

Section 6

CHILD AND ELDER ABUSE

Child Abuse

Child abuse and neglect is a problem⁵⁹⁻⁶¹ of "epidemic proportions"⁶² that affected approximately 20,000 Oregon children in 1997 and 1998.⁶² The victim of child abuse is an unmarried person, under the age of 18, who has been non-accidentally physically or mentally injured, negligently treated or maltreated, sexually abused or exploited, or who dies as a result of abuse or neglect.⁶²

Chiropractors observe and treat children on a regular basis. A chiropractor, having reasonable cause to believe any child with whom the chiropractor comes in contact has suffered abuse or any person with whom the chiropractor comes in contact has abused a child, is required by Oregon Law⁶³ to report⁶⁴ orally "by telephone or otherwise to the local office of the State Office for Services to Children and Families (SCF), to the designee of the State Office for Services to Children and Families or to a law enforcement agency within the county where the person making the report is located at the time of the contact." Any report made is subject to confidentiality⁶⁵ and the person making the report may not be sued for making a report in good faith⁶⁶.

Abuse can be classified into four basic categories:⁶²

- physical abuse;
- neglect;
- mental injury or emotional maltreatment;
- sexual abuse.

ORS 419B.005 defines child abuse as:

"Any assault, as defined in ORS chapter 163, of a child and any physical injury to a child which has been caused by other than accidental means, including any injury which appears to be at variance with the explanation given of the injury." This does not include reasonable discipline unless the discipline results in assault or any of the following conditions:

- "Any mental injury to a child, which shall include only observable and substantial impairment of the child's mental or psychological ability to function caused by cruelty to the child, with due regard to the culture of the child;
- "Rape of a child, which includes but is not limited to rape, sodomy, unlawful sexual penetration and incest, as those acts are defined in ORS chapter 163;
- "Sexual abuse, as defined by ORS chapter 163;
- "Sexual exploitation;⁶⁷
- "Negligent treatment or maltreatment of a child, including but not limited to the failure to provide adequate food, clothing, shelter or medical care that is likely to endanger the health or welfare of the child;
- "Threatened harm to a child, which means subjecting a child to a substantial risk of harm to the child's health or welfare;
- "Buying or selling a person under 18 years of age as described in ORS 163.537."

Elder Abuse (persons 65-years of age or older)

Abuse in its various forms affects our society from children to the elderly. It is estimated that approximately 2.5 million older people are abused each year; however, only about 10% of the cases are reported. Elderly victims of abuse "often have low self-esteem, blame themselves for the abuse, and do not want to admit their vulnerabilities or betray their families," and are usually abused by those with whom they live.⁶⁸ Neglect of, or ridicule toward, an elderly person can frequently be an indicator of elder abuse.

Comparatively, the definitions of abuse for older people are very similar to those for children. As with child abuse, chiropractors have a legal and ethical obligation to report any suspected elder abuse⁶⁹ with confidentiality "to the local office of the Senior and Disabled Services Division or to a law enforcement agency within the county where the person making the report is located at the time of contact."⁷⁰ They may not be sued for such reporting.⁷¹

Section 7

BOUNDARY ISSUES IN THE PATIENT-DOCTOR RELATIONSHIP

Across time and culture there has been recognition of the exceptional power given to physicians by patients and the potential for misuse of that power. A chiropractor, as a fiduciary, provides help and care for the patient.⁷² The patient is protected from abuses of power by the ethics and character of the chiropractor and the prescribed boundaries and roles that define professional behavior.

Boundaries define the expected psychological, physical and social distance between patients and practitioners. They are derived from ethical treatise, cultural morality and jurisprudence.⁷³ Boundaries form protection for the patient so that professional care occurs safely within the unique form of social intimacy of the patient-doctor relationship. Specific to this relationship, “The health and welfare of the patient shall always be the first priority of Chiropractic physicians.”¹⁶

Unprofessional conduct by a chiropractic physician, includes, but is not limited to: “Engaging in any conduct or verbal behavior with or towards a patient that may be reasonably interpreted by the patient as sexual, seductive or demeaning;”⁷⁴ proof of actual injury need not be established.”⁷⁴

Patients who are in pain or who are ill are vulnerable to psychological regression. Transferential dynamics are common in clinical encounters where patients are dependent and physically and emotionally more vulnerable. It is common for patients to be emotionally and/or physically attracted to professionals who care for them. When alerted, physicians should take extra steps to define or clarify the professional relationship. “The chiropractor is the one who must recognize and set the boundaries between the care and compassion appropriate to the chiropractic treatment and the emotional responses that may lead to sexual misconduct.”⁷⁵ The power differential inherent in the patient–doctor relationship makes true consent to sexual contact by the patient impossible.^{72,76}

With the exception of pre-existing consensual relationships, it is clearly unethical to have sexual contact or a romantic relationship with a patient concurrent with the patient-doctor relationship.^{70,76-91} There is a range of opinions with respect to the ability of the patient-doctor relationship to change after care has ended. Some suggest a sexual relationship may never be appropriate⁷⁰, while others indicate an interim period ranging from three months to one year between termination and initiation of a personal intimate relationship.^{77,81}

Even those authorities who indicate that sexual or romantic relationships with former patients may be ethical, prohibit the physician from the following:

- using or exploiting trust, knowledge, or influence of emotions derived from the previous professional relationship;
- using privileged information to meet their personal or sexual needs; and
- abusing authority or power derived from the previous professional relationship.^{74,86}

Where there may be a question as to the status of the patient, i.e. current or former, some licensing boards have chosen to adopt more subjective criteria to determine if sexual misconduct

has occurred. Following are some of the areas of consideration likely to be evaluated by a licensing board to determine the current status of the patient:

- evidence of termination procedures;^{73,74}
- circumstances of cessation or termination;^{74,92}
- time passage since therapy termination;^{74,92}
- nature and duration of therapy;^{73,74,92}
- former client's personal history and/or current mental status;⁹²
- statements and/or actions made by the physician during the course of care suggesting or inviting the possibility of a post termination relationship;⁹²
- likelihood of adverse impact on the person and/or others;⁹²
- transfer of patient's care to another physician;⁷⁴
- the nature of the patient's chiropractic problem;⁷⁴
- extent to which the patient has confided personal and/or private information to the chiropractor;⁷⁴
- degree of emotional dependence on the chiropractor;⁷⁴
- extent of chiropractor's knowledge about the patient;⁷⁴
- any other relevant information.⁷³

Consequences of sexual misconduct for patients of health care professionals have been documented to include:

- distrust and anger toward physicians;
- delays in seeking health care;
- increased depression, shame, guilt;
- psychosomatic symptoms;
- post-traumatic stress disorder (panic attacks, flashbacks, extreme guilt and self-destructive feelings).^{81,93}

Consequences of sexual misconduct extend beyond the patient to potentially affect the patient's family, the doctor's family, the doctor's staff, other patients, the community and the profession.⁸¹ Consequences of sexual misconduct for the chiropractor may include Board sanctions such as license suspension or revocation, probation, chaperone requirements and mandated counseling. Additionally, civil suits or criminal prosecution, extortion or retaliation are possible consequences of unprofessional conduct.

See Appendix C for strategies that may prevent boundary violations and/or allegations of sexual misconduct.

Section 8

THE PATIENT-DOCTOR RELATIONSHIP AND INDEPENDENT EXAMINATIONS

Independent and second opinion examinations are isolated chiropractic evaluations of an individual's health performed by a physician not involved in that person's care.^{94,95} When performed by a chiropractic physician, these may be referred to as IMEs (independent medical examinations) or ICEs (independent chiropractic examinations). All independent examinations performed by a chiropractor to determine the need for chiropractic care shall include a functional chiropractic analysis.⁹⁶ Some combination of the following of the PARTS exam constitutes a functional chiropractic analysis:

- P** Location, quality, and intensity of pain or tenderness produced by palpation and pressure over specific structures and soft tissues;
- A** Asymmetry of sectional or segmental components identified by static palpation;
- R** The decrease or loss of specific movements (active, passive, and accessory);
- T** Tone, texture, and temperature change in specific soft tissues identified through palpation;
- S** Use of special tests or procedures.⁹⁷

In the context of independent examinations the use of an investigational procedure is considered inappropriate.

These types of evaluations may be ordered by treating physicians, employers, patients and their attorneys, insurers, disability management companies and managed care organizations, workers compensation boards, and other entities that make determinations about disability and impairment.⁹⁵ An independent examination may be performed at various stages of an injury or illness and is generally utilized to clarify health and/or job issues.⁹⁵

At the outset of the examination, prior to gathering health information, the examining physician should ensure to the extent possible that the patient understands the ethical obligations of the physician to perform an impartial evaluation. The examiner also explains the differences between the role of independent examiner and the traditional fiduciary role of the physician. The examiner should explain who has requested the examination.

In an independent examination, the patient-doctor relationship is limited because the examiner does not monitor the patient's health over time, provide treatment or fulfill many duties traditionally performed by physicians.⁹⁴ Despite the limited relationship, important health information, diagnosis and treatment recommendations shall be made available to the patient, treating doctor, and patient's legal counsel or guardian via the independent report.^{98,99} Upon request, a copy of the independent report shall be made available to the patient, the treating doctor, and/or the patient's legal guardian.^{98,99}

Section 9

TERMINATION OF THE PATIENT-DOCTOR RELATIONSHIP

Once the patient-doctor relationship has been established, it may be terminated by either party.

Patient Termination

The most common way for patients to end the relationship is their recovery from the condition for which they were receiving chiropractic care.¹⁰⁰ Another way the patient may terminate the relationship is to discharge the physician at any time.¹⁰⁰ If at the time of termination by the patient, it is the opinion of the treating physician that the condition requires further care, it is suggested that the physician notify the patient. This should be documented by the physician.

Physician Termination

Physicians may terminate the patient-doctor relationship at their discretion, but must not abandon the patient. The patient must be given reasonable notice,¹⁶ preferably in writing. By sending the notice "return receipt requested" the physician will have the assurance that the patient was notified. The patient must also be given reasonable time to locate another physician. The courts have held that once a physician has agreed to treat a patient a physician cannot cease his treatment except, first with the consent of the patient, or secondly upon giving the patient time and notice so that he may employ another doctor or thirdly when the condition of the patient is such that medical treatment is no longer required.¹⁰⁰

Abandonment

Abandonment has been defined as "the unilateral severance by the physician of the physician-patient relationship" without reasonable notice, at a time when there is still the necessity of continuing medical attention.¹⁰⁰ Abandonment involves intent on the part of the physician to improperly terminate the patient-doctor relationship.¹⁰⁰ Examples of abandonment include:

- the physician fails to provide adequate withdrawal notice to the patient;
- the physician fails to see a patient within a clinically indicated timeframe;
- the physician withdraws from a patient case without making arrangements for continued care for lack of payment or any other reason.

Physician Substitution/Referral

Physicians are entitled to reasonable time away from their practices as long as arrangements are made for a competent, licensed substitute. Notice must be given to the patient of the substitution, as the patient may prefer to consult with a doctor other than the substitute.¹⁰⁰ If notice is not given and the patient's condition suffers an adverse effect the physician may be held to have abandoned the patient.¹⁰⁰ If the substitute is an "employee" of the physician, standard rules of vicarious liability may apply. If the substitute is unqualified or incompetent the physician may also be liable for the substitute's negligence. In multi-physician practices where each physician sees the others' patients on a rotating basis, none of the physicians can be held to have abandoned a patient if another member of the group or partnership has seen that patient.¹⁰⁰ When a physician refers a patient to a second physician, the referring physician cannot be held liable for abandonment as long as due care is used in selecting the second physician.¹⁰⁰ This referral should be documented by the referring physician

Physicians have the right to make reasonable limitations on their practice.¹⁰⁰ Physicians are not legally obligated to treat any patient beyond the chosen limitations of their practice. In such circumstances, referral to another physician does not constitute abandonment.¹⁰⁰

Section 10

PATIENT-DOCTOR RELATIONSHIP STANDARDS

1. Informed Consent

The patient has the right to informed consent regarding procedures, risks and alternatives, and answers to questions with respect to treatment, in terms that they can be reasonably expected to understand. In order to obtain the informed consent of a patient, the chiropractic physician shall explain the following:

- (a) In general terms the procedure or treatment to be undertaken;
- (b) That there may be alternative procedures or methods of treatment, if any; and
- (c) That there are risks, if any, to the procedure or treatment.²⁸ (Legal Type 1)

2. Patient Confidentiality

The patient has the right to expect that all communications and records pertaining to their care will be treated as confidential.^{19,39,40-43,45} The chiropractor shall preserve a patient's medical records from disclosure and will release specific records only on a patient's written consent stating to whom the records are being released or as required by State or Federal law.³⁸ (Legal Type 1)

3. Abandonment

The patient has the right to continuity of care once the doctor has agreed to treat the patient. The chiropractor may terminate the patient-doctor relationship only when the patient has been given reasonable notice.¹⁶ (Legal Type 1)

4. Patient-Doctor Boundaries

With the exception of pre-existing consensual sexual relationships, it is clearly unethical to have sexual contact or a romantic relationship with a patient concurrent with the patient-doctor relationship. Chiropractors shall not engage in any conduct or verbal behavior with or towards a patient that may be reasonably interpreted by the patient as sexual, seductive or demeaning.^{72,73,77-90} (Legal Type 1)

5. Independent Medical Examinations

All independent and second opinion examinations performed by a chiropractor to determine the need for chiropractic care shall include a functional chiropractic analysis.⁹⁶ A copy of the independent report shall be made available, upon request, to the patient, the patient's attorney and the treating doctor.⁹⁹ All independent and second opinion examiners have an ethical obligation to perform an impartial examination. (Legal Type 1)

6. Child and Elder Abuse Reporting

Chiropractors must report child abuse and elder abuse to the appropriate officials.^{63,69} (Legal Type 1)

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APPENDIX A

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

Oregon Revised Statute 192.525, 1997

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization.

I authorize _____ (name of hospital/health care provider) to release a copy of the medical information for _____ (name of patient) to _____ (name and address of recipient).

The information will be used on my behalf for the following purpose(s):

By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist:

- All hospital records (including nursing records and progress notes)
- Transcribed hospital reports
- Medical records needed for continuity of care
- Most recent five year history
- Laboratory reports
- Pathology reports
- Diagnostic imaging reports
- Clinician office chart notes
- Dental records
- Physical therapy records
- Emergency and urgency care records
- Billing statements
- Other

Please send the entire medical record (all information) to the above named recipient. The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

- *HIV/AIDS-related records
- *Mental health information
- *Genetic testing information

*Must be initialed to be included in other documents.

___ **Drug/alcohol diagnosis, treatment or referral information:

**Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed.

___ This authorization is limited to the following treatment:

___ This authorization is limited to the following time period:

___ This authorization is limited to a worker's compensation claim for injuries of _____ (date).

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

(Date)

(Signature of patient)

(Date)

(Signature of person authorized by law)

APPENDIX B

PRACTICE TIPS FOR IDENTIFYING AND TREATING THE ABUSED PATIENT

DOMESTIC VIOLENCE

Victim Barriers to Terminating or Disclosing Abusive Relationships

There are many reasons why victims don't report and/or terminate abusive relationships. Such barriers may include the following:

- shame, humiliation, embarrassment;⁴⁸⁻⁵¹
- psychological repression, poor self-esteem/self-image;^{48,50,52}
- fear of reprisal, retribution, repercussions, e.g. threats to kill or harm children, family, friends, etc.;^{48, 49, 51-54}
- fear of abandonment,⁴⁹ poverty/economic concerns^{48,50,52,54} loneliness,⁵² the unknown;⁵²
- fear of not being believed;⁵²
- legal consequences;^{49,50,52}
- religious traditions;^{48,50,52}
- cultural: social, family, marital expectations;^{48,50-52}
- feel protective of partner;⁵¹
- thinks the doctor does not know or care about or can help with domestic violence;⁵¹
- thinks the doctor is too busy;⁵¹
- alcohol or drug problems;⁴⁹
- language barriers;⁵⁰

Physician Barriers To Screening For/Identifying Domestic Violence

Health care providers identify several reasons why they are reluctant to ask patients about domestic violence. Such barriers to screening/identifying domestic violence may include the following:

- lack of knowledge and training,^{48,51,54} unprepared to respond;^{48,51}
- because of the clinical presentation, patients may appear to be neurotic or hypochondriacs;⁴⁸
- discomfort due to own feelings and reactions to a disclosure of abuse;⁴⁸
- misconceptions such as abuse is rare,⁴⁸ private,^{48,51} the battered victim's fault,^{48,51}
- opening up a "can of worms" or "Pandora's box;"^{48,51,54}
- fear of offending the patient;^{49,51,54,57}
- inability to "fix" abusive relationships;^{49,51}
- time constraints/lack of time to deal with the problem;^{49,51,54,57}
- personal bias against women in international community,⁵⁰ racial prejudice;^{50,54}
- sexism;^{50,54}
- frustration with outcome, don't think it will help and "she'll just go back to him;"^{51,57}
- physicians' beliefs or values about abuse;⁵⁴
- loss of control or feelings of powerlessness;⁵⁴
- belief that a victim can leave if he/she just wants to;⁵¹
- knowing the assailant and not believing he is capable of abuse.⁵¹

Patterns of Abuse

There is no single model which can describe all domestic violence patterns.⁴⁸ However, it is useful to consider the following models to conceptualize the abuse process in women.

One model describes a cycle of violence in phases where phase one begins with a minor battering/assault which gradually increases tension in the relationship. The victim may try to decrease the tension but is largely unsuccessful.⁴⁸ Phase two involves a discharge of building tension resulting in an acute battering incident which may be met with disbelief or denial and is dismissed by the victim as an isolated incident. Subsequent episodes are met with shock, rationalization, self blame, denial and repression.⁴⁸ Phase three is often referred to as the "honeymoon phase"⁴⁸ where the abuser expresses remorse, exhibits attentiveness, reaffirms love and promises it will never happen again.^{48,57} This is done mostly out of fear of being caught.⁴⁸ There is not always a honeymoon phase.⁴⁸

Another model highlights the roles of violence and withdrawal where some lesser degree of violence creates emotional withdrawal in the attacked partner. The abuser may be met with withdrawal the next time upset, needy or in want of support. This in turn provokes a more violent attack, which is followed by further withdrawal and/or fear. The escalating cycle of neediness is met with increasing withdrawal until the violence becomes severe.⁵⁸

In addition to the physical violence, emotional abuse always accompanies and typically precedes physical violence.⁴⁸ This cycle of violence is repetitive, escalates in severity and frequency^{48,49,57,58} and is used to gain compliance or control over the victim.⁵¹

Profile of the Abuser

Battering and abuse are learned behaviors that result from being personally abused or witnessing abuse.^{48,51} Abusers may be characterized by any or all of the following:

- extreme jealousy and possessiveness;⁴⁸
- inefficient coping skills;⁴⁸
- thinking they are unique and don't have to follow rules;⁴⁸
- justifying behavior with excuses blaming others for causing their behavior;⁴⁸
- viewing others as holding them back from being successful;⁴⁸
- minimizing abuse as part of avoiding responsibility for violent actions;⁴⁸
- having trouble experiencing close, satisfying relationships with others;⁴⁸
- substituting drama and excitement for closeness;⁴⁸
- being secretive, closed minded, self righteous;⁴⁸
- seeking to gain power and control;^{48,54,57}
- fragmentation (Dr. Jekyll and Mr. Hyde) using a public face that is childlike, dependent, insecure, charming, affectionate, seductive or manipulative;⁴⁸
- alcohol use or abuse involved^{48,49,52,54-57} but not established as causal.^{48,52}

Women at Increased Risk for Domestic Violence

There is no specific highly predictive profile of women at increased risk for domestic violence; however, following are some generalizations about vulnerabilities:

- witness or experience family violence as a child or adolescent;^{48,49,51,57} however, the majority did not grow up in abusive homes;⁴⁸
- under 35 years of age;^{49,54,57}
- refugee, migrant^{50,54} living in rural or remote areas,⁵⁰ homebound;⁵⁰
- conflicting evidence about minorities being more vulnerable;^{50,57}
- lower socioeconomic status^{50,54,57} or education;⁴⁹
- pregnancy;⁵⁷
- mental illness, physical disabilities;⁵⁴
- unmarried;⁴⁹
- unmarried couple living together;⁵⁸
- wives in marriages where their education or occupation level is higher than their spouse;⁵¹
- mixed marriages (religion or race);⁵¹
- history of alcohol abuse by male partner;⁵⁴
- recently separated or divorced.⁵⁷

Presentation

The majority of domestic violence presentations are not "injuries," but are seen for non-traumatic diagnoses.^{48,51,54} Chiropractors should be aware that chronic pain^{51,52,56,57} or back pain itself⁴⁸ may be the result of domestic violence. Other clinical findings that may suggest need for further investigation include the following:

1. Injuries

- explanation for injuries does not fit injuries observed;^{48,49,51,56}
- multiple injuries in various stages of repair;^{48,51,52}
- assaultive trauma, most commonly head, face, neck and areas covered by clothing; mandibular fractures; facial fractures; trunk trauma; blows to abdomen or other areas; other blunt trauma or injuries suggestive of defensive posturing like forearm fractures;^{49,51,52,56,58}
- "accident prone" history.^{51,52}

2. Pain
 - chronic pain; ^{51,52,56,57}
 - back pain; ⁴⁸
 - chest pain; ^{48,51,52,57}
 - pain from diffuse trauma without visible evidence. ⁵²

3. Somatic Complaints
 - headaches; ^{48,51,52,57}
 - choking sensation; ⁴⁸
 - hyperventilation; ^{48,57}
 - gastrointestinal symptoms; ^{48,51,52,57}
 - sexual dysfunction; ⁵²
 - neurologic concerns, syncope, ⁵⁷ paresthesias, ⁵¹ dizziness; ^{51,52}
 - palpitations; ^{51,52,57}
 - chronic non-specific medical complaints often presumed to be psychosomatic; ^{48,51,57}
 - sleep disturbance, e.g. insomnia; ^{48,51,52,57}
 - fatigue, decreased energy, difficulty concentrating; ^{51,52}
 - dyspnea; ^{51,52}
 - upper respiratory tract infections, bronchitis; ^{54,56}
 - poor control of diabetes, hypertension, heart disease. ⁵¹

4. Obstetric, Gynecologic Problems
 - miscarriages; ^{48,49,52,57}
 - injured pregnant woman ^{49,51,52,57} or fetus; ^{51,57}
 - register late ^{49,52,57} or no prenatal care; ⁵¹
 - pre-term labor; ^{49,51,52}
 - low birth weight infants; ^{49,57}
 - spontaneous abortions; ^{51,52}
 - frequent urinary tract infections or vaginitis; ⁵²
 - dyspareunia; ⁵²
 - pelvic pain; ^{48,51,52}
 - injuries to breasts, abdomen or genitals; ⁵²
 - substance abuse, poor nutrition and/or inadequate weight gain during pregnancy. ⁵²

5. Emotional and Behavioral or Psychological Sequelae of Violence
 - depression; ^{48,49,51-53,57}
 - suicide attempts; ^{48,49,51,52,56,58}
 - anxiety; ^{48,51,52,57}
 - mental illness; ⁴⁸
 - inability to cope; ⁵²
 - nervous behavior, lack of eye contact, worrying about staying too long in office, frequent comments that she has to check with her partner, comments that partner is jealous, financial dependence, shy, frightened, embarrassed, noncompliant, evasive, passive, cries; ⁴⁸
 - poor self-esteem, social isolation; ^{48,52}
 - hovering (batterer accompanies victim to monitor what is said); ⁴⁸
 - post-traumatic stress reactions/disorder; ^{49,52,57,58}
 - panic disorders; ^{51,52}
 - eating disorders; ^{51,52,57}
 - drugs and alcohol abuse. ^{48,49,51-53,56-58}

6. Other
 - more likely to be prescribed analgesics, minor tranquilizers ^{48,52,57} and antidepressants; ⁴⁸
 - multiple visits ⁵⁶ or frequent visits without physiologic abnormality; ⁵²
 - long term disability from injuries; ⁵⁸
 - homelessness or welfare. ⁵⁸

Screening and Identification

Physicians routinely screen for problems less prevalent than domestic violence, and yet routine screening for domestic violence is rarely practiced.^{48,49,53} This is especially true in the primary care setting where it is estimated that less than 10% of primary care physicians routinely screen for domestic violence during a regular office visit.⁵³ Battery is so prevalent that physicians in an entry-level health care system have an ethical obligation to consider abuse as a possibility in their evaluation of female patients.^{48,52} Screening is simply asking the patient a few direct questions. The goal of screening is not for the physician to “fix” the problem but to identify the abuse and provide appropriate education, support, and referrals, and to acknowledge and validate the situation as real and dangerous.^{48,52} Before initiating any discussions about domestic violence, the physician must put the patient in a position to disclose this information safely and confidentially (without partner and/or children present).^{48,51,54-57} The FAMILY VIOLENCE PREVENTION FUND recommends screening begin as early as age 14.⁵³ It is recommended that all female patients are screened whether signs or symptoms are present or not and whether abuse is suspected or not.

Battered women/victims favor routine questions about domestic violence and expect their physicians to initiate discussions about it.^{48,49} While many find it difficult to volunteer the information, most women are willing to discuss issues about violence if specifically asked. Questions should be direct, sensitive, empathetic, nonjudgmental and asked in a confidential setting.^{48-50,52,57} It is recommended that direct questions about abuse be included in the routine history^{49,52,57} as no one can be excluded from screening.⁵⁶ This is because the prevalence is so high,^{49,54,56} the prevalence of undetected cases is high,^{48,49,57} and there is no, or low, positive predictive presentations for the presence of domestic violence.^{48,52,54,57} In addition, screening for abuse should be considered for each new complaint or when the patient has a new intimate partner.⁵³

Phrasing Questions

An easy way to introduce the topic is a statement such as “Because violence is so common, I’ve begun to ask about it routinely” or “I’ve begun to ask all my patients about it.”^{52,53} This may then be followed by one of the following or similar questions:

- “Are you in a relationship with a person who physically hurts or threatens you?”⁵³
- “Have you been hit, kicked, punched or otherwise hurt by someone in the past year?”^{52,53,58} If so, by whom?”⁵⁴
- “At anytime has your partner or anyone at home hit, hurt or frightened you?”⁵³

Patient Denies Abuse or Does Not Want To Discuss The Topic

When patients’ deny abuse or are reluctant to discuss the topic, they should not be badgered.^{48,54} Providing a list of local programs presents a less threatening resource than face to face confrontation while still providing support for the patient.^{52,54} It is appropriate, however, to make further inquiries with more specific questions when the patient answers “no” or will not discuss the topic if there are signs and/or symptoms strongly indicating abuse.⁵² Some examples of this follow:

- “It looks as though someone may have hurt you. Could you tell me what happened?”⁵²
- “Sometimes when people come for healthcare with physical symptoms like yours, we find that there may be trouble at home. We are concerned that someone is hurting or abusing you. Is this happening?”⁵²
- “Sometimes when people feel the way you do, it’s because they may have been hurt or abused at home. Is this happening to you?”⁵²

Patient Acknowledges Abuse or Wants To Discuss the Topic

When the patient acknowledges abuse or wants to discuss the topic, it is important to listen non-judgmentally^{51,52,54} and assure the patient that the disclosure is confidential.^{48,53} In addition, validation^{48,52,54,57} of their position with any of the following statements provides further support:

- “No one deserves to be hurt or threatened with violence.” (The most important and easily provided intervention is this simple message.)^{48,54}
- “You are not to blame for the behavior of the perpetrator.”⁵⁴
- “You are not alone.”⁵²
- “You aren’t crazy.”⁵²
- “What happened to you is wrong.”⁵²
- “Help is available.”⁵²
- “I have treated others with this problem and am comfortable dealing with it.”⁵²

It is important to educate the patient^{48,49,54,57} about the escalating cycle of abuse (nature and course)^{48,49,57} which not only produces serious medical problems^{48,57} but is also a criminal act^{48,54} for which there are protective service agencies and legal assistance, e.g. civil protection orders/restraining orders, criminal prosecution, civil litigation, etc.^{49-52,54,55,57}

Legible, accurate, detailed and complete documentation by the physician is invaluable for legal purposes.^{51,52,54} This may provide the only evidence that abuse has taken place⁵¹ and improves the likelihood of successful prosecution.⁵⁴ Good records also frequently substitute for personal appearance by the physician in a legal setting.⁵⁷ It may be reasonable to establish a “confidential” file set for domestic violence cases in order to further limit access and protect the confidentiality of the patient. Along with the medical information, the file should include the arrival date and time, name, address, phone number of anyone with the victim and the address where the incident occurred.⁵² It is appropriate to begin with an all inclusive medical, trauma and relevant social history,⁵² in addition to a history of the incident using the patient’s own words^{48,51,52,54} with modifiers such as “the patient states...”^{48,51} when possible. A list of complaints and symptoms^{52,55} should be obtained and a complete physical examination including neurological examination, radiographic evaluation, and rape assessment,⁵² should be performed. If any special services aren’t available in the physician’s office, referral to an appropriate facility for documentation is indicated. (See Appendix D) Body diagrams/maps^{48,49,54} may be useful for documenting a detailed description of the injuries including extent,⁴⁸ resolution/acuity,^{48,52} measurements/size,^{48,52} type, number, and location.⁵² Results of laboratory testing, diagnostic imaging or other diagnostic procedures should be included in the chart. The physician should document whether the injuries are consistent with the patient’s explanation.⁵²

If possible, photographs should also be included because they are particularly valuable as evidence.⁵⁴ Prior to taking photographs, written informed consent should be obtained^{48,52,58} in addition to having a female chaperone present.⁴⁸ If available, a digital camera has the greatest versatility for documenting visible injuries. Two views of each injury should be taken, including a measuring device^{51,52} and at least one picture with the patient’s face for identification.^{51,52} The photographs should be marked with the following information: name of patient, photographer, witnesses,^{51,52} time,^{48,52} place,⁴⁸ chart/record number,⁵¹ and date and signature of the photographer.^{48,58} The photographs should be placed in a sealed envelope with the patient’s name and social security number and put in a safe place.⁴⁸ If a standard camera is used, label the films and keep secure until developed⁵¹ at which time 2-3 copies should be made.

If the police are involved, the investigating officer and any action taken should be documented if possible.⁵² The police should only be called with the patient’s documented consent; however, there are some exceptions where reporting is mandatory, which include the following:

- If there is evidence of injury by gunshot, knife or other deadly weapon.^{51,55,57,58}
- Child abuse, elder abuse or neglect.^{62,69}
- Where there is a duty to protect a potential third party victim from danger.^{48,51,52,55} According to the *Tarasoff* case of 1976, if it is determined the patient presents a serious danger of violence to another, the health care provider is obliged to use reasonable care to protect the intended victim against such danger via notification of the intended victim, notification of the police or taking whatever steps reasonably necessary under the circumstances. Sixteen states have adopted *Tarasoff* limiting statutes, which only require reporting when there is an explicit threat made.⁵⁵ “In Oregon, the duty to warn is **not** clear. In the case of possible domestic violence, the physician, **upon advice of legal counsel**, should err on the side of caution and warn the at-risk spouse or partner.”⁵²

It is very important to include an assessment of the patient’s danger and fear.^{48,51,52,54,57,58} To evaluate the patient’s level and immediacy of danger, it may be helpful to ask some further questions,⁴⁸ as the most critical components of assessment are the patient’s level of fear and appraisal of immediate and future safety.⁵² Following are some questions that may provide further insight to the patient’s position:

- “Are you in immediate danger?” “What do you think will happen when you go home?”^{48,54} (This is one of the most important questions: “Is it safe to go home?”⁵¹)
- “Is another violent attack imminent?”⁴⁸
- “How frequent and severe are the attacks?”^{48,51} “Are they escalating?”^{51,52}
- “Do they have a firearm or deadly weapon?”^{48,51,52,54}
- “Is there a history of violent behavior outside the home⁵¹ or history of violent acts or threats using a weapon?”^{51,58}
- “Have they threatened to kill you^{48,51,52} or you them?”^{48,51}
- “Is there drug or alcohol use?”^{48,51,58} as this makes behavior less predictable.⁴⁸

- “Have there been threats to children?”^{48,52,54,58}
- “Are you, or a partner, threatening suicide and if so, is there a suicide plan?” If so, the situation is urgent.^{48,51,52}
- “Are there forced unwanted types of sex or refusing to use birth control?”⁵³
- “Is there humiliation, swearing, name calling, mental instability, obsession with victim,^{51,58} drug/alcohol use or abuse?”⁵⁸
- “Are there threats to injure self or patient,⁵² reporting to immigration or stalking?”⁵⁸
- “Is there isolation which includes controlling access to friends and family and limiting outside involvement?”^{51,53,58}
- “Has there been destructive behavior such as destroying patient’s property, injuring pets of patient or child?”⁵⁸
- “Does the abusive partner control all the money?”^{51,58}

Appropriate treatment for the patient’s injuries should be provided⁵² as well as appropriate referrals for support. (See Appendix D) In addition, it is important to discuss alternatives in a safe place,^{51,56,57} giving the patient an opportunity to decrease the sense of isolation and lack of power.⁵⁷ The patient may or may not be in immediate danger and may or may not want access to a shelter. Based on these criteria, additional decision-making and appropriate action may proceed.

If the patient is in immediate danger, it should be determined if there are family or friends to stay with⁵⁰⁻⁵² or if immediate access to a shelter^{51,52,57} or police contact is wanted.^{52,54} An opportunity should also be given to use a private phone to assist with any/all of the above.⁵²

If there is no immediate danger or the patient doesn’t want immediate access to a shelter, the chiropractor may offer written information about shelters and other community resources^{48-52,54,55,57} or instructions how to find this information in the phone book.⁴⁸ Shelters and affiliated agency referrals should be made carefully and only to those dedicated to assisting battered women.⁴⁸ Affiliated agencies and community resources may include the following: children’s services, counseling, legal and employment services⁵⁴ and law enforcement.^{50,51} With respect to legal needs, possibilities are criminal prosecution, civil litigation,^{52,57} civil protection/restraining orders,^{51,52, 57} temporary custody, and mandatory payment of rent or mortgage.⁵⁴ It is important to remember that written information may be dangerous for the patient to possess.^{48,52} The patient should not be forced to take written information. The number of a local hotline or other information may be most safely given on a prescription blank or appointment card.⁵²

The victim should be assisted in developing a safety plan^{48,50-52,54,57,58} with which they can prepare for future situations as well as make judgments about the safety of their current situation. This should be an ongoing process where questions such as “Is it safe to go home?”^{48,51,54} can help the victim to regularly assess their safety status. Identification of potentially dangerous situations and appropriate responses increase the preparation and safety when or if the risk of violence increases.^{48,50} Options should include planning for immediate relocation to a shelter⁵⁷ and/or seeking shelter and financial help from family and friends.⁵⁰⁻⁵² If possible, three options should be included for emergencies where shelters may be full, family and friends are out of town, etc. Victims should be given information directly and/or made aware of how to access available resource numbers for assistance.^{48-52,54,55,57} A packed overnight bag⁵⁷ or “flight kit” which may be an unused suitcase placed in a well-hidden area⁵² should include as many of the following items as possible: enough money to get started, clothing, medicine, address book, car/house keys, valuables, books, children’s toys, papers (social security card, health insurance information, birth certificates, driver’s license, restraining order, etc.).⁵⁸

In the case where no apparent emergent situation exists and the patient is returning home, a follow up appointment should be scheduled.⁴⁸

Despite the limited and imperfect options for detecting and intervening in domestic violence situations, the benefits are substantial for families in which the cycle of abuse is interrupted.⁴⁹ Patients should not leave the health care facility without knowing that battering is a crime and there is help in the judicial system.⁵⁴ It would be useful for the physician to be familiar with, or help develop, a network with physicians, and community referral resources (shelters, legal services, law enforcement, district attorney’s office, etc.) as this can be extremely effective in developing a coordinated response to meet the complex needs of battered women.⁵¹

Educational Materials for the Health Care Providers

Chiropractors can increase public awareness about domestic violence,^{48,57} show willingness to discuss the topic,⁴⁸ and help women understand the problem⁵⁰ by having pamphlets, posters, etc. in the office. This is an important form of intervention and prevention.⁵⁷ There should be materials from community resources relating to domestic violence in the waiting room, examination room, female restrooms and other strategic locations.^{49,51,57} It is also

important to support culturally sensitive publications in different languages for women in the international community as it is more difficult for them due to cultural, religious, social, family, legal and immigration reasons.⁵⁰

Child Abuse

The various forms of abuse have potential physical and behavioral indicators.⁶²

(A) Physical abuse, possible physical indicators;

- bruises and welts on the body;
- bruises and welts reflecting the shape of an object used (electrical chord, belt buckle);
- various types of burns (cigarette, rope, etc.);
- laceration;
- fractures.

Physical abuse, possible behavioral indicators:

- wary of adult contacts;
- apprehensive when other children cry;
- behavioral extremes;
- frightened of parents;
- afraid to go home.

(B) Neglect, possible physical indicators:

- consistent hunger, poor hygiene, inappropriate dress;
- consistent lack of supervision;
- unattended physical and/or emotional problems or medical needs.

Neglect, possible behavioral indicators:

- begging, stealing food;
- extended stays at school;
- poor school performance;
- fatigue;
- alcohol or drug abuse;
- delinquency.

(C) Mental injury or emotional maltreatment, possible physical indicators:

- failure to grow;
- speech or sleep disorders;
- forced to dress in "opposite sex" clothing.

Mental injury or emotional maltreatment, possible behavioral indicators:

- behavior extremes: aggression or withdrawal;
- habit disorders (sucking, biting, rocking);
- attempted suicide;
- conduct disorders (antisocial, runaway, destructive behavior);
- emotionally needy.

(D) Sexual abuse, possible physical indicators:

- difficulty in walking or sitting;
- pain or itching in the genital area;
- bruises, bleeding or infection in external genital area;
- venereal disease;
- pregnancy.

Sexual abuse, possible behavioral indicators:

- withdrawal, fantasy or infantile behavior;
- poor peer relationships;
- delinquent or runaway;
- reports sexual assault (children seldom lie about sexual abuse);
- refer also to behavioral indicators of mental injury or emotional maltreatment.

Elder Abuse

Observations suggestive of elder maltreatment include:⁶⁸

(A) General

- absence of caregiver or abandonment;
- poor supervision;
- recent conflicts or crises;
- medication problems (duplications or unusual dosages);
- recurrent healthcare admissions or visits;
- delay in seeking care;
- unexplained injuries;
- inconsistent histories between patient and caregiver.

(B) Patient

- fearful of caregiver.

(C) Patient or caregiver

- depressed;
- reluctant to answer questions.

Physical indicators of elder abuse:⁶⁸

(A) Physical abuse

- unexplained bruises, wounds, burns, or other injuries;
- rope or restraint marks on wrists and/or ankles.

(B) Psychological abuse

- habit disorder (sucking, rocking);
- neurotic disorders (antisocial, borderline).

(C) Neglect

- dehydration or malnutrition;
- poor hygiene;
- inappropriate dress;
- unattended physical or medical needs.

APPENDIX C

STRATEGIES THAT MAY PREVENT BOUNDARY VIOLATIONS AND/OR ALLEGATIONS OF SEXUAL MISCONDUCT

A. Office Procedures

- provisions for chaperones as needed;
- provisions for patient modesty (privacy when disrobing, draping, etc);
- patient bill of rights;
- staff communication;
- staff availability near treatment rooms;
- consent to treat minors;
- documentation of incidents;
- follow-up/response to complaints;
- termination or referral of patients.

B. Staff Education

- sexual harassment policy;
- expectations regarding communication and behavior in the office;
- not discussing intimate subjects, personal problems or lives with patients;
- confidentiality;
- socializing with patients.

C. Self Assessment Tools to Analyze Risk

- Risk factor analysis (See Appendix E) ⁹¹
- The Exploitation Index: An early warning indicator of boundary violations in psychotherapy. (See Appendix F) ¹⁰¹

D. Access to Mentors or Second Opinions

Doctors are often isolated in practice. An experienced colleague or counselor can provide insight, and help with difficult and/or sensitive issues that arise in practice.

E. Patient Education/Orientation

- chaperone option offered to patient;
- query patients regarding their concerns;
- pamphlets, videotapes, report of findings, PARQ conference (see Section 3);
- clinic procedure regarding disrobing, gowning, and draping.

F. Identification of High Risk Situations for the Chiropractor

- attraction to a patient;
- personal relationship problems;
- times of emotional distress;
- substance abuse;
- burn-out.

G. Recognition of High Risk Patient Behaviors

- inappropriate gifts, cards or correspondence;
- inappropriate “personal” comments and questions;
- sexual innuendo and humor;
- seductive clothing or behavior;
- seeking inappropriate extended visits and/or care.

APPENDIX D

DOMESTIC VIOLENCE RESOURCES

NATIONWIDE DOMESTIC VIOLENCE 24-HOUR TOLL-FREE HOTLINE: 800-799-SAFE
TDD number for the hearing impaired: 800-787-3224 (non-English translators available)

ASHLAND

- Dunn House 541-779-4357

ASTORIA

- Clatsop County Women's Crisis Service 503-325-5735

BAKER CITY

- May Day, Inc. 541-523-4134

BEND

- Central Oregon Battering and Rape Alliance 541-389-7021 / 800-356-2369

BURNS

- Harney Helping Organization (HHOPE) 541-573-7176

COOS BAY

- Coos County Women's Crisis Center 800-448-8125

CORVALLIS

- Center Against Rape & Domestic Violence 800-927-0197

ENTERPRISE

- Safe Harbors 541-426-6565

EUGENE

- Family Shelter Network 541-689-7156
- Sexual Assault Support Services 541-343-7277 / 800-788-4727
- Womenspace 800-281-2800

FLORENCE

- Siuslaw Area Women's Center 541-997-2816

GRANTS PASS

- Women's Crisis Support Team 541-474-1400 / 800-750-9278

GRESHAM

- Gresham Police Domestic Violence Unit 503-618-2394

HILLSBORO

- Domestic Violence Resource Center 503-469-8620

HOOD RIVER

- Project Helping Hands Against Violence 541-386-6603

KLAMATH FALLS

- Klamath Crisis Center 800-452-3669

LAGRANDE

- Shelter from the Storm 541-963-9261

LAKEVIEW

- Crisis Intervention Center 800-338-7590

LINCOLN CITY

- Women's Violence Intervention Project 541-994-5959

MILL CITY

- Canyon Crisis Service 503-897-2327

MILWAUKIE

- Clackamas Women's Services 503-654-2288

MCMINNVILLE

- Henderson House 503-472-1503

ONTARIO

- Project Dove 541-889-2000

PENDLETON

- Domestic Violence Services 800-833-1161

PORTLAND

- La Linea de Crisis Para La Mujer 503-232-4448 / 800-556-2834
- Men's Resource Center and Women's Agenda Counseling 503-235-3433
- Multnomah County Mental Health Crisis Line 503-215-7082
- Portland Police Domestic Violence Reduction Unit 503-823-0961
- Portland Women's Crisis Line 503-235-5333
- Raphael House Of Portland 503-222-6222
- Salvation Army West Women's and Children's Shelter 503-224-7718
- Volunteers Of America Family Center 503-232-6562
- Yolanda House 503-977-7930
- Bradley-Angle House 503-281-2442
- Council For Prostitution Alternatives 503-282-1082

ROSEBURG

- Battered Person's Advocacy 800-464-6543

SALEM

- Mid-Valley Women's Crisis Service 503-399-7722

ST. HELENS

- Columbia County Women's Resource Center 503-397-6161

THE DALLES

- Haven From Domestic Violence 541-298-4789

TILLAMOOK

- Women's Crisis Center 800-992-1679

UMPQUA

- Lower Umpqua Victims' Services Day: 541-271-0261
Eve: 541-271-2109

VANCOUVER:

- YWCA Safechoice 360-695-0501

UPDATED 12/02

APPENDIX E

An Excerpt of Behind Closed Doors Gender, Sexuality, and Touch in the Doctor/Patient Relationship Angelica Redleaf with Susan A Baird

SEXUAL MISCONDUCT RISK FACTOR ANALYSIS

PURPOSE: The Risk Factor Analysis (RFA) is a tool that can be used to quickly evaluate your current risk level for sexual misconduct.

This questionnaire was created by Ben Benjamin, Ph.D., and Angelica Redleaf, D.C.; some portions are adapted from the article “Are You In Trouble With A Client?” by Estelle Disch, Ph.D., which appeared in *Massage Therapy Journal*, Summer 1992. Ben Benjamin is the director of the Muscular Therapy Institute in Cambridge, Mass. Estelle Disch has practiced for more than 20 years as a clinical sociologist and psychotherapist in Boston, Mass., and is the co-director of BASTA! (Boston Associates to Stop Therapy Abuse).

What is the Risk Factor Analysis?

The RFA asks very specific questions. Some are about stress you may be experiencing in your life or in your practice. Others are about attractions to patients, interactions with patients, and attitudes towards patients. The questions are based on typical kinds of doctor behaviors and attitudes.

The RFA is meant for you to keep to yourself. It can be taken again from time to time – for example, every six months – to give you a quick idea of your risk level. It can be used independently of the Practice Analysis, which includes more general questions about doctor and staff behavior and attitudes.

How does the RFA Differ from the Doctor Self-Analysis?

The RFA and the Doctor Self-Evaluation Questionnaire (DSE) both ask the practitioner to self-evaluate his or her level of risk. The DSE asks general questions about your behaviors, attitudes, skills, and attributes, and about your staff’s behaviors, skills, and attitudes. The RFA asks very specific questions that are designed to give you a quick idea of the level of risk you are incurring by practicing the way that you do.

By comparing your responses to both questionnaires, (see page 158) you will be able to gain a very clear picture of what *you think* about yourself as a practitioner, and of what *you think* about your staff. This information is a good start, but neither of these self-evaluations can see past your own blind spots.

The rest of the Practice Analysis will either confirm, challenge, or illuminate your ideas about yourself as a practitioner, and about your practice as a whole.

Instructions

Place a check-mark next to the number (1, 2, or 3) of each statement that applies to you. When you have completed the questionnaire, add up all of the numbers that are the same – i.e. add up all the number 1s on a page and write that number at the bottom of each sheet, then do the same for all the 2s and 3s on each sheet. Add up the totals for each number on the last page in the space provided. Directions for assessing your RFA numbers are on the next page.

At the end of the self-scoring section, there are guidelines for comparing your RFA results with the results of the Doctor Self-Evaluation and the rest of the Practice Analysis.

RISK FACTOR ANALYSIS QUESTIONNAIRE

1	I want this patient to like me.
1	I like it when my patients find me attractive. I keep this to myself.
2	Sometimes I schedule the patients that I really like last so that I can spend more time with them.
2	I am surprised by how much I anticipate this patient's visit.
2	I think about this patient frequently.
1	I have not been in a relationship in a long time.
1	I feel lonely much of the time, unless I'm working.
2	With certain patients I have trouble asking to be paid.
1	I talk about my personal life to my patients.
2	I find myself working weekends to accommodate a few patients I like.
1	Some of my patients rely on me a lot.
2	I feel as if I am under tremendous pressure.
1	I like it when my patients look up to me.
2	I feel like I have very little to give lately.
2	My relationship with my significant other(s) isn't meeting my needs.
3	I've sometimes touched patients in inappropriate ways.
3	I've had sex with patients.
3	I've had sex with patients in the office.
2	I dress particularly well when I know one or more of my patients has an appointment that day.
1	I fantasize about what it would be like to have sex with some of my patients.
2	I'm not charging one or more of the patients to whom I'm attracted.
2	I have some of my patients take off more of their clothes than they really need to remove.
2	I sometimes sneak looks as patients are undressing.
2	I believe it's okay to date my patients.
2	I sometimes tell dirty jokes to my patients.
2	I like doing treatments in those areas of patient's bodies that are close to their erogenous zones.
2	I compliment patients when I think they look nice.
1	This patient feels more like a friend.
2	I often tell my personal problems to one or more of my patients.
2	I feel sexually aroused by one or more of my patients.
3	I'm waiting to dismiss this patient so that we can become romantically involved.
2	To be honest, I think that good-by hugs last too long with one or more of my patients.
2	Appointments with one or more of my patients last longer than with others.
2	I tend to accept gifts or favors from this patient without examining why a gift was given.

Totals for this page:

1 _____ 2 _____ 3 _____

1	I feel totally comfortable socializing with patients.
1	I have a barter arrangement with one or more of my patients that is sometimes a source of tension.
3	I have had sexual contact with one or more of my patients.
2	I have attended professional or social events at which I knew that this patient would be present.
2	This patient often invites me to social events and I don't feel comfortable saying either yes or no.
2	Sometimes when I'm working on this patient, I feel like the contact is sexualized for myself and maybe for the patient.
2	There's something I like about being alone in the office with this patient when no one else is around.
2	I am tempted to lock the door when working with this patient.
3	This patient is very seductive and I don't always know how to handle it.
2	I have invited this patient to public or social events.
1	I find myself cajoling, teasing, joking a lot with this patient.
3	I allow this patient to comfort me.
3	Sometimes I feel like I'm in over my head with this patient.
2	I feel overly protective of this patient.
3	I sometimes have a drink or use some recreational drug with this patient.
3	I am doing more for this patient than I would for any other patient.
2	I find it difficult to keep from talking about this patient with other people who are close to me.
2	I find myself saying a lot about myself with this patient – telling stories, engaging in peer-like conversation.
3	If I were to list patients with whom I could envision myself in a sexual relationship, this patient would be on the list.
3	I call this patient a lot and go out of my way to meet with him/her in locations convenient to him/her.
2	This patient has spent time at my home.
3	I often tell my personal problems to this patient.
3	I enjoy exercising my power over some of my patients.
3	I'm going through a crisis at this point in my life.
2	Sometimes I'm afraid I might burn out.
3	I need someone to take care of <i>me</i> .
3	If a patient consents to sex, it's okay.

Totals for this page:

1 _____ 2 _____ 3 _____

Totals for both pages:

1 _____ 2 _____ 3 _____

The Risk Factor Analysis questionnaire is used with direct permission of Angelica Redleaf.

If you have checked off even one number 3: You are at risk. Know that you are a ticking time bomb who could potentially hurt yourself, your patient(s) and your profession! You would be very wise to get help from a therapist, consultant or significant other. You also should consider getting training in this area. Ignoring your high risk or attempting to get through this by yourself might be very unwise.

If you have checked off more than three number 2s: You have the potential for problems. The more number 2s you check off, the more your risk factor increases. You could use some help in getting yourself on track concerning professional boundaries.

If you checked off more than five number 1s: You may be overstepping your professional boundaries. You might not be in danger of overstepping them sexually, but you still could find yourself losing your effectiveness as a health provider. Be aware of your attitudes about patients, yourself, and your practice.

During times of stress and personal loss, we are more likely to overstep our professional boundaries. There are training sessions available that address the questions of boundaries and sexual misconduct, and there are therapists, mentors, friends, and colleagues who could help you at such times. Your risk is greatest when you attempt to go through such a transition all by yourself.

Redleaf A, Baird SA. Behind closed doors: gender, sexuality, and touch in the doctor/patient relationship. Westport, CT: Auburn House, 1998: 131-135.

APPENDIX F

THE EXPLOITATION INDEX

The Exploitation Index: Rate yourself according to the frequency that the following statements reflect your behavior, thoughts, or feelings with regard to any particular patients you have seen in psychotherapy within the past 2 years, by placing a check in the appropriate box. Approximate frequency as follows:

Rarely = about once a year or less Sometimes = about once every 3 months Often = once a month or more

Please give your immediate, “off the cuff” responses:

	Never	Rarely (Yearly)	Sometimes (Quarterly)	Often (Monthly)
1. Do you do any of the following for your family members or social acquaintances: prescribing medication, making diagnoses, offering psychodynamic explanation for their behaviors?				
2. Are you gratified by a sense of power when you are able to control a patient’s activity through advice, medication, or behavioral restraint? (e.g. hospitalization, seclusion)				
3. Do you find the chronic silence or tardiness of a patient a satisfying way of getting paid for doing nothing?				
4. Do you accept gifts or bequests from patients?				
5. Have you engaged in a personal relationship with patients after treatment was terminated?				
6. Do you touch your patients (exclude handshake)?				
7. Do you ever use information learned from patients, such as business tips or political information, for you own financial or career gain?				
8. Do you feel that you can obtain personal gratification by helping to develop your patient’s great potential for fame or unusual achievement?				
9. Do you feel a sense of excitement or longing when you think of a patient or anticipate her/his visit?				
10. Do you make exceptions for your patients, such as providing special scheduling or reducing fees, because you find the patient attractive, appealing or impressive?				
11. Do you ask your patient to do personal favors for you? (e.g. get you lunch, mail a letter)				
12. Do you and your patients address each other on a first-name basis?				
13. Do you undertake business deals with patients?				
14. Do you take great pride in the fact that such an attractive, wealthy, powerful, or important patient is seeking your help?				
15. Have you accepted for treatment a person with whom you have had social involvement or whom you know to be in your social or family sphere?				
16. When your patient has been seductive with you, do you experience this as a gratifying sign of your own sex appeal?				

The Exploitation Index questionnaire is used with direct permission of R. S. Epstein, MD

Please give your immediate, "off the cuff" responses:	Never	Rarely (Yearly)	Sometimes (Quarterly)	Often (Monthly)
17. Do you disclose sensational aspects of your patient's life to others? (even when you are protecting the patient's identity)				
18. Do you accept a medium of exchange other than money for your services? (e.g. work on your office or home, trading of professional services)				
19. Do you find yourself comparing the gratifying qualities you observe in a patient with the less gratifying qualities in you spouse or significant other? (e.g. thinking: "Where have you been all my life?")				
20. Do you feel that your patient's problems would be immeasurably helped if only he/she had a positive romantic involvement with you?				
21. Do you make exceptions in the conduct of treatment because you feel sorry for your patient, or because you believe that he/she is in such distress or so disturbed that you have no other choice?				
22. Do you recommend treatment procedures or referrals that you do not believe to be necessarily in your patient's best interest, but that may instead be to your direct or indirect financial benefit?				
23. Have you accepted for treatment individuals known to be referred by a current or former patient?				
24. Do you make exceptions for your patient because you are afraid she/he will otherwise become extremely angry or self-destructive?				
25. Do you take pleasure in romantic daydreams about a patient?				
26. Do you fail to deal with the following patient behavior(s): paying the fee late, missing appointments on short notice and refusing to pay for the time (as agreed), seeking to extend the length of sessions?				
27. Do you tell patients personal things about yourself in order to impress them?				
28. Do you find yourself trying to influence your patients to support political causes or positions in which you have a personal interest?				
29. Do you seek social contact with patients outside of clinically scheduled visits?				
30. Do you find it painfully difficult to agree to a patient's desire to cut down on the frequency of therapy, or to work on termination?				
31. Do you find yourself talking about your own personal problems with a patient and expecting her/him to be sympathetic to you?				
32. Do you join in any activity with a patient that may serve to deceive a third party? (e.g. insurance company)				

Scoring Key: Never = 0, Rarely = 1, Sometimes = 2, Often = 3.

A total of 27 or greater, scores in the highest 10% of a sample of 532 psychiatrists.

* Epstein, R.S. and Simon, R.I. "The Exploitation Index: An Early Warning Indicator of Boundary Violations in Psychotherapy"

* Epstein, R.S. Simon, R.I., and Kay, G.G. "Assessing Boundary Violations in Psychotherapy: Survey Results with The Exploitation Index." Bulletin of the Menninger Clinic 56:150-166, 1992.

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