG tests were negative by 48 hours and one to two drinks were not detected at 24 hours.

Dr. Skipper described how EtG/EtS testing can be effectively used in conjunction with PEth testing, since PEth remains present for up to three weeks following binge drinking and is not prone to positives from smaller amounts of extraneous exposure to alcohol. Therefore if EtG and/or EtS are positive and drinking is denied a PEth test can be obtained and if positive highly suggests binge drinking over the previous weeks. Dr. Skipper described a report that will soon be published (Skipper and Wurst, 2013) describing the effectiveness of using EtG and PEth in combination in this manner to document drinking.

Dr. Skipper described new photo cellular breathalyzers (PCB) that take a photo of the participants face as they blow in the breathalyzer and transmit their image and the breath alcohol level to a website. A pilot study will soon be

published that demonstrated the superiority of the PCB to standard random weekly EtG testing. In that pilot study 12 social drinkers volunteered to blow in the PCB four times daily and to submit weekly random samples for EtG testing for five weeks. Of 84 drinking episodes all were detected by PCB and only one was detected by random EtG testing. There are several models of PCBs on the market. Dr. Skipper predicts that use of a portable PCB will replace random EtG or EtS testing in the near future because of its real-time detection and superior sensitivity and specificity.

— *Martha E. Brown, MD, Judy Rivenbark, MD, and Gregory Skipper, MD*  
*Professionals Treatment at Promises*  
*Los Angeles, CA*

**SUNDAY, APRIL 21, 2013**

## THE LEGALIZATION OF MARIJUANA

### ***Collaboration between Physician Health Programs and Regulatory Bodies in Policy Development to Promote Public Safety***

On April 21, 2013, a panel presentation was made at the Federation of State Physician Health Programs' (FSPHP's) annual meeting concerning medical marijuana, as well as issues pertaining to the legalization of marijuana for recreational use in several states — most recently Colorado and Washington. The participants included Maureen Dinnan, JD, and executive director for Connecticut's Health Assistance Intervention and Education Network (HAVEN), James Broadhurst, MD, a family practice physician with added qualifications in addiction medicine who is affiliated with the UMass Memorial Medical Group in Massachusetts, and Doris C. Gundersen, MD, medical director of the Colorado Physician Health Program (CPHP).

The panelists discussed their experiences contending with recent legislation regarding the medicinal use of marijuana. Dr. Broadhurst discussed problems associated with the medicalization of marijuana, including the fact that it has bypassed the Food and Drug Administration's (FDA's) customary process of evidence-based testing of potential medicines for efficacy and safety. He noted that the definition of "debilitating medical condition" in his state, as well as others, offered diagnoses of such broad scope as to be clinically useless. He also commented on the easy diversion of medical marijuana, noting that data on teenagers in active treatment for marijuana addiction frequently reported obtaining marijuana from individuals who were legally certified to be in possession of marijuana for diagnosed debilitating conditions.

Maureen Dinnan shared data from several states regarding how proponents of the legalization of marijuana, for medicinal purposes and/or recreational use strategized in their legislative efforts. She reviewed a policy established at the HAVEN explicitly prohibiting the practice of medicine for those physicians using marijuana for debilitating medical conditions.

Dr. Gundersen reviewed Colorado's history with both the legalization of marijuana for medical purposes and subsequently recreational use. She reviewed information concerning physicians who were making recommendations for medical marijuana, a relatively small demographic (about 7% of practicing physicians in Colorado) who identified "severe pain" as a qualifying diagnosis in 94% of the patients they certified. She reported that CPHP also developed a policy, in consultation with the Colorado Medical Board (CMB) and Attorney General's office, which requires physicians to cease practicing while using marijuana for a debilitating condition.

All panelists expressed concern about the increased acceptability and perceived safety of marijuana by the public and the risk to public safety, particularly given the known cognitive impairment associated with regular use of marijuana. The fact that marijuana remains illegal under federal law and that physicians using marijuana may face unanticipated professional consequences, including risking participation in federally funded



Maureen Dinnan, Esq., FSPHP Board Member, with Dr. Pendergast



From the East: Lani Graham, MD, and Cathryn Stratton

programs, such as Medicare, was emphasized. Finally, panelist encouraged members of the audience to be proactive in their states and with their individual physician health programs in addressing new legislation proposed for the legalization of marijuana.

— *Doris C. Gundersen, MD*  
*Colorado Physician Health Program*  
*Denver, CO*

## PROFESSIONALISM AND PEER SUPPORT

The Center for Professionalism and Peer Support (CPPS) at Brigham and Women's Hospital (BWH) is dedicated to supporting and promoting a culture that values mutual respect, trust, and teamwork. We pursue this goal through five key initiatives: (1) strengthening a culture of professionalism, (2) establishing a network for peer support, (3) enhancing the disclosure process, (4) providing defendant support, and (5) collaborating on wellness programs. Dr. Shapiro's talk at the 2013 FSPHP Annual Education Conference focused primarily on this first of these: the CPPS professionalism initiative.

There is growing recognition that an environment in which professionalism is not embraced, or where expectations of acceptable behaviors are not clear and enforced, can result in medical errors, adverse events, and unsafe work conditions. Such environments also understandably contribute to stress, depression, and burnout. The BWH CPPS has developed a three-tiered approach to support a

culture of professionalism that encompasses prevention, identification, and remediation. Our prevention arm involves a mandatory professionalism-training program. To address the identification and remediation of professionalism lapses we have developed a confidential, centralized, clear, and expedient system that accessible to all staff.

Dr. Shapiro used the fictional "Dr. Dismissive" (Dr. D) to demonstrate how this part of the CPPS professionalism program works. Dr. D is a surgeon who is described by patients as arrogant, dismissive, and insensitive. In addition, various members of the anesthesia team report that Dr. D can be demeaning and hostile, blaming them for not moving the cases along fast enough.

Upon hearing the report of his problematic behavior, the CPPS director or associate director conduct multisource interviews to discretely determine the validity of the claims as well as any potentially exacerbating issues. Next, the anonymous findings are presented to Dr. D, explicitly defining expectations for corrected behavior, outlining a monitoring process, and stating the consequences of not adhering to the professional behaviors. The institution's unwillingness to tolerate any form of retaliation is also very explicitly stated. After a few months, another series of more limited interviews are performed to determine if progress has been made; additional meetings and consequences may result from these interviews.

Resources for supporting behavior change include professional behavioral coaching, intensive anger management or conflict resolution programs, and occasionally

professional evaluations. The CPPS has also developed a peer support program that is designed to support clinicians in times of stress, such as caring for trauma victims, having been involved in an adverse event or error, or being named in a lawsuit.

We recognize that some degree of unprofessional behavior can be rooted in an institutional culture that tacitly condones such behavior and/or discourages acknowledging and reporting it. Ultimately an institutional culture change is required in order to strengthen and support a culture of trust and mutual respect for individuals, teams, the institution, and patients, and their families.

— *Jo Shapiro, MD*

*Director, Center for Professionalism and Peer Support  
Chief, Division of Otolaryngology  
Brigham and Women's Hospital*

## TREATMENT OF TRAUMA IN HEALTH CARE PROVIDERS

Post-traumatic stress disorder (PTSD) is an anxiety disorder that may occur after exposure to a traumatic event(s). In order to meet DSM-IV-TR criteria for PTSD, a person must have witnessed an actual or threatened event that could result in injury or death to oneself or others, and

the person has experienced fear, helplessness, or horror. Common symptoms of PTSD include intrusive recollection, physiologic response or upset with recall, emotional avoidance or numbing, and hyper-arousal symptoms. Physiologic changes occur in the brain and in the autonomic arousal systems that have been elucidated using animal and human studies using functional imaging. PTSD has an 8% lifetime prevalence in adults (DSM-IV-TR). The National Comorbidity Study (1994) found that 52% of people diagnosed with a lifetime history of PTSD were also diagnosed with alcohol abuse or dependence, two times more often than adults with no history of PTSD. Thirty-five percent (35%) of people who had a lifetime diagnosis of PTSD were also diagnosed with drug abuse or dependence, three times more than adults with no history of PTSD. In 2000 nearly two-thirds of men and women seeking substance abuse treatment reported a lifetime history of trauma exposure (CSAT, 2000). Over the last two years, 12% of physicians entering chemical dependency treatment at Hazelden Springbrook have endorsed a history of trauma and 9% of the physicians met criteria for PTSD. There are conflicting findings about the risk of developing PTSD for health care providers working with trauma patients. A documented prevalence rate for PTSD in family physicians present during the Balkan war was 18% and for Balkan war refugees PTSD rates were 45 to 75%. Prevalence rates for PTSD in physicians working



From the West: Michael Ramirez, MS; Harry Haroutunian; and John Southworth

during the Gaza war was 16% and the data from studies of these physicians suggested that the physicians working during the war were at increased risk for developing PTSD if they had a personal exposure to trauma. Comorbid substance abuse with PTSD is associated with greater symptom severity, worse treatment outcomes, and increased medical/legal problems, than with PTSD alone (Najavits et al., 1998). In the past, treatment of comorbid substance abuse/dependence and PTSD were treated separately, but we now know there are better outcomes if both disorders are treated concurrently. The best studied and empirically validated psychological treatments for PTSD include Seeking Safety, Cognitive Processing Therapy (CPT), and Prolonged Exposure. Seeking Safety is a treatment that addresses both trauma and substance abuse, focusing on development of skills around safety for both disorders. There is also some data available for therapies such as Eye Movement Desensitization and Reprocessing (EMDR). The best data for medication therapies for PTSD-related anxiety and depression include the SSRIs such as the FDA-approved Paxil and Zoloft and the NSRIs with data for Effexor. There is also very strong evidence that prazosin (Minipress) can be very helpful for treatment of sleep disruption and nightmares commonly associated with PTSD.

— *Laura Ferguson MD*  
*Addiction Psychiatry, Medical Director*  
*Hazelden Springbrook*

**MONDAY, APRIL 22, 2013**

## **SEXUAL BOUNDARIES IN MEDICINE: CAN WE DO ANYTHING AT THIS POINT?**

The workshop offered an opportunity to review the impact social, professional, and personal boundaries have on the current practice of medicine. These experiences require self-awareness and self-monitoring throughout one's career and sensitivity to the life cycle and cultural influences of all involved in health care service delivery. Complementary, inclusive, and conflicting perspectives were presented that inform current definitions of professionalism and sexuality. It was stressed that medicine is not immune to the rapid changes and expectations. In fact, physician health programs are positioned to offer guidance in adaptation of the new DSM-V criteria for sexual disorders.

Ethical standards both national and international guided the discussion, which included risk factors associated with patients who have been victimized within the health care system. This offered an opportunity to review and consider interventions for healthy boundaries. The participants

gathered in small groups to discuss boundaries in medicine across time, which added to the already rich dialogue. Current fears and failures of cases contributed to the complex nature of this dynamic topic that appears illusive at times. However, physicians with sexual boundary problems rely on PHPs to understand their needs and licensing boards expect PHPs to have at least a fundamental knowledge of risk assessment, treatment modalities, and monitoring strategies. These expectations can create stress for PHP directors and staff especially with the potential for relapse and increased media coverage of "sex in medicine." Also, this workshop allowed participants to learn how a multimodal approach can inform their assessment and monitoring over time, as well as how their formulations and decision making could benefit from a process of "matching" physicians' needs with interventions.

Finally, the psychology of the educated professional concept was included to assist in the understanding of predisposing vulnerabilities and maintenance for aberrant sexual behaviors was presented for discussion. This segment of the workshop explored how the very skills, training, and personality traits that typically generate professional success can also be a set up for destruction, professionally and personally. The evolution and process of one's sexual ethics, which represents their internal rules to follow and an inner core of integrity that stems from an awareness of self and others was presented in the context of numerous case examples for application and discussion.

— *Philip Hemphill, PhD*  
*Professional Enhancement Program at Pine Grove*  
*Hattiesburg, MS*

— *James (Jes) Montgomery, MD*  
*Gentle Path at Pine Grove*  
*Hattiesburg, MS*

## **PERFORMANCE MANAGEMENT AND QUALITY IMPROVEMENT FOR PROFESSIONALS' MONITORING PROGRAMS**

Physician health programs have been criticized as having inadequate oversight, a lack of objective standards for operation, and inadequate systems for assessment and improvement of quality of services provided to participants, stakeholders, and the general public. The Virginia Health Practitioners' Monitoring Program (HPMP) is operated by the Division of Addiction Psychiatry, Department of Psychiatry, Virginia Commonwealth University, under a memorandum of agreement with the Virginia Department of Health Professions. HPMP has employed Performance Management and Quality



Improvement (PMQI) approaches to assessing adherence to our mission and improvement of the quality of services provided to our participants, as well as to the boards, health care institutions, treatment providers, and the general public. The approaches include internal auditing and peer review systems; group and individual clinical supervision of case managers; and use of Project Action Teams that consist of several staff members who work together on addressing specific program areas in need of performance improvement. This presentation presented an overview of HPMP's PMQI activities, outcomes, and goals for the future, followed by questions and discussion. We explored how monitoring programs can utilize multiple auditing processes, including external consulting and auditing, case reviews, peer review and clinical supervision, as approaches to quality improvement.

— *Penelope P. Ziegler, MD, and Janet Knisley, PhD*  
*Virginia Health Practitioners' Monitoring Program*  
*Richmond, VA*

## UNDERSTANDING THE IMPLICATIONS OF CONDUCTING A BASIC COGNITIVE/INTELLECTUAL ASSESSMENT ON PHYSICIANS SEEKING PROFESSIONAL ASSESSMENT

Doctors facing professional assessment related to concerns of problematic behaviors, such as drug and alcohol use, sexual boundary issues, and disruptive behavior, deserve to have the most comprehensive assessment to best understand their psychological, emotional, and cognitive makeup. It cannot be assumed that doctors have the cognitive functioning skills that their jobs require. Many physicians facing assessment have difficulties in domains that require further analysis or could help to explain their difficulties. It is important to consider small head injuries, heart surgeries, or other potentially impacting issues on cognitive functioning when initial history is given. It is well understood that use of drugs and alcohol can have an impact on cognitive functions and reasoning ability. Further, many other medical issues or psychological concerns can have an impact on intellectual functioning. These issues and their resultant effects on a doctor's thinking can be easily missed if a basic assessment of cognitive functioning is not conducted. A small-scale retrospective study of physicians who were given the Wechsler Adult Intelligence Scale-IV (WAIS-IV) was conducted. The WAIS-IV is a basic cognitive assessment that aids in understanding a client's abilities across verbal, perceptual, memory, and processing speed domains. This assessment, as part of a whole psychological battery, can aid in understanding a client's



**Bradly Hall, MD, FSPHP Board Member and Membership Co-Chair, and Lynn Hanks, MD, Past President**

strengths and weaknesses. This can aid in the creation of treatment recommendations, illuminate further assessment needs, and lead to an improved understanding of a doctor's basic skill set. In this small study, 28 doctors WAIS scores were reviewed. Of those 28 doctors, 26 had significant discrepancies in their scores. This can indicate a need for further review of their strengths and weaknesses and reevaluation of their skill sets. Further, those two whose profiles did not show significant issues across the scores, scored in the average range of intelligence. This could assist in understanding a doctor's skill ability. It should also be noted that 18 of the 28 doctors had either a Full Scale IQ or Index scores in the Average or Low average range. Understanding a physician's capabilities can help them recognize their functional capacity as well as help them learn to use their strengths to bolster their weaknesses. Of those doctors whose scores demonstrated strong areas of strengths and weakness, 16 had discrepancies that only occur in 10% or less of the population. These significant concerns led to recommendations about how best to strategize about the type of therapy that would be most beneficial; recommendations about how to understand why a doctor can be easily overwhelmed due to concerns with processing or memory; recommendations about further testing which can lead to a better understanding of medical concerns and recommendations about how client's mental health may be impacting their thinking or decision making ability. Without this assessment, many concerns could be missed. As the data indicates in this small study



Penelope Ziegler, MD, FSPHP Board Member, with Dr. Pendergast

indicates, conducting these types of assessments can be a beginning to understanding much about a struggling physician's whole personality and emotional functioning, and begin to create an understanding of why a physician is presenting with concerns.

*For more information on the use of cognitive assessments in professional assessments, or to review the data mentioned, please contact Dr. Mary Deitch at the Keystone ECU at (800) 733-6840 or [mary.deitch@uhsinc.com](mailto:mary.deitch@uhsinc.com).*

— *Mary Deitch, JD, PsyD*  
*Keystone Center Extended Care Unit*  
*Professional Assessment Center*

## LESSONS LEARNED FROM THE PHYSICIAN HEALTH PROGRAMS (AND VICE VERSA): INTEGRATING CO-OCCURRING PAIN AND ADDICTION TREATMENT WITHIN PRIMARY CARE AT THE NEW MEXICO VA HEALTH SYSTEM

Physician Health Programs (PHPs) offer a chronic care model to treat addiction, including focused monitoring, early intervention, case management, and ongoing support for extended periods. A similar approach is

employed by primary care providers (PCPs) to treat other chronic illnesses such as hypertension, diabetes, and asthma. Although factors contributing to the success of PHPs, including low relapse rates, low drop-out rates, and high return to practice rates are not easily reproduced (higher socio-economic status and intense initial residential programs), many of the monitoring procedures such as regular outpatient visits, contracts, urine toxicology screening, and aggressive management of relapses can be employed effectively by addiction treatment providers in other settings. The Co-occurring Disorders Clinic (CODC) is a unique treatment setting embedded within the Primary Care Clinics of the VA Medical Center in Albuquerque, New Mexico that utilized monitoring procedures developed by Virginia's Health Practitioners' Intervention Program. The clinic was established in 2009 to manage and treat patients with co-morbid pain and addiction. Patients include those with high-risk opioid dependency, prescription and illicit drug and alcohol use disorders, and high dose or complex regimens. The clinic manages patients utilizing monitoring methodology, including comprehensive assessment, contracting, frequent office visits, and urine toxicology screening. Buprenorphine/naloxone therapy is offered to patients with opioid dependency. Between June 2009 and November 2011, 143 patients were induced with buprenorphine/naloxone and 93 of these patients are continuing treatment with buprenorphine (65% retention rate). Furthermore, the pain scores pre- (6.39, 95% CI 6.2–6.6) and post- (5.6, 95% CI 5.4–5.8) induction with buprenorphine show a modest but statistically significant improvement. Co-morbid condition prevalence, concurrent treatment and monitoring, CODC operation, and buprenorphine induction and maintenance dosing was presented. Since the care provided by the CODC is not widely available to patients and providers in rural areas of New Mexico and surrounding states (a situation confronting many PHPs), the clinic provides tele-health to patients but more importantly to providers in remote areas. The clinic staff directs project Specialty Care Access Network (SCAN), modeled after the successful Project ECHO (Extension for Community Health Outcomes), a University of New Mexico effort and internationally recognized program that utilizes telemedicine to train rural (PCPs) to deliver specialty care. The program uses case-based training and didactic sessions to increase the skill level and confidence of the PCPs with the goal of gradually transferring the responsibility for providing complex care from specialist to PCPs. In March 2012, the first SCAN Veterans Administration eight-hour Buprenorphine training led to the training of 22 new providers. This technology and tele-health program would be ideal for state PHPs to improve

outreach, consistency of monitoring, and care and enhance monitoring capability to state PHPs, particularly those serving large geographical areas and rural program participation.

The presentation will feature data from one of five 2012 SAMHSA OBOT Science and Service Awards and was published: Pade P, Cardon K, Hoffman R, Geppert C, "Prescription opioid abuse, chronic pain, and primary care: A Co-occurring Disorders Clinic in the chronic disease model," *Journal of Substance Abuse Treatment* (2012)43:446–450.

— *Patricia A. Pade, MD*

*Center for Dependency, Addiction, and Rehabilitation (CeDAR)*

*Assistant Professor*

*University of Colorado School of Medicine, Department of Family Medicine*

## FSPHP NEWSLETTER ADVERTISING INFORMATION AND SPECIFICATIONS

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We look forward to working with you in future editions.

### FSPHP Publication Committee

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## FSPHP ANNUAL MEETING LOCATIONS 2015 AND 2016:

The FSPHP leadership has reviewed meeting location options for 2015 and 2016.

It was decided to continue the valuable interactions and education that take place in conjunction with meetings that overlap in the same location as the Federation of State Medical Boards.

Therefore, the FSPHP will meeting in Fort Worth, Texas, in 2015 and San Diego, California, in 2016. The specific meeting dates and hotel property are yet to be determined.

Look for opportunities this upcoming year, at regional meetings and by way of a survey to share your preferences for future FSPHP meetings after 2016.

### SPECIFICATIONS

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3.125" w x 2.25" h

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#### QUESTIONS?

Please contact Linda Bresnahan at [lbresnahan@mms.org](mailto:lbresnahan@mms.org)



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## PHYSICIAN HEALTH AND OTHER RELATED ORGANIZATIONS' NATIONAL MEETINGS

### **FSPHP Annual Meeting**

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

### **FSMB Annual Meeting**

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

### **2013 Canadian Conference on Physician Health**

November 15–16, 2013  
Hyatt Regency Calgary Hotel  
Calgary, Alberta, Canada

### **2014 International Conference on Physician Health**

(Dates to come)  
London, England

### **American Academy of Addiction Psychiatry Annual Meeting and Symposium**

December 5–8, 2013  
Scottsdale Resort and  
Conference Center  
Scottsdale, AZ

### **AMA House of Delegates Annual Meeting**

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

June 6–10, 2015  
Hyatt Regency Chicago  
Chicago, IL

June 11–15, 2016  
Hyatt Regency Chicago  
Chicago, IL

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

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

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

### **AMA House of Delegates Interim Meeting**

November 16–19, 2013  
Gaylord National  
National Harbor, MD

November 8–11, 2014  
Hilton Anatole, Dallas, TX

November 14–17, 2015  
Atlanta Marriott Marquis  
Atlanta, GA

November 12–15, 2016  
Walt Disney World Swan/Dolphin,  
Orlando, FL

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

### **American Psychiatric Association Annual Meeting**

May 3–7, 2014  
New York, NY

### **American Society of Addiction Medicine**

April 10–13, 2014  
Orlando, FL

April 23–26, 2015  
Austin, TX

April 14–17, 2016  
Baltimore, MD

### **International Doctors in Alcoholics Anonymous (IDAA) Annual Meeting**

July 31–August 4, 2013  
Keystone Resort  
Keystone, CO