

Chiropractic leadership in the eradication of sexual abuse

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Health practitioners work under fiduciary constraint, and are obligated to favour patient needs over all others and in particular their own. The principles of professionalism demand that professionals take great care to ensure that boundaries are maintained safely to provide an optimal setting in facilitating patient care. Boundary violations cause serious harm to the patient. Any romantic or sexual activity between parties is the most serious form of boundary violation. The chiropractic profession is included in the list of disciplines which are at an increased risk for boundary violations. The authors propose a four stage protocol which is designed to offer all parties maximal protection beginning with undergraduate professional education and then mandatory continuing education for registrants in professional practice. The protocol would affect all aspects of professional life including training in boundaries and jurisdictional regulation.
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Tout professionnel de la santé est contraint par des obligations fiduciaires, et les besoins du patient doivent avoir la priorité sur ceux de toute autre personne, y compris des siens. Les principes du professionnalisme exigent que les professionnels fassent très attention pour veiller à ce que les limites soient respectées en toute sûreté afin d'optimiser le milieu où le patient est soigné. Toute transgression à ces limites cause de graves dommages au patient. Une liaison romantique ou sexuelle entre les parties est la forme la plus grave de transgression d'une limite. La profession de chiropraticien fait partie de la liste des disciplines pour lesquelles il y a un plus grand risque de transgression des limites. Les auteurs de l'article proposent un protocole à quatre étapes conçu pour assurer une protection maximale, à partir de la formation professionnelle donnée au premier cycle, puis lors de l'éducation permanente obligatoire offerte aux praticiens professionnels. Le protocole toucherait à tous les aspects de la vie professionnelle, y compris une formation pour la sensibilisation aux limites et sur les pouvoirs de réglementation.
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MOTS CLÉS : Professionnalisme, exploitation sexuelle, chiropratique

Introduction

Much has already been written on the defining tenets and characteristics of professionalism and on that which

constitutes the position and work of a professional.¹⁻⁷ The two most basic and important features of all professions are control over a specialized body of knowledge,

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and a commitment to use this knowledge for good. The overriding construct governing professionals is that this specialized work is service based and is always, without exception, for the benefit of the client. However, putting the public interest ahead of the self interest of the members of the professions has constituted a growing conflict over the last few decades to seeing such groups becoming more political, whose major interest is advancing their own agendas.

This has given rise to tensions between professionals and the public and is manifest in various ways.⁸ One is the increase in the reporting of unprofessional behaviors to regulatory authorities.^{9,10} In response, jurisdictions have employed various tactics to ameliorate these disputes ranging from the use of cease and desist orders, dispute resolution, on to formal disciplinary hearings and litigation for the most offensive cases.¹⁰

We are able to understand why some of these professional-client disputes are occurring, and, most importantly, that an opportunity for the professions to formulate a strategy to resolve and remediate these difficult problems exists. We further propose that just such an opportunity is very timely for one profession, chiropractic, and that the profession demonstrate leadership to the professional and public domains, as representative of the social contract that all professions have with society.

In 1993 the province of Ontario enacted legislation with strict and absolute provisions for all of the health professions, targeting any regulated health care provider found guilty of patient sexual abuse, with the definitions of abuse much broader than had been described previously. The definitions included, not just overt sexual behaviours, but comments of an intimate and/or sexual nature.¹¹

This initiative represented the first Canadian legislative effort to detail a sexual abuse regime applicable to the regulated health professions. Included was the adoption of the “zero tolerance” of sexual abuse by health professionals, a mandatory five year revocation of the registration of a member found guilty of sexual abuse, and mandatory reporting requirements of members reasonably suspected in abuse of a patient by both other members and facility operators. All regulatory bodies are required to develop initiatives to address the prevention and eradication of sexual abuse within their profession.

In light of these advances, we propose that a much more thorough and comprehensive approach to identify

and prevent patient abuse is still needed with this being equally proactive and preventive at multiple levels of professional-public engagement. We propose that the current *status quo* approach to oversight is less than adequate and is inefficient. We conclude that specific comprehensive undertakings are necessary to offer protection to the public and to facilitate the restoration of public confidence in the professions.

Professionalism

Professionalism and ethics are integrally linked. All health professionals have an obligation to demonstrate a thorough understanding and hold to a high level of practice of the ethics and virtues of care. Professionals serve the public, and members of the public have great personal needs that they give over to a professional in that time of need. The professional then uses specialized education, skills, experience and judgment in caring for the client.

All definitions of professionalism embody responsibilities and privileges for the professional that relate to society, by which members are to abide.¹² The power differential between professional and client is a key component and predicates the professional’s responsibilities and privileges to the benefit of the client.^{13,14}

None of these concepts are new. Both Plato and Hippocrates recognized that a good doctor-patient relationship was essential to achieve the goals of care. Plato wrote that the best clinical medicine is practiced when “scientific knowledge is combined with a personal, trusting and professional relationship between doctor and patient.”¹⁵

The American Medical Association published its first Code of Medical Ethics in 1847. It reads more like a social contract detailing the rights and responsibilities for physician interaction with, not just the patient, but the relationship between other physicians and the community at large. Physician conduct occupies only a small part of the code.¹⁶

Harvard medical educator William Peabody stated in 1925: “The significance of the intimate personal relationship between physician and patient cannot be too strongly emphasized, for in an extraordinarily large number of cases, both diagnosis and treatment are directly dependent on it.”¹⁷ Optimal clinical care can only be achieved with a close, caring and safe relationship between doctor and patient.

More recently the American Board of Internal Medi-

cine has undertaken multiple initiatives to define professionalism in 2004.¹⁸ Others have joined in advocacy of this pursuit.¹⁹ One reason for the increased awareness and interest in professionals' ethics in the last decade is a growing concern and increased recognition from regulators and the public that unprofessional behavior by a physician or any health care provider causes great damage both to the individual abused and to the reputation of all the professions.

Our present society has been formed by accepted standards, mores and values over the past several decades. Moral decisions of right and wrong are now considered personal, subjective and relative to a given situation. This moral relativism contrasts sharply with the principles of professionalism.^{20,21} Professions have written codes of conduct, ethics and behaviors in order to guard against aberrant behaviour by individual members.²² If the changes in society's moral standards affected the professions, there would be an erosion of the high standards demanded of professionals.

While practicing in an ethical manner is not an option, the law, through legislation, regulations and standards, can only go so far in setting out what the minimum threshold is. This is often described in terms of what is forbidden in the professional-client encounter. While the law does not attempt to establish precise optimal performance, professionalism demands that individual members strive for and maintain excellence in both their clinical expertise and in the delivery of practice via humanism, empathy and compassion.

Social contract

Social contract theory emphasizes the mutual rights and obligations of citizens and those in authority. The public interest is served by practitioners who act with altruism, compassion, empathy, primacy of the patient (fiduciary relationship) and a commitment to excellence. This is the glue that forms the social contact between the professional and patient.²³

Though the role of the professions in society has always been altruistic (specialized knowledge used for the benefit of others), the reality of modern times is that problems have arisen that detract from the professional's role and work. Historically, the three most prestigious professions, medicine, the law and the priesthood were held up as exemplars of achievement and ones that other social

groups could emulate. But all three groups have struggled with ethical failures, inadequate self-regulation and much media scrutiny resulting in a troubling erosion of public trust.⁶

Many jurisdictions describe the various kinds of abuse that a professional must take care to avoid inflicting on a client. These include financial, emotional, physical and sexual abuse. All kinds of abuse cause damage to individuals and are malevolent acts. This contrasts with beneficence: an act of charity, mercy and kindness. Beneficence is actively doing good to others and invokes a wide array of moral obligation. It strives for the best care while ensuring not doing anything harmful. *Primum non nocere* ("first, do no harm") is an oath taken by health practitioners, and while designed to avoid things harmful as part of the ethical tenet non-maleficence, embraces the ethic of beneficence proactively. The overriding intent is to always ensure net benefit over harm.²⁴

Boundary inattention by the professional is a serious omission. It is not possible for a patient to discern that engagement in any activity that constitutes abuse by a professional could merit consent. In these situations, the power differential between the parties makes consent impossible. Even if the inappropriate activity is initiated or suggested by the patient, the party in the vulnerable position is not capable of legitimately consenting. No one willingly consents to being abused.

Boundaries

A boundary is the line separating both parties thereby distinguishing a therapeutic relationship between professional and patient with those other relationships that are casual, personal and familial. The key and foundational aspect of the doctor-patient relationship is for the professional to set and then maintain a healthy boundary, for it is a functional boundary that enables the caregiver to work towards an optimal clinical outcome. Conversely, a boundary violation causes *sequelae* to all parties.^{25,26} There can be a delicate aspect to boundary setting. What makes this delicacy sometimes difficult is reconciling the physician's role as a professional providing expert clinical care while embracing his or her own persona with that patient as another social being in community.

The call to maintain clear professional boundaries is one that has been heard from ancient times. What is currently changing is that health care is becoming less rigid

and formalized with health care providers being urged to focus on developing just and respectful relationships with patients, rather than adhering to rules based systems of ethics.^{27,28} Chiropractic has a reputation for superior communication is patient care. This may put the practitioner at an increased risk of crossing a patient's boundary by excessive self-disclosure or by gaining an inappropriate degree of patient familiarity. This is recognized as leading to boundary violations with the very real potential for patient abuse, often sexual.²⁹

The difference between a crossing and violation is usually one of degree. With some exceptions, a boundary crossing is inappropriate but does not subject the client to harm. A violation is not just inappropriate but subjects the patient to harm or the potential of harm. Boundaries are the key component of the clinical relationship which, when in balance, rightly positions the practitioner in the position of power, trust and authority, and the patient in the weaker and more vulnerable, subordinate position.^{28,29} Effective management of this power differential is an essential convention allowing the provider the opportunity to use his or her specialized skills and experience in facilitating the patient's healing response.

Boundary violation

Boundary violations are acts that breach the core intent of the professional-patient commitment. They occur when the practitioner violates the covenant to always and without exception act only in the patient's best interest, and instead consciously or unconsciously exploits the patient to meet personal needs. While unequivocally clear boundaries in the practitioner-patient relationship exist solely for the patient's safety and protection, the professional also derives enormous benefit from the establishment and maintenance of mutual boundaries, as they safely provide the limits on what is expected by each party. Altering these limits produces ambiguity, uncertainty and confuses the patient. By protecting the patient, protection is reciprocated back to the practitioner.

Sexual abuse

Sexual abuse is legally forbidden by all jurisdictions and for all disciplines. It is the most egregious form of offence that a professional inflicts on a patient.^{30,31} Any type of romantic or sexual activity represents the most serious boundary violation as it is highly detrimental to the pa-

tient's health and well-being. Shame, guilt, depression, post-traumatic stress disorder, addiction and suicidal tendencies have all been reported following sexual abuse.²⁵ Such patients are seriously harmed in their ability to form social relationships and in their ability to enjoy intimacy, quite apart from their difficulties in trusting future health care providers.

A practitioner not understanding the potential risk with a more casual clinical approach may risk a boundary violation that becomes sexually abusive. Personalizing is self-disclosure to the degree that it damages the professional-client relationship and causes harm.

In an attempt to understand the mechanism for a poorly maintained boundary leading to violations and abuse, some practitioners are clearly at risk: those whose basic emotional needs are unmet. Since by nature we are wired for intimacy, it is essential that the practitioner's deepest and most intimate personal needs are met outside of, and quite apart from, those people met in professional work. When a practitioner experiences difficulty in personal relationships with intimates, patients are at risk of being targeted. Since health care is recognized as a high stress vocation, it is therefore a high risk domain with the potential for patient abuse ever present.⁹

Some have queried as to how someone who has achieved such a high pinnacle of education and position within their community would, by word or deed, harm someone who is in the weak and vulnerable position.

A small number of practitioners behave in a predatory way and sexually exploit patients.²⁵ Mental illness is another cause of abuse with diagnoses including mania, psychoses and addiction. All of these factors represent a profound impairment of the professional's judgment. Even an emotionally healthy practitioner with poor communication skills risks a patient misinterpreting that performing a health care procedure was not in their best interest, and may report such to the regulating authorities.

Whenever and however the abuse scenario occurs, the dysfunction reverses the usual and customary relationship, wresting the caretaking role from the practitioner and giving that over to the patient, who ends up attempting to care for the professional.

A recommended solution

We propose that for the healing professions to fulfill their social contract with society there are four fundamental

undertakings which all health care practitioners must be subject. We make specific proposals to the chiropractic profession, as representing one of the high-risk groups, to proactively pursue at all levels of engagement with the public, embracing openness and transparency.³²

Traditional reliance on jurisdictional regulatory colleges, boards and associations for public protection is not optimal, based on the late stage nature of the regulator's involvement. This approach attempts to offer "curative" protection to the public against abusive professionals' behaviors, as the disciplinary actions taken in such cases are more "reactive" to disciplinary complaints, usually occurring late in the process. This does not dissuade the public's distrust in the professions as identified groups who are to be wholly trusted.

We propose the chiropractic profession recognize that much earlier "preventive" intervention is the only substantive approach in ameliorating future cases and reversing the trend to abuse, as follows:

1. Undergraduate instruction in ethics, boundaries and the prevention of specific sexual abuse is rigorously taught in all chiropractic colleges. The Council on Chiropractic Education standards must be changed to state explicitly that curricular content must serve this end.³³ The current requirements of both US and Canadian CCE standards are too broadly defined and subject to interpretation.
2. All jurisdictions must ensure zero tolerance for abuse, with strict and absolute disciplinary measures for chiropractors found guilty of sexual abuse, with a victim friendly process while engaged with regulatory protocols;
3. All jurisdictions must mandate periodic continuing education for risk management in ethics, boundaries and the prevention of sexual abuse. There also needs to be training on patient communication and informed consent, with this post-graduate ethics education being contingent on continued registration;
4. Jurisdictions must financially support the involved parties with psychotherapeutic counseling for victims, and remediation for involved practitioners (when deemed appropriate) for continued licensure.

Undertaking number one: Undergraduate education

The need for teaching ethics and professionalism to young chiropractors is based on the changing shift in moral atti-

tudes in Western society. Conventional community values that were once held as inviolable have been subjected to the effects of moral relativism, which began its influence in the 1960s.^{34,35}

Today's student has been raised in a climate of entitlement, permissiveness and materialism. Materialism has defined Western values as one of the pivotal defining characteristic of our modern society. Our society craves achievement and success to the point of excess. This contrasts sharply with the principles of professionalism and can be burdensome for educators, as the teaching of ethics in professional curricula is a relatively new field of study.

While the content of the ethics and professionalism curriculum produces a number of specific goals and objectives,³⁶ there are three pivotal competencies forming the *set* that every chiropractic student must demonstrate understanding of and competence in:

1. Professionals are held to higher standards than the general public;
2. The health practitioner holds the position of power and trust, with the patient being more weak and vulnerable;
3. The responsibility to maintain healthy and functional boundaries in all clinical encounters rests exclusively with the practitioner.

The *setting* for these three then follows:

1. Professionalism and ethics are key cornerstones that underscore all other content for chiropractic students acquiring basic science knowledge and clinical competence;
2. The public demands that chiropractic educators advocate for and uphold the principles of professionalism, codes of conduct, behaviors and ethics, and mentor students in the application of these tenets.³⁷

The *set* and *setting* support the applied learning objectives of altruism, compassion, empathy, primacy of the patient and commitment to excellence, to the more focused goals of professional ethics, setting of boundaries and the prevention of abuse of all kinds.

The recommendation for a comprehensive systematic course on ethics and professionalism to health care students in all disciplines was made years ago, yet the only two published studies that have surveyed ethics curricula in health care were in medicine and graduate nursing pro-

grams.^{38–41} These studies found no standardization in US educational institutions with some US medical schools offering almost no ethics content for students. (For example, one medical school totaled two hours in ethics content.)³⁸ Since no other health care disciplines have been studied, their curricula are unknown. Those published surveys in medicine and nursing revealed that there is no standardization in either content or learning objectives. Medical and nursing schools (and it is assumed other health care colleges) have apparently developed their curricula in an isolated, internal and anecdotal manner with little regard for the larger health care community. Some ascribe this paucity in ethics education to be primarily responsible for the increase in complaints made to regulatory bodies.⁹

The US Council on Chiropractic Education mandates content for ethics, but is described in very general terms. The January 2007 CCE requirements state in Section 2, Subsection O: Ethics and Integrity, Part (1) Attitudes, “the student must demonstrate an ability to” with this stem applied to six domains. Only one of the domains mentions sexual boundaries and the wording is not only ambiguous, but is applied to student inter-relationships, with nothing specified for future doctor-patient relationships. The Canadian CCE standards are almost identical in their wording. Neither the American nor Canadian CCE requirements specify contact hours, course objectives, teaching methods and assessment in the ethics curriculum for chiropractic students in the doctor of chiropractic program.

The need for improved standards is obvious. Minimum standards for contact hours, specific goals and objectives and assessment protocols must be established for all health care educational institutions.⁴² As there are ethical issues unique to each specialty, each discipline must add its specialized content in cooperation with other disciplines. This is congruent with the current trend in health care to integration of all disciplines for the benefit of the patient, as the patient journeys through the clinical encounter.

Most institutions employ periodic curricular review. The external institutional review protocol offers a superior method of curricular reform and allows for enhanced communication between multiple educational and regulatory parties.^{43,44} This is not a complicated process.

There is both anecdotal and published evidence that even students recognize the need for ethics education and that they perceive it to be important. Educators who fail to ascribe a high priority to the value of teaching ethics and

professionalism have been described as “silent conspirators who vicariously inflict harm on future patients”.⁴⁵ Students benefit from theoretical content being parlayed into the reality of clinical practice, with all parties benefiting from the recognition and reinforcement of positive behaviors during the educational process.⁴⁶

Second undertaking: Zero tolerance regulation

Once a chiropractic student learner has successfully transitioned out of professional education and has fulfilled all licensing requirements, he or she is then subject to the rules of practice set out by their jurisdiction. Since there is overwhelming evidence that sexual abuse profoundly damages a patient, the only just response to a practitioner found guilty of abuse must be decisive, strict and just.⁴⁷

All state and provincial legislators, regulators and professional associations have a duty to ensure existing laws, statutes and regulations adequately protect members of their public who have been subject to abuse. There is credible evidence that some jurisdictions and some disciplines are less than adequate in applying disciplinary measures to practitioners.¹⁰

Health law expert Rodgers examined the College of Physicians and Surgeons of Ontario in its approach to complaints of sexual abuse and reported on lenient penalties, institutional resistance, and remarkably that only one in twenty of those cases involving allegations of a physician sexually abusing a patient ever reached the disciplinary stage. This is despite the strict legislation governing regulated providers in the province.

Rodgers states reasons for this discrepancy. There is a lack of reporting by regulated health professionals, even though they are legally duty bound to report to the regulatory authority when there is reason to believe that a patient has experienced abuse, suggesting that there is non-compliance from members of the profession. Secondly, only one percent of public reporting of any kind of physician misconduct proceeded to a disciplinary hearing. The trend to quasi-criminal burden of proof and zealous attempts by counsels of accused doctors to access a complainant’s private records was described as re-abusive. While anecdotal communication with officials of the College of Chiropractors of Ontario would indicate that the chiropractic profession’s ratio of complaints to discipline is less disparate, there is no published evidence for confirmation.

All state and provincial legislators, regulators and professional associations have a duty to re-commit themselves to examining whether existing laws, statutes and regulations adequately protect members of their public who have been subject to abuse. We suggest that cultural inertia in both a reluctance to hold fellow members to account and institutional barriers in implementing disciplinary protocols are able to be remediated.

Third undertaking: Continuing education

Following the work established from the educational and enforcement undertakings, jurisdictions must then regularly require continuing education to their members. In order for a chiropractic practitioner to maintain practice competency, there must be periodic retraining in the area of ethics, boundaries and the prevention of sexual abuse, and that this retraining be conditional for continued licensure. While this post-graduate content is similar to that taught during undergraduate instruction, the ongoing discourse on ethics and professionalism in the academic setting versus the reality of practice offers greater insight to those already engaged in practice.

While all professionals commit to life long learning and updating their clinical skills, few jurisdictions have moved to mandate ethics post-graduate education to their members. For example the Province of Saskatchewan requires chiropractors to undergo 4 hours post-graduate training every two years for ethics and boundaries risk management. Currently there are only two Canadian provinces and twelve American states that require any type of ethics content in their continuing education for chiropractic registrants.⁴⁸

Fourth undertaking: Remediation and amends

When these undertakings are established, the health care professional will have been subject to education on boundaries and ethics, firstly as a student and then as a licensed practitioner. For the very small minority who are disciplined for ethical failures, jurisdictions will set out what the grounds for remediation and license retention are. In particular, when a practitioner has been found guilty of sexual abuse, jurisdictions must specify the remediation process's terms and conditions. Some cases would be deemed remediable, and for those practitioners, counseling should be mandated as one of the conditions for continuing in practice. Some jurisdictions already have just

such a protocol for practitioners having been found guilty of patient abuse.

Many professional groups offer services to their practitioners sometimes termed professional health programs.⁴⁹ While the intent of these programs is directed primarily towards the impaired practitioner, all types of compulsive and unprofessional behaviors are included. Both regulatory and professional associations should feature the services of the assistance programs to their members, with particular attention on their benefits and the grounds for a mandated referral, without practitioner consent.

Victims of sexual abuse are entitled to counseling assistance to deal with the damage caused by their violation. Some jurisdictions currently offer this support for assisting with the cluster of physical and mental problems that result from abuse. This is an important part of protecting the public, albeit from a reactive position, and one that the professions can employ as a means of restoring public trust and confidence.

Conclusion

That victims of sexual abuse and their family members suffer serious effects is not in dispute. The damage is deep and lasting. Making amends is a most worthy, important and just goal for all professional associations and regulators. No professional group is currently offering its practice members and the public a program that is comprehensive, proactive and preventive. This is a timely opportunity for the chiropractic profession to lead.

The profession has a history of success despite difficulties and persecution from within the *status quo* health care system. The twenty-first century features a move towards integration in health care that reduces the silo mentality of the disciplines, helping the patient in facilitating access to optimal care. There is a palpable critical mass emanating from chiropractic academia in moving the profession into a more credible position of cultural authority in the manual methods of health care, complementing the already well accepted public's understanding and use of the skills of its practitioners.

The opportunity for the profession to act in offering protection to public members is real and justified. The comparison to the lack of action, as seen in the studies done on the medical profession in Ontario, furthers our call to this vital profession on society's health care team.

Protecting the public starts early and continues for the practicing professional as the means; with the end realized by healthy interactions, with all parties deriving benefit. What we propose here is the most comprehensive, thorough and detailed approach yet to be undertaken by any group, and offers the greatest degree of protection to all parties.

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