Ethics and Chiropractic Practice

Since its genesis in 1895, the chiropractic profession has encountered a myriad of challenges regarding its philosophy, art and science. The chiropractic profession has undergone scrutiny by the medical profession, federal and state governmental bodies, the insurance industry and the general public. This scrutinization has involved a multitude of issues pertaining to the philosophy, art and science of the practice of chiropractic such as: the relative paucity of scientific evidence supporting the efficacy of chiropractic treatment; professionalism in chiropractic; the long standing absence of a prerequisite four year college degree prior to the commencement of chiropractic training (this has changed significantly in recent years with most chiropractic colleges now requiring an undergraduate degree); the wide variance in the scope of chiropractic from state to state; the significant differences amongst the practice styles, claims and beliefs between the various “straight” and “mixer” factions within the profession; the appropriateness of spinal manipulative treatment methodologies in response to both spinal related and organic diseases; utilization / over-utilization of treatment; professional boundaries; insurance billing practices; and ethics associated with the practice of chiropractic.

According to recent statistics, there are 71,283 Doctors of Chiropractic. Ostensibly, the vast majority of these men and women are ethical professionals dedicated to upholding the tenets of the Hippocratic Oath. However, due to the historically high level of scrutiny of the chiropractic profession, accounts of unethical behavior on the part of a relatively small number of chiropractors often times become sensationalized in the media.

The purpose of this continuing education seminar is to provide the Doctor of Chiropractic with an in depth analysis of the ethical challenges encountered during the practice of chiropractic. This course will define the elements of professionalism, provide an overview of the principles of ethics and morality, and examine ethical issues specific to the practice of chiropractic.

The Chiropractic Profession

Since 1895, the chiropractic profession has grown into one of the largest health care professions in the world. Members of the chiropractic profession have developed national professional associations, such as the American Chiropractic Association, and state associations which have created codes of ethics for the chiropractic profession.

Tenets of Chiropractic

Chiropractic is:

- “noninvasive, emphasizing the patient's inherent recuperative abilities.
- recognizes the dynamics between lifestyle, environment, and health.
- emphasizes understanding the cause of illness in an effort to eradicate, rather than palliate, associated symptoms.
recognizes the centrality of the nervous system and its intimate relationship with both the structural and regulatory capacities of the body.

- appreciates the multifactorial nature of influences (structural, chemical, and psychological) on the nervous system.
- balances the benefits against the risks of clinical interventions.
- recognizes as imperative the need to monitor progress and effectiveness through appropriate diagnostic procedures.
- prevents unnecessary barriers in the doctor-patient encounter.
- emphasizes a patient-centered, hands-on approach intent on influencing function through structure.
- strives toward early intervention, emphasizing timely diagnosis and treatment of functional, reversible conditions.”

According to a 2002 survey by the National Center for Complementary and Alternative Medicine, chiropractic care was among the ten most commonly used Complementary and Alternative Medicine (CAM) therapies among adults in the USA. The U.S. Department of Labor's Occupational Outlook Handbook suggests that chiropractic care will increasingly play an important role in health care:

"Because chiropractors emphasize the importance of healthy lifestyles and do not prescribe drugs or perform surgery, chiropractic care is appealing to many health-conscious Americans. Chiropractic treatment of the back, neck, extremities, and joints has become more accepted as a result of research and changing attitudes about alternative, noninvasive health care practices.”

Definitions

- **Profession** – A profession is the body of qualified persons in an occupation that requires considerable training and specialized study.

- **Professionalism** – Is the conduct, aims or qualities that characterize or mark a profession or a professional person.

- **Professionals** – Are groups in society that profess to possess a body of knowledge and skills that others in society do not possess. The attainment of professional skills and knowledge requires considerable time, study and resources.

The Pew Health Profession Commission

The Pew Health Profession Commission identified 21 characteristics of health care professions:

1. Embrace a personal ethic of social responsibility and service.
2. Exhibit ethical behavior in all professional activities.
3. Provide evidence-based, clinically competent care.
4. Incorporate the multiple determinants of health in clinical care.
5. Apply knowledge of the new sciences.
6. Demonstrate critical thinking, reflection and problem solving skills.
7. Understand the role of primary care.
8. Practice preventative health care.
9. Integrate population-based care and services into practice.
10. Improve access to health care for those with unmet health needs.
11. Practice relationship-centered care.
12. Provide culturally sensitive care to a diverse society.
13. Partner with communities in health care decisions.
14. Use communication and information technology effectively and appropriately.
15. Work in interdisciplinary teams.
16. Ensure care that balances individual, professional, and societal needs.
17. Practice leadership.
18. Provide quality care.
19. Contribute to continuous improvement.
20. Advocate for public policy that promotes and protects the health of the public.
21. Continue to learn and help others learn.

Comparison of Professional and Commercial Business Relationships

The doctor-patient relationship is a fiduciary relationship predicated on trust. Patients impart personal information to doctors with the belief that doctors will keep said information confidential. Consequently, the doctor-patient relationship is a professional one based on the concept of credat emptor. Translated from Latin, credat emptor means (let the taker believe in us). Conversely, in a commercial business relationship, the concept of caveat emptor (let the buyer beware) applies.

Characteristics of the Professional

- Professionals can command large sums of money for their services.
- Society often bestows on professionals social privileges, which in turn, place social responsibilities on the part of the professional.
- In return for the professionals knowledge, skills and expertise, society bestows on these individuals a high level of social stature.
- Professional autonomy is arguably the most important privilege a profession is granted and gives a profession incredible social authority.
- Professionals have the power to make independent decisions regarding their own behavior based on their own knowledge.
Professions are given autonomy with regard to self-regulation. They are expected to establish a code of ethics and regulations, and to enforce them.⁸

**Professional Authority**

According to Haldeman “social authority is bestowed with the expectation that the good of the consumer and society prevail over a professional’s self-interest. Additionally, provision of professional services should be based on patient needs (as opposed to wants). Although patient preference has a role in clinical decision making, congruence with the needs of the patient and the appropriateness of treatment is essential. For example, although a patient may want to receive a particular type of treatment or testing, professional accountability, and codes of professional conduct dictate that the appropriateness of treatment prevail when at odds with a patient’s desires. A professional possesses the perspicacity to differentiate a need from a want and should have the courage to confront the patient when their requests are questionable. Haldeman added that within the dynamics of the doctor-patient relationship the patient is the vulnerable party and may not be the best arbiter of quality or appropriateness.”⁹
Professional Duty

Professional duty is something that the professional is expected or required to do by moral or legal obligation. Professional duty is further defined as an action or task required by one's position or occupation. The primary element of a successful malpractice action by a patient against a doctor is proving that the physician owed some duty to the patient. It must be determined that a doctor–patient relationship had been established. This relationship does not require a written contract. For example, rulings have been made which establish a doctor–patient relationship when a doctor gives professional advice during a social encounter. To avoid the establishment of a doctor–patient relationship, avoid giving professional advice during social encounters, train staff not to give professional advice and avoid giving advice over the telephone. Also, an independent chiropractic examiner should never provide treatment services, or offer a diagnosis, prognosis or future treatment plan to an examinee. Doing so creates a doctor–patient relationship which can result in a malpractice claim. Strict adherence to independent chiropractic examination guidelines and procedures reduces the likelihood of successful malpractice prosecution. The 100 Hour Certified Chiropractic Insurance Consultant program offered by TheWiseDC.com contains valuable information to chiropractors on effective ways to protect their interests and the interests of their patient during the independent chiropractic examination process.

Duties of a Doctor of Chiropractic

- The doctor must abide by the rules and regulations promulgated by their State Board of Chiropractic Examiners.
- The doctor must provide only those chiropractic treatment services which fall within their states scope of practice.
- The doctor must stay abreast of treatment and technological advancements and meet the requirements for their states continuing education credit hours of postgraduate instruction.
- The doctor must explain to the patient their treatment plan and the risks of treatment. The doctor must inform the patient of alternative treatment options.
- The doctor must receive consent by the patient for treatment.
- The doctor must perform a thorough history taking of a patient's subjective complaints.
- The doctor must perform a thorough chiropractic, orthopedic and neurological examination of the patient.
- The doctor must render an accurate diagnosis.
- The doctor must perform appropriate diagnostic testing procedures consistent with the etiology and timing of the patient's injury / condition, patient subjective complaints and the provider of care's objective findings. If radiographic studies are utilized, they must be taken of the area/areas of patient complaint.
- The doctor must offer an efficacious course of care with the goal of amelioration of symptomatology or reduction of subluxation, depending upon philosophy.
- The doctor must offer quality treatment within a duration of time and at a frequency consistent with general chiropractic and cross discipline treatment parameters and guidelines. A general rule of thumb is the frequency of treatment should decrease over time commensurate with patient progress.
- Any adjunctive physiotherapy modalities utilized should be consistent with the diagnosed
condition with consideration of the modalities’ physiological effects.

- The doctor must document daily patient encounters utilizing the S.O.A.P. note format.
- Where significant clinical progression is not noted, the prudent doctor should refer the patient to the appropriate practitioner for alternative care. Failure to refer may result in the Doctor of Chiropractic being held to the same standard of care as the provider to whom the referral should have been made.
- The doctor must document clinical progression to warrant future care consideration.
- The doctor must ensure patient confidentiality.
- The doctor must never abandon a patient.
- The doctor must only bill for those services rendered.

**Duties of the Doctor of Chiropractic Imposed by Law**

- Continuing education credit requirements and license renewal.
- The Doctor of Chiropractic must adhere to their state’s chiropractic laws.
- Most states have legislative mandates requiring the Doctor of Chiropractic to report cases of child abuse.

**Alterations of Duties**

- Duties can be altered by one's state chiropractic association. However, typically, a position espoused by a professional association does not have the force of law.
- Duties can be altered by one's state licensing board, which have the full force of law.
- Duties can be altered by court rulings.

**Dereliction of Duty**

- Dereliction of Duty - any actions or tasks that do not meet the requirements of one's position or profession involving a deviation from standards of care.

**Professional Code of Ethics**

It is commonplace for professional organizations to draft a professional code of ethics. Written ethical codes are developed by professional organizations for the purpose of self-regulation of their membership. A professional organization’s code of ethics includes a specific code of conduct that members of the organization agree to abide by.

**Benefits of Developing a Code of Ethics**

A Code of Ethics Will…
Define accepted/acceptable behaviors.
Promote high standards of practice.
Provide a benchmark for members to use for self evaluation.
Establish a framework for professional behavior and responsibilities.
Serve as a vehicle for occupational identity and a mark of occupational maturity.

Perspectives on Professional Codes of Ethics

"The need for special ethical principles in a scientific society is the same as the need for ethical principles in society as a whole. They are mutually beneficial. They help make our relationships mutually pleasant and productive. A professional society is a voluntary, cooperative organization, and those who must conform to its rules are also those who benefit from the conformity of others. Each has a stake in maintaining general compliance."\(^{11}\)

"A code of ethics can be an instrument for persuasion both of members of (a) profession and the public. They enhance the sense of community among members, of belonging to a group with common values and a common mission."\(^{12}\)

"A profession's ethical standards must be compatible with our common morality, but they go beyond our common morality. You could say that they interpret our common morality for the specific details of work of a particular occupational group."\(^{13}\)

"The very exercise of developing a code is in itself worthwhile; it forces a large number of people...to think through in a fresh way their mission and the important obligations they as a group and as individuals have with respect to society as a whole."\(^{14}\)

Hippocratic Oath

The Hippocratic Oath is an oath traditionally taken by physicians pertaining to the ethical practice of medicine. Doctors of Chiropractic commonly take this oath during their graduation ceremony. It is widely believed that the oath was written by Hippocrates, the father of medicine, in the 4th century BC, or by one of his students. The Hippocratic Oath is considered a rite of passage for practitioners of medicine, although it is not obligatory and no longer taken up by all physicians.

The Classical Oath

"I swear by Apollo Physician and Asclepius and Hygeia and Panacea and all the gods and goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath and this covenant:

To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art - if they desire to learn it - without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed
me and to pupils who have signed the covenant and have taken an oath according to the medical law, but no one else.

I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.

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

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about.

If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.”

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The Modern Hippocratic Oath

The modern Hippocratic Oath has been altered over the years in various countries, schools, and societies as the social, religious, and political importance of medicine has changed. Most schools administer some form of oath, but the great majority no longer use the ancient version, which praised Greek deities, and forbade general practitioners from surgery, euthanasia and abortion. Also missing from the ancient Oath and from many modern versions are the complex ethical issues that face the modern physician.

Changed Portions of the Oath

1. *To teach medicine to the sons of my teacher.* In the past, medical schools would give preferential consideration to the children of physicians.

2. *To practice and prescribe to the best of my ability for the good of my patients, and to try to avoid harming them.* This beneficial intention is the purpose of the physician. However, this item is still invoked in the modern discussions of euthanasia.

3. *Never to do deliberate harm to anyone for anyone else’s interest.* Physician organizations in most countries have strongly denounced physician participation in legal executions. However, in a small number of cases, most notably the Netherlands, a doctor can perform euthanasia, by both his and the patient's consent.
4. To avoid violating the morals of my community. Many licensing agencies will revoke a physician's license for offending the morals of the community ("moral turpitude").

5. To avoid attempting to do things that other specialists can do better. The "stones" referred to are kidney stones or bladder stones, removal of which was judged too menial for physicians, and therefore was left for barbers (the forerunners of modern surgeons). Surgery was not recognized as a specialty at that time. This sentence is now interpreted as acknowledging that it is impossible for any single physician to maintain expertise in all areas. It also highlights the different historical origins of the surgeon and the physician.

6. To keep the good of the patient as the highest priority. There may be other conflicting 'good purposes,' such as community welfare, conserving economic resources, supporting the criminal justice system, or simply making money for the physician or his employer that provide recurring challenges to physicians.

7. To avoid sexual relationships or other inappropriate entanglements with patients and families. Sexualizing a doctor-patient relationship is a serious professional boundary violation.16

Ethics

The field of ethics, also called moral philosophy, involves analyzing, arguing, defending, and recommending concepts of right and wrong behavior. Ethical theories are commonly divided into three general subject areas: metaethics, normative ethics, and applied ethics. Metaethics investigates the origin of our ethical principles, and their meaning. The question often arises, “Are ethical principles merely social inventions”? Do they involve more than expressions of our individual emotions? Metaethical answers to these questions focus on the issues of universal truths, the will of God, the role of reason in ethical judgments, and the meaning of ethical terms themselves. Normative ethics is less ethereal and more practical in nature as this branch of ethics seeks to arrive at moral standards that regulate right and wrong conduct. This may involve articulating the good habits that we should acquire, the duties that we should follow, or the consequences of our behavior on others. Finally, applied ethics involves examining specific controversial issues, such as abortion, euthanasia, infanticide, animal rights, environmental concerns, capital punishment, or nuclear war.17

Metaethics

The term "meta" means after or beyond, and, consequently, the notion of metaethics involves a removed, or bird's eye view of ethics. Metaethics is the study of the origin and meaning of ethical concepts. When compared to normative ethics and applied ethics, the field of metaethics is the least precisely defined area of moral philosophy. Two issues, though, are prominent: (1) metaphysical issues concerning whether morality exists independently of humans, and (2) psychological issues concerning the underlying mental basis of our moral judgments and conduct.18
Metaphysics is the study of the physical and nonphysical things that exist in the universe. The five human senses allow us to perceive physical entities. Conversely, thoughts, spirits and gods would represent things that are nonphysical in nature. The metaphysical component of metaethics involves discovering specifically whether moral values are eternal truths that exist in a spirit-like realm, or simply human conventions. Proponents of the spirit-like, "other-worldly" view typically hold that moral values are objective in the sense that they exist in a spirit-like realm beyond subjective human conventions. They also hold that they are absolute, or eternal, in that they never change, and also that they are universal insofar as they apply to all rational creatures around the world and throughout time. An example of this view is found in the teachings of Plato, who was inspired by the field of mathematics. According to Plato, numbers and mathematical relations, such as 1+1=2, are timeless concepts that never change, and apply everywhere in the universe. Humans do not invent numbers, and humans cannot alter them. Plato explained the eternal character of mathematics by stating that they are abstract entities that exist in a spirit-like realm. He noted that moral values also are absolute truths and thus are also abstract, spirit-like entities. In this sense, for Plato, moral values are spiritual objects. Medieval philosophers commonly grouped all moral principles together under the heading of "eternal law" which were also frequently seen as spirit-like objects. 17th century British philosopher Samuel Clarke described them as spirit-like relationships rather than spirit-like objects. In either case, though, they exist in a spirit-like realm. A different other-worldly approach to the metaphysical status of morality is divine commands issuing from God's will. Sometimes called voluntarism, this view was inspired by the notion of an all-powerful God who is in control of everything. God simply wills things, and they become reality. He wills the physical world into existence, he wills human life into existence and, similarly, he wills all moral values into existence. Proponents of this view, such as medieval philosopher William Ockham, believe that God wills moral principles, such as "murder is wrong," and these exist in God's mind as commands. God informs humans of these commands by implanting us with moral intuitions or revealing these commands in scripture.19

The second perspective is a “this-worldly” approach to the metaphysical status of morality. This perspective follows in the skeptical philosophical tradition, such as that articulated by Greek philosopher Sextus Empiricus, who denied the objective status of moral values. “Technically skeptics did not reject moral values themselves, but only denied that values exist as spirit-like objects, or as divine commands in the mind of God. Moral values, they argued, are strictly human inventions, a position that has since been called moral relativism. There are two distinct forms of moral relativism. The first is individual relativism, which holds that individual people create their own moral standards. Friedrich Nietzsche, for example, argued that the superhuman creates his or her morality distinct from and in reaction to the slave-like value system of the masses. The second is cultural relativism which maintains that morality is grounded in the approval of one's society - and not simply in the preferences of individual people. This view was advocated by Sextus, and in more recent centuries by Michel Montaigne and William Graham Sumner. In addition to espousing skepticism and relativism, "this-worldly" approaches to the metaphysical status of morality deny the absolute and universal nature of morality and hold instead that moral values in fact change from society to society throughout time and throughout the world. They frequently attempt to
defend their position by citing examples of values that differ dramatically from one culture to another, such as attitudes about polygamy, homosexuality and human sacrifice".  

**Objectivism and Relativism**

**Moral objectivism** or **moderate moral realism** is the position that certain acts are objectively right or wrong, independent of human opinion. According to Richard Boyd, moral realism means that:

1. Moral statements are the sorts of statements which are (or which express propositions which are) true or false (or approximately true, largely false, etc.);
2. The truth or falsity (approximate truth...) of moral statements is largely independent of our moral opinions, theories, etc.;
3. Ordinary canons of moral reasoning—together with ordinary canons of scientific and everyday factual reasoning—constitute, under many circumstances at least, a reliable method for obtaining and improving (approximate) moral knowledge.

**Oxford Companion to Philosophy**

According to R. W Hepburn, to adopt objectivism is to argue that moral judgments can be rationally defensible, true or false, that there are rational procedural tests for identifying morally impermissible actions, or that moral values exist independently of the feeling-states of individuals at particular times.

**Moral Relativism**

“In philosophy, **moral relativism** is the position that moral or ethical propositions do not reflect objective and/or universal moral truths, but instead make claims relative to social, cultural, historical or personal circumstances. Moral relativists hold that no universal standard exists by which to access an ethical proposition's truth; moral subjectivism is thus the opposite of moral absolutism. Relativistic positions often see moral values as applicable only within certain cultural boundaries (cultural relativism) or in the context of individual preferences (moral subjectivism). An extreme relativist position might suggest that judging the moral or ethical judgments or acts of another person or group has no meaning, though most relativists propound a more limited version of the theory.”

**Psychological Issues in Metaethics**

A second area of metaethics involves the psychological basis of our moral judgments and conduct, particularly understanding what motivates us to be moral. Why do some people attempt to act morally while others do not? There are a myriad number of reasons why some people seek to act morally such as to avoid being punished for an immoral act, to gain praise from one’s parents, superiors and peers, to attain happiness, to be dignified, or to fit in with society.

**Egoism and Altruism**

“One important area of moral psychology concerns the inherent selfishness of humans.
17th century British philosopher Thomas Hobbes opined that many, if not all, of our actions are prompted by selfish desires. Even if an action seems selfless, such as donating to charity, there are still selfish causes for this, such as experiencing power over other people. This view is called psychological egoism and maintains that self-oriented interests ultimately motivate all human actions. Closely related to psychological egoism is a view called psychological hedonism which is the view that pleasure is the specific driving force behind all of our actions. 18th century British philosopher Joseph Butler agreed that instinctive selfishness and pleasure prompt much of our conduct. However, Butler argued that we also have an inherent psychological capacity to show benevolence to others. This view is called psychological altruism and maintains that at least some of our actions are motivated by instinctive benevolence.”

**Emotion and Reason**

Moral psychology involves a dispute concerning the role of reason in motivating moral actions. “18th century British philosopher David Hume argued that moral assessments involve our emotions, and not our reason. According to Hume, we can amass all the reasons we want, but that alone will not constitute a moral assessment. We need a distinctly emotional reaction in order to make a moral pronouncement. Reason might be of service in giving us the relevant data, but, in Hume’s words, "reason is, and ought to be, the slave of the passions.” 20th century philosopher, A.J. Ayer, similarly denied that moral assessments are factual descriptions. Ayer opined, although the statement "it is good to donate to charity" may on the surface look as though it is a factual description about charity, it is not. Instead, a moral utterance like this involves two things. First, I (the speaker) I am expressing my personal feelings of approval about charitable donations and I am in essence saying "Hooray for charity!" This is called the emotive element insofar as I am expressing my emotions about some specific behavior. Second, I (the speaker) am trying to get you to donate to charity and am essentially giving the command, "Donate to charity!" This is called the prescriptive element in the sense that I am prescribing some specific behavior.”

18th century German philosopher Immanuel Kant opposed Hume’s emotive theory of ethics and argued that moral assessments are acts of reason. Kant conceded that emotional factors often do influence our conduct. However, in his opinion, true moral action is motivated only by reason when it is free from emotions and desires. Rationalist, Kurt Baier, proposed direct opposition to the emotivist and prescriptivist theories of Ayer and others. Baier focuses more broadly on the reasoning and argumentation process that takes place when making moral choices. “All of our moral choices are, or at least can be, backed by some reason or justification. If I claim that it is wrong to steal someone’s car, then I should be able to justify my claim with some kind of argument. For example, I could argue that stealing Smith's car is wrong since this would upset her, violate her ownership rights, or put the thief at risk of getting caught. According to Baier, then, proper moral decision making involves giving the best reasons in support of one course of action versus another.”
Normative Ethics

Normative ethics involves arriving at moral standards that regulate right and wrong conduct. The Golden Rule is a classic example of a normative principle: Do unto others as we would have others do unto us. According to this principle, since we would not want someone to harm us, it would be morally wrong for us to harm someone else. Using this reasoning, normative ethics maintains that we can theoretically determine whether any possible action is right or wrong. The Golden Rule is an example of a normative theory that establishes a single principle against which we judge all actions. Other normative theories focus on a set of foundational principles, or a set of good character traits.

The key assumption in normative ethics is that there is only one ultimate criterion of moral conduct, whether it is a single rule or a set of principles. Three strategies will be noted here: (1) virtue theories, (2) duty theories, and (3) consequentialist theories.

Virtue Theories

“Normative ethics is based on the belief that morality consists of following precisely defined rules of conduct, such as "don't lie, cheat, kill or steal. Virtue theorists stress the importance of developing good habits of character, such as benevolence. Plato emphasized four virtues called cardinal virtues: wisdom, courage, temperance and justice. Other important virtues are fortitude, generosity, self-respect, good temper, and sincerity. In addition to advocating good habits of character, virtue theorists hold that we should avoid acquiring bad character traits, or vices. Virtue theorists believe that virtuous character traits are developed in one's youth. Adults, therefore, are responsible for instilling virtues in the young.”

Duty Theories

Duty theories base morality on specific, foundational principles of obligation. These theories are sometimes called deontological, from the Greek word deon, or duty, in view of the foundational nature of our duty or obligation. They are also sometimes called nonconsequentialist since these principles are obligatory. There are four central duty theories:

“1) 17th century German philosopher Samuel Pufendorf classified dozens of duties under three headings: duties to God, duties to oneself, and duties to others. Concerning our duties towards God, he argued that there are two kinds: (a) a theoretical duty to know the existence and nature of God, and (b) a practical duty to both inwardly and outwardly worship God. Concerning duties towards oneself, these are also of two sorts: (a) duties of the soul, which involve developing one's skills and talents, and (b) duties of the body, which involve not harming our bodies, as we might through alcohol or drug addiction or suicide. Concerning our duties towards others, Pufendorf divides these between absolute duties, which are universally binding on people, and conditional duties, which are the result of contracts between people. Absolute duties are of three sorts: (a) avoid wrong doing towards others; (b) treat people as equals, and (c) promote the good of others.
Conditional duties involve various types of agreements, the principal one of which is the duty to keep one's promises.

2) The second duty-based approach to ethics is rights theory. Most generally, a "right" is a justified claim against another person's behavior - such as my right to not be harmed by you. Rights and duties are related in such a way that the rights of one person implies the duties of another person. For example, if I have a right to payment of $10 by Smith, then Smith has a duty to pay me $10. 17th century British philosopher John Locke opined that the laws of nature mandate that we should not harm anyone's life, health, liberty or possessions. For Locke, these are our natural rights, given to us by God. There are four features traditionally associated with moral rights. First, rights are natural insofar as they are not invented or created by governments. Second, they are universal insofar as they do not change from country to country. Third, they are equal in the sense that rights are the same for all people. Fourth, they are inalienable which means that I can not hand over my rights to another person.

3) Kant offered a third duty-based theory which emphasized a single principle of duty. Kant believed that we have moral duties to oneself and others, such as developing one's talents, and keeping our promises to others. Kant called his principle of reasoning the "categorical imperative." Kant believed that we should treat people as an end, and never as a means to an end. That is, we should always treat people with dignity, and never use them as mere instruments.

4) The fourth and more recent duty-based theory is that by British philosopher W.D. Ross, which emphasizes apparent or prima facie duties. Ross argues that our duties are "part of the fundamental nature of the universe." Ross's list of duties include:

- Fidelity: the duty to keep promises.
- Reparation: the duty to compensate others when we harm them.
- Gratitude: the duty to thank those who help us.
- Justice: the duty to recognize merit.
- Beneficence: the duty to improve the conditions of others.
- Self-improvement: the duty to improve our virtue and intelligence.
- Nonmaleficence: the duty to not injure others.

Ross recognized that situations will arise when we must choose between two conflicting duties. In a classic example, suppose I borrow my neighbor's gun and promise to return it when he asks for it. One day, in a fit of rage, my neighbor pounds on my door and asks for the gun so that he can take vengeance on someone. On the one hand, the duty of fidelity obligates me to return the gun; on the other hand, the duty of nonmaleficence obligates me to avoid injuring others and thus not return the gun. According to Ross, I will intuitively know which of these duties is my actual duty, and which is my apparent or prima facie duty. In this case, my duty of nonmaleficence emerges as my actual duty and I should not return the gun.”28
Consequentialist Theories

- **Consequentialism**: An action is morally right if the consequences of that action are more favorable than unfavorable.

It is common for people to determine their moral responsibility by weighing the consequences of their actions. According to consequentialist normative theories, correct moral conduct is determined *solely* by a cost-benefit analysis of an action's consequences:

Consequentialist normative principles require that we calculate and add up both the good and bad consequences of an action. Second, we then determine whether the total good consequences outweigh the total bad consequences. If the good consequences are greater, then the action is morally proper. If the bad consequences are greater, then the action is morally improper. Consequentialist theories are sometimes called *teleological* theories, from the Greek word *telos*, or end, since the end result of the action is the sole determining factor of its morality.

There are three subdivisions of consequentialism:

- **Ethical Egoism**: an action is morally right if the consequences of that action are more favorable than unfavorable *only to the agent* performing the action.
- **Ethical Altruism**: an action is morally right if the consequences of that action are more favorable than unfavorable *to everyone except the agent*.
- **Utilitarianism**: an action is morally right if the consequences of that action are more favorable than unfavorable *to everyone*.

**Types of Utilitarianism**

Jeremy Bentham presented one of the earliest fully developed systems of utilitarianism. Bentham proposed that we add up the consequences of each action we perform and thereby determine on a case by case basis whether an action is morally right or wrong. This aspect of Bentham's theory is known as *act-utilitarianism*. Second, Bentham also proposed that we tally the pleasure and pain which results from our actions. For Bentham, pleasure and pain are the only consequences that matter in determining whether our conduct is moral. This aspect of Bentham's theory is known as *hedonistic utilitarianism*.

John Stuart Mill introduced a version of utilitarianism that was rule-oriented. According to rule-utilitarianism, a behavioral code or rule is morally right if the consequences of adopting that rule are more favorable than unfavorable to everyone. Unlike act utilitarianism, which weighs the consequences of each particular action, rule-utilitarianism offers a litmus test only for the morality of moral rules, such as "stealing is wrong." Adopting a rule against theft clearly has more favorable consequences than unfavorable consequences for everyone. The same is true for moral rules against lying or murdering. Rule-utilitarianism, then, offers a two-tiered method for judging conduct. A particular action, such as stealing my neighbor's car, is judged wrong since it violates a moral rule against theft. In turn, the rule against theft is morally binding because adopting this rule produces favorable consequences for everyone. \(^{29}\)
Applied Ethics

Applied ethics is the branch of ethics which consists of the analysis of specific, controversial moral issues such as abortion, animal rights, euthanasia, suicide and capital punishment. In recent years applied ethical issues have been subdivided into groups such as medical ethics, business ethics, environmental ethics, and sexual ethics. Generally speaking, two features are necessary for an issue to be considered an "applied ethical issue." First, the issue needs to be controversial in the sense that there are significant groups of people both for and against the issue at hand. The second requirement for an issue to be an applied ethical issue is that it must be a distinctly moral issue. Moral issues concern universally obligatory practices, such as our duty to avoid lying. Frequently, issues of social policy and morality overlap, as with murder which is both socially prohibited and immoral.

Normative Principles in Applied Ethics

The following principles are the ones most commonly appealed to in applied ethical discussions:

- Personal benefit: acknowledge the extent to which an action produces beneficial consequences for the individual in question.
- Social benefit: acknowledge the extent to which an action produces beneficial consequences for society.
- Principle of benevolence: help those in need.
- Principle of paternalism: assist others in pursuing their best interests when they cannot do so themselves.
- Principle of harm: do not harm others.
- Principle of honesty: do not deceive others.
- Principle of lawfulness: do not violate the law.
- Principle of autonomy: acknowledge a person's freedom over his/her actions or physical body.
- Principle of justice: acknowledge a person's right to due process, fair compensation for harm done, and fair distribution of benefits.
- Rights: acknowledge a person's rights to life, information, privacy, free expression, and safety.¹⁰

Medical Issues in Applied Ethics

Health care professionals are in an unusual position of continually dealing with life and death situations. The field of medical ethics focuses on a range of controversial issues to include: 1) Prenatal issues regarding the morality of surrogate mothering, genetic manipulation of fetuses, the status of unused frozen embryos, and abortion; 2) Patient rights and physician's responsibilities, such as the confidentiality of the patient's records; 3) The AIDS crisis has raised the specific issues of the mandatory screening of all patients for AIDS, and whether physicians can refuse to treat AIDS patients; 4) Medical
experimentation on humans and 5) The morality issues of suicide, the justifiability of suicide intervention, physician assisted suicide, and euthanasia.

Medical Ethics

Six of the values that commonly apply to medical ethics discussions are:

- **Beneficence** - a practitioner should act in the best interest of the patient. *(Salus aegroti suprema lex.)*
- **Non-maleficence** - "first, do no harm" *(primum non nocere).*
- **Autonomy** - the patient has the right to refuse or choose their treatment. *(Voluntas aegroti suprema lex.)*
- **Justice** - concerns the distribution of scarce health resources, and the decision of who gets what treatment (fairness and equality).
- **Dignity** - the patient has the right to dignity.
- **Truthfulness and honesty** – the patient has the right to an accurate diagnosis and the provision of appropriate treatment.  

Ethical Issues Specific to Chiropractic

Evidence-Based Practice

Historically, the chiropractic profession has been challenged by the medical profession and the general public to prove the efficacy of manipulative therapy. At present, the measurement of patient outcomes and the appropriate use of scientific evidence in clinical decisions are behind the current push towards evidence-based practice.

According to Haldeman, “at least 60 randomized clinical trials have been published on manipulation for neck and back conditions, all suggesting better or equivalent outcomes to comparative treatments. What remains unstudied are common clinical decisions chiropractors confront daily, such as… how does one treatment approach compare to another.”

“For chiropractors and other physicians who treat spinal disorders, the challenge regarding evidentiary practice revolves around the limited availability and quality of evidence from which to make clinical decisions. One of the greatest issues is reflected in the adage “absence of evidence does not equal evidence against.”
Documentation

Primary Functions of Health Care Records

Health care records document the immediate care and treatment of the patient. They allow the physician to gauge daily progress. Records allow other members of your own health care team or other health care providers to have an understanding of the patient’s daily subjective complaints, objective findings, procedures performed, and the patient’s response to therapy.

Records document your services for reimbursement purposes - they should be clear, concise and legible, written in ink and should not be erased or altered. Records are critical for legal purposes, including malpractice claims. Doctor identification on each record is critical especially in the case of multi doctor offices.

Writing in a Medical Record

- Medical writing should be accurate, legible, brief, and clear.
- Never exaggerate, or record information falsely to justify extra treatment.
- Medical writing should be contemporaneous to the patients visit. Evidence from insurance billing fraud cases revealed some unethical chiropractors making up data and writing S.O.A.P. notes before actually examining and treating a patient. In some of these cases, the patients were personal injury patients who received multiple treatments per week for many months or years and the chiropractors were found to be guilty of fabricating medical information. In other cases, chiropractors wrote S.O.A.P. notes and submitted bills for patients that did not receive treatment.
- Information should be objective and should never contain criticisms of other physicians or of the patient.
- Report information concisely, utilizing short, succinct sentences and standardized abbreviations. Handwriting must be legible and easily read.

Documentation Strategies

Protective Strategies

Maintain a daily patient sign in sheet. Never allow your receptionist to sign in for the patient and keep a cover over previous patient signatures to ensure confidently.
Have the patient periodically handwrite a list of symptoms and complaints which coincides with the submission of progress reports.
Have the patient periodically hand write, date and sign a progress form which qualifies their status.
Know what is in your forms.
Tailor your patient intake forms to your practice. Read over every form in your office.
Forms which contain treatment related historical information at the top of the page and insurance and reimbursement information at the bottom of the page should be separated into two forms. This will reduce inferences that your main concern is reimbursement and not the health and well being of the patient. Respect the patient’s privacy. For example, intake forms should not include unnecessary personal questions about a patient’s sexual history. Also, history taking and any other discussions of a personal nature should be done in private. Compliance with HIPPA regulations is strongly stressed.

Every condition or complaint identified by the patient should be addressed. Avoid the use of treatment frequency schedules as these schedules infer a cookie cutter approach to treatment. The frequency of treatment and the type of treatment provided should be dependent upon the patient's diagnosis, documented response to treatment and clinical progress.

Approximately 90 percent of a doctor’s diagnostic impression is derived from information attained during the history taking process. Consequently, the development of accurate and thorough history taking skills is essential. The information derived from the history taking process allows the doctor to arrive at a working diagnosis, develop short term and long term goals and a treatment plan, and render appropriate treatment methodologies.

Never use the terms "Omissions and Errors Included" or "Dictated but Not Read" in any of your documents. This infers a lack of thoroughness and professionalism. Thorough and accurate record keeping is a standard of care and is mandated by many state chiropractic laws.

Document patient noncompliance with prescribed treatment plans. Also, document dates where the patient did not keep a scheduled appointment and record an explanation. Keep patient records forever. The statute of limitations (the law which establishes a timeframe beyond which a suit cannot be brought) varies from state to state and is subject to a wide range of judicial interpretation. In some states, the time clock doesn't start running until the injury is discovered or, in the case of a child, until they reach adulthood. Record daily patient encounters utilizing S. O. A. P. notations. These notations should be documented contemporaneous with the patient encounter. Avoid writing all of your patients daily office notes at one time at the end of the day because recollection can be skewed with the passage of time.

Case Scenario--During the course of a trial a chiropractor testified that he provided services to a patient on January 2, 2004. However, evidence is produced which reveals this patient was actually in another state on vacation on January 2, 2004. What effect would these facts have on the credibility of the chiropractor? While mistakes can occur, billing for services which were not provided can result in insurance fraud investigation and manual claims review of all of that doctor's billing submissions.

**Introduction to S. O. A. P. Notes**

The Gold Standard for daily office notations is the S. O. A. P. note. S. O. A. P. is an acronym, with each letter representing a section of the patient note. S. stands for subjective complaints; O. stands for objective findings; A. stands for clinical assessment; and P. stands for treatment plan.
The S. O. A. P. note was introduced by Dr. Lawrence Weed as a method of organizing medical records. The S. O. A. P. note records what the physician does to manage the patient’s condition on a daily basis and is a standardized form of communication. Third party payers make decisions about reimbursement based on the quality, legibility, and completeness of daily office notations. The method of writing S. O. A. P. notes helps the physician to organize the thought processes involved in patient care and offers a structured way of thinking for problem solving. They are also used for quality assurance and improvement purposes and chronicle subjective and objective improvement, patient response to treatment, and the efficacy of care. Information reported in one note can be compared with measurements taken and recorded in the past to monitor patient progress.

Objective findings which may be found in S. O. A. P. notes may include orthopedic, neurologic, and chiropractic findings. A testing procedure that illicit a positive finding should be noted and re-tested on the next date of treatment. Information derived from objective testing should be organized under headings, should be written in a clear and concise manner and should list the results of objective measurement procedures performed by the physician.

Summary of Do’s and Don'ts of Record Keeping

Do

- Maintain records in ink.
- Make additions and changes appropriately.
- Identify patient name, date and year of service. Document unusual events.
- Identify the record keeper.
- Record all patient contacts.
- Maintain legibility.
- Maintain a legend for any codes used.
- Maintain records forever.
- Fill in all blanks or make a line through blank spaces.
- Initial all documents rather than scratching out the entire record.
- Customize the forms used.
- Document patient non-compliance.
- Proof-read correspondence and reports.

Do Not

- Erase, skip lines, leave spaces, “squeeze in” notes, use correction fluid, or back date or alter.
- Say anything disparaging about the patient.
- Avoid judgmental words.
- Ever enter data prematurely.
- Avoid ambiguous words.
- Criticize other providers.
- Use two different pens on the same day’s entry.
How Long Should You Keep Records?

As a general rule of thumb, maintain patient records forever. Also, be knowledgeable of the statute of limitations for your particular state. Most states have statutes of limitation of 3 - 7 years. This means that a malpractice claim must be made within 3-7 years after the date of the negligent act. There is an exception which applies to a negligent act against a child. A person that claims to have been a victim of a negligent act while they were a child must bring suit within one year after their 18th birthday.

Patient Consent for Treatment

Consent is compliance in or approval of what is done or proposed by another. Consent falls into two categories; Informed Consent and Implied Consent.

Informed Consent

Informed consent involves a verbal interaction between the doctor and patient. Essential elements of informed consent include discussion of the patient’s condition, identification and explanation of proposed treatment, warning of the risks or consequences of treatment, disclosure of alternative treatment options and their risks and the probability of success or failure of the proposed treatment. Informed consent should be discussed with the patient before care begins. Having the patient sign a written consent form is a prudent risk management strategy.

"Where there is risk of significant harm from the treatment proposed, this risk must be disclosed, understood, and accepted by the patient. Such informed consent is required for ethical and legal reasons. The best record of consent is one that is objectively documented, such as, a witness’s written consent or videotape."

The 1984 case of Mason v. Forgie involved the concept of informed consent. The court of New Brunswick awarded Hayden Mason a judgment against Dr. Forgie, DC for more than $200,000 for failing to obtain Hayden Mason’s informed consent and failing to advise the patient before initiating treatment of the risks of treatment, particularly the risk of stroke. Hayden Mason was provided a cervical manipulation and suffered a stroke before leaving the doctors office. While the court found that Dr. Forgie was not negligent in using excessive force or with respect to his examination of the patient, he was found negligent in not advising the patient of the risk of stroke.

Advise the patient of the risks of treatment and the risks of leaving their condition.
untreated. Be familiar with statistics regarding unfavorable treatment results. For example, in the *Mason v. Forgie* case, Scott Haldeman, M.D., D.C. opined that the odds of a patient suffering a stroke due to a cervical manipulation are one stroke per one million manipulations. Document your discussion of the risks of treatment with the patient and their decision to receive or not receive treatment. If the patient refuses to follow the doctor’s treatment recommendations have them sign a notation acknowledging their refusal.

**Implied Consent**

This form of consent is granted by the patient's voluntary presentation for treatment. Implied consent occurs on each visit to the doctor's office. In general, implied consent takes place after informed consent with the patient having full knowledge of the proposed care plan and the treatment methods to be employed.

The prudent physician should never breach the doctor--patient relationship contract by exceeding the consent given by the patient. Patients can limit the scope of consent given for treatment. Consent limitations expressed by the patient become an integral part of the contract for services. For example, a patient can instruct their treating chiropractor not to adjust their lumbar spine. The subsequent performance of a lumbar adjustment would be a breach of contract and could trigger a malpractice claim. The unauthorized touching of another is actionable in itself as a battery. The commission of a battery can result in both civil and criminal causes of action.

**Doctor-Patient Confidentiality**

The concept of "doctor-patient confidentiality" derives from English Common Law and is based on ethical principles. It is different from "doctor-patient privilege," which is a legal concept. Both, however, are called upon in legal matters to establish the extent by which ethical duties of confidentiality apply to legal privilege. Legal privilege involves the right to withhold evidence from discovery and the right to refrain from disclosing information gained within the context of the doctor-patient relationship.

The Hippocratic Oath includes the promise that "Whatever, in connection with my professional service, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret." 38

Patient confidentiality stems from the special relationship created when a prospective patient seeks the advice, care, and/or treatment of a physician. It is based upon the general principle that individuals seeking medical help or advice should not be hindered or inhibited by fear that their medical concerns or conditions will be disclosed to others. Patients entrust personal knowledge of themselves to their physicians, which creates an uneven relationship in that the vulnerability is one-sided. There is generally an expectation that physicians will hold that special knowledge in confidence and use it exclusively for the benefit of the patient.
Confidentiality covers all medical records as well as communications between patient and doctor, and it generally includes communications between the patient and other professional staff working with the doctor.

The duty of confidentiality continues even after patients discontinue receiving treatment from their doctors. Once doctors are under a duty of confidentiality, they cannot divulge any medical information about their patients to third persons without patient consent.

**Key Points**

- There is no duty of confidentiality owed unless a bona-fide doctor-patient relationship exists or existed.
- The scope of the duty of doctor-patient confidentiality, as well as the existence of a doctor-patient legal privilege, varies from state to state. No federal law governs doctor-patient confidentiality or privilege.
- Generally, confidential information is information that is garnered by a doctor, as a result of a doctor's communications with or examination of a patient.
- The duty of confidentiality is not absolute. Doctors may divulge or disclose personal information, against the patient's will, under very limited circumstances. For example, the contract that an individual establishes with their insurance company allows the insurance company to request medical information from the patient’s doctor for reimbursement purposes.

**The Doctor-Patient Relationship**

There must be a bona fide "doctor-patient relationship" between individuals and a physician before any duty of confidentiality is created. Generally speaking, individuals must voluntarily seek advice or treatment from the doctor, and have an expectation that the communication will be held in confidence. This expectation of confidentiality does not need to be expressed. It is implied from the circumstances.

“If individuals meet a doctor at a party, and in the course of "small-talk" conversation, they ask the doctor for an opinion regarding a medical question that relates to them, the doctor's advice would most likely not be considered confidential as no doctor-patient relationship was established, and no duty is owed. However, the prudent and ethical doctor would be wise to avoid diagnosing an individual’s condition in this type of social setting.

In the case of an independent medical examination, there is generally no physician-patient relationship and no duty of confidentiality is owed to the patients. This is because the examinee did not seek the physician's advice or treatment, and the relationship is at arm's-length.

**Health Insurance Portability and Accountability Act (HIPAA)**

The Health Insurance Portability and Accountability Act, known as HIPAA was passed by Congress in 1996. The goals of the legislative act were fourfold: 1) to make health insurance portable anywhere in the country; 2) to make patient information private and secure 3) to reduce health care fraud and abuse; and 4) to reduce health care costs.
Good Samaritan

**Good Samaritan laws** in the United States are laws that protect people from being sued who choose to aid others who are injured or ill. They are intended to reduce bystanders’ hesitation to assist, for fear of being sued or prosecuted for unintentional injury or wrongful death. The name Good Samaritan refers to a parable told by Jesus in the New Testament (Luke 10:29-37). Good Samaritan laws provide a defense against torts over the activity of attempted rescue. These laws do not constitute a duty to help someone in need. In the United States the details of Good Samaritan laws in various jurisdictions vary, including who is protected from liability and in what circumstances. Not all jurisdictions provide protection to laypersons, in those cases only protecting trained personnel.

**General Guidelines**

1. Unless a caretaker relationship (such as a parent-child or doctor-patient relationship) exists prior to the illness or injury, or the "Good Samaritan" is responsible for the existence of the illness or injury, no person is required to give aid of any sort to a victim.
2. Any first aid provided must not be in exchange for any reward or financial compensation. As a result; medical professionals are typically **not** protected by Good Samaritan laws when performing first aid in connection with their employment.
3. If aid begins, the responder must not leave the scene until:
   4. it is necessary to call for needed medical assistance.
   5. somebody of equal or higher ability can take over.
   6. continuing to give aid is unsafe (this can be as simple as a lack of adequate protection against potential diseases, such as vinyl, latex, or nitrile gloves to protect against blood-borne pathogens) — a responder can **never** be forced to put himself or herself in danger to aid another person.
7. The responder is not legally liable for the death, disfigurement or disability of the victim as long as the responder acted rationally, in good faith, and in accordance with his level of training.  

**Professional Boundaries And Chiropractic Practice**

The establishment of professional boundaries between a Doctor of Chiropractic and their patient is essential to the patient’s health and well being and the legal protection of the doctor. Professional boundaries are important because they define the limits and responsibilities of each individual involved in the doctor - patient relationship. “The definition of a boundary is the ability to know where you end and where another person begins. When we talk about needing space, setting limits, determining acceptable behavior, or creating a sense of autonomy, we are really talking about boundaries. It is a general misconception that having good boundaries will distance you from others. However, the truth is that when you know where you end and others begin, you can then
closely engage with others because you won’t feel overwhelmed or unprotected. Having a sense of autonomy prevents the need to distance our self from others with a barrier.”

**Boundary Violations**

Any behavior that damages the patient, the doctor, and/or the therapy is a boundary violation. A boundary violation is the victimization and exploitation of a patent by the doctor and is a betrayal of the fiduciary covenant of trust. Boundary violations include sexual and non-sexual misconduct.

Boundary violations harm the patient and the professional alike. The ramifications of boundary violations are widespread. The damage from boundary violations can extend to the Chiropractic profession in general and to the families of the patient and the doctor.

Many boundaries exist in the doctor–patient relationship. These include boundaries of role, time, place and space, money, gifts and services, clothing, language and physical contact. Sexual misconduct usually commences with violations of more minor boundaries: Simon writes, “The road to doctor-patient sex is paved with progressive boundary violations. Except when a patient is raped, the doctor who eventually sexually abuses a patient follows a remarkably predictable ‘natural history' of sexual misconduct.

The general stages of sexual misconduct include: the gradual erosion of doctor neutrality; socialization of therapy; the patient is treated as ‘special'; doctor's self-disclosures begin; physical contact begins (e.g. hugs, kissing); extra therapeutic contacts occur; dating begins; sexual intercourse occurs. The long-term emotional consequences for the patient of being sexually involved with a doctor have been likened to rape or incest.

**Professional Boundary Issues in Chiropractic Practice**

**Physical Contact**

Chiropractic means done by hand. The practice of Chiropractic can involve palpation of the patient’s body, the movement of extremities, and the touching of the patients body during examination and the application of physiotherapy procedures. These forms of reasonable physical touching of the patient could be easily misconstrued by the patient as being inappropriate. Therefore, it is imperative that the doctor communicate to the patient on the first visit the type of clinically correct therapeutic contact that takes place during the course of chiropractic treatment. Physical contact beyond the clinical encounter would represent a boundary violation. Even forms of physical contact which are generally acceptable as forms of greeting such as hugging and handshaking should be avoided in the clinical setting. Such touch can be interpreted as sexual or inappropriate which necessitates careful and sound clinical judgment when using touch for supportive or therapeutic reasons. Clinicians must be cautious and respectful when any physical
contact is involved, recognizing the diversity of cultural norms with respect to touching, and cognizant that such behavior may be misinterpreted.

The crossing of boundaries per se does not necessarily mean that an unethical act occurred: after all, the crossing or erosion of boundaries is a normal part of the evolution of intimate relationships between human beings. Nor do all boundary transgressions between doctor and patient ultimately lead to sexual misconduct. As Gutheil and Gabbard write, "... the specific impact of a particular boundary crossing can only be assessed by careful attention to clinical context". To decide whether any instance of a boundary crossing is a boundary violation, the analysis has to examine the profiles of offending doctors. As mentioned previously, sexual misconduct is often progressive in nature. Consequently, the offending doctor’s history may be demonstrative of numerous boundary crossings which eventually lead to a serious boundary violation.

**Self disclosure**

In some cases, self disclosure may be appropriate. However, doctors need to be careful that the purpose of the self disclosure is for the patient’s benefit. A number of dangers may exist in self disclosure including shifting the focus from the needs of the patient to the needs of the doctor or moving the professional relationship toward one of friendship. The blurring of boundaries can confuse the patient with respect to roles and expectations. The doctor needs to ask themselves the question "Does the self disclosure serve the patient’s therapeutic goals?" Excessive self-disclosure, where the doctor discusses personal problems or aspects of their intimate life with the patient or discusses feelings of sexual attraction, must always be avoided. Excessive self-disclosure by the doctor personalizes the doctor-patient relationship and may inadvertently lead to the development of a doctor-patient sexual relationship.

**Gift Exchange**

Giving or receiving gifts of more than token value is contrary to professional standards because of the risk of changing the therapeutic relationship. A gift exchange can cause a patient to feel pressured to reciprocate to avoid receiving inferior care. Conversely, if a doctor accepts a significant gift from a patient, they risk altering the therapeutic relationship and could feel pressured to reciprocate by offering "special" care.

**Dual Relationship**

A dual relationship is one where the doctor is both the clinician and also holds a different significant authority or emotional relationship with the same person. Examples can include course instructor, or family member. The purpose of avoiding dual relationships is to avoid exploiting the inherent power imbalance in the therapeutic relationship.

Doctors should avoid relationships with their patients outside of therapy where either the doctor or patient is in a position to give a special favor, or to hold any type of power over the other. For example, a doctor should avoid employing a patient or their close relatives.
and engaging in business ventures with the patient. Doctors should refrain from requesting favors or assistance from patients that involves a relationship outside of therapy.

**Developing Friendships**

Generally, doctors should avoid becoming friends with patients and should refrain from socializing with them. Although there are no explicit guidelines that prohibit friendships from developing once therapy has terminated, doctors must use their clinical judgment in assessing the appropriateness of this for the individual patient. Potential power imbalances may continue to exist and influence the patient well past the termination of the formal therapeutic relationship.46

**Personal Space**

The performance of therapeutic and diagnostic procedures can cause a doctor to unavoidably invade a patient’s personal space. With respect to personal space, the key to averting a boundary crossing / violation is to communicate to the patient your intended actions before acting and receiving their verbal consent for entering into their personal space.47

**Care of Relatives or Friends**

The treatment of relatives and friends is a common occurrence for the Doctor of Chiropractic. According to Haldeman, with respect to the care of relatives and friends, “Doctors should question themselves regarding their objectivity, training, emotional involvement, ability to sustain patient compliance and accountability to standards of care.”48

**Dress**

The Doctor of Chiropractic should dress in a professional manner at all times during the course of the treatment of patients. Both male and female doctors should dress appropriately in clinical attire. The continuum of appropriate clinical attire can include the wearing of casual business clothes and smocks to the use of a tie and suit jacket. Unprofessional looking clothes such as tee shirts with offensive printing should be avoided at all times.

**Money**

According to Haldeman “Transfers of money clearly delineates the business boundaries of therapeutic relationships. Non-monetary forms of payment and barter may be ill advised at current times. Boundary violations regarding billing and insurance are
common, and giving away free care may be construed negatively from a professional liability standpoint.\textsuperscript{59}

**Language**

The appropriate use of language is essential throughout the doctor - patient relationship. “Communication with patients on a first name basis can personalize doctor - patient relationships. The use of first names with pediatric patients is typically appropriate, yet a younger doctor may be better off to default to the use of Mr. or Ms. with an elderly patient.”\textsuperscript{50}

**Personal Contact with a Patient After the Termination of Care**

The inherent power imbalances that exist in the doctor patient relationship may continue to influence the patient well past termination of care. Professional standards tend to prohibit a doctor from engaging in a sexual relationship with a former patient to whom any professional service was provided in the past two years. Even the most casual dating relationship may lead to forms of affectionate behavior that could fall within the definition of sexual abuse.

Ignoring established conventions that help to maintain a necessary professional distance between patients and members can lead to boundary violations. Examples include providing treatment in social rather than professional settings, not charging for services rendered, not maintaining clear boundaries between living and professional space in home offices, or scheduling appointments outside of regular hours or when no one else is in the office.

During the course of the treatment of a patient, it is always a boundary violation when a doctor acts upon a feeling of attraction for a patient. Haldeman writes, “although patients or doctors experiencing feelings of attraction to one another is neither abnormal or wrong, choosing to act on such feelings is a boundary violation. Before a physician initiates any kind of dating or romantic relationship, at a minimum, the doctor - patient relationship should be terminated and documented in the patient record. Furthermore, the notation should be signed by the patient. Different jurisdictions may have specific requirements or prohibitions and some have established guidelines, such as a 2 year waiting period following discharge.”\textsuperscript{51}

**Sexual Misconduct**

Sexualizing a professional, health-care relationship is against the law in many states. Sexual abuse can be defined broadly as: sexual intercourse or other forms of physical sexual relations between a doctor and a patient; touching, of a sexual nature of the patient by the doctor; or, behavior or remarks of a sexual nature by a doctor toward a patient.
There are NO circumstances in which sexual activity between a doctor and a patient is acceptable during the care of the patient. Because of the unequal balance of power and influence in the doctor-patient relationship, it is impossible for a patient to give meaningful consent to any sexual involvement with their doctor. A patient’s consent and willingness to participate in a personal relationship does not relieve the doctor of their duties and responsibilities for ethical conduct in this area.

The ACA Ethics Committee opined that sexual intimacies with a patient is unprofessional and unethical based on the existing provisions in the ACA Code of Ethics: A(6), A(7), A(10) and C(2).52

In a 1992 survey of 10,000 doctors in the United States, Nonette Gartrell found that 9% acknowledge sexual contact with patients.53

In 1784 Ben Franklin wrote “the physician can, if he will, take advantage of his patient. Even if we ascribe to him superfluous virtue, since he is exposed to emotions which awaken such desires, the imperious law of nature will affect his patient, and he is responsible, not merely for his own wrong doing, but for that he may have excited in another.”54

**Warning Signs of Impending Sexual Misconduct**

There may be times in practice when a doctor could find himself or herself drawn toward a patient or could experience feelings of attraction to a patient. It is vital that these feelings be recognized as early as possible and actions must be taken to prevent the relationship from developing into something other than a professional one. If the patient attempts to sexualize the relationship, by initiating or consenting to sexual contact, the sexual relationship is still considered sexual misconduct on the part of the doctor.

Research has shown that before actual physical contact or abuse occurs there are often a number of warning signs, or changes in the doctor’s behavior. Be alert to such signs that suggest he or she may be starting to treat a particular patient differently. These may include sharing personal problems with the patient, offering to provide therapy in social situations such as over dinner, offering to drive a patient home, not charging for therapy, or making sure the patient’s appointments are scheduled when no one else is in the office.

**Guidelines to Prevent Sexual Misconduct Boundary Violations**

1. Respect cultural differences and be aware of the sensitivities of individual patients.
2. Do not use gestures, tone of voice, expressions, or any other behaviors which patients may interpret as seductive, sexually demeaning, or as sexually abusive.
3. Do not make sexualized comments about a patient’s body or clothing.
4. Do not make sexualized or sexually demeaning comments to a patient.
5. Do not criticize a patient’s sexual preference.
6. Do not ask details of a patient’s sexual history or sexual likes/dislikes unless directly related to the purpose of the consultation.
7. Do not request a date with a patient.
8. Do not engage in inappropriate ‘affectionate' behavior with a patient such as hugging or kissing.
9. Do not engage in any contact that is sexual, from touching to intercourse.
10. Do not talk about your own sexual preferences, fantasies, problems, activities or performance.

Learn to detect and deflect seductive patients and to control the therapeutic setting. Maintain good records that reflect any intimate questions of a sexual nature and document any and all comments or concerns made by the patient relative to alleged sexual abuse, and any other unusual incident that may occur during the course of, or after an appointment. 55

Statistical Analysis of the Chiropractic Profession

It has been reported that chiropractors are 3.39 times more likely to be involved in violating professional boundaries than medical physicians. 56 57

According to Foreman and Stahl’s retrospective analysis of 216 chiropractors disciplined in California January 1998 and April 2002, 49 (22.6%) were for sexual offenses. A comparison to medical doctors over the same period demonstrates 10% of their violations were for sexual misconduct. The discipline rate for California MD's was 0.23/1,000 practitioners. The incidence rate for chiropractors was 1.01/1,000 practitioners for a resultant rate of incidence that is 339% higher than the medical profession. 58

Physician Insurance Fraud

It has been reported by a number of authoritative sources that insurance fraud constitutes an estimated $100-billion-a-year problem. The United States Government Accountability Office (GAO) estimates that $1 out of every $7 spent on Medicare is lost to fraud and abuse and that in 1998 alone, Medicare lost nearly $12 billion to fraudulent or unnecessary claims. 59

Insurance Physician Fraud Perspectives

- Nearly one of three physicians say it's necessary to game the health care system to provide high quality medical care. Journal of the American Medical Association (2000) 60
More than one of three physicians says patients have asked physicians to deceive third-party payers to help the patients obtain coverage for medical services in the last year. 
*Journal of the American Medical Association (2000)*

One of 10 physicians has reported medical signs or symptoms a patient didn't have in order to help the patient secure coverage for needed treatment or services in the last year. 
*Journal of the American Medical Association (2000)*

### Types of Insurance Fraud and Abuse

The most common type of health insurance fraud is false claim schemes. The goal in these schemes is to obtain undeserved payment for a claim or series of claims. Such schemes include any of the following when done deliberately for financial gain:

- Billing for services, procedures, and/or supplies that were not provided.
- Misrepresentation of what was provided; when it was provided; the condition or diagnosis; the charges involved; and/or the identity of the provider recipient.
- Providing unnecessary services or ordering unnecessary tests.

Other illegal procedures include:

- Charging for a service that was not performed.
- Unbundling of claims: Billing separately for procedures that normally are covered by a single fee. An example would be a podiatrist who operates on three toes and submits claims for three separate operations.
- Double billing: Charging more than once for the same service.
- Up coding: Charging for a more complex service than was performed. This usually involves billing for longer or more complex office visits (for example, charging for a comprehensive visit when the patient was seen only briefly), but it also can involve charging for a more complex procedure than was performed or for more expensive equipment than was delivered. Medicare documentation guidelines describe what the various levels of service should involve.
- Miscoding: Using a code number that does not apply to the procedure.
- Kickbacks: Receiving payment or other benefit for making a referral. Indirect kickbacks can involve overpayment for something of value. For example, a supplier whose business depends on physician referrals may pay excessive rent to physicians who own the premises and refer patients. Another example would be a mobile testing service that performs diagnostic tests in a doctor's office. Kickbacks can distort medical decision-making, cause over utilization, increase costs, and result in unfair competition by freezing out competitors who are unwilling to pay kickbacks. They can also adversely affect the quality of patient care by encouraging physicians to order services or recommend supplies based on profit rather than the patients' best medical interests. In 2000, the Office of the Inspector General issued a fraud alert warning against kickbacks disguised as rental payments.
Excessive or Inappropriate Testing

Many standard tests can be useful in some situations but not in others. The key question in judging whether a diagnostic test is necessary is whether the results will influence the management of the patient. Billing for inappropriate tests—both standard and nonstandard—appears to be much more common among chiropractors and joint chiropractic/medical practices than among other health-care providers. The commonly abused tests include:

- **Computerized inclinometry:** Inclinometry is a procedure that measures joint flexibility. Inclinometer testing may be useful if precise range-of-motion measurements are needed for a disability evaluation, but routine or repeated measurements "to gauge a patient's progress" are not appropriate. 67
- **Nerve conduction studies:** These tests can provide valuable information about the status of nerve function in various degenerative diseases and in some cases of injury. 68 However, "personal injury mills" often use them inappropriately "to "follow the progress" of their patients.
- **Surface electromyography:** This test, which measures the electrical activity of muscles, can be useful for analyzing certain types of performance in the workplace. However, some chiropractors claim that the test enables them to screen patients for "subluxations" and to follow their progress. This usage is invalid. 69
- **Thermography:** Thermographic devices portray small temperature differences between sides of the body as images. Chiropractors who use thermography typically claim that it can detect nerve impingements or "nerve irritation" and is useful for monitoring the effect of chiropractic adjustments on subluxations. These uses are not appropriate. 70

Ethical Decision Making Methodologies for the Doctor of Chiropractic

**Recognize an Ethical Issue**

1. Is there something wrong personally, interpersonally, or socially? Could the conflict, the situation, or the decision be damaging to people or to the community?
2. Does the issue go beyond legal or institutional concerns? What does it do to people, who have dignity, rights, and hopes for a better life together?

**Get the Facts**

3. What are the relevant facts of the case? What facts are unknown?
4. What individuals and groups have an important stake in the outcome? Do some have a greater stake because they have a special need or because we have special obligations to them?
5. What are the options for acting? Have all the relevant persons and groups been consulted? If you showed your list of options to someone you respect, what would that person say?

**Evaluate Alternative Actions From Various Ethical Perspectives**

6. Which option will produce the most good and do the least harm?
Utilitarian Approach: The ethical action is the one that will produce the greatest balance of benefits over harms.

7. Even if not everyone gets all they want, will everyone's rights and dignity still be respected?

Rights Approach: The ethical action is the one that most dutifully respects the rights of all affected.

8. Which option is fair to all stakeholders?

Fairness or Justice Approach: The ethical action is the one that treats people equally, or if unequally, that treats people proportionately and fairly.

9. Which option would help all participate more fully in the life we share as a family, community, society?

Common Good Approach: The ethical action is the one that contributes most to the achievement of a quality common life together.

10. Would you want to become the sort of person who acts this way (e.g., a person of courage or compassion)?

Virtue Approach: The ethical action is the one that embodies the habits and values of humans at their best.

Make a Decision and Test It

11. Considering all these perspectives, which of the options is the right or best thing for me to do?

12. If you told someone you respect why you chose this option, what would that person say?
If you had to explain your decision on television, would you be comfortable doing so?

Act, Then Reflect on the Decision Later

13. Implement your decision. How did it turn out for all concerned? If you had it to do over again, what would you do differently?71

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