THE PRACTICAL PROFESSIONAL
in Healthcare

PROFESSIONAL BOUNDARIES, INC.

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JULY/AUGUST 2017

"But everyone does it."

WHY CARING *for* FRIENDS *and* FAMILY *is* ALMOST NEVER A GOOD IDEA.

IT HAPPENS EVERY DAY: someone on staff stops you in the hall and says they have a sinus infection or that their reflux is acting up. They ask you for a prescription or perhaps some samples off the shelf in the office. You may ask a couple of quick questions, but you're in a hurry, as are they, so you do as they ask and move on—unaware of the risks you've taken.

If a regular patient came to you with the same complaint, saying they had sinusitis or reflux, you would take a history, examine them, offer medical advice, answer any questions, address any concerns, arrange for appropriate follow-up and write

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everything up in their chart. Chances are you did none of these things when you "helped out" your colleague in the hallway. So if anything goes amiss—a bad reaction to the medication, complications from an undiagnosed condition—you are in deep trouble. Depending on the seriousness of the situation, you could face criminal charges, a malpractice suit and/or board discipline up to and including the loss of your license.

From the board's perspective, the primary problem is not the harm you've done to your "patient" or your failure to adhere to what the lawyers call "standard of care;" the board's fundamental concern is the "dual relationship" you have developed with your colleague/patient.

It's not uncommon, of course, for physicians and patients to know each other outside the office; in small communities it's unavoidable. And in most cases, there's no problem as long as the doctor and patient both understand the differences between their personal and professional relationships and respect the boundaries between the two realms. (Although it's up to the physician to remain vigilant and refer the patient to another provider if boundary issues emerge.)

The problem arises when the non-medical relationship is serious enough to compromise the doctor-patient relationship. It doesn't matter if it's romantic, friendly, familial, social or business-related—nor how confident the physician is that she can remain impartial—every dual relationship jeopardizes the physician's objectivity and interferes with her ability to focus on the patient's medical needs, undistracted by any personal concerns. This holds true both at work and at home.

TREATING COLLEAGUES AND FRIENDS. The hallway encounter is just one example of the complications that can arise from dual relationships. Consider another workplace scenario. A colleague makes an appointment and comes to see you as a patient. Even assuming you treat him or her as you would any other patient, you are still exposing yourself and your patient to considerable risks.

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UPCOMING LIVE COURSES

PBI COURSES FOR HEALTHCARE PROFESSIONALS
Boundaries | Ethics | Medical Records | Prescribing
August 4-6 | California

~~**MEDICAL ETHICS AND PROFESSIONALISM**~~
~~**August 4-5 | Californ**~~ SOLD OUT

PBI MEDICAL RECORD KEEPING COURSE
August 5-6 | California

THE PBI PRESCRIBING COURSE:
Opioids, Pain Management, and Addiction
August 5-6 | Georgia

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Boundaries | Ethics | Medical Records | Prescribing
August 18-20 | Georgia

PBI MEDICAL RECORD KEEPING COURSE
August 19-20 | Georgia

THE PBI PRESCRIBING COURSE:
Opioids, Pain Management, and Addiction
August 19-20 | Georgia

PBI COURSES FOR HEALTHCARE PROFESSIONALS
Boundaries | Ethics | Medical Records | Prescribing
September 8-10 | Illinois

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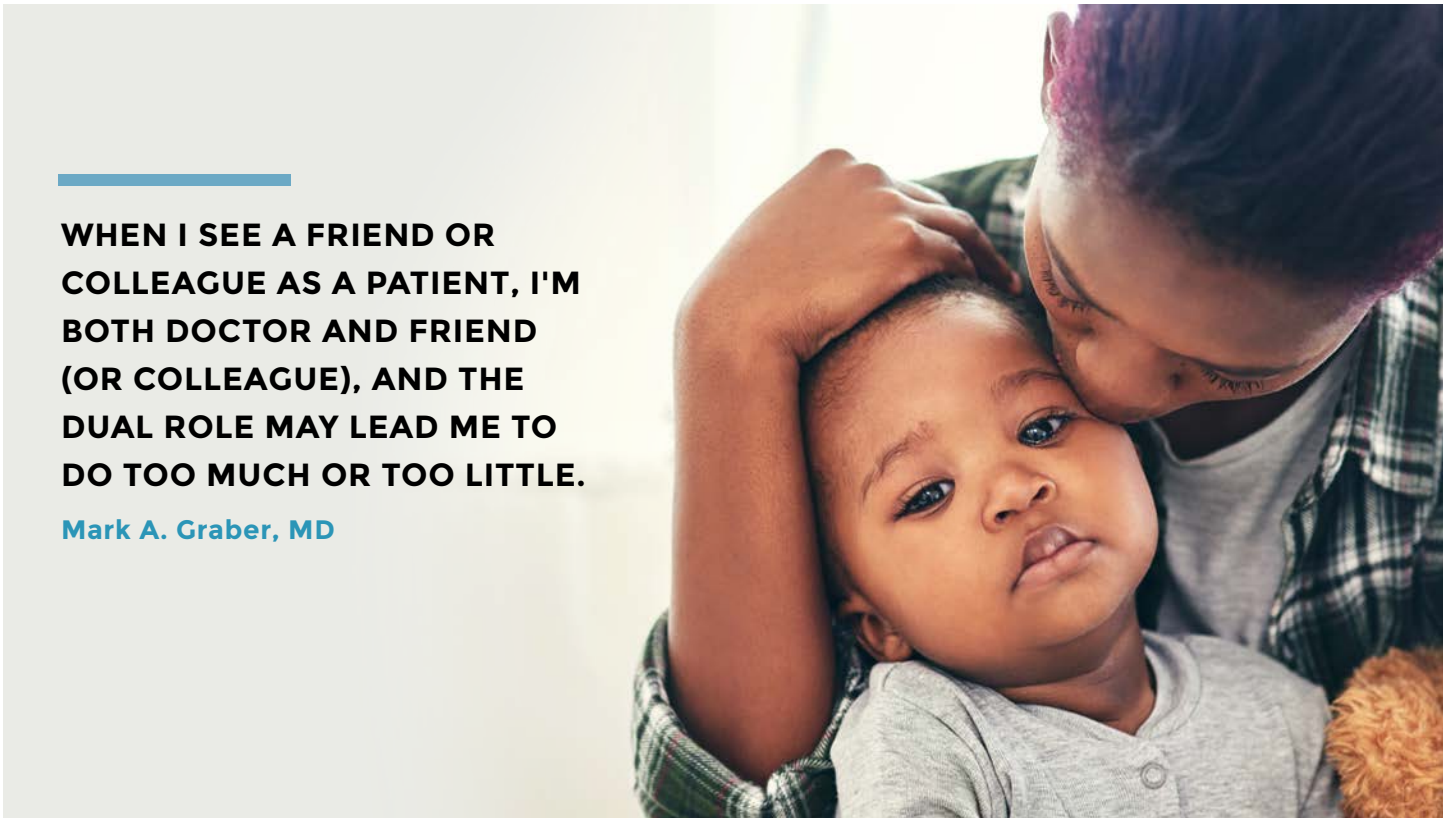

WHEN I SEE A FRIEND OR COLLEAGUE AS A PATIENT, I'M BOTH DOCTOR AND FRIEND (OR COLLEAGUE), AND THE DUAL ROLE MAY LEAD ME TO DO TOO MUCH OR TOO LITTLE.

Mark A. Graber, MD

"When I see a friend or colleague as a patient, I'm both doctor and friend (or colleague), and the dual role may lead me to do too much or too little," says Mark A. Graber, MD, professor of emergency and family medicine at the University of Iowa Carver College of Medicine.

> *"On the one hand, I may pursue investigations to the nth degree to avoid an error in diagnosis or treatment; I'm too invested in the outcome of this patient. My attitude may cause me to order unnecessary tests, with the patient bearing the attendant risk. For example, I may order a stress test on a low-risk colleague or friend—just to be sure. The result is a false positive, which leads to an invasive cardiac catheterization.*
>
> *On the other hand, I may have so great an emotional connection with the patient that I do too little. I may avoid potentially painful procedures that I would do if I were guided by more objective clinical judgment. I may perform a lumbar puncture for an "ordinary" patient with a headache and fever without a second thought but may be loath to do one on a friend. Friendship can cloud our judgment."*

TREATING FAMILY. Rather than bringing a sick spouse or injured child to the family doctor, physicians often provide needed care themselves, especially if the family member is in pain or the doctor's office is closed for the weekend.

Why make someone you love wait for relief when you can instantly provide first-rate compassionate care free of charge?

Although the practice is common, virtually all professional organizations—including the American College of Physicians, the American Academy of Pediatrics and the American Medical Association (AMA)—warn physicians away from treating family members. The AMA's Code of Ethics has discouraged the practice since it was first drafted in 1847.

The prohibition is not absolute. According to the AMA's *Code of Medical Ethics* (Opinion 8.19), "Physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians should not serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems." When it comes to pain management, however, the AMA cautions physicians not to prescribe controlled substances for family members except in extreme emergencies.

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AMONG THE MANY REASONS TO AVOID TREATING FAMILY MEMBERS, THE TEXAS MEDICAL ASSOCIATION INCLUDES THE FOLLOWING:

- Professional objectivity may be compromised.
- Physicians' personal feelings may unduly influence their professional medical judgment, thereby interfering with the care being delivered.
- Physicians may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination.
- Patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the physician is an immediate family member.
- Physicians may be inclined to treat problems that are beyond their expertise or training.
- Family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician.
- Physicians may feel obligated to provide care to immediate family members even if they feel uncomfortable providing care.

Behind each of these reasons stretch numerous cases of personal and professional pain. One ob-gyn treated her own child when he came down with a fever over a weekend. Confident that she knew all she needed to about her son, she didn't bother to take a full history, as she would have done with a regular patient. Without a proper workup, and unfamiliar with pediatric issues, she misdiagnosed her child and ended up having to rush him to the ER.

In another case, a gastroenterologist provided what he considered "bridge care" for his wife when the couple moved to an area far from the kind of psychiatric care she was accustomed to. When his wife, who suffered from chronic pain, told him she was unable to sleep, he prescribed medication to help ease her discomfort and help her get some rest. Without access to her records, and working outside his area of specialization, he failed to realize that he was over-prescribing and feeding his wife's growing addiction. When their family doctor examined the wife, she was alarmed by what she found and had her admitted to the hospital. Upon learning that the wife's husband had been the prescribing doctor, she filed a complaint with the board.

Not all dual relationships result in such hardship. Indeed, most pass by unnoticed. But the potential for harm, both to the physician and the patient, is real, which is why the American College of Physicians' *Ethical Manual* offers this advice: "If a physician does treat a close friend, family member, or employee out of necessity, the patient should be transferred to another physician as soon as it is practical... Otherwise, requests for care on the part of employees, family members, or friends should be resolved by assisting them in obtaining appropriate care." ■

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QUESTIONS & ANSWERS ABOUT CHAPERONES

The American Medical Association's Code of Ethics*, the American College of Obstetrics and Gynecology, the American Academy of Pediatrics and the American College of Physicians all recommend the use of chaperones, at least in certain situations. Seven states (Alabama, Delaware, Georgia, Montana, New Jersey, Ohio and Tennessee) now mandate that medical chaperones be present during intimate exams. And while statistics are hard to come by, Jon Porter, a health care attorney with more than 20 years of experience, says he has definitely seen a trend toward the use of chaperones over the past five years.*

Still, many physicians have concerns, so we asked Porter, who is also a PBI faculty member, to answer the most common questions about chaperones.

WHY SHOULD I USE A CHAPERONE? I'VE BEEN PRACTICING FOR 20 YEARS AND NEVER HAD A SINGLE COMPLAINT.

Chaperones are like insurance, something you pay for and hope never to use. Most states now require you to carry malpractice insurance, even if you've gone 20 years without a problem. The likelihood of your being sued may be small, but the potential consequences are huge. The same holds true for boundary violations.

The next patient who walks through your door may be the one who files a complaint against you. If the case goes before the board, it's likely to be your word against your patient's, and the board's job is to protect the public, not you. In fact, during a board hearing, the complainant is going to be called "the victim" until proven otherwise, which puts you behind the 8-ball right from the start.

Having a chaperone to back you up does not guarantee success, but it comes close. In the vast majority of cases, if the person has a chaperone I've been able to get the case resolved in their favor very quickly.

DO I NEED A CHAPERONE WITH EVERY PATIENT?

Many complaints are the result of miscommunication, which can happen at any time, with any patient, so the ideal is to have a chaperone present whenever you are with a patient. Of course, that's not always possible, so I recommend using a chaperone any time a patient is partially or fully undressed. At a minimum, intimate examinations (involving breasts, buttocks or genitalia) should never be conducted without a chaperone in the room. If you're not doing that, you might as well just put your medical license in a shredder.

That said, it's worth noting that the majority of complaints we hear about in PBI classes stem from non-intimate, un-chaperoned cases. And in my experience, accusations of improper touching are as likely when a patient is clothed as when they are undressed.

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I'M A FEMALE OB-GYN. WHY WOULD I NEED A CHAPERONE?

Times have changed. You can never be sure of a patient's sexual orientation, so gender doesn't matter much anymore. I've had gay people complain about gay people, and straight people complain about straight people, and straight and gay people complain about each other. The point is, you just don't know.

HOW DO CHAPERONES INTERACT WITH PATIENTS? I DON'T WANT THEM PUTTING IDEAS INTO PEOPLE'S HEADS.

Your chaperone should know ahead of time how to deal with situations that may arise. If a patient misunderstands something you are doing or saying, you might ask the chaperone to help clear things up and reassure the patient. If the chaperone wants to alert you to a potential problem, they can simply ask to speak to you privately.

WHO CAN I USE AS A CHAPERONE?

First of all, it's important to understand that family members are not chaperones. They are unlikely to be objective and will rarely testify in your favor, which is why the chaperone needs to be a member of your staff. If a family member does stay during an exam, remember that you need to communicate with everyone in the room and be the educator.

In a perfect world, a chaperone would have enough medical training to know what is appropriate during an exam and be able to help reassure nervous patients. If that's not always possible, it's better to have someone than no one. If the chaperone is not medically trained, you should prepare them ahead of time by explaining what they will be seeing and what you'll be doing, and answer any questions afterwards. It's also important that they understand and respect the rules about patient confidentiality.

WHAT IF MY PATIENTS OBJECT?

In the age of patient-centered care, many doctors and hospitals let patients decide if they want to have a chaperone present. That's a mistake. Neither you nor your patient knows ahead of time when a chaperone might be needed. It's best to have a policy in place and make patients aware of it. If they object, it's up to you to educate them about the benefits of having a chaperone and to respond to their concerns as best you can. In many cases, it helps to have a chaperone of the same gender as the patient.

If your patient still objects, you have two choices. You can explain why the exam is important and that given office policy, you will not be able to examine them without a chaperone. If they decline, be sure to document this matter in their chart. Your other choice is to go ahead without the chaperone, understanding that you are taking a serious risk.

CHAPERONES ARE EXPENSIVE. HOW AM I SUPPOSED TO COVER THE COST?

If you think a chaperone is expensive, consider the cost of defending yourself. An inexpensive lawyer is going to cost you at least $300 an hour, and without a chaperone, "he said, she-said" cases burn up a lot of hours.

The simplest way to hold down costs is to use people already on staff as chaperones. Scribes, who have been trained in specific specialties, are a particularly good option. While scribes generally make $10 to $15 an hour, advocates claim they more than pay for themselves by increasing physicians' efficiency and effectiveness. And since the scribe is already in the room, it costs nothing extra to have them serve as a chaperone.

Patients also tend to prefer chaperones who are actively doing something, rather than just sitting and watching them.

The one downside to using scribes as chaperones is that while tending to their primary job, they may miss something important. An effective chaperone has to be fully aware of what's going on in the room at all times. That can be more challenging for a scribe who's also taking notes, but it's doable. Ultimately, it's a balancing act.

A word of caution: In your zeal to be efficient, resist the temptation to use your chaperone as a gofer. A chaperone should stick with you like a shadow. They should not leave the room while you are with the patient and they should not stay behind if you leave the room.

WHAT KIND OF DOCUMENTATION IS NEEDED?

As I tell the people in my Medical Records class, if you don't write it down, it didn't happen. It's essential that you clearly document in the patient's chart who the chaperone was and that they were present throughout the visit. It's a good idea for the chaperone to co-document their presence, but it's not essential. ■

Jon Porter, JD, is an experienced attorney who focuses primarily on physician licensure defense and professional licensing for healthcare providers. Earlier in his career Porter served as both a prosecuting attorney and Director of Investigations and Compliance for the Texas Medical Board.

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The GROWING IMPORTANCE *of* CULTURAL COMPETENCY

If you've ever had to see a doctor while traveling abroad, you know how trying it can be. Even if you and the doctor are able to communicate in a common language, one or both of you is apt to misspeak or misunderstand precisely what the other is trying to say. Less obvious, and all the more disconcerting, are cultural misunderstandings. The physician who is trying to put you at ease may unwittingly come across as pushy and overly familiar, while your innocent questions may strike the doctor as interfering and mistrustful.

Physicians in this country face similar challenges every time they see a patient from another culture. Patient populations today are more diverse than ever before, and doctors and nurses are continually challenged to care for patients who do not share their cultural values or assumptions. In response, numerous programs and publications have been developed to help U.S.-trained physicians improve their "cultural competency," the ability to care for patients from different geographic, ethnic, racial, religious or social groups.

Less attention has been paid to the challenges confronting foreign-born physicians. These international medical graduates (IMGs) now account for more than a quarter of all U.S. physicians and many prominent health care officials have noted the increasingly important role IMGs play in meeting the country's demand for medical care. Yet while these providers are well-trained and skillful practitioners (see Facts and Figures below), many find themselves unprepared for cultural differences that can jeopardize their careers. As long ago as 2012, a program aimed at helping address the problem noted, "International Medical Graduates are more likely to be involved in complaints... and differences in culture and consulting style are suggested to be the cause."

In recent years, PBI's courses have included a growing number of health care professionals whose cultural myopia has blinded them to unintended boundary violations. Sometimes the offense is committed by an American physician who is

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insensitive to the expectations of patients from other countries. Other times, it's foreign-born doctors whose cultural assumptions clash with the expectations of U.S. patients.

AMONG A WIDE RANGE OF ISSUES, THREE ARE PARTICULARLY COMMON:

UNINTENDED SEXUAL HARASSMENT. In many parts of the Middle East, Latin America, Africa and southern Europe, people are far more comfortable with physical contact than most Americans are, especially in a medical setting. One Latin American physician who had been practicing in this country for years without incident, hugged a female patient who he thought needed comforting. Having done the same thing many times before, he was astonished when the woman claimed that he touched her breast and filed a complaint.

In another case, a Middle Eastern surgeon had routinely hugged nurses he worked with as a way of saying thank you. When he began practicing in the U.S., many of his coworkers tolerated his expressions of gratitude. But several female nurses felt uncomfortable and resisted what they considered improper touching. When the surgeon continued the practice, apparently oblivious to their discomfort, they filed charges.

The situation is reversed when U.S.-born doctors treat patients from cultures where physical contact between men and women is less tolerated than it is here. More than one religion forbids contact between members of the opposite sex who are not related. One physician failed to take this cultural sensitivity seriously enough. When a female patient's husband failed to accompany her as he had for every previous appointment, the physician tried to conduct the exam as usual. The woman was both offended and frightened and filed a complaint.

BLURRING PERSONAL AND PROFESSIONAL BOUNDARIES. While American patients generally understand that there are legitimate medical reasons for a doctor to ask about specific aspects of their personal lives, they resent any intrusion that seems to cross the line. Where that line is, however, is often culturally determined. One physician was accustomed to discussing matters of faith with patients in her home country. Both she and her patients felt that their spiritual and physical health were intimately related. But once the doctor started practicing in the U.S., where most people view religion as intensely personal, her patients took offense and filed charges when she asked what they considered intrusive questions about their religious beliefs.

Other physicians new to this country treat virtually all their patients, especially those from their own culture, as if they were relatives. Whether they are members of a close-knit Hispanic neighborhood or a first-generation Korean community, these doctors tend to have trouble saying no to people they regard as brothers and sisters. Rather than risk seeming rude, doctors in such situations have loaned patients large sums of money, put them up in their homes, accepted gifts and offered them employment—all against the explicit policies of the office they worked in.

CONFUSING COLLABORATION WITH INSUBORDINATION. Fifty years ago patients and staff in this country were expected to accept the authority of physicians and to follow their instructions without question. Today, patients often come to appointments with information they have gathered online, ready to participate in any decisions about their care. And staff are generally encouraged to voice concerns and share opinions.

Doctors trained in a more hierarchical society often react to this collaborative culture much as a physician from 1950 would: they are outraged. They feel disrespected by patients who ask questions and raise concerns, and sometimes react angrily to what they consider a lack of appropriate deference. The problem can be even more pronounced in dealings with colleagues—nurses and other medical professionals—whom these doctors tend to treat dismissively, if not with overt hostility. Needless to say, such behavior leads to complaints and often to disciplinary action.

With the recent furor over immigration, many leaders in the field of health care have recently pointed out how valuable foreign-born physicians are to this country. Immigration policies alone are not enough however. As both the patient population in the U.S. and the medical profession grow more diverse, more needs to be done to help health care providers gain the cultural competency they need to be effective and successful. ■

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FACTS & FIGURES

American Health Care Relies on Foreign-Born Providers

Health care currently has the largest proportion of foreign-born and foreign-trained workers of any industry in the country—**22% OF THE HEALTH CARE WORKFORCE, NEARLY TWICE THE NATIONAL AVERAGE.**[1]

Medicare patients treated by non-American doctors from foreign medical schools had a **5% LOWER CHANCE OF DYING** than those treated by U.S. medical graduates in the 30 days following hospitalization.[2]

Most non-native U.S. physicians and surgeons come from India, China, Philippines, Korea, Pakistan and Iran.[3]

International medical graduates were more likely to practice in **UNDERSERVED AREAS (67.8 %)** than U.S. medical graduates (39.8%). [5]

27.9%

of all doctors in the U.S. are immigrants. The percentage is even higher in certain specialties:[4]

- 50.7% *among geriatric medicine specialists*
- 47.2% *among kidney specialists*
- 43.6% *among cardiologists*
- 41.0% *among critical care specialists*
- 38.6% *among internists*
- 30.2% *among psychiatrists*

[1] "Healthcare Executive Summary," Georgetown Public Policy Institute, 2012
[2] "Quality of care delivered by general internists in US hospitals who graduated from foreign versus US medical schools: observational study," BMJ 2017
[3] Jeanne Batalova, a senior policy analyst and demographer at MPI, quoted in "How Trump's immigration ban threatens health care, in 3 charts," Vox, 2017
[4] Association of American Medical Colleges, 2015, see Vox, 2017
[5] "Role of International Medical Graduates Providing Office-based Medical Care: United States, 2005–2006," National Center for Health Statistics, 2009

RELEVANT READING

- Treating Your Own
- AMA Code of Ethics: Opinion on Physicians Treating Family Members
- Intimate Examinations by Doctors and the Role of Chaperones: Guidelines
- Chaperones– Recommended or Required?
- Do Patients Need a Chaperone?
- AMA Code of Ethics: Chaperones
- The Importance of International Medical Graduates in the U.S.
- Supporting International Medical Graduates Transition to their host-country
- Study Suggests that Immigrant Doctors Provide Better Care than U.S. Doctors
- How Good are Foreign-Trained Doctors