The Twenty-year Evolution of Colorado Physician Health Program
Todd Weiss, BA, Development Specialist

“I felt unable to do anything about our attending supervisor. I didn’t know where to turn other than to my residency supervisor, but I didn’t want to turn my attending in. So, I didn’t do anything. There was no physician health program. That man died about a year after I graduated. He was a suicide and nobody talked about it, but it was obvious to me he died of his alcoholism. He was only about 52. When sober (which was only a third of the time), he was an extremely talented man. So, I was really upset by that, and it was in the back of my mind when I heard that the American Medical Association (AMA) had taken an interest in all varieties of physician health care.”

Stephen L. Dilts, MD, the leading founder of the Colorado Physician Health Program (CPHP), recalled this tragic event from his 1970-73 residency at the University of Colorado. Ironically, during this same time, the AMA passed a resolution announcing to the medical profession their belief that physicians with a wide variety of illnesses were being hidden and urging the profession to take on the challenges of identifying and treating physicians who could jeopardize their practices.

1985. Key individuals from the Denver Medical Society (DMS), the Colorado Board of Medical Examiners (BME) and the Colorado Medical Society (CMS) were inspired and wanted to collaborate on the AMA’s physician health initiatives. The three local organizations formed a committee. They were soon invited to attend an international AMA conference in New Jersey regarding physician healthcare. Colorado was represented by Dr. Dilts and another pioneer of CPHP, Michael S. Sturges, MD. The two doctors arrived back in Denver armed with physi-

Depression and Suicide Among Physicians
Mary Ellen Caiati, MD, Associate Medical Director

Depression and suicide in physicians are problems generally given too little attention. Depending on specialty, we learn varying amounts about how to evaluate the symptoms of depression in our patients, but little emphasis is given to identifying depression or potential risk for suicide in our colleagues or ourselves, nor are most physicians trained to understand the specific difficulties physicians have in seeking
Women in Medicine
Doris C. Gundersen, MD
Associate Medical Director

Physicians have often been agitated by the demands of women to be admitted to the practice of medicine. It cannot be denied that feminine mental faculties suffice for the acquisition of medicine. On the other hand, only a few girls will take up the study, and these few will be those who are not really fitted for their maternal duty. Thus medicine, like the women, will not derive much benefit from these efforts. It will not amount to much.

Male Physician, Early 1900s

The error in this physician’s projection is obvious. One hundred years ago and in the context of a culture which embraced more traditional gender roles, this prediction was reasonable, not insensitive or sexist. It is true that before 1960, ninety five percent of physicians were male. Women occupied supportive roles, at home, in the office and hospital. In 2003, the number of women applying to medical school outpaced men for the first time. Today, more than half of students entering medical school are women. It is projected that by the year 2010, a full third of practicing physicians will be women.

While great strides have been made in terms of the absolute number of women in the field, they continue to be a minority in positions of leadership and remain underrepresented in some specialty areas. Most studies assume a gender based preference to account for the high numbers of women choosing primary care specialties. However, early in medical school, women show interest in all specialties in proportions similar to male students. Where things change is later in

perspectives from the executive director
Sarah R. Early, PsyD

Twenty years! This can be short or long depending on your viewpoint. When I think of the number of clients CPHP has helped—over 2400!—it feels as though CPHP has been around for a long time. When I think of the time it takes to develop a vision, implement the logistics to turn into a reality and become a nationally recognized organization, twenty years does not seem nearly enough time to have accomplished this.

The field of physician health has overcome much prejudice and stereotyping. Now CPHP is much more readily accepted as an accessible resource for every doctor. We have helped the medical community move beyond the erroneous viewpoint that CPHP is only for substance abusers or impaired physicians on the verge of losing their medical license. CPHP is now sought proactively for a variety of health or psycho-social issues.

The medical field has changed. “Old timers” speak of the horrendous volume of hours worked, lack of sleep for days on end, and blatant abuse by supervisors and attending physicians. These days, the belief that one’s career should be all-encompassing is not generally accepted. Young physicians are more concerned about a gratifying, balanced lifestyle, of which career is a rewarding part, and they strive to achieve this balance. With more women becoming physicians and entering the field, the goal of balance is more prevalent as women’s desires to have and raise children compete with career goals. Attaining a lifestyle in which many components (career, family, friends) are fulfilled is healthy and hopefully leads to greater life satisfaction!

The medical community has needed to move away from some often detrimental ideology including “doctor heal thyself” and “doctor treat thyself,” as well as the unrealistic belief that physicians should not get sick. Regrettably, physicians still do not consistently receive the quality healthcare they deserve, either through lack of appropriate diagnosis, treatment, and follow-up, or the lack of expertise of providers working with physicians. There is still much work for CPHP to accomplish. Fortunately, physicians are more accepting of their own and their colleagues’ need to stay healthy and to treat their health concerns effectively. CPHP has advanced to work with physicians preventively and with earlier intervention. Such involvement obviously leads to more successful outcomes and healthier, more contented physicians. I look forward to continued advocacy for physicians’ wellness and educating the medical community to support and promote physicians’ balanced lifestyle and good health.

Historical Events in 1986
• The restored Statue of Liberty was re-opened to the public as part of its tremendous centennial celebration.
• The Shuttle Challenger exploded.
• Chernobyl experienced a nuclear disaster.
• Martin Luther King Day was first celebrated.
• The Energizer bunny was introduced.
• IBM unveiled the first laptop.
• The Oprah Winfrey Show was launched.
In Their Own Words: How CPHP Helps

From a Resident

In addition to my residency, I had a lot of stress within my life: family, teenage sons, and a terminally ill family member. I knew about CPHP through a presentation your organization gave at the University of Colorado Medical School. My colleagues and I were enlightened during that presentation. I soon realized that it was confidential, and that was very appealing to me.

I must say that I was apprehensive about contacting CPHP because I’m a very private person. I generally don’t talk to a lot of people. But after working with the CPHP clinical staff, I have to say I just loved them. They were quite empathetic as they, too, seemed to have been in some similar situations at some point in their careers. One of the challenges of even getting treatment was my schedule and the time requirements imposed on me by the residency program. I must say that CPHP and their staff were very good about working with the residency program in order for me to make appointments and get the help I needed. They really helped me.

One thing that stood out at CPHP was the warm and friendly reception. They made me feel comfortable and relaxed. This enabled me to confide the difficulties I was having. The CPHP clinical staff genuinely conveyed a sense of concern for me and the problems I was dealing with.

Residents really need to know this program exists. They need to know it’s confidential and that the CPHP staff will work with the residency program to get appointments made. Additionally, I was impressed with all of the excellent resources available at CPHP. Your organization needs to continue getting the word out. A lot of physicians in training have stressors that need to be dealt with. They need to know that your program is confidential and a good way to get de-stressed and get some help.

From an Early Client

I’ve had over ten years of experience with CPHP. Initially, I was intimidated by CPHP and its structure, mostly due to my ego and the fact that the concept was new in Colorado. Originally, I thought CPHP was just an arm of the Board of Licensure. I came to realize that they were different and offered much more than I had thought.

I am extremely grateful to CPHP for the help and support they have given me over the years. The medical community really needs to know that CPHP is funded and available to all physicians finding difficulty in their personal and professional lives. Everything CPHP does is in a safe and non-judgmental environment.

Over the past twenty years, CPHP has improved by really reaching out to the medical community. Medical professionals now understand the organization much better than they did early on. CPHP can now be seen as a positive presence in our careers. I am currently involved with sharing my story with CU sophomore medical classes, and I see early education in medical careers as a priority for CPHP. Hopefully, your organization will find even stronger sources of funding to expand the already well-received program.

For me, CPHP has assisted in my continued recovery, potential life-threatening disease, the liquidation of my practice and support in continuing education for the recertification in my new specialty.

Finally, the most beneficial aspect in working with CPHP was the support and encouragement during recovery!

From a Training Program Director

Jim E. Keller, M.P.H., PA-C
Program Director
Physician Assistant Program
Red Rocks Community College

The Colorado Physician Health Program provides a service to both our students and faculty that is both necessary and rewarding. Physician assistant education is very intense and presents stressors and problems for our students and their families and loved ones that cannot be anticipated at the time of matriculation.

When such stressors are outside the scope of faculty academic counseling, CPHP staff is readily available to meet with our students in a timely manner, make the necessary assessments of the problems and issues, and provide the needed counseling and problem-solving to assist our students in successfully completing our twenty-four-month educational program.

Did you know . . . ?
CPHP’s direct client services are FREE to all Colorado medical licensed physicians and Colorado licensed physician assistants.

$ Did you know . . . ?
CPHP’s services are statewide.
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Did you know CPHP assists with any health-related concern?

- Depression • Relationship Issues
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- Stress • Bipolar Disorder • Sleep Disorders • Eating Disorders
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and obtaining treatment for these problems.

Depression occurs commonly, with about 20% of individuals in the general population experiencing a significant depressive episode at some point in their lives. Physicians have a rate of depression similar to that in the population, with 13% of male physicians and about 20% of female physicians reporting an episode of clinical depression during their lifetimes. Medical students and residents experience depression at even higher rates, with some studies estimating the rates as high as 30%.

Depression can lead to significant emotional distress or impairment in social life, home life, and work. Both depression and substance disorders have been identified as major risk factors in the high rate of suicide in physicians, with more than 90% of those physicians who suicide having a history of mood disorder and/or substance abuse. Suicide rates in physicians exceed those in the general population-about 70% higher for male physicians compared to non-physicians and about 250% to 400% higher for female physicians.

Identifying Depression

Although physicians are called on to diagnose depression in patients, recognizing this mood disorder in themselves or colleagues poses particular challenges for a variety of reasons.

In many ways, depression in physicians manifests like depression in the general population, but it occurs in a context of stress and demands that sometimes complicates the diagnosis. Many physicians come to Colorado Physician Health Program (CPHP) because of stress secondary to patient care, to administrative politics, to decreasing autonomy, to increasing financial strain, or to lawsuits. They may find themselves irritable with family or co-workers, or suffering from insomnia, or more withdrawn from efforts to manage increasing demands. While these can be normal responses to stress, if they persist for long periods of time or progressively worsen, these reactions may represent the onset of a mood disorder. Many physicians postpone evaluation because they believe that they are experiencing expectable reactions, but the delay in treatment can lead to a worsening of symptoms.

Physicians as a group have some characteristics which lead to special difficulties in confronting depression. Physicians tend to deny illness, likely because of anxiety about being seriously ill, or because of fears of the effect of an illness on ability to earn a living or on professional standing. This tendency may be all the more pronounced in the context of mental illness and its associated stigma. Many physicians have a need for control which can make it difficult to accept a patient role and to ask others (perhaps especially other physicians) for help.

Often, physicians find it difficult to consider depression in a colleague, let alone to confront a colleague having problems. Since depression can lead to significant psychological distress and eventual work impairment, and is an identified risk factor in the increased suicide rate in physicians, it is incumbent upon all of us to pay attention to warning signs of depression and suicide in our colleagues. While these warning signs are not specific, they may indicate the need for concerned questions or recommendation for evaluation. Physicians with depression may have a decline in job performance or a higher rate of absenteeism. They may become noticeably more withdrawn, irritable, or argumentative. They may be unable to take customary care of their appearance. Depressed physicians may begin to more frequently complain of aches and pains or express concerns of illness. Importantly, problems in depressed physicians may show up in the workplace last, after symptoms have led to withdrawal from community or recreational activities, problems with friends or peers, and eventually difficulties in relationships with family.

Similar Risk Factors for Suicide

Risk factors identified for suicide include mood disorders and substance use problems. The stresses that make physicians more susceptible to the development of depression may also make them more at risk for eventual suicide. Many physicians work long hours, which can deprive them of time spent with supportive family or friends. Long hours can also add to conflict internally and with family between work and personal life. Losses in personal and professional life, financial problems, career
Colorado Physician Health Program (CPHP) is proud to recognize the following individuals and organizations who participated in our annual Spirit of Medicine Campaign during fiscal year 2004-05. We are truly grateful for their generosity, which helps provide crucial support to CPHP as we strive to provide the highest quality physician health care services and meet the growing demand for our services throughout Colorado.

**LivingWell Giving Society**

CPHP extends special appreciation to the following founding members of the LivingWell Giving Society which began in 2003. This group of donors have pledged an annual contribution each year for five successive years, providing continuous funding for our work.

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Please Note: We have made every effort to give proper recognition to those who financially supported CPHP’s mission in 2004-05. If we have made an error, we apologize. Please contact CPHP’s Development Specialist at (303) 860-0122, ext. 221 so we may correct our records.
Growth of New Referrals, 1986-2005

The CPHP Team

(Standing: L to R) David A. Iverson, MD, Lynne Klaus, LCSW, Michael H. Gendel, MD, Shari Lewinski, LPC, Karen Chipley, MBA, CPA, Teresa Bajorek, CPCS, Jill Sample, BS, Sarah R. Early, PsyD & Mary Ellen Caiati, MD, (Seated) Todd Weiss, BA, Naomi Richards, LCSW, Brian Ellis, Cae Allison, LCSW, Sally Moody, MSW & Doris C. Gundersen, MD (Not Pictured) Michael S. Sturges, MD, Jay H. Shore, MD & Elizabeth “Libby” B. Stuyt, MD

*BME license renewal years
cian health information, and CPHP was born as a non-profit 501(c)(3) organization in the spring of 1986. Since the beginning, CPHP has been an independent entity governed by its Board of Directors. The Board of Directors has always been composed of both physicians and professionals within the medical community who are dedicated to the organization’s mission.

Like most new non-profit organizations, CPHP operated on a shoestring budget. Dr. Dilts was the Medical Director on a part-time basis, and Ms. Jacqueline Soter was the part-time executive director. Dr. Sturges served as president of the Board of Directors and would later become an associate medical director. In a humble, yet pleasant, basement office at 17th and Market Streets in downtown Denver, the organization was forming its roots. Word spread quickly throughout the medical community, primarily through the medical societies and local medical groups. As CPHP began to mature and require additional resources, the local medical societies stepped up with grant money and also engineered state legislation that created much needed revenue via a small surcharge on physician licensure fees and the development of a peer-assistance fund.

During the early nineties, CPHP was blossoming and experiencing typical growing pains such that additional office space was required. The organization moved to a roomier facility at Ninth and Washington near downtown Denver. At this time the Executive Director’s position became a full-time job, and Dr. Dilts’ time was increasing as well.

Linear growth of the organization was in full swing as masters level clinical staff and associate medical directors were added, along with the development of administrative positions. “Everything about CPHP was growing,” said Dr. Dilts. In light of this growth and the realization that physicians weren’t the only ones faced with burgeoning personal health challenges, a decision was made to extend services to residents and medical students. (Physician assistants and physician assistant students were added later.) In October of 1999, Dr. Dilts became Medical Director Emeritus, and Michael H. Gendel, MD, assumed the challenging role of Medical Director. With such continued growth the organization rounded out the decade with yet another move to CPHP’s current location at 899 Logan Street.

Taking a page from other such organizations, this feisty non-profit began a fundraising program to raise needed revenue not covered by the peer-assistance fund. The vital fundraising program, later dubbed *The Spirit of Medicine* campaign, is equally important today in 2006. Despite its humble beginnings, the campaign has enjoyed extraordinary commitment from the medical community. Individual physicians, hospitals, CMS, COPIC, and numerous local medical societies have supported CPHP through the years. Such support has allowed CPHP to expand on its much-needed services in order to assist an increasing number of medical professionals.

2000s. The undeniable need for CPHP’s services to Colorado’s medical professionals continued to dictate the growth of the program and the expansion of the offices at the Logan Street location.

“It has been a privilege to work alongside Steve at CPHP. I will miss his wisdom, humanity and humor. He’s been the soul of this organization,” said current Medical Director, Michael H. Gendel, upon the retirement of Dr. Dilts in 2004. The two have known one another for more than 30 years, and Dr. Gendel recognizes Dr. Dilts as a teacher, mentor, and colleague. Currently, Dr. Dilts remains involved as a Board Director with the organization he helped found.

CPHP has come a long way! During CPHP’s inaugural year, 15 clients were served. Just this past year alone, there were 216 new referrals with an average of 373 active clients. And since 1986, the organization has had over 2,400 referrals and served over 2,200 clients. A comparison of client referrals during 1998-99 to the organization’s most recent year shows a 65% jump. This increase is likely due to a greater awareness of CPHP’s many confidential services and the acceptance of such a program by medical professionals. Most people do not realize that CPHP’s original mission was to address a multitude of physical and psycho-social issues affecting physicians. However, it seems that only the evolution of both the organization and the entire medical community has allowed this to be fulfilled.
The following training programs have contracted with CPHP, entitling the residents and students access to CPHP services at no additional cost:

- University of Colorado School of Medicine
- University of Colorado Physician Assistant Program
- Red Rocks Community College Physician Assistant Program
- University of Colorado Graduate Medical Education
- St. Anthony Family Medicine Residency Program
- St. Joseph Hospital Graduate Medical Education
- Southern Colorado Family Medicine Residency Program

If your training program is interested in establishing a contract with CPHP, please contact Sarah R. Early, PsyD, Executive Director, at 303-860-0122 x232. Additional program services information is available on our website.

www.cphp.org

“Women in Medicine” continues from page 2

training, as women perceive difficulty in combining family and career and in the context of limited mentorship in some specialties.

More women enter primary care and work part time, likely reflecting efforts to integrate personal and professional roles. According to the Medical Colleges Association, in academia, only five percent of department chairs are women and 10% are deans. Finally, only 15% of full professorships are held by women.

Disproportionate gender representation in clinical arenas cannot be explained by specialty choice alone. Fewer women, compared to men who apply to surgical residencies match successfully. The factors contributing to these observed disparities are complex. While much has been done in the last two decades to eliminate inequities stemming from gender bias and discrimination, sexual harassment and role conflict, these factors continue to influence the lives of women in medicine.

Although the compensation gap is narrowing for “younger” (i.e. less than 45 years old) physicians, women continue to earn on average, $22,000 less per year than their male colleagues, even when such factors as hours worked, practice setting and specialty are controlled. In academia, female and male reviewers are more critical of the grant proposals submitted by female applicants. Women in academic arenas receive less institutional support (e.g. funding and administrative assistance) relative to their male colleagues. Female faculty members with children publish less, experience reduced career satisfaction and perceive themselves as less successful.

Gender discrimination may also manifest in the form of conscious or unconscious slights based on stereotypes. In an anonymous survey of male medical students, thirty percent believed that women of childbearing age pose a significant risk to the optimal functioning of a department. Nearly fifty percent of this same survey group agreed with the following statement: Women who spend long hours at work were neglecting their responsibilities to home and family. The lingering notion that women are not as serious or fitted for certain medical careers because they choose to incorporate motherhood into the mix, is an example of gender bias that can interfere with a female physician’s consideration for promotion.

The medical profession has become more sensitive to issues pertaining to sexual harassment. According to a Women Physician Congress survey conducted in 2005, 49% of members reported experiencing sexual harassment in their careers. Circumstances have improved dramatically in the last decade. However, more subtle forms of sexual harassment, (i.e. staring, suggestive looks) persist and are difficult to prove. Recipients report that such covert harassment is as distressing as overt behaviors including groping or frank sexual advances. The prevalence of sexual harassment is higher in subspecialties dominated by men. The literature continues to support that the vast majority of female trainees and practicing physicians who encounter this behavior are unlikely to report it. The reasons include “no energy beyond keeping up with the demands of training” to fears of retaliation. It is significant to note that sexual harassment in the workplace can be an important predictor of depression for female physicians.

continues on page 12 . . .
Role conflict is another factor which can impact a female physician’s career satisfaction and success. Pregnant physicians frequently encounter resentment from colleagues who inherit extra work in order to accommodate the new mother’s “medical leave.” A colleague of mine once likened her expanding waistline to “A scarlet letter; the ultimate betrayal to the house of medicine.” It is not uncommon for postpartum physicians to experience a degree of cognitive dissonance while celebrating a new birth and simultaneously contending with feelings of guilt or disloyalty related to imposing on colleagues.

More women than men make changes to accommodate children’s needs. For example, one survey (N=1,248) revealed that on average male physicians interrupted their careers for one month compared to female physicians who interrupted their careers for 8.5 months, to address child care issues. Female physicians are more likely than male physicians (85% vs. 35%) to change their career plans to accommodate children.

Female physicians continue to be responsible for the lion’s share of other domestic work. Even in two physician marriages, traditional role divisions predominate, leaving women with a far more complex juggling act. Female physicians who lack family support for their work role are at an increased risk for depression. Finally, family obligations compete with those networking opportunities (for example, national conferences) which are more likely to provide an early career physician exposure to superordinate female role models.

Discriminatory practices aside, most experts agree that a combination of biological hard wiring and early gender role socialization contribute to the prevailing differences between the sexes in terms of the way we think, feel and behave. Unfortunately, ultra sensitive gender politics has made it difficult to fully acknowledge, if not embrace and capitalize on those unique masculine and feminine traits that contribute positively to the practice of medicine.

Numerous studies reveal that parents, consciously or otherwise, interact differently with their sons and daughters. A child’s behavior, influenced by gender role socialization, can be reinforced by teachers, television, books and even the religious beliefs we subscribe to. Researchers have found that from preschool on, teachers, including female teachers, praise boys more than girls and are far more likely to accept a male student’s comments in the classroom.

Additionally, more (overt) expressions of aggression are tolerated in young male students. In contrast, girls are conditioned to be more relationship oriented and emotionally responsive to others. This kind of traditional gender shaping can contribute to a girl’s tendency to avoid situations which risk disapproval or involve conflict. Carol Gilligan, PhD, has written extensively about how boys tend to “play by the rules or get out of the game,” whereas girls are apt to change the rules to accommodate and/or avoid conflict. Finally, adolescent girls receive messages that competence and competition can pose liabilities, at least in terms of evolving relationships with the opposite sex. Sometimes, being too smart or outperforming male peers is not considered attractive. In this context, teenage girls can become self-conscious about their academic abilities.

The legacy of these childhood experiences manifests in the different expectations men and women have in the workplace. Very recently, Columbia University researchers examined men and women cross sectionally, in a broad variety of jobs. They found that women overwhelmingly put a high value on the congeniality of coworkers and the friendliness of their work environment. Men tended to place a higher value on issues pertaining to compensation and workplace control.

Deborah Tannen, PhD, has written extensively about how women are more likely to downplay their certainty and men their doubts. Men are more likely to attribute successes to their abilities and failures to task difficulty or other external variables. On the other hand, women are prone to internalizing failures (i.e. “I am not competent”). Finally, assertiveness studies reveal that most men experience relief after asserting themselves whereas for the majority of women, anxiety is heightened. Dr. Beth Vanfossen has observed that men talk more in public and are comfortable interrupting others. Women are more likely to allow themselves to be interrupted.

"Women in Medicine" continues from page 11
Male traits, such as placing a premium on decisiveness and lack of equivocation create an advantage in the business world. Autonomy, competition and goal-directedness are not inherently stressful. It makes perfect sense that more men than women are comfortable with hard negotiations, competition and instrumental relationships.

Feminine traits, including a tendency to be other directed and consensus-oriented, translate well into the examining room. Several studies show that both male and female patients tend to prefer female physicians for their primary care needs. Research has shown that female doctors spend more time with their patients and have good listening skills. Malpractice experts believe that this particular communication style confers some protection against malpractice suits. Female physicians are less likely to be sued by their patients compared to male physicians, even after adjusting for specialty.

Recently, Colorado Physician Health Program (CPHP) reviewed physician client data accumulated since 1986 to determine whether any obvious differences existed between our male and female physician client populations. In general, the problems physicians presented with reflected gender differences observed in the general population. For example, more men present with substance use disorders and behavioral problems, whereas women physicians endorsed more depression and anxiety.

We found that while male physicians are more likely to be mandated for evaluation, the vast majority of women present voluntarily. This supports the notion that women tend to be more help seeking and help accepting, obviating the need for forced evaluations. This finding is also consistent with the gender differences observed in presenting problem or diagnosis. Physicians engaging in disruptive behavior and/or who suffer from substance use disorders are less likely to voluntarily seek treatment.

In our preliminary examination of physician client data, CPHP also observed an age-based trend. Before the age of 50, women surpass men in seeking CPHP assistance by a large margin. In the over-fifty cohort, male clients predominate. Perhaps this reflects how early career role diversity can be stressful, but ultimately pay off.

Female physicians with multiple roles tend to report higher levels of health and happiness. Women with children have lower odds of burnout (40% less), provided they have the support of colleagues and spouse or significant other. Career satisfaction has a linear relationship to the number of children in a family. Historically, medical training conditioned physicians to adopt an impossibly demanding philosophy: Complete devotion to medicine at the exclusion of all else. This narrowly defined identity and linear progression of achievement creates vulnerability for the traditional male doctor. He may experience more crises in terms of conceptualizing life after medicine or considering other definitions of success.

Physician health research is in its infancy. Most of the physician health information we have today has been derived from surveys, questionnaires and cross sectional rather than prospective studies. The Colorado Physician Health Program is committed to examining physician health data more scientifically. Delineating gender differences and respective needs will likely enhance our provision of services to our physician clients. For example, women physicians have a 60% greater likelihood of having symptoms of burnout and the risk of burnout increases significantly (1-15%) for every 5 hours over forty hours worked per week. Research also shows that the suicide rate for female physicians is four times the national rate for women. While theories have been proposed to account for a higher suicide rate in physicians, no longitudinal studies exist to support them or guide Physician Health Programs toward more definitive preventive measures.

In 2005, CPHP embarked on a pilot project with Colorado Permanente Medical Group. Representatives from both agencies met over a several month period and developed a workshop which was offered to a selected group of women physicians. So far, the feedback has been positive. CPHP is introducing similar support to women physicians throughout Colorado via a series of presentations beginning this year. Our goal is to provide education to these physicians as well as obtain their input for developing specialized, gender sensitive services for our physician health program participants. We look forward to outreach to women physicians in this endeavor.

For article references, please see newsletter in its entirety on our website at: cphp.org.
dissatisfaction, administrative problems, and excessive professional demands can all contribute to an atmosphere of stress. A special danger for physicians who attempt suicide is that they are more likely to succeed than are those in the general population, possibly because of a greater familiarity with drugs.

Barriers to treatment include both physician personality characteristics and very real concerns about the consequences of seeking treatment. As noted above, physicians may be reluctant to admit vulnerabilities and experience the loss of control that might accompany acknowledged mental health issues, or they may simply deny their illness as long as they believe they can function in the workplace.

Physicians may believe that they ought to be able to manage their mood disorders themselves, which can end up with decisions to self treat. Many physicians with depression who present to CPHP relate some history of self medication, leading to inadequate care. As a secondary problem, self treatment may deprive physicians of the support of therapy, which at times is a critical treatment modality for worsening depression. Physicians may also receive inadequate care through “curbsiding” rather than seeking a complete evaluation with development of an appropriate treatment plan. Even in cases of formal consultation, treating clinicians may complicate treatment by deferring to the physician-patient’s ideas of treatment, or by over identifying with the physician-patient and missing more serious illness.

Many physicians worry that the confidentiality of their health problem will not be respected. They worry that peers or office staff may learn about diagnosis or treatment of depression or that reporting may be required to the BME (see below) or to hospital credentialing boards. They may worry that they will be prevented from practicing because a diagnosis of depression will be seen as an indication or confirmation of impairment and inability to practice. Physicians may be concerned that they will be denied health insurance, disability policies, or malpractice insurance if they acknowledge a mental health problem.

The Role of CPHP

CPHP was created to help physicians with problems such as depression, which, if untreated, could impair a physician’s ability to practice. CPHP can provide evaluation of physicians with depression and referral for treatment. CPHP works with physicians to determine whether their illnesses can be managed in a way that allows ongoing practice of medicine, or whether they are truly impaired in the ability to safely provide medical care. At times, the BME refers physicians to CPHP for evaluation in order to ensure that they receive the treatment and monitoring necessary to allow for safe function in the workplace, or to determine if a physician may be unable to practice.

CPHP evaluates many physicians who self refer, which, except in cases of significant impairment, allows them to choose the “safe haven” provision when applying or re-applying for licensure. This option allows physicians to maintain confidentiality about their illness from the BME so long as they are monitored by CPHP and are not significantly impaired.

For article references, please see newsletter in its entirety on our website at: cphp.org.

Common Myths About CPHP

Myth #1
CPHP is only for those with substance abuse problems.

Reality
CPHP assists with a wide variety of personal situations or problems such as practice decisions, family, marriage, emotional problems, behavioral issues, and professional boundary issues.

Myth #2
If you go to CPHP, the Board of Medical Examiners will know.

Reality
CPHP does not disclose the identity of, or information about, any current or former participant without a written release of information except in rare instances.

Myth #3
CPHP is only for physicians.

Reality
CPHP serves physicians, residents, medical students, physician assistants and physician assistant students.

Myth #4
CPHP provides treatment.

Reality
CPHP conducts diagnostic evaluations of a participant and makes recommendations for treatment or other interventions (such as education). In addition, CPHP provides support services for family members. Efforts are made to refer participants to community-based treatment and/or other resources in areas in which the physician/physician assistant resides so that he/she is able to continue practicing while receiving the necessary treatment.
Parting Words from Our Immediate Past Chair
Bruce H. Wilson, MD

Since CPHP’s founding in 1986, the organization has experienced remarkable growth in the number of physicians accessing CPHP for health-related issues. The number of medical professionals seeking treatment for a variety of health problems clearly reveals the greater acceptance of CPHP’s services within the medical community. During our twenty years of existence, we have seen the uncertainty change to encouragement by hospitals, medical groups and medical societies for CPHP’s services. This tells me that the medical community respects and values what CPHP does—They need healthy doctors to care for sick patients!

I believe that the de-stigmatization of physician illness and education on physician health issues is primarily responsible for this development. In addition, physicians are facing more challenges than ever before. They are being asked to do more with less in a constantly fluid medical environment. The consequences combine to create more stressors in a physician’s life, both professionally and personally.

The well-being of doctors will always be the goal championed by CPHP. As I step down as Chair of the Board of Directors, I am proud to have served with so many wonderful and dedicated people committed to serving medical professionals of our great state.

“The Twenty-year Evolution . . .” continues from page 10

The refined services of assessing complex problems, developing treatment plans and then monitoring such treatment, are now available to all licensed Colorado physicians, physician assistants, medical students, residents, and physician assistant students, with great success.

Dr. Dilts’ experience with his attending supervisor during his residency reads like a Greek tragedy. Perhaps if a physician health program had been in place in Colorado at the time, such an outcome could have been avoided. However, we now know that the AMA was aware of such physician pitfalls and potentially fatal outcomes. Dr. Dilts was deeply upset by the demise and ultimate death of an otherwise brilliant physician. However, he channeled his grief in a positive and creative direction and, along with a number of other like minded individuals passionate about physician wellness, shepherded an organization that has become vital to saving careers, families, and even lives.

CPHP is now recognized nationally as a leader in the field of physician healthcare and is poised to continue serving medical professionals in Colorado with the utmost care, dignity, and success. CPHP pioneer Dr. Sturges states, “During our twenty years of service, with the help and support of many people, we have achieved a significant place in providing services that complete CPHP’s mission and protect doctors’ health so they can do what they do so well—care for patients.”

If left untreated, the health maladies of our healthcare professionals could indeed adversely affect their ability to practice medicine safely. When those who heal others need healing themselves, CPHP is here to help. And, therein lies CPHP’s mission.

Number of Licensed Physicians in Colorado

<table>
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<th>Year</th>
<th>Number</th>
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<td>1986</td>
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<td>2006</td>
<td>17,200</td>
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Todd Weiss, Development Specialist, at a recent medical conference. CPHP strives to provide physician health education and outreach throughout the Colorado medical community.
Medical Director &
Associate Medical Directors

Michael H. Gendel, M.D.
Medical Director

Mary Ellen Caiati, M.D.
Associate Medical Director

Doris C. Gundersen, M.D.
Associate Medical Director

David A. Iverson, M.D.
Associate Medical Director

Jay H. Shore, M.D.
Associate Medical Director

Michael S. Sturges, M.D.
Associate Medical Director

Elizabeth “Libby” Stuyt, M.D.
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Clinician

Sally Moody, MSW
Clinician

Naomi Richards, LCSW
Clinician

Jill Sample, BS
Clinical Coordinator

Todd Weiss, BA
Development Specialist