PROFESSIONAL BOUNDARIES

FOR THE

FEDERATION OF CHIROPRACTIC LICENSING BOARDS

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PROFESSIONAL BOUNDARIES OUTLINE

I. Professional Boundaries - Definition and characteristics

A. Old subject dating even to hippocratic oath:

1. "Whatever house I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of al mischief, and in particular of sexual relationships with both female and male persons, be they free or slaves."

B. Personal Boundary is where you and I begin and end[1]

C. It's like a cell wall

1. semipermeable membrane letting some things in and keeping others out

D. boundaries are different for each person

E. They can be flexible and adaptable

F. They are often renegotiated as relationship progresses

G. Between 1-12% of physicians report sexual contact with patient; The percentage of physicians reporting a sexual attraction toward a patient is as high as 80%[2,3,4]

H. It is now well established that a sexual relationship between physician and patient is almost always damaging to the patient. Damage includes, but is not limited to sexual dysfunction, anxiety disorders, depression, increased risk of suicide and dissociative behavior.[5,6]

II. Professional Boundary Violation - Defined

A. Disruptions of the expected and accepted social, physical, and psychological boundaries that separate doctors from patients[7]

B. Violation may be based on perception

1. Legal definition= (148.10, (11) ". . . any behavior that is sexual, or which may reasonably be interpreted by the patient as being sexual. . ."

III. Types of Professional Boundary Violations

A. Non - Predatory

1. This results not from the doctors intent to sexually violate, but from other factors; naivete, insensitivity, etc.

2. Practitioner likely to be rehabilitated through education

B. Predatory

1. Practitioner actively pursues unprofessional relationship

2. Prognosis for true predator is extremely poor[8]

IV. Professional Boundaries - Contributors

A. Power . . . . . .

1. Society ascribes additional power to certain professions[9]

2. Patient is in pain and in need

a. needs may be as much psychological as physical

b. need for touch, warmth, caring, validation

3. Doctors viewed as having solution to their physical problems

4. Doctors may also provide things not often received in the home

a. as above, touch, warmth, caring, etc.

B. Patient's Contributors

1. Internal needs, such as pain relief, concern

2. Statistical pre-disposition to previous abuse

3. Transformation of doctor - patient relationship

C. Doctors Contributors

1. Naivete[10]

2. Inadequate training in Professional Boundary issues[11]

3. Inadequate training in touch, sexuality, and women's issues[12]

4. Insensitivity to patient's subtle signals

5. Lack of knowledge about responsiblity

6. Isolated/Solo practices[13,14]

7. Personal Stresses; difficulties at home or at the office
8. Lack of awareness of their own change from student to doctor[15]
9. Lack of awareness of their own power[16]
10. Failure to recognize the slippery slope
11. No "advisory panel" around to ask questions of.
12. some are just "rotten apples"[17]

V. Professional Boundaries - Responsible Party

A. Generally in law, the person who has the last best chance to avoid the accident has some or all responsibility[18]

B. Physician-patient sex is always the physicians "fault" and responsibility[19]

C. Courts have held that Doctors are responsible because patients are not in a position to give consent for sex.[20]

VI. Professional Boundaries - Liklihood of False Complaints

A. The percentage of false complaints is thought to be very low[21]

1. patients typically experience shame;
2. Fear of being further victimized
3. lack of power and stature in community
4. unclear goals

VII. Professional Boundaries - Regulatory Agency responsibility[22]

A. Victims need to be heard

B. Victims should be kept informed of the process

C. Charges of sexual Misconduct should be a matter of public record

D. support resources should be made known to the victims

E. resolution of complaints should be prompt in order to prevent victimization of others

F. public statement should be written and distributed to educate the public about the expected standards of physician behavior

VIII. Sexual misconduct proven, serious consideration be given to revocation[23]

1. Aggravating factors to be given attention in such considerations include:[24]
   a. Degree of exploitation by the physician of the doctor-patient relationship;
   b. actual or threatened bodily harm or violence by the physician;
   c. previous convictions of the physician;
   d. cruelty to the patient;
   e. vulnerability of the patient due to age, infirmity, history of prior sexual abuse, institutionalization
   f. evidence of multiple victims or multiple incidents;

2. evidence of a serious psychiatric impairment . . . or serious personality disorder
   a. evidence of planned or premeditated activity by the physician
3. Additional aggravating factors as stated by the consultation group include:
   a. failure to respond to rehabilitation
   b. evidence that drugs were administered or provided to a patient to facilitate the sexual misconduct, especially if the patient was a minor
   c. evidence that the physician demonstrated predatory grooming behavior
4. Mitigating factors
   a. absence of previous convictions;
   b. temporary physical or mental impairment of the physician;
   c. evidence of restitution or compensation by the physician;
   d. inexperience of the physician;
   e. evidence of genuine understanding of the inappropriateness of the physicians behavior and the harm it caused;
   f. evidence of genuine efforts at rehabilitation

ENDNOTES

1. Pam Staples, Psy.D.

2. MN Board of Medical Practice; Consultation Group on Physician Sexual Misconduct - 1995; Page 7

3. Gabbard GO, Nadelson D. Professional boundaries in the physician-patient relationship. JAMA. 1995; 273(18); 1445-1449

4. Wilbers D, Veenstra G, van de Weil HBM, Weijmar Schultz WCM. Sexual contact in the doctor-patient relationship in the Netherlands. BMJ. 1992;304:1531-1534

5. MN Board of Medical Practice; Consultation Group on Physician Sexual Misconduct - 1995; Page 7

6. Straburger LH, Jorgenson L, Sutherland P. The prevention of psychotherapist sexual misconduct: Avoiding the Slippery slope. Am J Psychother. 1992;46(4):544-555

7. Pam Staples, Psy.D.

8. MN Board of Medical Practice; Consultation Group on Physician Sexual Misconduct - 1995; Page 8

9. Pam Staples, Psy.D.

10. Angelica Redleaf, D.C.; FCLB, 1995

11. Pam Staples, Psy.D.

12. Angelica Redleaf, D.C.; FCLB, 1995

13. Pam Staples, Psy.D.

14. Angelica Redleaf, D.C.; FCLB, 1995

15. Pam Staples, Psy.D.

16. Angelica Redleaf, D.C.; FCLB, 1995

17. Angelica Redleaf, D.C.; FCLB, 1995

18. Angelica Redleaf, D.C.; FCLB, 1995

19. MN Board of Medical Practice; Consultation Group on Physician Sexual Misconduct - 1995; Page 12

20. Norberg v. Winrib; Supreme Court of Canada, 1992

21. MN Board of Medical Practice; Consultation Group on Physician Sexual Misconduct -1995; Page 9

22. MN Board of Medical Practice; Consultation Group on Physician Sexual Misconduct - 1995; Page 8-9

23. Ibid.

24. MN Board of Medical Practice; Consultation Group on Physician Sexual Misconduct - 1995; Page 18. Crossing the Boundaries, The British Columbia Experience, 1992