THE PRACTICAL PROFESSIONAL
in Healthcare

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Why GOOD PEOPLE Sometimes Do BAD THINGS

People don't always behave rationally or even in their own best interests. That may seem obvious, but Daniel Kahneman won the 2002 Nobel Prize in economics for experimentally proving just how wrongheaded it is to assume human beings always make rational economic choices.

AROUND THE TIME THAT KAHNEMAN WAS ACCEPTING HIS NOBEL, JONATHAN HAIDT, a social psychologist at the University of Virginia, was bringing the same ideas to the world of ethics. Contrary to accepted theory, he said, people do not make purely rational decisions about what's right and wrong. Rather, "moral judgment is generally the result of quick, automatic evaluations (intuitions)," and the reasons people give are much more like rationalizations than they are like rational thought. What's more, Haidt suggested that our moral intuitions are often influenced by factors we aren't even aware of, by the culture we live in, the social norms we grow up with and, most significantly perhaps, by our emotions.

Understanding the ways in which emotions and moods affect moral judgments, and by how much, is crucially important to everyone, including healthcare professionals who want to "do the right thing" and protect themselves against ethical lapses.

Too often, for instance, doctors trust in their own moral rectitude, believing that they would never allow themselves to have sex with a patient, no matter what the circumstances. What they fail to realize is that the judgments they make in the cool light of day are very likely to change in the heat of the moment.

In one study by Dan Ariely and George Loewenstein, male college students were asked a number of questions about how they would behave on a date. Would they slip a woman a drug if that would increase their chance of having sex? Would they keep trying to have sex even after their date said "no?" While most said they would not, their answers changed when they were aroused and looking at erotic photos.

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ARTICLES

> *"Hospitals suffer from boundary violations, too. And each one has its own vulnerabilities and faces its own risks."*
>
> STEPHEN SCHENTHAL, MD, MSW

WE WANT TO KNOW WHAT YOU THINK

Please let us know what you think of *The Practical Professional,* and what you'd like to see in upcoming issues.

You can email us at:
cindy@professionalboundaries.com

UPCOMING LIVE COURSES

THE PBI PROFESSIONAL BOUNDARIES COURSE
June 5-7 | Sacramento
June 26-28 | Atlanta

MEDICAL ETHICS AND PROFESSIONALISM (ME22)
June 5-6 | Sacramento
July 11-12 | Sacramento FILLED

PBI MEDICAL RECORD KEEPING COURSE (MR17)
June 6-7 | Sacramento
June 27-28 | Atlanta

MEDICAL ETHICS FOR PROFESSIONALS (ME15)
June 13 | Princeton
July 11 | Atlanta

THE PBI PRESCRIBING COURSE: OPIOIDS, PAIN MANAGEMENT, AND ADDICTION
June 27-28 | Atlanta

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The same study found that "people seem to have only limited insight into the impact of sexual arousal on their own judgments and behavior." It is hard to overestimate the importance of this finding to the ethical conduct of healthcare professionals. People who fail to understand how powerfully arousal can affect them are all too likely to overestimate their ability to control their behavior. "Any failure to appreciate the impact of sexual arousal on one's own behavior is likely to lead to inadequate measures to avoid such situations," write the study authors.

Another study reported in *Scientific American* reveals that something as seemingly innocuous as mood can have unexpected implications for ethical judgment. What the authors found was that people in a good mood are more likely to agree with a stated moral position, whatever it is, while those in a bad mood are more likely to disagree. Presented with a classic ethical dilemma—whether or not to save several people by sacrificing a single person—those in a positive frame of mind tended to agree with the alternative that was offered to them, regardless of which one it was. Similarly those in a negative mood disagreed with whichever alternative was presented.

Once again, a naïve trust in one's own moral compass seems misplaced, when a simple change in mood can tug the needle one way or the other. Euphoric after a major accomplishment, a physician might well agree with a patient's suggestion to go out for a drink, when the same clinician might react very differently after receiving bad news.

Complicating the ethical landscape still further are personal vulnerabilities. Several studies have shown that common life events increase a practitioner's risk of succumbing to temptation. A nurse in the midst of a divorce is far more likely to seize an opportunity for intimacy; a pharmacist in financial distress is more inclined to accept a lucrative offer for a controlled substance. Other vulnerabilities lurk well beneath the surface of conscious thought. Many, if not most healthcare professionals say that they chose their careers in order to help other people. But according to Stephen J. Schenthal and Gregory E. Skipper, this surface altruism can mask more deep-seated fears or desires—a need to be liked, a fear of criticism or competition, for instance.

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VIOLATION POTENTIAL

Just as important as personal vulnerabilities are the external situations that trigger them. The kinds of patients one treats, the conditions being treated and the setting in which one practices—all can play a role. Someone who has just lost an elderly mother may find his or her judgment unsettled when treating a female patient of a similar age with a life-threatening condition. Such risk factors vary by individual and some tend to change over time.

Even people whose vulnerabilities have been awakened by a particular situation may not succumb if they are being observed or otherwise feel that they will be held accountable. The simple presence of a third party, a chaperone, is generally enough to prevent even powerful feelings from taking hold.

Schenthal has captured these three variables—vulnerability, risk factors and accountability—in a formula that helps PBI students gauge their own potential for violating professional boundaries:

$$\text{VIOLATION POTENTIAL} = \frac{\textit{Risk Factors x Vulnerabilities}}{\textit{Accountabilities}}$$

Too often professionals discover this formula only after they have crossed a boundary and attended a remedial class. What they learn helps them protect themselves and their patients going forward. Almost all say they wish they had learned it all sooner. ■

Facts & Figures

DOCTOR SHOPPING

In our last issue, Dr. Jennifer P. Schneider mentioned that some patients visit multiple doctors to purchase more opioids than prescribed, a practice known as "doctor shopping." A 2014 study found that about a third of these patients crossed state lines to avoid detection by state-run **Prescription Drug Monitoring Programs (PDMPs).** Efforts to make PDMPs more effective seem to be making progress.

Prescription Drug Monitoring Programs (PDMPs)	2012	2014
STATES WITH PDMPs	31	45
PATIENT ID COLLECTED	4	24
MANDATORY UTILIZATION	13	22
ENGAGE IN INTERSTATE OPERABILITY	14	28

The above data is from surveys conducted by The Prescription Drug Monitoring Program Training and Technical Assistance Center (PDMP TTAC) at Brandeis in 2012 and 2014.

>> For all the results, click here.

The Three Most Common ETHICAL VIOLATIONS in Healthcare

An interview with *Gregory E. Skipper, MD, Fellow of the American Society of Addiction Medicine,* who has published widely and speaks nationally and internationally on various aspects of addiction, ethics and behavior among professionals.

Based on your experience, what are the most common ethical violations?

First, we distinguish between boundary violations, which involve crossing ethical lines in relationships, and ethics violations, which involve administrative breeches. So I'll limit my comments here to the most common ethics violations and leave the discussion of boundary violations for another time.

With that in mind I can say that the most common categories of ethics violations involve the problem of falsifying applications, that is, the inaccurate completion of questionnaires for licensure, license renewal, hospital privileges or credentialing, CME attestation and others.

Why have falsified applications become so common?

One reason I believe they are so common is that health professionals see these applications as a nuisance and simply want to get them out of the way. We tend to minimize past problems. We tend to think that minor inconsistencies will be overlooked and that minor past transgressions simply aren't worth mentioning. Often the omission involves a minor offence, such as a brief detention by police when a teenager. We're embarrassed by it and don't think it's relevant, because it was so minor and such a long time ago.

Health professionals don't realize how thorough boards are these days, that about six to eight years ago the regulatory boards, and even hospitals, started doing thorough background checks. Now it's so easy for boards to query national databases online that running searches has become routine. So even the most minor offense, no matter how long ago, is going to show up.

But if it's really a minor offence from years ago, why do boards take it so seriously?

Boards are commissioned to protect the public from dangerous practitioners, and are funded to meet that goal. They need to show that they have detected and disciplined practitioners, and it's often much easier to detect and prove minor violations than more complex violations.

Minor violations are often more definitive and clear-cut. For example a DUI conviction is much easier to prosecute than overuse of an ultrasound machine. With the DUI conviction there really can be no argument. It happened and it's officially documented. Whereas patient care issues, which are often more serious in terms of patient safety, are much more difficult to prove.

So much of what boards deal with is ambiguous, he-said she-said kinds of stuff. But lying on an application is black and white. No matter how small the crime, or how long ago it was, if you leave out something that shows up on a background check, you've falsified your application. No ifs, ands or buts, and boards have no difficulty prosecuting it.

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Medicare fraud is said to be running about $60 billion per year. How many of the people you see in remedial education courses are guilty of these crimes?

Those who intentionally set out to defraud the system are unlikely to be interested in getting help, and I suspect they represent a majority of the problem. But we do see a large number of cases of Medicare fraud, many of which are more about poor judgment or inattention than they are about outright fraud.

One common problem, for instance, has to do with up coding. Doctors use Relative Value Codes (RVC) to rate the level of care a patient receives, and the amount the physician will be reimbursed is directly related. If someone in a particular field is consistently assigning higher-level codes than others in the field, that's a red flag and that person is likely to be audited by Medicare. It may simply be that he or she is seeing fewer patients and providing more in-depth care, but that doesn't necessarily show up, especially if the doctor is not keeping careful records.

We always tell people to be really careful about recordkeeping and to self-audit their own files, because if the Medicare auditors find a problem in the 50 or 100 charts they review, they are going to extrapolate that problem to all your patients, and you can be looking at some very hefty fines and even imprisonment—not to mention the problems you'll have with your local board.

How common is addiction?

The rate of addiction among healthcare providers is about 10% over the average practitioner's lifetime. At any one time, about 1% of practitioners are thought to be abusing drugs or alcohol. That number is comparable to the prevalence of addiction in the general population. Doctors, nurses and pharmacists tend to become addicted for the same reasons other people do.

One of the big risk factors for healthcare professionals, of course, is the fact that they have more ready access to potent drugs. That's one of the reasons why anesthesiologists have the highest rate of addiction. They have ready access since they handle potent drugs daily, and it's relatively easy for them to divert the drugs for their own use, often by failing to waste (i.e. discard), the unused drugs that aren't used. It's also relatively easy for them (and others) to get drugs out of a hospital.

NO MATTER HOW SMALL THE CRIME, OR HOW LONG AGO IT WAS, IF YOU LEAVE OUT SOMETHING THAT SHOWS UP ON A BACKGROUND CHECK, YOU'VE FALSIFIED YOUR APPLICATION. NO IFS, ANDS OR BUTS.

What about pharmacists?

While you would think they have the easiest access of all, they are also under the strictest supervision. The larger pharmacies, in particular, have cameras that catch anyone taking drugs for themselves. Costco pharmacies in some locations have scales under each bottle, so after the pharmacist takes out pills and enters the number they have taken in the system, the bottle that is put back had better weigh the right amount, or they are going to be caught. ■

Dr. Skipper, PBI's medical director and faculty member, is director of professional health services at Promises Treatment Centers in Los Angeles. An associate professor of medicine at the University of Alabama, Birmingham and a Fellow of the American Society of Addiction Medicine, he is a certified Medical Review Officer.

MY STORY

"I crossed a boundary I never knew existed."

Another in our series of first person accounts from people who have crossed professional boundaries and found their way back. The following is a composite of more than one person's story.

Stephen Schenthal

I WILL NEVER FORGET THAT CALL. I WAS TALKING TO A CLOSE FRIEND WHEN HE BEGAN FEELING NAUSEATED. Within minutes he was having trouble breathing and sounding confused and desperate. After dialing 911 for an ambulance, I rushed over, arriving just as the ambulance did.

When we entered the house it was eerily quiet. We found my friend in the bedroom, unconscious. I told the EMTs that he had been having problems with kidney stones, but that would not explain his condition. Just before the ambulance pulled away, one of the EMTs found the likely cause: two bottles of heavy-duty painkillers stood empty on the nightstand.

By the time I arrived at the ER, my friend was gone. I was overwhelmed, but I turned the bottles that were found over to the doctors at the hospital. It turned out the pain pills had been prescribed by a G.P. in another town, who had been prescribing opioids for just about anyone who asked. It didn't take long for the DEA to begin investigating this guy.

I was flabbergasted when a few weeks later the DEA paid me a visit. Apparently they also found some medicine that I had prescribed for my friend nearly two years earlier when he was unable to get through to his own doctor. I come from a long line of doctors and had joined the profession because I wanted to help people. I had no idea—none—that prescribing for friends or family was a boundary violation. In fact, with a mother in the real estate business, I first thought that a "boundary violation" must have something to do with property rights.

I had not written any more prescriptions for my friend after that one time back in 2010, and since I mostly do research, I told the investigators that I would voluntarily give up my DEA number. They did not pursue the matter further, and I went to see my state medical board to explain what had happened. They told me that I should be sure to mention the issue whenever I was asked about such things on official documents.

I moved on with my life, but then a year later I was served papers by the state medical board, noting my previous encounter with the DEA and saying that I had lied on my reapplication by failing to mention it. What had happened is that my office manager had gone ahead without my knowledge and submitted an online application for me to renew my license. He was just trying to be helpful and he even used his own credit card, so the email that was sent out went to him instead of to me.

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MY MANAGER WROTE A LETTER TO THE BOARD EXPLAINING WHAT HAD HAPPENED, BUT I DID NOT DO MYSELF ANY FAVORS WHEN I GOT DEFENSIVE AND KEPT INSISTING THAT I HADN'T DONE ANYTHING WRONG AND IN FACT COULDN'T DO ANY MORE HARM SINCE I NO LONGER HAD A DEA NUMBER. THE BOARD TOLD ME I HAD TO TAKE A NUMBER OF REMEDIAL CLASSES, INCLUDING ONE ON PROFESSIONAL BOUNDARIES. IT WAS THE BEST THING THAT COULD HAVE HAPPENED TO ME.

One of the first things we had to do in the PBI class I took was research the state and federal regulations we had violated. I had never read these before, and no one in medical school or afterwards had ever suggested I should. As I took the open-book test enumerating the rules I had broken and detailing how they could hurt others, I finally realized what I had done. It was eureka time for me. And the stories I heard in class of what had happened to others in similar situations really drove home just how serious this all was.

That class and subsequent voluntary phone sessions have helped me understand not just what I did wrong but also why I was particularly vulnerable to making the mistakes I did. In part, I realized, my decision to go into research had left me isolated and eager to please others. It also made me feel like I had failed to measure up to my family's expectations (that long line of doctors were all in clinical practice). Writing those prescriptions was a way of dealing with these feelings.

After the PBI courses, I returned to the board and told them what I had learned about boundary violations and myself. I answered all their questions, and showed them my personal Boundary Protection Plan, which I had developed in class as a way of ensuring that I would take what I had learned back with me into the real world.

I was lucky. I never lost my license and am now practicing my chosen profession without restrictions of any kind. I continue to voluntarily participate in the follow-up phone sessions PBI offers, because I find them incredibly supportive and helpful in keeping me focused and vigilant about staying well within my professional boundaries. ■

PUBLICATIONS

PDF

THE HEAT OF THE MOMENT: THE EFFECT OF SEXUAL AROUSAL ON SEXUAL DECISION MAKING

Dan Ariely and George Loewenstein, *Journal of Behavioral Decision Making,* 19: 87–98 (2006)

READ ONLINE

HOW YOUR MORAL DECISIONS ARE SHAPED BY A BAD MOOD

Travis Riddle, *Scientific American,* March 12, 2013

PDF

THE EMOTIONAL DOG AND ITS RATIONAL TAIL: A SOCIAL INTUITIONIST APPROACH TO MORAL JUDGMENT

Jonathan Haidt, © 2001 by the American Psychological Association, Inc.

PDF

HOT-COLD EMPATHY GAPS AND MEDICAL DECISION MAKING

George Loewenstein, © 2005 by the American Psychological Association, 2005

READ ONLINE

THE ESSENTIAL ROLE OF MEDICAL ETHICS EDUCATION IN ACHIEVING PROFESSIONALISM: THE ROMANELL REPORT

Joseph A. Carrese, MD, MPH and others, © 2015 by the Association of American Medical Colleges

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PROFESSIONAL BOUNDARIES AND MEANINGFUL CARE

from the editor, *American Medical Association Journal of Ethics,* May 2015, Volume 17, Number 5: 416-418