THE PRACTICAL PROFESSIONAL
in Healthcare

PROFESSIONAL BOUNDARIES, INC.

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Welcome To The First Issue of *The Practical Professional*

Each professional facing a boundary violation charge feels isolated and alone, but the sad truth is that each has plenty of company. In fact, the number of physicians confronting disciplinary actions by state boards has remained nearly constant in recent years, averaging about 4,500 per year, according to the FSMB's most recent report.

That's not surprising. Physicians are human after all, trying to measure up to the exacting standards of a stressful profession, usually without any training that might help them avoid the patterns of misconduct all too familiar to those of us in the field.

The field itself has grown considerably over the years both in numbers and sophistication, and now includes a wide range of organizations and professionals. The purpose of this online journal is to:

1. Provide an ongoing forum where we can all share ideas, information and insights;
2. Create constructive dialogues about how education can best help boundary violators return to productive careers; and
3. Spark new, proactive educational initiatives that properly prepare healthcare professionals so they can avoid becoming violators in the first place.

The more of us who join this discussion, the more helpful The Practical Professional will become. So please consider this first issue a conversation starter. We've pulled together material we hope you will find helpful. And we hope that you will join our effort in future issues by letting us know what you think of our efforts, sharing ideas and suggestions and perhaps contributing some material of your own.

Our next issue will be out in June. We hope you'll be a part of it.

All the best,

STEPHEN SCHENTHAL, MD, MSW
Founder and CEO, Professional Boundaries, Inc.

> *"Everyone crosses the line. Those who notice can step back in time."*
>
> JON PORTER, JD

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The Dangers of Wearing A White Coat

As part of the "white coat ceremonies" common at most medical schools, new students are given the garment that will distinguish them for the rest of their professional lives. Throughout their careers, that white coat will play an important part in helping physicians, nurses and others establish clear professional boundaries between themselves and their patients. It can also lead to problems that ultimately dissolve those boundaries and end careers.

THE WHITE COAT AS ROYAL GARMENT

As part of the white coat ceremony, students generally vow to put the interests of their patients before their own, to behave honorably throughout their careers and to continually strive to be worthy of the privilege of being a doctor; and never to abuse that privilege.

But over time, the feeling of privilege can change. Physicians who have spent years healing the sick stop viewing their profession as an honor and come to see themselves as professionals to be honored. Humility gives way to hubris. Stephen Schenthal, who founded PBI in 2001 after his own license to practice was revoked, has since taught hundreds of professionals in similar situations. "Most of these people are really smart and they're good clinicians—that's how they got where they are in their profession—but their accountability has diminished with experience and age," he says.

For such professionals, the white coat has become something much grander over time, a kind of royal garment that endows them not only with a sense of infallibility, but also of invulnerability that is out of touch with reality. "That's one reason why a consummate professional who has been ethical for more than 20 years can do something unethical at the age of 47, which by the way, is the average age of boundary violators," says Schenthal.

The fall from such an exalted self-conception can be devastating and disorienting. And the process of recovery is almost always painful, as those who once felt invincible have to let go of their anger, accept responsibility for their situation and confront the issues that make them human, fallible and vulnerable.

THE WHITE COAT AS PRIESTLY VESTMENT

We may admire those who take religious vows of self-denial to devote themselves to others, but we don't expect the same selfless zeal from those who take the

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Facts & Figures

2014 U.S. MEDICAL REGULATORY TRENDS AND ACTIONS REPORT, compiled by the Federation of State Medical Boards, provides information to the public about the work of the nation's state medical boards and their mission of public protection. The report includes aggregated national data about medical licensing and disciplinary trends and actions and key data about state board governance and activities. Among the statistics in the most recent report:

878,194
TOTAL NUMBER OF LICENSED PHYSICIANS IN THE US

48,219
FIRST LICENSES ISSUED

4,479
NUMBER OF PHYSICIANS DISCIPLINED

857
PHYSICIANS PUT ON PROBATION

739
PHYSICIANS WITH A LICENSE SUSPENSION

275
PHYSICIANS WITH A LICENSE REVOCATION

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Hippocratic oath. Yet it is not uncommon for those who wear white coats to assume a similar role. In their book, The Wounded Healer, Richard Irons and Jennifer Schneider describe how some physicians become what they term, Self-Serving Martyrs. These doctors sacrifice time with their families and friends, even time for themselves, to devote their lives entirely to their professional duties. In many cases they are intentionally or unintentionally emulating the behavior of their own physician parents. In any case, their "selflessness" leaves these practitioners with the sense that they are simply "above the rules." This sense of entitlement grows stronger as years of overwork and self-neglect pile up, and as those around them express admiration and even a kind of reverence for their devotion.

But feelings of entitlement lead inevitably to feelings of resentment and self-pity. Having sacrificed so much for others, these Self-Serving Martyrs end up feeling betrayed and neglected, and all too often looking for compensation from inappropriate sources.

THE WHITE COAT AS A SUIT OF ARMOR

All too many of us find ways of avoiding painful issues; it's only human. And says Schenthal, "the doctors who come to my class are all too human, but there is so much denial of their human-ness because they are wearing a white coat. It's almost like armor that's hard to penetrate." Using another category from the Irons and Schneider book, Schenthal describes these doctors as Wounded Healers, physicians who wrap themselves in their professionalism to avoid confronting serious unmet needs or unresolved traumas.

The armor may afford them some protection from emotional pain, but it also leaves them feeling emotionally isolated, which causes these doctors to seek gratification and connection with others wherever they can. Not surprisingly, the majority of clinicians who have violated sexual boundaries fall into this category.

UNDERNEATH THE WHITE COAT

The physicians who take a class on boundary violations almost always enter the room in a state of anger and disbelief. "How could this happen to me? I didn't do anything wrong." To reclaim their lives and their careers, these practitioners have to let go of their anger, justified or not, accept responsibility for their situation and actually confront the issues that got them into trouble in the first place. Whatever their white coats have come to mean to them—royal garb, priestly vestments or suit of armor—they have to eventually trade them in for the simple white garment they were given on their first day of medical school. ■

NEWS

National Association of State Controlled Substances Authorities Endorses Federation of State Medical Boards Model Policy on Opioid Prescribing

Savannah, GA (Oct. 28, 2014) The National Association of State Controlled Substances Authorities (NASCSA) formally endorsed the Federation of State Medical Boards' (FSMB) Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain by unanimous vote during its annual meeting in Savannah last week. NASCSA provides an educational forum through which state and federal agencies and others work to increase the effectiveness of efforts to prevent and control drug diversion and abuse.
LEARN MORE >

FSMB Foundation Releases Updated Book Aimed at Curbing Opioid Abuse

Washington, D.C. (Oct. 23, 2014) – The Federation of State Medical Boards (FSMB) Foundation has published an updated and expanded edition of a book intended to help address the rise of opioid abuse and related deaths in the United States by better educating physicians and other clinicians about their risks and proper use. LEARN MORE >

How I Reclaimed My Life and My Practice

The following first-person account is just the first of many. While the author of this essay is a graduate of one of my classes, future authors will include a wide range of practitioners, patients, regulators and others. Over time, we hope, these personal stories will help deepen and clarify a number of fundamental issues. STEPHEN SCHENTHAL

HOW I LOST MY LICENSE. In 1981, I was treating a female patient in my psychiatric practice. She was a single mother subjected to intimate partner violence. Within about two years she was able to end the abusive relationship. It's not unusual in such situations for a patient to develop feelings for the doctor she regularly confides in, but I had underestimated how deep these feelings ran in my patient (transference), and how entangled they had become in her fantasy life.

In 1983, during a discussion about her young children, I casually mentioned to her that I had been looking all over for a particular toy that my child wanted, but that I couldn't find it anywhere. She told me she had access to a vendor and could easily pick it up for me. In my zeal to get the toy, I stopped by her house to complete what I regarded as a simple financial transaction. She greeted me at her residence and introduced me to her children. I paid her for the toy and in a few minutes I was on my way.

Five years later, when she requested that I treat her older daughter, I closed her therapy and referred her to another psychiatrist. I did not see her again until 1991. By that point, I had completed treatment of her child and she had remarried. She was facing marital problems, and her primary care physician had referred her to me for additional therapy.

Three years later, while still in my care, she heard from someone else that I had separated from my wife and had a girlfriend. She became enraged, terminated treatment and charged me with mishandling transference. She also reported sexual misconduct to the medical board, claiming that when I came to her house it was to have sex and nothing else. She went so far as to claim that I had visited her numerous times. The number varied—sometimes it was three, others it was seven or eight—but this discrepancy did nothing to tarnish her story. Neither did her assertion that she had visited a psychic who told her that she was going to marry me. Appearance seemed more damning than facts.

When licensing boards hear a charge like this, they of course take it very seriously. Their job is to defend the public, not the physician. In my case, I also had the misfortune of being prosecuted by a deputy attorney general who pursued my case with a vengeance. I disputed my patient's account, even took a lie detector test, but in the end they took away my license.

HOW I GOT MY LICENSE BACK. At first I was angry and hurt. I felt that I had been wronged by the system and blamed everyone but myself—my patient, the prosecutor, the board. Eventually, through therapy and insight, I was able to let go of the anger and get past who was at fault. The critical piece for me was to realize that what I had done was, in fact, a boundary infraction. I came to see that I had strayed outside the professional boundaries that are meant to protect both the patient and the physician. By disclosing more than was appropriate about myself, going to my patient's house and engaging in a financial transaction—all outside of my regular, well-documented practice—I created a dual relationship that confused her, affected the therapeutic relationship and brought opprobrium.

My first attempt to get back my license failed. Although I had gone through therapy and taken classes on record keeping and ethics, it was to be too soon.

So I looked into other courses and eventually found a program that was very helpful. An important element in such courses is the emotional benefit of sharing your own

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PUBLICATIONS

THE IMPACT OF COMPLAINTS PROCEDURES ON THE WELFARE, HEALTH AND CLINICAL PRACTISE OF 7926 DOCTORS IN THE UK: A CROSS-SECTIONAL SURVEY
BMJ Open, 2015

A NURSE'S GUIDE TO PROFESSIONAL BOUNDARIES
©2014 National Council of State Boards of Nursing, Inc.

CHALLENGES OF PROFESSIONAL BOUNDARIES (FOR MEDICAL STUDENTS)
Texas Medical Association, Committee on Physician Health and Wellness Representatives, reviewed September 2014

RESPONSIBLE OPIOID PRESCRIBING: A CLINICIAN'S GUIDE (REVISED AND EXPANDED)
by Scott M. Fishman, M.D., $16.95 (free CME credit available through October 1, 2016)

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story and hearing from others. You start to crawl out from under the shame and anger that have kept you from moving on. And you realize that you're not the only one struggling with these issues. The instructors in the course I took were well trained and compassionate; they created a safe place where all of us in the course could talk openly and honestly. As a result, we learned from each other and supported each other as we confronted our challenges.

As part of the class, we each developed a personal protection plan, which helps us stay out of trouble back in the real world. I have also continued ever since with weekly follow-up phone seminars, which allow me to keep learning from others and sharing what I have learned. This kind of ongoing support system has proved invaluable.

In 2011 I reapplied to the board and had my license reinstated. ■

WE WANT TO KNOW WHAT YOU THINK

Please let us know what you think of this first issue of *The Practical Professional,* and what you'd like to see in upcoming issues. You can email us at: **cindy@professionalboundaries.com**

What Looks Like Addiction is Sometimes Just Inadequate Pain Management

An interview with Jennifer P. Schneider, MD, PhD, a nationally recognized expert in the management of chronic pain with opioids.

DR. SCHNEIDER, YOU TEACH A TWO-DAY REMEDIAL COURSE ON PRESCRIBING. DON'T PHYSICIANS LEARN WHAT THEY NEED TO KNOW IN MEDICAL SCHOOL?

I wish they did, but the truth is they don't. It just isn't taught, not the medical issues and certainly not the legal issues. If medical students or residents received the education they should, they'd be much better prepared to treat patients with chronic pain and much less likely to get into trouble doing so.

WHAT KIND OF EDUCATION DO PHYSICIANS MOST NEED WHEN IT COMES TO PRESCRIBING FOR PAIN?

First and foremost, they need medical training in pain management and the use of opioids—topics like, how to evaluate patients, how to start them on opioids, how to get them off the drugs safely, the characteristics of the different drugs and their side effects. And of course there's a whole cloud of issues surrounding addiction.

Legal issues are also critically important and often sadly neglected. Physicians need to learn about lawful prescribing and the prevention of diversion, state and federal guidelines, how to write a prescription for a controlled substance and much more besides.

Too often, I think, remedial prescribing classes focus on the psychology of the physicians who have gotten in trouble, looking for personal vulnerabilities. That's important, of course, and we spend time on that in my class, too. But what's most important is understanding the drugs and how best to use them as part of an overall treatment plan. I devote a full day to that.

WHAT ARE SOME OF THE MOST COMMON PROBLEMS YOU SEE?

One of the biggest problems is confusing pseudo-addiction with genuine addiction. There are people who exhibit many of the behaviors we associate with addiction, not because they are looking for a high, but because they are looking for adequate pain relief.

CAN YOU ELABORATE?

People will do whatever they can to alleviate serious pain. If you're in enough pain and the Percocet that was prescribed is not providing relief, you'll take another, which means you'll run out in half the time. That's usually

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considered a red flag for abuse or diversion, but the fact is that not everyone who does something wrong is a criminal. They may just have under-treated pain. Give that patient adequate pain relief, so they can function, and they're going to become the world's most compliant patient.

SO HOW DO YOU TELL THE DIFFERENCE BETWEEN REAL ADDICTS AND PSEUDO ADDICTS?

Well, there are many ways to try and sort it out, all of which we cover in my class. Some aberrant drug-related behaviors are more predictive of addiction than others, for instance. It's also important to look at risk factors associated with opioid misuse, and there are risk-assessment tools available to help (although it's important to use them properly: risk does not equal abuse).

And of course, it's essential to monitor patients who are taking opioids. Random urine tests are useful, for instance, as long as they are truly unpredictable and you understand how to order the tests and interpret the results.

And one key aspect of monitoring a patient is to evaluate treatment outcomes. People generally talk about the four A's: Analgesia (pain relief), Activities of daily living (functional outcomes), Adverse effects (side effects) and Aberrant drug-related behaviors (running out of pills too soon or "doctor shopping" to get more pills). But many clinicians have now added a fifth A for Affect, the patient's mood, since depression and anxiety frequently exacerbate pain and many chronic pain patients are chronically depressed and require antidepressants and/or psychotherapy. ■

Dr. Schneider is certified by the American Board of Internal Medicine, the American Society of Addiction Medicine, and is a Diplomate of the American Academy of Pain Management. Dr. Schneider is a Fellow of the American College of Physicians and is the author of numerous papers in professional journals in the addiction and pain management fields as well as 8 books, including Living with Chronic Pain (Second Edition, 2009).

EVENTS

103rd FSMB Annual Meeting

April 23-25, 2015, Omni Fort Worth Hotel, Fort Worth, TX

An educational forum offered to the medical regulatory community, which includes physicians and public representatives from state medical and osteopathic boards and members of their staffs, influential federal and state government representatives, and leaders of national medical organizations. The Annual Meeting is comprised of an intensive three-day program that brings together national experts in the field of medical licensure and discipline to discuss a wide range of subjects relevant to medical regulators. LEARN MORE >

Upcoming PBI Courses LEARN MORE >