PHYSICIAN HEALTH NEWS

The Official Newsletter of the Federation of State Physician Health Programs

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

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

FSPHP CONTACT INFORMATION AND MAILING ADDRESS

IN THIS ISSUE

PRESIDENT'S MESSAGE

Paul H. Earley, MD, DFASAM

We are living in an era of national divisiveness, where poorly formed or baseless opinions are used as fodder for derision on the public stage. Fueled by social media, where truth is unnecessary or irrelevant, even our public leaders use unbridled hostility as a weapon

Paul H. Earley, MD, DFASAM

of power against those with whom they disagree. This attitude of considering the opposing views of others as categorically erroneous (and a sign of ignorance, stupidity, and even evil) has spread to all of us in varying degrees, even those who have been trained to rely on science as the basis for verisimilitude.

I recall the early 1990s, working with physicians who struggled with mental health and addiction disorders. Each year in Georgia, we had two to five physicians die of overdose or suicide—deaths of despair. Regrettably, some physicians suffer from an extraordinarily hostile self-concept, and without hope of proper treatment or well-structured disease monitoring, those at the edge of this curve died. Our state was late in sanctioning the development of a PHP; at that time our physicians suffered the brunt of this oversight. Today, in states covered by PHPs, vastly improved outcomes are the norm.

At the same time, professionals who struggle with these same potentially impairing conditions are exposed to wider varieties of information containing polarized opinions. Unfortunately, social media aimed at physician health has the same divergent content as politics and star fandom. Seeking help has become more confusing than ever before. With a plea to use science, those of us in the field urge our medical (and hopefully data-respecting) colleagues to be mindful of all sources of information, those that are credible and validated and those that are not.

We have obligations here, too (the we here is every state and province PHP as well as the FSPHP itself). It is our job to increase the dissemination of accurate information, clarifying the role of PHPs, the science of outcomes, and the stories of those whose lives have moved from despair to recovery and meaningful living. At the same time, we must eschew the natural tendency to react to our naysayers without consideration. Great value comes from being aware of divergence of opinion, especially when it is spewed into social media or published in faux-scientific journals. In doing so, we learn about how we appear to others, while deepening our patience with those who judge based on subjective and unvalidated anecdotal information.

The most important gathering of the year in physician health is the annual business and scientific meeting of the Federation of State Physician Health Programs. My impression is all who attended the 2019 FSPHP Annual Meeting, *Perplexing Problems and Effective Solutions for Treating and Monitoring Healthcare Professionals*, in Ft. Worth would agree. The wide range of important topics covered reminds me that we have a deep bench of subject matter experts in our field and that each presenter and participant were there to improve the lives of all who work in medicine. We learn from one another, widening our approaches and expanding our skills in this vital field.

Now more than ever, it is an important time for all of us to stay abreast of research in the field, to work together to create even better outcomes, and to participate in the FSPHP's quality improvement initiatives. At the same time, we should go forth sharing the PHP message of strength and hope to the wider healthcare field. Healthcare professionals with potentially impairing conditions need to hear with consistency and clarity that PHPs are a place for them to come forward to seek support and help for any potentially impairing conditions they face.

With all this in mind, please take the time to read and review summaries from our last conference. And, might I add, consider what you will bring to our 2020 meeting in San Diego! ∎

MESSAGE FROM THE FSPHP EXECUTIVE DIRECTOR ON BEHALF OF THE BOARD OF DIRECTORS

Linda R. Bresnahan, MS, FSPHP Executive Director

As we head into the last quarter of 2019 and enter our thirtieth

Linda R. Bresnahan, MS

anniversary year in 2020, I would like to summarize the FSPHP strategic areas, share our advocacy work and accomplishments, and highlight the tremendous work in progress.

The dedication and expertise of our members continues to be the hallmark of our strength with our fundraising, outreach, and services.

Thank you wholeheartedly for being part of the mission of the FSPHP. We are looking forward to more growth and development on behalf of our member Physician Health Programs in 2020!

FSPHP Strategic Areas

Accountability, Consistency, Excellence

- Performance Enhancement and Effectiveness Review (PEER)™ and Provider Accreditation Programs under development

Education, Visibility, Research

- Dissemination of timely and accurate information to the field that demonstrates the value and effectiveness of the PHP model

- Strategic communications, stakeholder partnerships/alignment, media, and PR

Membership

- Organizational growth, membership service and value, experienced and skilled leadership succession

Financial Stability and Operations

- Develop resources to support sustainable growth and deliver on mission, vision, and strategic goals

FSPHP Reach and Accomplishments in the Field

- Established an Accreditation Review Council, PEER™ Committee and Provider Accreditation Committee with stakeholder and subject matter experts to develop these programs

- The FSPHP Accountability, Consistency, and Excellence Committee work was unanimously approved by the FSPHP members, resulting in the publication of the **2019 FSPHP Physician Health Program Guidelines**: www.fsphp.org/guidelines

- Growing Support of Organized Medicine to date with sponsorship toward PEER™ and Provider Accreditation from multiple important organizations, including:
  – Federation of State Medical Boards
  – American Medical Association
  – American Council of Graduate Medical Education
  – American Psychiatric Association
  – American Osteopathic Association
  – American College of Physicians
  – American Board of Medical Specialties

- AMA Resolution 321 (A-19) passes, supporting the work of FSPHP and PHPS in June 2019!

- **"Programs and Resources to Alleviate Concerns with Mental Health Disclosures on Physician Licensing Applications":** https://jmronline.org/doi/full/10.30770/2572-1852-105.2.24

  In this article, the authors discuss how some state medical boards have taken steps to address barriers that prevent licensees from seeking help. The article reviews the work of the Federation of State Medical Board's work group on Physician Wellness and Burnout, which addresses concerns about physician wellness, burnout, and suicide prevention. The article includes a description of the role of Physician Health Programs, and this important update is likely to continue the progress being made by the FSMB work group.

- **"Physician Impairment and Rehabilitation: Reintegration Into Medical Practice While Ensuring Patient Safety: A Position Paper from the American College of Physicians":** https://annals.org/aim/fullarticle/2735179/physician-impairment-rehabilitation-reintegration-medical-practice-while-ensuring-patient-safety

  We appreciate the authors' comprehensive and nuanced exploration of issues related to physician health. The authors are: Philip J. Candilis, MD; Daniel T. Kim, MA, MPH; Lois Snyder Sulmasy, JD; and the ACP Ethics, Professionalism, and Human Rights Committee. Dr. Candilis has been a dedicated colleague in the work of the FSPHP and is currently affiliated with the Washington, DC, program. Lois Snyder Sulmasy, JD, is currently serving on the FSPHP Accreditation Review Council for the development of the FSPHP's PEER™—Performance Enhancement and Effectiveness Reviews and Provider Accreditation Programs. In addition, the FSPHP was pleased to contribute as a reviewer of this paper.

  Of note, the references in this paper include live links to other important references, many of which will prove useful for all of us in this field.

  Please feel free to share links to the paper (http://annals.org/aim/article/doi/10.7326/M18-3605) and the paired editorial (http://annals.org/aim/article/doi/10.7326/M19-1192).

- **FSPHP Statement on Sexual Misconduct in the Medical Profession** and references has been developed by the FSPHP Public Policy Committee and approved by the FSPHP Board of Directors in May 2019: www.fsphp.org/assets/docs/Sexual%20Misconduct%20in%20the%20Medical%20Profession%20Statement%20May%202019.pdf.

Message from the FSPHP Executive Director on Behalf of the Board of Directors

- Successful transition to new Website and data-base platform

- The FSPHP Bylaws and Membership committees clarified FSPHP bylaws in 2019! In states in which there is more than one PHP, more than one PHP is now eligible to be a member.

- FSPHP Membership has reached an all-time high with 222 FSPHP members as of September 2019! We have 47 State PHP members.

- Launched a new fundraising campaign, *Partnering to Advance PHPs*! In our third year of raising philanthropic dollars, the Fund Development Committee named our fundraising campaign, giving careful consideration and ensuring alignment with the FSPHP's mission to "support physician health programs in improving the health of medical professionals, thereby contributing to quality patient care."

Highlights of FSPHP Committee Work in Progress

Research Committee, Chaired by Drs. Karen Miotto and Lisa Merlo

The FSPHP's Research Committee goal is to develop, evaluate, and pursue research opportunities, including partnerships and funding that may be available to the FSPHP and to facilitate individual program research and present such opportunities to the FSPHP with recommendations. Progress is developing in these areas:

- Partner with credible researchers to promote research related to the PHP model

- 2001 National PHP survey to be repeated in the future to review structure, services, scope, funding, and referrals to PHP

- FSPHP to examine best approach to complete a future PHP participant outcome study (last one completed in 2005)

- Discussions are under way to examine method to create standardized data collection among PHPs

Meanwhile, the FSPHP is collaborating with an ongoing study with the National Institute on Drug Abuse— **"Imaging Biomarker for Addiction Treatment Outcome" with Osama A. Abulseoud, MD,** Associate Research Physician, National Institute on Drug Abuse, Neuroimaging Research Branch, Intramural Research Program, and **Elliot Stein, PhD,** Chief, Neuroimaging Research Branch, National Institute on Drug Abuse, Cognitive Neuroscience and Psychopharmacology

Section. Current PHP participants and physicians currently in treatment are potential subjects for this study, which hopes to expand our understanding of how brain circuits change in the first several years of recovery.

Publication Committee—Increasing PHP and FSPHP Visibility and Content, Chaired by Amanda Kimmel, MPA, and Sarah Early, PsyD

This committee has been actively providing regular oversight to guide relevant content for the FSPHP Website and Newsletter and to moderate the Yahoo! Groups. With the oversight of this committee, FSPHP will soon launch FSPHP into LinkedIn and create a "Research" section of the Website for abstracts to highlight the most relevant research in the field.

Website Updates Snapshot:

- ***Updated and Expanded Featured Articles and Podcasts*** page.* This page now includes podcasts and even more articles that focus on the great work that PHPs are doing and the restored lives and careers of our participants. The ***Featured Articles and Podcasts*** link is available via a Quick Links tab on the home page.

- ***New Event Photos*** page. Take a look at photos from last month's *2019 FSPHP Annual Education Conference and Business Meeting* in Fort Worth, TX, as well as look at FSPHP through the years!

- ***New photos*** on the ***Home Page Slideshow***. Check out the latest member photos!

- ***Updated listing*** of FSPHP ***Board of Directors***.

- The ***State Programs*** pages continue to be *updated weekly*.** Review your page to ensure your state program page is up to date.

- ***New Announcements and Upcoming Events*** with save the date messaging for the 2020 Annual Education Conference. Mark your calendars now!

Please be sure to visit www.fsphp.org to check out these exciting improvements and updates.

*If you have articles or podcasts that you would like included on the Featured Articles and Podcast page, please email them to ssavage@fsphp.org. All items will be subject to a review process prior to posting.

**Email any and all updates to your State Program page to ssavage@fsphp.org. Please allow for three to five business days for updates to be made.

Public Policy Has Several Future Goals, Chaired by Scott Hambleton, MD

- This committee will work with members on an FSPHP position statement that involves a review of PHP practices with cannabinoids.

- The committee will develop a FSPHP Policy to define a process for the development, updating, and sunsetting of new FSPHP Policies, Statements, and Guidelines.

Membership Committee— Focused on Membership Expansion, Chaired by Drs. Chris Bundy and Brad Hall

Your Membership Committee is examining ways to expand membership while maintaining the current governance structure with PHP members.

A work group of the FSPHP board is working with the Membership Committee, Bylaws Committee, and other relevant FSPHP resources to develop recommendations to the FSPHP Board for a new membership structure that will permit any individual or organization to be a member of FSPHP, without altering FSPHP governance.

The FSPHP Membership Committee is also actively involved in member recruitment, engaging new members, and mentoring the development of new PHPs in states without a PHP. It is also currently encouraging member PHPs to recruit more associate members affiliated with their PHP.

Finance Committee, Chaired by Deanne Chapman, PA-C

In May of 2019, FSPHP began its transition to a new FSPHP Treasurer from Robin McCown of GA PHP to Deanne Chapman PA-C, of the NH PHP.

Your Finance Committee meets regularly and is overseeing fiscal affairs, including the FSPHP dues structure. The Finance Committee met in August to examine and approve a 2020 FSPHP budget for the FSPHP Board's review.

Fund Development Committee (FDC), Chaired by Angela Graham, MPA, and Kelley Long, MBA

The purpose of the FDC is to plan and implement a comprehensive fund development initiative, to recommend fundraising strategies, and support funding initiatives. The FDC spearheaded the launch of the FSPHP's third year of fundraising activities with the "*Partnering to Advance PHPs*" campaign, which has currently raised over $23,370. We are on target to exceed our third successful year of fundraising over

$20,000 with 100 percent giving from the generous and dedicated leaders of the FSPHP—the Board of Directors: www.fsphp.org/board.

Ethics Committee, Chaired by Dr. Michael Baron

The Ethics Committee is in its third year of improving FSPHP practices with conflict of interest. FSPHP Board and committee members are highly regarded and sought-after experts in the field of physician health. As such, conflicts of interest are anticipated and managed with our policy that includes annual disclosures, proactive disclosure, and recusal when indicated. This past June, FSPHP completed its annual COI process for all committee and Board members and will review updates to COI policy in the coming year.

FSPHP Past President Committee, Chaired by Dr. Luis T. Sanchez

Many FSPHP Past Presidents remain active with the FSPHP, providing insight, experience, and expertise to the FSPHP. Dr. Luis Sanchez and Dr. Lynn Hankes are currently active members of the PEER™ committee and its development efforts. Dr. John Fromson remains an active advisor to FSPHP as well.

FSPHP Program Planning Committee, Chaired by Drs. Doris Gundersen and Martha Brown

This committee meets monthly to design the FSPHP Annual Meeting and Education Conference. FSPHP will be celebrating its 30th ANNIVERSARY YEAR in 2020!!!!!!!

The FSPHP 30th Anniversary Conference: Leading the Way in Physician Health Thursday, April 30, 2020–Sunday, May 3, 2020 Manchester Grand Hyatt, San Diego, California www.fsphp.org/2020-fsphp-annual-education -conference---business-meeting

The Abstract Submission deadline for **Oral Presentations** is **September 30, 2019** and the deadline for **Poster Presentations** is **January 15, 2020**.

FSPHP will offer an **FSPHP Excellence in Research Poster Symposium Award** to the top poster(s). FSPHP has reached out to fellows this year to encourage poster submissions.

This year's conference is organized around three main topic areas:

- **Strategies for Funding, Operational Performance, and Improving Professional Fulfillment in Physician Health Work**

Message from the FSPHP Executive Director on Behalf of the Board of Directors

- **How Best to Evaluate and Improve Participant Experiences**
- **Legal and Regulatory Topics for Treatment Providers, PHPs, and Licensing**

Regional Meeting Plans in Place

Central FSPHP Regional Membership Meeting
Thursday, October 3–Friday, October 4, 2019
Hopewell, 130 E. Chestnut Street, 1st Floor,
Columbus, Ohio

Western FSPHP Regional Membership Meeting
Friday, October 18, 2019
Arizona State University, Center for Applied Behavioral Health Policy
College of Public Service and Community Solutions
Many thanks to the Arizona Physician Health Program for hosting the meeting with the FSPHP Western Regional Directors on the Board.

Northeast FSPHP Regional Membership Meeting
Monday, November 18, 2019, 8:30 a.m.–3:30 p.m.
Pennsylvania Medical Association, 777 East Park Drive,
Harrisburg, PA 17111

Many thanks to the Pennsylvania Physicians' Health Program for hosting the meeting with the NE Regional Directors on the Board.

AMA Delegates, Drs. Scott Hambleton and Luis Sanchez

AMA Resolution Supporting the work of FSPHP and PHPs passes in June 2019!!

RESOLUTION 321—PHYSICIAN HEALTH PROGRAM ACCOUNTABILITY, CONSISTENCY, AND EXCELLENCE IN PROVISION OF SERVICE TO THE MEDICAL PROFESSION

"Our AMA will continue to work with and support FSPHP efforts already under way to design and implement the physician health program review process, Performance Enhancement and Effectiveness Review (PEER™), to improve accountability, consistency, and excellence among its state member PHPs. The AMA will partner with the FSPHP to help advocate for additional national sponsors for this project. Our AMA will continue to work with the FSPHP and other appropriate stakeholders on issues of affordability, cost effectiveness, and diversity of treatment options."

Full Resolution page 4: www.ama-assn.org/system/files/2019-06/a19-refcommc-report.pdf.

Public Relations—Supporting Member PHPS

A recent task force of the FSPHP Board of Directors met to examine FSPHP Communication Strategies. The committee recommended that the FSPHP Board direct the development of a Strategic Communication Committee under the Media, Education, and Research Work Group to organize communications for the FSPHP and its members.

FSPHP Nominating Committee, Chaired by Dr. Brad Hall

The FSPHP Nominating Committee will begin its annual process soon to **call for candidates** and to nominate officers and director positions to fill terms on the board that will be open in April 2020. There are four regional positions terms that will be open in May 2020 and the president-elect term. If you are interested in a leadership position with the FSPHP, watch for the "Call for Candidates" in October.

Our other FSPHP Committees continue to address business as well. The FSPHP Bylaws Committee and the Medical Student and Resident Committee continue to meet and execute their respective functions within our organization.

The FSPHP Board of Directors meets almost monthly and met in person September 21–22, 2019, following the American Conference on Physician Health at the same location. At this time, all committee work and FSPHP strategic priorities are reviewed and refreshed with revisions or additions. ∎

GROWING OUR MEMBERSHIP!

Significant potential benefits are available to those interested in physician and professional health when they join the FSPHP. Member Benefits: www.fsphp.org/benefits-of-membership

Our Network is Growing

We now have our largest number of members ever at 222. New members benefit by the deep experience of our current member PHPs, and in turn, new members bring exciting ideas to our members. Our dedicated current members are a vital part of the passion and effectiveness of our overall mission: *"To support Physician Health Programs in improving the health of medical professionals, thereby contributing to quality patient care,"* and our vision: *"a society of highly effective PHPs advancing the health of the medical community and the patients they serve."*

We Want To Inspire New Members To Join FSPHP. State PHP Members—We Need Your Help! Please Share Information About Membership.

We ask State PHP members to *share information* about FSPHP membership with your staff, board members, and committee members who are welcome to join as associate members and benefit from the learning involved in the FSPHP membership. We are encouraging each state member to increase its associate memberships in 2020. While budget considerations may limit the number of FSPHP members a PHP can fund, a designee of the PHP board or committee may be willing to fund their own membership, especially after recognizing the benefits of doing so.

Individual and Organization Membership Opportunity Exists

The individual and organization membership categories allow our membership to grow. The benefits of FSPHP membership may be of interest to colleagues in your state aligned with the FSPHP mission, such as the following:

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

The Value of Membership

FSPHP members have access to exclusive networking, resources, collaboration opportunities, and educational opportunities at the leading edge of physician health. In addition, the FSPHP provides education and exchange of ideas for physician health through its member e-mail groups. Membership provides access to the members-only section of the FSPHP website. Members have access to FSPHP policies and guidelines, leadership opportunities, new employment opportunities, and up-to-date information on the latest issues affecting physician and professional health at the state and national levels. FSPHP new members receive a discount on our annual conference and complimentary participation in FSPHP Regional Membership Meetings.

The FSPHP has six categories of membership: State, Associate, International, Organizational, Honorary, and Individual. A description of each membership type can be reviewed here: www.fsphp.org/classes-of-membership

We look forward to your membership and growing the FSPHP. FSPHP is extremely grateful to all our members for your support and participation. We sincerely appreciate all that you do to help us continue our mission of supporting physician health programs.

Paul H. Earley, MD, DFASAM
FSPHP President

Partnering to Advance Physician Health Programs (PHPs)

Please join me and our 2019 fellow donors below in supporting the Federation of State Physician Health Programs' (FSPHP) new campaign: ***"Partnering to Advance Physician Health Programs (PHPs),"*** which was launched this past summer with a mailing that was sent to all FSPHP members and affiliates.

If you have not done so already, please consider making a gift today at www.fsphp.org/donate!

For almost three decades, the FSPHP has provided professional education, collaboration, and advocacy to assist our member PHPs across the country. FSPHP strives to support physicians, and in some states, other licensed healthcare professionals, who have a health condition that is affecting their ability to practice safely and effectively.

It is nearly impossible for us to do our important work without your support. Your donation will ensure that FSPHP continues to implement new initiatives, uphold an environment of fellowship and networking, establish best practices, and assist PHPs in their quest to protect the public. Your investment in FSPHP is essential now more than ever before!

We ask for your support today. It will enable us to:

- Expand the visibility of our member PHPs to ensure they are able to reach those in need at a time when barriers to get help are increasing.

- Reaffirm and extend the message of our PHP members, to encourage those at risk of potential illness to come forward for support and help.

- Convey to those in the healthcare community that PHP Participants are better physicians.

- Educate and implement the 2019 *FSPHP Physician Health Program Guidelines*, increasing accountability, consistency, and excellence of PHPs.

- Provide a robust and valuable annual education meeting and newsletters to keep members abreast of critical national issues.

- Arrange for tools and resources for members, including policies and guidelines and individualized consultation supporting strong advocacy with many national organizations that have partnered with FSPHP to reaffirm and advance their mission.

Further, the outcome of the Performance Enhancement and Effectiveness (PEER)™ program will include validation of the current PHP practices and an identification of areas that will benefit from improvements. As such, reviews become more common. The data will enable the development of deeper insight and awareness into the importance of allowing our professionals the dignity to be patients, as well as providers, thereby enhancing patient health and safety.

We will continue collaboration with our membership and increase engagement on a national level, but we cannot do this without your help! Will you join us in *Partnering to Advance PHPs*?

Please visit www.fsphp.org/donate if you would like to support the FSPHP!

2019 FSPHP GENEROUS DONORS AS OF SEPTEMBER 30, 2019

Since our FSPHP inaugural fundraising campaign and silent auction, FSPHP raised $22,840 in 2017, $28,145 in 2018, and $23,370 in 2019 as of September 30, 2019.

FSPHP and our fund committee members would like to thank the numerous dedicated donors. We are grateful for this ongoing support. Board members, FSPHP members, and others invested in physician health have made contributions with a few matching PHP donations. This growing support will further our strategic goals to develop a Performance Enhancement Review Program and a Treatment Center Review Program and increase member services and support, while furthering our research and education goals, too. To donate online, you may click here: www.fsphp.org/donate.

Thank you to our recent donors:

Ally of Hope ($2,500–$4,999)
Chris Bundy, MD, MPH
P. Bradley Hall, MD
Scott Hambleton, MD, DFASAM
Robin McCown

Advocate ($1,000–$2,499)
Linda Bresnahan, MS
Paul H. Earley, MD, DFASAM
Doris C. Gundersen, MD
Scott Teitelbaum, MD, FAAP, FASAM

Caregiver ($500–$999)
Reid Finlayson, MD
Fran Langdon, MD, ABAM
Barry Lubin, MD
Karen Miotto, MD
Laura Moss, MD
Ohio Physicians Health Program
Michael Wilkerson, MD, FASAM
Dennis Wolf, MD

Friend ($1–$499)
Anonymous
Michael Baron, MD, MPH, DFASAM
Paul Cheng, MD, MPH, DFSAM
Paula Colescott, MD
Dianne Gay
Angela Graham, MPA
David Granovetter, MD
Mitchell Hall, MBA
Scott Hambleton, MD, DFASAM
Lynn Hankes, MD

Stephen Heimbach, MD
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Jon Shapiro, MD
Ray Truex, MD, FACS, FAANS
Robert Westcott, MD
Sherry Young, PhD, CSAT
Cecilia Zinnikas, MHR

A SPECIAL THANK YOU TO OUR SILENT AUCTION DONORS AND WINNERS WHO EACH HAVE MADE A SIGNIFICANT CONTRIBUTION TO THE FSPHP.

Donors
Michael Baron, MD, MPH, DFASAM
Martha E. Brown, MD
Tish Conwell, COO Florida Professionals Resource Network
Wanda Earley and Paul Earley, MD
Erica Frank, MD and NextGenU.org
Marlene Hall and Brad Hall, MD
Doris Gundersen, MD
Scott Hambleton, MD, DFASAM
Robert McKinnon, GAPHP
Sherry Young, PhD, CSAT Right Fit Consulting
Park Hill Fine Art Portraits
Pine Grove, Susan Jett McCall/Lisa Lucas
Positive Sobriety Institute, Dan and Dominic Angres
Sierra Tucson
Talbott Recovery, Crista Anderson, LPC, NCC

Winners
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Paul Cheng, MD, MPH, DFSAM
David Granovetter, MD
Mitchell Hall, MBA
Scott Hambleton, MD, DFASAM
Stephen Heimbach, MD
Fran Langdon, MD, ABAM
Barry Lubin, MD
Robin McCown
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Karen Miotto, MD
Laura Moss, MD
Robert Westcott, MD
Michael Wilkerson, MD, FASAM
Sherry Young, PhD, CSAT ■

2019 ANNUAL EDUCATION CONFERENCE LECTURE SUMMARIES

TRANSFORMING BOUNDARIES WILL TRANSFORM YOUR LIFE

Sarri Gilman, LMFT

The focus of my work is how you can use your boundaries and your inner compass to have better self-care, increased well-being, and better relationships. I teach on the subject of boundaries and

Sarri Gilman, LMFT

overwhelming recovery and specifically for people in healthcare and human services. For my presentation at FSPHP, the focus was on boundaries and self-care.

Here are a few concepts to know so we can speak the same language to understand boundaries. Your boundaries are made up of what you say yes to and no to. You have a compass inside you for your own yes and no. The key to your self-care is in your boundaries. Tuning in and listening to your compass can be very challenging. Your boundaries have one job: to take care of you. But we often are focused on what other people need and want from us and we respond to all that is coming toward us by using one or more of the seven patterns.

The seven patterns are Sacrificer, Workaholic, Caretaker, Lover, Isolator, Numbing, and Protector.

Your self-care and boundaries can be best understood through the seven patterns. These patterns are used all over the world. Cultures favor certain patterns more than others; families favor certain patterns. Certain professions also favor certain patterns.

You must tie your self-care activities to your pattern, to increase effectiveness of your self-care. Your self-care may be random, or things that feel good, but are not necessarily related to the pattern you are using in your work, family, and relationships. If your self-care is random and not tied to your pattern, it won't help you recover from your pattern.

Your pattern can interfere with listening to your compass, your true yes and no. If you are not listening to your compass, you will get symptoms. The symptoms may be running away, anxiety, depression, not sleeping, high-risk behavior, physical symptoms in the body—stomach pain, headaches, and so forth. There are many symptoms you can get from not listening to your boundaries.

Usually, we treat the symptoms, but do not really get to dig down and get to the authentic yes and no. For your self-care to help you the most, it must help you bring balance to the seven patterns—and specifically to the one, two, or three patterns you are using. And we must get to your authentic yes and no.

All recovery involves boundary recovery.

You can learn more about Sarri's work on her website: www.Sarrigilman.com.

Her books, *Transform Your Boundaries and Naming and Taming Overwhelm*, are available on Amazon. ■

CONFIDENTIALITY OF PHP RECORDS: 42 CFR PART 2, PEER REVIEW AND HIPAA

Stacy Cook, JD, LLM, Barnes and Thornburg

This presentation covered the federal and state confidentiality laws that potentially apply to physician health programs ("PHPs") and de-

Stacy Cook, JD, LLM

scribed certain best practices to help PHPs achieve compliance with applicable laws, particularly 42 CFR Part 2.

1. Federal Laws

A. 42 CFR Part 2.

42 CFR Part 2 ("Part 2") is a federal law that applies to individuals and entities that hold themselves out as providing, and do provide, referral for substance use disorder treatment, and/or substance use disorder treatment, and are federally assisted. A program is considered federally assisted if it has received tax exempt status from the IRS, has a DEA registration, is enrolled in Medicare, or has other licensure or government authority to operate, or receives any funds from the federal government.

Part 2 generally prohibits programs from disclosing to a third party any information that identifies someone as having a past or current substance use disorder or being a past or current PHP participant. Disclosure is only permitted (1) with written consent that meets specific requirements, (2) if a court issues an order for disclosure under Part 2, or (3) if an exception under Part 2 applies. Unlike other confidentiality laws, Part 2 has very few exceptions allowing disclosure. For

example, Part 2 does not have an exception that allows disclosure for payment purposes, or even to treat the individual. As another example, Part 2 does not have an exception for disclosing information in response to a subpoena. Also, if Part 2 conflicts with a state law, Part 2 overrides state law. As a result, if state law permits or requires disclosure of information, but Part 2 prohibits disclosure, Part 2 controls. However, there is a procedure under Part 2 for programs and other third parties to seek a court order allowing disclosure of the information.

Part 2 does allow a program to disclose information to a third party that provides certain services to the program, which Part 2 defines as a Qualified Service Organization (QSO). Before disclosing information to a QSO, the program is required to obtain a written agreement with the QSO containing terms specified in Part 2.

The following are best practices to help Part 2 programs achieve and maintain compliance with Part 2:

- Have a template QSO Agreement that meets Part 2 requirements.

- Implement written policy/procedures to identify QSOs and obtain QSO Agreements.

- Implement written policy/procedures specifying the Part 2 confidentiality requirements and limited exceptions that allow disclosure without consent or court order.

- Train relevant staff on policy/procedures upon hire and every year.

- Have a template consent document that complies with Part 2.

- Provide the written notice to participants that is required under Part 2.

- Implement a file checklist to ensure compliance with consents and other Part 2 requirements.

- Include the required language on each page of disclosed documents: "42 CFR Part 2 prohibits unauthorized disclosure of these records."

- Implement written technical and physical security measures to protect the information

B. HIPAA

HIPAA is a federal law that applies to healthcare providers who engage in HIPAA "standard transactions." Most activities that come within the definition of a standard transaction all relate to submitting electronic claims in a certain format to third-party payers. In other words, providers who submit industry-standard electronic claims to insurance companies are subject to HIPAA. On the other hand, providers who bill an individual directly are not subject to HIPAA. For this reason, many PHPs are not subject to HIPAA.

For PHPs that are subject to HIPAA, the law generally prohibits use or disclosure of the individual's information unless the individual consents, or a HIPAA exception applies. HIPAA contains many more exceptions than Part 2. However, if a PHP is subject to Part 2 and HIPAA, it must comply with both requirements. So, for example, if HIPAA permits a disclosure, but Part 2 prohibits the disclosure, the program must comply with Part 2.

2. State Laws

In addition to federal laws, each state has its own confidentiality laws. For example, many states have peer-review laws, laws on health records, and laws that govern provider–patient confidentiality. Because there are a number of potentially applicable laws, another best practice is for a program to conduct a legal review to determine which laws apply, and if multiple laws apply, to understand which laws override any other conflicting laws.

Please note: This presentation summary is information only. It does not constitute legal advice. ∎

SUPPORT FOR HEALTHCARE PROFESSIONALS WITH SUBSTANCE USE DISORDERS

Penelope Ziegler, MD; Mary Raum, MD; Christopher Bundy, MD; and Michael McCormack, DO

Penelope Ziegler, MD

Mary Raum, MD

A panel discussion titled "Support for Healthcare Professionals with Substance Use Disorders" was presented at the 2019 Annual Meeting

Christopher Bundy, MD

Michael McCormack, DO

Support for Healthcare Professionals with Substance Use Disorders

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by Penelope Ziegler, MD, Mary Raum, MD, Christopher Bundy, MD, and Michael McCormack, DO. The focus was on International Doctors in Alcoholics Anonymous, IDAA, the largest support organization for healthcare professionals and families recovering from addiction. Dr. Ziegler spoke about the history of the organization, its operations and activities, and its annual conference. Dr. Raum discussed the expanded membership that now includes, in addition to doctoral-level healthcare providers, all pharmacists, CRNAs, ARNPs, and physician assistants. She emphasized the nonregulatory and confidential nature of the program and its specialized subgroups for women, LGBTQ professionals, agnostics, and so forth. Dr. Bundy focused on the ways IDAA can complement and support the work of professional health programs, as well as on the inclusion of all members of the professional's family. Dr. McCormack shared his own experiences with IDAA as a critical support to him, his wife, and their children in their recovery journey.

Although IDAA developed in the early days of Alcoholics Anonymous, the panelists discussed the inclusion of other Twelve Step programs (NA, SAA/SLAA, GA, etc.) More recently, when available, alternatives to Twelve Step programs such as Smart Recovery, Refuge Recovery, and secular groups have been made available. Several investigators have worked on research projects with IDAA. IDAA's plan to explore additional opportunities for research on aspects of addiction recovery also was referenced. The panel also provided information about other professional support groups, including International Lawyers in A.A. (ILAA), Anesthetists in Recovery (AIR), and groups in other countries, including British Doctors and Dentists Group (BDDG) and Australian and New Zealand Doctors in Recovery (ADR).

The workshop included many questions and comments from attendees, some of whom have been referring their patients to IDAA and monitoring program participants for years. Others were not familiar with the program and were eager to learn more and to access written and online sources of information about meetings, cyber activities, and local support systems. ■

PHYSICIAN HEALTH AND FITNESS FOR DUTY (FFD): AN EXPLORATION OF OUTCOMES AND NEXT STEPS

Reid Finlayson, MD; Michael Baron, MD; Ron Nuefeld, BSW (and Richard J. Iannelli, PhD, who was unable to attend)

Reid Finlayson, MD

Michael Baron, MD

Ron Nuefeld, BSW

Richard J. Iannelli, PhD

In this presentation, Ron Neufeld reviewed the components of Vanderbilt's independent comprehensive assessment process and provided a second review and comparisons of referral reasons, evaluation findings, diagnosis, and outcome data for physicians licensed in Tennessee who were referred by the Tennessee Medical Foundation (PHP). The first outcome review was based on 141 Tennessee physicians who were referred between 2001 and 2008 and was published in collaboration with the late Dr. Roland Gray.

Dr. Michael Baron, who succeeded Dr. Gray, outlined differences in referral reasons between the earlier sample and referrals for evaluation between 2009 and 2018. There was a decrease in referrals for sexual boundary issues and an increase in evaluation requests for substance use disorders. There was a slight increase noted in referrals for disruptive behaviors.

Dr. Reid Finlayson reported that the number of physician suicides had declined from five to one between the first and second samples. Benzodiazepine use by physicians who died by suicide remained an associated risk factor. He also presented raw data illustrating possible associations between psychometric personality measures and physician outcomes during PHP contracts.

A lively discussion followed about potential research collaborations involving other evaluators and outcome data from additional state physician health programs. Dr. Michael Gendel voiced a preference for more specific hypotheses in place of the more recent big data and

machine learning approach to investigation. Future research plans include exploring the link between benzodiazepine use and physician suicide and whether the *Joint Commission Sentinel Event, Issue 40* on behaviors that undermine a culture of safety (2008) may be associated with any changes in referral patterns, evaluation, and outcome findings.

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TIPS FOR SUCCESSFUL ADVOCACY FOR MODERNIZING STATE LICENSING BOARD QUESTIONS ON MENTAL HEALTH

Eileen Barrett, MD, MPH, FHM, FACP

Eileen Barrett, MD, MPH, FHM, FACP

Physicians are often reluctant to seek mental health care for many reasons, including concerns that doing so can affect their ability to practice (1). Most states ask questions on license applications about mental health diagnoses, and when living in those states, physicians are less likely to seek care for mental health conditions (2). However, many times these questions are not answered accurately (3). States asking questions about mental health diagnoses on their applications are not following recommendations from the Federation of State Medical Boards (FSMB), which recommends boards evaluate if they need to ask questions about mental health diagnoses, and if so, to focus on impairment, stating: "where boards wish to retain questions about the health of applicants on licensing applications, the FSMB recommends that they use the language: Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No)" (1).

States asking these questions may not be able to manage the volume of referrals since some residency programs make mental health appointments for all trainees (4). These issues highlight the need to modernize medical license applications, and all of us can help them do so. States want healthy and safe physicians and patients, and we can leverage the FSMB recommendations, our professional experience, and our shared interests in promoting healthy communities to promote physician health.

When seeking to work with your state on this issue, start by building a team of stakeholders—including the Physician Health Program, medical board members, medical schools, professional societies, and the state medical society. Many professional societies have existing policy to support this work, such as the American College of Physicians and the American Medical Association (5). Patients also may be powerful allies in supporting this work, lending their voices for how physicians' work may put physicians at risk for being unwell (6).

Unite your stakeholders around the shared interest in supporting physician health so that we can all take care of patients. Once you have consensus, contact the medical board and ask to come to an upcoming meeting to discuss this issue. Ask if you may submit testimony ahead of time and if you may bring handouts.

On the day of the medical board meeting, show you care about your audience and don't take things personally. Stories can be a powerful supplement to national recommendations and data, and after that make sure you state your "ask": that you wish to be part of a collaboration to update the license application to ensure alignment with FSMB recommendations. In follow-up meetings, continue to build relationships, utilize FSMB guidance, and work cooperatively to emphasize your shared interest in protecting the public's health through ensuring a healthy physician workforce. And when your efforts are successful, start education about the updated license with groups such as residency programs, medical schools, and medical and professional societies.

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IF RAINMAN WERE A DOCTOR: HIGH-FUNCTIONING AUTISM AMONG PHYSICIANS

Scott Humphreys, MD

Scott Humphreys, MD

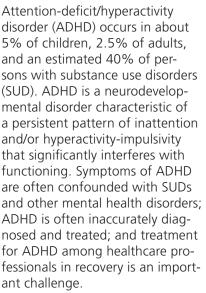Autism affects one to two percent of the general population. Autism is a disability and should be considered as such. The media tend to focus on autistic savants. These individuals have special talents that are extensions of certain autistic traits. But, the vast majority of people with autism do not have these special gifts, leaving them with only the disabling aspects of the disorder.

To illustrate this during our presentation, we discussed the differences between the fictional physician portrayed in the television program, *The Good Doctor*, and the tragic journey of a real-life physician struggling with high-functioning autism. The fictional physician in *The Good Doctor* was a savant with a superhuman ability to diagnose and operate. Because of his savantism, this doctor's quirky and offensive behavior was begrudgingly tolerated. By comparison, we followed the real-life legal saga of a physician with autism. He was terminated from two training programs due to his behavior and inability to effectively communicate. This physician tried to sue the last program under the ADA and his appeal was summarily dismissed. This story is the reality of a physician with autism. Their communications are misunderstood, often with disastrous consequences.

At CPHP, our most common mandated referral is for professional behavioral reasons. We realized many of our physicians referred for behavior issues are on the autistic spectrum. It occurred to us that we should consider treating them with an autism-specific treatment rather than the traditional coaching/therapy we recommend for most of our behavioral referrals. At the time of our talk at the FSPHP conference, we had only identified a handful of new referrals who fit this category, so our numbers were small. But, preliminarily, there appears to be reason for optimism regarding this change in approach. Two of the three physicians who received autism-specific therapy were already inactivated. This is compared to only one of the six who received traditional coaching/therapy. In addition, all three who received autism-specific therapy expressed their gratitude for the treatment despite being very resistant at first. ■

UNDERSTANDING THE IMPORTANCE OF ACCURATELY DIAGNOSING AND TREATING ADHD IN ADDICTED HEALTHCARE PROFESSIONALS

Brad H. Sokal, PhD; Joseph E. Schumacher, PhD; Michael W. Wilkerson, MD, FASAM; and Don Cornelius, MD

Brad H. Sokal, PhD

Joseph E. Schumacher, PhD

Michael W. Wilkerson, MD, FASAM

Don Cornelius, MD

Attention-deficit/hyperactivity disorder (ADHD) occurs in about 5% of children, 2.5% of adults, and an estimated 40% of persons with substance use disorders (SUD). ADHD is a neurodevelopmental disorder characteristic of a persistent pattern of inattention and/or hyperactivity-impulsivity that significantly interferes with functioning. Symptoms of ADHD are often confounded with SUDs and other mental health disorders; ADHD is often inaccurately diagnosed and treated; and treatment for ADHD among healthcare professionals in recovery is an important challenge.

This presentation discussed the challenges of diagnosing and treating ADHD in healthcare professionals with SUDs. Among 880 healthcare professionals receiving residential addiction treatment in one residential addiction treatment facility from October 2016–August 2018, 90 healthcare professionals (10%) were referred to a Clinical Neuropsychologist for an evaluation. Reasons for referral were based on a positive ADHD screening score, lack of psychometric testing for prior ADHD diagnosis, questionable use of prescribed stimulants, or need for confirmatory/differential diagnoses. The Diagnostic Neuropsychological Evaluation for ADHD consists of meeting symptomatic criteria for ADHD, review of medical records, comprehensive clinical interview, collateral interviews, behavior rating scales, intellectual functioning, and

neuropsychological testing of processing speed, language, memory, attention, and executive functions.

 Healthcare professionals (N=90) were nurses (36%), medical doctors (26%), and other medical professionals (38%). Average age was 40, and 41% were females. Over three-fourths (84%) had screened positive for ADHD on a self-report scale. However, among the 90 evaluated for ADHD, only 16 (18%) met threshold criteria for adult ADHD, and another 9 (10%) were diagnosed with other specified ADHD. Others who were not diagnosed were not unimportant, such as medical students or residents with unconfirmed ADHD diagnoses using prescribed stimulants to cope with demands of their training and attentional/hyperactivity symptoms due to other etiologies, such as traumatic brain injury, sleep disorders (e.g., narcolepsy and obstructive sleep apnea), trauma-related disorders, chronic pain, or the side effects of anticonvulsant medications.

The results from three representative evaluations were presented: a case of confirmed ADHD diagnosis, a case of no ADHD diagnosis; and a case of attentional/hyperactivity symptoms due to another etiology. The presenters concluded that ADHD is overdiagnosed in addicted healthcare professionals. Compared to an estimated prevalence of 2.5% in the general population, 9% of the 880 healthcare professionals had previous diagnoses of ADHD, but only 2.8% of the 880 healthcare professionals had an ADHD disorder. Overdiagnosis of ADHD has added to the risks for the misuse of stimulants. Other medical and psychiatric conditions account for the high number of healthcare professionals misdiagnosed with ADHD. There is a growing body of evidence that suggests proper treatment for psychiatric and medical conditions improves cognition, and significant cognitive deficits are associated with greater risk of relapse. Proper diagnosis and treatment of ADHD and other psychiatric and medical conditions may, therefore, result in a reduced risk of relapse. For addicted healthcare professionals with ADHD, there are nonstimulant, nonaddictive pharmacological interventions, and cognitive behavioral approaches have also been demonstrated to be effective. ∎

NEUROCOGNITIVE ASSESSMENT OF PHP-INVOLVED PHYSICIANS

Benjamin R. Phalin, PhD; and Scott Teitelbaum, MD, University of Florida College of Medicine, Department of Psychiatry, UF Health Florida Recovery Center

Benjamin R. Phalin, PhD

Scott Teitelbaum, MD

Neurocognitive assessment is an important component of the comprehensive evaluation process for physicians referred by state Physician Health Programs, providing a unique contribution to the understanding of an individual's functional capacity to engage in the activities of their work with the skill and safety required of their profession. In obtaining an accurate sample of an individual's abilities through the use of scientifically validated and well-normed neuropsychological measures, the recommendations and opinions arising from test results can help to ensure the safety of the individual and the public, and can provide the PHP with valuable information as it works to advocate for the individual's efforts to return to the practice of medicine.

Interpretation of neurocognitive test data is based on a thorough understanding of the psychometric properties of chosen test instruments, the influence of substances on brain function, and the implications of positive findings for this unique population of individuals. Evidence-based neurocognitive assessment, for the purpose of informing the PHP, must address pragmatic questions (e.g., ability to return to work) while remaining sensitive to long-term recovery issues. Cognitive screening measures, while useful, should not substitute for formal neuropsychological evaluation, which can provide a more thorough examination of functioning in cognitive domains vital to clinical competency and should include measures with proven validity and reliability (suggestions are provided by this presentation). Further, results of the evaluation must be understood in the context of patient-specific variables and must therefore include a detailed review of relevant psychosocial, medical, and mental health issues while also considering the practice-specific skill requirements of the individual in offering return-to-work recommendations.

Beyond its contributions to decision making at the comprehensive evaluation stage, neuropsychological

testing and knowledge of a participant's cognitive functioning, particularly if there is evidence of deficits, can have substantial benefits for the participant who is in need of treatment, but who may not yet have insight into the need for change. Review of test data using techniques of motivational enhancement during the evaluation process can yield positive results, helping the participant to progress along the Stages of Change continuum. As well, such data, when combined with the findings from psychological evaluation of mood and personality styling, can help to understand the participant's suitability for treatment and their behaviors and progress during the treatment process, and it can assist in tailoring the treatment plan to best suit the individual's needs. ■

EVIDENCE-BASED METHOD FOR ASSESSING AND MONITORING SUICIDE RISK IN PHYSICIANS

Sally Moody, LCSW; and Lacey Herrington, PhD

It is well known to Physician Health Programs that physicians represent an elevated risk for suicide when compared to the general population (Agerbo, Gunnell, Bonde, Mortensen, and Nordentoft, 2007; Gold, Sen, and Schwenk, 2013; Hern et al., 2005; Milner, Niven, Page, and LaMontagne, 2015). With suicides representing nearly 45,000 deaths in the United States in 2016, which is more than death by homicide, auto accidents or terrorism, this is obviously a significant

Sally Moody, LCSW

Lacey Herrington, PhD

issue that warrants further understanding, assessment, and response. As those monitoring physicians, a comprehensive understanding of this issue is needed, as well as effective ways to monitor and support distressed physicians (CDC, 2018). While professionals have been adept at assessing for suicidal ideation, it remains difficult to predict which individuals may go on to engage in a suicide attempt, versus those individuals who will not.

This presentation explored potential causes of elevated suicide risk in physicians, including exploration of the Interpersonal Theory of Suicide (IPTS) as a potential explanatory theory. The IPTS postulates that three precursors need to be present for suicide to occur: perceived burdensomeness, thwarted belongingness, and capability for suicide. Perceived burdensomeness is an individual's belief that their death would be more beneficial to others than continuing to live. Thwarted belongingness is a disconnectedness or isolation from others. Capability for suicide refers to the physical capacity to inflict lethal self-harm, as well as a fearlessness of death. IPTS has been widely supported in various populations and has been shown to be useful for understanding suicide among physicians. For example, research with a physician population found that perceived burdensomeness predicted suicidal ideation, while thwarted belongingness predicted prior suicide attempts (Fink-Miller, 2015). Additionally, physicians displayed capability for suicide similar to a group who had attempted once before, which is a population that has been shown to display elevated capability for suicide (Anestis and Joiner, 2011).

This presentation explored the barriers that limit access to supportive resources, including stigma surrounding mental illness and seeking help for depressive symptoms. In addition, an evidence-based method of suicide risk assessment was reviewed to assist those in a helping/monitoring role with physicians. Interventions to address physicians with elevated suicide risk (moderate to imminent) were outlined. Ways to document appropriate suicide risk assessment were reviewed, as well as actions that may be detrimental to suicide risk, such as safety contracts. Methods to implement screening for suicide risk with physician participants within PHP programs or in coordination with outside providers were discussed as well as barriers to assessment.

Ideas on how to implement the IPTS theory in PHPs were reviewed. These included assessment of suicide with every visit, PHPs and outpatient treatment providers communicating about the suicidality of participants, and each program assessing nuances of their program to determine how best to implement suicide assessment. Additional questions to consider in suicide assessment were presented, for example: "Do you feel connected to others?" and "Do you feel like you belong?" These questions integrate the IPTS theory. ■

BIAS IN THE EVALUATION OF PHYSICIANS: SOURCES AND SOLUTIONS

Michael Gendel, MD

Michael Gendel, MD

This talk did not directly address what is often referred to as "implicit bias," conscious or (usually) less-than-conscious bias related to skin color, gender, sexual orientation, or body weight. Rather, the majority of the talk described bias in physician evaluation related to the way our brains work, as described in the work of Daniel Kahneman and Aaron Tverski, and based on my observations of 30 years in the field of physician evaluation.

Kahneman describes two systems of decision making and judgment in humans. The first works very rapidly, relies on shortcuts known as heuristics, and performs amazingly well most of the time. These heuristics also have shortcomings that lead to poor decision making under some circumstances. The second system is analytic; it works slowly and requires considerable mental effort, so much effort that often it just signs off on the judgment of the fast system without consideration, though it is capable of correcting mistakes. It is involved in "thinking through" a problem.

A number of cases were presented in which bias in physician assessment occurred. Diagnosis, prognosis, treatment recommendations, assessment of progress, fitness for duty, and work restrictions were examples of areas of biased judgments. Analysis and discussion of each case addressed the specific heuristic(s) that caused the problem. Examples include the representativeness heuristic (in which the physician appears to be a representative of a particular class of problem/illness), the affect heuristic (in which our feelings about some aspect of the physician affect judgment), the availability heuristic (in which judgments are based on the most recent or dramatic event(s) rather than looking at the big picture), the law of small numbers (in which the role of chance is underappreciated in assessing a problem, or the decision is skewed by the small sample size of concerning events), associative coherence (in which false connections are made, and incorrect conclusions drawn, by our need to create a good narrative that supposedly explains a problem), and substitution (thinking we have answered the relevant question, but having substituted an easier question that we then answer). Transference and countertransference phenomena can also lead to bias. These were also addressed in the above case examples.

Special issues were discussed related to assessing physicians who might have addictive illness and related to whether the evaluating professional is in their own personal recovery, or not. It was suggested that this has been a simmering issue in the FSPHP that is rarely if ever openly discussed. The Federation would profit from open discussion of bias (or the impression of bias) related to this.

The decisions of PHPs, and other evaluating professionals and institutions, are subject to considerable scrutiny and potential criticism from licensing boards and referral sources (e.g., hospitals, HMOs, large practice groups, malpractice carriers). This was discussed in terms of the phenomenon of priming (in which decisions are based on an environmental influence that is usually less than conscious. For instance, one donates more to the "honesty box" at work, used to finance coffee and tea for employees, if there is a photo of two eyes next to the box rather than a photo of flowers). Imagining how a licensing board would react to our decisions, or simply making such decisions with the licensing board's scrutiny in the back of our minds, creates a pressure to make more cautious decisions. This is enhanced by the tendency to use hindsight bias (in which a reasonable judgment looks irresponsible in retrospect, based on information that was not available at the time of the judgment, or based only on the poor outcome). Excessive caution was named "the safety bias"—a good and necessary aspect of PHP work, but a bias nonetheless. The pressure of scrutiny and hindsight bias can lead to bureaucratic solutions, relying on standard operating procedure, which is less easy to criticize, rather than considering each case individually.

Managing the above-described bias requires several strategies. Chief among these is working in a team, in which more than one observer/evaluator meets with the physician, and the case is discussed with all team members present, not just professionals, but also front and back office staff who may have important observations. Critical to the success of such meetings is an atmosphere in which everyone can speak candidly, including to those most senior or "expert," without fear. This culture is very hard to create and sustain. Evaluators and staff must be educated about bias. There should be a system to review and discuss cases that did not go as predicted. Professionals and other staff should meet infrequently but regularly to leisurely consider policies and procedures that would identify and balance the natural biases discussed above. It is important to identify the forces that could lead to bias in a given case, acknowledge what is unknown or

Bias in the Evaluation of Physicians: Sources and Solutions
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confusing without prematurely creating a narrative to explain matters, and marshal the forces that lead to facts. The courage to make decisions that feel risky, if the facts support such decisions, should be supported. But groups are not immune from groupthink (in which one idea or conclusion becomes infectious and everyone agrees immediately). This is best countered by the team having at least one gadfly who will question authority, confront consistency for its own sake, and ask questions that no one wants to ask. Such people can be irritating, but they are necessary. ■

ADDICTION AND ITS COMPLEX INTERACTION WITH MENTAL HEALTH AND TRAUMA; FRAMEWORK DATA IMPLICATION IN ASSESSMENT AND REFERRAL TO APPROPRIATE TREATMENT

Sherry Young, PhD; Michael Baron, MD; and Mikel Sucher, MD

Sherry Young, PhD   **Michael Baron, MD**   **Mikel Sucher, MD**

Addiction research has enhanced our understanding of the complexity of the neuroscience of brain reward circuitry that impacts mental health and trauma and of the social science contexts of addiction's origins. This implosion and explosion of knowledge expanded well beyond addiction studies with Bruce Alexander's Rat Park research beginning in 1970 and his publications in 2010 explaining the social context of addiction. Looking outside the addiction to drivers and causes led to the Kaiser Permanente ACE (Adverse Childhood Experience) Study conducted in 1995 and 1997 with long-term follow-up for health outcomes and that provides concrete data that endorses Bowlby and Ainsworth's Attachment Theory, first presented in the late 1950s.

Additionally, our understanding of the complexity of addiction coupled with mental health comorbidity and the drivers of adverse childhood experiences, attachment wounding, and trauma compel us to utilize assessment tools that offer clear indicators of what issues an individual is dealing with and how to treat them effectively. This internal and external scope of knowledge changes the way we need to think about using comprehensive assessment prior to making treatment recommendations and throughout the delivery of treatment for mental health and substance use disorders. Assessment following treatment would improve outcome studies and lead to evidence-based care improvements and appropriate aftercare recommendations that improve long-term recovery.
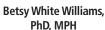
Discovery

Addiction recovery is enhanced at all levels of referral, treatment, and aftercare recommendations by assessment and evaluation of core drivers/contributors to addictive thinking and behavior and mental health issues. Appropriate assessment prior to referral ensures clinically sound recommendations to treatment. Assessment during and throughout treatment establishes benchmarks of progress toward recovery, and assessment prior to and during aftercare assists the client in achieving long-term recovery and organizations and referents improving outcome success. ■

CHILDHOOD TRAUMA AND PROFESSIONAL PERFORMANCE ISSUES

Betsy White Williams, PhD, MPH; Philip Flanders, PhD; Dillon Welindt; Anna Stumps; and Michael V. Williams, PhD

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There is now a broad and well-understood literature demonstrating a correlation between exposure to early life adverse events and medical and mental health issues in later life. Adverse childhood experiences include exposure to verbal, physical, and sexual abuse, and/or lack of a nurturing environment due to physically or emotionally absent parental figures. In addition to medical and mental health issues, exposure to early life trauma can contribute to attachment-related difficulties, including problems establishing and maintaining appropriate boundaries, trust and suspiciousness, lack of reciprocity, and lack of emotional competency. These can include difficulties labeling and expressing feelings and internal states. Difficulties with self-concept, such as poor sense of self, low self-esteem, and feelings of shame and guilt have also been associated with prior exposure to adverse childhood experiences (1–3). Examples of unprofessional behaviors leading to workplace concerns frequently include difficulties with collaboration, self-regulation, accepting feedback, and establishing and maintaining appropriate personal and professional boundaries, as well as poor self-reflective awareness, and poor self-care. Given our clinical observations, we hypothesized that a high percentage of individuals referred for evaluation would have a history of adverse childhood events. We were interested in comparing the patterns of types of adverse events experienced by referral type and the potential implications the findings might have for those who assess, treat, and/or monitor these individuals.

The study was a retrospective analysis of 127 medical students, residents, and physicians referred for fitness-for-duty evaluations secondary to concerns about disruptive behavior, poor boundaries, and possible substance use disorders. Seventy percent of the subjects reported at least one ACE, while almost one quarter of the respondents reported four or more event types, which is associated with an elevated odds ratio of a number of health risk factors. Compared to national data, the results showed higher occurrence of event frequency of one, two, and three or greater, and lower occurrence of zero events relative to a national comparison. Results indicated that based on the pattern of traumatic experience, the participants showed a different pattern of problematic behaviors.

Findings extend earlier findings indicating that exposure to adverse childhood events can be associated with professionalism lapses (4–7). These data have implications for how physician health programs, evaluators, and treaters engage with clients referred for professionalism concerns as there may be issues of trust in referred trainees and physicians, particularly a lack of trust of authority figures. Recognizing the high prevalence of trauma would suggest that trying to provide reassurance, providing opportunities to enhance a sense of control, addressing emotions associated with the process, and seeking ways to increase trust and minimize re-traumatization would all be important elements to consider as part of working with these clients. Future work assessing rates of childhood traumatic experiences in medical trainees and physicians with professionalism issues, including those with well-being concerns against a comparison group of trainees and physicians without such issues, would help elucidate the potential role of childhood trauma in contributing toward career difficulties.

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THE DARKNET—
A VIRTUAL ABYSS TO
FULFILL ANY DESIRE

Anish John, MD

The burgeoning online world has played a significant role in the marketing, sale, and distribution of various psychoactive substances. The transformation from a street market to a virtual space that

Anish John, MD

offers anonymity and round-the-clock access has been enhanced by the hidden "Deep Web," which encompasses regions of the Internet that are concealed from the public, and more specifically a secure subsection termed the "Darknet" or "Dark Web." The "surface Web" consists of data that standard search engines (i.e., Google, Yahoo, etc.) can index. Traditional search engines, however, see only a small amount of the information that is available, whereas the Deep Web is several orders of magnitude larger. The Deep Web is the part of the World Wide Web whose content is not indexed by such standard search engines. The analogy of an iceberg has frequently been used to represent the division between "surface" and "deep" Web. While illegal and criminal activities commonly take place on the Deep Web, not all of the activities undertaken there are nefarious—examples include being a forum for activists under oppressive regimes and a space where confidential medical records can be stored. Within the Deep Web, hidden purchasing activities have been made easier with the availability of the Grams Darknet Market search engine. Grams is a search system, like Google, in which vendors can buy a set of keywords that allow their listings to go to the top of search results. The Dark Web specifically can only be accessed by using special software, the most common of which is Tor, which is short for 'The Onion Router.' This was initially a worldwide network of servers developed with the U.S. Navy that enabled people to browse the Internet anonymously. The first purpose of Tor is to hide the locations of users who are browsing the Web, the second is to hide the location of the website itself. The Darknet is a haven for a number of illegal activities, including the sale of weapons, hacking services, pornography, and drugs. The access to novel psychoactive substances (NPS) online has been facilitated by the development of electronic cryptocurrencies, the most common of which is Bitcoin, a decentralized virtual currency that is not associated with banks or systems that can detect money transfer, and hence is able to guarantee more anonymous online transactions. This poses a significant challenge for practitioners in the field of addiction as Internet access is ubiquitous, and routine toxicology does not detect several compounds that are typically purchased and used. During this poster presentation, attendees were given the opportunity to use an attached iPad to scroll through and explore a visual real-time representation of the Dark Web, created by Hyperion Gray. This provided a tangible way to understand how the Darknet exists and view the patterns of thematically connected websites. Improving our awareness of the constantly evolving portals of access to NPS and determining efficient ways to detect them are paramount to advancing mental health and the treatment of addiction. ■

PHYSICIAN SEXUAL
MISCONDUCT
EVALUATIONS: WHAT IS
THE STANDARD OF CARE?

Renée Sorrentino, MD

Despite the well-documented prevalence of sexual misconduct by physicians, the #MeToo Movement has not permeated the medical profession. The absence of complaints

Renée Sorrentino, MD

against prominent physicians, as seen in other settings that appear to have responded to the #MeToo era of no tolerance, suggest the medical profession is immune to such behaviors. Renewed attention to the issue of sexual misconduct presents an opportunity to address problematic sexual behaviors in physicians. A review of the literature related to the evaluation of physicians who have engaged in sexual misconduct revealed there is no consensus on the components of such an evaluation. Most evaluations focus on psychological traits related to boundary issues and or violence. Some evaluations, especially in cases of sexually abusive behaviors, consisted of a psychosexual evaluation that focused on the identification of risk factors for engaging in future sexually abusive behaviors and were more aligned with sex offender evaluations. The absence of a consensus on how to conduct evaluations in physicians who engage in sexual misconduct suggests that there is no standard of care or standardized guidelines. As we integrate the #MeToo movement in medicine, we need to understand what leads to physician sexual misconduct. Future directions include employing different evaluation tools and measuring recidivism outcomes in order to achieve guidelines for evidence-based evaluations. ■

CARING FOR OURSELVES AND EACH OTHER IN THE HIGH-STAKES UNIVERSE OF PHYSICIAN HEALTH

Chris Bundy MD, MPH; Doina Lupea, MD, MHSc; Laura Moss, MD; and Mel Pohl, MD

Burnout is a topic that is discussed regularly in most industries and certainly in healthcare.

This session focused on directing clinicians to explore their own self-care practices and behaviors, and to identify strategies for dealing with stressors. This included several exercises in order to problem solve potential solutions with other audience members and faculty.

The goal of this session was to provide participants with practical and actionable strategies and techniques to reduce stress and improve professional fulfillment that they can begin using right away, with the derivative effect of improving the care we provide for our participants and our satisfaction with life. This presentation was an interactive brainstorming session that called on participants to create an action plan to address their sources of stress that might lead to burnout.

Participants were introduced to the Mental Health Continuum with a color-coded assessment tool that each of us could identify to rate his or her mood from: "Healthy" to "Reacting" to "Injured" to "Ill." Next, audience members did a self-assessment of stress-management tools and how often they used them.

Examples of stressors included areas of physical, social, mental, and spiritual resources that might be "leaking" or depleted. Stressors specific to functioning in physician health programs included the following:

- Challenges with boards, participants, and public detractors
- Not enough time for all obligations such as practice, meetings, exercise, family, other work responsibilities

Chris Bundy MD, MPH

Doina Lupea, MD, MHSc

Laura Moss, MD

Mel Pohl, MD

- Fear of making mistakes
- Knowledge deficits
- The high-stakes nature of the work

Stress-management strategies were discussed among the audience members and faculty and included but were not limited to the following:

- Mindfulness, coaching, and yoga
- Managing time more creatively and effectively
- Utilizing a personal recovery program such as a Twelve Step or other supportive mutual help group
- Reaching out to others—through mentorship with colleagues and friends
- Organizational strategies to create a work-life balance

Individuals were encouraged to identify a challenging source of stress and to make a firm commitment to following through with a plan for implementation to build resilience to better manage stress. Part of the process was to anticipate barriers and include an accountability factor in a "prescription for health."

At the end of the session, audience members had completed a participatory experience to acknowledge the stress that is intrinsic in physician health programs and to build awareness, resilience, and support. Participants were able to develop and practice skills to ensure their own mental health hygiene and enhance life, identify priorities, and then commit to a plan so that we can model health for our participants. ■

DO PHPS IMPLEMENT THE PRINCIPLES OF CONTINGENCY MANAGEMENT?

Paul H. Earley, MD, DFASAM

Paul H. Earley, MD, DFASAM

Over the past 40 or more years, Physician Health Programs (PHPs) have come to a type of consensus in describing our work as "monitoring recovery" when applied to participants with Substance Use Disorders (SUDs). Some of us (this author included) slip into this jargon when describing what we do with participants who have other psychological and psychiatric conditions as well. This description of what we do appears to be accurate on the surface: We follow the recovery status of our participants using objective data. This data, in

Do PHPs Implement the Principles of Contingency Management?

turn, is used to advocate for physicians with addiction histories so they may continue to practice. Monitoring is critical because addiction, when left alone, waxes and wanes similarly to other chronic diseases. When waxing, people who suffer from addiction affect those around them, and professionals, like physicians, have the potential to risk public safety. Therefore, our participant agreements define the parameters of oversight the PHP uses to determine the recovery status and, by derivative, whether a physician is safe to practice.

But is passive monitoring all we do? Does closely following the illness do something more? Researchers believe tracking a disease alters its course, not just for addiction but also for diabetes, hypertension, and other medical conditions. Anyone who places a fitness tracker on their wrist has experienced an unsettling increase in angst about exercise.

Contingency Management (CM) is a behavioral modification theory commonly applied to the treatment of substance use disorders. It is based on Operant Conditioning. It may not be as sexy as other therapeutic techniques such as EMDR or Experiential Therapies, but it has tons more research that proves its efficacy. When I first read about CM, I pushed my chair away from my desk, -slapped my head, and said, "That is what we do in Physician Health Programs!" As often happens, I later learned this is somewhat inaccurate, but it was a startling realization and led me to an in-depth exploration of CM theory, its efficacy in addiction treatment, and how PHPs should consider this valid treatment technique with our participants.

CM uses the basics of operant conditioning in its techniques. To review, positive reinforcement in operant conditioning strengthens a behavior by responding to that behavior with a consequence an individual finds rewarding. Negative reinforcement is the removal of an unpleasant reinforcer to strengthen a paired behavior. Traditional CM uses positive reinforcement most of the time. We can conceptualize traditional PHP actions as negative reinforcement if we consider the removal of an unpleasant reinforcer (the inability to practice or a potential loss of license) reinforcing compliance with our agreements. Prima facie, this delayed and distant connection works among physicians because we are experts in delayed gratification. Sad but true.

Our PHP is considering ways of using additional Contingency Management techniques. For example, should we consider decreasing the frequency of drug screening when a participant "checks in" consistently and reliably produces negative screens? Should we decrease the length of contracts in those who are most compliant with aspects of monitoring? These are our current considerations and discussions. Our PHP does not want to risk losing the amazing results of PHPs based on decades of experience that came before us. But we are always curious and innovating with caution. ∎

STATE MEDICAL BOARDS (SMB) AND PHPS: NEXT STEPS TO IMPROVE PHYSICIAN WELLNESS

Doris Gundersen, MD, Arthur S. Hengerer, MD, and Thomas Mansfield, JD

Doris Gundersen, MD   Arthur S. Hengerer, MD   Thomas Mansfield, JD

The session was designed to discuss present efforts occurring to coordinate SMB and PHP actions to improve wellness. It is well known that today's environment leads to the potential of mental health issues with self-referral or required intervention. There are meetings and summits that have occurred involving members of regulatory authorities with medical societies, academic and hospital systems, insurance carriers, medical practices, and public members to address these issues that could be duplicated in other states. Our two groups can focus on the physician to help them seek early interventions by reducing the stigma and fear of punitive actions when these issues are identified. Highlights of the guidelines drafted by the FSMB to change mental health questioning in license applications and how they apply were reviewed.

Attention was then turned to examples of some of the efforts—the first being a symposium by the North Carolina board and PHP (in collaboration with the state medical society and physician-owned mutual insurance company), which addressed wellness with members of the leadership in organizations listed above. There are plans for another summit this year with system leaders and administrators to emphasize system problems and potential solutions. These will likely include leadership

commitment, technology advances, communication, and physician involvement in decisions.

North Carolina also has made changes to the medical license application by deleting the long-standing question about health conditions and replacing it with an advisory stating that the physician is expected to receive care for any mental or physical health issue. There is no longer a question requiring the applicant to list and explain their health conditions. At present, the result of this change made about 15 months ago is not known. Sixteen other states have taken steps or are discussing possible changes to their application questions as well.

The other topic chosen was to highlight for PHPs how sudden and potential legislative changes can impact a program. The Colorado PHP has had a long-standing very successful program caring for 5300 physicians over 32 years with appropriate safe haven rules in place. This later aspect has been challenged and puts the program in jeopardy. Other boards were given insight for steps to take when these types of incidents occur. It requires calling on support from all your stakeholders and explaining the unintended consequences to legislators.

Finally, it was proposed that our groups should come together to commit to doing surveys and collecting data on burnout and mental health issues that result in PHP involvement, the program, and outcome. Also discussed was what is learned about the timing and events that were affecting these physicians and how to use that information to share with the medical community and help avoid or correct the needed care. The potential for assistance in developing surveys and grant support in association with the FSMB was also discussed. ∎

FSPHP WELCOMES THE FOLLOWING NEW MEMBERS!

These new members have joined FSPHP since the last issue in Spring 2019! Please join us in welcoming our new members.

State Voting Members

Joseph Lasek, MD, Medical Director, Vermont Practitioner Health Program

Shawn Sullivan, MD, Executive Director, Gateway Recovery Institute, Arizona

Associate Members

Kristy Cole, PHP Manager, Greenberg and Sucher, PC, Arizona

William Jacobs, MD, Associate Medical Director, Professionals Resource Network, Florida

Bara Litman-Pike, PsyD, Executive Director, Physician Health Services, Inc. (PHS), , Massachusetts

Matthew Moore, Case Manager, West Virginia Medical Professionals Health Program

Amber Kay Roane, Administrative Assistant, Montana Professional Assistance Program

Delena Torrence, MS, CAP, ICADC, Case Manager Supervisor, Professionals Resource Network, Florida

Individual Members

Charl Els, MBChB, FCPsych, MMedPsych, DipABAM, MROCC, ACBOM, Clinical Professor, University of Alberta

Philip Hemphill, PhD, Professor of Practice, Tulane University

Robert White, LCPC, Director, Behavioral Health, University of Maryland Psychiatry ∎

SAVE THE DATE

2020 FSPHP ANNUAL EDUCATION CONFERENCE AND BUSINESS MEETING

Thursday, April 30 to Sunday, May 3, 2020
Manchester Grand Hyatt, San Diego, CA

The FSPHP 30th Anniversary Conference: Leading the Way in Physician Health

Highlights

- Networking Opportunities with leaders in the field of professional health and well-being
- Large exhibitor space with all meal functions with attendees
- Interactive general and breakout sessions each day to highlight the essentials of physician health programs
- Emphasis on Panel Presentations
- Daily Peer Support Groups
- Daily Gentle Mindfulness Meditation
- Poster Symposiums and Reception

Topic Areas

- **Strategies for Funding, Operational Performance, and Improving Professional** Fulfillment in Physician Health Work: Media, Research, and Public Relations: Building and Fostering Relationships to Create Impactful Outreach with Stakeholders; Strategies for PHPs Funding/Fundraising; Use of Innovative IT and Business Solutions to Improve Operational Performance
- **Participant Experience: How Best to Evaluate and Improve Participant Experience:** Advancement and Innovation in Clinical Practice; Clinical and Monitoring Best Practices; Collaborative Case Management Strategies Among PHPs for Different Complex or Relapsing Participant Situations; Peer Support Groups, Spirituality and Mindfulness; Policies and Practices for Addressing Complaints or Disagreements with PHP Clinical Recommendations; Strategies to Include Participant Voice in PHP Practices; Toxicology Testing Practices for Healthcare Professionals
- **Legal and Regulatory Topics for Treatment Providers, PHPs, and Licensing:** Best Practices with PEER Review; How Is Diversion Working in Your State: Safe Haven and Non-Reporting Examples

Manchester Grand Hyatt, San Diego, CA
One Market Place, San Diego, CA 92101
(619) 232-1234

$259 (single/double rate) plus tax. Visit www.hyatt.com/en-US/group-booking/SANRS/G-SPHP to book your overnight room at the Manchester Grand Hyatt.

EXHIBITOR REGISTRATION: Visit https://fsphp.memberclicks.net/2020-exhibitor-information-page- for more information on how you can become an FSPHP Exhibitor.

Visit https://fsphp.memberclicks.net/assets/docs/2020%20FSPHP%20Exhibitor%20Registration%20Packet.pdf to download the Exhibitor Prospectus

WEDNESDAY
Board of Directors Meeting Exhibitor Registration and Setup

THURSDAY
Registration/Exhibits Open
Luncheon
General Session
Committee Meetings
Silent Auction Dinner

FRIDAY
Walk the Wharf
Mutual Support Meeting
Gentle Mindfulness Meditation
New Member Meeting
General and Breakout Sessions
Poster Symposiums and Reception
Board and Committee Chair Dinner

SATURDAY
Walk the Wharf
FSPHP/FSMB Joint Session
FSPHP Regional Member Meetings Exhibitor Session
Annual Business Member Meeting

SUNDAY
General and Breakout Sessions
Exhibitor Drawings and Closing Remarks

2019 FSPHP ANNUAL EDUCATION CONFERENCE AND BUSINESS MEETING

2019 Awards Presentation

Central Region Member Meeting

2018–2019 FSPHP Board of Directors (L to R): Scott Hambleton, MD, DFASAM; Doris Gundersen, MD; Daniel I. Perlin, MD; Jon Shapiro, MD; Paul H. Earley, MD, DFASAM; Warren Pendergast, MD; Michael Ramirez, MS; Robin F. McCown; P. Bradley Hall, MD, DABAM;Chris Bundy, MD, MPH; Michael Baron, MD, MPH; Mary Fahey, LCSW; Terry Laverly, LCPC; and Mary Ellen Caiati, MD.

2019 Exhibit Hall

2019 FSPHP Members

More 2019 FSPHP Event Photos Here: www.fsphp.org/event-photos

Dr. Chris Bundy at the Annual Business Meeting

Dr. Brad Hall and Dr. Lynn Hankes

**Mary Fahey, LCSW at
the Annual Business Meeting**

Silent Auction

Northeast Region Member Meeting

More 2019 FSPHP Event Photos Here: www.fsphp.org/event-photos

Western Region Member Meeting

Southeast Region Member Meeting

Paul H. Earley, MD, DFASAM, FSPHP President

More 2019 FSPHP Event Photos Here: www.fsphp.org/event-photos

PHYSICIAN HEALTH AND OTHER RELATED ORGANIZATIONS NATIONAL MEETINGS

FSPHP MEMBER ANNUAL MEETINGS

2020
FSPHP 30th Anniversary Conference:
Leading the Way in Physician Health
Thursday, April 30–Sunday, May 3, 2020
Manchester Grand Hyatt
San Diego, CA

2021
FSPHP Education Conference and Business Meeting
Thursday, April 29–Sunday, May 2, 2021
Minneapolis Marriott City Center
Minneapolis, MN

FSPHP REGIONAL MEMBERSHIP MEETINGS

Central FSPHP Regional Membership Meeting
October 3–4, 2019
Hopewell—130 E. Chestnut Street, 1st Floor
Columbus, OH

Western FSPHP Regional Membership Meeting
October 18, 2019
Arizona State University
Center for Applied Behavioral Health Policy
College of Public Service and Community Solutions
Phoenix, AZ

Northeast FSPHP Regional Membership Meeting
November 18, 2019
Pennsylvania Medical Association
Harrisburg, PA

FSMB ANNUAL MEETINGS

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

2021
109th Annual Meeting
April 29–May 1, 2021
Hilton Minneapolis
Minneapolis, MN

AMERICAN ACADEMY OF ADDICTION PSYCHIATRY

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

31st Annual Meeting and Scientific Symposium 2020
December 10–13, 2020
La Cantera Resort and Spa
San Antonio, TX

AMERICAN BOARD OF MEDICAL SPECIALTIES ANNUAL CONFERENCES

ABMS Conference 2019
September 23–25, 2019
JW Marriott
Chicago, IL

ABMS Conference 2020
September 22–25, 2020
JW Marriott
Indianapolis, IN

AMA HOUSE OF DELEGATES ANNUAL MEETINGS

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

June 12–16, 2021
Hyatt Regency Chicago
Chicago, IL

June 11–15, 2022
Hyatt Regency Chicago
Chicago, IL

June 10–14, 2023
Hyatt Regency Chicago
Chicago, IL

AMA HOUSE OF DELEGATES INTERIM MEETING

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

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

November 13–16, 2021
Walt Disney World Swan and Dolphin Resort
Orlando, FL

November 11–15, 2022
Hilton Hawaiian Village
Honolulu, HI

November 11–14, 2023
Gaylord National Harbor Hotel
National Harbor, MD

ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION

2020 Annual Educational Conference
February 27–March 1, 2020
Hilton San Diego Bayfront and Marriott Marquis
San Diego Marina, San Diego, CA

2021 Annual Educational Conference
February 25–28, 2021
Gaylord Opryland Resort and Convention Center
Nashville, Tennessee

2022 Annual Educational Conference
February 24–27, 2022
Rosen Shingle Creek Resort
Orlando, Florida

2023 Annual Educational Conference
February 23–26, 2023
Gaylord Opryland Resort and Convention Center
Nashville, Tennessee

2024 Annual Educational Conference
March 7–10, 2024
Rosen Shingle Creek Resort
Orlando, Florida

2025 Annual Educational Conference
February 20–23, 2025
Gaylord Opryland Resort and Convention Center
Nashville, Tennessee

AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW

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

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

AMERICAN PSYCHIATRIC ASSOCIATION ANNUAL MEETING

2020
April 25–29, 2020
Philadelphia, PA

2021
May 1–5, 2021
Los Angeles, CA

AMERICAN SOCIETY OF ADDICTION MEDICINE

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

ASAM 52nd Annual Conference
Thursday April 22–Sunday, April 25, 2021
The Gaylord Texan Resort
Dallas, TX

ASAM 53rd Annual Conference
Thursday March 31–Sunday April 3, 2022
The Diplomat Beach Resort
Hollywood, FL

INSTITUTE FOR THE ADVANCEMENT OF BEHAVIORAL HEALTH

The 9th Annual National RX Drug Abuse and
Heroin Summit
April 13–16, 2020
Nashville, TN

INTERNATIONAL CONFERENCE ON PHYSICIAN HEALTH

2020
September 14–16, 2020
IET London: Savoy Place
London, UK

INTERNATIONAL DOCTORS IN ALCOHOLICS ANONYMOUS (IDAA) ANNUAL MEETING

IDAA Annual Meeting 2020
August 5–9, 2020
Spokane, WA

IDAA Annual Meeting 2021
August 4–8, 2021
West Palm Beach, FL

NATIONAL ACADEMY OF MEDICINE

Action Collaborative on Clinician Well-Being and Resilience
December 4, 2019
Washington, DC

Physician Health and Other Related Organizations National Meetings
continued from page 29

NATIONAL ASSOCIATION OF MEDICAL STAFF SERVICES

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

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

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

NATIONAL ORGANIZATION OF ALTERNATIVE PROGRAMS

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

PHYSICIAN WELL-BEING INITIATIVES: ACGME PHYSICIAN

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

> **Please visit the National Organization Events page on the FSPHP website for a listing of physician health and other related organizations' national meetings and events.**

FSPHP E-Groups—Please Join!

The Yahoo! e-groups provide a user-friendly capability to share information among our members. As you may know, we have two e-groups. I know there can be confusion about the two groups, so please let me provide an overview. Membership in either e-group is open only to Federation members. This is one of our most valued membership benefits. Visit https://www.fsphp.org/assets/docs/egroup_guidelines_sept_6_2016.pdf for guidelines on the use of the e-groups.

fsphpmembers@yahoogroups.com is an information-exchange venue for all FSPHP membership categories. These include State PHP members, Associate PHP members (affiliated with state PHPs), Honorary members, International PHP members, and non-PHP member categories such as Individual and Organizational memberships of the Federation of State Physician Health Programs, Inc.

statePHP@yahoogroups.com is for "PHP" membership categories, including the State PHP members, Associate PHP members (affiliated with a PHP), Honorary members, and International PHP Members.

All PHP membership categories (State, Associate, Honorary, and International members) are eligible for both groups.

- The statePHP@yahoogroups.com group purpose is for internal, anonymous, case-specific, administrative, or physician health program–specific discussions or questions.

- The fsphpmembers@yahoogroups.com group purpose is for broader topic-related physician health, such as sharing of articles, information, programmatic updates, resources, and overarching field topics.

There might be times when you want to reach everyone in both groups. To do so, email both groups! Since both groups are optional and members must opt in, not all FSPHP members are in each group. We have 222 FSPHP members. Currently there are 156 members of the StatePHP@yahoogroups.com and 135 members of the FSPHPMembers@yahoogroups.com.

For any questions concerning the two e-groups, please email Sandra Savage (ssavage@fsphp.org) or Linda (lbresnahan@fsphp.org).

PHYSICIAN HEALTH NEWS

The FSPHP produces a newsletter twice a year in March/April and again in August/September that is sent to all state programs, medical societies, and licensing boards. The FSPHP requests articles (500 words or fewer) and other related information be submitted for inclusion in the FSPHP Newsletter.

SUBMISSIONS FOR NEWSLETTER

By **January 30** for the spring issue

By **May 31** for the summer issue—*the summer issue is typically reserved for content related to our FSPHP annual meeting.*

This newsletter is intended to help members stay abreast of local, state, and national activities in the area of physician health. Please consider a submission to help keep all states informed of your program's activity and progress in the field of physician health.

Please send submissions by email to lbresnahan@fsphp.org.

Items that you may want to consider include:

- Important updates regarding your state program
- A description of initiatives or projects that have been successful, such as monitoring program changes, support group offerings, outreach and/or education programs, and so forth
- Notices regarding upcoming program changes, staff changes
- References to new articles in the field
- New research findings
- Letters and opinion pieces
- Physician health conference postings and job postings

Please limit articles to 500 words or fewer and other submissions to 200 words or fewer.

WE WANT YOUR INPUT!

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