



THE PRACTICAL PROFESSIONAL *in Healthcare*



PROFESSIONAL
BOUNDARIES, INC.

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*Of Fleas,
Blades and Shrinks:*

HOW SPECIALTIES DIFFER IN THEIR POTENTIAL FOR **BOUNDARY VIOLATIONS**

by Stephen J. Schenthal,
MD, MSW, CEO and Founder of PBI

Each specialty seems to have its own moniker. Surgeons are known as “blades” for obvious reasons. Psychiatrists are “shrinks,” a reference, some say, to head shrinking. And since internists have to stay with dying patients long after other specialists have left, they are often referred to as “fleas,” which are generally considered “the last ones to jump off a dying dog.”

But for all the silliness around nomenclature, each specialty does have distinctive characteristics, which may explain why so much has been written about the ways in which personality types might or should influence people’s choice of medical specialty.

What warrants more research, suggests Dr. Stephen Schenthal, CEO and Founder of Professional Boundaries, Inc. is how various specialties tend towards specific boundary violations. After 15 years of working with practitioners who have been sanctioned for such violations, Schenthal has noted a degree of consistency not between personality types and specialties, but between those who work in certain specialties and the boundary violations they are most vulnerable to.

Schenthal stresses that every situation is unique and that almost always a practitioner’s personal history is the primary factor in any boundary violation. But each specialty not only attracts certain types of people, it also involves certain kinds of interactions with patients and staff that predispose people to cross particular boundaries. While Schenthal’s observations are based on his own years

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*“Nothing is more
devastating to an innocent
physician’s defense against
the allegations of medical
malpractice than an
inaccurate, illegible or
skimpy record, except for
a record which has been
changed after the fact,
and therefore inevitably
compromises the otherwise
defensible case.”*

**BRAD COHN, MD,
PEDIATRICIAN
CHAIRMAN, MIEC
BOARD OF GOVERNORS
OAKLAND, CALIFORNIA**

*Medical Record Documentation
for Patient Safety and Physician
Defensibility, © Copyright 2008
Medical Insurance Exchange
of California, Oakland, CA*



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KNOWING WHERE THAT LINE IS, AND HOW OTHERS IN YOUR SPECIALTY HAVE TRIPPED OVER IT CAN HELP PHYSICIANS PREVENT A NASTY FALL.



of experience, rather than statistically valid research, he believes they can help some practitioners avoid problems their peers have succumbed to.

Consider internists. By virtue of their practice, which often ranges from young adult to geriatric, general practitioners tend to see the same patients over long periods of time. Not surprisingly, they develop relationships with these longer-term patients, often coming to see them as friends. And yet in one very important respect the doctor-patient relationship is the antithesis of a friendship: friends see each other as equals, whereas physicians and patients are anything but equal. At least as far as the professional relationship goes, the doctor is in a superior position, with contractual, fiduciary responsibilities. Based on their training and licensing, doctors order tests, prescribe medicines and ultimately are paid for their services. There is none of the reciprocity inherent in a friendship.

“The challenge for internists is to maintain an appropriate degree of elevation and authority,” says Schenthal. “What happens in a boundary violation is that the space between the physician and the patient collapses, and the physician comes to see himself on equal terms with the patient.” At that point it is all too easy for the doctor to become, or be seen as exploitive. In effect, two contradictory relationships have developed—one personal, one professional—and when they come into conflict, as they almost inevitably do, the patient is likely to feel betrayed, especially if the friendship has become romantic or sexual.

Not all that long ago, a degree of paternalism insulated internists from any sense of equality with patients. But dissatisfaction with paternalism has grown dramatically over the years, and patients now generally expect more of a partnership with their doctor. Moving beyond paternalism “raises new complexities,” however, notes an article in the *British Medical Journal*. “Because a partnership between patient and doctor can take different forms, it is not intuitively apparent what this model would look like.” No matter what form it takes, nothing can change the fact that it is the physician who is ultimately responsible for the outcome of the relationship. Both doctors and patients forget this at their peril.

Surgeons have very different relationships with their patients, often seeing them for only brief periods of time before and after surgery. It is therefore more common for surgeons to run into trouble with people on their surgical teams than it is for them to cross boundaries with patients. Both surgeons and ER doctors tend to work for years with the same group of professionals, often under intense conditions, and it is not unusual for these team members to develop strong, family-like, even intimate feelings for each other. Once again, the danger arises when doctors forget the inherently unequal nature of these relationships.

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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:
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UPCOMING LIVE COURSES

**MEDICAL ETHICS AND
PROFESSIONALISM
(PE22 PHARMACIST)**
October 17-18 | Irvine

**THE PBI PROFESSIONAL
BOUNDARIES COURSE**
October 23-25 | Atlanta

**THE PBI PRESCRIBING COURSE:
OPIOIDS, PAIN MANAGEMENT,
AND ADDICTION**
October 24-25 | Atlanta
November 7-8 | Irvine

**MEDICAL ETHICS AND
PROFESSIONALISM (ME15)**
October 24 | Atlanta

**MEDICAL ETHICS AND
PROFESSIONALISM (ME22)**
November 6-7 | Irvine

**PBI MEDICAL RECORD
KEEPING COURSE (MR17)**
November 14-15 | Orlando

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At the opposite extreme, surgeons and ER doctors also can cross boundaries by abusing the power differential between themselves and their team. Older physicians in particular sometimes fail to recognize how much the culture has changed and that what used to be considered acceptable behavior now qualifies as sexual harassment or creating a hostile work environment.



ER doctors face yet another challenge, because they deal with patients who are generally suffering from severe emotional stress and who are likely to feel especially vulnerable. With no chance to build any kind of trusting relationship, the doctor's best protection in these cases, says Schenthal, is the use of a chaperone. All too often, doctors dismiss the use of chaperones because the exam they are conducting is not "intimate," or because the patient says they don't want or need a chaperone. "What physicians have to remember is that the chaperones are there to protect them, as much as the patients," says Schenthal. If a patient complains that her doctor has inappropriately touched her during an examination, the doctor has no way to refute the claim if there is no objective third party in the room.

Psychiatrists often decide on their specialty out of a strong desire to understand and care for troubled patients. Such compassion can be a valuable trait in a friendship, but it is a potential source of trouble in the doctor-patient relationship. "All too often I see psychiatrists over-extend themselves out of a deep desire to relieve a patient's suffering," says Schenthal. They may loan money or make other arrangements outside of the therapeutic relationship that they feel will be helpful. But by doing so they are essentially crossing the boundary between professional and personal relationship. Some vulnerable patients end up feeling betrayed when they eventually realize that the doctor's "kindness" does not

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Facts & Figures

ELECTRONIC HEALTH RECORDS

According to a Feb. 1, 2015 article in *USA Today*...

Federal statistics show **78%** of office-based physicians used electronic health records, or EHRs, in 2013, up from 18% in 2001.

78%

More than **257,000** doctors are being notified they face a reduction in Medicare reimbursements because they did not follow the federal EHR mandate.



In a federal survey last fall, **15%** of 10,000 doctors responding said electronic records had led them to choose the wrong medication or lab order. Three times as many said the technology alerted them to safety problems, but critics say problems are still too much of a risk.

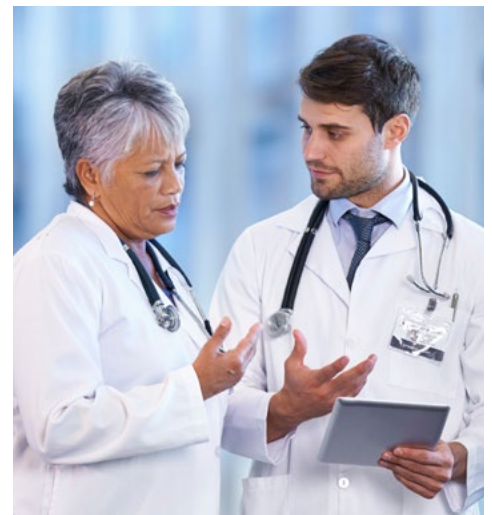


A 2013 AMA/RAND study found that **EHRs are the leading cause of physician dissatisfaction.**



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signify something deeper; others sense weakness and seek to manipulate the psychiatrist. And of course there are times when both patient and doctor allow the personal to overwhelm the professional and enter into the kind of inappropriate relationship for which the doctor can lose both her license and even her freedom.



Neither personality nor choice of specialty dooms anyone to violating a professional boundary, of course, and most practitioners go through their whole careers without incident. But the best way to avoid problems is to be aware of how easy it is for anyone in any specialty to cross the line between personal and professional. “Knowing where that line is,” concludes Schenthal, “and how others in your specialty have tripped over it can help physicians prevent a nasty fall.” ■



Good Record Keeping Is

GOOD MEDICINE

An interview with Jon Porter, JD, 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. Prior to law school, he worked as a Licensure Investigator for the Board.



You have worked in health law for more than 15 years, first prosecuting and now defending physicians and others who have run afoul of licensing boards. What's the most common issue you've seen?

Poor record keeping. Don't get me wrong. There are physicians out there who do real harm to patients, but there are a whole lot more who are perfectly good clinicians who get into serious trouble because they fundamentally misunderstand the purpose and value of medical records.

Which are...?

Medical records are primarily for the benefit of those who will care for the patient later on and for the protection of the doctor who takes the notes. What a lot of physicians fail to understand is that the records they keep are not solely for their own use. If they were, you could just scrawl something that no one but you would understand. But the notes you write are the only way the next provider knows what has been done, so they have to be legible, contemporaneous and complete.

I understand legible and complete, but why contemporaneous?

Because very few of us have perfect recall. By the end of the day or even of the morning, a physician may have seen a dozen or more patients. You're just asking for trouble if you

try to write notes for all of them after the fact. Most Boards argue contemporaneous means as soon as possible after you saw the patient.

But it's less the "contemporaneous" part of the requirement that's problematic. Where providers often fall short is in providing complete records. Today, licensing boards insist that a record "stand on its own." That means that when the next physician looks at that record, he or she has to be able to understand from start to finish what you've done and why, which means giving a pretty good sense of the relevant history up to that point. Additionally, the Board demands to see the medical justification for all the clinical decisions a provider makes.

That sounds incredibly time-consuming.

It is. In the past, you could think of a patient's whole medical record as a novel. If you read just one page or the notes from one visit, it would be like reading a single chapter: you might not understand all the characters in the book or every aspect of the plot. Well now the boards want each individual record to be a short story, with a beginning, middle and end—complete and intelligible all on its own.

So how does all that help protect the doctor?

As a faculty member of Professional Boundaries, Inc., I see a lot of doctors who have gotten in trouble with their licensing boards. Very few come to my course voluntarily.

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But what I tell all my students is that a good medical record is their first line of defense with their Boards, malpractice suits, insurance companies and hospitals.

If you don't write it down, it didn't happen, so if a patient complains after the fact that you did such and such, all you can do is say, 'No I didn't.' And the board is in business to protect the public, not you, so who do you think they are going to believe?

Most boards go so far as to say that good record keeping is good medicine; they consider it a "standard of care" issue. Therefore, even if there is no patient harm; but the medical records are bad, the Boards view that as a violation of the standard of care. In my experience this happens frequently.

It sounds like the standards for record keeping have grown considerably more stringent over time.

Is that true?

Well, they have certainly changed. And not only does the government keep changing the rules, most of the doctors I see don't know that the rules have changed, because they never knew the rules in the first place! In a class of 15, I typically find maybe one or two people who have actually read the rules. And often they only read them after they get in trouble.

Can you give an example of a recent rule change?

It varies from board to board, but one of the biggest trends I've seen in recent years is about documenting functionality in chronic illnesses. It used to be that if you saw in a patient's chart that a blood pressure medicine had been

prescribed and renewed several times, you would just assume it was working. Now you have to document that fact. You have to demonstrate that the patient's blood pressure is within acceptable limits under the medication. That's triply true in the case of any pain medication.

I imagine rules have changed considerably for opiates...?

Yes, and both state and federal authorities are going after potential abuses aggressively. Having a written controlled substance contract is fast becoming another standard of care. The contract can take different forms, but the goal is to clarify upfront for the chronic-pain patient—or for patients taking psychotropic drugs, for that matter—exactly what the doctor will and won't do. It might spell out, for instance, that if the patient asks for an early renewal because they lost some pills, the doctor has the right to do a drug screen to make sure the patient is not abusing the drug. It might also detail the steps the doctor will take to ensure that the patient is not hoarding or selling the drug.

How much has the move to electronic record keeping lessened the burden on doctors?

EMR, electronic medical records, are both wonderful and awful. The new systems—once you master them—can make it much simpler to keep comprehensive records, but they can also cause some serious mischief. One of the common problems I've seen is that many of the forms auto-populate: you hit a button and a bunch of fields get filled in. Not long ago, I was going through a client's records

MOST BOARDS GO SO FAR AS TO SAY THAT GOOD RECORD KEEPING IS GOOD MEDICINE; THEY CONSIDER IT A "STANDARD OF CARE" ISSUE.

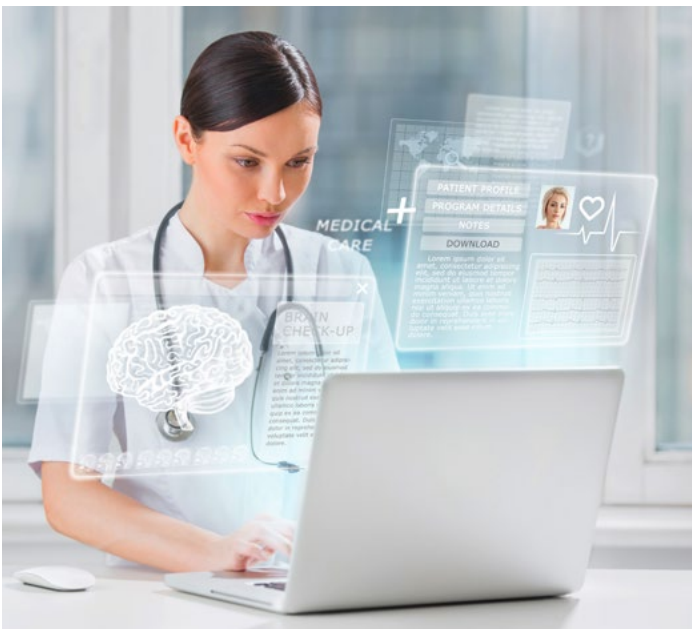


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and I noticed that the system had plugged in a breast exam for every single patient, male or female, regardless of age. So to make the point crystal clear to this general practitioner, I called him up and asked why he was giving every one of his patients a breast exam every time they came in. He said, 'I don't do that!' And I said, "Let's just go through the records." Needless to say, he's a lot more careful now.

And boards are becoming much more astute about this. If they start seeing the same exact information in patients' records over and over again, they are going to start asking what they can really believe.



It all sounds pretty intimidating. Any parting words of advice?

The best advice I can give is focus on documenting not just more, but more intelligently. Understand the rules and the purpose of record keeping and make sure you note what's important for the patient, for the next provider and for your own protection. Your records must show your clinical decision making; justifying your diagnosis and treatments. ■



PUBLICATIONS



THE MYERS-BRIGGS TYPE INDICATOR AND MEDICINE

by Louise O'Donnell, Ph.D.
Psychologist and Assistant Professor
UTHSCSA Department of Psychiatry
and Pediatrics, Veritas 2013



MEDICAL RECORD DOCUMENTATION FOR PATIENT SAFETY AND PHYSICIAN DEFENSIBILITY

A Handbook for Physicians and
Medical Office Staff, January 2008,
© 2008 Medical Insurance Exchange
of California, Oakland, CA



WHAT DO WE MEAN BY PARTNERSHIP IN MAKING DECISIONS ABOUT TREATMENT?

By Cathy Charles, Tim Whelan
and Amiram Gafni, © 1999, *British
Medical Journal*



ABILITY OF PROSPECTIVE ASSESSMENT OF PERSONALITY PROFILES TO PREDICT THE PRACTICE SPECIALTY OF MEDICAL STUDENTS

by Bradley A. Maron, MD, Steven
Fein, PhD, Barry J. Maron, MD,
Alexander T. Hillel, MD, Mariam
M. El Baghdadi, BA, and Paul
Rodenhauser, MD, © 2007, Baylor
University Medical Center

MY STORY

“One moment I was a successful physician; the next, I was in jail.”

Another in our series of first person accounts from people who have crossed professional boundaries and found their way back. The following story has been altered to protect the privacy of those involved. STEPHEN SCHENTHAL



I was in shock. The judge had just told me I was being sentenced to one year and one day in prison. I had arrived at the courthouse that morning ready to plead guilty to eight counts of medical fraud, but my lawyer had told me that I would not have to serve any jail time and that my license would therefore not be in jeopardy. That's what I had told my ex-wife, my friends and most importantly, my teenage daughter.

I tried to talk to the judge, but he wouldn't listen. The fact was that he was being lenient, giving me the shortest possible prison term under federal sentencing guidelines. It didn't matter what my lawyer had told me; the law was the law. If I had been convicted of all 146 counts of medical and wire fraud that I had originally been indicted for, I could have gone to jail for more than 20 years.

I started that day a free man, a respected physician with a nice house, who had never been in trouble with the law. By nightfall, I had been taken off to prison, where I was humiliated in ways I will never forget, and locked in a cell. It was a week before I could get out of bed and even talk to anyone.

As the weeks passed I kept going over how I had ended up where I was. The first hint of trouble had come three years earlier when my practice had been "red-flagged" by

a health insurance company for billing more than other comparable practices in the area. Surprised and concerned, I agreed to attend a meeting with the companies.

At that point, I was proud of the practice I had built up over the years. Alternating between two offices, I had highly qualified physician assistants seeing patients in both locations. My patient list had grown extraordinarily fast, which I took as a sign of my success in caring for people. Realizing that I could no longer handle the enormous amount of paperwork involved in billing, I had contracted out the work to a well-regarded company in the area.

A representative from the billing company agreed to come with me when I met with the insurance company, but assured me that there was nothing to worry about and that he would make sure there were no further problems. At the meeting itself, the focus quickly became an expensive piece of equipment which I was told insurance would not cover. The financial impact of that decision distracted me from what seemed at the time less important billing problems.

A year later, the insurance company audited my practice, and a year and a half after that they called me in for another meeting. I was more annoyed than worried until the FBI contacted me a month before the meeting and said they wanted copies of billing sheets and patient charts.

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Up to that point all I ever saw from the billing company was a monthly summary of the bills that had been sent out—so many office visits, x-rays, lab tests, that kind of thing. What I did not realize was that all of the practitioners at both offices had been billing under my name, which made it look like I was billing for services I could not possibly have provided. And there were other billing mistakes as well, none of which I discovered until I got out of prison. By that point, the billing company had dropped me as a client and sold me a software key so that I could get access to all the billing they had done.

Once the FBI got involved, the snowball started rolling downhill pretty fast. The attorney general got involved, a grand jury indicted me on all those counts of fraud, and I started meeting with a lawyer who, like the billing company, had come highly recommended. He told me that “we” were totally unprepared for a trial, presented me with the plea bargain and left me just one day to decide what to do. He put nothing in writing.

I was lucky. I served less time than I expected before being released to a halfway house, where I worked for minimum wage so I could go home on weekends to see my daughter. I was lucky, too, if you can call it that, when I was called before the medical board. The board only took away my license for six months and told me I had to take two classes in professional ethics.

I enrolled at Professional Boundaries, Inc., which is one of the best things I ever did. It was an enormous relief to hear from other physicians, who had made serious mistakes. At least I knew I wasn’t the only one in the world to make such bad decisions. And the work I did in the PBI class helped me prepare for my second appearance before the board.

I went into that meeting humbled by what I had done, rather than angry about what the board had done to me. I had learned that my practice was my responsibility and that I had to accept the consequences of what I had allowed to happen. If I had understood what was at stake and done more early on, perhaps I could have avoided the problems that overwhelmed me. But once I was facing felony charges, the time for holding others accountable was long past.



.....
I ALSO WENT INTO MY SECOND HEARING BEFORE THE BOARD WITH A PROTECTION PLAN THAT I HAD DEVELOPED WITH PBI’S HELP. IT CLEARLY LAID OUT MY UNDERSTANDING OF WHAT I HAD DONE WRONG AND HOW I WAS GOING TO AVOID MAKING THE SAME MISTAKES AGAIN.
.....

This time the board reinstated my license to practice, with no restrictions, and I was able to get back my Oklahoma controlled substance license. I expect to have my DEA number back within the next few weeks and I have a job offer from a local clinic. While I was able to get malpractice insurance, I will no longer be able to get reimbursed by health insurance companies, which means I cannot accept any patients who rely on health insurance.

Still, I am grateful to have gotten the help I needed and looking forward to continuing the career I am still passionate about. ■