



NEWS FROM THE PENNSYLVANIA PHYSICIANS' HEALTH PROGRAM

A LIFE *changed:* LAURA DELLIQUADRI, PAC



Laura Delliquadri, PAC

"A life changed" highlights the work of a PHP participant and shares how the program has impacted their life. If you're interested in sharing your story for a future issue of PHP Update, please email Cassandra Davis at cdavis@pamedsoc.org.

Laura Delliquadri was meant for a life in medicine. Growing up north of Pittsburgh, she volunteered as a candy striper at the local hospital.

"Classes like anatomy and other science-related courses came easy to me and I enjoyed them," she said.

She was unaware, however, of many of the career opportunities available to her. Without the treasure trove of internet resources that high school students have today, Delliquadri's fear served as a road block to medical school.

"I was not very good in math and I was afraid to take the MCATs as I feared I would not score well," she said. "I also was daunted by the cost and felt that was not something I could undertake at the time."

While she was encouraged to pursue a different career avenue, she discovered the physician assistant path. She applied and was granted one of the last available spots at Gannon University.

"I had a sound, quality education and it has served me well as a career choice over the last 27 years," she said.

Delliquadri's fear almost kept her from a career she loved.

"I've learned now from an early age fear has kept me from doing some of the things I should've had the courage to do," she said. "I was the type that was good at a lot of things, but the things I was not naturally good at, I did not attempt. I've learned now that failure is only a perspective view. And all experiences are worthwhile regardless of the outcome."

Delliquadri's fear also nearly kept her from her rewarding work on the PHP Advisory Committee. When she was approached to serve, she thought she would have nothing to offer – that she was not "good enough" to accept a committee position.

"In 12-step recovery, we are taught to never say 'no' when our experience can be of benefit to others," she said. "Although I initially did not want to get involved with this type of work, I am exceedingly glad that I did."

Delliquadri's position on the PHP Advisory Committee has given a new outlook on the work being done behind the Foundation walls.

"The work of the PHP is invaluable to the medical profession," she said. "Of course, I didn't feel like that at the beginning when I was first involved with them as a participant, but I have since come to appreciate them for the help they gave me and countless others."

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PHP UPDATE

Physicians' Health Program
The Foundation of the Pennsylvania Medical Society
777 East Park Drive
P.O. Box 8820
Harrisburg, PA 17105-8820
www.paphp.org
(717) 558-7819
In Pennsylvania: (866) 747-2255
Fax: (717) 558-7818
Hours:
Monday-Thursday
7:30 a.m.-5 p.m.
Friday, Emergency Calls Only
(717) 558-7817

PHP STAFF

Jon A. Shapiro, MD, DABAM, FASAM, MRO

Medical Director

Raymond C. Truex Jr., MD, FAANS, FACS

Medical Director

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Case Manager

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EXECUTIVE DIRECTOR MESSAGE

Speaking our truth

Have you ever had someone say something completely untrue about you? Your family, your job? If we are all honest, probably everyone on the planet has experienced being the victim of a falsehood. Fabricated stories posing as fact are not likely to go away any time soon.

The Foundation, and specifically the Physicians' Health Program, often deals with falsehoods and fake news. New participants are sometimes fearful and misinformed. They make claims that everyone else has the problem and that they do not suffer from a substance use disorder. They claim the evaluator is bad, the treatment provider isn't fair and the employer is just trying to get rid of them. While this is a minority of our client base, the damage can be lasting.

Often, through time as living a sober life continues, participants adopt a philosophy of gratitude and appreciation. The anger recedes. Participants recognize how hard they worked for their sobriety and that often it takes a village to ensure that one continues to live in sobriety. In unfortunate cases, the harm of earlier rants continues as legacy of falsehood and misperception.

This year, the PHP program has been praised for its work nationally. Our program is one of the oldest and most robust programs in the country. Our trustees faithfully protect our mission and dutifully protect the PHP program. Sadly, the PHP has also experienced the drama of false accusations and fake news. Pennsylvania PHP isn't the first and definitely won't be the last victim of fake news.

For the PHP, our best way to fight misinformation is with fact. Facts spoken by those who enter our program and successfully live in a life of sobriety. Facts spoken by our carefully vetted and experienced evaluators, treatment providers and recovery partners. Facts provided by our seasoned casework staff and medical directors, and partners whose work and commitment save careers and change lives.

It can be exhausting speaking against misinformation and falsehoods, but for the sake of those who come before us, who are currently with us and those who will come after us – the PHP's core principles of confidentiality, accountability, ethical behavior, patient safety and commitment to sobriety will endure. This year we have shared many true stories of hope and lasting change. Thank you for being part of the truth-telling underpinning for the PHP narrative.

Be well,

Heather A. Wilson, MSW, CFRE, CAE
Executive Director



Heather A. Wilson, MSW,
CFRE, CAE

*"Our program is
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and most robust
programs in the
country."*

OUR MISSION

The Foundation of the Pennsylvania Medical Society provides programs and services for individual physicians and others that improve the well-being of Pennsylvanians and sustain the future of medicine.

A LIFE CHANGED

Continued from page 1

She believes the medical profession makes it challenging to admit when help is needed.

"It is very difficult for health care professionals to admit to themselves that they have issues for which they need help and can simply no longer rely upon themselves," she said. "The hardest thing to do is accept help when we are trained to always be helping others."

During her years on the committee, Delliquadri has come to appreciate the weight of the responsibility the program carries when advocating for physicians and other health care professionals.

"I know now that being a PHP participant and then moving on to become a member of the advisory committee has impacted my life in a way that I cannot possibly put into words," she said. "I have a deeper understanding of myself and others. I have a sincere gratitude for what they have done for me and I have an acute sense of a debt that can never be fully repaid. Part of my duty to make amends for the past is to be present and of maximum service to others today. The PHP has given me a beautiful opportunity to do this."

In 2019, she was elected chair of the PHP Advisory Committee.

"Again, the feeling of inadequacy and fear takes over," she said. "I felt that this is not something I can do or am qualified for, although I realized what an honor it is."

Over the years, Delliquadri has been fortunate to learn the innerworkings of the program which helped her return to a career she loves.

"Another gift of being involved in the PHP is the fact that I have a chance to give back to an organization that has given so much to me," she said. "Anytime I needed an advocacy letter, some free advice or a kind comment, all the staff at the PHP

have been available to reach out and help me not only as part of their job but because they care. Through the years I have seen a lot of changes in the PHP and I am extremely proud of the work that they do. I am truly honored and blessed to be a part of it."

Delliquadri feels so strongly about her dedication to the PHP that she has led by example and voluntarily entered into a long-term contract because she believes the work is so important.

"It is strange for me to say, but at this point I couldn't imagine not being in the PHP. But at times it was at the top of my resentment list. It took me time to realize that my actions, my behavior and my inability to accept help was exactly the reason I needed their help," she said. "The group of people currently administrating the PHP are not only highly qualified individuals, but are sincere in their mission to help suffering

health care professionals get back onto the right track. Sometimes that means suggesting things that none of us want to hear or that may seem too difficult to do. I can attest that although things can be difficult and overwhelming in the beginning, it is well worth it in the end. All of the things that are required of PHP participants are required for a reason and serve a greater purpose than what it seems on the surface."

Through her work on the committee, Delliquadri has made a positive impact on the lives of countless fellow health care professionals. The PHP is grateful for her dedication and she feels gratitude to the organization that provided the opportunity.

"It would seem easy to say that I wish I never had the issues that got me involved in the PHP from the beginning," she said, "but I know I would not be where I am today if it were not for the PHP and all the wonderful dedicated professionals who run it." ■

"Part of my duty to make amends for the past is to be present and of maximum service to others today. The PHP has given me a beautiful opportunity to do this."

National Physician Suicide Awareness

September 17 is National Physician Suicide Awareness Day

With more than 400 deaths each year, suicide among physicians is a crisis we cannot ignore. Nearly every person in the medical community has been affected by physician suicide.

We invite you to honor the life of someone lost with a memorial gift to the Foundation. The work being done at the Physicians' Health Program supports eligible health care professionals during their time of need. Your generosity goes toward resources that save lives.

To donate and honor the memory of a physician gone too soon, contact Lori Storm at lstorm@pamedsoc.org or call (717) 558-7861.



PHP MEDICAL DIRECTOR MESSAGE

Reflections on suicide

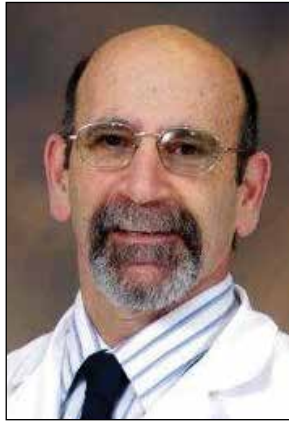
Jon A. Shapiro, MD, DABAM, FASAM, MRO

I'd like to share some reflections about suicide, both professional and personal. In 1929, my maternal grandmother developed melancholia following the birth of my mother. Today we would diagnose post-partum depression. She died by suicide, hanging herself when she could see no relief from the darkness.

My mother was raised with lots of love, first by an aunt and later by my grandmother, Rose. My mother's personality was shaped by this foundational event of suicide. Despite therapy and rational thinking, my mother never shook the idea that she contributed to her mother's death. It caused her to be a strong person, always reaching for control of those she loved. Mentally, she steered us all through the world as if she were a spider in the center of a giant web of caring. She survived my father's early death. She survived lung cancer and two breast cancers. Through these incredibly strong personality traits, my siblings and I were also molded by the tragedy of our grandmother's suicide, similar to the children of survivors of any major tragedy.

My niece is a wonderful woman. She has lovingly fostered a child from a family disrupted by substance abuse. She is tough, but she is scarred. When she was an infant, her mother shot herself with a shotgun. No family members were able to care for her, so she was shunted into foster care for years. Foster care was sometimes good, sometimes horrid and never predictable. My brother and sister-in-law were able to adopt her when she was 11 – finally providing her with nurturing stability.

Suicide does not have a single victim. It spreads in waves of grief from the person who dies to family, friends and co-workers. Articles about suicide tote out facts and statistics about physicians' high rate of suicide and our stressful work environment, but it is hard to capture the second-hand trauma that is so common among us. We lose colleagues and friends. It compounds our already stressful profession.



Jon A. Shapiro, MD,
DABAM, FASAM, MRO

"Suicide does not have a single victim. It spreads in waves of grief from the person who dies to family, friends and co-workers."

In my role as a medical director at a Physicians' Health Program (PHP), I have also been exposed to physician suicides. Whereas the average physician sees one or two colleagues die by suicide, those of us working with PHPs witness them year after year. Perhaps this is expected with the population with whom we work – health care professionals with severe substance use disorders and other psychiatric illness. These horrible few outcomes are offset by our great successes – doctors assisted, doctors re-employed and doctors launched on a lifetime of personal spiritual growth in recovery.

In the America of the 1960s there was an increase in physician suicide. Investigation revealed that doctors addicted to alcohol or drugs were persecuted, prosecuted, defrocked and thrown to the side of the road. This is what led to the development of PHPs. We facilitate a non-disciplinary path to treatment and recovery for our colleagues with mental illness.

There are PHP detractors out there who have seized on anecdotes to blame PHPs for physician suicide. This is like blaming antibiotics for death caused by pneumonia. Of course antibiotics are a marker of high risk, but they aren't causing the death. Similarly, physicians referred to PHP are already at high risk for suicide by virtue of their mental illness.

As a profession, we need to respond to suicide with education and prevention. We need to normalize and destigmatize mental illness so that people can come forward for treatment without fear of professional repercussions. We need a dose of humanity in the way we train our students and residents. And we need PHPs to monitor, to advocate and to facilitate our recovery.

We are all affected by suicide. It doesn't stop with the one who dies or their family. Friends, coworkers and even unborn generations are influenced by these deaths. Gratefully, recognition of the problem has begun. Let us embrace all the resources at hand to prevent physician suicide and all its secondary trauma. ■



Raymond C. Truex, Jr. MD, FACS,
FAANS

Dr. Raymond Truex, Jr. to receive award at House of Delegates

The Foundation of the Pennsylvania Medical Society would like to extend a sincere congratulations to Raymond C. Truex, Jr., MD, FACS, FAANS, who will receive the Pennsylvania Medical Society's Distinguished Service Award at the House of Delegates on Oct. 26, 2019, at the Hershey Lodge & Convention Center.

Dr. Truex is a tireless advocate for physicians in recovery. He has been sober for 32 years and is a champion for those participating in the Physicians' Health Program.

He has served as a trustee on the board of the Foundation of the Pennsylvania Medical Society since 1999. Dr. Truex retired in 2017 after an impressive career in neurosurgery, and in July of that year, he joined the Physicians' Health Program as a part-time medical director.

"Dr. Truex embodies the 'three T's' of selflessness – he shares his time, treasure, and talent to create and ensure a healthier physician community across our commonwealth and beyond," said Heather Wilson, executive director of the Foundation of the Pennsylvania Medical Society and deputy EVP for PAMED.

The Foundation looks forward to honoring Dr. Truex on Oct. 26.

WORKING FOR YOU

This regular feature in PHP Update introduces staff members from the Physicians' Health Program at the Foundation of the Pennsylvania Medical Society.

Name Katie Gruber

Title Case Manager

Number of years with the PHP 3-1/2 years

What do you do at the PHP?

Every day is a little different. Mainly, I help answer phones and make sure the needs of participants are being met. This could mean completing check-in calls, connecting participants to resources or talking with providers.

Why do you think the work being done at the PHP is so important?

I believe those suffering from substance use disorders and mental health are often an overlooked population. I believe this work is meaningful because it helps give people a chance to succeed.

Please share a personal "fun fact"

I am a big road tripper. I have been on road trips to Nashville, TN; Pigeon Forge, TN; New Orleans, LA; Kalamazoo, MI; and Ohio. I like road trips because you get to hit a bunch of different places in one trip and never get bored with one locale.

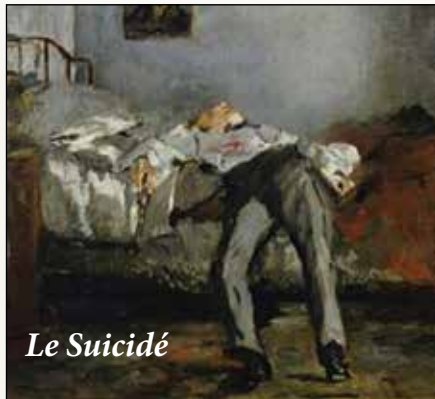
Contact Katie Gruber at php-foundation@pamedsoc.org or (717) 558-7819.



PHP MEDICAL DIRECTOR MESSAGE

Physician suicide

By Raymond Truex Jr., MD, FACS, FAANS



The term *Suicide* is derived from Latin, with *sui* referring to “self” and *cida* meaning “killing.”

Over the past several years, we have experienced a cascade of ominous themes about what’s happening to Americans in general, and to physicians in

particular. First, we heard alarms over “burnout,” which this year has evolved into recognition of the rising incidence of suicide. This phenomenon is not limited only to physicians, where the rate of fatality is highest, but in the U.S. population in general.

Review of a simple line graph by year confirms that the 21st century has not been good for self-induced fatalities, and that males are so inclined more than females in the general population. The suicide rate in the general population is 12.3 per 100,000 people. In real numbers, 44,965 suicides occurred in 2016 and 47,173 in 2017.

Suicide seems to be particularly prevalent among Caucasians. The preferred method of choice among men is firearms, as depicted in the 1877 painting by Eduard Manet, while females prefer drug overdose.

Physicians seem to be particularly at risk. Of all occupations, medical practitioners are the most likely to die by suicide. Compare the suicide risk of the general population (12.3 per 100,000) with physicians. The physician suicide rate is almost twice that of the general population (28-40 per 100,000).

Think about that: every year 300-400 physicians take their own lives, or in other words, the equivalent of two to three medical school classes lost each year; or, one physician

death every day. Although female physicians attempt suicide far less often than females in the general population, because they have the skill and the means, their actual completion rate exceeds that of both the general population AND that of male physicians. The suicide completion ratio for male physicians is 1.41, while for females it is 2.27, with 1.0 being the reference rate for the general population.

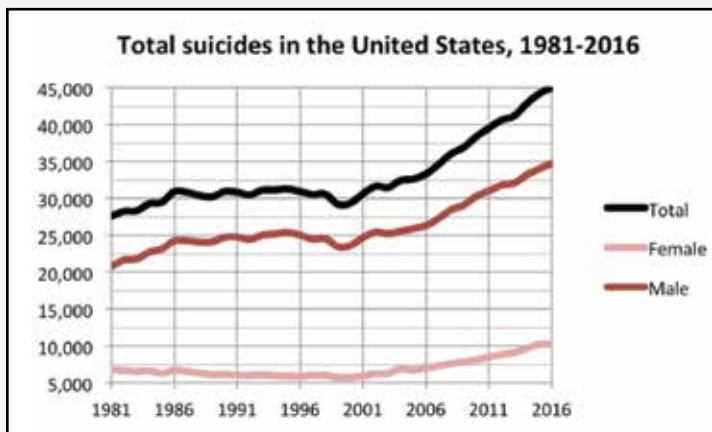
But one must ask, with our post-modern enlightened understanding of the world – why is the incidence of suicide so alarmingly on the ascent? The stigma of suicide has been with us since recorded history. In ancient Athens, a person who took their own life without state approval was denied the honor of a normal burial, and was placed alone in a grave outside the city without a headstone. In 1670 in France, Louis XIV declared that a person who had committed suicide should be drawn through the streets face down, and then hung or thrown on a garbage heap and his property confiscated. During the Enlightenment, a more modern perspective began to dawn, with a shift in public opinion, and by the late 19th century, there was the recognition that suicide was caused by mental illness rather than sin.

Nevertheless, there continues to be a stigma or negative connotation about suicide that persists to the present. This stigma prevents persons at risk from reaching out for help, and that is particularly true for physicians, who fear imposition of sanctions on their medical license by state boards of medicine.

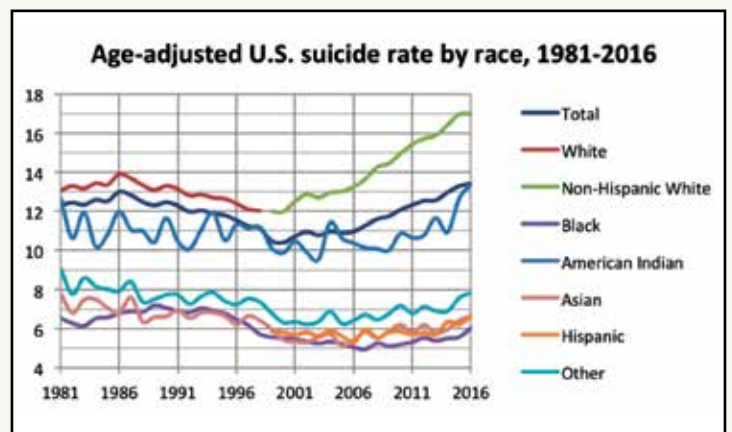
There is no one path to suicide. Suicide is caused by the convergence of multiple risk factors that predispose one to the act of self-harm. Underlying all suicide is mental illness. Mental illness is seemingly handed down family lines in a genetic fashion, and major depression, bipolar disorder, schizophrenia and borderline personality disorder are strongly related to suicidality. Genetics appears to account for 40-50 percent of suicidal behaviors.



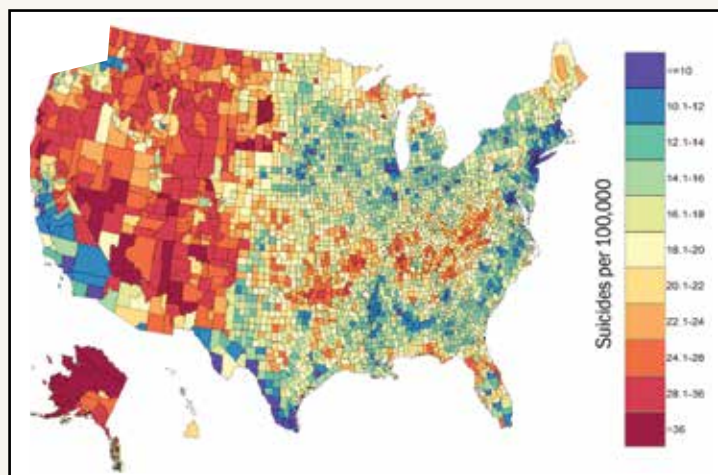
Raymond C. Truex Jr., MD, FACS, FAANS



Total Suicides in the United States, 1981-2016. Data from CDC WISQARS Fatal Injury Reports. [1]



There are also acquired causes of suicidal thought and action, which include environmental exposure, such as PTSD in war veterans or victims of abuse, drug and alcohol addiction, response to major illness or loss, a family history of suicide, poverty and isolation. With regard to isolation, physical and social, the accompanying suicide heat map of the United States strikingly demonstrates the effect of isolation in the less densely populated western mountain states.



But these general factors do not explain why the suicide rate is so high among physicians. There must be some factors particular to our profession that predispose us to higher rates of self-harm. Many of these factors have been related to the culture of medicine for many years, and do not explain the recent uptick in physician suicide.

Physicians have always worked long hours, and are encouraged to “power through” in the interest of patient care without complaint or showing weakness. This macho attitude is similar to that found in law enforcement and the military. The culture has long been unforgiving for any sign of weakness, and faint on praise but long on bullying and shaming for any mistake or any deficiency of knowledge or skill.

Because of the limited number of medical school seats, there is a hypercompetitive aspect to medicine beginning in the undergraduate years, leading to an unhealthy “survival of the fittest” mentality. More recently, the competition for limited residency slots has fueled the dilemma, and the need to pay off large student loan debt often requires younger physicians to moonlight in second jobs.

Personality wise, physicians tend toward perfectionism. This sets them up in medical school for self-doubt and depression, which Dr. Danielle Ofri in Slate magazine describes as “The Tyranny of Perfection”:

“So much of medicine is a tyranny of perfection. Medical students are asked to absorb an immense body of knowledge. Prima facie, this is a seemingly reasonable request of our doctors to be. But the number of facts is larger than any human being can realistically acquire, and is ever expanding. Yet we act as though this perfection of knowledge is a realistic possibility. No wonder nearly every student feels like an imposter during his or her training.”

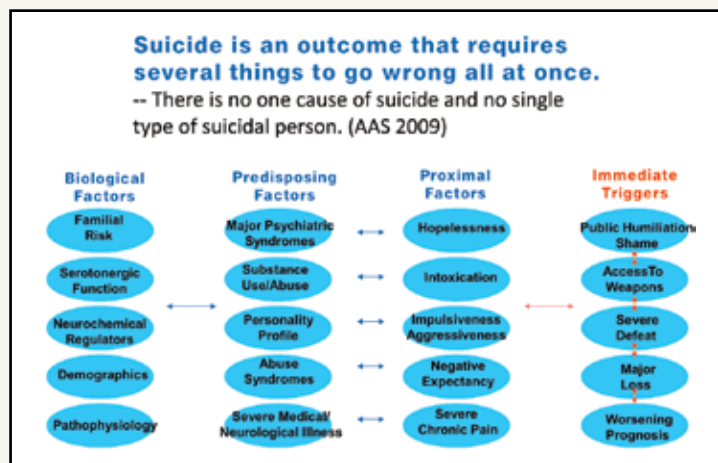
The one socioeconomic factor, however, that best coincides time-wise with the accelerating suicide rate is the corporatization of health care, which has robbed the physician of autonomy and integrity, and the imposition of ever-increasing regulation and

oversight by government, insurers and the legal system, bringing with them the threat of lawsuits or unemployment.

Once again, I quote Dr. Ofri, from Slate, who said it best:

“Once in clinical practice, we physicians are faced with a similarly reasonable sounding assignment – take care of your patients. But in reality, this means covering all aspects of your patient’s health, following up on every test result, battling with documentation, navigating insurance company hurdles and administrative mandates. You are exhorted to be cost effective, time efficient, patient centered and culturally competent. You must be conscious of patient satisfaction, and quality indicators. You must avoid liability, but not over order tests. You must document extensively, but not keep patients waiting. You must comply with every new administrative regulation, and keep up your board certifications. And you must of course achieve those all-important ‘productivity measures.’”

To summarize, the path to suicide for any individual is multifactorial, based upon a toxic mixture of genetics, life experience and the unique stresses required of the modern medical practitioner. This complex pathway was best summarized in a lecture I attended at the FSPHP Annual Educational Conference in Fort Worth, TX, given by Michael F. Myers, MD, as follows:



At the Pennsylvania PHP, we are very aware that we are dealing with sometimes fragile individuals who are experiencing the type of stressors listed in the right two columns, notably public humiliation and shame, hopelessness, intoxication and severe defeat – all factors in the suicide risk matrix. At the same time, these individuals are often in denial about their possible addiction problems, think that they can solve their own problems and resist our recommendations.

We are aware that we walk a very fine line that could push a depressed participant toward self-harm. In fact, some authors have suggested that PHP’s may play a participatory role in physician suicide by creating inflexible authoritarian dictates. We are cognizant of the suicide risk in our population, and when a participation seems at risk, we perform a suicide risk assessment and will notify a crisis center of an individual in distress.

We certainly have no interest in adding to the many factors causing physician suicide. Our goal is to enable a physician with an impairing problem to confidentially obtain treatment, return to the practice of medicine with reputation and license intact, yet at the same time to protect the citizens of Pennsylvania from harm. ■

NATIONAL PHYSICIAN SUICIDE AWARENESS

Honoring a life lost

"He elevated the mood in the room wherever he went."

This is how Mara Rice-Stubbs describes the second-year resident she worked with during her time as an emergency room nurse prior to returning to Pennsylvania. He died by suicide at just 27 years old.

"From the outside, he was one of the happiest people you ever met, always smiling," she said. "He was very engaging with patients and a joy to work with as a nurse. He always involved us in the patient's care."

Rice-Stubbs worked with the resident just two days prior to his death. His mother was in the ICU at the hospital, but she didn't notice any change in his demeanor.

"He was his same lively self," she said.

When she returned after the weekend off, she heard that there had been an incident. The resident was brought into the emergency room after a carbon monoxide poisoning. His mother subsequently died in the ICU just two days later.

"Everyone was shocked," she said. "No one anticipated it. No one recognized the problem until it went that far."

Rice-Stubbs, now a fourth-year medical student at the University of Pittsburgh, describes her experience working in the emergency department as one of a big family. The resident was succeeded by his dog who is now taken care of by his former colleagues. The emergency room residents also take a wellness retreat once a year, honoring his memory.

"They take a day and go to a national park to get away from medicine to reconnect with one another," Rice-Stubbs said. "They talk about their experiences as emergency physicians, both the

ups and downs. They take time to check in with one another in an environment free from the stress of wait-times and patient satisfaction scores."

The hospital systems' reaction came from place of fear, rather than recognition.

"The culture of the hospital was to sympathize that a sad event occurred, now get back to patient care," Rice-Stubbs said. "The hospital's clear intent was to move on as quickly as possible."

She said the emergency department team held a vigil and had a dinner while working, but no one really talked about what had happened. No one really knew what to say.

"A few people who were really involved told his story at national meetings," Rice-Stubbs said, admitting it was up to the individual to spark change in the face of tragedy.

As a fourth-year medical student, she bears witness to a lot of stress.

"I've learned that people are very good at covering their emotions and [mental] state," she said. "I am a keen observer of changes in my colleagues. I definitely don't take the words 'I'm fine' at face value."

She relays advice she was given by a medical student two years her senior – "ask people how they are doing twice."

Losing such a jubilant colleague to suicide was an eye-opening experience for Rice-Stubbs.

"It's changed how I have gone through medical school," she said.

While there are many individuals recognizing the need for a change, the recognition needs to move to the systems level.

"It's not necessarily in the hospital's best interest to be

discussing concerns of physician suicide," Rice-Stubbs said. "So it's up to the providers. No change will be made unless we start to speak up."

The issue of physician suicide should be a rare occurrence. But more than 400 physicians nationwide die by suicide each year.

Rice-Stubbs believes open communication and human connection are key.

"We need to stay connected to one another as human beings first and foremost and secondarily as colleagues."

"Medicine is such a busy profession," she said. "We are actually doing 10 things at once in our mind, and only truly present in our environment half the time. This makes it challenging to identify changes in colleagues."

She added that while there may be hesitation about reaching out to those who are struggling, concern doesn't have to come from a place of judgment.

"Saying, 'I noticed you seemed a little stressed lately,' is not an accusatory statement," she said. "We all recognize that stress is inherent in medicine and it invites the other provider to open up. Be an open ear and listen. Listening is key and is therapeutic by itself."

"We all must understand and be able to recognize the difference between being stressed vs. being depressed. Stress is expected, depression should not be," she said. "We need to stay connected to one another as human beings first and foremost and secondarily as colleagues." ■

"Observe, don't judge"

Dr. Peter Cianfrani was loved dearly by his patients. During his 40 years as a family care physician in Montgomery County, he cared for many of them from the time they were born until they were adults and had children of their own.

Dr. Cianfrani started his medical practice in 1977 in the small town of Pennsburg. His wife, Leah, remembered the growth his practice experienced in the early years. At one count, Dr. Cianfrani had more than 10,000 charts. Leah served as his office nurse, receptionist, bookkeeper and custodian when he first opened his practice and he was the sole practitioner for a number of years, she said.

As managed care became the norm, Dr. Cianfrani eventually made the decision to sell his practice to a health system and despite changes in ownership, Dr. Cianfrani's dedication to his patients never wavered.

"He always continued to care for his patients regardless of the health system he was associated with," Leah said.

Dr. Cianfrani was instrumental in getting a medical facility built in the area, which housed his practice, as well as a laboratory, physical therapy, x-ray services and a number of specialists.

Leah recalled the many activities her husband enjoyed outside of medicine.

"He was a voracious reader," she said. "He spent a lot of time going to an old archive book store where he would buy 10 books at a time."

He also enjoyed cooking, playing his "beloved Martin guitar" and exercising, often going on long bike rides with friends.

"We had a house full of people

most of the time. We entertained a lot," Leah said. "He had a full, active life."

"He had a full, active life."

But Leah said her husband was also an introspective, quiet man.

"He didn't share anything," she said. "He never talked about his patients – the good outcomes or the tough diagnoses."

Leah said her husband had always been a worrier, but she noticed he had more worries in June 2017. He was turning 70. He was concerned about his board recertification exam. He was worried about the new computer system coming into the health system. He grappled with thoughts of retirement and if it was the right time.

"His worrying didn't set off any red flags, because he always worried," she said.

But Dr. Cianfrani had visited a psychiatrist outside his health system after a blood pressure scare in May 2017, and that doctor had prescribed him Alprazolam. It was something that he did not reveal to his wife until his abnormally reclusive behavior became a concern on a family vacation to Cape Cod that summer.

When he told his wife about the prescription, Dr. Cianfrani said the doctor had given him a list of things to do and he was trying to do them.

While on a European vacation several weeks later, Leah's concerns for her husband were met with validation from one of her three sons traveling with them. She decided upon return, she would help him make a plan for retirement to ease some of his worries.

But one day shortly after returning from their trip to Europe, Dr. Cianfrani left for work and didn't come home.

Leah began a search for her missing husband. She called the doctor listed on the empty bottle of Alprazolam she found – a prescription he had refilled a few days before he went missing. The doctor told Leah she should call the police.

Dr. Peter Cianfrani's body was found on a trail where he walked his dogs every weekend. He had overdosed on Alprazolam.

"His worrying didn't set off any red flags, because he always worried."

"It completely shocked us all," Leah said. "I truly believe that the Alprazolam is what took him. I believe he was taking more than he should have. One of the side effects is suicidal ideation. His worries converted from rational to irrational as his anxiety became more apparent."

If Dr. Cianfrani never talked about his patients at home, it wasn't for a lack of caring or impact on the community. Leah said more than 1,000 people attended the memorial service held for him. A local business, and patients of Dr. Cianfrani, posted "God Bless, Dr. Cianfrani" on their roadside sign and it remained there for months for all to see as they drove past.

"I found out how much he meant to his patients because they came through the line and told me the stories of how he had helped

continued on page 10

NATIONAL PHYSICIAN SUICIDE AWARENESS

continued from page 9

them," she said. "At Christmas, a patient always brought a container of pizzelles. He would bring them home. I didn't care for pizzelles, but he would enjoy them until they were gone. She came through the line and said she would bring him the pizzelles every Christmas because she said, 'I went through a similar situation you're going through right now and he would stop by my house and check on me on his way home from work.'"

After the memorial service, Leah handwrote more than 300 thank-you cards to patients, family and friends who had personally reached out to offer condolences and comfort. She felt a responsibility to his patients – to comfort them in return.

Leah believes there needs to be a change at the systems level.

"The way his hospital system reacted to his death was unconscionable. They pretty much ignored me with the exception of having HR contact me immediately to tell me what my benefits were. As far as my pension and his retirement funds that were through them would be distributed. They were very matter of fact about it," she said. "The way they treated me, I'm sure they wouldn't have been understanding or helpful to him if he expressed any of the anxiety he was experiencing. I'm sure they would've insisted that he not get help but retire."

When her husband was missing, she asked one of his close practice associates if she thought he was

"We never know what someone is going through. What pain someone is going through if they don't share it."

depressed. The associate replied, "We're all depressed."

"Because of the way health care is today, the summer before he died he often remarked, 'it's just not fun anymore,'" Leah said. "And it's not fun anymore because physicians can no longer make decisions they once made with autonomy. It's now based on insurance reimbursement conditions and approvals for care, and the forms they are required to fill out, and the electronic medical records that guide them to make some decisions that may not be necessary."

She believes her husband was frustrated by these circumstances outside of his control, affecting the way he practiced medicine.

"They're not allowed to make decisions based on their experience, observation, medical knowledge, and knowledge of the patient," she said. "I think that's part of what is the overall umbrella of worry that formed this perfect storm for him to just say, 'you know what, I've had enough.'"

She also believes he was prescribed a drug that should never have been prescribed and then not managed. Dr. Cianfrani cancelled a follow-up appointment with his

psychiatrist but was still permitted a refill of the Alprazolam prescription.

"What do you do?" Leah asked rhetorically. "It's always in retrospect. Unless someone has made an attempt – he never talked about suicide. He never talked about anything that would lead me to believe that this would be the outcome of his frustration. I think one of the things my sons and I realize is that we need to communicate more openly. Even with painful topics, you need to talk about them and get them out. It's changed all of us."

She said her family has adopted a new mantra.

"Observe, don't judge," she said. "We never know what someone is going through. What pain someone is going through if they don't share it."

Leah said the grief comes and goes, and it hits at times when least expected.

"We are doing just OK," she said. "We aren't doing great."

She said the stigma surrounding a death by suicide makes it harder to deal with publicly.

"If he had died of cancer, there would be a better explanation," she said. "Dying of mental illness, there is no good explanation. Because I believe the kind of help you can get for cancer doesn't exist for mental illness."

And for the loved ones of physicians and other medical professionals, Leah has a piece of advice: "Try to communicate," she said. "If you see a change in behavior, take it seriously." ■

If you or someone you know is in crisis, call the National Suicide Prevention Lifeline (Lifeline) at 1-800-273-TALK (8255), or text the Crisis Text Line (text HELLO to 741741). Both services are free and available 24 hours a day, seven days a week. The deaf and hard of hearing can contact the Lifeline via TTY at 1-800-799-4889. All calls are confidential.

PHP DIRECTOR MESSAGE

An inspiring day

By Kendra Parry, MS, CADC, CIP, CCSM

In June, the Foundation hosted a Physician Resiliency Summit in Lancaster. It was an inspiring day. The speakers we convened are pioneers in the fields of physician wellness and burnout, and they brought great information to the attendees. I was lucky enough to sit in on several of the sessions and learn from these incredible health care leaders.

Dr. Tait Shanafelt kicked off the event with his keynote address. An internationally known leader in the field of physician well-being, he shared about personal and organizational approaches to physician well-being. His keynote and breakout session were amazing and we were fortunate that we could bring him from Stanford to share his work.

Dr. Heather Farley, chief wellness officer at Christiana Care Health System in Newark, Del., shared her charge to bring joy back to the practice of medicine and the innovative work she is doing in her health care system to support her colleagues.

COL Catherine Kimball-Eayrs, MD, is the chief experience officer at Walter Reed Medical Center. She discussed how the implementation of her position has impacted both the patient and staff experience, bringing a culture to the health system that focuses on joy. In turn, this has resulted in better resilience among the staff and overall better patient outcomes.

Dr. Stacia Dearmin, founder of Thrive: Insight, Education, Support, held an extremely important discussion on how to deal with adverse outcomes. She helps her colleagues by providing insight and alleviating isolation during some of the most difficult times they will face as a health care provider.

Dr. Pamela Wible, the afternoon keynote speaker, spoke on physician suicide. Physician suicide is an important topic that we have covered throughout this issue of *PHP Update*.

What was even more impactful than the presentations themselves was listening to the attendees gather at the end of the sessions sharing their ideas and excitement for how they could take what they learned and implement it back at their own health care systems. There was such great energy and passion for helping their fellow colleagues who may be facing burnout and stress. This passion for helping is what keeps the PHP staff going day after day. We provide support and advocacy to our participants as they face some of the most challenging times of their lives.

In addition to our referral and monitoring services, the PHP medical directors present several times a year across the state on the topic of physician burnout and stress. This CME-eligible presentation is, by far, the most requested activity we offer. The learning objectives include having participants identify and implement practical approaches and utilize available resources to effectively recognize and address concerns related to physician impairment, specifically burnout and stress, in the workplace.

If you would like to learn more about our educational offerings, please visit our website at www.paphp.org. To schedule a presentation, call or email the PHP at (717) 558-7819 or php-foundation@pamedsoc.org. ■



Kendra Parry, MS, CADC, CIP, CCSM

"Even if you don't need us, the chances are someone you come in contact with professionally will."



The Foundation of the Pennsylvania Medical Society Physicians' Health Program (PHP) seeks mental health professionals to serve physicians and other eligible health care professionals in monitoring.

Through our physician-driven mission, we provide services to help physicians and other eligible health care professionals who struggle with substance use disorders, mental health or behavioral challenges obtain the necessary resources allowing them to safely work in their chosen profession. Participants of the PHP need mental health care. Confidentiality is crucial.

The PHP continually strives to increase its capacity to serve its participants through identifying resources in a participant's local community. The generosity of service, time and financial support from the physician community enables the PHP to expand outreach efforts and ensure those we serve have the support they need.

Please contact us at (717) 558-7819 or php-foundation@pamedsoc.org



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