



PHYSICIAN HEALTH NEWS

The Official Newsletter of the Federation of State Physician Health Programs



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Welcome to the 20th 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 (associate) membership is \$100. We sincerely hope you respond as an indication of your commitment to a stronger, more cohesive Federation of State Physician Health Programs.

For more information on each of the membership categories, including new categories for organizational and individual members, please contact Debbie Brennan.

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MESSAGE FROM THE PRESIDENT

Twenty-Five Years: A Remarkable Journey!

As far back as 1958, formal efforts were made to address issues pertaining to physician illness and impairment. Historically, the Federation of State Medical Boards (FSMB) identified addiction among physicians as a disciplinary problem rather than a health problem, consistent with the belief that addiction was a moral failure, rather than the disease we know it is today. Ultimately, the FSMB called for the development of a model program to assist physicians through rehabilitation and protect the public by placing recovering physicians on probation to



Doris Gundersen, MD

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monitor their health. About 10 years later, the FSMB approved a resolution — another call to encourage the development of physician health programs (PHPs) nationwide.

The Sick Physician

In February 1973, the *Journal of the American Medical Association* published a landmark policy paper prepared by the AMA Council on Mental Health, “The Sick Physician: Impairment by Psychiatric Disorders, Including Alcoholism and Drug Dependence.” The council emphasized the ethical responsibility for a physician to address a colleague’s inability to practice medicine adequately due to physical or mental disorders, including alcohol and drug addiction. The article identified factors to overcome, including poor identification of illness, lack of knowledge or competence to intervene on an ill colleague’s behalf, and lastly, the “Conspiracy of Silence” that was prevalent in the medical field. The AMA publicly acknowledged the existence of physician impairment, providing a catalyst to address it in a timely fashion. In the early 1970s treatment programs specifically designed to treat addicted physicians emerged. Many of the thought leaders in this field were recovered physicians with a passion to help colleagues similarly afflicted.

PHPs Launch

In 1974, model legislation was developed that offered a therapeutic alternative to discipline related to physician illness. The AMA held a physician health conference in April 1975 and another in 1977, officially addressing the health problems physicians may be vulnerable to. A flurry of articles published in the late 1970s served to educate and raise awareness about physician addiction. By 1980, less than a decade after the AMA’s policy paper, all but 3 of 54 U.S. medical societies (of all states and jurisdictions) had either authorized or implemented “impaired” physician programs.

FSPHP Established

In 1990, the FSPHP was born out of a need for individual state programs to work together in discussing and promoting best practices, and especially to influence national public policy. The first annual meeting, following the development of bylaws, was attended by approximately 20 state PHP representatives. The FSPHP was very fortunate to receive assistance from the AMA in the form of a central office, plus staff and support services.

Over the next decade, the FSPHP annual meeting grew in popularity, content, and sophistication. Each year, friends and colleagues convened and shared program developments, new ideas, and wish lists. While lacking in uniformity from state to state, the members of the FSPHP worked hard to create clinical guidelines and other policies, derived mostly from collective clinical

experiences working with physicians, given the limited research on physician health.

The Joint Commission Standards on Physician Health

In 2001, the State PHP e-group formed, providing a platform for immediate consultation from the nation’s experts on physician health, an avenue for disseminating important contemporary clinical data, and a means to keep abreast of legislative and other changes impacting individual state PHPs. That same year, The Joint Commission (TJC) created a new Medical Staff Standard (2.6) requiring hospitals to separate disciplinary matters from those pertaining to a physician’s health status, an early effort to focus on assistance rather than punishment for ill or impaired physicians.

Another TJC standard, MS.11.01.01, pertaining to the health of licensed independent practitioners, came out in 2001. FSPHP had a voice with TJC on this standard. Before it was officially implemented, TJC agreed to permit PHPs to provide the “process” for meeting the standard. Rather than creating an in-house committee, hospitals were allowed to make direct referrals to PHPs if a physician developed or was suspected of having a health concern, thereby reducing the hospital’s burden and increasing confidentiality for the physician.

AMA Physician Health Policy

In 2004, the AMA House of Delegates adopted a physician health and wellness ethics policy, reinforcing “The Sick Physician” mandate: “To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, construed broadly as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress.” The policy stated that every physician should have a physician to avoid compromised objectivity. It appealed to physicians caring for colleagues to maintain strict confidentiality for their physician-patient and provide only the minimum amount of information as required by law or to preserve public safety be disclosed. This policy reinforced what the PHP community was striving to promote.

FSPHP and FSMB Collaboration

In 2005, the FSPHP celebrated its first joint session with the FSMB, paving the way for the development of a mutually respectful and interdependent relationship, as well as the realization that we have overlapping goals: physician health and public safety. The FSPHP was granted official “observer status” with the AMA, allowing FSPHP representation at the AMA’s House of Delegates meetings. While not able to cast votes, the FSPHP earned a new opportunity to offer opinions about proposed resolutions as well as improve our networking capacity. I believe this connection further strengthened our relationship with the

AMA and allowed cross-pollination of ideas to support physicians in an ever changing health care world.

FSPHP International Membership

As our organization grew and matured, it was important to have the ability to articulate our mission and respond to media inquiries. That year, the Public Policy Committee was established and we also created a new category of International Membership, establishing an even larger pool of experts and information to inform our work and advocate strongly for physician health. One of the most important accomplishments this year was the development of FSPHP guidelines on the treatment and monitoring of physicians with substance abuse or mental health problems. Guidelines for addressing professional boundary problems followed shortly thereafter.

The Joint Commission and Disruptive Behavior

As more physicians abandoned private practices and became employees, hospitals began to grapple with “the disruptive physician.” In 2007, a proposal was made to have the TJC create a new standard regarding disruptive behavior, later softened to “behavior that undermines a culture of safety.” Even before this standard was established, PHPs were presented with a new opportunity to educate health care organizations about how and when to intervene. In working with physicians engaging in disruptive behavior, we have learned that many of them are very distressed, rather than “bad doctors,” and have the potential to rehabilitate behavior through treatment.

Challenges to PHPs

Sadly, in July 2007 the California Medical Board voted to end its 27-year-old diversion program, creating more than a chill up the FSPHP’s spine. While a bill introduced in 2008 to create legislation to establish a new PHP passed, the governor of California vetoed it. A similar bill introduced in 2009 had a similar fate. This did not deter PHP advocates in the least, though. Later that year, several organizations mobilized under the leadership of the California Medical Association and formed California Public Protection and Physician Health, Inc. (CPPPH), whose mission remains to develop a comprehensive physician health program for the state. For now, private monitoring organizations continue to provide some services in California, attempting to fill the need-gap created by the loss of the diversion program.

Milestone Outcome Study Supports PHP Model

The Blueprint Project (McLellan, Skipper, Campbell and Dupont, 2008) elevated the status of PHPs by highlighting the excellent recovery rates achieved with our model of treatment and monitoring.

Confidentiality for PHPs Reaffirmed

In 2009 we also became more vigilant, as detractors, such as the Citizen Advocacy Center (CAC), wanted to dismantle physician confidentiality for those physicians affiliated with PHP. Several FSPHP members volunteered, at their own expense to attend CAC meetings in the summer and fall of 2009. We were successful in delivering several cogent points via a roving microphone concerning the importance of confidentiality in assisting ill physicians who may otherwise go underground, eventually become impaired, and pose a danger to patients. Over the years, the tone has thankfully softened with this organization.

FSPHP and AMA Collaboration Continues

When the AMA formed a new department, Physician Health and Healthcare Disparities, it afforded the FSPHP a new opportunity to enhance our communication and collaboration with the AMA. The FSPHP provided input to an updated resolution regarding the health of physicians. In June 2009, the resolution entitled “Model Physician Health Program Act” was put forward at the AMA Annual Meeting in Chicago. The promotion of physician health then became part of the AMA’s strategic plan.

Challenges to a PHP

Another hiccup on the FSPHP roadmap: In 2010 the Oregon PHP was eliminated by the successful passage of House Bill 2345, heightening our awareness of the vulnerability each state faced in having our nonprofit organizations usurped by for profit entities. There is movement in the state to create a new PHP.

Further AMA and ASAM Collaboration

In 2011, a taskforce of FSPHP members submitted a draft of revisions to the AMA’s Model Physician Health Program document. Our draft was accepted by the AMA and incorporated into a formal report, which was then accepted by the AMA’s Council on Science and Public Health. The same year, FSPHP worked together with both FSMB and the American Society of Addiction Medicine to help them update policies pertaining to PHPs.

Updated Mission Statement

In the fall of 2011, the FSPHP board of directors (BOD) developed a new mission statement and ordered priorities for our organization. ***Our mission is to support physician health programs in improving the health of medical professionals, thereby contributing to quality patient care.*** In terms of priorities, we vowed to continue in our efforts to form alliances with all organizations connected to the physician health movement, bravely embrace new technology to enhance our communication

with members and overall messaging and continue on our quest to polish our guidelines, improve our accountability, and find ways to pursue research to build our evidence that PHPs save lives and protect the public.

A New PHP Launches in Georgia!

Another celebration was in November 2011, when the Georgia Professional Health Program, Inc., was awarded a 501(c)(3) status as a charitable organization and a successful request for proposal (RFP) with the state of Georgia followed.

Administrative Changes

The AMA gave us roots as well as wings. We knew we had established ourselves as an authority on physician health when the AMA gently nudged us in the direction of independence, a true watershed point in our history.

Beginning in 2012, we began the process of moving the administrative responsibilities of the FSPHP away from the AMA headquarters in Chicago to Waltham, Massachusetts. We are fortunate to have the administrative and executive support from the Massachusetts Medical Society (MMS) subsidiary, Physician Health Services (PHS), Inc. The FSPHP BOD voted to sign an administrative contract with MMS effective January 2013 as we continue in our evolution.

FSPHP Collaboration Surges with FSMB, AMA, ASAM & ABMS

The FSMB convened the “Special Committee on Reentry for the Ill Physician” in the fall of 2012. Again, FSPHP was invited to the table and provided input that ultimately led to a new FSMB document supportive of physician health and rehabilitation. Additionally, FSPHP contributed to the FSMB Policy on Physician Impairment and played a role in developing physician health policies with the AMA and ASAM alike. FSPHP earned a seat at another table in 2012 as we began discussions with and provided education to the American Board of Medical Specialties.

FSPHP Membership Opportunities Expand

While I sometimes evaluate federal prisoners in “lock-down,” I never anticipated experiencing the same. Our 2013 Annual Meeting took place in Cambridge, shortly after the Boston marathon bombings. We were literally on hotel “lockdown” while local law enforcement hunted down two terrorists only blocks away. We had one of our best conferences ever with robust attendance, attesting to an unwavering commitment to our mission.

In 2013, the BOD voted to expand membership categories to include individuals and organizations aligned with our mission. We are now benefitting from the addition of new colleagues, with energy and fresh perspectives. In

step with our 2011 retreat goals, a Website Taskforce was formed to jettison our organization into the 21st Century.

In June 2014 we said goodbye to our Executive Director Jonathon Dougherty and wished him well in his pursuit of his county medical association work. We will be forever grateful to Jonathan for guiding FSPHP through rapid stages of development. Several FSPHP board members stepped in to help with the transition and Brenda Williams from the Tennessee Medical Foundation has been generously offering her time assisting with meeting minutes. Michael Todd, FSPHP treasurer, began improving our accounting system and is making good progress in this area.

ABMS Collaboration Continues

Representatives from the FSPHP continued our dialogue with the ABMS about the hurdles PHP participants face when attempting to obtain board certification or recertification. We are participating in the development of an ABMS policy to address this problem and are optimistic that this joint venture will result in a more friendly process. Finally, we initiated contact with the FSMB about the Interstate Compact Licensure being developed and learned that as long as PHP participants were in good standing with their state medical boards, they would be eligible to apply for this licensure.

Current FSPHP News and Progress

In December 2014, Deb Anglin of the Iowa PHP entered into retirement. FSPHP is extremely grateful for her service on the BOD. We wish her a wonderful retirement.

On January 5, 2014, I provided a “Happy New Year” update of all FSPHP activities and will be brief here. We continue into our second year of administrative contracting with PHS. Jessica Vautour and Debbie Brennan, not to mention Linda Breshnahan (who in September 2014 the FSPHP BOD voted to serve as Interim Executive Director through December 2015), have been extraordinarily efficient, productive, and enthusiastic. Dr. Warren Pendergast has generously agreed to take over FSPHP’s “observer status” with the AMA, following Dr. Luis Sanchez who served effectively in this role for several years.

A particularly important new FSPHP undertaking is the Taskforce on the Promotion of Accountability, Consistency, and Excellence. This year, Maureen Dinnan and Charles Meredith, MD, are charged with leading an expert group of FSPHP volunteers in developing a procedure for measuring our progress and efficacy in updating and developing new FSPHP guidelines. Your Public Policy Committee is working diligently to provide us with effective tools to assist us with media inquiries. 123SignUp, a complete software solution for providing automated member management and event registration,

is coming along. Stayed tuned for the official launch along with a new website later this year. All of the active FSPHP initiatives of 2014 remain active in 2015. I plan to keep you posted with all new developments, and to my FSPHP family, Happy 25th Anniversary! I will look forward to seeing you at the annual meeting in April 2015.

— *Doris C. Gunderson, MD, Medical Director, Colorado Physician Health Program*

MESSAGE FROM THE INTERIM EXECUTIVE DIRECTOR

It has been my pleasure to serve you as interim executive director since last August 2014. I have been involved with the FSPHP since the early '90s when I began my work with the Massachusetts Physician Health Services (PHS), at that time a Committee of the Massachusetts Medical Society. One of the most valuable aspects of an incredibly rewarding job at the MA PHS has been the benefit of joining FSPHP, and getting to know each of you, and the incredible work you do in your state to help preserve the health and wellness of physicians and health professionals. I have always felt so fortunate to have stumbled into this work, having a small part in helping doctors stay or become well, and serving those physicians who work for the Massachusetts program, and the FSPHP improve all our approaches and programs along the way. I can't say enough about the tremendous giving that is portrayed throughout this organization, so many impressive volunteer efforts of the FSPHP Board, Committee chairs and members move this important work forward. I hope you will all consider joining a committee if you are not already involved. Now, more than ever our work is expanding with increased awareness of FSPHP and more collaboration with national organizations. We can use your help. Please visit www.fsphp.org/2014-2015CommitteeRosters.pdf to consider a committee to join.

— *Linda Bresnahan, MS, Interim Executive Director FSPHP*



Linda Bresnahan, MS

FSPHP UPDATES

Administration

The FSPHP Board of Directors has continued into a third year with the approval of an administrative contract with Physician Health Services (PHS) in Waltham, Massachusetts. Jessica Vautour and Debbie Brennan continue to provide the core administrative activities for the membership and especially our annual meeting. Additionally,

Brenda Williams from the Tennessee Medical Foundation has been assisting with meeting minutes since June 2014. As you may know, in September of 2014, the FSPHP Board reviewed and entered into an additional contract with PHS in Massachusetts for Interim Executive Director Services through December 2015.

MedScape

In December, FSPHP was contacted by a senior editor of *Medscape* interested in writing a series of articles on physician health. FSPHP was pleased to have this credible education and outreach opportunity. If you have not already seen these articles, they can be found on Medscape.com. The *Medscape* articles focus on what others should know about PHPs, the warning signs of substance abuse in physicians, risk factors, and the treatment perspective too. In addition, the challenges of the current health care environment and its impact on the physician workforce will be discussed with reflection on professional coaching for physicians. Many PHP leaders were interviewed and contributed their expertise to these valuable educational pieces. The article titles are as follows:

“How Impaired Physicians Can Be Helped”

More doctors need help than are getting it, even though programs with good track records in treating substance use disorders, behavioral problems, or burnout in physicians are increasingly available.

“Impairment among Physicians Is Growing: Why?”

While many physicians struggle with drug and alcohol abuse, there are other impairments that also harm the lives of doctors today.

“What’s the Prognosis for Impaired Physicians?”

Physicians get just as addicted to alcohol and drugs as the general population, yet their treatment is more intensive and their outcomes are a good deal better. Here's why.

“Quiz: Is Your Knowledge of Physician Impairment Up-to-Date?”

How much do you know about physician problems with drug and alcohol abuse? What other issues create impairments? Which doctors are most at risk? Take this quiz and find out.

National Practitioner Data Bank

In January 2015, the National Practitioner Data Bank (NPDB) organization reached out to request for Dr. Doris Gunderson to participate in collaboration via conference call. Dr. Gunderson participated in the “National Practitioner Data Bank Stakeholder Engagement — The Impaired Practitioner.” The conference call session was

thought to be a great success and Dr. Gundersen was pleased that FSPHP had been invited to the table. NPDB sent appreciation: “Thanks to you and your colleagues’ valuable input, we are better informed on the complexity of the matters surrounding impaired practitioners and alternative disciplinary programs.”

As for next steps, NPDB will continue to delve into the issues around impaired practitioners to better understand implications for reporting to the NPDB and to better craft policy guidance on this topic. Once the guidance is refined it will be disseminated to FSPHP and other stakeholders for review.

NPDB wrote to FSPHP: “We are committed to understanding issues like these so that we may continue to provide the most accurate policy guidance and assistance to our stakeholders. As other topics for stakeholder engagement emerge, we may again invite you to lend your expertise to our discussion.”

American Medical Association (AMA) — Observer Status

As you may know, FSPHP has a seat at the AMA meetings in an “observer status.” Dr. Luis Sanchez served in this role in past years. Currently, our past president Dr. Warren Pendergast continues in this role, attending AMA meetings on behalf of our FSPHP. Plans are underway for a keynote speaker to present at the AMA Annual Meeting in June 2015. To have “Physician Health” featured at this national meeting is yet another example of physicians’ health and well being obtaining increasing awareness and attention.

Physician Well-Being Policy

This year, Dr. Pendergast, along with Drs. Luis Sanchez, Brad Hall, and Doris Gundersen, remain involved on a workgroup with the AMA and World Medical Association on the development of a Physician Well-Being Policy. This paper has been going through revisions with significant collaboration around the globe. It has been a terrific experience for our leadership to be involved in this effort, and we thank the AMA International Relations Department for involving FSPHP.

International Conference on Physician Health (ICPH) 2016

As you may know, the British Medical Association (BMA) hosted the 2014 conference in London. The AMA will host the 2016 conference in the United States. The location will be Boston, Massachusetts, in September. The AMA has reached out to FSPHP, inviting participation in the planning process.

More information will become available on at www.ama-assn.org/ama/pub/physician-resources/physician-health.page?

Task Force for the American Board of Medical Specialties (ABMS)

We have had a series of meetings with representatives of the ABMS to encourage their member organizations to embrace a treatment-oriented approach towards physicians who wish to maintain and/or regain their board certification(s). The collaboration and influence FSPHP has had is encouraging. A taskforce of our members has designed a standard of compliance information from a PHP to submit to ABMS for use by specialty boards as a method to create more uniformity in the process and ideally more understanding of the importance of compliance information when reviewing applicants for specialty boards with PHP involvement. Please stay tuned for news from this taskforce on their work.

Federation of State Medical Boards (FSMB)

FSMB and FSPHP collaboration is ongoing with conference calls and several initiatives. FSMB Chair Don Polk, DO, and FSMB board member Art Hengerer, MD, along with other leadership of the FSMB, were on a conference call in January 2015 with our leadership of the FSPHP to discuss the FSMB’s upcoming annual meeting in Fort Worth, Texas, where the two organizations have a joint educational session, and to explore additional collaborative opportunities, such as resources and solutions to help lessen physician burnout and stress. Also, FSPHP is looking to understand the criteria for compact license in order to educate physicians in monitoring programs of its implications. Plans are underway for the 2015 FSPHP Joint Session as well. As a reminder of an important development in 2013, FSPHP worked extensively with the FSMB on a reentry document, which is available on the FSMB website at www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/special_committee_reentry.pdf.

Task Force for the Promotion of Accountability, Consistency, and Excellence

The Task Force for the Promotion of Accountability, Consistency, and Excellence is working on a report to submit to the members at the 2015 Annual Meeting. Their important work will supply FSPHP and PHPs with a method to consider for measuring our PHP’s progress with FSPHP guidelines.

Public Policy Committee

Your public policy committee has been meeting regularly to prepare a document to assist PHPs and FSPHP with media inquiries, and writing new policy statements for a new website.

New Member Support

FSPHP members have always been generous and supportive to developing and new professional health programs. As new members are introduced to our e-group, colleagues reach out. I am proud of our member's collegial support to our mission this way.

New Members

- Daniel Angres, associate medical director,
Illinois Professionals Health Program
- Carl Christensen, MD, medical director,
Health Professionals Recovery Program (Michigan)
- Cindy Clark, assistant director,
North Carolina Physicians Health Program
- Paula Colescott, assistant medical director,
Alaska Medical Association
- Jason Green, LMHC, wellness program
director and clinical coordinator,
Washington Physician Health Program
- Peter Grinspoon, MD, associate director,
Physician Health Services (Massachusetts)
- Nelson H. Heise, MS, MA, PPC, LICDC-CS,
case manager, Ohio Physicians Health Program
- Robert Hunt, clinical coordinator,
Alabama Physician Health Program
- Tammy King, executive director,
North Dakota Professional Assistance Program, Inc.
- Jamie LeBlanc, monitoring support specialist,
Physicians' Health Foundation of Louisiana
- Lisa Lefebvre, MD, PHP associate medical director,
Ontario Medical Association
- Ann Leiseth, administrative assistant,
North Dakota Professional Assistance Program, Inc.
- Liz Lococo, MS, MAC, LMHC,
clinical coordinator and family services liaison,
Washington Physician Health Program
- Barrie March, MD, medical director,
North Dakota Professional Assistance Program, Inc.
- Sherman Master, MD, medical director,
Virginia Health Practitioners' Monitoring Program
- Kathy Musson, assistant,
Oklahoma Health Professionals Program

- Andrea P. Newman, PhD, LISW, LADAC,
executive director,
New Mexico Monitored Treatment Program
- Kay O'Shea, client services coordinator,
Missouri Physicians Health Program
- Kimberly Pennell, case manager,
Georgia Professional Health Program, Inc.
- Derek Puddester, MD, PHP associate medical director,
Ontario Medical Association
- Teresa Roberts, MD, member, Physician Health Program,
Medical Society of the District of Columbia
- Linda Rodriguez, LCSW-C, Clinical Manager,
Maryland Physicians Health Program
- Donna Singer, Donna Singer Consulting
- Kurt Snyder, MMTG, LSW, LAC, president,
North Dakota Professional Assistance Program, Inc.
- Jacquelyn Starer, MD, associate director,
Physician Health Services (Massachusetts)
- Kristin Wallace, administrator,
Mississippi Professionals Health Program
- Vern Williams, MD, consultant, Pu'ulu Lapaau,
Hawaii Program for Health Care Professionals

**New Membership Application (123SignUp)
and New FSPHP Website**

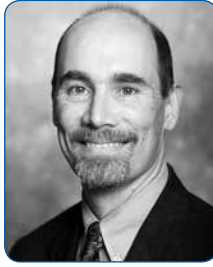
Throughout 2014, with the guidance of the FSPHP Website Taskforce and Publication Committee, the FSPHP has entered into an agreement with 123SignUp. This complete software solution will provide automated member management and event registration. FSPHP will be implementing the software throughout 2015. Plans are also underway to launch it along with a new website for members in 2015.

FSPHP Committees

A current list of all FSPHP committee's goals and current members is on our website at www.fsphp.org/2014-2015CommitteeRosters.pdf. If you would like to join an FSPHP committee, please email Debbie Brennan at dbrennan@mms.org. The process to join a committee involves approval of the FSPHP Board of Directors. At our annual business meeting, a form is available to sign up to join a committee as well. You can also obtain a copy of this form from the FSPHP website. If you are omitted from a committee listing in error, please let us know right away.

AMA OBSERVER UPDATE

Since following Luis Sanchez in the role of FSPHP AMA Observer, I've attended three AMA meetings. The first was the interim meeting at Maryland's National Harbor in November 2013, then last June's annual meeting in Chicago. Most recently, I attended the House of Delegates Interim Meeting held November 8–11 at the Hilton Anatole in Dallas, Texas. This was right on the heels of the acute Ebola scare in Texas, but that didn't seem to influence attendance at the meeting. While there were no issues directly related to physician health, there was some discussion about two issues of particular importance to PHPs and our participants:



Warren Pendergast, MD

1. FSMB Interstate Compact (AMA Board of Trustees Report 3 — Facilitating State Licensure for Telemedicine Services).

This Board of Trustees report was supportive of the FSMB Interstate Compact for Medical Licensure in general, and specifically empowers the AMA to support expeditious adoption of the Compact by individual states. This was discussed in reference committee and generated considerable supportive testimony and little opposition. There was some concern that the compact might undermine states' authority, but the reference committee ultimately was reassured that the interstate commission would not have this effect. Current AMA policy does oppose national licensure.

AMA House of Delegates action: Board of Trustees Report 3 adopted and the remainder of the report filed.

2. Maintenance of Certification (MOC) (Resolutions 920, 926, 928, 929 extracted for discussion)

This generated considerable testimony and great passion, mostly in opposition to the general concept of MOC and/or the way it is being implemented by the various specialty boards. Some of the testimony centered on the idea that specialty boards are a "money-making" proposition. The American Board of Internal Medicine appeared to be a specific focus of concern for some AMA members. The reference committee recommended that Resolution 920 be amended and adopted.

The reference committee's goal seemed to be to promote ongoing AMA support for the concept of MOC (keeping physicians up-to-date), while also addressing the loud voices of concern and

opposition to the specific manner in which MOC is currently being implemented.

Principles on Maintenance of Certification

RESOLVED, that our American Medical Association amend the Policy H-275.924, Principles on Maintenance of Certification (MOC), to include the following:

- MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
- The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
- MOC should be used as a tool for continuous improvement.
- The MOC program should not be a mandated requirement for licensure, credentialing, reimbursement, or network participation, or employment.
- Actively practicing physicians should be well-represented on specialty boards developing MOC.
- MOC activities and measurement should be relevant to clinical practice.
- The MOC process should not be cost prohibitive or present barriers to patient care. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA encourage specialty boards to investigate and/or establish alternative approaches for MOC; (Directive to Take Action) and be it further

RESOLVED, That our AMA prepare a yearly report regarding the maintenance of certification process; (Directive to Take Action) and be it further

RESOLVED, That our AMA work with the American Board of Medical Specialties to eliminate practice performance assessment modules, as currently written, from the requirement of MOC;

AMA House of Delegates action: Substitute Resolution 920 adopted as amended in lieu of Resolutions 920, 926, 928 and 929, and the following proposed amendment to Policy H-275.924 referred:

Specialty boards, which develop MOC standards, may approve curriculum, but should be independent from entities designing and delivering that curriculum, and should have no financial interest in the process.

A related resolution (Resolution 815) was also adopted, this addressed the issue of hospitals requiring board certification to remain on staff.

Anyone who is an AMA member and interested can access the preliminary reports at www.ama-assn.org/resources/doc/hod/x-pub/i14-reference-committee-reports.pdf.

FSPHP members should also be aware of the current Council on Ethical and Judicial Affairs (CEJA) initiative to review and update the AMA Code of Ethics (the comment period ended on 1/15/2015):

www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page.

In particular, those of us engaged in physician health should look at CM 9—Professional Self-Regulation, which contains most of the material on physician health and behavioral issues at www.ama-assn.org.

The next AMA Annual meeting is scheduled for June 6–10, 2015, at the Hyatt Regency Chicago. I'll be there and would encourage any fellow FSPHP members to attend — please let me know if you're going, and we can divide up the reference committees.

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

FSMB'S INTERSTATE MEDICAL LICENSURE COMPACT

In November 2014, Doris Gundersen, MD, participated in a conference call with Eric Fish, JD, senior director of FSMB Legal Services, to discuss the Interstate Medical Licensure Compact and its impact for physicians involved with board discipline, and/or involved with physician health programs.

The interstate compact would expedite multi-state licensure for qualified applicants. To be eligible for a compact license a physician must (1) be a graduate of an accredited educational program or a medical school listed in the International Medical Education Directory or its equivalent, (2) pass each component of the national licensing exams in three attempts or fewer; (3) successfully completed graduate medical education in an ACGME approved program; (4) be Board certified or hold a time-unlimited specialty certificate; hold a full, unrestricted license in a compact member state; (5) have no convictions or deferred dispositions for any criminal offense (i.e., a clean criminal record); (6) have never been disciplined by any medical board; (7) have never had a controlled substance license or permit suspended or revoked by the DEA; and (8) not be currently under investigation by a licensing agency or law enforcement in any jurisdiction.

The interstate compact would not make any changes to the traditional medical licensure process. Physicians who do not qualify for a compact license or who do not want to practice in multiple jurisdictions may continue to apply for licensure

as they always have. Additionally, the interstate compact does not interfere with a state's ability to set practice standards nor does it modify the state's medical practice act.

During the November call, Dr. Gunderson and Attorney Fish discussed the definition of “discipline used in the eligibility factors” and its relation to physicians involved in health programs. Attorney Fish explained that for physicians who are self-referred to physician health programs and/or involved confidentially without any action on their licensure, the Interstate Medical Licensure Compact would be available to them, as there has been no official board disciplinary action taken. Alternatively, physicians with current or past “disciplinary action” which resulted in a public action taken on a license would not be eligible for a compact licensure. Rather these physicians would need to pursue licensure through the individual states in which they are seeking a license. Through its rule-making function, the Interstate Commission, the body responsible for the implementation of the interstate compact, may further clarify how participation in physician health programs to ensure that eligible physicians are not improperly denied the ability to participate in the expedited license process. The Interstate Commission may also work to help health programs coordinate services in the various states where a physician may be practicing. There is no hard date on when the interstate compact will be implemented; this will depend on when it is enacted by seven states. When this takes place, the commission will meet for several days, tentatively planned for the late summer or early fall of 2015, to develop rules.

As a next step, FSPHP will request an observer status with the FSMB Interstate Commission to weigh in on the implications for physicians involved in physician health programs.

In terms of background information on the Interstate Medical Licensure Compact, in September 2014, the FSMB issued the following statement regarding the completion of the drafting process for model legislation to create an Interstate Medical Licensure Compact that would speed the process of issuing licenses for physicians who wish to practice in multiple states. “With the drafting process complete, state legislatures and medical boards can now begin to consider the adoption of this model legislation establishing an interstate medical licensure compact,” said Dr. Humayun J. Chaudhry, president and CEO of FSMB. “The FSMB is pleased to have supported the state medical board community as it developed this compact to streamline licensure while maintaining patient protection as a top priority. We look forward to working with states that wish to implement this innovative new policy.”

The interstate medical licensure compact model legislation creates a new process for faster licensing for physicians interested in practicing in multiple states and establishes the

location of a patient as the jurisdiction for oversight and patient protections. The compact is a dynamic system of expedited licensure over which the member states can maintain control through a coordinated legislative and administrative process. Participation in an interstate compact would be voluntary, for both states and physicians. The interstate compact is expected to significantly reduce barriers to the process of gaining licensure in multiple states, helping facilitate licensure portability and telemedicine while expanding access to health care by physicians, particularly in underserved areas of the nation.

Information regarding the Interstate Medical Licensure Compact can be found on the FSMB website including model legislation at www.licenseportability.org. As of January 15, 2015, 25 state medical and osteopathic boards support their state's formal participation in the Interstate Medical Licensure Compact. Legislation that would formally enact the interstate compact has been introduced in six states, and the FSMB estimates 5 to 10 more introductions. — *Linda Bresnahan, MS, Interim Executive Director FSPHP*

HOW TO EFFECTIVELY COLLABORATE WITH A STATE MEDICAL BOARD: A LOOK AT THE COLORADO PHYSICIAN HEALTH PROGRAM (CPHP)

State PHPs ultimately desire one thing: the healthiest physicians able to provide their best care to patients. PHPs seek effective means of reaching that end, which is an environment that encourages physicians to better their health and well being *confidentially*. The ability for PHPs to be successful in caring for physicians is directly affected by the relationship with the state's medical board. PHPs and medical boards want successful communication, to problem solve in a respectful and understanding manner, and develop productive working relationships filled with trust. Establishing effective collaboration may be a challenge, in particular when natural tension lies between the two parties. Specifically, a medical board's duty is to protect the public and a PHP's primary mission is assisting physicians with their health needs. In Colorado, small steps make a difference in forging a relationship within these different (but often complementary) missions. CPHP would like to share some



Amanda Parry, MPA



Sarah Early, PsyD

strategies that have worked for us. Hopefully, you may be able to use similar strategies based upon your program and resources, to enhance the relationship you have with your medical board:

Organization Reports

CPHP is contractually obligated to report de-identified client statistics concerning program usage as well as administrative activities to the Colorado Medical Board (CMB) on both a quarterly and annual basis. This data is presented to the CMB Full Board Meetings as a standing agenda point, allowing all board members to ask pertinent questions, garner understanding, and communicate future goals.

Quality Assurance

CPHP conducts regular internal and external program evaluations, the results of which are shared with the CMB. The two parties then discuss various plans to improve quality and CPHP provides follow-up reports.

Task Force Meetings

CPHP and CMB have developed task force meetings for leadership to discuss process and policy challenges. These meetings occur as needed, and involve appropriate interested parties (e.g., attorney generals) based upon the agenda. A multitude of topic discussions have resulted in mutual understandings of rationale of various policies. For instance, at a recent CPHP/CMB Task Force Meeting, leadership met to determine specific guidelines defining "non-compliance" in client interactions with the program.

Workgroups

More project-specific workgroups are formed to build procedures or projects that are workable at the staff level. As an example, a workgroup was formed to develop a shorter/standardized report for physicians with DUI charges that do not meet criteria for a Substance Use Disorder. Workgroups occur to make the operational relationship between both parties ultimately more efficient.

Client Reports

When clients are formally referred to CPHP, written comprehensive evaluation/monitoring reports are provided to the CMB. In addition to the information detailed in the formal reports, the CMB may also call CPHP directly to clarify report data or client status. CPHP conducts regular (generally weekly) staff-level communication with our medical board concerning clients being monitored or in the process of being evaluated. The CMB may also request that CPHP medical directors discuss a case or answer specific questions directly with CMB Panel Members at their monthly meeting.

Education/Presentations

CPHP is invited to educate new CMB members at orientation, demonstrating effectively the open collaboration the two organizations share. CPHP Medical Directors are also invited to present to the CMB Full Board to educate about physician health topics or CPHP in general; such as *Step by Step: The CPHP Process* or *The Legalization of Marijuana: What Doctors Need to Know*.

A successful collaboration between medical boards and PHPs requires clear and frequent communication, a mutual understanding of respective missions, commitment to hard work, and trust. Trust that the other party, whether focused primarily with public safety or physician health, ultimately desires the same result: healthy doctors who provide their best care to patients.

— Sarah Early, PsyD, Executive Director, CPHP; and Amanda Parry, MPA, Director of Public Affairs, CPHP

PHYSICIAN HEALTH PROGRAMS: WORTH OUR WEIGHT IN GOLD

Parallels between the airline industry and health care abound. Here's a new one:

Tony Fernandes, the CEO of AirAsia, knew a depressed asset when he saw one. The government airline of Malaysia owned all of two airplanes and was in debt to the tune of \$11 million. Fernandes purchased the two planes and all that debt for the steep price of one Malaysian ringgit. That would be 26 cents in U.S. currency. He borrowed against his home and invested in this newly acquired depressed asset. Within a year he went from losing money to making money. Turn the clock forward a decade and Fernandes is worth \$650 million. He understood how to turn a depressed asset into a moneymaker. He also understood that in order to make money, you often need to invest in what you believe in.

Physician health programs represent a depressed sector of our health care economy. Health care is a 3 trillion dollar industry. It represents approximately 18% of the United States domestic product. How much of that war chest does the industry invest in physician health programs? In relatively well-endowed states, the physician health spending is about 0.0025% of the total health care spend. That's \$1 out of every \$40,000. In some states, the physician health spend is less than half of that. And then there is the handful of states that limp along without any programs whatsoever. There's a reason that physician health programs feel like



Steve Adelman, MD

underfunded, bootstrap operations stretched way too thin — with very few exceptions, that's exactly what we are.

I think I know a bargain when I see one. The work we do is extremely valuable, and, at times, invaluable. We do it for a pittance, and because we are underfunded we are not coming close to realizing our full potential. The health care industry is in the midst of a growing occupational health crisis. Addictive disorders are but one piece of a large and growing pie. Other large pieces of the bulging pie are mental disorders, unprofessional behavior, performance problems on the industrialized health care assembly line, occupational stress, burnout, and, neurocognitive and medical problems that are emerging in our aging physician workforce.

In Massachusetts we have increased our yearly funding target from \$30 per employed physician to \$50 per employed physician. As we all know, doctors answer to many different parties these days. We are appealing to all of them to fund our program: malpractice carriers, large integrated systems, hospitals, group practices, and medical staff organizations. We hit the road for education and outreach events on a weekly basis. We take care to schedule meetings with medical and administrative leaders in conjunction with these presentations, and an explicit agenda item at each meeting is the funding gap that interferes with our ability to comfortably meet the growing needs of physicians and their institutions. These concerted efforts are getting traction, and our funding gap is beginning to close. — Steve Adelman, MD, Director, Physician Health Services, Inc. of Massachusetts

NONDISCIPLINARY RECOVERY TRACKS AND PROTECTION OF THE PUBLIC HEALTH

Before discussing the benefits of a PHP with a nondisciplinary recovery track, I need to acknowledge that I am frequently asked to explain how *any* PHP can protect the public health. Unfortunately, some PHPs have been accused of “hiding out sick doctors.” Although this may have happened in isolated cases, it is safe to say that when PHPs are underutilized, for any reason, public safety is compromised, and society, as a whole, pays the price.

Several states do not have PHPs, much less a PHP with a nondisciplinary recovery track. In these states, regulatory agencies are responsible for managing physicians with known addictive disorders. In many cases, management



Scott Hambleton, MD

FSPHP PAST PRESIDENTS



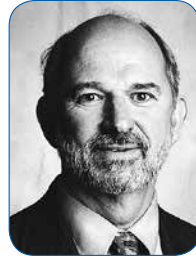
Warren
Pendergast, MD, Chair
2012-2014



Peter Mansky, MD
2009-2012



Gary Carr, MD
2009-2009



Luis T. Sanchez, MD
2005-2009



Michael H. Gendel, MD
2003-2005



Martin C. Doot, MD
(In Memoriam)
2001-2003

FSPHP THROUGH THE YEARS



Past FSPHP Annual Business Meeting



Past FSPHP Annual Meeting



**Lynn Hanks, MD,
FASAM
1999–2001**



**John Fromson, MD
1997–1999**



**Gerald L. Summer, MD
(In Memoriam)
1995–1997**



**David Dodd, MD
(In Memoriam)
1993–1995**



**Violet Eggert, MD
(In Memoriam)
1988–1990**

**PAST PRESIDENTS
NOT PICTURED:**

**Susan McCall, MD
2005–2005**

**Richard Irons, MD
(In Memoriam)
1990–1993**

FSPHP THROUGH THE YEARS



Left to Right: Warren Pendergast, MD, FSPHP Past President; Mick Orescovich, MD, FSPHP Program Planning Committee Chair; Jeffrey Selzer, MD, FSPHP Past Board Member; and Michael Kaufmann, MD, Ontario PHP Director and FSPHP Member



Left : Gerald Summer, MD **Right:** Roger Goetz, MD
Past FSPHP Leaders



Left to Right: Scott Alberty, Past FSPHP Membership Committee Chair; Lynn Hanks, MD, FSPHP Past President; Warren Pendergast, MD, FSPHP Past President; Dan O'Neill, MD, Former Chair of WPHP Board of Directors



Left to Right: Luis Sanchez, MD; Gary Carr, MD; and Candace Backer, LCSW, LCAC

continued from page 11

of these physicians is very similar to the management of the hundreds of thousands of Americans who are incarcerated because of crimes related to untreated addiction. In the case of a regulatory agency, without the highly specialized staff of a PHP, action is taken against the medical license of the physician, addiction is not addressed, and the result is a physician with a public record who cannot practice medicine, with an untreated addictive disorder. In the criminal justice system, action is taken against the freedom of the individual, and if addiction is not appropriately addressed during incarceration, the person will continue to engage in addictive behaviors, resulting in an ongoing burden to society. The assumption is that abstinence during incarceration or the incarceration itself will result in termination of addictive behaviors. Unfortunately, this assumption is egregiously incorrect. Without treatment, neither abstinence nor punishment will consistently result in cessation of addictive behaviors. However, when abstinence and punishment, or the fear of punishment is combined with effective longitudinal treatment, the results are spectacular. The appropriate use of this type of leverage is one of the primary reasons that PHPs are so successful.

Obviously, one of the main benefits of a PHP is that physicians with addictive disorders are effectively treated! The PHP style of management of physicians with addictive disorders unequivocally represents the “Gold Standard” of management of addictive disorders. There is no other mechanism, on the planet, which consistently produces results of this caliber. The PHP Blueprint Study and other studies have clearly documented the success of PHPs, as well as the safety of patients managed by physicians being monitored by PHPs. Not surprisingly, some of the harshest critics of PHPs often become the strongest supporters of PHPs after they receive proper education about addictive disorders and the necessity of the programs.

The main benefit of a PHP with a nondisciplinary recovery track is increased utilization of the PHP’s services. PHPs which have agreements with their state regulatory agencies facilitating a confidential recovery track experience dramatically increased referrals compared to PHPs without them. These PHPs typically monitor 1–2% of the actively practicing physicians in the state. In Mississippi, referrals to our PHP increased four-fold within one year of our program adopting a confidential recovery track in the 1990s, and we currently monitor approximately 2% of the actively practicing physicians in the state.

Since the generally accepted lifetime prevalence of substance use disorders in physicians is approximately 12%, the point prevalence over a 30-year career is roughly 0.4%.

The Federation of State Medical Boards (FSMB) reports that the total number of physicians disciplined for serious reasons is approximately 0.3% per year. Of these, the majority are disciplined for reasons other than addictive disorders. Considering that effective PHPs typically monitor 1–2% of actively practicing physicians in the state, the necessity of a functional PHP is obvious, and the potential for harm to the public in states without a PHP is difficult to ignore.

The FSPHP faces many challenges, and one of the most important will be to assist in the development of improved methods of marketing our services to our shareholders. We are certain to experience much gratification as we face this challenge and accomplish our goals — not only because of the benefit to our fellow physicians — but because of the potential to benefit society as a whole.
— *Scott Hambleton, MD, FASAM, Medical Director, Mississippi Professionals Health Program*

THE PREVALENCE OF SUBSTANCE USE DISORDERS IN AMERICAN PHYSICIANS

Am J Addict. 2014 Nov 19. doi: 10.1111/j.1521-0391.2014.12173.x. [Epub ahead of print] Oreskovich MR1, Shanafelt T, Dyrbye LN, Tan L, Sotile W, Satele D, West CP, Sloan J, Boone S.

*University of Washington, Seattle, WA.

Abstract

Background

There have been few studies on the prevalence of substance use disorders (SUDS) in the physician population at large nor have any studies compared the prevalence of SUDS in American physicians by specialty.

Methods

We conducted a national study of SUDS in a large sample of U.S. physicians from all specialty disciplines using the AMA Physician Masterfile. Substance Use Disorders (SUDS) were measured using validated instruments.

Results

Of the 27,276 physicians who received an invitation to participate, 7,288 (26.7%) completed surveys. 12.9% of male physicians and 21.4% of female physicians met diagnostic criteria for alcohol abuse or dependence. Abuse of prescription drugs and use of illicit drugs was rare. Factors independently associated with alcohol abuse or dependence were age (OR = .985; $p < .0001$), hours worked (OR = .994; $p = .0094$), male gender (OR = .597; $p < .0001$), being married (OR 1.296; $p = .0424$) or partnered (OR 1.989; $p = .0003$), having children (OR .745; $p = .0049$), and being in any specialty other than internal medicine (OR 1.757; $p = .0060$). Specialty choice

was strongly associated with alcohol abuse or dependence ($p = .0011$). Alcohol abuse or dependence was associated with burnout ($p < .0001$), depression ($p < .0001$), suicidal ideation ($p = .0004$), lower quality of life ($p < .0001$), lower career satisfaction ($p = .0036$), and recent medical errors ($p = .0011$).

Conclusion

Alcohol abuse or dependence is a significant problem among American physicians. Since prognosis for recovery of physicians from chemical dependency is exceptionally high, organizational approaches for the early identification of problematic alcohol consumption in physicians followed by intervention and treatment where indicated should be strongly supported. (*Am J Addict* 2014;XX:1–9).

— © *American Academy of Addiction Psychiatry*.

PMID: 25409782

[PubMed — as supplied by publisher]

THE NORTHEAST FEDERATION OF STATE PHYSICIAN HEALTH PROGRAMS (NEPHP) MEETING

NEPHP met in Portland, Maine on October 10, 2014. Northeast Regional Director Maureen Dinnan, JD, (Connecticut) and Vice Director Dan Perlin, MD, (Washington, D.C.) put together a terrific agenda for the day. The meeting, which was hosted by the Maine Medical Professionals Health Program, was set in one of Portland's tallest buildings with a beautiful view of the city and coast. Though the view was compelling, the discussions and collaboration among attendees were the real highlight of the day.

The meeting was attended by 25 program leaders from nine different states and focused largely on case-related challenges and program issues. The meeting agenda provided many opportunities for states to brainstorm monitoring options, share administrative practices, and support each other as we navigate the unique clinical, political, and legal issues of monitoring medical professionals in recovery. One highlight — of many — was probably the four challenging, anonymous cases that were shared and discussed.

There wasn't nearly enough time (there never is), but the meeting was invaluable. Thank you to all who attended and shared your wisdom, experiences, and struggles — we all have so much to learn from each other! Thank you to our host, Maine Medical Professionals Health



Cathryn R. Stratton

Program (MPHP), and Medical Mutual Insurance of Maine. Thank you also to our education event sponsors and advertisers: Affinity eHealth, Caron Treatment Centers, FirstLab, Marworth, Pavillon, Pine Grove, Pride Institute, Promises, Sante, and Talbott Recovery.

— *Cathryn R. Stratton, Program Manager, Medical Professionals Health Program*

NEW PROJECTS FROM CALIFORNIA

While CPPPH parent organizations continue to strive for legislation that will authorize and fund a PHP for California, it continues support for the well being committees in medical staffs and medical groups. We developed a new project to identify experienced evaluators because it was a frequent request in the workshops CPPPH offers them every four months.

The project began with a day-long workshop titled *Evaluation of Health Care Professionals — From Screening to Full Assessments and Fitness for Duty Reports* based on the criteria in two guideline documents that list what medical staffs should look for when selecting an evaluator. The two guidelines are “Evaluations of Healthcare Professionals” and “Assessing Late Career Practitioners: Policies and Procedures for Age-based Screening” (both of which are available at www.cppph.org).

The project combined activities intended to convey core information as well as identify those who can demonstrate that they meet the criteria. There was a CPPPH Certificate of Completion for those who completed these steps:

- Participating in a CPPPH workshop that includes didactic presentations as well as a review, in a faculty-led small group, of at least one report that the registrant had submitted to an organization for which he/she performed an evaluation
- Successfully completing a pre/post test assessing mastery of the information in the workshop and the reading materials sent in advance
- Providing a current, dated CV and a letter of reference from at least one committee for which he/she conducted an evaluation and submitted a report

Eighty-three (83) people attended the workshop and 10 completed the additional requirements for a certificate of completion. The project will repeat in 2015.

The next series of Saturday morning workshops will be titled *Disruptive Behavior and the Medical Staff's Response: Clinical, Administrative, and Legal Aspects* — again because it was the request of those who attend the workshops. Like the question of aging practitioners, the matters surrounding behavior have related legal protections: in the case of



Back Row: Cathy Stratton (ME); Linda Bresnahan, MS (MA); Maureen Dinnan, Esq. (CT); Joe Baillie, LPC, CADC II (DC); Daniel Perlin, MD (DC); Shirley Stuppy (PA); Steve Sheehan, LCSW (CT); Martin Rusinowitz, MD (MD); Laura Berg, LCSW-C (MD); Tanya Bryant, LCSW-C (MD); Robert Chagrasulis, MD (ME); Jeffrey Selzer, MD (NY) **Front Row:** Paul Davis (ME); Lani Graham, MD, MPH (ME); Heidi LaMonica (ME); Jon A. Shapiro, MD (PA); Susan Silvia (RI); Chae Kwak, LCSW-C (MD); Kathleen Boyd, MSW, LICSW (RI); Debra Grossbaum, Esq. (MA)

disruptive behavior it is the protection for whistle blowers; in the case of aging, it is protection against discrimination. As part of the workshop content on behavior, CPPPH will develop a white paper designed to assist those who are implementing policies in medical staffs and medical groups.

On another front, CPPPH is assisting the newly formed Western States Health Care Professionals Group (WSHCPG) (www.wshcpg.com) to offer its first weekend meeting on March 13–15. The new group is patterned after the New England Professionals Group and the Midwest Health-care Professionals in Recovery and will be a meeting place for physicians sharing experience, strength, and hope through the principles of AA and the fellowship of active recovery. — *Gail Jara, California Public Protection and Physician Health (CPPPH)*

MAINE MEDICAL PROFESSIONALS HEALTH PROGRAM (MPHP)

Educational Conference: The MPHP is hosting a wellness conference April 17, 2015, scheduled to take place in Portland, Maine. We would like to invite all of our colleagues and participants in other states to join us for a one-day educational program on addiction, mental health, and well being. Featured speakers include **Sarah Allen Benton** (Understanding the High Functioning Addict), **Dr. Elissa Chesler** (Genetic and Genomic Studies of Addiction at Jackson Laboratories), and **Dr. Lisa Latourneau** (Physical and Behavioral Health Integration, Maine Quality Counts). Visit the MPHP website, www.mainemphp.org, for more information and to sign up for the conference.

Participant Experience Survey: The MPHP recently performed a couple of internal and external assessments. As the MPHP has grown to serve additional professionals (e.g., physicians, physician assistants, dentists and allied professionals, pharmacists, nurses, veterinarians), we've recognized some new issues that have affected our practices. We're working hard to assess the impact the MPHP is making and how to best meet the needs, both collectively and individually, of the professions we serve.

A recent confidential participant survey conducted with the assistance of the MPHP Advisory Committee, assessed the experiences and levels of satisfaction active participants felt about various aspects of the MPHP. Sixty percent (60%) of the participants contacted responded to the survey. Here are a few highlights we think other PHPs might find interesting and helpful:

- 93% said they would recommend the program to a colleague struggling with substance use or mental health illnesses
- 50% of respondents reported having experienced some form of discrimination in the workplace (voluntary and mandated participants alike)
- Collection sites were cited for confidentiality issues, inconvenient hours, and high prices
- Licensing Board standards regarding the posting of consent agreements on the Internet were identified as a substantial barrier to obtaining work and returning to a normal life in the community
- Length of monitoring contracts and contractual terms were criticized because of the lack of research to support the standards — “One size does not fit all”
- Education and advocacy were identified by participants as an important and primary responsibility of the MPHP.

For additional information on the MPHP survey, please feel free to contact Dr. Lani Graham at lgraham@mainemed.com. — *Cathryn R. Stratton, Program Manager*

NEVADA PROFESSIONALS ASSISTANCE PROGRAM (NPAP) UPDATE

NPAP had a productive year in 2014. We focused a lot on educating the licensees of various regulatory boards, as well as hospitals and large physician practices, on addiction, substance abuse, and physician health. We have also provided several continuing legal education courses throughout Southern Nevada, which has helped us in spreading the word to the community about the services we are now providing for the State Bar of Nevada, as well as the services and resources we provide to health care professionals. The NPAP has had an influx of medical students and residents in the program. Again, we believe part of this is due to the efforts we have made in educating the students, faculty, and staff at our local medical



Peter Mansky, MD

school, osteopathic school, and hospitals on addiction and substance abuse. Our alumni program continues to grow and grow. We have been very pleased with the number of participants willing to voluntarily continue as alumni.

Peter Mansky, MD, continues to serve on the Board of Trustees for the Clark County Medical Society, the largest medical society in Nevada. Dr. Mansky also served on the Nevada Attorney General’s Substance Abuse Working Group, a committee with the goal of developing strategic plans in addressing the prescription pill abuse epidemic. His input was imperative and an opportunity to highlight the issues professionals face in treating patients that require controlled substances.

NPAP will be working on developing a 5 to 10 year plan over the next year. We are considering trying to obtain funding from outside resources such as licensing boards, hospitals, and/or state and local medical societies. As more of the community becomes educated about physician health, our hope is that they will want to invest in the future of the Physicians Health Program and the positive outcomes it provides

— *Shauna Eger, BA, MHA, Senior Associate Director, Nevada Professionals Assistance Program*

SOUTH DAKOTA HEALTH PROFESSIONALS ASSISTANCE PROGRAM (SDHPAP) UPDATE

2014 has been a year of transformation for SDHPAP. The program has secured funding allowing operation in a more independent manner, and for the first time in the program’s history, the program is not housed at one of the participating licensing boards or at one of the major competing hospital systems in the state. In addition, all participants who hold active licenses under participating regulatory boards may now access the program free of charge. These changes were made with the support of all stakeholders, and the program maintains a strong collaborative relationship with regulatory bodies, state and regional treatment organizations, and state hospital systems.

The program welcomes Amanda McKnelly as the program director. She joins Maria Eining, executive director, Sue Harris, and Sherry Grismer. The program is also pleased to welcome Craig Uthe, MD, who is a family practice physician and holds ASAM certification, on staff as the physician/medical advisor. Dr. Uthe has supported the program for the past 15 years in a volunteer capacity as a member of the HPAP Evaluation Committee. The additional program staff has increased opportunities for outreach and for improved collaboration with our participants and treatment partners.

The program formally serves four participating regulatory boards and is a potential resource for the 33,000 individuals holding licenses. Increased staff has allowed the program to be more visible, available, and accessible to those in need of service and to our stakeholders. We are thankful to all who supported this transition, and grateful to the support, leadership and guidance available to SDHPAP through membership in the FSPHP.

— *Maria Eining, MA, LPC-MH, LAC, QMHP, Midwest Health Management Services, LLC; South Dakota Health Professionals Assistance Program Executive Director*

WASHINGTON PHYSICIANS HEALTH PROGRAM (WPHP)

Welcome New Associate Medical Director Dr. Chris Bundy and New Administrative Manager Niki Ellis

WPHP is thrilled to welcome new Associate Medical Director Chris Bundy, MD, MPH, to our program. Dr. Bundy completed medical school, residency, and fellowship at the University of Washington and earned his master's degree in public health at the Harvard School of Public Health with an emphasis in health care policy and management. He is board certified in addiction medicine and is a board-certified adult and geriatric psychiatrist with broad clinical experience in outpatient, inpatient, and emergency mental health settings. Dr. Bundy came to WPHP from the VA Puget Sound Health Care System where he was the Associate Chief of Staff, Chief of Mental Health, and Chief of Psychiatry. Dr. Bundy draws upon this experience as a health care leader to inform his work with WPHP staff, clients, health care employers, and stakeholder organizations. In his role as associate medical director, Dr. Bundy is primarily responsible for the clinical and operational oversight of WPHP's addictive disorders program. In addition, he assists the behavioral health team in the assessment and monitoring of health care providers with psychiatric, behavioral, and co-occurring disorders. Dr. Bundy's other duties involve close collaboration with the WPHP medical director on research, outreach, education, quality assurance, and strategic planning initiatives.

Dr. Bundy joined WPHP in May 2014 upon the retirement of long-time WPHP Clinical Director Scott Alberti. Mr. Alberti served WPHP for over 20 years and his presence in the office and among clients is sorely missed. We wish him good health and happiness in his new journey!

WPHP also welcomed new Administrative Manager Niki Ellis. Niki received her BA from the University of Washington and is working toward a master's degree in Health

Administration. Prior to joining WPHP she held various administrative positions in health care, higher education and non-profit settings. Niki leads the WPHP administrative support team and ensures overall office management. She is a wonderful addition to the team!

WPHP Expands its Services to Enhance the Health of Medical Professionals

WPHP is broadening its scope of services to include programming designed to enhance the health of clinicians so they are better able to help others. These various programs are open to any health care professional in the state, not just those who are being monitored by WPHP.



Charles Meredith, MD

The first such program is Mindfulness for Healthcare Professionals. This is an experiential learning program designed to promote mental health and improve functioning by engaging the mind and the body. The format is adapted from Jon Kabat-Zinn's Mindfulness Based Stress Reduction, and incorporates five behavioral components: breathing awareness, body scan, walking meditation, eating meditation, and yoga. This five-week series combines didactic presentations, exercises, interactive discussions, and homework. WPHP began offering mindfulness programming in the fall of 2014 and will host several offerings throughout 2015. Thus far, the demand for this program has exceeded availability and initial feedback from participants has been very positive.

Multiple researchers have demonstrated that learning and implementing the practice of mindfulness meditation can combat and prevent the development of burnout. Specifically, mindfulness techniques have been shown to be an effective approach for treating or preventing the development of burnout in physicians. In fact, a number of allied health professional training programs are altering their student curriculum to incorporate content on wellness and mindfulness training. Mindfulness does not eliminate life's pressures, but it can help us respond to pressures in a calmer manner that benefits our heart, head, and body.

In addition, the WPHP Wellness Program is investigating other offerings to introduce in the months ahead. These include more courses, a lecture series, or a conference devoted to physician wellness, a peer support program and promoting or facilitating smaller group activities.

— *Charles Meredith, MD*

WEST VIRGINIA MEDICAL PROFESSIONALS HEALTH PROGRAM'S (WVMPHP) APPALACHIAN ADDICTION AND PRESCRIPTION DRUG ABUSE CONFERENCE

The annual Appalachian Addiction and Prescription Drug Abuse Conference was held in Charleston, West Virginia, October 23–25, 2014. This was the third conference of its type since inception of the licensure board's three-hour CME Best Practices Prescribing of Controlling Substances required education.



P. Bradley Hall, MD

Support for the meeting was provided by the West Virginia State Medical Association, the WVMPHP, the West Virginia Society of Addiction Medicine, the West Virginia Board of Medicine, the West Virginia Board of Osteopathic Medicine, the West Virginia Osteopathic Medical Association, and the WVDHHR Bureau for Behavioral Health and Health Facilities. CME joint sponsorship was provided by CAMC Health Education and Research Institute. Attendees earned 15.25 CME credits, inclusive of the three-hour board mandatory CME; those in attendance included 134 physicians, physician assistants, nurses, dentists, and social workers. P. Bradley Hall, MD, executive medical director, WVMPHP was a featured speaker and the primary planner and organizer of this conference.

Speakers included Kimberly Walsh, deputy commissioner, WVDHHR; Jonathan Lee, MD; Kenneth Thompson, MD; Carl Alves; Chapman Sledge, MD; Roland Gray, MD; James Berry, DO; Carl R. Sullivan, III, MD; Allen Mock, MD; James Ferguson, DO; Evan Jenkins; Michael Goff; Edward Eskew, DO; Jimmy Adams, DO; and Denzil Hawkinberry II, MD.

Topics covered a broad range of relevant issues related to prescription drug abuse, addiction, and the paradigm for the epidemic, including the disease model of addiction, addiction and co-morbid illness, marijuana (the Colorado experience), neonatal abstinence syndrome, pain, proper prescribing, updated epidemiologic statistics, and a number of case studies.

Sponsorships by a physician education grant through the WVDHHR provided additional support inclusive of 10 scholarships for early career students and residents. Other organizations in the field were represented, including Aegis Sciences Corporation, Affinity eHealth, Alkermes,

Assurex Health, Caron Foundation, Cornerstone of Recovery, CorrLabs PLLC, Cumberland Heights, Elements Behavioral Health, Firstlab, IntegraLabs, Las Vegas Recovery Center, Life Center of Galax, Marworth Treatment Center, Millennium Labs, Mount Regis Center, Orexo US, Inc., Pavillon, Physician Choice Laboratories-PCLS, Pine Grove Behavioral Health, Quest Diagnostics, Ridgeview Institute, Talbott Recovery Campus, The Farley Center at Williamsburg Place, Tennessee Medical Foundation, Timberline Knolls Residential Treatment Center, West Virginia Health Information Network, WV Medical Insurance Agency, WV Medical Professionals Health Program, WV Society of Addiction Medicine and WV Mutual Insurance Company.

The success of the conference is an excellent example of collaboration and communication among organized medicine within the state and the expertise, passion, and support of the FSPHP membership and relevant others. The WVMPHP has been informed it has been awarded a similar grant from the WVDHHR/BBHFF to continue its efforts in the area of physician and provider education for 2015. As always, such support, assistance and guidance is a primary reason the WV Medical Professionals Health Program exists as it does today. On behalf of the WVMPHP, the providers we serve, and West Virginia, I thank you all!

Access to speaker presentations from this meeting are available on the WVSMA website at www.wvsma.org/conferences. — **P. Bradley Hall, MD, DABAM, FASAM, MROCC; Executive Medical Director, WVMPHP; President-Elect, FSPHP**

WYOMING PROFESSIONAL ASSISTANCE PROGRAM (WPAP)

During the legislative session of 2014, the Wyoming Professional Assistance Program (WPAP) successfully lobbied to have the state statute expanded to allow WPAP to assist professionals with mental/behavioral health issues. WPAP is grateful to all the state PHPs that shared their mental health program guidelines and monitoring agreements. We began offering this service to Wyoming professionals in September 2014. — **Candice Cochran, Executive Director, Wyoming Professional Assistance Program**



Candice Cochran



WV Governor Joe Manchin signing the legislation allowing for the formation of the WVMPPH in 2007

MOVING FSPHP FORWARD ~ BRING YOUR IDEAS FORWARD

The FSPHP Board of Directors is very interested in your ideas and suggestions, and we welcome agenda items you would like to bring before the board. It is important to be organized in our approach in order to make sure ideas are fully explored and vetted. Thus, the board established a policy that members are asked to submit written requests for consideration directly to FSPHP Interim Executive Director Linda Bresnahan at lbresnahan@mms.org or Debbie Brennan at dbrennan@mms.org. You may also prefer to submit to your regional director on the FSPHP Board of Directors. This will ensure an organized chain of communication between you and your representatives. Thank you for your assistance!

WELLNESS CONFERENCE FOR MEDICAL PROFESSIONALS



MPHP Professionals Conference: Health, Wellbeing and Awareness
Friday, April 17, 2015 8:00 AM - 4:30 PM ~ Holiday Inn By The Bay Portland, Maine

Date: Friday, April 17, 2015 ~ 8:00 AM to 5:00 PM
Location: Holiday Inn by the Bay, Portland, ME
Sponsored by: Maine Medical Professionals Health Program
Registration: \$150 (includes lunch)
How to register: www.mainemphp.org

Featured speakers include (visit our website for a complete listing of sessions):

Sarah Allen Benton, MS, LMHC, LPC — Author and therapist at Insight Counseling in Ridgefield, CT

“Understanding the High Functioning Alcoholic: Breaking the Cycle and Finding Hope”
Elissa Chesler, PhD, Jackson Laboratory

“Genetic and Genomic Studies of Addiction in Model Organisms”

Make plans today to join us for a comprehensive one-day wellness conference designed to help medical professionals, employers, treatment providers, and colleagues better understand the factors affecting recovering professionals. Additional information is available at www.mainemphp.org or by contacting Cathy Stratton at cstratton@mainemed.com or (207) 623-9266, ext. 3.

PHYSICIAN HEALTH AND OTHER RELATED ORGANIZATIONS NATIONAL MEETINGS

FSPHP Annual Meetings

April 24–27, 2015
Worthington Renaissance Forth Worth Hotel
Fort Worth, TX

April 27–30, 2016
Manchester Grand Hyatt
San Diego, CA

2017
Fort Worth, TX
Date and Location TBD

FSMB Annual Meetings

April 23–25, 2015
Omni Fort Worth Hotel
Fort Worth, TX

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

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

2015 Canadian Conference on Physician Health

October 16–17, 2015
Winnipeg, MB

2016 AMA-CMA-BMA International Conference on Physician Health

Date and location TBD
Boston, MA

American Academy of Addiction Psychiatry

Annual Meeting and Symposium
December 3–6, 2015
Hyatt Regency Huntington Beach
Resort and Spa
Huntington Beach, CA

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

American Academy of Psychiatry and the Law

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

AMA House of Delegates Annual Meeting

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

AMA House of Delegates Interim Meeting

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

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

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

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

American Board of Medical Specialties

National Policy Forum
April 21–22, 2015
Washington, D.C.

American Psychiatric Association Annual Meeting

May 16–20, 2015
Toronto, Canada

May 14–18, 2016
Atlanta, GA

May 20–24, 2017
San Diego, CA

May 5–9, 2018
New York, NY

May 18–22, 2019
San Francisco, CA

American Society of Addiction Medicine

April 23–26, 2015
Hilton Austin
Austin, TX

April 14–17, 2016
Hilton Baltimore
Baltimore, MD

AMERSA (Association for Medical Education and Research in Substance Abuse)

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

International Doctors in Alcoholics Anonymous (IDAA) Annual Meeting

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

Managing Workplace Conflict: Improving Personal Effectiveness

March 19–20, 2015
Waltham, MA
Jointly provided by the Massachusetts Medical Society and Physician Health Services, Inc.

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

Medical Group Management Association

October 11–14, 2015
Nashville, TN

National Association of Medical Staff Services

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

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

NAMSS 41st Educational Conference and Exhibition
The Broadmoor
October 21–25, 2017
Colorado Springs, CO

NAMSS 42nd Educational Conference and Exhibition
Long Beach Convention Center
September 29–October 3, 2018
Long Beach, CA

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

National Organization of Alternative Program

March 17–20, 2015
West Palm Beach Marriott
West Palm Beach, FL

Northeast FSPHP Membership Meeting

October 29, 2015
Waltham, MA



FEDERATION OF STATE PHYSICIAN HEALTH PROGRAMS, INC.

Annual Education Conference and Business Meeting

FRIDAY, APRIL 24—MONDAY, APRIL 27, 2015

THE WORTHINGTON RENAISSANCE FORT WORTH HOTEL — FORT WORTH, TEXAS

Will coincide with Federation of State Medical Boards Conference

Pursuing Physician Health Best Practices: Promotion of Accountability, Consistency, and Excellence

HIGHLIGHTS

- General and breakout sessions each day to highlight physician health best practices for achieving accountability, consistency, and excellence
- Networking Opportunities
- Daily Peer Support Groups
- Large exhibitor space for networking in the field

SCHEDULE AT A GLANCE

FRIDAY

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

SATURDAY

FSPHP/FSMB Joint Session
New Member Meeting
Administrative Session
General Sessions
Poster Session
Board and Committee Chair Dinner

SUNDAY

General Sessions
FSPHP Regional Meetings Exhibitor Session
Annual Business Meeting

MONDAY

General Sessions
Adjournment

AUDIENCE

Your audience will primarily be composed of physicians from all specialties; administrative personnel and support staff of state physician health programs; and others interested in learning more about how to identify, intervene, refer for treatment, and monitor physicians with substance use, mental disorders, and/or behavioral issues.

PROGRAM OBJECTIVES

Upon completion of the activity, participants should be able to:

1. Identify best practices and describe the methods in which PHPs can achieve accountability, consistency, and excellence
2. Compare different treatment modalities for substance use and co-occurring disorders and define outcomes
3. Discuss strategies for identifying and assessing cognition issues
4. Describe programs that promote healthy lifestyle in the profession and strategies that reduce burnout in physicians

POSTER SESSION OBJECTIVES

Poster viewing hours: Saturday, April 25 from 8:00 a.m. to 6:30 p.m.

Poster session: Saturday, April 25 from 5:00 to 5:45 p.m.

Upon completion of this session, participants should be able to:

1. Assess science-based information on substance use disorders treatment, precursors that are predictive of impairment, and alternatives to traditional 12-step based recovery programs.

2. Explain the impact of prolonged professional burnout and wellness activities on individual physical and mental health, and on patient behavior and safety.
3. Describe the spectrum of sexual issues for physicians, ranging from case management for those with problematic sexual behavior to behaviors that constitute criminal sexual misconduct.
4. Cite reasons why some individuals continue to relapse after treatment and benefits of a therapeutic alternative to discipline.
5. Utilize skills to prevent and respond effectively to criticisms regarding physician health programs.
6. Identify similarities of beliefs in patients with chronic pain and addiction, and the high risk for overdose in health care professionals with opioid dependence following abstinence-based treatment.

CONFERENCE SESSIONS

- ***FSPHP and Physician Health Update***
Doris C. Gundersen, MD
- ***The Evolution of Physician Health Programs over the Last 25 Years***
Lynn Hankes, MD
- ***Using the ASAM Criteria when Treating Health Care Workers***
Michael Wilkerson, MD; and Paul H. Earley, MD, FASAM
- ***Joint FSPHP and FSMB at the Omni Fort Worth Hotel, Fort Worth, Texas***
- ***Challenging Toxicology Cases in Monitoring Health Care Professionals***
Penelope P. Ziegler, MD; Martha E. Brown, MD; and Joseph Jones, MS, NRCC-TC
- ***Assessing Late-Career Physicians: What is Possible? What is Practical?***
Gail Jara; William Perry, PhD; and Richard D. Barton
- ***Special Presentation — FSMB Speaker***
Janelle Rhyne, MD, MACP
- ***Psychiatric and other Conditions Affecting Disruptive Behavior***
Penelope P. Ziegler, MD; Martha E. Brown, MD; and Lisa J. Merlo, PhD, MPE
- ***Distressed Physicians: A Synthesis of PHPs' Best Practices***
Christina Gaudiana, LMHC; and Betsy Williams, PhD, MPH
- ***Development and Implementation of Occupational Health Monitoring for Physicians in Need of Professional Coaching***
Steve Adelman, MD; and Debra Grossbaum, Esq.
- ***The Role of Spirituality in Physician Recovery***
John A. Fromson, MD
- ***Southeast Regional FSPHP Member Survey to Assess Treatment Provider Services***
Scott Hambleton, MD; and Paul H. Earley, MD, FASAM

CONCURRENT SESSIONS

- ***Physician Suicide Behavior Following Fitness-for-Duty Evaluation***
Alistair James Reid Finlayson, MD; Roland Gray, MD; and Ron L. Neufeld, BSW, LADAC
- ***Using Intake Interviews to Enhance Identification of Suicidality in PHP Populations***
Elizabeth Brooks, PhD; and Doris C. Gundersen, MD
- ***Moving from Compliance to Recovery: Using Motivational Interviewing to Help Clients Build Their Recovery***
John Ordiway, MS, LPC, LAT
- ***What to Do with Sexual Boundary Violations: History, Assessment and Treatment***
James C. "Jes" Montgomery, MD; Phillip Hemphill, PhD; and Andrew C. Stone, MD, MPH
- ***Promotion of Wellness among Medical Students to Improve Physician Health***
Lisa J. Merlo, PhD, MPE; and Penelope P. Ziegler, MD
- ***Cognitive Problems among Participants in the Colorado Physician Health Program: A Review of Cases 1986–2014***
Michael H. Gendel, MD; and Elizabeth Brooks, PhD
- ***Cognitive Dysfunction and the Older Physician: Is Your Organization Ready to Meet Emerging Demand?***
Chris Bundy, MD, MPH; Charles Meredith, MD; and Amanda Shaw, MPH
- ***Preventing Physician Suicide: Best Practices for Promoting Hope and Resilience***
Michael Groat, PhD, MS



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




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FSPHP THROUGH THE YEARS



Left : John Fromson, MD **Right:** Gerald Summer, MD



Roland Gray, MD, Current FSPHP Board Member



William Modclair, Rhode Island PHP, Past FSPHP Treasurer



Left : Martin Doot, MD **Right:** Michael Gendel, MD,
Past FSPHP Presidents



Left: Peter Mansky, MD, Past FSPHP President
Right: Terrance Bedient, FACHE, Past FSPHP Treasurer

FSPHP E-Groups — Please Join!

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

FSPHS e-groups are a forum for discussion of issues, problems, ideas, or concerns, relevant to State PHPs. Membership to the e-groups is only open to Federation members. Visit www.fsphp.org/FSPHPEGroupGuidelines11.14.pdf for guidelines on the use of the e-group.

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



for an email invitation to join this group, if you are not already on it.

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

- statePHP@yahoo.com

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

— Linda Bresnahan, MS,
Interim Executive Director FSPHP

FSPHP NEWSLETTER ADVERTISING INFORMATION AND SPECIFICATIONS

Dear prospective *Physician Health News* advertisers:

We would like to invite you and your organization to advertise your services in the future editions of *Physician Health News*. *Physician Health News* is mailed to all state programs and state licensing boards. The newsletter is also distributed widely at the FSPHP Annual Meeting. Articles and notices of interest to the physician health community, the newsletter includes planning information about the upcoming physician health meetings and conferences including FSPHP meetings.

We offer ad design and proofreading services for an additional fee. For your convenience, full ad specifications and PDF instructions can also be provided upon request.

We hope you will consider taking advantage of this once-a-year opportunity to advertise your facility, services, and contact information. Become part of a great resource for state physician health program professionals.

We look forward to working with you in future editions.

FSPHP Publication Committee

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