

Maryland **Medicine**

VOLUME 20 ISSUE 5



**In Their Own Words:
Physicians Share Their
Experiences**

**System Issues That Impact
Physician Burnout**

**Physician Wellness
Resources**

From the CDC: Outbreak of Lung Injury Associated with E-Cigarette/Vape Use, Including Maryland

The CDC, FDA, state and local health departments, and other clinical and public health partners are investigating a multistate outbreak of lung injury associated with use of e-cigarette, or vaping, products. There have been twenty-three reported cases of lung injury associated with using vaping products in Maryland, and Virginia reported its first death this week.

The following information, including recommendations for clinicians, was developed by the CDC for distribution. Local contact information for reporting has been identified and confirmed by MCMS staff.

What We Know

- As of October 3, 2019, 1,080 lung injury cases associated with using vaping products have been reported to the CDC from forty-eight states and one U.S. territory.
- Eighteen deaths have been confirmed in fifteen states: Alabama, California (2), Delaware, Florida, Georgia, Illinois, Indiana, Kansas (2), Minnesota, Mississippi, Missouri, Nebraska, New Jersey, Oregon (2), and Virginia.
- All patients have reported a history of using vaping products.
- Most patients report a history of using THC-containing products. The latest national and regional findings suggest products containing THC play a role in the outbreak.
- Approximately 70 percent of patients are male.
- Approximately 80 percent of patients are under thirty-five years old.
- 16 percent of patients are under eighteen years old
- 21 percent of patients are eighteen to twenty years old

Reporting Possible Cases

The Maryland Secretary of Health has issued a directive and order regarding reporting beginning October 3, 2019. All practitioners licensed by the state of Maryland must:

1. Become familiar with the criteria for a suspected case of vaping associated lung injury, which is as follows: Use of any e-cigarette (“vaping”) or dabbing in 90 days prior to symptom onset AND Pulmonary infiltrate, including opacities on plain film chest radiograph or groundglass opacities on chest CT AND No alternative plausible diagnoses (e.g., infectious, cardiac, rheumatologic, or neoplastic process);
2. Submit, within one working day, telephonic or written morbidity reports of suspected vaping-associated lung injury to the local health department for the jurisdiction in which the health care is located;

3. Consult the Maryland Department of Health Vaping Associated Lung Injury website for updated information and additional resources at phpa.health.maryland.gov/OEHFP/EH/Pages/VapingIllness.aspx;
4. Educate and instruct the patient on appropriate measures to prevent further injury.

Local Health Departments, for reporting purposes:

All reports in Maryland should be sent directly to the county health department, not to the Maryland Department of Health's Environmental Health Bureau.

UnitedHealthcare of Maryland Initiates New Monthly Physician Relations “POP-UPS” on November 7 at Montgomery County Medical Society

Montgomery County Medical Society will be the first “pop up” site for UHC's new initiative. From 10 a.m. to 2 p.m., UHC Provider Relations Representatives will be available to meet with individual physicians and/or practice staff to share updates, listen to concerns, and assist with any issues that physicians are experiencing. Appointments are preferred and are offered every thirty minutes in a confidential setting. To schedule an appointment, contact MCMS at 301.921.4300 or email ahawkins@montgomerymedicine.org.



From the President...

Benjamin Z. Stallings, II, MD, President, MedChi

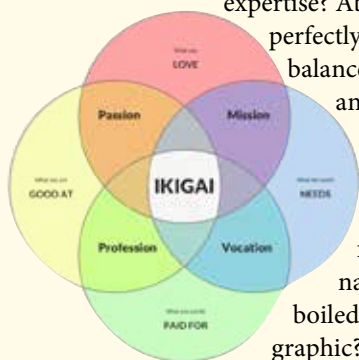
The Japanese word **ikigai** describes the perfect alignment of our purpose and passion with our skills and contributions. Simply put, doing what you love is the secret for happiness and for longevity. Ikigai is credited for contributing significantly to the longevity of the citizens of Okinawa, who enjoy the highest life expectancy in the world.



I'm thinking of ikigai as we explore the idea of physician wellness in this issue of *Maryland Medicine*. As physicians, we are constantly required to balance the demands of our patients, staff, administrators, colleagues, and ourselves.

Our personal lives and relationships are certainly a main consideration as well! It's a delicate dance that can (and too often does) lead to that much-discussed state of "burnout." And burnout stands as a polar opposite to ikigai.

For many of us, ikigai is entirely achievable...at least on paper. Do we love being physicians? Of course we do. Are we good at it? I think most of us are. Does the world need us? It certainly does. Can we be paid for our skills and expertise? Absolutely. Our profession is perfectly positioned to capture that elusive balance of passion, mission, vocation, and profession. In theory, ikigai is within our grasp.



So why are so many of us struggling? Where do we turn for the support and resources to navigate a profession that cannot be boiled down to a simplistic motivational graphic?

For more than 200 years, MedChi has served as your resource for reducing administrative burdens, improving health outcomes, connecting physician colleagues and more. And for more than 40 years, MedChi has also operated the Maryland Physician Health Program for substance dependency issues, mental health concerns, physical or cognitive impairments, stress, or other impediments to the optimal practice of medicine. I encourage you to reach out if you need support or refer a colleague who is struggling.

Within this issue you'll find resources and inspiration for finding joy in the practice of medicine, taking good care of yourselves and each other, and taking a step closer to ikigai.

MedChi Addresses the Systemic Issues That Lead to Physician Burnout

Colleen George, Exec. Dir., MedChi Center for the Private Practice of Medicine

MedChi realizes there are systemic issues that lead to burnout and has implemented many initiatives to help.

Collaboration to Address the Opioid Epidemic in Maryland and How it Affects Maryland Physicians

MedChi's Opioid Task Force was founded by Gary Pushkin, MD, in 2017 and is an interdisciplinary workgroup that strives to evaluate, develop, and share balanced, evidence-based, effective responses to the opioid epidemic in Maryland. The task force examines legislative remedies, clinical tools, and alternative treatments in collaboration with a coalition of like-minded organizations, including the statewide Opioid Operation Command Center (OCCC), that seek to effect significant improvements in the health of Marylanders.

The Ever-Increasing Issues Facing Independent Physicians

The Center for the Private Practice of Medicine provides business support tailored to your practice. Some of the services we offer:

- All aspects of practice operations and workflow
- HIPAA policy review and practice-specific HIPAA compliance manual
- Privacy & security risk management
- EMR selection and implementation
- Charge master and fee schedule analysis
- Credit balance analysis and corrective action plan
- Coding and medical record documentation review
- Insurance credentialing and payer contracting

Every year there are legislative and regulatory victories that ease the day-to-day burden of practicing medicine in Maryland. A few of those victories for 2019:

- Protected access to physician services.
- Worked closely with the Maryland Society of Eye Physicians and Surgeons to protect patients from harmful surgical expansion while allowing for appropriate optometric scope of practice expansion.
- Successfully stopped naturopaths from gaining prescribing authority, a practice that is rightfully restricted to physicians who have completed residency.
- Successfully eased administrative burdens to allow physicians to dispense topical medications under a streamlined permit
- Ensured timely delivery of health care services.
- Successfully strengthened Maryland's prior authorization laws to provide greater continuity of care for patients and increased transparency.
- Advocated successfully for sensible guidelines for the establishment of the Prescription Drug Affordability Board.

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The Pace of Change

Brooke Buckley, MedChi Board Member and Vice President and CMO of Meritus Health in Hagerstown, Maryland

Burnout is real. In ICD-11, the World Health Organization enhanced the definition: “Burnout is a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed,” citing the following characteristics: feelings of exhaustion, cynicism, and reduced efficacy.¹ As a physician, we know this feeling all too well. There are many efforts in development to assist us, but the ongoing physician narrative includes bewilderment at the lack of meaningful progress

on the burnout epidemic. Generally, we are as exhausted from the work as we are trying to explain the enormity of the problem. It feels like we are standing before a tsunami in

our bathrobes, begging it to recede. And so eloquently captured in the moral injury² literature, our reactions are heightened from the sense that our short-comings have driven this disease.

So much of what drives the inability to manage the stress is the dizzying pace of change. Many of these drivers are apparent: electronic medical records, less time with patients, more complex diseases and tests, less free time, more after-hours work, increased call burden, career stage, and less control, among others factors.³ The consequences include increased errors, disengagement, and disruptive behaviors.

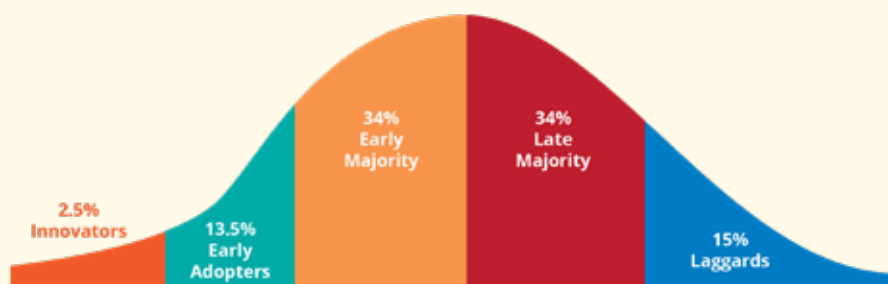
Change is hard. I often hear colleagues harken back to the days of Marcus Welby, MD; simple times...before the eighty-hour work week, in the days of giants, when a doctor could be a physician. This brings to mind the change adoption curve. This curve is commonly used for product innovation, but is a useful lens through which to view our change conundrum (see graphic). Perhaps surprisingly, 50 percent of us are not going to be engaged with innovation and nearly 20 percent of us will actively try to stop change. Every scenario is different. What change are you trying to create? What change are you trying to stop?

Change is happening all around us. In our social lives, our politics, and in our families. Some of this is welcomed, and we lead the curve. Other change is difficult. Family, tradition,

financial security, geography, education, and phase of life inform where we sit on the curve. I find it illuminating to reflect on both my eagerness for change as well as my resistance. I take inventory of the reasons, my ‘why’. Can I articulate my enthusiasm such that I may be able to convert an early pragmatist? Do I have a logical reason to remain a laggard? Is resistance consistent with my values? Is change consistent with my character, my oath, my commitment to my patients?

It has been said that the world’s only constant is change. If change is always our norm, why does it feel so hard? The pace of our practices and the complexity of our patients push our

patience as we evolve. Our dedication to safety and protecting people’s lives pushes conservatism in our practice. As we are pushed to partner and align for modernization, being clear on our needs, our values, and our bandwidth is essential to being a voice for the practice of medicine, to forging a happier future, and for the safety of our patients.



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IN THEIR OWN WORDS

Two Physicians Share Their Experience with the Maryland Physician Health Program

May 8th, 2008 was a horrible day for me. I was struggling with an addiction to opioids and alcohol and had no idea, despite the writing on the wall. I went to work impaired that day and was sent home after a urine screen that I knew would be positive. I have never felt shame like that before or since.

I was sent to the MPHP (Maryland Physician Health Program) for help, but was too frightened to get honest, despite the kindness that I discovered there. I entered into a monitoring agreement, but never stopped drinking. I could barely live with myself, but did not confide in anyone about my struggles. A year later, I was using opioids again and was sent to treatment for the first time. I also entered into the MPRP (Maryland Professional Rehabilitation Program), as I was reported to the Board of Physicians. Luckily, the people who cared for me at MedChi remained the same.

I began to accept my addiction during my first inpatient treatment. However, when I was discharged, I was still full of shame and was not open with many people about my struggles. I worked closely with the MPRP, and an excellent program of recovery was created for me including regular visits with my case manager, my psychiatrist, and my psychologist, in addition to participation in Alcoholics Anonymous and random toxicology monitoring. I had lost my job and was trying to rebuild my life. After several months and a lot of help, I was able to find work, and things on the outside seemed to be improving. I was able to

stay abstinent for a while, but did not truly feel comfortable in recovery. I eventually relapsed and things got bad really quickly.

It was a miserable time for me. I wanted to get sober, but simply could not. I was lying to everyone, including myself. When I was eventually caught again, I was prepared to surrender my license and walk away from medicine. The Board summarily suspended my license, and I was fired from my job. I was afraid and ashamed. Luckily, my case manager called my wife and, together, they convinced me to agree to the treatment I needed.

I went to Atlanta for treatment for four months and was finally ready to be sober and recover. Treatment was a wonderful experience, and I was in close touch with the MPRP while there. When I came home, I had a lot of work to do to get my life

“I never felt alone because those at the MPRP, and the program that was created for me, were there to guide me.”

together. I was unemployed, had no medical license, and nobody could trust me. Despite all of this, I felt great because I finally felt like I could live a life of recovery, whatever that might be. I also had the support I needed. This early period was so critical. It could have been lonely and so easy to return to the coping mechanism of old. However, I never felt alone because those at the MPRP, and the program that was created for me, were there to guide me.

I have now been sober for over eight years, and my life is better than ever. After completing mandatory monitoring with the MPRP, I signed up for voluntary participation in the MPHP. I simply cannot imagine continuing my recovery without those people who were so essential in helping me get my life back.

When I first started drinking, I found alcohol provided a means to navigate social situations; to reduce the anxiety of interacting with my peers. Over the years, the results of my drinking habits became more unpredictable. Though mostly confined to weekends, sometimes I would continue to drink until I passed out or blacked out. Drinking also became more solitary and isolated, and I began to avoid most social events. After an arrest for a driving under the influence, I did what I was advised to — “clean it up.” I went to Alcoholics Anonymous (AA) meetings and did not drink for many months after the arrest. I started seeing a therapist who specialized in addiction. None of it really mattered to me at the time, as I always intended to resume drinking once the legal problems were resolved. I did not want to take the advice given to me, and I thought I just needed to be more careful with my drinking.

“The PHP has been very helpful providing a solid framework for recovery throughout the process, including toxicology testing, constant contact, and support.”

Once I started drinking again, the amount escalated fairly rapidly, and I was back to drinking on weekends and some weeknights. I attempted to control my drinking with limited success, or at least I believed that these attempts had an effect on my drinking habits. This point cannot be overemphasized. The illusion that I had some control over drinking was a significant obstacle to seeking treatment. The belief that, since I was not a daily drinker and sometimes only had a few drinks, I was not an alcoholic, became a way to rationalize negative consequences.

I ultimately came to the Maryland Physician Health Program (MPHP) at MedChi after a serious DUI car accident while in a blackout. I was facing legal action and revocation of my medical license. The PHP was instrumental in helping me navigate early

recovery. They provided options for inpatient rehabilitation programs specializing in physician recovery, and after I completed the program, they assisted in setting up outpatient treatment and follow-up. Inpatient treatment provided a strong foundation in the AA program, in which I continue to be an active member. After completing the inpatient program, I returned home, went to daily AA meetings, got a sponsor, and started working on the steps.

I started random urine toxicology screening with the MPHP and followed their outpatient treatment recommendations.

Due to the severity of the car accident, I later served time in prison, and my medical license was revoked. After release, I reestablished enrollment in the MPHP with random toxicology testing and outpatient treatment, as well as daily AA meetings. The process of license reinstatement was long, costly, and difficult. Reestablishing a career in medicine has been equally difficult. The MPHP has been very

helpful providing a solid framework for recovery throughout the process, including toxicology testing, constant contact and support, and important documentation. Another core component of my sobriety has been involvement in the AA program. People in the rooms of AA share a common desire for recovery, and the process of open and honest sharing of experiences provides a powerful catalyst for sobriety. Working the steps continues to help me navigate the challenges of daily life.

Alcoholism is an insidious disease; the hardest part of the entire process was admitting I had a problem. The cost was unfortunately very high. Participation in AA and the MPHP have been instrumental in the recovery process. The support I received provided stability in early recovery and continues to provide me with the necessary framework for long-term sobriety.

EDITORIAL STATEMENT

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Foundation Initiated by Montgomery County Medical Society Offers Counseling to Physicians Suffering From Stress & Burnout

Susan D'Antoni

In a 2014 study conducted by Mayo Clinic and the AMA, 54.4 percent of physician respondents indicated they were exhibiting at least one symptom of burnout. In MCMS's 2016 Physician Practice Survey, 53.7 percent of physician respondents indicated they were experiencing moderate to high levels of burnout. Seventy physicians indicated they would use an early intervention, confidential, no-cost physician counseling service if offered.

This information led Montgomery County Medical Society to initiate the formation of The National Capital Physicians Foundation (NCPF) which is a 501(c)3 educational and charitable tax-exempt foundation. The organization's first initiative is dedicated to physician health and well-being. Healthy physicians = healthy communities.

As a result, initial efforts of the National Capital Physicians Foundation were focused on development of PRN, the Physicians' Resources Network, which initiated a Physician Well-Being Program, which includes confidential counseling provided by MSWs and PhD psychologists. Modeled after a successful physician counseling program in Eugene, Oregon, this service is now available to all physicians who are practicing in Montgomery County. NCPF President, Robert B. Karp, MD, said, "We anticipate broadening the availability of counseling services to additional physicians throughout the National Capital area as funding is received." At present, PRN funds three visits with therapists who have residence-based practices.

Physician stress is increasing. In MCMS's 2017 survey, the percentage of physician respondents indicating moderate to high levels of burnout went from 53.7 percent to 62.5 percent. Louis Ari Kopolow, MD, is the Medical Director of PRN, and indicated, "The Foundation's program is focused on early intervention long before impairment or suicide, and it has worked cooperatively with The Center for a Healthy Maryland's Physician Health Program in its development."

Since the inception of the program in late 2017, thirty-three physicians have reached out to PRN and have received counseling funded by the National Capital Physicians Foundation. Evaluations of the program have been stellar, with



many physicians noting that it made a considerable difference in their ability to respond to the challenges of medical practice.

To learn more about the program or to make a tax-deductible donation, contact PRN at 301.921.4300, ext. 300, or go to www.dedicatetohealth.org.

Susan D'Antoni, FAAMSE, serves as the CEO of Montgomery County Medical Society and the National Capital Physicians Foundation. She can be reached at sdantoni@montgomerymedicine.org.

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Why “Happy” Doctors Die by Suicide

Pamela Wible, MD

Yet Another Physician Suicide

He was the go-to sports guy in Washington, DC. A masterful surgeon with countless academic publications, he trained orthopaedic surgeons across the world and was the top physician for professional sports teams and Olympians.

Dr. Benjamin Shaffer had it all.

Yet Ben was more than a stellar surgeon. He was a kind, sweet, brilliant, and sensitive soul who could relate to anyone — from inner city children to Supreme Court justices. He was gorgeous and magnetic with a sense of humor and a zest for life that was contagious. Most of all, he loved helping people. Patients came to him in pain and left his office laughing. They called him “Dr. Smiles.”

Ben was at the top of his game when he ended his life. So why did he die?

Underneath his irresistible smile, Ben hid a lifetime of anxiety amid his professional achievements. He had recently been weaned off anxiolytics and was suffering from rebound anxiety and insomnia — sleeping just a few hours per night and trying to operate and treat patients each day. Then his psychiatrist retired and passed him on to a new one.

Eight days before he died, his psychiatrist prescribed two new drugs that worsened his insomnia, increased his anxiety, and led to paranoia. He was told he would need medication for the rest of his life. Devastated, Ben feared he would never have a normal life. He told his sister it was “game over.”

Ben admitted he was suicidal with a plan though he told his psychiatrist he wouldn't act on it. Ben knew he should check himself into a hospital, but was panicked. He was terrified he would lose his patients, his practice, his marriage, and that everyone in DC—team owners, players, patients, colleagues — would find out about his mental illness and he would be shunned.

The night before he died, Ben requested the remainder of the week off to rest. His colleagues were supportive, yet he was ashamed. He slept that night, but awoke wiped out on May 20, 2015. After driving his son to school, he came home and hanged himself on a bookcase. He left no note. He left behind his wife and two children.

Hiding Chronic Anxiety

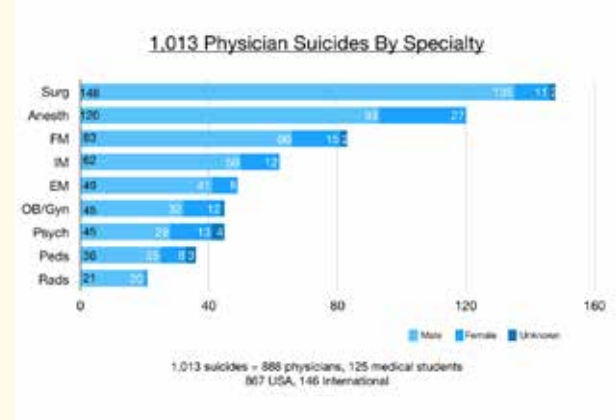
I feel a kinship with Ben, partly because I used to suffer from chronic anxiety that I hid under academic achievements, but mostly because I'm a cheerful doctor who was once a suicidal physician too. In 2004 I thought I was the only suicidal

physician in the world — until 2012 when I found myself at the memorial for our third doctor suicide in my small town. Despite his very public death, nobody uttered the word suicide aloud. Yet everyone kept whispering “Why?” I wanted to know why. So I started counting doctor suicides. Within a few minutes I counted 10. Five years later I had a list of 547. By January this year, I had 757 cases on my registry. As of today that number is 1,013.

High doctor suicide rates have been reported since 1858.¹ Yet 160 years later the root causes of these suicides remain unaddressed. Physician suicide is a global public health crisis. More than one million Americans lose their doctors each year to suicide—just in the US². Many doctors have lost several colleagues to suicide. One doctor told me he lost eight physicians during his career with no chance to grieve.

Of these 1,013 suicides, 888 are physicians and 125 are medical students. The majority (867) are in the USA and 146 are international. Surgeons have the greatest number of suicides on my registry, then anesthesiologists.³

However, when accounting for numbers of active physicians per specialty, anesthesiologists are more than twice as likely to die by suicide than any other physician. Surgeons are number



two, then emergency medicine physicians, obstetrician/gynecologists, and psychiatrists.⁴

For every woman who dies by suicide on my registry, we lose four men. Suicide methods vary by specialty, region, and gender. Women prefer overdose. In the USA, men use firearms. Jumping is popular in New York City. In India, doctors are

continued on page 12

Why “Happy” Doctors Die, continued from pg. 11

found hanging from ceiling fans. Male anesthesiologists are at highest risk among all physicians. Most anesthesiologists overdose. Many are found dead inside hospital call rooms.

Doctor suicides on the registry were submitted to me during a six-year period (2012–2018) by families, friends, and colleagues who knew the deceased. After speaking to thousands of suicidal physicians since 2012 on my informal doctor suicide hotline and analyzing registry data, I discovered surprising themes — many unique to physicians.

Public perception maintains that doctors are successful, intelligent, wealthy, and immune from the problems of the masses. To patients, it is inconceivable that doctors would have the highest suicide rate of any profession.⁵

Even more baffling, “happy” doctors are dying by suicide. Many doctors who kill themselves appear to be the most optimistic, upbeat, and confident people. Just back from Disneyland, just bought tickets for a family cruise, just gave a thumbs up to the team after a successful surgery — and hours later they shoot themselves in the head.

Doctors are masters of disguise and compartmentalization.

Turns out some of the happiest people — especially those who spend their days making other people happy — may be masking their own despair. Reading this excerpt from the 1858 *Manual of Psychological Medicine*, I’m reminded of so many brilliant doctors I’ve lost to suicide:¹

“Carlini, a French actor of reputation, consulted a physician to whom he was unknown, on account of the attacks of profound melancholy to which he was subject. The doctor, among other things, recommended the diversion of the Italian comedy; ‘for,’ said he, ‘your distemper must be rooted indeed, if the acting of the lively Carlini does not remove it.’ ‘Alas!’ ejaculated the miserable patient, ‘I am the very Carlini whom you recommend me to see; and, while I am capable of filling Paris with mirth and laughter, I am myself the dejected victim of melancholy and chagrin.’”

The Consequences for Physicians of Acknowledging Mental Illness

Many of our most inspiring and visionary leaders — artists, actors, even doctors — suffer from mental illness. Yet students enter medical school with their mental health on par with or better than their peers. Suicide is an occupational hazard in medicine. Doctors develop on-the-job PTSD — especially in emergency medicine. Patient deaths — even with no medical error — may lead to self-loathing. Suicide is the ultimate self-punishment. Humans make mistakes. When doctors make mistakes, they are publicly shamed in court, on television, and in newspapers (that live online forever).

As doctors we suffer the agony of harming someone else — unintentionally — for the rest of our lives

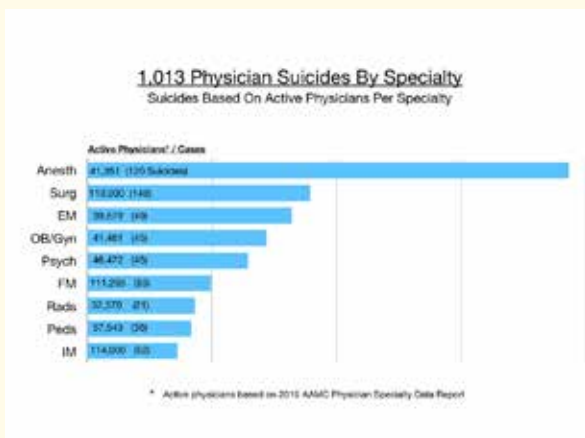
Blaming doctors increases suicides. Words like “burnout” and “resilience” are employed by medical institutions to blame and shame doctors while deflecting their own accountability for inhumane working conditions in failing health systems. When doctors are punished for occupationally induced mental

health wounds, they become even more desperate.

If physicians do seek help, they risk being disciplined. Doctors rightfully fear lack of confidentiality when receiving mental health care as private conversations with therapists could be turned over to medical boards and illegally accessed by their supervisors via electronic medical records at their institutions. So physicians drive out of town, pay cash, and use fake names in paper charts to hide from state boards, hospitals, and insurance plans that interrogate doctors about their mental health and may prevent or delay state licensure, hospital privileges, and health plan participation.

With a great work ethic until their last breath, doctors are often checking in on patients, reviewing test results, and dictating charts minutes before orchestrating their own suicides. Many leave apologetic heartfelt letters detailing the reasons for their suicide for friends, family, and staff. One orthopaedic surgeon simply wrote: “I’m sorry I couldn’t fix everyone.”

Doctors choose suicide to end their pain (not because they want to die). Suicide is preventable if we stop the secrecy, stigma, and punishment. In absence of support, doctors make impulsive decisions to end their pain permanently. I asked several male physicians who survived their suicides, “How long after you



decided to kill yourself did you take action — overdose on pills or pull the trigger?” The answer: 3 to 5 minutes.

Ignoring doctor suicides leads to more doctor suicides. Let's not wait until the last few minutes of a doctor's life when heroic interventions are required. Most physician suicides are multifactorial involving a cascade of events that unfold months to years prior. So reach out to “happy” doctors today — especially male anesthesiologists and surgeons who are least likely to cry or ask for help.

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5. American Psychiatric Association (APA) 2018. Abstract 1-227, presented May 5, 2018.



Physician Stress & Burnout: Research & Resources

Physician Health Program — The Center for a Healthy Maryland (<https://bit.ly/2AVR6N4>): The Maryland Physician Health Program is a private, confidential, nondisciplinary program that provides clinical care for physicians and allied health professionals. Administered by MedChi's foundation, the Center for a Healthy Maryland, this HIPAA-compliant program provides assessment, monitoring, referral, and support services for physicians impaired by:

- Substance Misuse/Abuse: Depression, anxiety, or mood instability
- Alcohol Abuse: Physical or cognitive impairments
- Anger Management: Behavioral Issues
- Boundary Issues: Stress

American Medical Association (<https://bit.ly/2Izhy39>): The AMA's website provides many articles and CME resources on physician stress. Example: Physician Well-Being: Protect Against Burnout and Encourage Self-Care.

The Physicians Foundation (<https://physiciansfoundation.org/vitalsigns/>): Vital Signs — Helping physicians recognize their level of stress and providing resources to help physicians address their own vital signs related to their health, emotions, attitude, relationships and temperament.

Mayo Clinic (<https://mayocl.in/2MyPxgv>): Mayo Clinic has established a research center for physician well-being.

Stanford Well MD Center (<https://stanford.io/2IyauUh>): Provides support to physicians so that they, in turn, can provide the best health care.

You Can Be a Happy MD (Dike Drummond, MD): Coaching, training, and consulting organization focused on the treatment and prevention of physician burnout (<https://www.thehappymd.com>).

Preventing Physician Suicide (<https://bit.ly/2Mn3ZVv>)
Pamela Wibel, MD.

Stress & Burnout Counseling Service for Physicians Practicing in Montgomery County (<http://www.dedicatedtohealth.org>): Services are provided through PRN (Physicians Resource Network) confidential and complimentary to licensed physicians practicing in Montgomery County. Offered by the National Capital Physicians Foundation in conjunction with the Montgomery County Medical Society. Requests can be made through secure portal.

Have You Ever...

- Noticed while at work that a physician colleague smelled of alcohol?
- Been concerned by a physician who was so upset and angry with colleagues that it interfered with patient care?
- Been plagued with worry or concern because a colleague "just doesn't seem right?"

Do You Know Where To Turn If...

- You think a physician friend might have a drinking problem?
- A colleague is self-prescribing pain-killers or other controlled medications?
- A colleague seems depressed, is experiencing mood instability, or is overly anxious to the point that their performance is being affected?



MPHP is a private, confidential, non-disciplinary program that advocates for the health and well-being of all physicians and other allied health professionals who are licensed by the Maryland Board of Physicians to safeguard the public. MPHP is HIPAA compliant, and protects the confidentiality of participant records as set forth under state and federal law. MPHP is administered by the Maryland State Medical Society's 501 (c)(3) affiliate, the Center for a Healthy Maryland, and is separate from the Maryland Board of Physicians.

For more information and/or a confidential consultation for you or a colleague who may benefit from our help, please call **800-992-7010** or **410-962-5580**.

MPHP

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The Maryland State Medical Society

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How Headspace Helps Physicians, Medical Students Tame Stress

Sara Berg, American Medical Association Senior Staff Writer

There are many system-level drivers of physician burnout, which require the attention of medical organizations. There are also some ways that physicians can work to cut stress on their own time. A surgeon, pathologist and medical student have found one way — by practicing mindfulness meditation with the Headspace app.

Headspace is a meditation and sleep app that can have a positive impact on health professionals' personal and professional lives. AMA members can get a free, two-year subscription to Headspace.

Three AMA members — a surgeon, a pathologist, and a medical student — share how they are using the Headspace app to reduce the impact of stress on their lives in medicine.

Preoperative Prep

Ravi D. Goel, MD, a comprehensive ophthalmologist and cataract surgeon in Cherry Hill, New Jersey, often uses the Headspace app for meditation before surgery. Because ophthalmologists and microsurgeons often have “back and neck issues,” mindfulness meditation can help with relaxation, he said.

“Initially, it helps with focus and relaxation. We all have different places where we throw stress — your back, your neck — and mindful meditation can help you with an almost instant relaxation,” he said. “Mindfulness meditation can have a similar effect on me as a one-hour yoga session. And with a ten-minute session before I start the day, the positive effects can last for many hours each day.”

Dr. Goel has found that he can destress while becoming more mindful in the present moment for increased focus during surgeries because “it’s a power tool in my mission of protecting sight.”

Winding Down

Nicole Riddle, MD, a pathologist in Tampa, Florida, and member at-large of the AMA Young Physicians Section governing council, uses Headspace to help her sleep at night.

“I have a racing mind and it helps me to have something to focus on that is relaxing and helps me fall asleep,” said Dr. Riddle. “I also use the tools — either with the phone or on my own — to get back to sleep in the middle of the night.”

“I also try to use it for a five to ten-minute moment of mindfulness to help relieve stress and relax myself or calm myself down during the work day.”

Dr. Riddle said that she has felt her heart rate and perceived stress level fall when she uses the app’s exercises, whether during the day or at bedtime.

“As it helps me sleep, that definitely leads to better overall health, as well as lessening stress,” she said.

Keeping Up in Med School

Heather Bird, an osteopathic medical student at Pacific Northwest University of Health Sciences in Yakima, Washington, almost ended medical school after her first year because of burnout and low-back pain.

Fortunately, during the summer after her first year of medical school, she found meditation, which helped her regain her focus.

“My meditation practice is comparable to my tooth-brushing practice — it is as important to maintain my mental wellness hygiene as it is to keep up on my physical hygiene,” said Bird. “It is

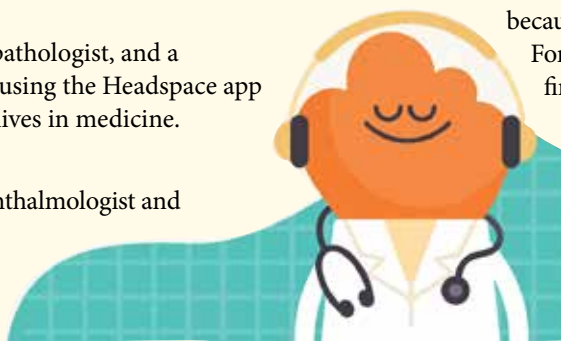
one of the tools I use in the morning to greet the day and in the evening to fall asleep.”

She will also use the Headspace app in the middle of the day if she begins to “feel anxiety creeping into my day,” and uses the download capability for walking meditations.

“I am currently on a clinical rotation that is close enough to walk to,” said Bird. “While listening to the app on my walk, I notice the beautiful colors of the plants, birds hopping about seem to emanate joy and the sunshine energizes my vibe! It makes going to clinic a lovely journey and I arrive happy, ready to work.”

Committed to making physician burnout a thing of the past, the AMA has studied, and is currently addressing, issues causing and fueling physician burnout — including time constraints, technology and regulations — to better understand and reduce the challenges physicians face. By focusing on factors causing burnout at the system-level, the AMA assesses an organization’s well-being and offers guidance and targeted solutions to support physician well-being and satisfaction.

Originally published to the AMA website on September 5, 2019. AMA members: To redeem your free two-year subscription to Headspace, visit ama-assn.org/headspace-benefit.



MedChi's Newest Physician Members

MedChi welcomes the following new members, who joined between July 30, 2019, and September 12, 2019.

Azra Ashraf, MD — Ashraf Plastic Surgery
Preeti Chidambaram, MD, MPH — Mercy Health Clinic
Gina Dapul-Hidalgo, MD
Ryan Gabriel, DO — Meritus Health
Chesahna Kindred, MD — Kindred Hair and Skin
Rebecca Levitt, MD — Growth and Wellness Pediatrics
Khalida Malik, MD — Multi-Specialty Health Care
Reshma Modi, DO, MD — Adfinitas Health
Rohan Moffatt, MBBS — Memorial Hospital at Easton
Colin Murphy, MD — University of Maryland

**1 in 11 Americans have diabetes.
Your help is their hope.**

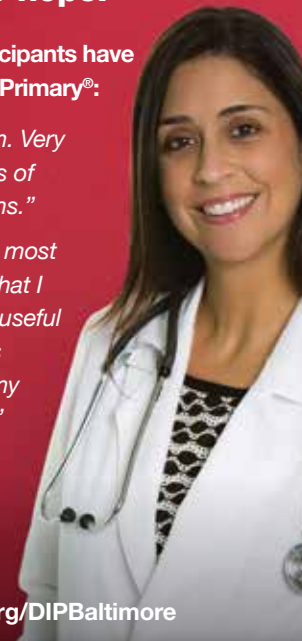
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November 21, 2019 | Hyatt Regency Baltimore Inner Harbor
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CRISP FREE Services for Ambulatory Practices

Connect. Share. Improve Patient Care

CRISP is a regional health information exchange (HIE) serving Maryland and the District of Columbia. CRISP is a non-profit organization advised by a wide range of healthcare industry stakeholders. All of the following services are available for FREE to ambulatory practices. For more information, visit the CRISP website at www.crisphealth.org.

Clinical Query Portal

The CRISP Portal is a free tool available to clinical staff. As clinical information is created and shared with CRISP, it is made accessible in real time to participating health care providers through the CRISP Portal.

Encounter Notification Service (ENS)

ENS allows primary care physicians, care coordinators, and others responsible for patient care to receive real-time alerts when patients are admitted/discharged at hospitals. Proactively coordinate your patients' care and schedule any necessary follow-up treatment or visits.

Prescription Drug Monitoring Program (PDMP)

The Maryland Prescription Drug Monitoring Program gives prescribers, dispensers and other licensed staff access to prescription information for all Schedule II-V drugs filled in Maryland, Virginia and some neighboring states.

For more information and to sign up for any of the **CRISP User Services** contact MedChi at **410-878-9698** or email cgeorge@medchi.org.

Member Profile: Col. (Ret.) Robert L. Henderson, MD — Great-Grandson of a Civil War Physician

Col. (Ret.) Robert L. Henderson, MD, was born in Palmedale, Alabama, in June of 1937, son of a printer and a Sunday school teacher. His formative years taught him to persevere regardless of the obstacles set before him. His father served in the Navy during WWII, leaving Dr. Henderson to spend his time with his grandfather who was a candy maker. His great-grandfather had been a Civil War physician, and Dr. Henderson knew from a very young age that this was the path he would take.

In 1959, he married Sylvia Herrmann of Birmingham, Alabama. They are celebrating fifty-nine years of marriage and have three daughters — Parrie, Pamela, and Patricia — as well as six grandchildren.

Dr. Henderson graduated from the University of Alabama Medical School in 1962, and volunteered for the U.S. Army, where he was assigned an internship at Tripler U.S. Army Hospital in Hawaii. During his time there he joined the Special Forces as a physician and was sent to Ft. Benning, GA, for airborne/jump school training. Over the next three years he would be deployed to active duty service as a combat physician in Vietnam, as well as being relocated to Ft. Bragg, NC.

After returning from deployment Dr. Henderson entered residency training at Brooke Army Medical Center in San Antonio, Texas. After a three year stay in Texas he was relocated to Wuerzburg, Germany, for residency training. During his time in Germany he was one of only three otolaryngologists. Dr. Henderson at this time also joined and performed with an officers club musical act allowing him to see and interact with not only his fellow military members but with the Germans.

During his assignment in Germany, Dr. Henderson was hand selected by Major General Walker to be the Division Surgeon for the 3rd Infantry Division.

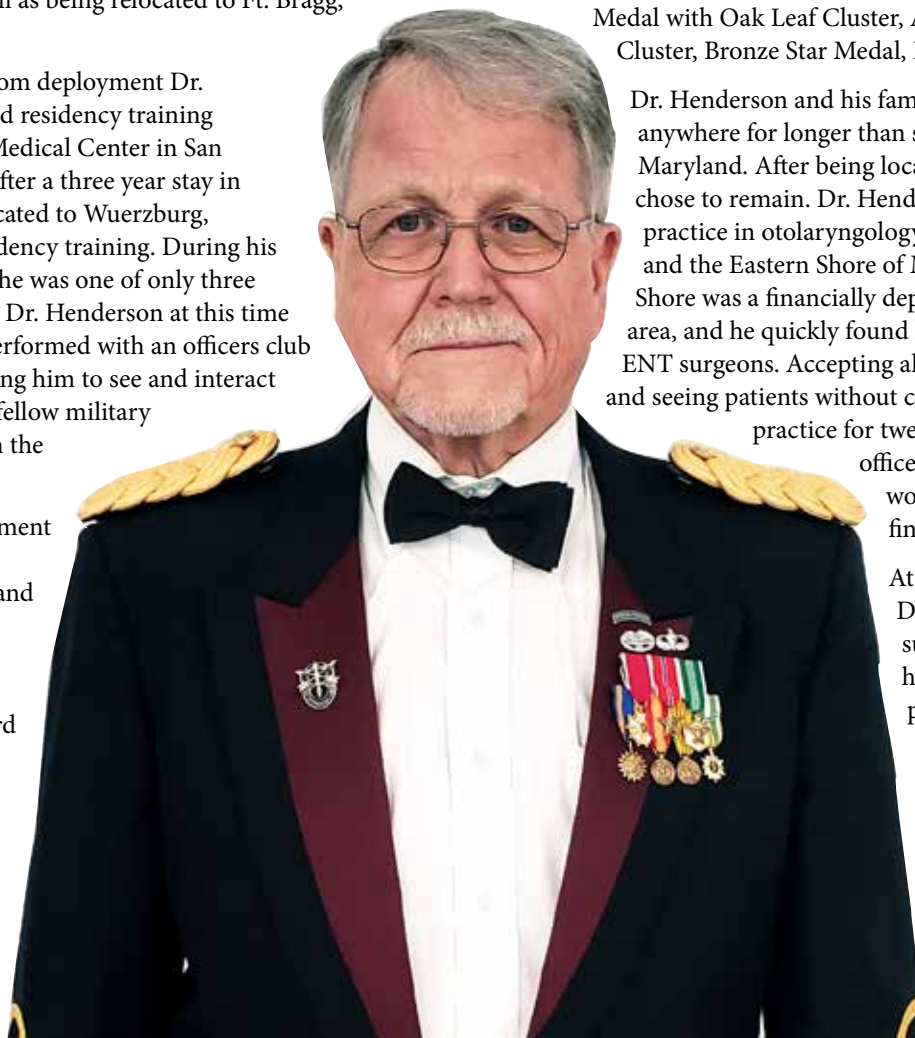
Dr. Henderson was selected as the Chief of

ENT services at Letterman Army Hospital in San Francisco, CA, at the conclusion of his stay in Europe. After only one year at this post he was appointed by the U.S. Surgeon General to be the chief of Otolaryngology, Head and Neck Surgery services and director of Residency Training Program for Walter Reed National Military Medical Center. In this capacity, Dr. Henderson oversaw the training of twenty-eight physicians and qualified them for their board examination. In addition, he acted as special consult to the U.S. Surgeon General for ENT Surgery and Audiology. While Chief of Walter Reed ENT, Dr. Henderson established the Walter P. Straight Memorial Conference, which was the first Otolaryngology conference to be held in Washington, DC.

After a twenty-year career and having achieved the rank of Full Colonel, he retired from the Army in 1982. During his military career he was awarded the Senior Parachutist Badge, Combat Medical Badge, Vietnamese Parachutist Wings, Vietnam Defense Ribbon, Vietnam Campaign Ribbon, German Marksmanship Medal in Silver, German Sport-Military Medal in Bronze, National Defense Ribbon, Army Commendation Medal with Oak Leaf Cluster, Air Medal with Oak Leaf Cluster, Bronze Star Medal, Legion of Merit.

Dr. Henderson and his family had never lived anywhere for longer than seven years other than Maryland. After being located in Maryland, they chose to remain. Dr. Henderson established a private practice in otolaryngology in both Howard County and the Eastern Shore of Maryland. The Eastern Shore was a financially depressed and underserved area, and he quickly found himself one of only three ENT surgeons. Accepting all forms of insurance and seeing patients without coverage, he remained in practice for twenty-nine years, closing his office only after the hospital he worked out of closed due to financial concerns.

At the age of seventy-nine, Dr. Henderson discontinued surgical procedures, but has remained in practice part-time in the Howard County region. He has been a MedChi member since 1983.



Strengthening the voice of **Maryland physicians**

Your membership in MedChi, The Maryland State Medical Society and the American Medical Association (AMA) ensures you have powerful allies amplifying your voice and advocating for the needs of Maryland patients and physicians—in your community and across the country.

Start your AMA and MedChi memberships today.
 Join the AMA at ama-assn.org/mmm-medchi.
 Join MedChi at medchi.org/membership.

“In Maryland, we are close to the federal government, and politics is our ‘home sport.’ MedChi and the AMA are experts at advocating for physician and patient interests in Annapolis and in DC.”

Stephen Rockower, MD
 AMA MEMBER SINCE: 1982
 AMA House of Delegates



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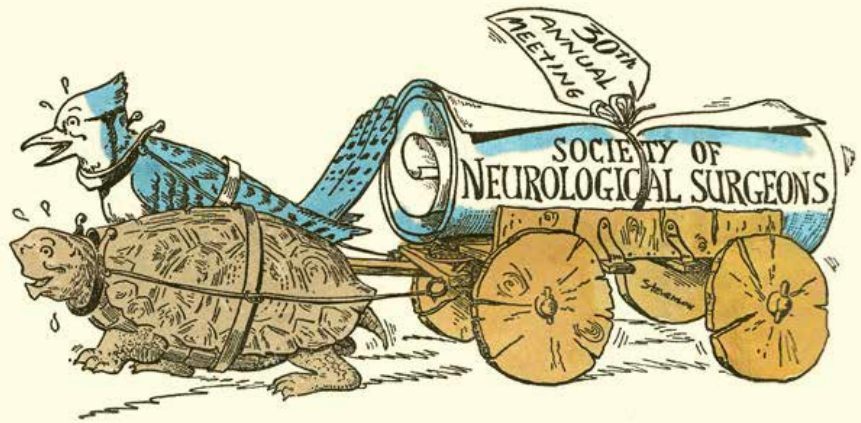
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From the Archives

MedChi's archives date back to the early 1800s, but there are more contemporary items that reside there as well. This hand-colored engraving from 1949 was created for the Society of Neurological Surgeons' 30th Annual Meeting at the Maryland Club. The Terrapin and the Blue Jay are the mascots of the University of Maryland and Johns Hopkins, respectively. As with all of the specialty societies MedChi manages, physicians from both organizations work in cooperation with each other as they have over the decades.



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Events

For a complete list of MedChi and component events, visit <http://www.medchi.org/Events>.

November 2

MedChi Annual Mtg & Fall House of Delegates Mtg. Hotel at Arundel Preserve, 7795 Arundel Mills Blvd, Hanover, MD. Catherine Johannesen, 410.539.0872 ext. 3308.

November 6

BCMA Board of Governors' Mtg. 6:15 pm. GBMC, Rooms D & E, 6701 N. Charles St, Baltimore, MD. Patricia Keiser, 410.296.1232.

November 13

BCMA CME Event: Anesthesia Alternatives to Opioids and Postoperative Pain in the Chronic Pain Patient. Conf Ctr at Sheppard Pratt, 6501 N Charles St, Baltimore, MD 21204. Patricia Keiser, 410.296.1232.

St. Mary's County CDS CME Roadshow Mtg: Prescription Drug Monitoring Program (PDMP) Best Practice and Clinical Use. Speaker: Dr. Gary Pushkin. 5–8 pm. MedStar St. Mary's Hospital, 25500 Point Lookout Rd, Leonardtown, MD. Amalia Oven, 410.539.0872, ext. 3321.

BCMS Board Meeting. 6 pm. MedChi Bldg, Malouf Board Rm, 1211 Cathedral St, Baltimore, MD. Lisa Williams, 410.625.0022.

November 20

BCMS & BCMS Foundation Annual Meeting & Furlong Lecture. Sinai Hospital. Lisa Williams, 410.625.0022.

November 21

MedChi Board of Trustees Meeting. Zoom Teleconference. Catherine Johannesen, 410.539.0872 ext. 3308.

December 5

BCMS Town Hall. 6–8 pm. MedChi Bldg, Osler Hall, 1211 Cathedral St, Baltimore, MD. Lisa Williams, 410.625.0022.

December 6

BCMA Legislative Breakfast. Conf Ctr at Sheppard Pratt, 6501 N Charles St, Baltimore, MD 21204. Patricia Keiser, 410.296.1232.

December 7

MedChi Presidential Gala. Royal Sonesta Harbor Court Hotel, 550 Light St, Baltimore, MD. Catherine Johannesen, 410.539.0872, ext. 3308.