Professional Boundaries

Exclusively for D.C.s

IDENTIFICATION AND CONSEQUENCES OF SEXUAL MISCONDUCT

Third Edition

NCMIC
We Take Care of Our Own
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Due to the nature of its content, Professional Boundaries—Defining Limits of Personal Responsibility contains sexually explicit material that may be considered offensive in nature. Reader discretion is advised.

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The issue of professional boundaries is becoming an area of increasing concern for every healthcare profession—and chiropractic is no exception.

On one hand, the social pendulum of sexual mores continues to transform America and the rest of the world. Just 50 years ago television shows such as “The Dick Van Dyke Show” and “I Love Lucy” showed married couples sleeping in twin beds. Pregnancy was referred to through euphemisms as “in a family way.” Because of what was thought to be excessive pelvic undulations by Elvis Presley on the “Ed Sullivan Show,” CBS censors were forced to film him from the waist up. Nowadays, it is not uncommon to see television shows, billboard ads and commercials openly discussing specific sexual activities, bodily functions and other once-taboo topics.

On the other hand, today’s doctors, along with business and management employees in corporate America, are being held to higher standards for professional boundaries in the regulatory and legal arenas than they had been in the past. For Doctors of Chiropractic, the challenge is compounded because the
chiropractic adjustment requires the D.C. to palpate, measure, touch and often provide ongoing supportive and/or maintenance care to the same patient over many years. This can result in a greater potential for relationships, regardless of how honorable, to be misconstrued.

Part of the difficulty in dealing with the topic of professional boundaries is the fact that there are no hard and fast lines of demarcation. In essence, a professional boundary literally can be a moving target because the individual affected determines where the “line” is. What may be acceptable to one person or in one situation may be totally inappropriate in another.

This guide is by no means complete because social mores and personal values cannot be quantified or standardized. The challenge for anyone, particularly members of the healthcare professions, is to be sensitive to even the slightest indicator of individual uneasiness and to use intuition and common sense as a guide to clarification and resolution.

At NCMIC, we know a simple complaint by a patient alleging sexual misconduct is stressful as well as potentially damaging to your professional and personal life. Additionally, what often happens is that a companion complaint of malpractice is added to a sexual misconduct allegation, and the doctor is thrust into an entirely different legal arena. For these reasons, we want to help you do everything possible to avoid a boundary violation entirely.

To guide you, we have developed an updated document on professional boundaries and sexual misconduct. Much of this guide is based on research by Michael Stahl, D.C., and Stephen Foreman, D.C. We thank them for providing most of the initial research for this monograph.

As you read through this booklet, you’ll notice it’s practical, rather than philosophical, in nature. It starts with simple, proactive tips for avoiding a professional boundary violation and then continues with increasingly serious violations and implications.

Unfortunately, there is no guide to proper behavior that will encompass every possible encounter doctors will experience during their years of practice. However, awareness of the subtle indicators that a patient may be uncomfortable can sensitize a practitioner as well as his or her staff. This sensitivity to the patient can help

For Doctors of Chiropractic, the challenge is compounded because the profession is more hands-on than many other healthcare fields.
doctors take steps that minimize the possibility of violating a boundary.

For the majority of doctors who are trying to do the right thing, this document can help you improve your awareness of today’s mind-sets.

For doctors who believe it is their actions rather than the patient’s perspective that counts, this guide may enlighten you to the changing world of doctor/patient relationships in the 21st century.

For the few practitioners who intend to seek personal gratification under the guise of a professional encounter, this document will not help. These individuals have made a conscious choice to exploit patient trust and dependency and should instead seek personal introspection and submit to counseling.

If you’re a D.C. who would like practical guidance about professional boundaries and sexual misconduct, read on for information about:

- Why the patient—not the doctor—sets the boundaries
- What you can say (and should avoid saying) to patients
- How you can reduce the risks associated with the physical aspect of patient treatments
- How you can identify and prepare for high-risk situations
- What to do if a boundary violation has already occurred
- Ways a doctor’s behavior can lead to a boundary violation
- What legal implications are involved
- What specific risk factors you should be aware of as an employer

Naturally, you want to provide professional care in the most upstanding way. By applying the tips provided in this guide, you can practice in a manner above reproach and focus on providing the best clinical care possible to your patients.

Sincerely,

Louis Sportelli, D.C.
NCMIC President
Many D.C.s find it disconcerting to learn that a **sexual boundary violation is not always a clear-cut, blatant act**, and that they can breach a patient’s boundaries even though the behavior was not intended to be sexually offensive.

**WHY IS THIS?** One reason is that the patient—not the doctor—sets the boundaries, and a doctor’s statements or actions can be perceived differently than how the doctor intended them.

In addition, chiropractors may be at greater risk due to the unique nature of the chiropractic profession. It’s more hands-on than many other healthcare specialties and, because chiropractors often treat the same patients over many years, the doctor/patient relationship tends to become more familiar. As a result, D.C.s tend to develop excellent rapport with their patients, and while this is a testament to the profession, doctors need to be careful not to compromise the professional aspect of their relationships with patients.

Finally, another important issue is how judges and juries might view a doctor’s behavior. Keep in mind that these individuals may look at a D.C.’s actions several years later, with 20/20 hindsight and preconceived notions about what actually transpired.
Why Doctors Are Held to Higher Standards

Some doctors have questioned why they are held to higher standards than some other non-healthcare professionals. One reason is the “fiduciary” nature of the doctor/patient relationship—meaning doctors are required and have a duty to make decisions in the best interest of their patients, not themselves.

Those who aid others typically are held at the higher ends of social standing. With this elevated status comes added fiduciary responsibilities: Lawmakers and the public expect healthcare providers to conform to the highest moral and ethical standards.

Doctors also are more accountable due to the intimate nature of the doctor/patient relationship. Patients need to be able to trust their healthcare providers. Without this trust, many patients would not share certain facts about themselves that would enable proper care and treatment. The fact that a patient is frequently at the mercy of a doctor’s decision causes an inequity in the distribution of power in the doctor/patient relationship.

An unethical doctor has the ability, and more importantly the power, to convince a patient that unnecessary tests and treatments might be needed. It is unreasonable to expect a patient to have the expertise and/or medical knowledge to decide if, in fact, the doctor is telling the truth about the need for treatments or the manner in which they are administered. Thus, a doctor may have the ability to manipulate a vulnerable patient due to the patient’s perception of the doctor’s power.

WHAT HAPPENS IN THE CORPORATE WORLD?

Society has begun to recognize the inherent imbalance of power in employer/employee relationships, as well as in doctor/patient relationships. Thus, the sexual boundary issue is being taken very seriously in the corporate world with numerous training programs geared to educating supervisors and employees about behavior in the workplace. What does this mean to you as a doctor? The patient population is much more educated about—and possibly more sensitive to—sexual boundary issues when they seek healthcare treatment.
When Patients May Feel More Vulnerable

As noted previously, one concept that surprises many doctors is that the patient—not the D.C.—sets and determines the boundaries. (The exception is when a patient’s boundaries are inappropriate. See page 13 for further guidance on this topic.) Doctors are accustomed to being in charge, and they may believe they are surrendering their professionalism when they provide patients with a sense of control. Doctors can reduce the risk of a boundary violation by enabling patients to maintain a degree of control over their bodies and encouraging mutual decision making regarding care approaches.

By being aware of the following situations when many patients feel vulnerable, doctors can take steps to help patients feel more comfortable:

- **Requests for intimate details.** When the patient is asked to share personal details about his or her life or health, which may be clinically necessary, the patient may feel vulnerable.

- **Owing the doctor money.** Many doctors don’t consider a patient who owes them money to be vulnerable since they see billing as a separate aspect of the practice. However, patients who owe doctors money may be hesitant to express concerns about a doctor’s treatment.

- **Not questioning the doctor’s decisions.** Often, when patients remain quiet, doctors assume it’s because the patient understands and agrees with the recommended course of treatment. However, many patients hesitate to ask questions out of a fear of appearing unintelligent.

- **Feeling vulnerable due to personal circumstances.** A patient with low education or income levels may feel intimidated by a doctor’s displays of numerous diplomas or the use of complex, sophisticated equipment.

- **Disrobing.** When patients enter a doctor’s office, they are fully clothed. Examinations that require the patient to disrobe can create a climate of exposure and intimidation for the patient. This can increase a patient’s sense of vulnerability before receiving treatment.

- **Fear of exposure.** Many patients experience anxiety that their private areas will be revealed—even if the doctor has no intention to do so.

Many doctors are surprised to learn that the patient sets and determines the boundaries.
Risk Management Practice Tips for Common Patient Scenarios

Though you may not be able to eliminate all of the risks associated with practicing chiropractic, you can take steps to manage risks and practice in a reasonable manner. Here are some tips:

Consider verbal communications
One of the ways doctors can help patients overcome feelings of vulnerability and regain a sense of control is through communications. You can tell patients in advance where you plan to touch them, what they can expect, what will happen next and so on. Here are some tips:

▶ Clearly explain what you are going to do and why during the initial exam, so there are no surprises that could be perceived as a boundary violation. A patient’s first visit to your office is an especially critical time for effective communications.

▶ Give explicit instructions regarding the articles of clothing to be removed. Example: “Please remove both of your shoes, socks, pants, and shirt, but do not remove any of your undergarments. Wear the gown with the opening in the back. Be sure and close the gown using the Velcro or ties on the back.” After giving the instructions to the patient, the patient should be given instructions to slightly open the examination room door to acknowledge that they have finished gowning. This prevents the doctor from walking in while the patient is still in the process of putting on the gown. By asking patients to open the door, they initiate the examination process and maintain more control.

▶ Explain all tests and obtain patients’ permission before performing them. This usually requires explaining the clinical necessity of examinations. A patient’s consent and permission is especially important for exams involving any private areas.

▶ Explain the types of treatments performed. This helps avoid misunderstandings. For example, someone with radicular lower extremity pain secondary to a piriformis syndrome might not understand the need to ultrasound the sciatic nerve in the buttock region. Therefore, the patient may be reluctant to expose the area for an ultrasound. Without a proper explanation, the patient may feel out of control and may misconstrue this as an erotic act or improper treatment.

▶ Consider informed consent. Some states are beginning to mandate that doctors implement an informed consent process with all their patients. Consult with your state licensing board regarding the form and substance of its informed consent requirements.

▶ Be aware that even activities such as texting, blogging and posting to social networks may constitute a boundary or HIPAA violation.
Be aware of physical interactions

The practice of chiropractic involves a great deal of hands-on interaction between doctors and patients. The fact that chiropractors place their hands on patients more than most health professionals could be a risk factor to the profession. Helping patients feel in control to the extent possible and using the measures listed below can help minimize risks during visits:

▸ Perform all initial examinations, whenever possible, during normal business hours. This is especially important with patients of the opposite sex. After-hours examinations, when the chiropractor is the only staff member present in the office, can result in misunderstandings. These misunderstandings can lead to allegations of improper conduct and ultimately he said/she said scenarios.

▸ Consider performing initial examinations in a room close to the front office. This will enable you to call in staff to chaperone, if necessary. It may also avoid the appearance that treatment was purposely conducted away from the front office.

▸ Consider a chaperone when it is necessary to examine the patient’s genitals, breasts or rectum. In addition, when the doctor encounters a patient who is making inappropriate comments or actions that may escalate into overt problems (see the section on the high-risk patient on page 13) or when terminating the doctor/patient relationship, a chaperone is strongly advised. Ideally, a patient should be given the option to request a third party be present during any examination. You may wish to add a question to the patient intake form.

Example: “Do you wish to have a third person present during your examination and treatment?” This question may help identify patients who are sensitive to such issues before they even enter the examination room. The response could also alert the staff to provide a chaperone without the patient having to request one.

Helping patients feel a sense of control during visits can help minimize a doctor’s risks.

▸ Use examination gowns when necessary. If your practice requires patients to don a gown, make sure to administer gowning procedures consistently. (For example, require all patients wear a gown or patients with previously identified conditions wear a gown.) Gowns that afford the greatest degree of privacy while allowing for a complete competent clinical examination should be used. Examples include large gowns or gowns with shorts. Consider the following gowning example of how a doctor/patient interaction could be misconstrued, potentially leading to a boundary violation:
A female patient enters a male D.C.’s office for the first time. When the D.C. enters the room, the patient is wearing jeans under the gown.

In this situation, the doctor may think: My staff did not instruct the patient to remove all of her outer clothing. However, the patient may have abuse issues or may be concerned that chiropractic maneuvers may reveal more of her body than she is comfortable with.

The manner in which a doctor handles a situation like this can be critical. Some doctors may attempt to reassure the patient by becoming more physically demonstrative, but this can be a mistake if a patient doesn’t want to be touched. The doctor’s ability to avoid a boundary violation in this situation may hinge upon his or her ability to relinquish some sense of control to the patient.

- **Drape for privacy.** When the clinical investigation includes placing the patient in a prone position, draping of a towel over the buttocks is suggested. This affords the patient the highest level of privacy without interfering with the clinical investigation.

- **Avoid removal of patient undergarments and do not place hands inside of undergarments.** Proper chiropractic care would require the removal of undergarments in only the rarest of clinical situations. Example: a patient needed to remove her brassiere for X-rays. If clinically required, explain the procedure to the patient and why the removal of undergarments is necessary. Seek the patient’s permission and expose the smallest area possible. This will help patients feel more in control over their bodies.

- **Have a parent/guardian of the same gender supervise when treating a minor,** even after the parent signs a “consent to treat a minor” authorization.

Keep in mind that staff should be involved in helping you manage the risk for your practice through appropriate verbal communications and physical interactions. Training can be done when staff is hired and/or during regular staff meetings. Always post or print in a manual the policies and procedures for staff in areas only staff can see. Note: additional training is available online through various seminars throughout the country.
Identifying and Preparing for High-Risk Situations

As most seasoned doctors are clearly aware, there are situations in which a patient initiates improper behavior. In such situations, what can you do to regain the professional environment and to protect yourself against false allegations of improper conduct? Two steps can be beneficial in this regard: (1) identifying and (2) preparing for the high-risk patient.

Identifying the high-risk patient

Though the patient normally establishes the boundaries, there are three exceptions (keeping in mind a patient may fall into more than one category):

- The flirtatious patient. Some flirtatious patients may just want a reaction from the doctor while others wish to establish a relationship with the chiropractor. These patients may attempt to justify inappropriate behavior by saying something like, “Don’t worry. It’ll be our little secret.” Other patients may be naturally flirtatious or flirtatious only with the doctor—the doctor may not be able to differentiate the behavior.

By asking your staff to observe the patient outside the treatment room, you can gather clues about the patient. For example, is the patient flirtatious in the waiting room as well as in the examination room? By collecting information from your staff, you’ll be better able to determine the best management approach to use with the patient, such as including a chaperone.

- The predatory patient is one who is looking for a lawsuit or has a hidden agenda. He or she may appear to be simply flirtatious, but is actually very scheming. A predatory patient may:
  - Want to be your last patient of the day or see you only after hours—always a red flag.
  - Be very blatant and intimidating with staff. (Note: staff often will recognize this behavior before the doctor.)
  - Disregard staff instructions (e.g., may appear naked in the treatment room).
  - Attempt to appeal to your ego. For example, he or she may say, “The last two doctors I saw were idiots, but I’ve heard wonderful things about you.”

- Patients with unrealistic expectations/perceptions of the doctor. These are patients who unconsciously idolize or see the doctor as a replacement for another important person from the patient’s past.
or present. When trust develops between a doctor and a patient, these extremely vulnerable patients may unconsciously misinterpret the role of the clinician as follows:

- **Dr. Perfect** (idealization)
- **Dr. Prince Charming** (romantic idol, rescuer)
- **Dr. Good Parent** (nurturing, re-parenting)
- **Dr. Magical Healer** (savior)
- **Dr. Beneficent** (devoted caretaker, e.g., nanny or the first doctor)
- **Dr. Indispensable** (only one who can cure)
- **Dr. Omniscient** (knows and understands all)

Though this may be difficult for doctors to pick up on, watch for out-of-the-ordinary behavior. For example, a patient who sees you as “Prince Charming” may come dressed in seductive clothing and cologne and ask: “Don’t I look nice today?”

**Preparing for high-risk situations**

By being prepared and establishing your personal policy in advance, you can avoid being caught off guard, thus avoiding some awkward—and potentially risky—situations. Here are some ways you can get ready for situations in which you must establish control:

- **Train your staff on how to:**
  - Be aware of risky patients and situations. Develop procedures for staff to alert you to potential problems—without letting the patient know. One office developed a fictional code name of “Dr. Black” for situations where the doctor wanted a staff member present during the treatment phase. The doctor would tell a staff member, “Dr. Black needs copies of the records” to communicate the need to be present and assist in the treatment of a high-risk patient.
  - Recognize, respond and deal with aggressive patients and empower your staff to handle difficult situations.

- **Make sure that you listen to your staff even if it goes against your ego**—staff will tend to have a more objective viewpoint and can observe patients’ behavior with staff and other patients.

- **Check with past doctors** to find out why a patient was discharged (a release from the patient will be needed to contact his or her prior doctor). Flirtatious and/or predatory patients are experts at appealing to a doctor’s ego, and this step can provide doctors with a reality check.
Understand diversity within cultures and how this affects sexual boundaries. Different cultures have different expectations regarding touching, personal space, chaperoning and the parts of their bodies they consider private. Be aware of the needs of ethnic or cultural groups, especially those prevalent in your community.

Ensure effective communications — Not only does this mean avoiding inappropriate jokes, you also should plan ahead for ways to put patients at ease without appearing inappropriate. For example, doctors should be less chit-chatty with mildly flirtatious patients, while being firmer with patients who exhibit blatant behavior. Doctors also should be able to communicate honestly with their patients if they feel uncomfortable about a patient’s behavior.

Include a chaperone in the treatment room. The presence of a third party in the room will usually stop inappropriate behavior. If a high-risk patient refuses to receive treatment while a chaperone is in the treatment room, this is a huge warning flag. Appropriate discharge procedures should be considered.

Always get consent for photography, medical or otherwise. And with minors, have a parent in the room.
Taking Action When a Boundary Violation May Have Already Occurred

Sometimes Doctors of Chiropractic unknowingly cross a sexual boundary violation or they find out they violated a boundary after the fact. The following can help you to identify and mitigate these situations and take more drastic measures if needed:

**Watch for signs of patient discomfort**
When patients feel uncomfortable, they often will provide certain clues such as:

- **Patient pulls away when touched.**
  Doctors should ask if that particular touch made the patient feel uncomfortable or caused pain. As a way to measure a patient’s comfort level, the doctor may wish to start with a touch to the forearm. The doctor then can demonstrate the degree of pressure applied during a chiropractic palpation and what it will feel like. A touch to the forearm is generally considered acceptable because it is nonsexual and allows the patient to see and respond to the touch without surprise. In contrast, a patient who has no prior experience with chiropractic care or one who has issues with being touched may react negatively if a chiropractor’s first touch is the doctors’ hands being placed from behind the patient on the shoulders.
This form may be given to patients following their appointments and returned to a secure destination that is only accessible by the physician. Please adapt this form to suit your own practice.

___________________________________________________________________________

Please rate the following on a scale of 1-10 with 10 being the best:

_______ Attitude of staff

_______ Courtesy of staff

Were you embarrassed at any of the questions or comments made? ...........☐Yes ☐No

Did any person make you feel uncomfortable during your visit? .............☐Yes ☐No

Did the doctor answer all of your questions? ...........................................☐Yes ☐No

Do you feel comfortable with your relationship with the doctor? ............☐Yes ☐No

Do you feel comfortable with your relationship with the staff? ...............☐Yes ☐No

If you answered “No,” please explain: _______________________________________

___________________________________________________________________________

___________________________________________________________________________

Name _______________________________________________   Date ________________

Adapted from The Chiropractic Form and Sample Letter Book. ©2003, PracticeMakers Products, Inc.
The patient or the patient’s significant other makes comments to staff. If a patient tells a nurse or assistant that he or she felt uncomfortable with your “bedside manner,” it’s time to change your behavior and to include a chaperone in the room during treatment. Furthermore, doctors should establish procedures for patients to inform the doctor when they feel uncomfortable. A nonjudgmental patient questionnaire tool (see sample at left) can be used to share patient concerns with the doctor.

The patient does not return for appointments or returns with another person. If the patient returns with another person, listen to how the patient introduces the other person. For example, if the patient says, “Doctor, this is my husband. I want him to be in the room with us,” it could be a red flag that either the patient or the patient’s husband is feeling distrust of the doctor.

You receive notification from another provider that the patient felt uncomfortable with your treatment.

You receive a complaint from the patient.

Further steps for at-risk situations
Sometimes identifying problems and planning ahead is not enough to resolve particular patient situations. At that point, you may need to take some or all of the following actions:

If a patient tells a nurse or assistant that he or she felt uncomfortable with your “bedside manner,” it’s time to change your behavior.

1. Seek help from a peer, legal counsel or a sensitivity training course. It’s not taboo to discuss patient situations as long as you maintain the patient’s confidentiality.

2. Document as carefully and precisely as possible all office visits and events. In addition, keep all letters, phone messages, etc.

3. Terminate the doctor/patient relationship and refer the patient to another doctor. (See the section that follows for further guidance.)

4. Call your malpractice carrier.
If you’re an NCMIC policyholder, call our confidential Claims Advice Hotline at 1-800-242-4052 to discuss any concerns you’re not sure how to handle. We’ll assist you in obtaining an attorney if you need legal counsel.

Terminating the doctor/patient relationship
Terminating the doctor/patient relationship may be necessary in some high-risk situations.
situations. Once you have determined you need to take this step, be sure to:

- **Communicate with the patient** that you will no longer be able to treat him or her and document this in the patient’s chart.

- **Explain that you will need to refer the patient to a colleague** (a patient with a history of sexual abuse will often benefit by seeing a doctor of the same gender) or to a doctor in another healthcare field (e.g., a general practitioner or a specialist). Provide the names of several different doctors to the patient.

- **Include a colleague or staff member in the room** when you refer the patient to another doctor.

- **Give the patient adequate time to find another doctor** to avoid allegations of abandonment. Offer to make copies of the patient’s records available to the new doctor, without charge.

- **Even if you’re able to tell the patient in person that you will no longer be able to treat him or her, send a withdrawal letter** by certified mail, return receipt requested. (This letter should be worded diplomatically.) Keep the certified receipt when it is returned. Maintain a copy of the letter in the patient’s file with the receipt attached.
Ways Doctors Can Avoid Behavior That Can Lead to a Boundary Violation

Sometimes a doctor’s own behavior can contribute to a boundary violation. By heightening their sensitivity toward certain behaviors, doctors can minimize their risks. Following are some of the preventative measures suggested by researchers Summer and McCrory:

1. **Do not seek emotional support from patients.** It is inappropriate for doctors or patients to discuss personal issues, such as personal finances, marital problems, social issues or sexual fantasies.

2. **Do not ask patients to perform personal services for you** and avoid seeing patients after hours. Avoid personal interactions that create the impression of breaching the doctor/patient relationship.

3. **Recognize and stop any problem behavior in its tracks.** If you would feel comfortable in telling a joke or making a comment in front of a child, typically you could do so at the office. However, if you would not feel comfortable, omit these behaviors.
4. **Be careful when exchanging gifts with patients.** This includes being lax about fees or allowing fees to mount. It may be questioned later about what types of considerations were in place, if fees were not collected.

5. **Take action if a patient is aggressively seductive.** For example, say in a calm voice: “This behavior is inappropriate and not in the best interest of our professional relationship.” Document the situation. If the doctor/patient relationship does not terminate after this incident, use a chaperone for subsequent office visits and consider discharging the patient. (See the section on “identifying the high risk patient” on page 13 for additional tips.)

Also, it is advisable to establish a code with your office staff to alert them that a problem may be present and that you would like them to be in the room during treatment.

**The “downhill slide” to the most serious violations**

Though there are occasions when doctors abuse patients at their first doctor/patient meeting, it’s more common for sexual misconduct to occur over a period of time. During this longer timeframe, there are subtle actions, which may evolve into the most serious type of abuse—sexual intercourse between doctor and patient.

By recognizing the warning signs of this progression toward a boundary violation or sexual misconduct, doctors can take steps to prevent the inappropriate behaviors from progressing. The following is a typical progression of a doctor on the way to a professional boundary violation:

**Recognize the warning signs to prevent inappropriate behaviors from progressing.**

1. Intrusive thoughts of the patient
2. Feelings of falling in love with the patient
3. Arranging appointments with the patient for times when other staff have left the office
4. Thoughts of meeting the patient outside the office
5. According “special” treatment to the patient
6. Increasingly irrelevant self-disclosure to the patient
7. Behavior/activities the doctor would not want colleagues or family to know about

Clearly, the amount of time and the number of patient visits can influence the progression to a boundary crossing. For example, a first-time visit likely would not provide sufficient time for the doctor to cross several boundaries. Also, a doctor’s degree of “power” over a patient tends to increase over time and with additional visits.
Spectrum of Sexual Misconduct

Though no doctor wants to be accused of any form of sexual misconduct violation, there are different levels of sexual misconduct and boundary violations that can take place.

The prohibition against sexual acts between doctors and their patients dates back to Hippocrates. However, the breadth of possible misconduct is now quite diverse, ranging from nonphysical acts to intercourse. Summer and McCrory identified 10 sexual offenses, which reveal the breadth of the spectrum:

- Affairs with patients
- Inappropriate sexual touching through massage or masturbation
- Inappropriate affectionate behavior
- Unnecessary sexual talk with patients (talking about irrelevant sexual conduct, orgasms, masturbation, etc.)
- Exposing the patients
- Rape of patients
- Taking pictures or videos of patients for sexual purposes
- Peeping on patients while they are undressing
- Using patients to gain sexual access to their children
- Sexual involvement with staff

The inclusion of sexual exploitation with sexual misconduct adds to the spectrum of what is considered inappropriate behavior:

PATIENT REACTION TO SEXUAL EXPLOITATION

A doctor may not be aware that a patient has a previous history of being sexually exploited or abused because many patients are unwilling or reluctant to share this information. However, the patient may exhibit signs and symptoms of post-traumatic stress disorder—if the person was profoundly affected by the situation and reacted to it with extreme feelings of “fear, helplessness, or horror.” In these patients, you may see the following symptoms, individually or in combination:

- Difficulty with concentration
- Anger or rage
- Preoccupation with death
- Anxiety or panic
- Depression
- Suicidal feelings
- Psychosomatic complaints
1. Inappropriate touching

2. Sexually exploitative relationships that may occur during or after a formal professional relationship

3. “Therapeutic sexual acts” when a healthcare provider claims a sexual act with the provider will benefit the patient

4. Sexual assault of impaired, sedated or decision-compromised patients.

(Note: Though sedating patients is generally not within the scope of practice in a chiropractic office, a number of patients today take medications or sedatives that can cloud their clarity of thought.)
Nonsexual Relationships with Current and Former Patients

There are a variety of “types” of doctor/patient relationships that may pose ethical difficulties for the Doctor of Chiropractic. These run the gamut from nonsexual friendships and business relationships with former patients to sexual relationships with current patients.

Nonsexual relationships with former patients

There are many doctor/patient relationships that are more common than the sexual variety. Though they seem harmless at first glance, consider the following when forming nonsexual relationships with former patients:

1. The former patient may return for care. A significant business relationship after care ended would make return to treatment difficult as the business relationship can skew the chiropractor’s clinical objectivity or alter the patient’s level of trust and respect for the doctor’s treatment opinions, depending on the business outcome.

2. Some patients are mentally or emotionally vulnerable and may improperly rely on the chiropractor in other types of relationships. Such vulnerability may open them up to being taken advantage of.
3. **The doctor may be required to furnish records or testify in court about past chiropractic care.** Examples include offering professional opinions in court about injuries, pain and suffering, and future chiropractic care after an automobile accident. The same can be true for the injured worker who now requires permanent disability or vocational rehabilitation. In these cases, the doctor must be an independent observer of the patient’s clinical condition and unbiased by personal or business connections.

If a doctor would like to terminate a doctor/patient relationship, the chiropractor should take formalized and definitive steps to formally end the doctor/patient relationship. (See steps on page 18)

The regulatory boards do not have a unified position on the subject of ethical standards of former doctor/patient relationships. This is true in other professions as well; some states take no ethical or regulatory position on sexual relations with former patients, while others advocate a permanent prohibition. The dominant view is that a practitioner should not have a sexual relationship with a former patient, while some ethics experts advocate waiting until some time period has passed. Since there is no universally accepted time period, each state’s licensing board should be consulted when in doubt about this situation.

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**With chiropractic care, there may never be a formalized end to the doctor/patient relationship, which can complicate any outside relationship with a patient.**

### Sexual relations with former patients
As one might imagine, the area of sexual relationships with former patients can be a gray one since chiropractic care differs from many other medical specialties in how the doctor/patient relationship is terminated. With many medical specialties, the doctor/patient relationship ends after a specific condition is treated. With chiropractic, on the other hand, there may never be a formalized end to the doctor/patient relationship since many chiropractors emphasize lifelong care and many patients claim benefit from such care.

### Sexual relations with current patients
There is universal agreement from all corners of the world, by regulatory statues and/or ethical edicts, that sexual relations with current patients should be prohibited.

Specifically, the American Chiropractic Association (ACA) has weighed in on the sexual misconduct issue in their 1991 code of ethics statement: “The physician/patient relationship requires the Doctor of
James Ramsey, D.C.,* a married 38-year-old with two children, had a very busy, growing practice. He was active in the community, involved with his church and held in high esteem by his patients and peers.

This all changed when Dr. Ramsey was alleged to have been sexually inappropriate with a patient.

The patient was initially offended by soft tissue work Dr. Ramsey was performing in her lumbar-sacral area. It may have been simply a misunderstanding due to the fact that Dr. Ramsey failed to explain what he was doing and why. Unfortunately, while he was performing the soft tissue work, Dr. Ramsey inadvertently reinforced the patient’s perception that his behavior was inappropriate when he jokingly asked: “Where is the rest of your underwear?”

Consequently, the patient decided to file a complaint against Dr. Ramsey for sexual misconduct with the state’s board of chiropractic examiners.

He was found guilty of sexual misconduct and his license was suspended for two years.

The resulting publicity severely affected Dr. Ramsey’s family and his practice. A divorce ensued; the doctor’s professional reputation was damaged; and his patient flow diminished. (Dr. Ramsey had to hire a new graduate to keep his practice open during the suspension.)

Two years and three months later, after complying with all the board’s requirements, Dr. Ramsey’s license was reinstated. However, he was required to have a female on staff observe all of his treatments with female patients and make other changes to his office policies before he could practice again. As a result of his conduct, Dr. Ramsey learned a costly lesson and paid an enormous personal, financial and professional price.

* The doctor’s name is fictitious. Any use of real names is purely unintentional.
Chiropractic to exercise utmost care that he or she will do nothing to ‘exploit the trust and dependency of the patient.’ Doctors of Chiropractic should make every effort to avoid dual relationships that could impair their professional judgment or risk the possibility of exploiting the confidence placed in them by the patient.” The ACA ethics committee further clarified, “It is the opinion of the committee that sexual intimacies with a patient is unprofessional and unethical based on the existing ethical provisions in the ACA code of ethics: A(6), A(7), A(10), and C(2).”

The International Chiropractic Association (ICA) also has a code of ethics with general language that prohibits doctor/patient sexual relationships. ICA code of ethics, Principle 1K states, “The Doctor of Chiropractic shall not take physical, emotional, or financial advantage of the public or any patient he/she serves.”

**Review your state laws defining unethical patient relationships.**
Legal Implications for Sexual Misconduct

There are various ways in which a violation of professional boundaries can result in “legal trouble.” Not only can a chiropractor be accused of violating sexual boundaries by having a relationship with a current or former patient, hugging or telling a joke could also result in such allegations being brought forward.

It is quite possible that when an allegation of sexual misconduct is made, many different legal actions will be levied against the doctor. Each legal proceeding carries with it a different set of rules and evidence standards. There is an ever-cascading scenario of legal trouble when an allegation of sexual misconduct occurs. Even if the doctor manages to defeat each and every allegation levied, the doctor may not be able to overcome the tremendous financial, professional and personal reputation losses for many years.

Civil legal system

The civil legal system allows a venue where wronged and injured parties can be made whole for their damages. This court system has the lowest standard of evidence for a determination of finding. The complaining party, the plaintiff, must convince the jury by a “preponderance of the evidence.” In practical terms, this
equates to a mere tipping of the evidence in favor of the plaintiff to prevail.

Due to the tawdry and emotional allegations involved with sexual misconduct, other types of civil legal actions more than likely will occur. These other civil proceedings will inevitably be proportional to the seriousness of the allegations. For example, if the doctor is accused of having sex in his office, subsequent civil proceedings may include divorce proceedings and child support hearings. Legal representations for these proceedings are generally borne solely by the doctor as virtually all insurance policies exclude coverage for intentional acts.

**Administrative/regulatory boards**

The administrative/regulatory boards are publicly funded agencies, which are entrusted with protecting the public. Typically, there is a separate regulatory board for each profession. Each regulatory board has a mandate to ensure a minimal level of competency for that particular vocation or profession. The rules governing the various vocations and professions are typically codified in state regulations and acts. If there is an allegation of a breach of conduct, the proceeding is overseen by a board. The standard necessary for an adverse ruling in an administrative hearing is typically “clear and convincing evidence.” This burden is greater than what is needed in civil courts but lower than what is required in criminal trials.

A regulatory/administrative board can revoke or suspend a doctor’s license, as well as issue a citation, fine or letter of censure. And this information becomes a matter of public record where others can read about it.

The mandate of the administrative system is different than civil courts. This is why doctors accused of sexual transgressions may find themselves defending parallel actions in administrative court and civil court at the same time.

**Criminal justice system**

The criminal justice system has the mandate of protecting society at large. Such protection may mean incarceration to protect the public. This differs from administrative mandates, which protect the public by acting on a doctor’s license. Incarceration is not taken lightly in the criminal justice system. A criminal conviction requires the jury to determine the evidence was “beyond a reasonable doubt.” This represents the highest standard of evidence required to be found guilty of criminal conduct.

In the past, the criminal justice system only became involved with a doctor/patient sexual relationship in two instances: when the patient was underage or the sexual advances were unwanted by the patient.

*Today, criminal charges can be filed even when no physical contact with the patient occurred.*
Today, traditional criminal acts and jail time can occur even when no direct physical contact with the patient occurred. An example of this was a complaint filed by the United States Attorney’s Office. The government charged a chiropractor with the “production of a visual depiction of a minor engaging in sexual explicit conduct.” The unsuspecting victims, both minors and adults, were instructed to disrobe completely and then change into a hospital gown. The patients were then told to perform various flexibility exercises while standing directly over a hidden camera, which was concealed in the floor of the X-ray room. Officers confiscated 380 videotapes in the chiropractor’s office. The doctor stated that he intended to place the videos on the Internet to fund his retirement. The doctor surrendered his license to practice to the state board.

Even if the doctor manages to defeat each and every allegation levied, he or she may not be able to overcome the tremendous financial, professional and personal reputation losses for many years.

JURISDICTIONAL MANDATE TO REPORT COLLEAGUES

Doctors may have a jurisdictional mandate to report other physicians for inappropriate behavior. These are most often mandated by the state licensing boards and typically can cover:

- Alcohol and/or drug abuse
- Excessive questions into the personal sex life of patient
- Disrespectful sharing of patient information with peers (e.g., “She is hot!”)
- Witnessing or observing peers making patient calls outside of business hours that seem to be personal rather than professional in nature
- Frequent late night hours without staff
This point bears repeating: Criminal charges are again not limited to physical contact between a doctor and a patient. With the advent of technology, new areas of misconduct also evolve. A recent prominent example of such a situation involves a California chiropractor who was indicted in November 2002 for possession of child pornography.11

The mere possession, no matter where this material is located (office or home), is considered a federal offense. The doctor was alleged to be part of an international ring that sold these images worldwide. Investigators in California are checking the more than one million images stored on the chiropractor’s computer on the 400 confiscated compact disks. An accusation against the doctor to revoke his license to practice has been filed.12

Legal representation and associated costs needed to defend a doctor from criminal allegations are once again generally borne by the doctor.

**State associations and/or professional societies**

Depending on the outcome of criminal and/or administrative hearings, a state association may ask for a doctor’s membership to be withdrawn. Since there are no associated required rules of evidence for such proceedings, many of the actions taken can be quite arbitrary and political in nature.

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- **Strange and or unconventional treatments**
  - being used on patients. (Some chiropractic approaches are more likely to be misconstrued than others.)

- **Inappropriate use of language**, touching or personal space violations

- **Quid Pro Quo**—The concept of getting something of value in return for giving something of value

Even well-intentioned doctors can get into trouble with this mandate to report other physicians. In Iowa, for example, a doctor could be penalized for not reporting a D.C. in his practice who is treating patients while under the influence of a drug or alcohol. If it became known that the first doctor knew about the substance abuse but did not report it, he could be called to appear before his state licensing board. Even if the D.C. didn’t know about the mandate, the board could hold the doctor accountable for not adhering to the requirement.
Maintaining Professional Boundaries in the Age of Social Communication

Many D.C.s have a desire to keep their personal and professional lives separate. Yet, many doctors frequent online chat rooms, social networking sites or maintain blogs where they identify themselves as doctors, and millions of unknown users may stumble upon the information. What innocuous information might be misconstrued? What snap judgments could be made about your personal life that have nothing to do with your professional life? Remember, doctors are held to higher standards of personal conduct than other groups in society.

Rest assured, activities on social networks will be scrutinized by the plaintiff’s attorney in any litigation.

Some practice and risk management experts recommend that a doctor interested in social networking have two separate pages—one personal and one professional. Moreover, accepting patients’ invitations to be “friends” or asking patients to be your Facebook friend is not recommended as it blurs the lines between doctor/patient/friend—establishing an environment ripe for a boundary violation.

It may be a good idea to develop a standard response in this area. For example, tell patients that you make it your policy not to friend current or former patients on social networking sites out of respect for the doctor/patient relationship and to safeguard patient confidentiality. Some doctors also develop a social media policy that addresses the professional use of all types of social media by the doctor and practice staff. This policy could be incorporated into the practice’s new patient information packet.

If a doctor elects to have a profile on one or more social networking sites, privacy settings will require extreme care and regular attention.
As an employer, you naturally have additional obligations when it comes to sexual boundaries. Not only must you consider your own actions, but you are also responsible for your staff’s behavior as well. Therefore, it is imperative to have policies and procedures and follow through on them consistently and appropriately. The following are considerations relating to sexual misconduct the doctor should bear in mind as an employer:

1. **Comply with the Equal Employment Opportunity Commission’s (EEOC) definition of sexual harassment:**

   “Unwanted and repeated verbal or physical advances, derogatory statements or sexually explicit remarks, made by someone in the workplace, which has the effect of offending or humiliating the recipient.”

2. **Ensure appropriate office communications, which include communicating with staff, establishing an office manual, enforcing policies and documenting all actions:**

   - Prohibiting employees from soliciting patient for sexual or financial benefit
   - Providing chiropractic services to staff with the same care and professionalism, quality and record keeping used with outside patients.
   - Requiring written and printed materials to be professional and appropriate. (For example: “It is inappropriate for sexually explicit materials, including inappropriate magazines, cartoons or drawings to be within the clinic. This includes the waiting room, employee break room and the doctor’s office.”)
   - Prohibiting inappropriate material on the office computer. Internet filters can prevent downloading and accessing of inappropriate websites or software programs by staff. It also allows the doctor to monitor the Internet sites accessed by staff members. Downloading sexually explicit pictures or written material is a serious situation and should be dealt with as soon as the doctor becomes aware of it.
   - Investigating and responding appropriately to patient or staff complaints.

3. **Be aware of vicarious liability issues.**

   You may be liable for the inappropriate actions of staff.

4. **Understand the risk of disgruntled former employees.** They may be vindictive and derive satisfaction from sharing confidential information about your office with the Centers for Medicare & Medicaid Services, the IRS, competitors, state licensing boards, insurance companies, etc.

5. **Know the risks of blogging about patients.** Seriously consider prohibiting your staff from blogging, texting or posting information about your patients.
Boundary Violations—A Concern for All Healthcare Providers

Every healthcare provider has reason to be concerned about the possibility of an allegation of a boundary violation, not to mention a conviction of such conduct.

By recognizing the warning signs outlined in this guide, you can minimize your chances of acting inappropriately and being accused of sexual misconduct. In doing so, you’ll be able to focus on providing care to your patients.
Cited References


3 **Anonymous.** “A Case of Professional Sexual Misconduct.” North Carolina Medical J. Vol. 57m No. 4, 208-211.


7 **ACA Code of Ethics:** A(6), A(7), A(10) and C(2).

8 **International Chiropractic Association Code of Ethics,** Principal 1K

9 **Gormley, L.** “FBI Files Video Peeping Charge,” Appeal-Democrat, January 5, 2001

10 **California Board of Chiropractic Examiners,** May 2001, Default Decision #2001-228.


12 **California Board of Chiropractic Examiners,** Accusation #2003-325.
Professional Development

for Doctors of Chiropractic

NCMIC has partnered with state and local chiropractic associations to bring informative risk management and continuing education seminars to Doctors of Chiropractic.

For a listing of seminars, including those on professional boundaries, go to the Continuing Education section of www.ncmic.com