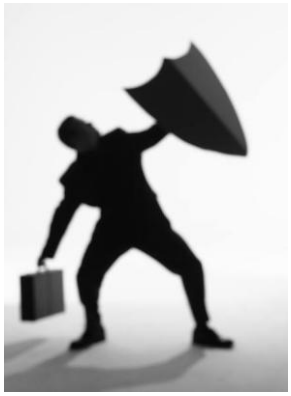
Goliath v. David

Medical authorities in California have weighed in against osteopathic physician David Steenblock on three occasions. The decisions handed down and their handling by some media sources raise questions about accuracy & fairness

By

Choctaw Doc



Winston Churchill once said "A lie gets halfway around the world before the truth has a chance to get its pants on." If he were alive today he would likely amend his statement to reflect how lies, half truths and "bad press" can literally appear on web and blog sites across the world well before those who are privy to the "whole story" can even get through the first such post!

Consider doctors who get into trouble with their medical boards. Some are, yes, foolish, incompetent, lazy or even criminal. Others encounter problems that arise from being medical mavericks who are genuinely pushing the medical envelop; men and women who employ established medical methods, drugs and technology "off-label" or sometimes new spins on established treatments that do not violate FDA or other regulatory laws to try and effect improvements in patients who have exhausted all that conventional or standard medicine has to offer. Some patients do not get better or do but are in some way not satisfied with their results, and file a complaint with the medical or osteopathic board that governs the doctor in question. Others file complaints for other reasons such as a dispute over a payment or reimbursement matter.

Of course, when one of these physicians does get in hot water as part of the process of discovery and exploration connected with a complaint, the bad news spreads fast and in some instances leaves a lot unsaid that would have readily transformed a black chapter into a gray or off-white one.

Even medical board findings and decisions can leave out mention of mitigating circumstances or (to paraphrase something famed journalist Paul Harvey was so fond of saying), "And now, the rest of the story."

Skeptics and critics of doctors who deviate from orthodoxy or have legal difficulties seemingly relish posting and/or publishing one-sided exposes without even asking their "target" for his or her response or input. This may not be something required under "good journalism" practices in some quarters, although it surely smacks of unfairness if not bias. It also tends to stack the proverbial deck against a person who does not possess the visibility in the press or Web to bring to light things left unsaid in black & write pronouncements; to "balance the equation or scales" as it were.

Let's take a case-in-point: Osteopathic physician David A. Steenblock.

Dr. Steenblock has practiced medicine for over 40 years and has devoted his career to trying and testing various combinations of therapies and treatments to elicit a healing response in patients who by-and-large are saddled with intractable and even terminal medical diseases and conditions that were not responsive to conventional medical treatments, or were for a time and then ceased being so. Among the many things he has tried in various forms and combinations down through the years are hyperbaric oxygen, heavy metals IV chelation therapy, low fat diets to halt and even reverse coronary artery disease (since 1966 actually), and most recently the harvesting of patient's own stem cell rich bone marrow and then its infusion back into their bodies by primarily IV means.

The treatment regimens Dr. Steenblock prescribes are sometimes expensive and typically not covered by insurance or such. Not surprisingly some patients go into treatment having filtered out all Dr. Steenblock's admonitions and caveats concerning the experimental nature of their agreed to course of treatment, then complain bitterly if their treatment results do not measure up to what they thought or assumed was supposed to be the case.

You might be tempted to say, "Well, why do this out-of-the-box medical stuff anyway? It sounds like a high risk-low return sort of thing. Why not leave this sort of work to researchers in major universities and government funded institutions?" The simple fact is that many medical discoveries and innovations would not have seen the light of day of it were not for individual practitioners "doing their (experimentation) thing." In fact, it is no secret that many original medical ideas and trailblazing new spins on treating disease begin with a single doctor's "tinkering."

In Dr. Steenblock's case, he has accrued some sometimes impressive case histories of turnarounds that involve novel off-label treatments and combinations of treatments. Many of his regimens produced profound clinical improvements that were subsequently replicated in many other patients with similar medical issues, while in some instances only a subset of patients got better (Something possibly linked to shared genetic features among those who did respond favorably.) He has also come up with some unique spins on the cause of some chronic diseases, something informed not just by his keen powers of observation and decades of medical experience, but also by years he spent working as a pathologist

(Pathologists being “medical detectives” who are experts in figuring out the “who done it” behind causes of disease and death.)

And like all research-oriented clinicians or experimentalists, Dr. Steenblock has had his share of non-responders. He has also had treatment approaches he devised bomb out. In such instances he has revised and retested them. Those that did not produce results no matter what, he abandoned.

Some of you may have read that case histories or “testimonials” based on them are pretty much evidentially worthless in medicine and science; that “anecdotal evidence” is too untrustworthy to hang one’s hat on. But consider what one skeptic and one skeptic-expert have to say concerning this kind of evidence:

In an article titled “Science vs. Alternativism” posted on Quackwatch, writer Gregory L. Smith, MD states that:

“Testimonials can be great places to start looking for answers, but they should not be considered the end of the journey. Many scientific discoveries start with an observation that leads to a hypothesis that eventually can be tested with a randomized controlled trial (Emphasis mine). However, people who use testimonials probably have little better to offer. After all, it is possible to get a testimonial from someone for nearly anything. In the 19th century, quack doctors sold medicines that were radioactive or gave patients bits of radioactive metal to wear near their skin. Many patients gave enthusiastic testimonials. They may have sincerely *felt* they were better, but experience showed that it wasn't doing them any favors—it ultimately made them much worse.”

Steven Novella, MD, an academic clinical neurologist at Yale University School of Medicine, ably captures this in an article he wrote titled “The Role of Anecdotes in Science-Based Medicine”:

“But should anecdotes play any role in medical evidence? Yes, but a very minor and clearly defined one. Anecdotes, with all their weaknesses, are real life experience. It is possible that a treatment does in fact work and personal experience may be the first indication that there is a meaningful biological effect in play. But here are two limiting factors in how anecdotes should be incorporated into medical evidence:

The first is that anecdotes should be documented as carefully as possible. This is a common practice in scientific medicine, where anecdotes are called case reports (when reported individually) or a case series (when a few related anecdotes are reported). Case reports are anecdotal because they are retrospective and not controlled. But it can be helpful to relay a case where all the relevant information is carefully documented - the timeline of events, all treatments that were given, test results, exam findings, etc. This at least locks this information into place and prevents further distortion by memory. It also attempts to document as many confounding variables as possible.”

OK, so case histories can in some instances serve as a source of genuine insight and discovery in medicine. And Dr. Steenblock has seemingly accumulated at least a few of these if not more. And he has had at least a few patients express their disappointment with expected outcome in the form of strident

complaining. On rare occasions one would take their beef to the Osteopathic Medical Board of California (OMBC) in the form of a complaint; a governing body whose actions and conduct has at various times fallen short of the high mark of fairness and objectivity according to many doctors (Something self-styled "consumer advocates" or "protectors" did not bother to ferret out. And when it came to Dr. Steenblock, none even contacted him to get his take on the "story behind the story.")

Not surprisingly some of these proceedings did not go well for Dr. Steenblock, who to his chagrin found himself in the unenviable position of having to sign off on something simply because battling on would have bankrupted him or worse. However, what is telling is the fact that "page two" didn't make it into the official rulings or, instances in which it did, were ignored or glossed over by those reporting on this to the public.

Let's look now in detail at board decisions as reported by one medical consumer advocate, namely Stephen Barrett, MD on Quackwatch:

http://www.quackwatch.org/11Ind/steenblock1.html

Dr. Barrett wrote:

"In 1991, David Alan Steenblock, D.O., of San Clemente, California, was charged with negligence in connection with two patients he had treated. One was a seriously ill 13-year-old girl who he saw over a 5-month period and allegedly misdiagnosed, mistreated, and failed to refer to a specialist. The other was a man who he allegedly treated with adrenal cortical extract for a complaint of fatigue. In 1994, the case was settled with a stipulation under which he agreed to serve five years of probation, pay $10,000 for costs, and take extra continuing education courses in pharmacology, medical charting, and ethics."

Now look at this from the Regulatory Agreement:

Respondent neither admits nor denies the allegations in Amended Accusation No. 91-1, but for the purposes of this stipulation and for no other purpose, respondent agrees he is in violation of sections 2234(b) and 2234(d) of the Code as alleged in Amended Accusation No. 91~1 in that, he failed to adequately document his examinations and treatment in the charts of patients Ariann W. and James C., and that he failed to warn the family of patient Ariann W. about the possible side effects of the iron injectable medication.

Note that the only violation Dr. Steenblock signed off on in the Regulatory Action agreement with the OMBC concerned charting and issuing a warning concerning injectable iron. All the other allegations were contested from day 1 (And the charting allegation was contested as well, though Dr. Steenblock ultimately chose not to fight this in order to avoid a lengthy and costly court battle).

Now to the "flip side" or "untold story": Among the things they are not reflected at all in the Regulatory Action documents, but are supported and corroborated by independent investigation and testimony:

(1) During his initial visit with the young girl, Ariann, Dr. Steenblock urged her aunt (who had assumed custody of the girl) to have her examined by doctors at a local children's hospital. The aunt demurred, stating that Ariann had been through the hospital gamut many times and was not one whit better for it.

(2) Dr. Steenblock ordered an exhaustive array of diagnostic tests for the diarrhea-plagued little girl including a history and physical, a battery of urine and stool tests, a chest x-ray, UGI (Upper GI tract exam) and BE (Barium enema). The aunt had all the tests done, save for barium enema. The diagnostic tests indicated the child had thrush (fungal infection), iron deficiency anemia, massive dental caries, intestinal Candidiasis, malnutrition and a urinary tract infection. All these conditions were subsequently treated by Dr. Steenblock using FDA approved drugs.

(3) Following these first few visits, the little girl started missing appointments. Dr. Steenblock's office tried to reach the aunt and ascertain what was afoot, to no avail.

(4) The aunt eventually brought Ariann into see Dr. Steenblock, who ordered repeat blood and stool tests plus a barium enema. A colonoscopy and barium enema was also ordered, but declined by the aunt (The barium enema was eventually done and interpreted by the examining physician as being normal)

(5) Blood tests revealed that the girl's anemia had not been caused by daily use of liquid iron. Injections of iron plus Lidocaine were begun, which the aunt was taught to administer by Dr. Steenblock's nurse Lidocaine was included to help offset pain that the girl was acutely reactive to (This is an FDA approved combination).

(6) Another physician became involved in the case and, having never heard that iron mixed with Lidocaine is an FDA approved combination readily available on the market, filed a complaint against Dr. Steenblock.

(7) The little girl was admitted to hospital and put on high dose steroids, which resulted in a clot in a major blood vessel to the heart. Ariann went into cardiac arrest, but was resuscitated. Three weeks later the physicians in charge of her case elected to do a colectomy (Remove part of the colon).

(8) The colectomy was done by a resident and was botched, which ultimately lead to the little girl's death.

(9) Department of Consumer Affairs investigators visited Dr. Steenblock, examined his charts and declared that he was in the clear.

A little over a year after the Consumer Affairs investigation concluded, copies of Dr. Steenblock's case records were examined by an OMBC member who apparently was a non-practicing physician. These copies included charting and diagnostic information that was so poorly reproduced as to be illegible. *The doctor did not request readable copies, but instead decided that Dr. Steenblock had committed grievous*

blunders that warranted legal action. He recommended that the state Attorney General revoke Steenblock's license.

What followed was a legal struggle that basically forced Dr. Steenblock to accept a "plea bargain" on the charges brought against him. And even in this, Dr. Steenblock was misled and wound up signing off on a document that totally misrepresented what had transpired with regard to Ariann's care.

When asked by me if Dr. Barrett ever contacted him to get his side of things, Dr. Steenblock said no query ever reached him.

http://www.quackwatch.org/11Ind/steenblock2.html

Dr. Barrett wrote:

"In 1997, Steenblock was charged with violating his probation by not paying the $10,000 assessment and by using three unlicensed "physical therapy assistants" to administer patient services. (In 1997, the employees were convicted of practicing physical therapy without a license.) In 2000, after Steenblock had paid the $10,000 and hired a licensed physical therapist to supervise the others, the board assessed another $3,500 toward costs but decided not to penalize him "aiding and abetting the unlicensed practice of physical therapy." The proceedings also had the effect of extending his probation for three months (to March 28, 2000)."

Note the wording contained in the Regulatory Action immediately below. It tells the tale here.

"In view of Findings 4, 5, 6, 7, 8, 9, 10 and 11, the ALJ in the present instance concludes that at all relevant times, respondent was acting in good faith and at no time were his patients at risk of receiving substandard treatment. Respondent was, and currently is, intent on respecting the board's mandates and on complying fully with the laws, rules, and regulations governing his practice. Accordingly, the legitimate purposes of disciplinary proceedings, to protect the public and rehabilitate the practitioner, would not be furthered by disciplining respondent"

The salient part here:

"..respondent was acting in good faith and at no time were his patients at risk of receiving substandard treatment."

Dr. Barrett's summarization of this decision was somewhat selective in the sense it focused on the factually negative and mentioned nothing whatsoever about the fact the board found Dr. Steenblock "was acting in good faith and at no time were his patients at risk of receiving substandard treatment." Some might call this unfair, even biased in the cherry-picking things sense of the word.

Now stop and think for a moment: State medical and osteopathic boards are by their very nature charged with protecting the public from doctors who are clearly incompetent, reckless, engaged in criminal activities or the like. Their members, investigators and expert consultants act on complaints

with a mind to determining whether the doctor under investigation violated state laws and regulations governing the practice of medicine. Most people assume that these boards do their jobs without the undue influence of bias or of any agenda other than determining what is true with regard to the allegations before them. Like a well-oiled machine, allegations go in one end and fair and just decisions out the other. This is the ideal, yes, *but not the reality*.

Here are two examples of how recent misconduct on the part of medical boards in two separate states, Texas and Alabama, became the focus of activism on the part of the Association of American Physicians and Surgeons, Inc:

http://www.aapsonline.org/press/122107.php

12/21/2007

DOCTORS SUE TEXAS MEDICAL BOARD FOR MISCONDUCT

Cites institutional culture of retaliation & intimidation

The entire Texas Medical Board (TMB) and its officials have been named in a lawsuit filed by the Association of American Physicians and Surgeons (AAPS). The complaint, filed this week in District Court in Texarkana, accuses the board of misconduct while performing its official duties, specifically:

1. Manipulation of anonymous complaints;
2. Conflicts of interest;
3. Violation of due process;
4. Breach of privacy; and
5. Retaliation against those who speak out.

http://www.aapsonline.org/judicial/herrera-amicus.pdf

HALL OF SHAME – ALABAMA BOARD OF MEDICAL EXAMINERS

- Politically motivated license revocation on the pretext of sloppy handwriting

The AAPS's filing (link above) in the case of a physician named Pascual Herrara, Jr. who had his license to practice medicine revoked by the Alabama Board of Medical Examiners, is very telling because this decision was based in part on Dr. Herrara's alleged sloppy handwritten medical notes with respect to a case involving "three young adults from prominent families died from an overdose of OxyContin in Gadsden, Alabama" (The AAPS goes on to state in its suit that "Dr. Herrera had no connection or culpability with that tragedy, but as a foreign-born physician he was a convenient scapegoat.")

Continuing from the AAPS "*AMICUS CURIAE* BRIEF OF THE ASSOCIATION OF AMERICAN PHYSICIANS & SURGEONS (AAPS) IN FAVOR OF PETITIONER" filing:

"The Commission's asserted reasons for revoking Dr. Herrera's license are woefully inadequate. The Commission based its revocation in part on the alleged sloppiness of Dr. Herrera's handwriting. That rationale, if affirmed, would support the revocation of the licenses of hundreds of thousands of physicians, and quite a few attorneys as well. If that were truly the Commission's concern, then it could simply require training and monitoring to address the issue. In fact, the handwriting of the Board's own expert was no more legible than Dr. Herrera's. The other cited bases for revocation are even less legitimate and self contradictory. The Commission found that Dr. Herrera failed to perform an adequate history and physical on three patients, but that he also performed unnecessary diagnostic tests on them and prescribed excessive medication. Thus, he supposedly tested too little and also tested too much."

Now, from page 4 of this article concerning one of many things not recorded or noted in the California osteopathic board's decision with respect to the case that focused on Dr. Steenblock and "Adriann":

A little over a year after the Consumer Affairs investigation concluded, copies of Dr. Steenblock's case records were examined by an OMBC member who apparently was a non-practicing physician. These copies included charting and diagnostic information that was so poorly reproduced as to be illegible. *The doctor did not request readable copies, but instead decided that Dr. Steenblock had committed grievous blunders that warranted legal action.* He recommended that the state Attorney General revoke Steenblock's license.

The AAPS's filing presents some logically powerful arguments suggesting that Alabama's medical board basically railroaded an MD. There was, in short, a legitimate page 2 or flip side that brings to light failings on the part of this particular state medical board. And as was illustrated in the preceding pages of this article with respect to the two OMBC cases against Dr. Steenblock, there is a page 2 or flip side that never made its way into the official findings or pronouncements.

Many more examples exist in the public domain that point to the fact that members of various state medical and osteopathic boards have had their conduct influenced by powerful outsiders, bias, axes to grind or worse.

Now stop and consider these questions: How would a medical or osteopathic board handle a complaint lodged against a doctor whose practice by its very nature "offended their sensibilities"? That is, a practice whose approach to treating certain chronic diseases included the off label use of drugs or modalities like hyperbaric oxygen or chelation therapy? (*Mind you, the very kind of tinkering or experimentation that history has shown leads to new insight and discoveries in medicine*)? Especially if the doctor in question had at various times rubbed elbows with other doctors engaged in this sort of thing or been castigated by them in the past? Do you fancy that a "red flag" might readily become a "war flag" in such an instance? And what would such a board do if any sort of complaint against that doctor crossed their desk?

This brings us to: A chronic stroke sufferer (CA) who was treated by Dr. Steenblock in his Mission Viejo (CA.) clinic from 11-23-04 thru 5-25-05.

Dr. Steenblock prescribed a series of hyperbaric oxygen (HBOT) and physical therapy treatments that commenced during late November 2004. Readers can get a feel for the rationale that informed Dr. Steenblock's use of HBOT by clicking these links:

BRIEF REVIEW OF HYPERBARIC OXYGEN FOR STROKE REHABILITATION by David A. Steenblock, D.O.

Summary of patient responses at Dr. Steenblock's clinic presented as a Poster Session titled "Improved therapy for Rehabilitation of Stroke" given by Dr. Steenblock at the National Stroke Association Ninth Annual Stroke Rehabilitation Conference

Video: Hyperbaric Oxygen Explained

Video: Stroke patient Joe Beschen discusses his turnaround following HBOT

While the use of HBOT for chronic stroke is controversial there have not been sufficient studies to reach conclusions concerning efficacy. It certainly cannot be dismissed willy-nilly as being ineffective. This perspective is reflected in an Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services document titled "Hyperbaric Oxygen Therapy for Brain Injury, Cerebral Palsy, and Stroke" (Evidence Report/Technology Assessment No. 85):

"Evidence from well-conducted clinical studies is limited. The balance of benefits and harms of HBOT for brain injury, cerebral palsy, or stroke has not been adequately studied. Future research of HBOT should include dose-ranging and safety studies to establish the optimum course of HBOT to evaluate in outcome studies." From the Summary section (page 5)

Dr. Steenblock, who has been doing HBOT for various neurologic conditions since 1989, has seen HBOT effect clinically significant improvements in a large enough population of patients to compel his continued reliance on it right on up to the present (2011.)

C.A. completed a course of 60 HBOT and PT sessions and then *requested* additional ones (He had a total of 87 HBOT & as many PT treatments by May 2005.) Dr. Steenblock's office manager observed: "When Mr. C.A. first came to Dr. Steenblock's office for treatment he was in a wheelchair and when he, Mr. C.A., had finished his treatment Mr. C.A. was walking and seemed very pleased with his improvement."

Before we proceed further it is important for you, the reader, to be aware of a number of things C.A. signed off on when he became a patient of Dr. Steenblock:

- Upon enrolling as a patient of Dr. Steenblock's C.A. and his wife signed various documents including the Physician Patient Arbitration Agreement and the Advanced Beneficiary Notice (ABN.) At the same time they were advised that they would have to pre-pay for any treatments Dr. Steenblock prescribed and that his office is not a Medicare "participating office" and

customarily does not accept assignments (Patients are advised file any claims for reimbursement from Medicare and/or their private insurance provider themselves.) But, as a courtesy to Mr. and Mrs. C.A. the front office crew agreed to submit C.A.'s billing to Medicare for *direct reimbursement* payment to he and his wife. Note that the Advanced Beneficiary Notice (ABN) Mr. C.A. signed states that "Medicare probably will not pay for services 99203, 99215, 44 PT sessions, 60 1.5 hrs HBO because it may not be deemed medically necessary by payer."

- On the ABN Mr. C.A. check marked and initialed an option designated #1 (YES) which states "I want to receive these items or services. I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision." Just above the signature of Mr. C.A. it states in all capital (bolded) letters that **"I AGREE TO PAY FULL FEE FOR SERVICES WITHOUT LIMITS"**

As you can see things were set up so that any monies paid by Medicare to Mr. C.A. would be sent directly to him. Unfortunately Medicare officials made a scanning error on the dates of service while processing C.A.'s paperwork which came to the attention of Dr. Steenblock's office manage. She wrote a letter to them on 5-6-2005 in which she requested the claims be resubmitted and any check issued sent directly to Mr. and Mrs. C.A. (A copy was sent to Mr. and Mrs. C.A.)

On 5-31-05 Dr. Steenblock's office received a letter from Valerie Walker, Medicare Overpayment Recoupment Unit, of CMS (Center for Medicare and Medicaid Services) in which she expressed thanks for being informed of the processing error and stating that the claims were being reprocessed to reflect the correct information.

The office manager then made numerous phone calls to make sure that Mr. and Mrs. C.A .received the full reimbursement from Medicare that they were entitled to.

What should have then happened is issuance of a check to C.A. by Medicare. Instead, the government agency sent the check to Dr. Steenblock's Clinic in his (Dr. Steenblock's) name. Naturally Dr. Steenblock's office manager and billing clerk immediately set about to get this snafu straightened out including returning the check to Medicare along with a request that they send the check directly to C.A. This resulted in a delay in Mr. C.A. getting due reimbursement but eventually he got this. Unfortunately during the period of time in which the Medicare screw-up was being worked out he and his wife got frustrated with the situation and filed a complaint with the California state medical board. Mind you, their unilateral move actually violated the very Physician Patient Arbitration Agreement they had signed which states (Article 1) "Agreement to arbitrate: it is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered will be determined by submission to arbitration…" and (Article 2) that it is "the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the

physician including any spouse". Just above the signature line of the arbitration agreement it states in bold capitol letters "**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL."**

There was, in short, **no** misrepresentation, fraud or other act of wrongdoing on the part of Dr. Steenblock or his office crew. Unfortunately, Mr. and Mrs. C.A.'s act of filing a complaint obligated the state medical board to investigate.

In California the Medical Board of California (MBOC) is the first to investigate a complaint (Click this link for a schematic of the MBOC enforcement process.) When the complaint is made against an osteopathic physician (D.O.) they do an investigation and then forward their findings on to the Osteopathic Medical Board of California.

In Dr. Steenblock's case the MBOC carried out their investigation and concluded the complaint had **no** merit and should not be not go forward. The OMBC on-the-other-hand followed a course-of-action that should raise concern on the part of anyone interested in justice and fairness. How so? Take a look at the litany of charges they came up with:

(1) The accusation alleged gross negligence, repeated negligent acts, acts of clearly excessive prescribing and treatment, and a failure to maintain adequate records, all in connection with respondent's provision of hyperbaric oxygen and physical therapy treatment to stroke patient C.A.

(2) The accusation also alleged that respondent engaged in an act involving dishonesty, that he improperly held himself out as board certified, and that he disseminated a public communication containing a false, misleading, or deceptive statement, all in connection with a representation on his two websites that he was "board certified" by two particular entities.

(3) Finally, the accusation alleged, as a "discipline consideration," that respondent's license had been previously disciplined in 1994 for failing adequately to document his examination and treatment of two patients.

Rather than go through each of the allegations it is easier to list the OMBC's findings:

a. Respondent failed, during his initial assessments of C.A., **adequately to document** C.A.' s condition, diagnosis, and rationale for treatment. This failure constituted a simple departure from the standard of care.

b. Respondent failed, during the course of his ongoing treatment of C.A., **adequately to document** C.A.'s continuing need for HBO and physical therapy after January 2005. This failure constituted an extreme departure from the standard of care.

c. Respondent committed acts of clearly **excessive prescribing of treatment** and **clearly excessive use of treatment facilities** by virtue of the continuation of C.A.'s physical therapy after January 2005. These acts constituted a simple departure from the standard of care. Respondent did not, however, prescribe clearly excessive HBO for the period after January 2005.

d. Respondent **failed to maintain adequate records** of his treatment of C.A., and this failure constituted an extreme departure from the standard of care. This finding follows necessarily from Findings 50(a) and (b).

e. Respondent committed a dishonest **act by falsely representing on his two websites** that he was board certified by the American Board of Family Practice and the American Board of Chelation Therapy.

f. **Respondent held himself out to be board certified** by the American Board of Chelation Therapy and the American Board of Family Practice **without such certification having been granted by these two boards**. This finding necessarily follows from Finding 50(e).

g. **Respondent disseminated and caused to be disseminated a public communication through an internet website containing a deceptive or misleading statement** for the purpose or with the likely effect of inducing the rendering of professional services in connection with the professional practice for which he is licensed. This finding follows from Finding 50(e).

Now let's break these down and look at them:

I. Articles a., b. and d. concern inadequate documentation (charting.) Even if one allows that this was the case as concluded by the OMBC – something disputed by Dr. Steenblock and his expert witness, Ken Stoller, MD (This is contained in the body of the Board's decision) – it is a "sin" shared by many practicing doctors. Consider what Cynthia M. Lipsitz, MD, MPH, wrote about this in a post titled "'Top 5 Physician Documentation Errors":

As the senior medical reviewer for Washington and West, a denials management company, I've seen documentation errors and omissions that clearly put hospitals and physicians at risk for denials. What's more, as I review medical records from across the country, I'm starting to see patterns of errors at individual hospitals and by individual physicians. And, if I'm seeing patterns as one lone reviewer, you can just imagine what government auditors are finding.

Understandably, health care providers put patient care first, and we wouldn't want things any other way. When I'm called to see a patient with chest pain, writing a detailed note is just not the first thing on my priority list. Too often, though, providing excellent patient care is used as an excuse for very poor documentation.

Some physicians feel that writing good notes isn't their concern – that they have PA's, NP's or residents to do the work. Some don't see the link between quality care and documentation, and think that as long as their patients do well, that's all that really matters. Of course everyone is stressed for time, and so notes are dashed off all too quickly. And some physicians honestly don't have the information they need to do a better job of documenting.

The fact is, we physicians haven't been taught very much about documentation in medical school or training. We usually get a general introduction to writing histories and physicals, and to the problem-oriented medical record. We get some legal tips on documentation practices aimed at reducing professional liability risks. But when it comes to writing detailed notes that justify our medical care decisions, well, that medical school class never happened.

I have introduced Dr. Lipsitz's spiel not to justify or excuse any real or perceived deficiencies in Dr. Steenblock's charting and documentation but, rather, to illustrate the fact that this sort of thing likely can be said of many if not most practicing physicians. I suspect that were MBOC investigators to randomly pull a handful of charts from the files of 20 practicing MD's and the OMBC investigators did likewise with respect to 20 practicing DO's they would find charting and documentation errors that constitutes or could be construed or interpreted as a "departure from the standard of care."

If documentation and charting errors or lapse are indeed a commonplace sin of omission then Dr. Steenblock is likely in good company. And again, while this does not justify or excuse any bona fide or perceived failings on his part most fair-minded folks would have to wonder how much weight to give this in the scheme-of-things. Perhaps less than the OMBC did when it adjudicated Dr. Steenblock's case.

II. Article c. concerns "excessive prescribing of treatment and clearly excessive use of treatment facilities by virtue of the continuation of C.A.'s physical therapy after January 2005." Excessive apparently is in the eye-of-the-beholder. According to Dr. Steenblock's office manager (Noyemy) in a sworn affidavit:

"When Mr. C. A. first came to Dr. Steenblock's office for treatment he was in a wheelchair and when he, Mr. C.A., had finished his treatment Mr. C.A. was walking and seemed very pleased with his improvement.

Upon information and belief and based on my recollection of the facts of the case the A's were so pleased with Mr. C.A.'s progress after the first 60 HBOT sessions that they requested more HBOT and Physical Therapy sessions."

When something works is it then *excessive*? So wasn't the OMBC aware of the fact Mr. C.A. improved? They heard this from Dr. Steenblock but basically hung their hat on a single criterion reflected in the

testimony of the OMBC's own expert witness, Jerome Stenehjem, M.D. who stated that "Excessive treatment is determined by a review of the patient's chart."

Among Dr. Stenehjem's other comments:

"According to Dr. Stenehjem, respondent's records for November 30, 2004, were inadequate because they did not document a level of impairment or disability from which a treatment could be assessed, i.e., they did not quantify the level of C.A.' s paralysis adequately, so that it could serve as a benchmark for measuring the effects of treatment."

"Dr. Stenehjem testified that respondent's ongoing charting for C.A. represented an extreme departure from the standard of care because it was inadequate to justify continued HBO and physical therapy treatments for C.A. after January 2005."

"Dr. Stenehjem testified that the HBO and physical therapy treatments provided to C.A. after January 2005 were excessive, because of the absence of documentation showing any continuing benefit to be derived from these modalities. This excessive treatment constituted an extreme departure from the standard of care." (Note: The OMBC disagreed with Dr. Stenehjem: "Respondent did not, however, prescribe clearly excessive HBO for the period after January 2005.")

As Dr. Steenblock's charting was dealt with in the prior section there is really no need to belabor this. However, is it fair for any medical board to decide whether a treatment is excessive where charting notes are inadequate, incomplete or missing? Yes, point out charting issues and impose remedies on the physician who failed to "clear the bar" – but why not allow for input from those with intimate knowledge of the patient's responses to therapy to help fill in the gaps? Dr. Steenblock and his office manager offered this. Little weight was apparently given this by the OMBC. OK, so why did their investigators not include asking Mr. C.A. about his responses to therapy? If they did nothing made its way into the OMBC Decision. For this reason I suspect they did not but if they had would likely have had Dr. Steenblock and his office manager's assessments confirmed.

If the rules are intended to catch physician failings in the documentation realm, this is all fine and good. But when it comes to determining whether a course of therapy had merit or conversely had little or none (and was even excessive) it seems – especially in a situation in which a physician's license is on the line – that some latitude would be given in terms of searching out supplemental information from the patient and those who were involved in his or her care.

III. Articles e., f. and g. round out the OMBC's findings with respect to Dr. Steenblock and concern some his having "committed a dishonest act by falsely representing on his two websites that he was board certified by the American Board of Family Practice and the American Board of Chelation Therapy."

As the OMBC notes in its Decision, "Respondent was certified with the American Board of Family Medicine from 1977 to 1984. He is not currently certified with that board." And "The American Board of Chelation Therapy was established in 1982. The name was later changed to the American Board of Clinical Metal Toxicology (ABCMT). Respondent is not currently a member of the ABCMT, and had not been a member for at least the past five years."

The references to board certification appeared on two of the many websites Dr. Steenblock maintains: Namely, www.strokedoctor.com and www.stemcelltherapies.org.

Dr. Steenblock does not dispute that these statements existed on the aforementioned websites. But he does take exception with the OMBC 's conclusion that this constituted "a deceptive or misleading statement for the purpose or with the likely effect of inducing the rendering of professional services in connection with the professional practice for which he is licensed. " The simple fact is Dr. Steenblock directed one of his assistants at his nonprofit research institute (SRI = Steenblock Research Institute) – a biostatistician/administrative assistant who handled the websites in question – to have the board certification notations struck from them back well before Mr. C.A. became his patient. Unfortunately this directive got lost in the shuffle at SRI and was not brought to anyone's attention until the OMBC filed its charges.

Bottom line: The Board imputed a sinister motive ("…for the purpose or with the likely effect of inducing the rendering of professional services…") where none actually existed. Dr. Steenblock and the overworked biostatistician/administrative assistant discussed this with anyone and everyone who asked. The Board came down on the side of this episode constituting something self-serving on Dr. Steenblock's part as opposed to a slip-up on the part of an underling.

Concluding Remarks

Journalists, medical consumer advocates, researchers, and members of the justice system (among others) have a professional obligation to zero in on the truth; and to do this with a focus on being accurate and fair. This is missing in many respects from the OMBC's dealings with Dr. David Steenblock and in the way many medical consumers and reporters have summarized their decisions.

It is easy and even convenient to accept official pronouncements and findings as well as media stories and consumer advocate pieces as "gospel." Unfortunately, this sort of thing tends to let unjust and unfair practices, conclusions and acts on the part of public officials and members of the 4th estate slip through the cracks, "We the people" need to resist this sort of thing as anything less makes it likely they will not only be perpetuated but become an accepted "way of doing business." History gives ample testimony to the fact that this can have tragic consequences including but not limited to spirited societal and political backlash.

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