Objective

The primary objective of this patient-centered, evidence-based document is to provide an educational tool to assist chiropractic physicians and their patients in making decisions about appropriate chiropractic health care for better patient outcomes. The strength of this document is that it is patient-centered, supported by the best available evidence and not solely condition based.

Further this document is profession-initiated with broad representation by Oregon licentiates in the development process. Extensive grassroots support facilitates the educational process and promotes implementation. Patient-centered, evidence-based objectives put the interest of the patient first, based on the best available evidence. Individual differences mandate that what may be good for a typical patient may not be good for the individual patient requiring flexibility in interpretation. Consensus based standards of quality derived from high level evidence, provides a basis for peer review criteria, to assist the profession in decision making based on predetermined elements of care against which aspects of individual chiropractic care can be compared. Perfect decisions about optimum care are not possible since the process of analyzing evidence and opinion is imperfect. Nevertheless the potential benefits from patient-centered, evidence-based objectives are protection of patients, reduction in practice variation, quality assurance, and improved risk management.
The Status of Chiropractic Practice Guidelines in North America

Interest in chiropractic practice and utilization guidelines gained momentum in the latter part of the 1980’s. Prior to 1990 several states, including Ohio, Oregon and Washington, had begun guideline development. With the publication of Vear’s book: Chiropractic Standards of Practice and Quality of Care in 1992\(^1\), some issues surrounding guidelines for chiropractic practice became formalized as standards. Beginning with the Mercy Conference Guidelines, published in 1993\(^2\) practice guidelines for the chiropractic profession came into the national arena. Following directly on this publication, the politically driven Wyndham guidelines\(^3\) were published by a group of straight chiropractors dissatisfied the Mercy proceedings. The process for both sets of guidelines that were based on consensus relied heavily on the use of authoritative theory and opinion, lacking a systematic evaluation of supporting evidence.

Procedure based guidelines significantly impacting the chiropractic profession have also been developed on a national level by the RAND Corporation\(^4\,^5\) and the Agency for Health Care Policy and Research\(^6\). Both groups evaluated supporting evidence for the use of manipulation in the treatment of acute low back pain, concluding that it is both safe and effective. These studies have been embraced enthusiastically by some chiropractors, which has gained more mainstream recognition for a limited role in which the chiropractor treats only back pain, and possibly neck pain and some forms of headache. Such a limited role, however, is not consistent with the broad scope of practice in the State of Oregon.

Guidelines continue to be put forth both nationally by the International Chiropractic Association (ICA)\(^7\) and the Council on Chiropractic Practice (CCP)\(^8\) and at the state level\(^9\) (Florida). These documents are still largely based on consensus opinion, without the panel members reviewing the best available evidence, and far from meeting the Institute of Medicine\(^10\) criteria for guideline development. The ICA, CCP and Florida Guidelines have conflicts with the accepted practice of chiropractic in Oregon relative to diagnosis, assessment and informed consent. The CCP guidelines are designed specifically for vertebral subluxation practice, which is not inclusive or representative of the practice of chiropractic in the State Oregon. In addition some contributors and panel members listed in these guidelines did not participate directly in the consensus process. Of serious concern is the significant number of misleading references. Although found to be more acceptable, the Mercy guidelines are based primarily on consensus and have not been updated, necessitating development of a current document to guide chiropractic practice in the State of Oregon.\(^11\)
Current Status of Practice and Utilization Guidelines in Oregon
The Oregon Chiropractic Practice and Utilization Guidelines were published in 1991\textsuperscript{12} by the Oregon Board of Chiropractic Examiners (OBCE) in response to public demand for more accountability. Developed through consensus, these guidelines were recognized in the Northwest as one of the most advanced documents at the time. Given the more than ten years that have elapsed since these guidelines were initiated, serious questions regarding their adequacy have been raised. In response to these questions, the OBCE implementing the strategic planning process, appointed a steering committee comprised of doctors of chiropractic, representative of the various constituencies in the State of Oregon, including: Chairman Charles Simpson (OBCE representative), members John Cafferty (subluxation based chiropractor), Thomas Dobson (initiator of the current guideline process), Janet Steward, and Jack Pederson (broad scope practitioners) with Meridel Gatterman as process consultant. Dr. Gatterman has 11 years of guideline development experience including: the Oregon Practice and Utilization Guidelines,\textsuperscript{12} the Mercy Guidelines\textsuperscript{2} and the Canadian Guidelines\textsuperscript{13}. Published works that employed a facilitated consensus process include development of chiropractic nomenclature\textsuperscript{14}, and a patient centered paradigm for both chiropractic\textsuperscript{15}, and complementary medicine.\textsuperscript{16}

The steering committee utilized the following four approaches to assess the status of the Oregon Chiropractic Practice and Utilization Guidelines, Volume I:

- survey of stakeholders;
- focus groups and key person interviews;
- expert reviews;
- application of the Institute of Medicine (IOM) of the National Academy of Sciences “provisional assessment instrument”.\textsuperscript{10}

The survey and focus groups responses, key person interviews, and expert reviews all identified deficiencies in the 1991 guidelines. The steering committee concluded that the 1991 guidelines (derived primarily through consensus of expert opinion with little documentation of evidence) are in need of revision. Inclusion of current scientific evidence coupled with broad professional consensus was designed to make the revision more accountable, credible, as well as patient centered and evidence-based.
Patient Centered, Evidence-based Care
Patient centered care puts the patient first, before cost cutting by managed care, doctor's egos, or financial gain. Patient centered practice evaluates the individual patient’s clinical state, predication, and preferences, and applies the most efficacious interventions to maximize the quality and quantity of life for that person. Chiropractic practice has traditionally been patient centered with anthropological and sociological studies providing evidence and seed material for a patient centered paradigm. Following evaluation of these studies combined with the philosophical first principles of chiropractic, a patient centered paradigm emerged. Subsequent to identification using qualitative methodology, a nominal panel comprised of chiropractic educators, researchers and practitioners validated a patient centered paradigm through a nominal consensus process. Based on this model the following characteristics of a patient centered paradigm were refined and agreed upon by the nominal consensus panel charged to assist in the development of the Oregon Practice Guidelines:

1. Recognition and facilitation of the innate organization and adaptation of the person;
2. Recognition that care should ideally focus on the total person;
3. Acknowledgment and respect for the patient’s values, beliefs, expectations and health care needs;
4. Promotion of the patient’s health through a preference for drugless, minimally invasive, and conservative care;
5. A proactive approach that encourages patients to take responsibility for their health;
6. The patient and patient centered practitioner act as partners in decision making, emphasizing clinically effective and economically appropriate care, based on various levels of evidence.

Evidence-based Care
Evidence-based practice has been defined as:

“the conscientious explicit, and judicious use of the current best evidence in making decisions about the care of individual patient’s”

Evidence-based practice means:

“integrating individual clinical expertise with the best available external evidence from systematic research”

Sackett emphasizes that “Good doctors use both individual clinical expertise, and the best available external evidence, and neither alone is enough. He notes that without clinical expertise, practice risks becoming tyrannized by evidence, because even excellent external evidence may be inapplicable or inappropriate for an individual patient. Without current best evidence, practice risks rapidly becoming out of date, also to the detriment of the patient. Evidence-based practice is not “cookbook practice.” It is also recognized that the best available evidence is not just limited to external evidence from randomized controlled trials but also involves the individual clinicians' expertise along with the
consensus of leading chiropractic clinicians and researchers based on varying degrees of
patient-centered clinical research. A thorough literature review is crucial to successful
evidence based practice.\textsuperscript{17}

**The Epistemology of Scientific Knowledge**
Consideration of how we know what we know is based on a hierarchy of ways of
knowing. This hierarchy gives us the degree of certainty that can be attributed to
evidence.

1. **Laws or Principles of Science**
   Theories that have been scientifically demonstrated and are now accepted as scientific
   fact based on a sequence of events occurring with unvarying uniformity under the same
   conditions. Laws and principles explain natural actions.

2. **Theories of Science**
   A set of related ideas that have the potential to explain or predict human experience in an
   orderly fashion and that are based on data. Theories follow a hypothesis that has been
   investigated and is now in an advanced data gathering mode. Although there are many
   questions that still need to be answered, this category of scientific knowledge is
   frequently used clinically as if it were a demonstrated fact.

3. **Hypothesis**
   Hypotheses are testable statements referred to as the working tools of science. A
   question or conjecture is presented and tested through observation and data gathering and
   processing.

4. **Conjecture**
   An opinion of an expert person in a given field of science based on slight evidence.

**Guidelines for Grading Evidence**
The strength of both scientific and legal evidence is graded according to three levels.
Standards of practice require higher levels of supporting evidence on which to judge
competency. Due to resource limitations, evidence ratings in this document are limited to
Standards. References following statements clearly indicate what evidence supports this
document.

**Scientific Evidence**
The convention for grading scientific evidence is based on a hierarchy of levels that
provide degrees of predictability.

**Type I**
Evidence provided by one or more well designed\textsuperscript{*} randomized controlled clinical trial(s)
(RCT) for therapeutic interventions or by one or more well designed descriptive studies
that address sensitivity, specificity, and predictive value (for diagnostic
procedures/devices).

**Type II**
Evidence provided by one or more well designed observational studies, such as a case
control or cohort study, or a well designed prospective case series, or clinically relevant
basic science studies that address sensitivity, specificity, and predictive value.
Type III
Evidence provided by studies not meeting the criteria of Type I or II, that may include expert opinion, field practitioner consensus, or other sources, as judged by an Expert Panel.

* For the purpose of this document, “well designed” refers to a study that has, at a minimum, relatively high internal validity (low systematic error) and sufficient precision for statistical significance (adequate study numbers)

Legal Evidence
Legal evidence is also based on a hierarchy of supporting evidence ranging from statutes which are mandatory to legal opinion that is discretionary.

Legal Type I
This administrative aspect of practice is mandated by ORS or OAR, or is found to be essential and is necessary (A standard of practice).

Legal Type II
This administrative aspect of practice is supported by uncontrolled studies and/or published legal opinion and is recommended, and in some cases mandatory (Official AG opinion vs., “legal opinion” written in a legal peer review journal vs. “case law” opinion)

Legal Type III
This administrative aspect of practice is supported by a consensus of practitioners as determined by the Expert Panel or by expert legal opinion and is discretionary.
A Three Tiered Evidence-based Consensus Process

The process used to develop the following chapters involves three levels of consensus. Each chapter is developed first through a seed statement from a seed panel composed of 5-7 panel members that review the best available evidence. Seed statements are then reviewed by a 9-15 member nominal panel that reviews all chapters for consistency, continuity and to minimize redundancy. The final review is by a 100-member Delphi panel that reviews one or all chapters and participates in the consensus process by mail.

Panel Selection

Selection of panel members is made by the Steering Committee based on the following criteria:

A. Geographical representation
B. Philosophical representation
C. Gender representation
D. Practice experience representation

Where possible a balance of each population identified will be included. To facilitate frequent meetings balanced geographical representation is not always possible at the seed panel level.

Challenges to the Consensus Process

Challenges to the consensus process have included lack of differentiation between guidelines and standards, political opposition to guideline development, limited resources, and a scarcity of quality evidence.

Standards versus Guidelines

Despite peer reviewed publication of a paper by two steering committee members and one nominal panel member that differentiated between guidelines and standards⁴¹, there remains the perception by many that guidelines are synonymous with standards. This in part is due to the inappropriate use of guidelines as absolute standards by third party payers and attorneys. While this utilization of guidelines is not consistent with the defined use of these terms in the literature, the process has been hampered by the fear that development of guidelines will lead to misuse.

Guidelines are considered to be recommendations that allow for flexibility and individual patient differences. Standards are more binding and require a high level of supporting evidence. While guidelines serve as educational tools to improve the quality of practice, standards that outline minimum competency are used more as administrative tools on which to base policy. Confusion generated by poor differentiation of guidelines from standards therefore contributes to mistrust of the guideline process. Because of this challenge the updated Oregon Practice and Utilization Guidelines document is referred to as a Manual for Evidence Based Chiropractic Practice. Where applicable, standards are clearly stated.
**Political Opposition**

Opposition to updating the Oregon practice and utilization guidelines by representatives of one political organization is an ongoing challenge to the process. A concerted attempt by members of the steering committee, the OBCE and members of the profession to engage these individuals in continued participation in the process has been made, emphasizing that the way to ensure that the process is inclusive is to participate. Various claims regarding lack of inclusion of evidence or changes in seed statements as they proceeded through the process could have been easily addressed and resolved if these individuals would have communicated their concerns in a timely manner and continued their participation. At all times the process has worked to improve seed statements as they achieved consensus through the seed panel, nominal panel and Delphi process.

**Resources**

A challenge to the current process is the lack of adequate resources to fully support an ambitious effort. A grant application for outside funding was not successful and a request for additional funding from the OBCE was not approved by the 2001 Legislative Session. This prevented contracting with a project manager as planned, contributing to slower progress.

However, the process has proceeded with strong support from numerous Oregon chiropractors who have contributed their time and energy to review evidence, draft seed statements, and attend meetings or review drafts sent to them by mail. The OBCE has supported this effort by providing meeting space, mailings, and printing services within its current budget.

**Lack and Quality of Evidence**

The greatest challenge to evidence-based practice is the lack of evidence. This is true of all health care professions. This has been especially acute for the chiropractic profession that has long been denied external funding. It is only in the recent past that significant federal funding has been applied to the study of chiropractic. This has created a problem of legitimization in which the science of chiropractic has been evaluated through the lens of the medical paradigm.

**Paradigm**

A paradigm is a socially constructed disciplinary matrix, grounded on habits of mind and webs of belief. It is characterized by symbolic generalizations, shared models and shared values. It includes concepts, perceptions, and techniques shared by a scientific community and used by that community to define legitimate problems and legitimate solutions. A paradigm is useful as both a plan of action and a lens through which the chiropractor views the patient. The chiropractor is thus provided with a worldview through which the science of chiropractic can advance, in the patient’s interest.
The Chiropractic Paradigm

The Association of Chiropractic Colleges (ACC) agreed to the following chiropractic paradigm that has subsequently been adopted by the World Federation of Chiropractic:

The purpose of chiropractic is to optimize the patient’s health. This is based on the principle that the body’s innate recuperative power is affected by and integrated through the nervous system. The practice of chiropractic within the chiropractic paradigm includes:

- establishing a diagnosis;
- facilitating the body’s homeostasis through emphasis on neurological and biomechanical integrity, and
- promoting health.

The Chiropractic Foundation

The foundation of chiropractic includes philosophy, science, art, knowledge, and clinical experience. The chiropractic paradigm directly influences the following:

- patient health through quality care;
- education;
- research;
- health care policy and leadership;
- relationships with other health care providers;
- professional stature; public awareness and perceptions

The Subluxation

Chiropractic is concerned with the preservation and restoration of health, and focuses particular attention on subluxation. A subluxation is a complex of functional and/or structural and/or pathological articular changes that compromise neural integrity and may influence organ system function and general health. A subluxation is evaluated, diagnosed, and managed through the use of chiropractic procedures based on the best available rational and empirical evidence.

Chiropractic Scope of Practice

Members of the Association of Chiropractic Colleges educate students for the competent practice of chiropractic. These accredited academic institutions have defined the scope of chiropractic practice within the chiropractic paradigm.

Since human function is neurologically integrated Doctors of Chiropractic evaluate and facilitate biomechanical and neuro-biological functions and integrity through the use of appropriate conservative, and diagnostic and chiropractic care procedures. Therefore, direct access to chiropractic care is integral to everyone’s health care regimen.

Chiropractic Practice

A. Diagnosis
Doctors of Chiropractic, as primary contact health care providers, employ the education, knowledge, diagnostic skill and clinical judgment necessary to determine appropriate chiropractic care and case management. Doctors of Chiropractic have access to diagnostic procedures and/or referral resources as required.

B. Case Management
Doctors of chiropractic establish a doctor/patient relationship and utilize adjustive and other clinical procedures unique to the chiropractic discipline. Doctors of Chiropractic may also use other conservative patient care procedures, and when appropriate, collaborate with and/or refer to other health care providers.

C. Health Promotion
Doctors of Chiropractic advise and educate patients and communities in structural and spinal hygiene and healthful living practices\textsuperscript{24}.
Chiropractic Nomenclature Developed through Consensus
Chiropractic nomenclature has been developed through agreement obtained by a rigorous process using both nominal and Delphi consensus methods\textsuperscript{14}. Moving through increasingly complex stages agreement was reached on the following ten terms used to discuss chiropractic science:

**Articular functional units.**
- Motion segment-A functional unit made up of the two adjacent articulating surfaces and the connecting tissues binding then to each other.
- Spinal motion segment- Two adjacent vertebrae, and the connecting tissues binding then to each other.

**The lesion treated by chiropractors.**
- Subluxation-A motion segment, in which alignment, movement integrity and/or physiological function are altered although contact between joint surfaces remains intact.
- Manipulable (chiropractic) subluxation-A subluxation in which alignment, movement integrity and/or function can be improved by manual thrust procedures.
- Subluxation complex-A theoretical model of motion segment dysfunction (subluxation) which incorporates the complex interaction of pathological changes in nerve, muscle, ligamentous, vascular and connective tissues.
- Subluxation syndrome-An aggregate of signs and symptoms that relate to pathophysiology or dysfunction of motion segments.

**Treatment procedures utilized by chiropractors.**
- Adjustment-Any chiropractic therapeutic procedure that utilizes controlled force, leverage, direction, amplitude, and velocity which is directed at specific joints or anatomical regions. Chiropractors commonly use such procedures to influence joint and neurophysiological function.
- Manual therapy-Procedures by which the hands directly contact the body to treat the articulations and/or soft tissues.
- Manipulation-A manual procedure that involves a directed thrust to move a joint past the physiological range of motion, without exceeding the anatomical limit
- Mobilization-Movement applied singularly or repetitively within or at the physiological range of joint movement, without imparting a thrust or impulse, with the goal of restoring joint mobility.
Introduction to the Philosophy, Science and Art of Chiropractic

The Traditional Philosophy of Chiropractic
The traditional vitalistic philosophy of chiropractic is based on the scientific philosophy of biology that features the functional organization of living beings. Living beings are capable of maintaining their overall organization in the face of extensive variations in their environment. Similar organization does not occur in the non-living world. According to D.D. Palmer, the founder of chiropractic, the vital functioning of each individual is directed by the body’s innate intelligence, and expression of universal intelligence. Universal intelligence accounts for the universal regularities and laws of nature that are the concern of physics and chemistry, and the particular regularities and laws of physiology.

That those processes of bodily functioning whereby the body is regulated through electrophysiological, biochemical, immunological, and other mechanisms, forms the basis of the science of physiology. Palmer’s concept of “innate intelligence”, the ability of the body to regulate and repair itself, is also referred to as homeostasis. The philosophy of chiropractic is based on the belief that the true locus of health comes from within through modulation by the nervous system. Recognition of the role of the nervous system in health and disease has increased in the last decade. Recent evidence that supports Palmer’s traditional concept is exemplified by the emerging focus on neuroimmunology which provides evidence in support of a strong relationship between nervous system and immunological function.

The philosophy of chiropractic is both vitalistic and holistic. Chiropractic holistic philosophy views the patient as a whole person, not as a disease bearing organism. The body is seen as an integral unit capable of maintaining health. The systems of the body are viewed as complex, interactive, and have a powerful ability to self-correct provided functional integrity is maintained. The holistic philosophy of chiropractic promotes health, prevents illness, and encourages healing through care that focuses on the total individual in the context of personal, familial, social, and environmental factors.

Holism with respect to humans recognizes that the whole has properties that its parts lack and the properties of the parts interact to form the whole. Perceiving the whole is more difficult than the parts. It often requires subdividing the whole looking for connections and the interaction of the parts in the context of the whole. In the historical perspective of chiropractic philosophy there is an important interrelationship between optimal nerve function, the integrity of the musculoskeletal system, and health.

The Science of Chiropractic
Traditionally, the science of chiropractic has focused on the modulating function of the nervous system in the self healing of the human organism, and the role that interference with the nervous system has on the loss of optimal health. While this is fundamental to
chiropractic principles the most compelling scientific evidence to date supports chiropractic treatment of neuromusculoskeletal conditions.

In the more than one hundred years that chiropractic has been in existence, much of the significant and reproducible research has been compressed within the past two decades. The past five years has been particularly significant with the evidence supporting the primary chiropractic intervention (manipulation) as one of the first-line means of health care intervention in the treatment of acute low back pain in adults. The science of chiropractic comes from basic science evidence, case studies, clinical trials, and other outcome studies.

In 1975 the NINCDS (National Institute of Neurological, Circulatory, Disorders and Stroke) conference found that “specific conclusions cannot be derived from the scientific literature for or against either the efficacy of spinal manipulative therapy or the pathophysiological functions from which it is derived”. Given the impetus of this conference, considerable research has been conducted demonstrating the safety and efficacy of this procedure. In spite of the paucity of funds, (up to 1994 coming solely from the profession itself), chiropractic researchers have made steady gains. With external funding, future gains promise to add significant data to support the uniqueness of chiropractic theories and to sustain evidence-based practice.

Basic science studies have been primarily been designed to test theories related to one piece of the core of chiropractic practice, the chiropractic spinal subluxation. Where the spinal subluxation seen by allopathic (medical) practitioners is viewed radiographically and frequently demonstrates hypermobility, the chiropractic subluxation typically exhibits restricted motion, along with misalignment and altered neurological function.

Anatomical studies related to subluxation have primarily investigated the components of the spinal motion segments including the zygapophyseal joints, structures surrounding the intervertebral foramen, and the sacro-iliac joints. Basic scientific evidence for chiropractic subluxation has also been demonstrated in 16 studies of animal models.

Studies in the field of neuroscience have included investigation of the innervation of components of the spinal motion segment, spinal nerve roots, peripheral nerves, and the autonomic nervous system. Studies of systemic effects of spinal manipulation through nervous system modulation include changes in immune function. Neurophysiological investigations into pain modulation include, spinal cord mechanisms of referred pain and neurologically linked physiological aberrations.

Numerous biomechanical studies related to subluxation and manipulation have been conducted advancing the science of chiropractic. A major area of chiropractic research has focused on the characterization of the forces applied to the surface of the patient during various adjustive procedures, others investigators have evaluated loads and displacements used to measure the mechanics of spinal segments. The mechanical effects of cavitation and the audible release accompanying high velocity low amplitude thrust procedures have also been studied.
These investigations, primarily conducted by chiropractors are but a small part of basic science research that validates chiropractic theories. Studies conducted by basic scientists in other related fields have provided considerable support beyond the studies mentioned here. Knowledge gained by basic science models has yielded information on subluxation not available by measurements on living humans.

The most compelling evidence for chiropractic care comes from clinical trials that evaluate the effectiveness spinal manipulation for neuromusculoskeletal conditions. Over 40 clinical trials of spinal manipulation for the treatment of low back pain have been conducted. These have been subjected to evaluation of methodological quality and meta-analysis. This has led to acceptance of manipulation as a viable alternative to allopathic care in the treatment of acute low back pain. Chronic low back pain while subjected to less scrutiny, has also demonstrated significant response to chiropractic manipulation. Evidence from clinical trials also supports the treatment of neck pain with manipulation. Benefit from cervical manipulation has also been demonstrated from headache trials studying tension, migraine, and cervicogenic types.

Non musculoskeletal conditions for which clinical trials of varying rigor supporting chiropractic intervention include obstetric and gynecologic disorders (such as dysmenorrhea and premenstrual syndrome), and pediatric conditions, (such as: colic, otitis media, and hyperactivity). Trails of chiropractic care of other conditions have demonstrated mixed results. Hypertension studies involving adults demonstrated both short-lived reductions and no significant alteration in blood pressure readings. Studies of children with enuresis have demonstrated both the effectiveness of chiropractic treatment and no efficacy beyond the natural history of the condition. Asthma trials studying both children and adults have shown positive results, no significant improvement, and both no benefit, and a significant decrease in nighttime symptoms, in the same study.

In addition to the clinical trials previously mentioned, a variety of methods have been used for outcomes research including community based trials, observational studies and cross sectional surveys all of which provide supporting data. Among the community based trials the Meade studies reported greater effectiveness of chiropractic care for low back pain compared to hospital-based physical therapy. Observational studies of chiropractic care designed to assess patient outcomes for low back pain have been reported. Cross-sectional studies of chiropractic have evaluated care-seeking for acute and chronic low back pain. Physicians’ beliefs and behaviors regarding management of low back pain and patient’s satisfaction with the care provided have also been studied. A preliminary study suggests that geriatric patients under chiropractic care are more apt to report better health status, more likely to exercise vigorously, and more likely to be mobile in the community.

This discussion has not included many of the cohort studies, case series or case reports that document the effectiveness of chiropractic care. There is evidence from these types of studies also contributes to chiropractic science. In addition these studies provide clues
as to the direction of future chiropractic research. Agendas for prioritizing future research related to chiropractic theories and practice are conducted nationally on an annual basis\textsuperscript{123}, and internationally on a biannual basis\textsuperscript{124}. Regular research conferences that present the results of chiropractic are held worldwide including those sponsored by the Foundation for Chiropractic Education and Research (The International Conference on Spinal Manipulation), and the World Federation of Chiropractic.

There is little doubt that evidence from clinical trials clearly supports the treatment of low back pain by chiropractors\textsuperscript{125}. Evidence for the treatment of neck pain\textsuperscript{126} and headaches\textsuperscript{81-88} is also convincing. Although both clinical experience and expert opinion in the chiropractic, osteopathic, and medical literature\textsuperscript{127-131} suggest an observable link between manipulation and improvement in at least some non-musculoskeletal conditions clinical trails lag far behind actual practice. To date at least 73 randomized clinical trials of a broadly defined spinal manipulative procedure have been reported in the English language literature. No trial to date has found manipulation to be statistically or clinically less effective than the comparison treatment\textsuperscript{132}. Causation related to subluxation remains to be demonstrated. It is imperative to remember that lack of evidence does not constitute evidence against, while further research accumulates in the field of chiropractic science.

The Clinical Art of Chiropractic

Chiropractic practice is fundamentally patient centered and pragmatic, based on empirical results. This patient centered orientation as opposed to an illness orientation has traditionally been central to the clinical art of chiropractic\textsuperscript{133}. Coulehan\textsuperscript{134} states that chiropractors do not subtract the patient to get to the disease as if peering through a translucent screen to find a disease entity within. He also states that the application of this clinical art is a matrix of acceptance, validation, explanation and treatment.

The sense of acceptance or positive regard for a patient is considered one of the core qualities necessary for patient-doctor interaction\textsuperscript{134}. Validation includes acknowledging the patient’s perceptions, values, health care preferences and expectations. Genuineness both as the ability to be oneself in a relationship without hiding behind a role or facade\textsuperscript{134}, and genuine caring\textsuperscript{135} have also been noted as prominent in chiropractic care.

Chiropractic art includes a clear and understandable explanation of the patients condition\textsuperscript{134}. This explanatory model is mechanistic, holistic and based on science. Additionally, it is based on a logical set of beliefs presented in scientific terminology, promoting a natural noninvasive approach to healing\textsuperscript{135}. It includes stressing influences on health, “drugless” treatment and a positive, dynamic view of the healthy state\textsuperscript{135}. Patients are encouraged to take responsibility for their health and enter into a partnership in decision making\textsuperscript{15}. Chiropractors strive to develop a positive image of patients’ personal control over their health that requires commitment and cooperation\textsuperscript{135}.
Primary to the chiropractic explanatory model is the emphasis that the chiropractic adjustment facilitates a change in physiology which can translate into improved health. Traditional chiropractic thought explains this phenomenon as the body’s innate capacity for healing. Additionally chiropractic art includes enhancing patients’ focus on their health. Current understanding of biopsychosocial factors explains how the chiropractor strengthens patients’ belief that they will recover and is considered to be included in the chiropractic clinical art\textsuperscript{135}. Chiropractors seek to create conditions in their patients that are conducive to the liberation of patient’s innate recuperative capacities, thus enabling them to return to their optimal state of health\textsuperscript{15}.

Chiropractic treatment is characterized by advanced skill in manual procedures. The level of skill necessary to perform a successful adjustment requires years of training in the art of palpation and adjusting. Both the chiropractic examination and treatment involves extensive “laying on of the hands”\textsuperscript{135}. Mastery of chiropractic technique procedures utilizes the healing power of touch, adding comfort to the clinical action of the treatment.

Beyond the skills of patient evaluation and diagnostic testing germane to portal of entry providers, much of the art of chiropractic involves the location and correction of subluxation. This includes the skill at analysis used to locate the subluxation, the specific adjustive technique used to reduce or correct the subluxation, and the assessment used to determine the type of future care. Chiropractic adjustive procedures are specific and include high velocity low amplitude thrust techniques (manipulation), mechanically assisted techniques, light touch techniques, soft tissue techniques and reflex procedures\textsuperscript{136}.
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Standards of Quality

1. The patient centered chiropractor acts first and foremost in the patient’s interest.
2. The patient centered chiropractor approaches the patient as a whole being.
3. The patient and patient-centered chiropractor act as partners in decision making that encourages the patient to take responsibility for his/or her health.

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Those who participated in the process so far include:

Steering Committee: Current members (as of 2-1-03) Drs. David Day, Chair, Thomas Dobson, Kathleen Galligan, and Meridel Gatterman,. Former members: John Cafferty, Janet Fabricius-Steward, Barry Kop, Jack Pedersen, and Charles Simpson.


Evidence Seed Panel: Drs. John Cafferty, Meridel Gatterman, Michael Freeman, Ron LeFebvre, and Chuck Simpson.

Patient-Doctor Relationship Seed Panel: Drs. Kevin Holzapfel, Sunny Kierstyn, David Saboe, Steve Sebers; and Jan Nelson.

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Educational Manual for Evidence-Based Chiropractic

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Relationships are the bedrock of all interchanges between two people, and in general, involve caring, feeling, trust, power, and a sense of purpose. In a patient centered relationship the purpose is to help the patient. The helping relationship is founded on: empathy, congruence, genuineness, respect, positive regard, caring and concern for the other. Chiropractors offer a patient centered form of clinical care that exhibits these characteristics. The partnership arrangement, also characteristic of patient centered care, demands a sharing of power and control between the patient and doctor. The resulting alliance enhances patients’ sense of control over themselves. Tools for refining patient centered care in the chiropractic consultation can influence the locus of control in the patient-chiropractor relationship and enhance the patient’s sense of congruency.

The shift to patient centered care is reflected in the current trend in terminology, referring to the patient–doctor relationship instead of the doctor-patient relationship. Studies have found significantly greater patient satisfaction with chiropractic care over other practitioners treating similar conditions. The patient-doctor relationship plays an important part in patient satisfaction.
Section 2

PATIENT’S RIGHTS AND RESPONSIBILITIES

Awareness of patients’ rights has been heightened with the rise in health care consumerism. An increase in patient participation in the patient-doctor encounter has evened the power relationship with patients demanding the right to become more involved in their own health care decisions. This has led to more patient autonomy, a more egalitarian relationship, and active participation by patients in making decisions about their health care. The conventional model where the doctor “always knows best” no longer goes unchallenged. Relinquishing power to patients includes acknowledging a patient’s bill of rights.

Patient’s Bill of Rights

A patient and/or his/her legal representative has the right to:

- receive informed consent regarding procedures, risks and alternatives, and receive answers to questions with respect to treatment;
- refuse treatment and accept the potential consequences of that choice after thorough explanation;
- expect reasonable safety insofar as the health care environment is concerned;
- be interviewed and examined in surroundings that permit reasonable visual and auditory privacy;
- have another person present during examination and/or treatment;
- expect that all communications and records pertaining to their care should be treated as confidential;
- receive complete, current information concerning diagnosis, treatment, and prognosis in terms reasonably understood;
- know the identity and professional status of the individual providing service to them and know who has the primary responsibility for coordinating their care;
- expect reasonable continuity of care;
- be fully advised of and accept or refuse to participate in any research project and/or O.B.C.E. approved investigational procedure(s);
- receive and examine an explanation of charges for services rendered;
- receive considerate and respectful care;
- expect not to be denied treatment solely on the basis of race, color, religion or sexual preference.
Patient's Responsibilities

A patient and/or his/her legal representative has the responsibility to:

• be honest and forthright with the doctor and office staff and to provide accurate and complete information about present complaints, past illnesses, accidents, hospitalizations, medications and any other information related to his/her health; 14,15

• report to the doctor in a timely manner any new incident, trauma or changes in his/her health condition; 15*

• acknowledge and consider instructions provided by the doctor and/or office staff; 14*

• request clarification about any aspect of his/her care not fully comprehended; 14,15*

• keep scheduled appointments or give adequate notice of delay or cancellation; 14*

• treat doctors and office staff with respect and courtesy. 14

* Considering the above items, lack of cooperation may cause endangerment to the patient’s health and/or impaired results of care. Chiropractors have the right to select their cases and patients. It is permissible for the doctor to discontinue treatment of a patient when the patient fails to cooperate in an agreed upon plan of management. 16
Section 3

INFORMED CONSENT

Informed consent is the issue pertaining to a patient’s right to make a decision about treatment based on adequate foreknowledge or understanding of that treatment and its anticipated outcome.\(^{17-24}\) It is the process of giving patients information needed to make educated decisions concerning their treatment.\(^{17,19,25,26}\) Informed consent serves as an opening for dialogue with the patients and involves them in their care.\(^{27}\) It is the process of effectively communicating with patients in terms they understand, allowing them the opportunity to ask questions.

One of the goals of these guidelines is to inform practitioners about the ethical issues and legal precedents within which they must work. The basic principle of consent is that competent persons have the right to choose what will be done to them. It is the responsibility of the physician to inform the patient, in non-technical terms, of anticipated practices and procedures and to receive the patient’s informed consent prior to examination and therapy procedures.\(^{19}\) When applicable, the physician should also explain reasonable alternative treatments.\(^{19,26}\)

Informed consent can be viewed as an opportunity to establish trust and rapport and to collaborate with patients in the decision-making process. Through informed consent, the chiropractor can strengthen a person’s commitment to treatment by promoting understanding of what can be accomplished.\(^{25}\)

Informed consent is an important risk management tool.\(^{23}\) By adding the element of trust and respect for the patient, an atmosphere of joint decision making is created. It gives the practitioner a chance to educate patients about the value of chiropractic and how it may benefit them.

To gain informed consent, Oregon health care practitioners are required to utilize a Procedures, Alternatives, Risks and Questions (PARQ) Conference.\(^{28}\) In this PARQ conference the physician shall explain the following:

(a) in general terms the procedure or treatment to be undertaken;
(b) that there may be alternative procedures or methods of treatment; and
(c) that there are risks, if any, to the procedure or treatment.

After giving the explanation specified above, the physician shall ask the patient if the patient wants a more detailed explanation. If the patient requests further explanation, the physician shall disclose to the patient in substantial detail the procedure, the viable alternatives, and the material risks, unless to do so would be materially detrimental. In determining that further explanation would be materially detrimental, the physician shall give due consideration to the standards of practice of reasonable chiropractic practitioners in the same or a similar community under the same or similar circumstances.\(^{28}\)

The essence of informed consent is communication between the patient and doctor, whether written or oral.\(^ {29}\) This responsibility should be seen as an ethical, as well as a legal, obligation.\(^ {26}\) Therefore, **patient-doctor discussion is the key.**\(^ {12,19-21,30,31-33}\) The doctor must be prepared to expand the explanation, if necessary, and the information should be tailored to the patient and the procedure or treatment.
Suggestions for Documenting Informed Consent

Most authorities recommend that informed consent be documented. The following methods are offered as options for charting informed consent. However, the practitioner is not limited to these specific suggestions.

1. Patients can be given standardized forms which they sign. However, practitioners should not rely exclusively on those forms and must communicate directly with the patients. The use of a written consent form is at the discretion of the individual practitioner in the State of Oregon. If a written form is used, it must be signed by the patients and included in their record.

2. The acronym PARQ can be written in the patient’s chart indicating that the physician has explained the procedures (P), viable alternatives (A), material risks (R), if any, and asked if the patient has any questions (Q). If the patient requests further information, the physician can underline the PARQ chart notation to reflect the patient’s request and that the physician provided more detailed information.

It is important to note that consent to have one physician perform a procedure is not consent for any other physician unless the patient agrees to substitute care. The practitioner may make a written entry into the patient’s record, or, if a written form is used, the practitioner may wish to include a sentence to address this issue.

There are situations in which the method for obtaining informed consent may need to be modified. For example, each parent of minor children (under 18) has the authority and responsibility to consent to health care for his/her minor children unable to consent for themselves. If the parents are divorced, the noncustodial parent may authorize the physician’s treatment in the absence of the custodial parent. In the case of minor parents who cannot consent for either their own care or that of their children, consent must come from a third party such as a parent, grandparent or legal guardian.
Section 4

DISCLOSURE AND CONFIDENTIALITY OF RECORDS

"The chiropractic physician shall preserve a patient's medical records from disclosure and will release them only on a patient's written consent stating to whom the records are being released or as required by State or Federal law". 38

Confidentiality is an ethical and legal responsibility and is also necessary if practitioners expect individuals to be straightforward and honest. Patients must be confident that information will remain private and secure from public scrutiny. This confidence forms the basis for the principle that all patient-doctor communications are privileged and confidential. 19,39-43 Practitioners must not disclose whether an individual is, or has been, a patient. This includes disclosing information to the immediate family of the patient, with the exception of a parent or guardian of a minor or person legally declared incompetent.19 The practitioner is responsible for observing professional and legal requirements of confidentiality, as well as ensuring these requirements are met by any employee involved in the preparation, organization, filing or other handling of patient records. 39

Ultimately, patients have the right to have any information pertaining to their health kept confidential and not made available to others without authorization. 19,38-45 This information remains privileged even after the patient dies. 19, 41, 43 Even though an individual pays for professional services, they do not own the resulting records.19 With few exceptions, e.g. federally assisted drug or alcohol abuse programs, patients have the right to copy, 41,42 inspect, 41,42 correct, amend, authorize or restrict access, 19,40-42 be notified of intended disclosures 19,40-42 and pursue breach of duty remedies with respect to their personal health records. 42

There are few exceptions to the rules of disclosure. However, the following situations allow disclosure without permission of the patient:

- response to certain court orders;
- conformity with statutory reporting law, e.g. child, 45 elderly abuse;
- communicable disease reporting, e.g. TB;
- injuries allegedly resulting from a criminal act, e.g. knife or gunshot wounds;
- cases where an individual threatens harm to themselves and/or others with a reasonable probability they will carry out the threat. 40-43

In the cases of communicable disease where the patient refuses to inform or allow someone else to inform an endangered third party, or when there is a threat of physical violence where a third party may be in danger, the duty for disclosure to both public officials and the third party may exist. 41, 42

The State of Oregon has developed a statute encouraging health care providers to adopt voluntary guidelines that will give health care recipients access to their medical records in addition to preserving them from unnecessary disclosure. This statute recommends utilizing a written release authorization form. (See Appendix A)

If, in the professional judgement of a physician, disclosure of a medical record or part of a record would be injurious to a patient, the provider may withhold that record or provide an accurate and representative summary of the information contained in the record. In addition, a health care provider may withhold another provider's record in their possession even after receiving a written release authorization. In either of these situations, the health care provider must disclose
the author and date of the withheld record(s) and/or summary(s), or declare the record provided to be a summary. "A patient may not maintain an action for damages against a health care provider for disclosures made by the health care provider in good faith reliance on a properly executed written release authorization…" 44

With respect to workers' compensation claims, signed forms 801, 827, 829, and 2837 (Release of Information) give medical providers the authority and responsibility to release relevant medical records to the insurer, the insurer's representative, or the Director of the Department of Consumer and Business Services.46

In order to protect the patient's right to privacy, the health care provider must have further specific consent for admitting a non-essential person (e.g. student intern) where privacy may be compromised or when taking pictures for clinical or professional purposes. Like other forms of consent, this should be documented. 19

If information is going to be electronically transferred, a confidentiality statement should be utilized as a cover sheet to preserve confidentiality. 40, 41, 45 For example,

PLEASE NOTE: The information contained in this transmission is confidential in nature. The information is to be used for its intended purpose only and is to be destroyed after the stated need has been fulfilled. Please deliver IMMEDIATELY to the individual indicated above. If you have received the transmission in error, please notify us immediately by telephone and destroy the transmitted documents.

The health care provider may even want to include in their release of record document a check box that gives the patient the choice to not have their records transmitted electronically as the confidentiality of these systems is somewhat less reliable. The healthcare provider should maintain records of any electronic transmissions and request the receiver to sign and return attached receipts when the data has been received. 40, 45 The increasing reliance on electronic storage and transmission of health record data requires that the provider take all reasonable precautions to ensure that confidentiality is maintained. 41- 43

It is the patients' responsibility to be aware of their insurance company's policy with respect to releasing medical records; i.e. who is allowed access to their private health records. In order for the healthcare provider to submit a standard health insurance claim form to an insurance carrier, the patient must "...authorize the release of any medical or other information necessary to process this claim." 47

Other areas may compromise confidentiality including sign-in sheets, patient files, door/wall hanging file holders, “thank you for referral” cards, etc. Health care providers should establish policies and procedures that ensure reasonable protection of the patients' right to confidentiality in addition to acting as role models by demonstrating their commitment to patient privacy and confidentiality. 40, 41, 43, 45
Section 5

DOMESTIC VIOLENCE

Domestic violence is one of the major, serious public health problems affecting families in America and globally.\(^{48-51}\) Domestic violence, child abuse and elder abuse are all included in the broader category of family violence.\(^{49}\) Most definitions of domestic violence (a.k.a. intimate partner abuse (IPA), intimate partner violence (IPV)) include the following components:

1. ongoing pattern of intentional violent or assaultive or coercive behaviors or tactics.\(^{48, 51-58}\)
2. purposeful tactics or behaviors directed at achieving and maintaining power, compliance or control over the victim,\(^{51, 52, 57}\) thereby denying their individual and civil rights.\(^{56}\)
3. may include any or all of the following:

   Physical abuse: \(^{48-57}\)
   - injuries of a non-accidental or unexplained nature including shaking, slapping, hitting, kicking, punching, choking, biting, throwing, use of conventional and household objects as weapons;\(^{52}\)
   - injuries commonly targeted to proximal areas so they remain concealed;\(^{52}\)
   - denial of medical attention, physical needs (food, water, shelter, sleep), access or use of contraceptives or other safe sex techniques;\(^{52}\)
   - restraint or not allowing victim to leave their room or home;\(^{52}\)
   - murder.\(^{52, 54-57}\)

   Sexual abuse: \(^{48-53, 56, 57}\)
   - rape;\(^{52}\)
   - making sexual jokes or comments intended to humiliate or demean;\(^{52}\)
   - forcing any person to watch pornography or others having sexual contact, or participating in prostitution or pornography.\(^{52}\)

   Emotional or psychological abuse: \(^{48, 50-54, 57}\)
   - social isolation or deprivation;\(^{48, 52, 53, 57}\)
   - verbal abuse or intimidation and threats;\(^{48, 52, 53, 56, 57}\)
   - control by isolation from family and friends;\(^{52-54, 57}\)
   - techniques of coercion or brainwashing designed to use children against a partner; e.g. threatening to take or hurt the children, using children to continue contact through custody or visitation.\(^{52}\)

   Economic coercion or control: \(^{48, 51, 52, 54, 57}\)
   - in any type of relationship: adult, adolescent, current heterosexual, homosexual including former dating, marriage, and cohabitating.\(^{48, 52, 53, 58}\)

Domestic violence is a gender-neutral term and universal problem, which cuts across all racial, socioeconomic, national, religious and ethnic boundaries.\(^{48, 49, 54, 57}\) The overwhelming majority of victims, 90-95\%, are women;\(^{48, 49, 57}\) however, expert opinion and initial studies suggest domestic violence among lesbians gay, bisexual and transgender individuals may be comparable to domestic violence perpetrated against heterosexual women.\(^{53}\) There is no standardization of what constitutes a violent act. This results in conflicting estimates of the number of women and men affected by “violence.”\(^{54}\) There is paucity of data about domestic violence against men.
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The following statistics help to illustrate the pervasiveness of violence against women:

- estimates of incidents of violence to women range from 1-12 million/year\(^{48}\) but the most commonly reported incidence rate is 2-4 million/year; \(^{48,51,54,57}\)
- prevalence ranges from 20-54% of women experiencing violence in a relationship or lifetime; \(^{48,52,54,56,57}\)
- battering is the single greatest cause of injury to women; \(^{48}\)
- 30-75% of women killed in the U.S. are murdered by a domestic partner; \(^{48,55}\)
- 1 in 10 women are in a violent relationship at any given time; \(^{48}\)
- 75% of spousal assaults occur at the time of separation or divorce; \(^{55}\)
- violence tends to be repetitive and averages six violent episodes/year; \(^{49}\)
- 4-24% of pregnant women are physically assaulted; \(^{48,51,53,57}\)
- abuse of women and children occurs concurrently an estimated 30-70% of the time; \(^{54,57}\)

While these statistics are useful to illustrate the magnitude of the problem, they are only estimates. Many cases of domestic violence are unreported or undetected so the true incidence is unknown. \(^{48-50,54}\)

The toll of domestic violence is enormous.\(^{49,51}\) It is estimated that 1.8 billion dollars per year are spent directly on health care for victims.\(^{51}\) In addition to the healthcare cost, there is a high societal cost.\(^{49}\) Boys who are reared in violent homes have an increased risk of becoming abusers\(^{51}\) and girls who witness or experience violence have an increased risk of becoming victims.\(^{48,51}\) Children who live in violent homes have higher rates of learning difficulties, decreased academic performance, increased behavioral problems and are more likely to be violent adults.\(^{57}\)

Chiropractors have the opportunity to play an important role in shaping societal values by naming the disease, domestic violence.\(^{56}\) This is a primary responsibility and may allow the survivor to begin seeing his/her situation differently, giving them the opportunity to start taking control of their lives.\(^{56}\) The public may come to understand that domestic violence is unacceptable behavior when physicians make it clear that it’s important to ask whether an intimate or formerly intimate partner caused injuries.\(^{56}\) If the root cause of an incomplete diagnosis, prescription for medication, recurrence of injury, or stress related injuries is domestic violence, the practitioner has the opportunity to protect the patient from escalating risk by addressing this issue.\(^{56}\) If the practitioner recognizes and helps a victim with “minor” signs or symptoms of domestic violence, a serious or even fatal episode could be prevented.\(^{56}\)

**For practice tips for identifying and treating the abused patient see Appendix B**
Section 6

CHILD AND ELDER ABUSE

Child Abuse

Child abuse and neglect is a problem of "epidemic proportions" that affected approximately 20,000 Oregon children in 1997 and 1998. The victim of child abuse is an unmarried person, under the age of 18, who has been non-accidentally physically or mentally injured, negligently treated or maltreated, sexually abused or exploited, or who dies as a result of abuse or neglect.

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

Abuse can be classified into four basic categories:

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

ORS 419B.005 defines child abuse as:
"Any assault, as defined in ORS chapter 163, of a child and any physical injury to a child which has been caused by other than accidental means, including any injury which appears to be at variance with the explanation given of the injury.” This does not include reasonable discipline unless the discipline results in assault or any of the following conditions:

- “Any mental injury to a child, which shall include only observable and substantial impairment of the child's mental or psychological ability to function caused by cruelty to the child, with due regard to the culture of the child;
- “Rape of a child, which includes but is not limited to rape, sodomy, unlawful sexual penetration and incest, as those acts are defined in ORS chapter 163;
- "Sexual abuse, as defined by ORS chapter 163;
- "Sexual exploitation;
- "Negligent treatment or maltreatment of a child, including but not limited to the failure to provide adequate food, clothing, shelter or medical care that is likely to endanger the health or welfare of the child;
- “Threatened harm to a child, which means subjecting a child to a substantial risk of harm to the child's health or welfare;
- "Buying or selling a person under 18 years of age as described in ORS 163.537."
Elder Abuse (persons 65-years of age or older)

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

Comparatively, the definitions of abuse for older people are very similar to those for children. As with child abuse, chiropractors have a legal and ethical obligation to report any suspected elder abuse\(^\text{69}\) with confidentiality "to the local office of the Senior and Disabled Services Division or to a law enforcement agency within the county where the person making the report is located at the time of contact."\(^\text{70}\) They may not be sued for such reporting.\(^\text{71}\)
Section 7

BOUNDARY ISSUES IN THE PATIENT-DOCTOR RELATIONSHIP

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

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

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

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

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

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

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

Where there may be a question as to the status of the patient, i.e. current or former, some licensing boards have chosen to adopt more subjective criteria to determine if sexual misconduct
has occurred. Following are some of the areas of consideration likely to be evaluated by a licensing board to determine the current status of the patient:

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

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

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

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

See Appendix C for strategies that may prevent boundary violations and/or allegations of sexual misconduct.
Section 8

THE PATIENT-DOCTOR RELATIONSHIP AND INDEPENDENT EXAMINATIONS

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

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

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

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

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

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

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

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

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

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

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

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

Physicians have the right to make reasonable limitations on their practice. Physicians are not legally obligated to treat any patient beyond the chosen limitations of their practice. In such circumstances, referral to another physician does not constitute abandonment.
Section 10

PATIENT-DOCTOR RELATIONSHIP STANDARDS

1. Informed Consent
The patient has the right to informed consent regarding procedures, risks and alternatives, and answers to questions with respect to treatment, in terms that they can be reasonably expected to understand. In order to obtain the informed consent of a patient, the chiropractic physician shall explain the following:
   (a) In general terms the procedure or treatment to be undertaken;
   (b) That there may be alternative procedures or methods of treatment, if any; and
   (c) That there are risks, if any, to the procedure or treatment.  

2. Patient Confidentiality
The patient has the right to expect that all communications and records pertaining to their care will be treated as confidential. The chiropractor shall preserve a patient’s medical records from disclosure and will release specific records only on a patient’s written consent stating to whom the records are being released or as required by State or Federal law. 

3. Abandonment
The patient has the right to continuity of care once the doctor has agreed to treat the patient. The chiropractor may terminate the patient-doctor relationship only when the patient has been given reasonable notice.

4. Patient-Doctor Boundaries
With the exception of pre-existing consensual sexual relationships, it is clearly unethical to have sexual contact or a romantic relationship with a patient concurrent with the patient-doctor relationship. Chiropractors shall not engage in any conduct or verbal behavior with or towards a patient that may be reasonably interpreted by the patient as sexual, seductive or demeaning.

5. Independent Medical Examinations
All independent and second opinion examinations performed by a chiropractor to determine the need for chiropractic care shall include a functional chiropractic analysis. A copy of the independent report shall be made available, upon request, to the patient, the patient’s attorney and the treating doctor. All independent and second opinion examiners have an ethical obligation to perform an impartial examination.

6. Child and Elder Abuse Reporting
Chiropractors must report child abuse and elder abuse to the appropriate officials.
REFERENCES

16. Oregon Administrative Rule 811-035-0005 Duties and obligations of Chiropractic physicians to their patients.
33. Smith RC, Hoppe RB. The patient’s story: integrating the patient- and physician-centered approaches to
47. Health Insurance Claim Form, HCFA-1500.
63. Oregon Revised Statute 419B.010 Duty of officials to report child abuse; exceptions; penalty.
64. Oregon Revised Statute 419B.015 Report form and content; notice to law enforcement agencies and local office of State Office for Services to Children and Families.
65. Oregon Revised Statute 419B035 Confidentiality of records; when available to others.
67. Oregon Revised Statute 419B.005 Definitions.
69. Oregon Revised Statute 124.060 Duty of officials to report.
70. Oregon Revised Statute 124.065 Method of reporting; content; notice to law enforcement agency and to division.
71. Oregon Revised Statute 124.075 Immunity of person making report in good faith; identity confidentiality.
74. Oregon Administrative Rule 811-035-0015 Unprofessional conduct in the chiropractic profession
77. Colorado Revised Statute 12-33-117(1)(z),(aa).
78. Australian Medical Association 1995; Sexual conduct between doctors and their patients.
92. Washington Assurance Commission 246-807-311 Sexual misconduct
94. AMA policy statement 5-10.03: Patient-physician relationships in the context of work related and independent medical examinations. Dec, 1999
APPENDIX A

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS
Oregon Revised Statute 192.525, 1997

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

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

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

____________________________________

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

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

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

___*HIV/AIDS-related records
___*Mental health information
___*Genetic testing information
*Must be initialed to be included in other documents.

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

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

___ This authorization is limited to the following treatment:

___ This authorization is limited to the following time period:

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

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

______________________________  ____________________________
(Date)                        (Signature of patient)

______________________________  ____________________________
(Date)                        (Signature of person authorized by law)
APPENDIX B

PRACTICE TIPS FOR IDENTIFYING AND TREATING THE ABUSED PATIENT

DOMESTIC VIOLENCE

Victim Barriers to Terminating or Disclosing Abusive Relationships
There are many reasons why victims don’t report and/or terminate abusive relationships. Such barriers may include the following:

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

Physician Barriers To Screening For/Identifying Domestic Violence
Health care providers identify several reasons why they are reluctant to ask patients about domestic violence. Such barriers to screening/identifying domestic violence may include the following:

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

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

One model describes a cycle of violence in phases where phase one begins with a minor battering/assault which gradually increases tension in the relationship. The victim may try to decrease the tension but is largely unsuccessful.48 Phase two involves a discharge of building tension resulting in an acute battering incident which may be met with disbelief or denial and is dismissed by the victim as an isolated incident. Subsequent episodes are met with shock, rationalization, self blame, denial and repression. 48 Phase three is often referred to as the “honeymoon phase” 48 where the abuser expresses remorse, exhibits attentiveness, reaffirms love and promises it will never happen again. 48,57 This is done mostly out of fear of being caught. 48 There is not always a honeymoon phase 48.
Another model highlights the roles of violence and withdrawal where some lesser degree of violence creates emotional withdrawal in the attacked partner. The abuser may be met with withdrawal the next time upset, needy or in want of support. This in turn provokes a more violent attack, which is followed by further withdrawal and/or fear. The escalating cycle of neediness is met with increasing withdrawal until the violence becomes severe.\textsuperscript{58}

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

**Profile of the Abuser**

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

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

**Women at Increased Risk for Domestic Violence**

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

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

**Presentation**

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

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

\textsuperscript{- 25 -}
2. Pain
   • chronic pain; 51,52,56,57
   • back pain; 48
   • chest pain; 48,51,52,57
   • pain from diffuse trauma without visible evidence. 52

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

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

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

6. Other
   • more likely to be prescribed analgesics, minor tranquilizers 48,52,57 and antidepressants; 48
   • multiple visits 56 or frequent visits without physiologic abnormality; 52
   • long term disability from injuries; 58
   • homelessness or welfare. 58
Screening and Identification
Physicians routinely screen for problems less prevalent than domestic violence, and yet routine screening for domestic violence is rarely practiced.\textsuperscript{48,49,53} This is especially true in the primary care setting where it is estimated that less than 10\% of primary care physicians routinely screen for domestic violence during a regular office visit.\textsuperscript{53} Battery is so prevalent that physicians in an entry-level health care system have an ethical obligation to consider abuse as a possibility in their evaluation of female patients.\textsuperscript{48,52} Screening is simply asking the patient a few direct questions. The goal of screening is not for the physician to “fix” the problem but to identify the abuse and provide appropriate education, support, and referrals, and to acknowledge and validate the situation as real and dangerous.\textsuperscript{48,52} Before initiating any discussions about domestic violence, the physician must put the patient in a position to disclose this information safely and confidentially (without partner and/or children present).\textsuperscript{58,51,54-57} The FAMILY VIOLENCE PREVENTION FUND recommends screening begin as early as age 14.\textsuperscript{51} It is recommended that all female patients are screened whether signs or symptoms are present or not and whether abuse is suspected or not.

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

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

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

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

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

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

- “No one deserves to be hurt or threatened with violence.” (The most important and easily provided intervention is this simple message.)\textsuperscript{48,54}
- “You are not to blame for the behavior of the perpetrator.”\textsuperscript{54}
- “You are not alone.”\textsuperscript{52}
- “You aren’t crazy.”\textsuperscript{52}
- “What happened to you is wrong.”\textsuperscript{52}
- “Help is available.”\textsuperscript{52}
- “I have treated others with this problem and am comfortable dealing with it.”\textsuperscript{52}
It is important to educate the patient about the escalating cycle of abuse (nature and course) which not only produces serious medical problems but is also a criminal act, for which there are protective service agencies and legal assistance, e.g. civil protection orders/restraining orders, criminal prosecution, civil litigation, etc.

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

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

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

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

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

- “Are you in immediate danger?” “What do you think will happen when you go home?” (This is one of the most important questions: “Is it safe to go home?”)
- “Is another violent attack imminent?”
- “How frequent and severe are the attacks?” “Are they escalating?”
- “Do they have a firearm or deadly weapon?”
- “Is there a history of violent behavior outside the home or history of violent acts or threats using a weapon?”
- “Have they threatened to kill you or them?”
- “Is there drug or alcohol use?” as this makes behavior less predictable.
• “Have there been threats to children?” 54,58
• “Are you, or a partner, threatening suicide and if so, is there a suicide plan?” If so, the situation is urgent. 48,51
• “Are there forced unwanted types of sex or refusing to use birth control?” 53
• “Is there humiliation, swearing, name calling, mental instability, obsession with victim, 51,58 drug/alcohol use or abuse?” 58
• “Are there threats to injure self or patient reporting to immigration or stalking?” 55,58
• “Is there isolation which includes controlling access to friends and family and limiting outside involvement?” 51,53,58
• “Has there been destructive behavior such as destroying patient’s property, injuring pets of patient or child?” 58
• “Does the abusive partner control all the money?” 51,58

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

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

If there is no immediate danger or the patient doesn’t want immediate access to a shelter, the chiropractor may offer written information about shelters and other community resources 48-52,54,55,57 or instructions how to find this information in the phone book. 48 Shelters and affiliated agency referrals should be made carefully and only to those dedicated to assisting battered women. 38 Affiliated agencies and community resources may include the following: children’s services, counseling, legal and employment services 50,51 and law enforcement. 50,51 With respect to legal needs, possibilities are criminal prosecution, civil litigation, 2,54 civil protection/restraining orders, 51,52, 57 temporary custody, and mandatory payment of rent or mortgage. 54 It is important to remember that written information may be dangerous for the patient to possess. 36 The patient should not be forced to take written information. The number of a local hotline or other information may be most safely given on a prescription blank or appointment card. 32

The victim should be assisted in developing a safety plan 48,50-52,54,57,58 with which they can prepare for future situations as well as make judgments about the safety of their current situation. This should be an ongoing process where questions such as “Is it safe to go home?” 48,51,54 can help the victim to regularly assess their safety status. Identification of potentially dangerous situations and appropriate responses increase the preparation and safety when or if the risk of violence increases. 48,50 Options should include planning for immediate relocation to a shelter and/or seeking shelter and financial help from family and friends. 50,52 If possible, three options should be included for emergencies where shelters may be full, family and friends are out of town, etc. Victims should be given information directly and/or made aware of how to access available resource numbers for assistance. 48-52,54,55,57 A packed overnight bag 57 or “flight kit” which may be an unused suitcase placed in a well-hidden area 32 should include as many of the following items as possible: enough money to get started, clothing, medicine, address book, car/house keys, valuables, books, children’s toys, papers (social security card, health insurance information, birth certificates, driver’s license, restraining order, etc.). 58

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

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

Educational Materials for the Health Care Providers
Chiropractors can increase public awareness about domestic violence, 48,57 show willingness to discuss the topic, 38 and help women understand the problem by having pamphlets, posters, etc. in the office. This is an important form of intervention and prevention. 57 There should be materials from community resources relating to domestic violence in the waiting room, examination room, female restrooms and other strategic locations. 49,51,57 It is also
important to support culturally sensitive publications in different languages for women in the international community as it is more difficult for them due to cultural, religious, social, family, legal and immigration reasons.  

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

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

Physical abuse, possible behavioral indicators:
- wary of adult contacts;
- apprehensive when other children cry;
- behavioral extremes;
- frightened of parents;
- afraid to go home.

(B) Neglect, possible physical indicators:
- consistent hunger, poor hygiene, inappropriate dress;
- consistent lack of supervision;
- unattended physical and/or emotional problems or medical needs.

Neglect, possible behavioral indicators:
- begging, stealing food;
- extended stays at school;
- poor school performance;
- fatigue;
- alcohol or drug abuse;
- delinquency.

(C) Mental injury or emotional maltreatment, possible physical indicators:
- failure to grow;
- speech or sleep disorders;
- forced to dress in "opposite sex" clothing.

Mental injury or emotional maltreatment, possible behavioral indicators:
- behavior extremes: aggression or withdrawal;
- habit disorders (sucking, biting, rocking);
- attempted suicide;
- conduct disorders (antisocial, runaway, destructive behavior);
- emotionally needy.

(D) Sexual abuse, possible physical indicators:
- difficulty in walking or sitting;
- pain or itching in the genital area;
- bruises, bleeding or infection in external genital area;
- venereal disease;
- pregnancy.

Sexual abuse, possible behavioral indicators:
- withdrawal, fantasy or infantile behavior;
- poor peer relationships;
- delinquent or runaway;
- reports sexual assault (children seldom lie about sexual abuse);
- refer also to behavioral indicators of mental injury or emotional maltreatment.
Elder Abuse
Observations suggestive of elder maltreatment include:68

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

(B) Patient
- fearful of caregiver.

(C) Patient or caregiver
- depressed;
- reluctant to answer questions.

Physical indicators of elder abuse:68

(A) Physical abuse
- unexplained bruises, wounds, burns, or other injuries;
- rope or restraint marks on wrists and/or ankles.

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

(C) Neglect
- dehydration or malnutrition;
- poor hygiene;
- inappropriate dress;
- unattended physical or medical needs.
APPENDIX C

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

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

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

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

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

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

F. Identification of High Risk Situations for the Chiropractor
- attraction to a patient;
- personal relationship problems;
- times of emotional distress;
- substance abuse;
- burn-out.

G. Recognition of High Risk Patient Behaviors
- inappropriate gifts, cards or correspondence;
- inappropriate “personal” comments and questions;
- sexual innuendo and humor;
- seductive clothing or behavior;
- seeking inappropriate extended visits and/or care.
APPENDIX D

DOMESTIC VIOLENCE RESOURCES

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

ASHLAND
- Dunn House 541-779-4357

ASTORIA
- Clatsop County Women’s Crisis Service 503-325-5735

BAKER CITY
- May Day, Inc. 541-523-4134

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

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

COOS BAY
- Coos County Women’s Crisis Center 800-448-8125

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

ENTERPRISE
- Safe Harbors 541-426-6565

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

FLORENCE
- Siuslaw Area Women’s Center 541-997-2816

GRANTS PASS
- Women’s Crisis Support Team 541-474-1400 / 800-750-9278

GRESHAM
- Gresham Police Domestic Violence Unit 503-618-2394

HILLSBORO
- Domestic Violence Resource Center 503-469-8620

HOOD RIVER
- Project Helping Hands Against Violence 541-386-6603

KLAMATH FALLS
- Klamath Crisis Center 800-452-3669

LAGRANDE
- Shelter from the Storm 541-963-9261

LAKEVIEW
- Crisis Intervention Center 800-338-7590
LINCOLN CITY
• Women’s Violence Intervention Project 541-994-5959

MILL CITY
• Canyon Crisis Service 503-897-2327

MILWAUKIE
• Clackamas Women’s Services 503-654-2288

MCMINNVILLE
• Henderson House 503-472-1503

ONTARIO
• Project Dove 541-889-2000

PENDLETON
• Domestic Violence Services 800-833-1161

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

ROSEBURG
• Battered Person’s Advocacy 800-464-6543

SALEM
• Mid-Valley Women’s Crisis Service 503-399-7722

ST. HELENS
• Columbia County Women’s Resource Center 503-397-6161

THE DALLES
• Haven From Domestic Violence 541-298-4789

TILLAMOOK
• Women’s Crisis Center 800-992-1679

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

VANCOUVER:
• YWCA Safechoice 360-695-0501

UPDATED 12/02
APPENDIX E

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

SEXUAL MISCONDUCT RISK FACTOR ANALYSIS

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

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

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

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

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

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

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

Instructions
Place a check-mark next to the number (1, 2, or 3) of each statement that applies to you. When you have completed the questionnaire, add up all of the numbers that are the same – i.e. add up all the number 1s on a page and write that number at the bottom of each sheet, then do the same for all the 2s and 3s on each sheet. Add up the totals for each number on the last page in the space provided. Directions for assessing your RFA numbers are on the next page.
At the end of the self-scoring section, there are guidelines for comparing your RFA results with the results of the Doctor Self-Evaluation and the rest of the Practice Analysis.

### RISK FACTOR ANALYSIS QUESTIONNAIRE

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

Totals for this page:

1.  
2.  
3.  

- 36 -
1. I feel totally comfortable socializing with patients.
2. I have a barter arrangement with one or more of my patients that is sometimes a source of tension.
3. I have had sexual contact with one or more of my patients.
2. I have attended professional or social events at which I knew that this patient would be present.
2. This patient often invites me to social events and I don’t feel comfortable saying either yes or no.
2. Sometimes when I’m working on this patient, I feel like the contact is sexualized for myself and maybe for the patient.
2. There’s something I like about being alone in the office with this patient when no one else is around.
2. I am tempted to lock the door when working with this patient.
3. This patient is very seductive and I don’t always know how to handle it.
2. I have invited this patient to public or social events.
1. I find myself cajoling, teasing, joking a lot with this patient.
3. I allow this patient to comfort me.
3. Sometimes I feel like I’m in over my head with this patient.
2. I feel overly protective of this patient.
3. I sometimes have a drink or use some recreational drug with this patient.
3. I am doing more for this patient than I would for any other patient.
2. I find it difficult to keep from talking about this patient with other people who are close to me.
2. I find myself saying a lot about myself with this patient – telling stories, engaging in peer-like conversation.
3. If I were to list patients with whom I could envision myself in a sexual relationship, this patient would be on the list.
3. I call this patient a lot and go out of my way to meet with him/her in locations convenient to him/her.
2. This patient has spent time at my home.
3. I often tell my personal problems to this patient.
3. I enjoy exercising my power over some of my patients.
3. I’m going through a crisis at this point in my life.
2. Sometimes I’m afraid I might burn out.
3. I need someone to take care of *me*.
3. If a patient consents to sex, it’s okay.

Totals for this page:

<table>
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<th>1</th>
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<tbody>
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<td>1</td>
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Totals for both pages:

<table>
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<th>1</th>
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<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
If you have checked off even one number 3: You are at risk. Know that you are a ticking time bomb who could potentially hurt yourself, your patient(s) and your profession! You would be very wise to get help from a therapist, consultant or significant other. You also should consider getting training in this area. Ignoring your high risk or attempting to get through this by yourself might be very unwise.

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

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

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

**APPENDIX F**

**THE EXPLOITATION INDEX**

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

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

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

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

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

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

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

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

The Exploitation Index questionnaire is used with direct permission of R. S. Epstein, MD.
Section 7

BOUNDARY ISSUES IN THE PATIENT-DOCTOR RELATIONSHIP

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

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

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

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

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

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

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

Where there may be a question as to the status of the patient, i.e. current or former, some licensing boards have chosen to adopt more subjective criteria to determine if sexual misconduct
has occurred. Following are some of the areas of consideration likely to be evaluated by a licensing board to determine the current status of the patient:

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

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

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

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

\textbf{See Appendix C for strategies that may prevent boundary violations and/or allegations of sexual misconduct.}
Section 8

THE PATIENT-DOCTOR RELATIONSHIP AND INDEPENDENT EXAMINATIONS

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

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

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

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

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

In an independent examination, the patient-doctor relationship is limited because the examiner does not monitor the patient's health over time, provide treatment or fulfill many duties traditionally performed by physicians. Despite the limited relationship, important health information, diagnosis and treatment recommendations shall be made available to the patient, treating doctor, and patient’s legal counsel or guardian via the independent report. Upon request, a copy of the independent report shall be made available to the patient, the treating doctor, and/or the patient’s legal guardian.
Section 9

TERMINATION OF THE PATIENT-DOCTOR RELATIONSHIP

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

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

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

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

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

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

Physicians have the right to make reasonable limitations on their practice. Physicians are not legally obligated to treat any patient beyond the chosen limitations of their practice. In such circumstances, referral to another physician does not constitute abandonment.
Section 10

PATIENT-DOCTOR RELATIONSHIP STANDARDS

1. Informed Consent
   The patient has the right to informed consent regarding procedures, risks and alternatives, and answers to questions with respect to treatment, in terms that they can be reasonably expected to understand. In order to obtain the informed consent of a patient, the chiropractic physician shall explain the following:
   (a) In general terms the procedure or treatment to be undertaken;
   (b) That there may be alternative procedures or methods of treatment, if any; and
   (c) That there are risks, if any, to the procedure or treatment.  

2. Patient Confidentiality
   The patient has the right to expect that all communications and records pertaining to their care will be treated as confidential. The chiropractor shall preserve a patient’s medical records from disclosure and will release specific records only on a patient’s written consent stating to whom the records are being released or as required by State or Federal law. 

3. Abandonment
   The patient has the right to continuity of care once the doctor has agreed to treat the patient. The chiropractor may terminate the patient-doctor relationship only when the patient has been given reasonable notice.

4. Patient-Doctor Boundaries
   With the exception of pre-existing consensual sexual relationships, it is clearly unethical to have sexual contact or a romantic relationship with a patient concurrent with the patient-doctor relationship. Chiropractors shall not engage in any conduct or verbal behavior with or towards a patient that may be reasonably interpreted by the patient as sexual, seductive or demeaning.  

5. Independent Medical Examinations
   All independent and second opinion examinations performed by a chiropractor to determine the need for chiropractic care shall include a functional chiropractic analysis. A copy of the independent report shall be made available, upon request, to the patient, the patient’s attorney and the treating doctor. All independent and second opinion examiners have an ethical obligation to perform an impartial examination.

6. Child and Elder Abuse Reporting
   Chiropractors must report child abuse and elder abuse to the appropriate officials.
REFERENCES

16. Oregon Administrative Rule 811-035-0005 Duties and obligations of Chiropractic physicians to their patients.
61. Oregon Revised Statute 419B.010 Duty of officials to report child abuse; exceptions; penalty.
62. Oregon Revised Statute 419B.015 Report form and content; notice to law enforcement agencies and local office of State Office for Services to Children and Families.
65. Oregon Revised Statute 419B035 Confidentiality of records; when available to others.
67. Oregon Revised Statute 419B.005 Definitions.
69. Oregon Revised Statute 124.060 Duty of officials to report.
70. Oregon Revised Statute 124.065 Method of reporting; content; notice to law enforcement agency and to division.
71. Oregon Revised Statute 124.075 Immunity of person making report in good faith; identity confidentiality.
74. Oregon Administrative Rule 811-035-0015 Unprofessional conduct in the chiropractic profession.
77. Colorado Revised Statute 12-33-117(1)(z),(aa).
78. Australian Medical Association 1995; Sexual conduct between doctors and their patients.
APPENDIX B

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

House Bill 2305, Sept 2003
Be It Enacted by the People of the State of Oregon:

SECTION 1. (1) It is the policy of the State of Oregon that an individual has:
(a) The right to have protected health information of the individual safeguarded from unlawful use or disclosure; and
(b) The right to access and review protected health information of the individual.
(2) In addition to the rights and obligations expressed in sections 1 to 7 of this 2003 Act, the federal Health Insurance Portability and Accountability Act privacy regulations, 45 C.F.R. parts 160 and 164, establish additional rights and obligations regarding the use and disclosure of protected health information and the rights of individuals regarding the protected health information of the individual.

SECTION 2. As used in sections 1 to 7 of this 2003 Act:
(1) “Authorization” means a document written in plain language that contains at least the following:
(a) A description of the information to be used or disclosed that identifies the information in a specific and meaningful way;
(b) The name or other specific identification of the person or persons authorized to make the requested use or disclosure;
(c) The name or other specific identification of the person or persons to whom the covered entity may make the requested use or disclosure;
(d) A description of each purpose of the requested use or disclosure, including but not limited to a statement that the use or disclosure is at the request of the individual;
(e) An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure;
(f) The signature of the individual or personal representative of the individual and the date;
(g) A description of the authority of the personal representative, if applicable; and
(h) Statements adequate to place the individual on notice of the following:
(A) The individuals right to revoke the authorization in writing;
(B) The exceptions to the right to revoke the authorization;
(C) The ability or inability to condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization; and
(D) The potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer protected.
(2) “Covered entity” means:
(a) A state health plan;
(b) A health insurer;
(c) A health care provider that transmits any health information in electronic form to carry out financial or administrative activities in connection with a transaction covered by sections 1 to 7 of this 2003 Act; or
(d) A health care clearinghouse.
(3) “Health care” means care, services or supplies related to the health of an individual.
(4) “Health care operations” includes but is not limited to:
(a) Quality assessment, accreditation, auditing and improvement activities;
(b) Case management and care coordination;
(c) Reviewing the competence, qualifications or performance of health care providers or health insurers;
(d) Underwriting activities;
(e) Arranging for legal services;
(f) Business planning;
(g) Customer services;
(h) Resolving internal grievances;
(i) Creating de-identified information; and
(j) Fundraising.
(5) “Health care provider” includes but is not limited to:
(a) A psychologist, occupational therapist, clinical social worker, professional counselor or marriage and family therapist licensed under ORS chapter 675 or an employee of the psychologist, occupational therapist, clinical social worker, professional counselor or marriage and family therapist;
(b) A physician, podiatric physician and surgeon, physician assistant or acupuncturist licensed under ORS chapter 677 or an employee of the physician, podiatric physician and surgeon, physician assistant or acupuncturist;
(c) A nurse or nursing home administrator licensed under ORS chapter 678 or an employee of the nurse or nursing home administrator;
(d) A dentist licensed under ORS chapter 679 or an employee of the dentist;
(e) A dental hygienist or denturist licensed under ORS chapter 680 or an employee of the dental hygienist or denturist;
(f) A speech-language pathologist or audiologist licensed under ORS chapter 681 or an employee of the speech-language pathologist or audiologist;
(g) An emergency medical technician certified under ORS chapter 682;
(h) An optometrist licensed under ORS chapter 683 or an employee of the optometrist;
(i) A chiropractic physician licensed under ORS chapter 684 or an employee of the chiropractic physician;
(j) A naturopathic physician licensed under ORS chapter 685 or an employee of the naturopathic physician;
(k) A massage therapist licensed under ORS 687.011 to 687.250 or an employee of the massage therapist;
(L) A direct entry midwife licensed under ORS 687.405 to 687.495 or an employee of the direct entry midwife;
(m) A physical therapist licensed under ORS 688.010 to 688.220 or an employee of the physical therapist;
(n) A radiologic technologist licensed under ORS 688.405 to 688.605 or an employee of the radiologic technologist;
(o) A respiratory care practitioner licensed under ORS 688.800 to 688.840 or an employee of the respiratory care practitioner;
(p) A pharmacist licensed under ORS chapter 689 or an employee of the pharmacist;
(q) A dietitian licensed under ORS 691.405 to 691.585 or an employee of the dietitian;
(r) A funeral service practitioner licensed under ORS chapter 692 or an employee of the funeral service practitioner;
(s) A health care facility as defined in ORS 442.015;
(t) A home health agency as defined in ORS 443.005;
(u) A hospice program as defined in ORS 443.850;
(v) A clinical laboratory as defined in ORS 438.010;
(w) A pharmacy as defined in ORS 689.005;
(x) A diabetes self-management program as defined in ORS 743.694; and
(y) Any other person or entity that furnishes, bills for or is paid for health care in the normal course of business.

(6) “Health information” means any oral or written information in any form or medium that:
(a) Is created or received by a covered entity, a public health authority, an employer, a life insurer, a school, a university or a health care provider that is not a covered entity; and
(b) Relates to:
   (A) The past, present or future physical or mental health or condition of an individual;
   (B) The provision of health care to an individual; or
   (C) The past, present or future payment for the provision of health care to an individual.

(7) “Health insurer” means:
(a) An insurer as defined in ORS 731.106 who offers:
   (A) A health benefit plan as defined in ORS 743.730;
   (B) A short term health insurance policy, the duration of which does not exceed six months including renewals;
   (C) A student health insurance policy;
   (D) A Medicare supplemental policy; or
   (E) A dental only policy.
(b) The Oregon Medical Insurance Pool operated by the Oregon Medical Insurance Pool Board under ORS 735.600 to 735.650.

(8) “Individually identifiable health information” means any oral or written health information in any form or medium that is:
(a) Created or received by a covered entity, an employer or a health care provider that is not a covered entity; and
(b) Identifiable to an individual, including demographic information that identifies the individual, or for which there is a reasonable basis to believe the information can be used to identify an individual, and that relates to:
   (A) The past, present or future physical or mental health or condition of an individual;
   (B) The provision of health care to an individual; or
   (C) The past, present or future payment for the provision of health care to an individual.

(9) “Payment” includes but is not limited to:
(a) Efforts to obtain premiums or reimbursement;
(b) Determining eligibility or coverage;
(c) Billing activities;
(d) Claims management;
(e) Reviewing health care to determine medical necessity;
(f) Utilization review; and
(g) Disclosures to consumer reporting agencies.

(10) “Personal representative” includes but is not limited to:
(a) A person appointed as a guardian under ORS 125.305, 419B.370, 419C.481 or 419C.555 with authority to make medical and health care decisions;
(b) A person appointed as a health care representative under ORS 127.505 to 127.660 or a representative under ORS 127.700 to 127.737 to make health care decisions or mental health treatment decisions; and
(c) A person appointed as a personal representative under ORS chapter 113.

(11)(a) “Protected health information” means individually identifiable health information that is maintained or transmitted in any form of electronic or other medium by a covered entity.
(b) “Protected health information” does not mean individually identifiable health information in:
(A) Education records covered by the federal Family Educational Rights and Privacy Act (20 U.S.C. 1232g);
(B) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); or
(C) Employment records held by a covered entity in its role as employer.

(12) “State health plan” means:
   (a) The state Medicaid program;
   (b) The Oregon State Children’s Health Insurance Program; or
   (c) The Family Health Insurance Assistance Program established in ORS 735.720 to 735.740.

(13) “Treatment” includes but is not limited to:
   (a) The provision, coordination or management of health care; and
   (b) Consultations and referrals between health care providers.

SECTION 3. A health care provider or state health plan:
   (1) May use or disclose protected health information of an individual in a manner that is consistent with
   an authorization provided by the individual or a personal representative of the individual.
   (2) May use or disclose protected health information of an individual without obtaining an authorization
   from the individual or a personal representative of the individual:
      (a) For the providers or plans own treatment, payment or health care operations; or
      (b) As otherwise permitted or required by state or federal law or by order of the court.
   (3) May disclose protected health information of an individual without obtaining an authorization from
   the individual or a personal representative of the individual:
      (a) To another covered entity for health care operations activities of the entity that receives the
      information if:
         (A) Each entity has or had a relationship with the individual who is the subject of the protected health
         information; and
         (B) The protected health information pertains to the relationship and the disclosure is for the purpose of:
            (i) Health care operations as listed in section 2 (4)(a) or (b) of this 2003 Act; or
            (ii) Health care fraud and abuse detection or compliance;
      (b) To another covered entity or any other health care provider for treatment activities of a health care
      provider; or
      (c) To another covered entity or any other health care provider for the payment activities of the entity
      that receives that information.

SECTION 4. A health care provider or state health plan that receives an authorization to disclose protected
health information may charge:
   (1) No more than $25 for copying 10 or fewer pages of written material and no more than 25 cents per
   page for each additional page;
   (2) Postage costs to mail copies of protected health information or an explanation or summary of
   protected health information, if requested by an individual or a personal representative of the individual; and
   (3) Actual costs of preparing an explanation or summary of protected health information, if requested by
   an individual or a personal representative of the individual.

SECTION 5. A health care provider may use an authorization that contains the following provisions in
accordance with section 3 of this 2003 Act:

SECTION 6. A health care provider or a state health plan does not breach a confidential relationship with an
individual if the health care provider or state health plan uses or discloses protected health information in
accordance with section 3 of this 2003 Act.

SECTION 7. Nothing in section 2 or 3 of this 2003 Act may be construed to create a new private right of
action against a health care provider or a state health plan.

SECTION 8. ORS 192.525 and 192.530 are repealed.
SECTION 9. ORS 353.117 is amended to read:
353.117. (1) Pursuant to ORS 353.050, Oregon Health and Science University may create and maintain an entity that is exempt from federal income tax under section 501(c)(3) of the Internal Revenue Code, as amended, for the purpose of conducting clinical care and practice and advancing other university missions by the faculty.

(2) Any entity created by the university under subsection (1) of this section shall be considered:
(a) A public employer for purposes of ORS 236.605 to 236.640 and ORS chapter 238;
(b) A unit of local government for purposes of ORS 190.003 to 190.130;
[(c) A public provider of health care for purposes of ORS 192.525;]
[(d)] (c) A public body for purposes of ORS 30.260 to 30.300 and 307.112;
[(e)] (d) A public agency for purposes of ORS 200.090; and
[(f)] (e) A public corporation for purposes of ORS 307.090.

SECTION 10. ORS 433.009 is amended to read:
433.009. (1) Notwithstanding ORS 192.501 (3), 192.502 (2), 192.525 and 433.045, if, during the course of a criminal investigation, a law enforcement unit acquires information that the person who is charged with a crime or sentenced for a crime has a reportable disease, the law enforcement unit shall disclose that information to the public health authorities who shall confirm the diagnosis and notify any police officer, corrections officer or emergency medical technician who had significant exposure to the person.

(2) As used in this section:
(a) “Emergency medical technician” has the meaning given that term in ORS 682.025.
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION FORM

I authorize: ____________________________ (Name of person/entity disclosing information) to use and disclose a copy of the specific health information described below regarding: ____________________________ (Name of individual) consisting of:

(Describe below information to be used/disclosed)

________________________________________________________________________

To: ____________________________ (Name and address of recipient or recipients)

For the purpose of (describe each purpose of disclosure or indicate that the disclosure is at the request of the individual):

________________________________________________________________________

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

___ HIV/AIDS information
___ Mental health information
___ Genetic testing information
___ Drug/alcohol diagnosis, treatment, or referral information.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

PROVIDER INFORMATION You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, please send a written statement to ____________________________ (contact person) at ____________________________ (address of person/entity disclosing information) and state that you are revoking this authorization.

SIGNATURE
I have read this authorization and I understand it. Unless revoked, this authorization expires ____________ (insert either applicable date or event).

By: ____________________________ Date: ____________________________

(individual or personal representative)

Description of personal representative’s authority: ____________________________
APPENDIX B

PRACTICE TIPS FOR IDENTIFYING AND TREATING THE ABUSED PATIENT

DOMESTIC VIOLENCE

Victim Barriers to Terminating or Disclosing Abusive Relationships
There are many reasons why victims don’t report and/or terminate abusive relationships. Such barriers may include the following:

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

Physician Barriers To Screening For/Identifying Domestic Violence
Health care providers identify several reasons why they are reluctant to ask patients about domestic violence. Such barriers to screening/identifying domestic violence may include the following:

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

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

One model describes a cycle of violence in phases where phase one begins with a minor battering/assault which gradually increases tension in the relationship. The victim may try to decrease the tension but is largely unsuccessful. 48 Phase two involves a discharge of building tension resulting in an acute battering incident which may be met with disbelief or denial and is dismissed by the victim as an isolated incident. Subsequent episodes are met with shock, rationalization, self blame, denial and repression. 48 Phase three is often referred to as the “honeymoon phase” where the abuser expresses remorse, exhibits attentiveness, reaffirms love and promises it will never happen again. 48,57 This is done mostly out of fear of being caught. 48 There is not always a honeymoon phase. 48
Another model highlights the roles of violence and withdrawal where some lesser degree of violence creates emotional withdrawal in the attacked partner. The abuser may be met with withdrawal the next time upset, needy or in want of support. This in turn provokes a more violent attack, which is followed by further withdrawal and/or fear. The escalating cycle of neediness is met with increasing withdrawal until the violence becomes severe.48

In addition to the physical violence, emotional abuse always accompanies and typically precedes physical violence.48 This cycle of violence is repetitive, escalates in severity and frequency 48,49,55,58 and is used to gain compliance or control over the victim.51

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

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

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

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

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

1. Injuries
   - explanation for injuries does not fit injuries observed; 48,49,51,56
   - multiple injuries in various stages of repair; 48,51,52
   - assaultive trauma, most commonly head, face, neck and areas covered by clothing; mandibular fractures; facial fractures; trunk trauma; blows to abdomen or other areas; other blunt trauma or injuries suggestive of defensive posturing like forearm fractures; 49,51,52,56,58
   - “accident prone” history. 51,52
2. Pain
   - chronic pain; \(^{51,52,56,57}\)
   - back pain; \(^{48}\)
   - chest pain; \(^{48,51,52,57}\)
   - pain from diffuse trauma without visible evidence.\(^{52}\)

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

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

5. Emotional and Behavioral or Psychological Sequelae of Violence
   - depression; \(^{48,49,51-53,57}\)
   - suicide attempts; \(^{48,49,51,52,56,58}\)
   - anxiety; \(^{48,51,52,57}\)
   - mental illness; \(^{48}\)
   - inability to cope; \(^{52}\)
   - nervous behavior, lack of eye contact, worrying about staying too long in office, frequent comments that she has to check with her partner, comments that partner is jealous, financial dependence, shy, frightened, embarrassed, noncompliant, evasive, passive, cries; \(^{48}\)
   - poor self-esteem, social isolation; \(^{48,52}\)
   - hovering (batterer accompanies victim to monitor what is said); \(^{48}\)
   - post-traumatic stress reactions/disorder; \(^{39,52,57,58}\)
   - panic disorders; \(^{51,52}\)
   - eating disorders; \(^{51,52,57}\)
   - drugs and alcohol abuse. \(^{48,49,51-53,56-58}\)

6. Other
   - more likely to be prescribed analgesics, minor tranquilizers\(^{48,52,57}\) and antidepressants; \(^{48}\)
   - multiple visits \(^{56}\) or frequent visits without physiologic abnormality; \(^{52}\)
   - long term disability from injuries; \(^{58}\)
   - homelessness or welfare. \(^{58}\)
Screening and Identification
Physicians routinely screen for problems less prevalent than domestic violence, and yet routine screening for domestic violence is rarely practiced.48,49,53 This is especially true in the primary care setting where it is estimated that less than 10% of primary care physicians routinely screen for domestic violence during a regular office visit.53 Battery is so prevalent that physicians in an entry-level health care system have an ethical obligation to consider abuse as a possibility in their evaluation of female patients.48,52 Screening is simply asking the patient a few direct questions. The goal of screening is not for the physician to “fix” the problem but to identify the abuse and provide appropriate education, support, and referrals, and to acknowledge and validate the situation as real and dangerous.48,52 Before initiating any discussions about domestic violence, the physician must put the patient in a position to disclose this information safely and confidentially (without partner and/or children present).48,51,54-57 The FAMILY VIOLENCE PREVENTION FUND recommends screening begin as early as age 14.51 It is recommended that all female patients are screened whether signs or symptoms are present or not and whether abuse is suspected or not.

Battered women/victims favor routine questions about domestic violence and expect their physicians to initiate discussions about it.48,49 While many find it difficult to volunteer the information, most women are willing to discuss issues about violence if specifically asked. Questions should be direct, sensitive, empathetic, nonjudgmental and asked in a confidential setting.48,50,52,57 It is recommended that direct questions about abuse be included in the routine history9,52,57 as no one can be excluded from screening.56 This is because the prevalence is so high,49,54,56 the prevalence of undetected cases is high,48,49,57 and there is no, or low, positive predictive presentations for the presence of domestic violence.48,52,54,57 In addition, screening for abuse should be considered for each new complaint or when the patient has a new intimate partner.53

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

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

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

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

Patient Acknowledges Abuse or Wants To Discuss the Topic
When the patient acknowledges abuse or wants to discuss the topic, it is important to listen non-judgmentally51,52,54 and assure the patient that the disclosure is confidential.48,53 In addition, validation48,52,54,57 of their position with any of the following statements provides further support:

• “No one deserves to be hurt or threatened with violence.” (The most important and easily provided intervention is this simple message.)48,54
• “You are not to blame for the behavior of the perpetrator.”54
• “You are not alone.”52
• “You aren’t crazy.” 52
• “What happened to you is wrong.”52
• “Help is available.”52
• “I have treated others with this problem and am comfortable dealing with it.”52
It is important to educate the patient about the escalating cycle of abuse (nature and course) which not only produces serious medical problems but is also a criminal act for which there are protective service agencies and legal assistance, e.g. civil protection orders/restraining orders, criminal prosecution, civil litigation, etc.

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

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

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

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

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

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

• “Are you, or a partner, threatening suicide and if so, is there a suicide plan?” If so, the situation is urgent.

• “Are there forced unwanted types of sex or refusing to use birth control?”

• “Is there humiliation, swearing, name calling, mental instability, obsession with victim, use or abuse?”

• “Are there threats to injure self or patient reporting to immigration or stalking?”

• “Is there isolation which includes controlling access to friends and family and limiting outside involvement?”

• “Has there been destructive behavior such as destroying patient’s property, injuring pets of patient or child?”

• “Does the abusive partner control all the money?”

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

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

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

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

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

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

**Educational Materials for the Health Care Providers**

Chiropractors can increase public awareness about domestic violence and help women understand the problem by having pamphlets, posters, etc. in the office. This is an important form of intervention and prevention. There should be materials from community resources relating to domestic violence in the waiting room, examination room, female restrooms and other strategic locations. It is also...
important to support culturally sensitive publications in different languages for women in the international community as it is more difficult for them due to cultural, religious, social, family, legal and immigration reasons.  

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

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

Physical abuse, possible behavioral indicators:
- wary of adult contacts;
- apprehensive when other children cry;
- behavioral extremes;
- frightened of parents;
- afraid to go home.

(B) Neglect, possible physical indicators:
- consistent hunger, poor hygiene, inappropriate dress;
- consistent lack of supervision;
- unattended physical and/or emotional problems or medical needs.

Neglect, possible behavioral indicators:
- begging, stealing food;
- extended stays at school;
- poor school performance;
- fatigue;
- alcohol or drug abuse;
- delinquency.

(C) Mental injury or emotional maltreatment, possible physical indicators:
- failure to grow;
- speech or sleep disorders;
- forced to dress in "opposite sex" clothing.

Mental injury or emotional maltreatment, possible behavioral indicators:
- behavior extremes: aggression or withdrawal;
- habit disorders (sucking, biting, rocking);
- attempted suicide;
- conduct disorders (antisocial, runaway, destructive behavior);
- emotionally needy.

(D) Sexual abuse, possible physical indicators:
- difficulty in walking or sitting;
- pain or itching in the genital area;
- bruises, bleeding or infection in external genital area;
- venereal disease;
- pregnancy.

Sexual abuse, possible behavioral indicators:
- withdrawal, fantasy or infantile behavior;
- poor peer relationships;
- delinquent or runaway;
- reports sexual assault (children seldom lie about sexual abuse);
- refer also to behavioral indicators of mental injury or emotional maltreatment.
Elder Abuse
Observations suggestive of elder maltreatment include:68

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

(B) Patient
- fearful of caregiver.

(C) Patient or caregiver
- depressed;
- reluctant to answer questions.

Physical indicators of elder abuse:68

(A) Physical abuse
- unexplained bruises, wounds, burns, or other injuries;
- rope or restraint marks on wrists and/or ankles.

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

(C) Neglect
- dehydration or malnutrition;
- poor hygiene;
- inappropriate dress;
- unattended physical or medical needs.
Appendix C

Strategies that may prevent boundary violations and/or allegations of sexual misconduct

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

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

C. Self Assessment Tools to Analyze Risk
   • Risk factor analysis (See Appendix E) ⁹¹
   • The Exploitation Index: An early warning indicator of boundary violations in psychotherapy. (See Appendix F) ¹⁰¹

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

E. Patient Education/Orientation
   • chaperone option offered to patient;
   • query patients regarding their concerns;
   • pamphlets, videotapes, report of findings, PARQ conference (see Section 3);
   • clinic procedure regarding disrobing, gowns, and draping.

F. Identification of High Risk Situations for the Chiropractor
   • attraction to a patient;
   • personal relationship problems;
   • times of emotional distress;
   • substance abuse;
   • burn-out.

G. Recognition of High Risk Patient Behaviors
   • inappropriate gifts, cards or correspondence;
   • inappropriate “personal” comments and questions;
   • sexual innuendo and humor;
   • seductive clothing or behavior;
   • seeking inappropriate extended visits and/or care.
APPENDIX D

DOMESTIC VIOLENCE RESOURCES

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

ASHLAND
• Dunn House 541-779-4357

ASTORIA
• Clatsop County Women’s Crisis Service 503-325-5735

BAKER CITY
• May Day, Inc. 541-523-4134

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

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

COOS BAY
• Coos County Women’s Crisis Center 800-448-8125

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

ENTERPRISE
• Safe Harbors 541-426-6565

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

FLORENCE
• Siuslaw Area Women’s Center 541-997-2816

GRANTS PASS
• Women’s Crisis Support Team 541-474-1400 / 800-750-9278

GRESHAM
• Gresham Police Domestic Violence Unit 503-618-2394

HILLSBORO
• Domestic Violence Resource Center 503-469-8620

HOOD RIVER
• Project Helping Hands Against Violence 541-386-6603

KLAMATH FALLS
• Klamath Crisis Center 800-452-3669

LAGRANDE
• Shelter from the Storm 541-963-9261

LAKEVIEW
• Crisis Intervention Center 800-338-7590
LINCOLN CITY
- Women’s Violence Intervention Project 541-994-5959

MILL CITY
- Canyon Crisis Service 503-897-2327

MILWAUKIE
- Clackamas Women’s Services 503-654-2288

MCMINNVILLE
- Henderson House 503-472-1503

ONTARIO
- Project Dove 541-889-2000

PENDLETON
- Domestic Violence Services 800-833-1161

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

ROSEBURG
- Battered Person’s Advocacy 800-464-6543

SALEM
- Mid-Valley Women’s Crisis Service 503-399-7722

ST. HELENS
- Columbia County Women’s Resource Center 503-397-6161

THE DALLES
- Haven From Domestic Violence 541-298-4789

TILLAMOOK
- Women’s Crisis Center 800-992-1679

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

VANCOUVER:
- YWCA Safechoice 360-695-0501

UPDATED 12/02
APPENDIX E

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

SEXUAL MISCONDUCT RISK FACTOR ANALYSIS

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

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

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

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

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

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

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

Instructions
Place a check-mark next to the number (1, 2, or 3) of each statement that applies to you. When you have completed the questionnaire, add up all of the numbers that are the same – i.e. add up all the number 1s on a page and write that number at the bottom of each sheet, then do the same for all the 2s and 3s on each sheet. Add up the totals for each number on the last page in the space provided. Directions for assessing your RFA numbers are on the next page.
At the end of the self-scoring section, there are guidelines for comparing your RFA results with the results of the Doctor Self-Evaluation and the rest of the Practice Analysis.

**RISK FACTOR ANALYSIS QUESTIONNAIRE**

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

Totals for this page:

1 ____________ 2 ____________ 3 ____________
|   | The Risk Factor Analysis questionnaire is used with direct permission of Angelica Redleaf. |   |

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

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<tr>
<td>2</td>
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<td>3</td>
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Totals for both pages:

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<td>1</td>
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<td></td>
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<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
If you have checked off even one number 3: You are at risk. Know that you are a ticking
time bomb who could potentially hurt yourself, your patient(s) and your profession! You would
be very wise to get help from a therapist, consultant or significant other. You also should
consider getting training in this area. Ignoring your high risk or attempting to get through this by
yourself might be very unwise.

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

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

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

Redleaf A, Baird SA. Behind closed doors: gender, sexuality, and touch in the doctor/patient relationship. Westport,
### APPENDIX F

**THE EXPLOITATION INDEX**

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

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

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

<table>
<thead>
<tr>
<th>1. Do you do any of the following for your family members or social acquaintances: prescribing medication, making diagnoses, offering psychodynamic explanation for their behaviors?</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Are you gratified by a sense of power when you are able to control a patient’s activity through advice, medication, or behavioral restraint? (e.g. hospitalization, seclusion)</td>
</tr>
<tr>
<td>3. Do you find the chronic silence or tardiness of a patient a satisfying way of getting paid for doing nothing?</td>
</tr>
<tr>
<td>4. Do you accept gifts or bequests from patients?</td>
</tr>
<tr>
<td>5. Have you engaged in a personal relationship with patients after treatment was terminated?</td>
</tr>
<tr>
<td>6. Do you touch your patients (exclude handshake)?</td>
</tr>
<tr>
<td>7. Do you ever use information learned from patients, such as business tips or political information, for your own financial or career gain?</td>
</tr>
<tr>
<td>8. Do you feel that you can obtain personal gratification by helping to develop your patient’s great potential for fame or unusual achievement?</td>
</tr>
<tr>
<td>9. Do you feel a sense of excitement or longing when you think of a patient or anticipate her/his visit?</td>
</tr>
<tr>
<td>10. Do you make exceptions for your patients, such as providing special scheduling or reducing fees, because you find the patient attractive, appealing or impressive?</td>
</tr>
<tr>
<td>11. Do you ask your patient to do personal favors for you? (e.g. get you lunch, mail a letter)</td>
</tr>
<tr>
<td>12. Do you and your patients address each other on a first-name basis?</td>
</tr>
<tr>
<td>13. Do you undertake business deals with patients?</td>
</tr>
<tr>
<td>14. Do you take great pride in the fact that such an attractive, wealthy, powerful, or important patient is seeking your help?</td>
</tr>
<tr>
<td>15. Have you accepted for treatment a person with whom you have had social involvement or whom you know to be in your social or family sphere?</td>
</tr>
<tr>
<td>16. When your patient has been seductive with you, do you experience this as a gratifying sign of your own sex appeal?</td>
</tr>
</tbody>
</table>

The Exploitation Index questionnaire is used with direct permission of R. S. Epstein, MD
### Please give your immediate, “off the cuff” responses:

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

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

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

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


The Exploitation Index questionnaire is used with direct permission of R. S. Epstein, MD.
Educational Manual for Evidence-Based Chiropractic

Chapter 2
Diagnostic Imaging
Acknowledgements

We wish to acknowledge the hard work and expertise of the volunteers who comprised the steering committee, the seed panels that produced the seed statements, the nominal and Delphi panels who refined these statements, and the facilitators who conducted the consensus process. In addition we wish to thank the efforts of Meridel Gatterman who has served as process consultant, process manager, and compiler of the manuscript, and Kelly Bird and Dave McTeague who have edited the final copy.

Those who participated in the process so far include:

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**Sectional seed panel:** Peggy Seron DC DACBR, John Hyland DC DACBR DABCO MPH, Brian Enebo MS DC.

**Videofluoroscopy Seed Panel:** Drs. Ann Goldeen DC, Don Ferrante DC, Alexe Bellingham DC, Beverly Harger DC DACBR, K.C. Snellgrove DC, Tyrone Wei DC DACBR.

**Facilitators:** Drs. Cathy Cummins DC DACBR, John Colwell DC & Meridel Gatterman MA DC M.Ed.

**Nominal Panel Members:** Drs. Jim Bartley, Paula Conklin, Thomas Freedland, Meridel Gatterman, Kevin Holzapfel, Sunny Kierstyn, Ron LeFebvre, John Noren, Christene Olshove, Bruce Pace, Don Peterson, David Saboe, LaVerne Saboe Jr., Steve Sebers.

**Steering Committee:** Current members (as of 6-3-05) Drs. David Day-Chair, Thomas Dobson, Kathleen Galligan, John Colwell and Meridel Gatterman.
DIAGNOSTIC IMAGING

INTRODUCTION

The fundamental purpose of diagnostic imaging is to provide information to assist in the development of a diagnosis or otherwise impact the treatment plan. It is the responsibility of the chiropractic physician to keep abreast of advancements in diagnostic imaging. The chiropractic physician must make imaging decisions based on what is best for the patient. This chapter presents current knowledge regarding the utilization of diagnostic imaging in the assessment of chiropractic patients.

APPROPRIATE UTILIZATION OF RADIOGRAPHIC STUDIES

While diagnostic-imaging procedures may be vital to diagnosis and case management, the decision to utilize any diagnostic imaging procedure should be based on a demonstrated need (i.e. clinical necessity) following an adequate case history and physical examination.

Once radiographs have been obtained, it is required that a report of the findings be recorded and placed in the patient's permanent record. It is the responsibility of the clinician to ensure that all radiographs are evaluated for pathologic and biomechanical information. All radiographic reports will include the patient’s name, age, sex, date of examination and report, and area of study and views. A narrative of radiographic findings, and impressions should be included.

The following discussion is designed to assist in the plain film radiographic decision-making process. The guidelines are divided into categories as shown in Table 1. These categories include: clinical indicators, structural and functional abnormalities, other indicators, and inappropriate use of x-rays. All relevant clinical and historical information needs to be considered. The practitioner's clinical judgment will be the basis for determining whether to take radiographs or not.

CLINICAL INDICATIONS

Table 1: Guidelines for Chiropractic Utilization of Radiographic Studies

- History of malignancy (with unexplained new symptoms)
- Significant trauma, recent trauma, repetitive trauma with significant clinical findings
- Old trauma in the area of complaint
- Suspected fractures
- Clinically significant neurologic signs and symptoms
- Unexplained weight loss
- Unrelenting night pain
- Pain unrelieved by recumbency
- Suspicion or history of inflammatory arthritis with change in symptoms
- Known or suspected bone density loss
- Palpable mass
- Substance abuse
• Prolonged corticosteroid use 4,5,7,14,17
• Fever of unknown origin (>100° F) 4,5,7,14,17
• Suspected infection 5,6,7,11,29
• Abnormal laboratory finding (Erythrocyte Sedimentation Rate [ESR], White Blood Cell Count [WBC], etc.) 5,6,7,11,17
• Recent surgery or invasive procedure related to chief complaint 5,17
• Failure to improve without prior radiography 4,5,6,14,17
• Patients over 50 years of age are at greater risk of having significant pathologies 4,5,7,12,14,17,19,29,32

**Identification of Structural or Functional Abnormalities**
• Scoliosis or deformity 5,17,20,21,30
• Congenital anomaly 5,13,27
• Surgical history at area of chief complaint 5,6,17,22
• Postural abnormalities 17
• Hyper/hypomobility 23,24,36
• Aberrant motion 32

**Other Indicators**
• Suspected physical abuse 28
• Environmental exposure to toxic or infectious agents 17
• Recent immigration or foreign travel 17
• Medicolegal implications when combined with clinical indicators 4,17,25

**Inappropriate use of x-rays**
• Pregnancy - unless the patient's symptoms are of such significance that failure to x-ray would result in a substantial health risk to the mother 8,9
• Financial gain 4,17,33
• Patient education 4,17
• Routine (habitual) screening procedure 4,17,26,33
• Research without sanctioned review-board approval 34
• Unnecessary duplication of services
• Routine pre-employment screening 17
• Inadequate equipment to produce a diagnostic radiograph 3,5,10,17
• Routine discharge radiographs 17,33
• Non-licensed operator 3,17

**IMAGING MODALITIES**

There are a number of imaging modalities available to the chiropractic physician to utilize in the diagnostic work-up and treatment of patients. The following will be a discussion of those modalities including plain film radiography, tomography, fluoroscopy, videofluoroscopy, computed tomography (CT), magnetic resonance (MR) imaging, radionuclide imaging (bone scan), myelography, DEXA, PET, and ultrasound.
Plain Film Radiography

The use of plain film radiography in the chiropractic profession began in 1910. It was initially used as a research tool and later as the imaging modality of choice for diagnosis of pathology as well as evaluation of postural and biomechanical integrities of the spinal column and pelvis. Use has expanded to include the appendicular skeleton.

Plain films offer the doctor insight into pathology, indications and contraindications for chiropractic adjustment, as well as postural and biomechanical alterations. The risk of exposure to ionizing radiation mandates that a thorough history and examination be performed prior to the decision to utilize these procedures.

AP and lateral radiographs of the skeleton are the most common imaging procedure used in the chiropractic office. Additional views to the minimum diagnostic series include oblique views, angulated spot views, and dynamic stress studies. Oblique projections are essential in evaluating the facet joints of the cervical and lumbar spine as well as the intervertebral foramina (IVF) in the cervical spine. In the appendicular skeleton, oblique projections more fully demonstrate complex anatomy. Angulated projections are helpful in confirming or denying the presence of osseous versus soft tissue lesions. The sacroiliac joints are more clearly demonstrated on the angulated projection than on any other study. Dynamic stress views include flexion/extension and lateral bending of the cervical and lumbar spine. These studies reveal information related to the end range of motion. Stress radiography is also utilized to evaluate injured joints of the appendicular skeleton.

Soft Tissue Radiography

Soft tissue radiographs, chest and abdomen, are also utilized by the chiropractic physician. These types of studies may require specialized equipment i.e. film, screens, and grids to produce high quality radiographs. As with all radiographic procedures it is essential to obtain the highest quality radiographs when performing these procedures. Radiographs of soft tissues are strictly taken to evaluate for pathology. Poor quality radiographs reduce the likelihood that abnormalities will be identified.

In addition to plain film radiography of the abdomen, contrast studies of the digestive tract, barium swallow and enema, may be utilized by the chiropractic physician. Specialized equipment, i.e. fluoroscope, is needed to insure proper exposure and to produce superior quality radiographs. The images of the procedure must be videotaped. Initial evaluation of these procedures should be done in real time. Special training and experience are required to perform and interpret contrast studies.

Minimal Diagnostic Radiographic Series

It is accepted within the healthcare community that a minimum series of diagnostic radiographs are needed to evaluate each region of interest. As a general rule two views 90° to each other should be obtained. Some areas require additional views as an essential part of the minimal diagnostic series. The following tables represent the accepted standards.
### Table 2: Minimum Standard Views for the Axial Skeleton, Chest, and Abdomen

<table>
<thead>
<tr>
<th>AREA</th>
<th>AP</th>
<th>LATERAL</th>
<th>OBLIQUE</th>
<th>APOM</th>
<th>PA</th>
<th>ANGULATED</th>
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<tbody>
<tr>
<td>CERVICAL(^{39})</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
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<tr>
<td>THORACIC(^{40})</td>
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<td>X</td>
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</tr>
<tr>
<td>*LUMBAR(^{41})</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>PELVIS</td>
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<td>X</td>
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<tr>
<td>SACRUM/COCCYX</td>
<td>X</td>
<td>X</td>
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<tr>
<td>STERNUM</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
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<tr>
<td>CLAVICLE</td>
<td>X</td>
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<tr>
<td>RIBS</td>
<td>X</td>
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<tr>
<td>†SKULL</td>
<td>PA Caldwell</td>
<td>X</td>
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<tr>
<td>CHEST (Full Inspiration)(^{42})</td>
<td>LEFT</td>
<td></td>
<td></td>
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<td>UPRIGHT</td>
</tr>
<tr>
<td>ABDOMEN</td>
<td>X</td>
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</table>

*Lumbar spots may be needed, dependent upon the ability to visualize the L5-S1 region. Lateral spot or AP angulated spot radiographs should be considered after evaluation of the AP and lateral.

†To rule out pathology plain radiographs of the skull should only be taken as part of a study that includes computed tomography or MRI.\(^{43}\)
Table 3: Minimum Standard Views for the Extremities**

<table>
<thead>
<tr>
<th>AREA</th>
<th>VIEWS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACROMIOCLAVICULAR JOINT</td>
<td>Bilateral AP</td>
</tr>
<tr>
<td>SHOULDER</td>
<td>Internal and external rotation</td>
</tr>
<tr>
<td>ELBOW</td>
<td>AP and Lateral</td>
</tr>
<tr>
<td>WRIST</td>
<td>Dorsopalmar, dorsal oblique, and lateral</td>
</tr>
<tr>
<td>HAND</td>
<td>Dorsopalmar, dorsal oblique, and lateral</td>
</tr>
<tr>
<td>FINGERS</td>
<td>Dorsopalmar, dorsal oblique, and lateral</td>
</tr>
<tr>
<td>HIP</td>
<td>AP and frog leg lateral</td>
</tr>
<tr>
<td>KNEE</td>
<td>AP and lateral</td>
</tr>
<tr>
<td>PATELLA</td>
<td>AP, lateral, and sunrise</td>
</tr>
<tr>
<td>ANKLE</td>
<td>AP, medial oblique, and lateral</td>
</tr>
<tr>
<td>CALCANEUS</td>
<td>Axial and lateral</td>
</tr>
<tr>
<td>FOOT</td>
<td>AP, medial oblique, and lateral</td>
</tr>
<tr>
<td>TOES</td>
<td>AP, medial oblique, and lateral</td>
</tr>
<tr>
<td>LONG BONES</td>
<td>AP and lateral</td>
</tr>
<tr>
<td>TEMPOROMANDIBULAR JOINT</td>
<td>Lateral (TM joint is better evaluated with advanced imaging – MRI)</td>
</tr>
</tbody>
</table>

**Complete extremity series are dependent upon patient presentation and findings on initial radiographs.
NEUROMUSCULOSKELETAL SPECIAL IMAGING PROCEDURES

The choice of an appropriate imaging modality is a case specific process. A given patient may have specific needs or limitations that affect choices. The exact nature and degree of the pathology suspected affects imaging choices. These factors and the continuing development of imaging protocols make consultation with a radiologist valuable. The information provided here is intended as a general guide.\textsuperscript{15,46-58}

**Magnetic Resonance Imaging**

Magnetic resonance imaging (MRI) is a valuable diagnostic tool in neuromusculoskeletal imaging. Sectional images can be obtained through all body areas in axial (transverse), sagittal and coronal planes, or at oblique angles for smaller anatomical areas. No ionizing radiation is produced with MRI and risks to appropriately chosen patients have not been identified. Patients with pacemakers, some aneurysm clips, metallic foreign bodies, and other ferromagnetic artifacts are not appropriate candidates for MRI.

In general, MRI images tissues based on their hydrogen atom content, reflecting total quantity and molecular bonds. Therefore, both free and intracellular water, and fat produce the majority of the MRI "signal" which creates the image. MRI is an excellent procedure for imaging soft tissues of the body including the brain, spinal cord and cerebrospinal fluid, intervertebral discs, articular cartilage, muscles, tendons, ligaments, menisci, and most organs. MRI does not image cortical and trabecular bone though changes in the surrounding marrow can be diagnostic for many osseous pathologies.\textsuperscript{51}

MRI is rarely used as the initial imaging procedure. In many cases, MRI will provide additional information after evaluation of plain film radiographs. MRI may be used as the initial study in cases of significant or rapidly progressing neurologic changes, especially those that indicate central nervous system (CNS) pathology. MRI is also useful as a follow-up imaging procedure after surgical treatment for IVD herniation and neoplasm.\textsuperscript{51}

**Computed Tomography**

Computed tomography (CT) combines the imaging physics of plain film x-ray with the advantages of sectional imaging. Like plain film, CT produces its images through the interaction of x-ray photons with the tissues of the body, and is quite valuable in imaging osseous structures.\textsuperscript{15} CT also carries the same consideration of the potential harmful effects of ionizing radiation. The radiation dose should be kept as low as possible without losing diagnostic information and the risk-benefit ratio carefully weighed. Pathologies containing calcium densities may also be evaluated with CT. Some soft tissues, particularly of the chest and abdomen are best imaged with CT due to limitations of MRI in those areas.

Previously known as the CAT (computed axial tomography) scan, it is important to remember that primary or direct images are obtained in the axial plane. Sagittal and coronal reconstructions can be formed with the data obtained in the axial plane, but some extrapolation is done by the computer with a resultant loss of detail. Three-dimensional CT offers limited diagnostic information and is used primarily as a surgical planning tool.

Computed tomography is used extensively, with and without intravenous contrast agents, for chest and abdomen examinations. It is superior to MRI in most scenarios for the chest and
abdomen since the motion artifacts produced by heart contractions and bowel peristalsis may interfere with the acquisition of MR images. Plain film radiographs, as scout films, will often be used for preliminary examination of the chest and abdomen before CT imaging.

CT provides detailed evaluation of fractures. This is particularly useful in unusually shaped bones or areas difficult to image with plain film such as the pelvis, craniovertebral junction, posterior elements of the spine, and ankle. Computed tomography may be combined with arthrography when the differential list includes cartilaginous and bony abnormalities or when MRI is inconclusive, such as some cases of glenoid labrum tear. CT evaluation in the musculoskeletal system typically follows radiographic examination.

Computed tomography is also used extensively, though less than MRI, in evaluation of the spine, spinal canal, and intervertebral discs. CT is superior to MRI in detailing significant osseous changes, but MRI is usually more valuable in evaluating the impact on neurologic structures. Myelography can improve the ability of CT to evaluate neurologic structures, especially the thecal sac. In some cases, both procedures will be used to reach an accurate diagnosis and provide information for surgical planning. In cases where MRI is not available or not appropriate, CT, with or without myelography, is typically the imaging procedure of choice.51

CT is also used to evaluate head trauma injuries where fracture and acute intracranial bleed are suspected

**Radionuclide Imaging**

Radionuclide imaging of bone (bone scan) involves the intravenous administration of a radionuclide tagged to a phosphate analog, which is incorporated in the hydroxyapatite crystal of bone. Gamma rays emitted by the radionuclide are then detected quantitatively to produce an image. The image produced reflects blood flow and areas of increased bone production. Bone scan is much more sensitive than plain film for detecting osseous abnormalities but is distinctly nonspecific and would not be used as the only imaging procedure. A bone scan is typically used when the presence or the location of osseous pathology is questioned. Since almost all pathologies of bone lead to some reactive bone growth, bone scan may be applicable in a wide variety of suspected pathologies. It is most commonly used in the detection of radiographically occult stress fractures, neoplasms, and infection. It is used extensively in the evaluation of skeletal metastasis since the entire skeleton can be imaged at once.15,51

Single photon emission computerized tomography (SPECT) is a very useful method for displaying multiple planes of radionuclide activity. SPECT is especially useful to identify small areas of osseous pathology, particularly in the spine.

Radionuclide scans are also available for many organs. These scans may allow some degree of visualization to evaluate the size and location of organs. They are most useful in their ability to indicate the functional quality of the tissue in question.

**Diagnostic Ultrasound**

Diagnostic ultrasound (US) is an imaging procedure that relies on the reflection or transmission of sound waves by body tissues for producing images. The added capabilities of Doppler ultrasound allows for the quantification of flow rates in given structures, like arteries. Among the
most significant advantages of US are availability, low cost, noninvasiveness, and lack of known harmful effects. This procedure is used frequently in abdominal imaging where it is capable of determining organ size, organ masses, and in distinguishing between cystic, solid, and complex masses. It is typically the first imaging procedure chosen for thyroid abnormalities and can provide useful information in breast imaging. Diagnostic ultrasound is also increasing in use for musculoskeletal imaging and it is capable of detecting tears or hypertrophy in some of the commonly injured and more superficial soft tissue structures. Superficial masses may also be initially evaluated by ultrasound.

The large quantity of cartilage relative to bone in the pediatric skeleton, especially the very young, lends itself to evaluation by ultrasound. Diagnostic ultrasound of the adult spine is controversial due to a lack of consensus on normal versus abnormal findings.  

**Videofluoroscopy**

Videofluoroscopy (VF) is a modality that enables clinicians to view dynamic, real-time imaging of anatomy and function. VF is also a diagnostic test that can reliably record dynamic function of joints and their range of motion. The role of VF has been well established in interventional radiology and in the evaluation of neuromusculoskeletal, gastrointestinal, myelographic, and other studies requiring the injection of contrast material. 

VF like other advanced imaging modalities is not typically utilized as an initial imaging procedure. It may be used as a follow-up to demonstrate abnormal joint mobility that is suspected clinically but not adequately substantiated by other diagnostic studies. The value of VF, by comparison to static imaging modalities, is its ability to visualize the entire range and character of joint motion. The ability of VF to absolutely define segmental range of motion and the therapeutic significance of direct visualization of spinal dynamic function needs further investigation. 

Practitioners utilizing VF must document clinical justification and be cognizant of its contraindications, and limitations. Specialized training is needed to adequately interpret the images acquired. Operators of this equipment must be knowledgeable in the basic concepts of radiobiology and fluoroscopy systems.
<table>
<thead>
<tr>
<th>PATHOLOGY</th>
<th>PLAIN FILM</th>
<th>COMPUTED TOMOGRAPHY</th>
<th>MRI</th>
<th>RADIONUCLIDE STUDY</th>
<th>ULTRASOUND</th>
<th>CLINICAL CONSIDERATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muscle or tendon injury of extremities</td>
<td>Minimal use: May identify secondary effects, such as subluxation, gross disruption of Achilles’ and quadriceps tendons.</td>
<td>No routine use; may add info regarding associated osseous structures</td>
<td>Ideal imaging in most cases</td>
<td>No routine use</td>
<td>Best imaging choice in some cases, particularly where structure is superficial (rotator cuff, Achilles’ tendon, quadriceps tendon, many muscles)</td>
<td>Imaging often not required; most useful in evaluating for suspected instability and the need for surgery</td>
</tr>
<tr>
<td>Ligamentous injury of extremities</td>
<td>May identify secondary effects such as subluxation stress studies may be diagnostic</td>
<td>No routine use; may add info regarding associated osseous structures</td>
<td>Ideal imaging in most cases</td>
<td>No routine use</td>
<td>Limited, specific applications</td>
<td>Imaging often not required; most useful in evaluating for instability and need for surgery</td>
</tr>
<tr>
<td>Fibrocartilage injury</td>
<td>Offers little or no diagnostic information</td>
<td>Offers little or no diagnostic information</td>
<td>Imaging of choice in most cases</td>
<td>No routine use</td>
<td>No routine use</td>
<td>Arthroscopy may be the most appropriate procedure</td>
</tr>
<tr>
<td>Muscle, tendon or ligament injury of spine $^{15}$</td>
<td>May identify secondary effects such as subluxation, especially on stress studies.</td>
<td>No routine use; may add info regarding associated osseous structures</td>
<td>No routine use; gross soft tissue disruptions may be appreciated</td>
<td>No routine use</td>
<td>Limited specific applications</td>
<td></td>
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Table 4: Comparison of Imaging Procedures
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<tr>
<th>PATHOLOGY</th>
<th>PLAIN FILM</th>
<th>COMPUTED TOMOGRAPHY</th>
<th>MRI</th>
<th>RADIONUCLIDE STUDY</th>
<th>ULTRASOUND</th>
<th>CLINICAL CONSIDERATIONS</th>
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<tr>
<td>IVD pathology (excluding routine degenerative change)</td>
<td>Limited information; may be used to rule out other diagnoses</td>
<td>Provides some imaging of disc, herniations; addition of myelography provides some information of effect on adjacent neural structures</td>
<td>Best imaging choice, provides anatomical and physiological information and the effect on adjacent neural structures without added contrast</td>
<td>No routine use</td>
<td>No routine use</td>
<td>Incidental bulges and herniations may have no clinical significance. Discogram may be useful to identify symptomatic anular tears.</td>
</tr>
<tr>
<td>Stenosis: central canal, lateral recess, intervertebral foramen</td>
<td>Limited value in evaluating presence or extent of stenosis; often first imaging choice to evaluate gross osseous changes</td>
<td>Excellent for determining and quantifying osseous and some soft tissue causes of stenosis; addition of myelography allows evaluation of effect on neural structures</td>
<td>Often imaging of choice due to less invasive nature, lower risks. Excellent for determining soft tissue causes of stenosis and for determining effect on neural structures; less useful in evaluating osseous impact</td>
<td>No routine use</td>
<td>No routine use</td>
<td></td>
</tr>
<tr>
<td>Post-surgical spine, new or increased symptoms</td>
<td>Appropriate for initial evaluation; stress views may be useful in evaluating fusion</td>
<td>May be useful in evaluating osseous abnormalities; surgical changes may make interpretation difficult</td>
<td>Appropriate for evaluating effect on neurologic structures; with contrast can identify scar tissue</td>
<td>May be useful in detecting pseudoarthrosis</td>
<td>No routine use</td>
<td></td>
</tr>
<tr>
<td>PATHOLOGY</td>
<td>PLAIN FILM</td>
<td>COMPUTED TOMOGRAPHY</td>
<td>MRI</td>
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<td>CLINICAL CONSIDERATIONS</td>
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<tr>
<td>Fracture, acute, extremity (1)</td>
<td>Initial imaging of choice; often only imaging required</td>
<td>Useful for complex fractures, areas of complex anatomy (elbow, ankle, etc.); appropriate for evaluation of intra-articular extent of fracture</td>
<td>Excellent for identifying bone contusions and subtle fractures may be used following CT to determine effect on neurologic structures</td>
<td>Useful when clinical suspicion of fracture is high and radiographs are negative or inconclusive</td>
<td>No routine use</td>
<td></td>
</tr>
<tr>
<td>Fracture, acute, spine</td>
<td>Initial imaging of choice; may require follow-up with CT or MRI</td>
<td>Excellent for evaluating spinal fracture; appropriate when suspicion of spinal fracture is high and radiographs are negative or inconclusive; sagittal and coronal reconstructions may be helpful; useful in areas of complex anatomy (crabiovertebral and pelvis, etc.)</td>
<td>Appropriate for spinal injury with positive neurologic findings; Excellent for evaluating effect on neural structures; offers little fracture detail; can differentiate simple compression fracture from pathologic fracture</td>
<td>May be used when clinical suspicion of fracture is high and radiographs are negative; SPECT imaging may be required</td>
<td>No routine use</td>
<td></td>
</tr>
<tr>
<td>Fracture, stress</td>
<td>Initial imaging of choice; many will be radiographically</td>
<td>May be used to determine extent; not usually required; may be</td>
<td>Sensitive to early changes; may be difficult to differentiate</td>
<td>Appropriate for detection of radiographically occult, clinically</td>
<td>No routine use</td>
<td></td>
</tr>
<tr>
<td>PATHOLOGY</td>
<td>PLAIN FILM</td>
<td>COMPUTED TOMOGRAPHY</td>
<td>MRI</td>
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<tr>
<td>occult, especially in early stages</td>
<td>useful for pars interarticularis</td>
<td>stress fracture from other pathologies</td>
<td>suspected stress fracture; may require SPECT imaging, especially in the spine and other areas of complex osseous anatomy</td>
<td></td>
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<tr>
<td>Dislocation</td>
<td>Most appropriate initial imaging</td>
<td>Useful if radiographic findings questionable; may be used for additional detail, especially to detect associated fracture</td>
<td>May be useful in detailing associated soft tissue injuries and/or effect on adjacent neurovascular structures</td>
<td>No routine use</td>
<td>No routine use</td>
<td></td>
</tr>
<tr>
<td>Articular cartilage pathology</td>
<td>Depicts general cartilage loss; may show calcinosis secondary to crystal deposition; not effective for focal defects</td>
<td>No routine use</td>
<td>Diagnostic in most cases; intra-articular contrast (MRI-arthrogram) may improve sensitivity</td>
<td>No routine use</td>
<td>No routine use</td>
<td></td>
</tr>
<tr>
<td>Suspected intra-articular body</td>
<td>Most appropriate initial imaging; may not provide information with uncalcified, unossified</td>
<td>With arthrography, can provide diagnostic information</td>
<td>Can provide diagnostic information; excellent for osteochondritis dessicans</td>
<td>No routine use</td>
<td>No routine use</td>
<td>Arthroscopy preferred if clinical suspicion is high</td>
</tr>
<tr>
<td>PATHOLOGY</td>
<td>PLAIN FILM</td>
<td>COMPUTED TOMOGRAPHY</td>
<td>MRI</td>
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<tr>
<td>Cartilagenous bodies</td>
<td>Initial imaging of choice</td>
<td>May provide detail in complex osseous malformation</td>
<td>May provide valuable information regarding associated soft tissue or neural abnormalities</td>
<td>No routine use</td>
<td>No routine use</td>
<td></td>
</tr>
<tr>
<td>Congenital malformation 15</td>
<td>Appropriate for initial imaging; stress views may be required; fluoroscopy may add information</td>
<td>May be useful as follow-up to radiographically identified abnormalities</td>
<td>May be useful; stress studies may be useful</td>
<td>No routine use</td>
<td>No routine use</td>
<td></td>
</tr>
<tr>
<td>Biomechanical aberration</td>
<td>Imaging of choice</td>
<td>Rarely provides additional information; some complex or surgical cases may benefit</td>
<td>May be useful in evaluating some complications, such as stenosis</td>
<td>Can identify sites of involvement, but very non-specific</td>
<td>No routine use</td>
<td></td>
</tr>
<tr>
<td>Degenerative joint disease 53,54</td>
<td>Imaging of choice</td>
<td>Can detect some changes earlier than plain film</td>
<td></td>
<td>No routine use</td>
<td>No routine use</td>
<td></td>
</tr>
<tr>
<td>Inflammatory arthritis 55,56</td>
<td>Imaging of choice</td>
<td>Rarely provides additional information</td>
<td>Can detect articular cartilage involvement</td>
<td>No routine use</td>
<td>No routine use</td>
<td></td>
</tr>
<tr>
<td>Crystal deposition disease 57,58</td>
<td>Imaging of choice</td>
<td>More sensitive to calcium deposition, but rarely provides additional information</td>
<td></td>
<td>No routine use</td>
<td>No routine use</td>
<td></td>
</tr>
<tr>
<td>PATHOLOGY</td>
<td>PLAIN FILM</td>
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<tr>
<td>Infection (^7,15)</td>
<td>Initial imaging of choice; radiographic latent period from several days to several weeks</td>
<td>May be useful as follow-up to radiographically identified abnormalities</td>
<td>Very sensitive; no significant latent period; useful in radiographically occult cases and to determine extent of involvement</td>
<td>Much more sensitive than plain film; non-specific; useful in cases of high clinical suspicion and negative radiographs</td>
<td>No routine use</td>
<td></td>
</tr>
<tr>
<td>Neoplasm, osseous (^7)</td>
<td>Initial imaging of choice</td>
<td>May be useful as follow-up to radiographically identified abnormalities or in areas of complex anatomy</td>
<td>Very sensitive; may provide useful histologic information; useful in radiographically occult cases and to determine extent of involvement. Procedure of choice for multiple myeloma</td>
<td>Much more sensitive than plain film; non-specific; useful in cases of high clinical suspicion and negative radiographs, and to determine the extent of skeletal metastasis</td>
<td></td>
<td>Metastasis evaluation requires very specific protocols based on a number of patient variables</td>
</tr>
<tr>
<td>Neoplasm, soft tissue (^59)</td>
<td>Initial imaging of choice, but frequently non-diagnostic; use soft-tissue technique</td>
<td>Useful in evaluating tumors containing fat, calcium or bone; useful in determining osseous involvement</td>
<td>Most appropriate imaging</td>
<td>No routine use</td>
<td></td>
<td>P.E.T. useful for detecting breast, colon and brain neoplasms</td>
</tr>
</tbody>
</table>

16
<table>
<thead>
<tr>
<th>PATHOLOGY</th>
<th>PLAIN FILM</th>
<th>COMPUTED TOMOGRAPHY</th>
<th>MRI</th>
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<th>ULTRASOUND</th>
<th>CLINICAL CONSIDERATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avascular necrosis</td>
<td>Initial imaging of choice; significant radiographic latent period</td>
<td>No routine use</td>
<td>Most appropriate in cases of high clinical suspicion and negative radiographs; demonstrates extent of involvement</td>
<td>Sensitive, but not specific; appropriate in cases of high clinical suspicion and negative radiographs</td>
<td>No routine use</td>
<td>No routine use</td>
</tr>
<tr>
<td>Metabolic disease</td>
<td>Secondary skeletal changes may be identified and monitored</td>
<td>Not likely to add significant information</td>
<td>Some complications, changes may be identified</td>
<td>May provide information regarding sites of skeletal involvement</td>
<td>No routine use</td>
<td>No routine use</td>
</tr>
<tr>
<td>Head injury</td>
<td>Not likely to provide significant information</td>
<td>Imaging of choice in suspected skull fracture; provides significant information regarding acute brain trauma</td>
<td>Provides significant information regarding brain trauma; CT may be more appropriate in early stages</td>
<td>No routine use</td>
<td>No routine use</td>
<td>No routine use</td>
</tr>
<tr>
<td>Chronic sinus disease</td>
<td>Appropriate for initial evaluation; not as sensitive or specific as CT</td>
<td>Most appropriate imaging; initial imaging in most cases</td>
<td>May be used as follow-up to CT findings in unusual cases</td>
<td>No routine use</td>
<td>No routine use</td>
<td>No routine use</td>
</tr>
<tr>
<td>GI disease</td>
<td>Abdomen plain film does not provide adequate information in most scenarios; used as initial</td>
<td>Provides best imaging of many organs; frequently used with addition of</td>
<td>Useful for evaluation of some organs; presence of gas and intestinal motility often</td>
<td>Scans for specific organs can be useful</td>
<td>Frequently used in evaluation of abdominal disease; especially useful for solid organs</td>
<td>No routine use</td>
</tr>
<tr>
<td>PATHOLOGY</td>
<td>PLAIN FILM</td>
<td>COMPUTED TOMOGRAPHY</td>
<td>MRI</td>
<td>RADIONUCLIDE STUDY</td>
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<tr>
<td></td>
<td>evaluation for suspected acute obstruction or perforation; barium studies may be diagnostic</td>
<td>barium</td>
<td>provides for poor imaging</td>
<td></td>
<td></td>
<td>and cystic abnormalities</td>
</tr>
<tr>
<td>GU disease</td>
<td>Frequently used as initial study, but usually requires additional imaging; addition of contrast agent often required</td>
<td>Often provides best imaging; usually includes contrast agent</td>
<td>Frequently useful; may not provide adequate imaging of some areas</td>
<td>No routine use</td>
<td>Frequently used for evaluation of kidney and bladder disease</td>
<td></td>
</tr>
</tbody>
</table>
IMAGING OF BIOMECHANICAL ABNORMALITIES

Chiropractic radiographic analysis that includes appropriate views, when combined with clinical findings, is intended to provide a better understanding of the patient’s condition. High quality radiographic images are essential to rule out pathology and evaluate structural alignment. When radiographs are part of a biomechanical analysis it is paramount to evaluate images for pathologies that may weaken bony architecture, requiring modification of therapy.

Biomechanical analysis is used to determine misalignment, postural and motion abnormalities, and to guide manipulation.

Many radiographic lines, angles, and measurements have been demonstrated to be reliable indicators of postural and biomechanical abnormalities.

Spinal Radiographic Analysis

Most chiropractic methods of radiographic analysis have stressed the importance of assessing the patient in the upright, weight-bearing position. This allows for both full spine and regional postural evaluation. Specific consideration is given to the identification of abnormal spinal curves, that may compromise efficient biomechanical function. Studies that evaluate the reliability, validity and clinical relevance of radiographic line drawing have produced conflicting evidence.

Reliability

Reliability is the repeatability of a measurement and indicates consistency and precision when a procedure is done by different examiners and at multiple times. Factors that influence the reliability of spinal radiographic analysis include: anatomic variants, positioning of patient and x-ray equipment. In addition to these and other potential sources of systematic error, random measurement error adversely affects the reliability of measurement methods. While inter-examiner reliability of the actual marking of x-rays has been demonstrated, the reliability of the entire procedure has not been established. Reliability does not establish the clinical relevance or validity of measurement procedures.

Validity and Clinical Efficacy

Validity refers to how accurately an assessment procedure measures, identifies or predicts the true state of the patient. While construct validity (a measure of the theoretical concept of x-ray line marking) has been evaluated, the predictive validity (the clinical relevance of x-ray line marking, i.e. can it identify current spine problems, predict future occurrences, or measure resolution) has not been established through well-designed clinical trials. Predictive validity is crucial; it is far more relevant than construct validity or reliability tests in establishing the clinical efficacy of assessment procedures.
Functional Radiographic Analysis

Functional radiographs are practical tools for the evaluation of spinal segmental motion. Since Hviid in 1963, chiropractors including Sandoz, Anderson, Conley, West, Grice and Henderson have advocated cervical templating techniques to determine hypomobility, hypermobility and instability of spinal motion segments. Functional radiographs may be used to evaluate the segmental range of motion by comparing the neutral position to the end range of movement in either the sagittal or coronal planes. Medical investigators, including Penning and Dvorak, have established normative values for gross segmental flexion and extension without reference to the neutral lateral view. However, clinical information may be lost when the information from the neutral position is not included in the assessment.

The key to accurately evaluating motion on functional spinal radiographs is precise standards of patient positioning. Meticulous attention to the details of positioning cannot be overemphasized if the information obtained from the resultant radiographs is to be considered a reliable assessment of that particular patient’s function. Functional radiographic studies have traditionally been performed with active movement by the patient. Dvorak et al emphasized the value of obtaining functional radiographic studies of the cervical spine both actively and passively. While they claim that many more hypermobile segments are discovered on the passive stress studies the application of force at the end of active range of motion risks injury to the patient. These systems of functional radiographic analysis may be of clinical value to the doctor of chiropractic who provides spinal manipulation/adjustments to specific levels of segmental dysfunction. The reliability and clinical validation of cervical flexion extension studies have been demonstrated.

Full Spine Radiography

Depending on history and clinical findings, the need for full spine radiography is based on the clinical judgment of the doctor. The choice of sectional or full spine views is dependent on clinical necessity and the ability to produce diagnostic quality radiographs. AP/PA full spine radiographs are used for evaluation of pathology and biomechanical analysis. Single exposure, lateral full spine radiographs are not recommended.

The use of full spine radiographs is of value when clinical findings indicate the involvement of multiple spinal levels. Taylor has noted the following circumstances in which the PA full spine radiograph may be preferred over sectional radiographs:

- cases in which clinical examination disclosed the need for radiography of several spinal sections;
- cases in which severe postural distortions are evident, scoliosis evaluation after clinical assessment;
- cases in which a mechanical problem in one spinal area adversely affects other regions;
to specifically evaluate complex biomechanical or postural disorders of the spine and pelvis under weight bearing conditions.\textsuperscript{32}

Full spine radiographs can be considered to be of diagnostic quality\textsuperscript{80} with less radiation exposure to the patient compared to sectionals of the multiple levels involved. This requires appropriate technology and technique with careful attention to exposure factors, film speed, and shielding.\textsuperscript{78,81,82} The evaluation of suspected pathology may require sectional or spot views to attain better detail.\textsuperscript{63} Analysis of full spine radiographs has been used to identify biomechanical faults, chiropractic subluxations and joint dysfunction.\textsuperscript{63} There is a variety of line marking systems used to evaluate radiographs. The validity and reliability of the full spine analytical systems has been studied with mixed results.\textsuperscript{63,83,84,85}

\textbf{PATIENT SAFETY}

Patient safety in diagnostic imaging encompasses a range of activities performed before, during and after the actual imaging exam. The primary goal of these efforts is to provide the most clinically significant information with the lowest possible risk and cost to the patient.\textsuperscript{86,87,88} The following key areas should be addressed: patient education and informed consent (PARQ), patient comfort, selection criteria, radiation safety, image quality control, facilities maintenance and record keeping.

\textbf{Patient Education and Informed Consent (PARQ)}

The chiropractic physician should explain the diagnostic imaging procedures and follow up, the time and cost involved, risks and contraindications, and patient preparatory procedures. This should be done regardless of whether the treating physician will perform the imaging or order it from another facility. (See patient/doctor relationship chapter)

\textbf{Patient Comfort}

A clean, safe, comfortable environment should be provided for waiting, changing garments, securing personal items, and performing the imaging procedure. The privacy of the patient should be guarded during preparation for and execution of the exam, as well as with the storage of radiographs and reports.

\textbf{Radiation Safety}

The most important aspect of patient safety is to minimize the radiation dose to the patient. There is no known safe dose of ionizing radiation. Even the smallest dose can produce genetic damage. Diagnostic imaging doses do not typically produce clinical manifestations. The benefit to the patient must outweigh the risk.\textsuperscript{88-92} As Low As Reasonably Achievable (ALARA): Efforts should be made in all areas of the imaging procedure to provide the lowest possible dose to the patient without compromising image quality.\textsuperscript{90}
Patient Selection Criteria

The planned diagnostic imaging procedures must supply significant clinical information that cannot be otherwise determined. If the diagnosis, treatment or prognosis will not likely change based on imaging findings, the imaging is not appropriate. Every exposure, including post-treatment exposures and scanograms, must have clinical justification with adequate documentation consistent with the patient’s case history.93

Chiropractic physicians are responsible for ordering necessary and appropriate imaging studies. More than one study may be indicated to fully evaluate a patient. Pre-existing x-ray studies should be accessed if possible. These may be repeated if timely access is not feasible, they are of poor quality or are not clinically relevant. Consultation with a radiologist may be helpful in determining which studies are most appropriate for a case.

Image Quality Control

Assurance of image quality and low patient dose is dependent on many equipment and procedure factors. Attention is required in the setup and maintenance of equipment as well as during the imaging procedures.86,87,89,94

The following factors are listed as a guide for evaluating and monitoring plain film quality as it relates to patient safety. These should be considered to assure the highest possible film quality and lowest possible patient dose.

Equipment

- Tables and film holders: stable, level, and plumb
- Control arm / tube holder: stable, locking mechanism for maintaining appropriate angle, markings for consistent and reproducible source image distance (SID)
- Collimation: accurate, centered, apparent on three sides
- X-ray tube and exposure controls: calibrated, current exposure charts
- Film/screen combinations: as fast as possible while maintaining adequate detail, screens clean and without defects, cassettes marked and without defects
- Markers: adequate to identify patient, anatomy, special procedures, proper placement
- Filters and shields: devices for reducing dose to sensitive tissues such as eye, thyroid gland, breast, and gonads should be available for frequently performed studies
- Processor: chemicals should be changed at prescribed intervals, processing temperature and speed consistently monitored
- Darkroom: film storage and handling should be safe from fogging factors
Technique

- Technique charts: current and appropriate to the equipment; charts used consistently, factors recorded
- Positioning: standard and consistent positioning; options in positioning that may reduce dose employed (PA for full-spine; anode-heel effect).\textsuperscript{95,96} minimum diagnostic series to assure complete evaluation
- Patient prep: gown as appropriate, remove jewelry, dentures, other artifacts as appropriate
- Repeat films rates: monitored to identify problems

Facilities Maintenance

Equipment such as a floating tabletop, movable wall bucky, and the locking tube arm mechanism should be stable. Storage of chemicals should not pose a hazard to patients.

Facilities should allow for adequate performance of chosen procedures. Room size should accommodate the longer source-image distance (SID) required of projections such as the lateral cervical spine and PA and lateral chest. A horizontal surface should be available to accommodate certain extremity studies, lumbar imaging on larger patients, and patients with difficulty remaining immobile.\textsuperscript{2} Referral may be necessary when facilities will not accommodate for special patient needs. Appropriate shielding should be utilized. Extremity and chest radiographs require specific film/screen combinations. Additional materials such as supports, weights and compression bands should be available. The patient should be referred to an appropriate facility if available equipment is not adequate to perform a chosen study.

Test and evaluation procedures are recommended at given intervals.\textsuperscript{93,96} (See Appendix A.)

Record Keeping

Following production and processing of radiographs, films should be checked for proper identification. (See Appendix B.) A written report should be generated that includes identifying information, the study performed, pertinent findings and a clinical impression. Optimally one copy of this should be kept with the films in addition to a copy that should be placed in the patient’s file. Films should be stored in an area that provides for patient privacy and has physically appropriate conditions to protect film quality.\textsuperscript{86}
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Videofluoroscopy Bibliography


APPENDIX A
Imaging Test/Evaluation Procedures

The following test/evaluation procedures are recommended at the given intervals:

Daily (before use)
- Warm up processor (prescribed time)
- Check developer temperature
- Fill rinse tank
- Clean cross-over rollers
- Run and check "clean-up" film
- Warm up x-ray tube
- Visually inspect darkroom

Daily (end of use)
- Turn off processor
- Offset processor cover
- Drain rinse tank

Monthly
- Inspect film and chemical storage areas
- Inspect darkroom
- Check accuracy of built-in processor thermometer

Quarterly
- Evaluate retake rate, reasons
- Clean intensifying screens
- Inspect screens and cassettes

Semi-annually
- Test darkroom for light leaks
- Evaluate film fog from safelight
- Check film fixer retention
- Check collimator light field to radiation field
- Evaluate intensifying screen/film contact
• Sensitometry-densitometry

Annually (Most performed by service engineer)

• Check/calibrate kVp accuracy
• Check mAs reproducibility
• Check radiation dose reproducibility
• Evaluate filtration
• Check SID accuracy
• Check x-ray beam perpendicularity, bucky centering
• Evaluate focal spot size
• Check grid uniformity and alignment
• Check phototimer reproducibility
• Check exposure timer accuracy

Modified from: Guidelines for Establishing Radiographic Quality Assurance and Quality Control Programs," State of California; Continuous Quality Assurance and Quality Control Program.
APPENDIX B

Legal Requirements for taking X-rays in the State of Oregon

The following changes were made to Chapter 811 administrative rules in November 2004 by the Oregon Board of Chiropractic Examiners. (New language is underlined, deleted language is struck through.)

Supervision

811-030-0011 Staff employees of a Doctor of Chiropractic may be directed to take X-rays of a patient if they are in possession of a permit issued by the State Board of Radiologic Technology, but this permit is limited only to the taking of X-rays. (ORS 684.155)

Scope of Radiography in the Chiropractic Practice

811-030-0020 (1) The radiographic diagnostic aspect of Chiropractic practice shall include all standard radiographic procedures that do not conflict with ORS 684.025.

(2) All radiographs shall be of diagnostic quality. Radiographic films are subject to review by the Board to determine quality. Poor quality radiographs may result in disciplinary action.

(3) X-ray is not to be used for therapeutic purposes.

(4) Fluoroscopy shall not be used as a substitute for an initial radiographic study and shall be used only with documented clinical justification. In order for anyone to operate a fluoroscopy unit they must be properly trained and they must have written documentation that shows that these requirements are met. (OAR 333-106-045)

(5) Use of radio-opaque substances for diagnostic X-ray, other than by mouth or rectum, is not permitted.

(6) Pregnant females shall not be radiographed unless the patient's symptoms are of such significance that the proper treatment of the patient might be jeopardized without the use of such radiographs.

(7) All critical parts, i.e. fetus, eyes, thyroid gland, breasts and gonads, beyond the area of primary examination shall be shielded. (684.155)

X-ray Departments, Equipment and Procedures

811-030-0030 (1) All X-ray departments, equipment and procedures including fluoroscopy shall be in compliance with the current rules and regulations of the Oregon State Health Division Radiation Control Section, including but not limited to, the physical design of the department, occupational exposure, collimation, shielding and exposure charts and fluoroscopy.

(2) In addition:
(a) The patient shall be an adequate candidate for the radiographic or fluoroscopic procedure employed;

(b) The radiographic field shall be restricted to the area of clinical interest;

(c) Specialized views shall be used any time the area of clinical interest is not clearly visualized on a standard film;

(d) Every exposure, including post-treatment exposures, and scanograms, shall have clinical justification with adequate documentation consistent with the patient's case history;

(e) The operator shall maintain a record on each exposure of each patient containing the patient's name, the date, the operator's name or initials, the type of exposure and the radiation factors of time, mA, kVp and target film distance, including those exposures resulting in the necessity of repeat exposure for better diagnostic information such as patient motion or poor technical factors. For computerized and automated systems the recording of technique factors is not necessary as long as the equipment is calibrated and maintained. OAR 333-106-045 requires the facility to determine the typical patient exposure for their most common radiographic examinations, i.e. technique chart.

(f) Each film shall be properly identified by date of exposure, location of X-ray department, patient's name and number, patient's age, right or left marker and postural position marker; and indication of the position of the patient;

(g) The patient with tremors must be immobilized;

(h) The radiographs of a patient with an antalgic posture may be taken in an upright position only if the patient is adequately supported and immobilized to insure diagnostic quality. Otherwise, the recumbent position shall be used;

(i) Upright or postural views shall not be used for any patient whose size exceeds the capacity of the X-ray equipment. Penetration must be adequate on all films;

(j) Full Spine (14 x 36 inch) radiographs: (A) Sectional views shall be taken in preference to a single 14 x 36 inch film if the patient’s size or height prevents diagnostic qualify on a single 14 x 36 inch film;

(Elizabeth) (k) If two exposures are made on a single film, the area of exposure shall be critically collimated to avoid double exposure of the overlapping area;

(C) (l) All views shall employ graduated filtration or adequate devices to attenuate the primary beam for the purpose of reducing unnecessary radiation and to improve film quality. Split screens, gradient or graded screens, paper light barriers inside the cassette, or any other attenuating device in the beam between the patient and the film shall not be permitted, other than the grid controlling scattered radiation.

(k) (m) A record of radiographic findings on every set of radiographs reviewed shall be included in the patient's permanent file;

(l) (n) Radiographs shall be kept and available for review for a minimum of seven years or until a minor becomes 18 years of age, whichever is longer. (ORS 441.059, 684.025, 684.150)
STANDARDS

In addition to the legal requirements for taking x-rays in the State of Oregon, the following standards shall apply:

1. The chiropractic physician must make imaging decisions based on a demonstrated need (clinical necessity) and what is best for the patient.

2. Efforts should be made in all areas of the imaging procedure to provide the least possible dose to the patient without compromising image quality.

3. Standard views for a minimum series of diagnostic radiographs are needed to evaluate each region of interest. As a general rule two views 90° to each other should be obtained. Some areas require additional views as an essential part of the minimal diagnostic series.

4. When radiographs are part of a biomechanical analysis it is paramount to evaluate images for pathologies that may weaken bony architecture, requiring modification of therapy.

5. The choice of sectional or full spine views is dependent on clinical necessity and the ability to produce diagnostic quality radiographs.

6. Chiropractic Physicians are responsible for ordering necessary and appropriate imaging studies. Relevant pre-existing x-ray studies should be accessed, if possible.
Chapter 3
Record Keeping
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Those who participated in the process include:

Record Keeping Seed Panel: Drs. Steve Sebers (Facilitator), Sunny Kierstyn, Richard Layman, Donald Skei and John Noren

Nominal Panel Members: Drs. Jim Bartley, Paula Conklin, Thomas Freedland, Meridel Gatterman, Kevin Holzapfel, Sunny Kierstyn, Ron LeFebvre, John Noren, Christene Olshove, Bruce Pace, Don Peterson, David Saboe, LaVerne Saboe Jr., and Steve Sebers.

Steering Committee: Current members (as of 6-3-05) Drs. David Day-Chair, Thomas Dobson, Kathleen Galligan, John Colwell, Michael Vissers and Meridel Gatterman.

Delphi Panel: A total of 152 chiropractic physicians participated in the Delphi review, broken down into two groups. Group 1 was doctors who have participated in previous Delphi reviews (88 respondents). This includes six external reviewers. Group 2 was identified from the Oregon Chiropractic Physicians Survey conducted by the OBCE in March 2005 (64) responses.
RECORD KEEPING

Sections:

1. Introduction
2. Record keeping
   a) Internal Documentation
   b) External Documentation
   c) Chart/File Organization
   d) Maintenance of Records
   e) Patient Consents
   f) Malpractice Tips
3. HIPAA – Health Insurance Portability and Accountability Act
4. Practice Standards
5. References
INTRODUCTION

The importance of keeping complete and accurate records cannot be overemphasized. Documentation of patient care is often as important as the rendition of care itself. Proper record keeping is the documentation of the patient-doctor interaction. This record should be constructed so that it may be understood by others necessary to support a patient’s health and reimbursement needs.

As a critical component of our health care delivery system, the accumulation of essential information, known as a patient record, serves many purposes, including:

- It provides a historical accounting of the patient’s health concerns and treatments. While the actual record belongs to the provider, the information contained within the record belongs to the patient.

- Record keeping should facilitate and maintain communication between health care professionals. “…clinicians must ensure that their documentation of a patient’s health status is understood by others on the health care team.” Each health care provider having access to that record has the same duty to record patient information and ensure that it is safeguarded.

- Quality record keeping allows a physician or reader to follow the conditions presented by the patient through the evolution of a diagnosis and treatment plan and the patient’s response to the treatment. The quality of the patient record may be considered a reflection of the quality of patient care.

- In the context of medico-legal concerns the record serves as the legal instrument to provide “substantive evidence on whether care rendered met the legal standard of care.” “… the courts side with whatever the patient has said … ‘If it’s not in the chart, from a legal standpoint, either the procedure didn’t happen or the comment wasn’t made’.”

- The patient record documents the services provided allowing the physician to be properly reimbursed. “It is often the quality of the documentation, rather than the condition of the patient, that determines the amount of care deemed medically necessary by the insurance company or auditors.”

- The record should include documentation of informed consent. Any limitations as requested by the patient should also be noted.

- Patient records have also been used to evaluate physicians for the purposes of teaching, research, and to provide data for public health needs.

- The information in the record constitutes the foundation for writing accurate reports to health care providers, 3rd-party-payors, attorneys or any other interested parties.

As many health care systems grow, mature, and interrelate on an ever-increasing basis, the health care record becomes more and more important. “Ultimately, good record keeping is a necessity. It is important to everyone: patient, doctor and staff.” Each physician has an ethical, as well as legal, duty to
construct these records in such a manner as to be accurate, legible, complete and organized. Finding ways and methods that allow for the most complete compilation of this essential data in a simple and easy manner is a frequent challenge.

There are numerous forms and methods of record keeping available, including standard formats and other organizational systems used throughout healthcare fields. Each doctor may standardize files in the way best suited to each particular practice. SOAP format is recommended. “Good decisions are often the result of accurate and complete facts being retrievable from a patient record.”

**RECORD KEEPING**

“Each patient shall have exclusive records which shall be sufficiently detailed and legible as to allow any other chiropractic physician to understand the nature of that patient’s case and to be able to follow up with the care of that patient if necessary.”

“It will be considered unprofessional conduct not to keep complete and accurate records on all patients, including but not limited to case histories, examinations, diagnostic and therapeutic services, treatment plan, instructions in home treatment and supplements, work status information and referral recommendations.” Oregon Administrative Rule 811-015-0005(1)

**INTERNAL DOCUMENTATION**

**Patient record**

Information contained in the patient file is the foundation of the patient’s permanent record. Each page in the patient file shall contain the patient’s name and/or ID number. The following additional information shall also be included in the patient file/s:

- Patient identification/pertinent demographic information
- Patient/case history
- Examination findings
- Imaging, laboratory and special study findings
- Diagnoses
- Treatment plan
- Chart notes
- Insurance and billing information
- Consent documentation
- Reports and other correspondence
- Referring physicians

Often, the patient record is stored in a folder. The folder itself may also become part of the record if the practitioner writes patient data on the folder, such as personal information, treatment plan, diagnoses, etc.; however, care should be taken to comply with patient privacy laws (e.g. HIPAA). Outdated portions of the patient record may be removed and stored in an archive file. If this is done, a note should be kept in the active file identifying the location of those records.
Doctor/clinic identification
Basic information identifying the practitioner and/or clinic should appear on each page of documentation.
[4, 9, 10] This information should include:

- Practitioner’s name and professional degree [4, 10]
- Facility name (if different) [4, 10]
- Street address and mailing address (if different) [4, 10]
- Telephone numbers [4, 10]

Patient identification
The record shall clearly identify each patient. [1, 5, 6] This information is often obtained by using preprinted forms that are completed by the patient and may include the following:

- Name (prior/other names) [4, 10]
- Date of birth, age [4, 10]
- Gender [4, 10]
- Occupation/employer [4, 10]
- Marital status/spouse’s name, occupation [4, 10]
- Name(s) of dependents [4, 10]
- Race [4, 10]
- Address, telephone numbers (home and work) [4, 10]
- Social security number [4, 10]
- Case/file number (when applicable) [4, 10]
- Name of consenting parent or guardian (when applicable) [4, 10]
- Letter of guardianship (when applicable) [4, 10]
- Radiograph/lab identification [4, 10]
- Emergency contact name/number [4, 10]
- Photographs

Patient case history
A detailed case history is an important part of the patient record as it is the foundation of the clinical database for that patient. [4, 10] This information should include an adequate description of the patient’s perception of their history. [4, 10] History questionnaires, drawings and other information completed by the patient should be included in the patient record. [4, 10]

Elements of the patient history may include the following:

- Presenting or chief complaint [4, 9, 10]
- Date or time of onset of symptoms [4, 9, 10]
- Description of accident or injury (if applicable) [4, 9]
- Past and present health history [4, 9, 10]
- Family and social history [4, 9, 10]
- Systems review (as appropriate) [4, 9, 10]
- Past and present therapeutic and diagnostic procedures [4, 9, 10]
Examination findings
The results of all examination procedures performed, ordered or requisitioned must be recorded and will become part of the permanent patient record. Objective information is obtained by a physical examination/assessment of the area of complaint and related areas and/or systems. Preprinted and formatted examination forms may be used to facilitate the gathering and recording of this information. Documentation should include the date of the examination and the name or initials of the examining practitioner. If abbreviations are used, a legend should be available.

The examination and diagnostic procedures may include the following:

A. Physical examination

- Vital signs
- Heart, lung and abdomen
- EENT
- Integumentary examination
- Chiropractic, orthopedic and neurological tests
- Static and motion palpation of spine and extremities
- Postural analysis
- Muscle testing including dynamic, isokinetic, static and manual
- Functional examination
- Other

B. Diagnostic Imaging

- Plain film radiography
- MRI
- CT
- Diagnostic ultrasound
- Radionuclide bone scan
- Other

Reports with clinical findings should be reviewed, initialed, and dated upon receipt.

Regarding radiographic examinations, “The operator shall maintain a record on each exposure of each patient containing the patient's name, the date, the operator's name or initials, the type of exposure and the radiation factors of time, mA, kVp and target film distance, including those exposures resulting in the necessity of repeat exposure for better diagnostic information such as patient motion or poor technical factors”
For computerized and automated systems the recording of technique factors is not necessary as long as the equipment is calibrated and maintained. OAR 333-106-0045 requires the facility to determine the typical patient exposure for their most common radiographic examinations (i.e. technique chart).

“Each film shall be properly identified by date of exposure, location of X-ray department, patient's name or number, patient's age, right or left marker and postural position marker.”[14]

C. Laboratory

Results of laboratory exams ordered or performed by the physician may include:

- Complete blood count[4]
- Erythrocyte Sedimentation Rate[4]
- Urinalysis[4]
- Chemistry Screen [4]
- Other

Reports with clinical findings should be reviewed, initialed, and dated upon receipt. [4, 9, 10]

D. Special Examinations

Results of special exams ordered or performed by the physician may include:

- Gynecological examination [8]
- Proctological examination [8]
- Obstetrical examination [8]
- Minor surgical examination [8]
- Electrodiagnostic evaluation [8]
- Vascular evaluation [8]
- Psycho-social assessment
- Testicular
- Other

Reports with clinical findings should be reviewed, initialed, and dated upon receipt. [4, 9, 10]

**Clinical impression or diagnosis**

Upon the completion and assessment of the patient’s history, subjective complaints, and examination findings, the physician arrives at a clinical impression or diagnosis. The clinical impression or diagnosis must be recorded within the record. [4, 10, 15] Since they may change with new clinical information, time and treatment, it is important that the clinical impression or diagnosis be dated.[4, 10] It is not necessary to update this category at each visit, but periodic re-examinations should be performed and the results included in the record along with any change in the clinical impression or diagnosis. [8]
Accurate recording of the patient’s condition frequently requires more than one diagnosis. Of particular concern to the chiropractic practitioner is identification of the biomechanical lesion (subluxation/segmental dysfunction). Recording this information documents the spinal region involved and is the basis for the adjustment/manipulation that is emphasized in chiropractic practice. In addition, the pathoanatomic diagnosis gives the location and severity of specific structures damaged and helps to formulate the prognosis for the patient’s condition. A patient may have only a pathoanatomical lesion or only a biomechanical (functional) lesion. However, the biomechanical lesion is most often linked to a pathoanatomical condition.  

Components of the clinical impression/diagnosis may include:

- Phase of lesion \[^{[8]}\] (e.g. acute, subacute, chronic, acute recurrent, chronic recurrent)
- Severity \[^{[4, 8]}\] (e.g. mild, moderate, severe, Grade I, II, III)
- Mechanism of lesion \[^{[8]}\] (e.g. traumatic, postural, overuse, hyperextension, torsional)
- Location \[^{[4, 8]}\] (e.g. spinal level, muscle, ligament, neurological structures)
- Type of lesion (e.g. sprain, strain, subluxation, myofascitis, DJD)
- Neurological involvement (e.g. nerve root involvement, distribution, site of nerve root or cord compression/irritation)
- Complicating/associated factors \[^{[4, 8]}\] (e.g. neurological involvement, DJD, stenosis)
- Resulting anatomical damage or syndrome (e.g. cervicogenic headache, facet syndrome)
- Concomitant pathological diagnoses \[^{[4]}\] (e.g. COPD, neoplasm, CHF, HTN)

**Treatment plan**

The treatment plan is the portion of the patient record that deals with the proposed action by either the treating physician or the patient. \[^{[17]}\] The plan arises from the accumulation of clinical data and the initial clinical impression or diagnosis. \[^{[4, 10]}\] The treatment plan must be recorded in the patient file.

The treatment plan should include, when applicable:

- The prescribed therapeutic treatment plan (including modes, frequency and duration of care) \[^{[4, 10, 17]}\]
- Additional diagnostic testing recommended or being considered \[^{[4, 10]}\]
- Reassessment schedule \[^{[4, 10]}\]
- Patient education and self-care plan \[^{[4, 10, 17]}\]
- Referrals or consultations \[^{[4, 10, 17]}\]
- Goals and outcome measures

**Chart/progress notes**

“Every page of chart notes will identify the patient by name, and the clinic of origin by name and address. Each entry will be identified by day, month, year, provider of service and author of the record.” \[^{[3]}\] Oregon Administrative Rule 811-015-0005(1)(b)

Chart notes (often referred to as progress notes) are made in a patient’s chart to record the patient’s state of health, what transpired during patient visits as well as any significant changes in the clinical picture, assessment or treatment plan. \[^{[4, 8, 10]}\] Chart notes should document the patient’s response to the physician’s management of their case. All record should be made in a systematic and organized manner. \[^{[4, 8, 10]}\] The
record shall be legible and clear enough to allow a peer to assume management of the case after an initial review of the chart notes.\textsuperscript{[1, 8]}

Since the 1970s the classic format has been known as \lq\lq S.O.A.P.\rq\rq notes.\textsuperscript{[17]} S.O.A.P. is an acronym for Subjective, Objective, Assessment, and Plan or Procedures.\textsuperscript{[7]} This pertinent clinical information can be organized in the SOAP format in a variety of ways. While full S.O.A.P. charting at each visit is strongly recommended, it is not required. Components of the record should include: \textsuperscript{[8]}

Subjective complaints: These should be in the patient’s own words when possible, indicating improvement, worsening or no change.\textsuperscript{[8]}

Objective findings: Changes in the clinical signs of a condition should be noted at each visit in the doctor’s own words. \textsuperscript{[8]}

Assessment or diagnosis: It is not necessary to update this category at each visit. However, periodic clinical reevaluations should be performed and these results included in the daily entries with any modification of the diagnosis. \textsuperscript{[18]}

Plan of Management: A provisional plan of management should be recorded initially and further entries made as this plan is modified and/or as a patient enters a new phase of treatment. Changes in procedures should be noted. \textsuperscript{[18]} Daily recording of procedures performed should include adjustment/manipulation performed (for example, direction and force of the thrust), soft tissue techniques, modalities used (including time, location and intensity), exercises prescribed, nutritional supplementation or prescribed diet and activity instructions or advice. Any significant adverse response to therapies should be noted. \textsuperscript{[18]}

Financial records
Financial records may be kept in the patient record and may include the following:

- Patient account ledgers (including date and type of services billed, payments received and from which source, account balance) \textsuperscript{[4, 15]}
- Billing statements \textsuperscript{[4]}
- Insurance records (explanation of benefits, proof of payment, etc.) \textsuperscript{[4]}

Internal memoranda regarding patient
Internal memoranda regarding individual patients should be kept in the patient record and may include the following:

- Intra-office staff messages \textsuperscript{[4]}
- Phone messages and/or summaries of phone conversations \textsuperscript{[4]}
- Copies of emails sent/received \textsuperscript{[4]}
- Copies of sign-in sheets \textsuperscript{[4]}

Any correspondence sent out of the treating practitioner’s office should contain the doctor and clinic name and address, phone number and current date. \textsuperscript{[19]}
**Electronic records**
The computerization of the medical record has accelerated rapidly in recent years. The use of electronic or computer-assisted record keeping systems is becoming more common in chiropractic offices. These systems may include computer-assisted writing, voice recognition or other developing technologies. Some systems accept input not only from the computer keyboard, but from touch screens, light pens, scanners and other input devices. If an electronic record-keeping system is used, the provider needs to take reasonable steps to ensure the system is so designed and operated that the record is secure from loss, tampering, interference or unauthorized use or access and complies with all state and federal confidentiality regulations.

**EXTERNAL DOCUMENTATION**

External documentation includes relevant information received from an outside source and may include correspondence from numerous sources: referring physicians, other previous/concurrent practitioners, attorneys, various pay groups, consultative reports, diagnostic studies, etc. The original of each of those relevant external documents, if available, should be kept in that patient’s record.

Any external clinical documents such as reports or diagnostic studies should be initialed, dated and included in the patient’s file. This notation provides evidence that the document has been read by the doctor.

**CHART/FI LE ORGANIZATION**

**General**
Records should be entered in the sequence events took place, and kept in chronological order. Records should be neat, legible, organized and complete, and recorded in dark ink or other permanently retrievable method within 24 hours of occurrence. The record should never be backdated, erased, deleted or altered in any way. If corrections need to be made, a line should be drawn through the error and the change initialed and dated. If records are kept electronically, amendments should be made in such a way that preserves the original record. Records must be complete enough to provide the practitioner with enough information for subsequent care or reporting to outside parties.

**Preprinted Forms**
Forms may be used based on the practitioner’s discretion. Forms provide an orderly means of obtaining the history, noting examination findings and charting progress. If preprinted forms are used, they should include appropriate doctor/clinic identification. If part of a form does not apply to a practitioner’s practice, the section should be deleted and the form reprinted.

**Abbreviations/Symbols**
“Recordable abbreviations and terminology should be internally consistent and a key for these abbreviations must be available.” All records sent to a third party should be accompanied by a legend of codes or abbreviations used.
MAINTENANCE OF RECORDS

Oregon Administrative Rules

Records
811-015-0005 (1) It will be considered unprofessional conduct not to keep complete and accurate records on all patients, including but not limited to case histories, examinations, diagnostic and therapeutic services, treatment plan, instructions in home treatment and supplements, work status information and referral recommendations.

811-015-0005 (3) A patient’s records shall be kept by the Chiropractic physician a minimum of seven years. If the patient is a minor, the records shall be kept seven years or until the patient is 18 years of age, whichever is longer.[24]

Disclosure of Records
811-015-0006 (1) A Chiropractic physician shall make available within a reasonable time to a patient or a third party upon the patient’s written request, copies or summaries of medical records and originals or copies of the patient’s X-rays.

(a) The medical records do not necessarily include the personal office notes of the Chiropractic physician or personal communications between a referring and consulting physician relating to the patient.

(b) The Chiropractic physician shall preserve a patient’s medical records from disclosure and will release them only on a patient’s written consent stating to whom the records are being released or as required by State and Federal law.

(2) The Chiropractic physician may establish a reasonable charge to the patient for the costs incurred in providing the patient with copies of any portion of the medical records. A patient shall not be denied summaries or copies of his/her medical records or X-rays because of inability to pay or financial indebtedness to the Chiropractic physician.[25]

Confidentiality

All patient/doctor communications and interactions are privileged and confidential. This is an ethical responsibility as well as a statutory and/or regulatory one.[4, 10, 15] All information regarding a patient must be kept confidential unless its release is authorized by the patient or is compelled by law.

Assurance of confidentiality is necessary if patients are to be open and forthright with the practitioner. Patients have the right to expect that information regarding their health will remain private and secure from public scrutiny.[4, 10, 26] The unauthorized disclosure of patient records by a physician may create legal liability unless the disclosure is to an authorized source, authorized by law, or justified by a superior public interest.[27] A patient who is injured by disclosure of his or her confidential information may pursue legal remedies against the providers not only for breach of privacy, but also for breach of implied contract of confidentiality, malpractice and/or infliction of emotional distress.[26]

The doctor is responsible for staff actions regarding record keeping. Any employee involved in the preparation, organization, filing, or discussion of records should fully understand professional and legal requirements, including the rules of confidentiality.[4, 10, 28]

Records Retention and Retrieval

Health records should be retained in a way that facilitates retrieval. To the extent possible, they should be kept in a centralized location. In most circumstances, recent records are maintained on premises either as
hard copy or electronically. After a period of time they can be archived, microfilmed or microfiched and placed in storage. While there are administrative rules governing the length of time that records must be kept, from a patient and risk management perspective, it is desirable for all records to be retained indefinitely by the physician. 

If a chiropractic office closes or changes ownership, secure retention of the health care record must be ensured. Arrangements should be made through wills or estate plans for the orderly transfer of patient records to another doctor or to a special administrator or caretaker of the records. If health records are to be destroyed, they must be disposed of in a manner protective of patient confidentiality.

**Administrative Records**

Administrative records are primarily those relating to the non-clinical side of practice, and may include telephone logs, schedules and appointment records, patient personal information, insurance forms and billing documents. These records can be kept separately from the patient file, but they must be maintained in a legible and retrievable form.

**Records Transfer**

It is mandatory that health care data requested by another provider currently treating a present or former patient be forwarded upon receipt of an appropriate request and patient consent. When responding to a request for patient records, determine whether all or only part of the record is requested. If the nature of the request is not clear, an inquiry to the person making the request will usually clear up what material is required. A subpoena asking for “all medical records pertaining to the care and treatment of ‘patient x’ between January and June 1995” means that the physician is to produce all medical records for ‘patient x’ between those dates regardless of the source. A request for “all records documenting your care and treatment of ‘patient x’ means all records of the physician’s own care, not someone else’s.

**Electronic Records**

When records are kept electronically, they must be protected by proper back-up, firewall and confidentiality/security procedures. Increased use of electronic mail, the Internet and remote access creates new opportunities for tampering. This may result in errors of data identification, authentication, availability, and integrity. Availability refers to the ability of an authorized user to access the medical information. Integrity describes the system’s capability to prevent outsiders and/or unauthorized insiders from altering data and unauthorized access.

The federal laws that are most relevant to electronic communications include the Electronic Communications Privacy Act of 1986 (ECPA), 18 U.S.C. 2510 et seq., and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d. HIPAA requires health care providers and health plans to “maintain reasonable and appropriate administrative, technical and physical safeguards (a) to ensure confidentiality of the information, and (b) protect against (i) threats or hazards to the security of the information; and (ii) unauthorized uses or disclosures of this information.”

**Chiropractic Records Ownership Management and Responsibility**

The content of the medical record is owned by the patient; however, the physician has the obligation to maintain the record intact for the use of the patient and to copy it upon request. Upon receipt of a properly executed release of records request, a chiropractic physician shall make available copies or summaries of medical records to the patient or third party within a reasonable time. Although Oregon Law allows release of records under certain circumstances without patient approval, it is strongly
recommended prior to release of any records, a properly executed authorization be in place for the full protection of the patient and physician.

When a practice is closed, sold or there is a transfer of ownership, secure retention of the records must be ensured.[4] If a single physician’s office is closed, that physician remains responsible for maintenance of records for a minimum period of time, i.e. for adults seven years or for a minor patient, seven years or to the age of 18 whichever is longer.[24] In the case of a group practice closure, the issue of record keeping/maintenance may be dealt with by a contractual agreement.[32] File transfers resulting from the sale/purchase of a practice must follow statute, regulations and policies to ascertain whether a patient authorization is required at the time of the file transfer.[32] If the seller does not keep a copy of the files, the contract/agreement covering the transaction should impose an obligation upon the purchaser to maintain the records and allow access to them by the seller in order to satisfy their professional obligations.[32]

Management of healthcare records in a single physician’s office is a relatively straightforward situation where that physician is responsible for all aspects of records management. A more complex set of circumstances occurs when considering records management within the context of a multiple physician/group practice where dissolution, sale, closure or other change is taking place. Many of the potential difficulties with respect to maintenance of records in this type of situation can be avoided with proper contractual arrangements established at the outset of the relationship.[32] Contracts should anticipate the necessity for providing the physician with copies and should establish whose duty it is to provide and pay for duplication.[30] If physicians choose not to retain copies, a release should be obtained from each patient involved guaranteeing access to the records in the future, should the need arise.[30] Keeping a copy of all records after dissolution of a contractual relationship is expensive but vital.[30]

Virtually all state disciplinary actions and malpractice suits turn on the content of the record.[30] The physician who does not maintain custody is at the mercy of the others who may lose, alter or attempt to deny access to records essential to their own defense.[30] Perhaps the best way for the physician to ensure access to the records (e.g. employment contracts, managed care groups, nursing homes, etc.) is to have the patient sign a release (preferably at the initial visit) entitling the physician to obtain complete copies of any medical records containing information related to that physician’s care of the patient.[30]

Within the context of a physician leaving a practice, the dissolution of a group practice, or an associate physician arrangement, there are several different scenarios that require further discussion with respect to records management.

- If a patient has been seen by more than one physician, the original file or a copy should be maintained at the clinic.[32]
- If the original file is removed, a signed, dated authorization form should be received from the patient directing that file be provided to a specific practitioner.[32]
- If the patient has been seen only by the remaining physician/s, a copy may be provided to the departing physician with a signed, dated authorization form.[32]
- If the patient has been seen only by the departing physician/s, no consent form is necessary to remove the file unless the file was opened in the name of a group practice or there is a separate agreement stating all records are the property of the clinic.[32] In this case, a copy or the original should be maintained at the clinic and a written authorization for transfer of records out of the facility is required.[32]
• With respect to files where radiographs are involved, due to the costly nature of reproduction, the original films should be kept as part of the original file. [32]

When a practice facility changes status, e.g. purchase/sale, dissolution of a contractual relationship, etc. the most vital concerns with respect to records management are maintenance of privacy/confidentiality and ensuring intact records are readily accessible for the benefit of the patient/s healthcare. In a multi-physician/group practice, an explicit contract defining the responsibilities of all parties involved is a critical component of ensuring proper maintenance of records.

PATIENT CONSENTS

Informed consent must be recorded for evaluation and treatment, treating a minor, obtaining or releasing health records, taking and releasing photos or videos, participation in research or inclusion in publication. [12] The original of any signed written form regarding these consent issues belongs in the patient file.

While legal experts are strong advocates of written consent forms, [4], [10] doctors are reminded that forms may not provide full protection against lawsuits. [33][17] Whether written or verbal, informed consent for evaluation and treatment should include a discussion with the patient and should be documented as a PARQ conference. For further discussion of informed consent including the PAR/PARQ notation, refer to the Patient/Doctor Relationship Chapter.

Written forms for the release or procurement of health records are required. Written forms for permission to treat a minor are recommended. [17, 34] If a second doctor observes and/or treats the patient, a second consent is necessary. [33]

MALPRACTICE TIPS

Today’s practice environment requires careful documentation of patient care. [35] The patient as a plaintiff has the burden of proving that a health care professional has acted negligently. [36] The most useful factor defending against an accusation of malpractice is the record, [6] and risk-management is the best line of defense. [6, 36] Patient records allow the professional to show that proper rather than negligent care was provided. [36, 23]

The legal definition of malpractice includes four criteria. [6]

1) There must be a duty between the two parties, i.e. a patient/doctor relationship. [3]
2) There must be a breach of that duty, i.e. something wrong has to have occurred between the two parties. [3]
   (Note: Anger toward the doctor is the most frequent instigating factor. [6])
3) Harm or injury must result from that breach of duty. [6]
4) There has to be ‘proximate cause’, i.e. a relationship in time between the breach and the injury. [6]

If a lawsuit occurs and the patient file (including all billings) cannot be provided or is incomplete, inaccurate or illegible [23], the doctor could be found liable even though not at fault. [6] If documents
are lost and not included or billings are not provided (even though the doctor may have not known they needed to be included), the doctor’s credibility may be compromised.)

In the event a potential malpractice situation actually does occur, the chiropractic physician should stay calm and act responsibly. The physician should avoid repeating the procedure, monitor the patient, follow any risk-management procedures as outlined by your insurance company and document the incident. The chiropractic physician should contact legal counsel prior to meeting with the plaintiff(s) and/or their attorneys. [6]

The following is a list of suggestions, habits and/or risk-management techniques that create good patient records:

- Stay within licensure boundaries. [22]
  - (See the Chapter 811 Oregon Administrative Rules for those details.)

- Explain procedures and treatments as care proceeds. [6]
  - This treatment narration aids in building rapport with the patient which has been shown to be one of the best defenses against anger and/or malpractice behaviors. [6]

- Make accurate statements about the prognosis. [6]
  - Avoid exaggeration of what may be achieved from the treatment. [6]

- Records should not be edited or altered even for the most innocent reason. [35], [36], [37]
  - Refuse a request to “change” a record. [22]
  - Deliberately changing or altering a record can be considered a fraudulent action. [35]
  - Most malpractice carriers have a clause which voids coverage in the case of hiding any important information, misleading, attempting to defraud or lying.

- If asked to not make a record, consider the legal obligations.
  - Failure to comply with these obligations may result in severe penalties. [6]
  - Explore the motive behind the request (the wish to not weaken one’s battle in court, to avoid stigma for political or other reasons, celebrity status, a concern about possible embarrassment, paranoia, abuse). [22]
  - Suggestions for refuting the request without offending the patient include
    1) acknowledge and gently allay concerns,
    2) explain the need to keep a record,
    3) describe your confidentiality procedures (e.g. the HIPAA protections),
    4) negotiate some acceptable form of recording and/or write only the minimum needed to convey reasonable care has been delivered,
    5) consider refusing the case. [22]

- Correct errors with a line, signature or initials, and date it. [1], [23], [30], [38]
  - Avoid obliteration of any entry. [39]
  - Learn to think: “The first draft is the final product”. [1]

- Use the SOAP or equivalent format for office notes and progress notes. [1], [6], [23]
Have patient's name, chart number (if used), doctor/clinic identification on every page of chart notes. [1],[40],[39]

- Date and sign/initial every entry. [1],[6],[39]
- Write legibly [35],[23],[1] in dark ink; [1],[39]
- Use standard abbreviations; [1],[6],[23] [39]
- Use the patient's own words to describe how they are feeling; [6]
- Make an assessment about the patient's progress; [6]
- Avoid signing/initialing any entry not written by you. [1]
- Have staff sign their own entries, then the chiropractic physician may countersign the entries; [39]
- Make a habit of charting upon occurrence to avoid omissions. [30] Make your entries within 24 hours of contact; [1],[30]
- Chart the procedures and/or treatments that occurred during that date of service, including any recommended home treatments; [6]
- Avoid blank spaces between dates of service; [1],[39]
- Computer-generated and written chart notes must be sufficiently individualized to accurately reflect the clinical findings at each visit;
- Record patient’s relevant family, marital, and job stresses; [1],[39]
- Proof read and initial dictated records; [6],[23]
- Attempt to document every patient contact [30] such at telephone calls, emails, etc. [6],[23],[39]

- Record a full and complete history and physical examination. [23],[37] Make a diagnosis only after an appropriate physical examination [6]
  - Record the relevant facts accurately [1],[35],[37]
  - Chart the negative as well as the positive. [39] Avoid exaggeration or making the patient sound worse than he/she is. [39]
  - Use objective, non-judgmental, language. [1],[6],[23],[39]
  - Write an opinion supported by the relevant facts. [35] Include your recommendation for follow-up and [23],[39] include any prescription(s) given [1],[6]

- Avoid recording derogatory, trivial or loose comments about or from patients and/or other health care professionals. [1],[35],[39] Avoid egotistical remarks. [39]

- Document all procedures or treatments recommended by the doctor and refused by the patient, including any non-compliance of treatment recommended by other health care professionals. [1],[23],[37],[39]

- Chart important events or adverse reactions conspicuously, rather than burying them in the record. [39]

- Consider including a written informed consent in the file [1,6,23]
  - Oregon Administrative Rules do not require this document, but many legal sources recommend the use of a form. (Read 'Informed Consent' in the Patient/Doctor Relationship chapter of this volume.)
  - Whether a form is used or not, include a notation documenting your consent discussion with the patient. [39]
• Tailor forms to your individual office. [37]

• Respond to each Request for Records, releasing only the information specifically requested. [30]
  o Before releasing any records, be certain to meet compliance with state and federal privacy guidelines. [35]

• Retain all original records. [37]

• Records should be kept according OAR 811-015-0005.
  o The rule states “ …a minimum of 7 years. If the patient is a minor, the records shall be kept seven years or until the patient is 18, whichever is longer” [24]
  o Protect patient confidentiality (refer to Section III - HIPAA). [35]

Implement a system to ensure that important patient information can be located and is easily accessible. [23]

**HIPAA - Health Insurance Portability and Accountability Act of 1996**

The following material is a summary of Federal Law.

With the advent and extensive use of electronic media in the health care realm, there is a greater possibility of widespread dissemination and abuse of a patient’s Protected Health Information (PHI). “Protected Health Information means individually identifiable health information created, maintained or in the possession of our practice relating to the past, present or future physical or mental health of any individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual.” [41] Even if the information provides a reasonable basis to believe it can be used to identify an individual, it is considered individually identifiable health information. [42]

In August 1996 the Health Insurance Portability and Accountability Act (HIPAA) bill was passed giving the Federal Government the ability to regulate how covered entities (health care plans, providers, and clearing houses) use, store, disclose and transmit Protected Health Information.

Prior to the passage of HIPAA there were no national or industry standards mandating or regulating the privacy and confidentiality of a patient’s PHI. Individual states had a variety of rulings related to patient privacy and disclosure of PHI that were very often disjointed and incomplete. HIPAA provides national standards for the protection and security of one’s PHI, while improving the efficacy of healthcare provision by providing standards for transmitting patient’s financial information to which all covered entities must adhere. The Privacy Rule holds violators accountable by imposing civil and criminal penalties.

HIPAA generally encompasses two rules- The Privacy Rule and the Security Standard. The Privacy Rule, (Standards for Privacy of Individually Identifiable Health Information), regulates the use and disclosure of PHI and encompasses three essential purposes. The first purpose is to protect the rights of patients by providing them access to their PHI and the ability to control the use and disclosure of it. The second purpose is to restore public trust in the healthcare delivery system, and the third is to improve the efficiency and effectiveness of healthcare delivery in the US by creating a national framework of healthcare privacy. [43]
The Privacy Rule provides the first national standards for protecting the privacy of health information. It mandates how covered entities (healthcare plans, providers, and clearing houses) use, store, disclose, and transmit PHI. It sets boundaries on the use and disclosure of medical records, by requiring safeguards that most healthcare entities must provide to protect the privacy of health information. It encompasses the practitioner’s use of the patients’ PHI within their office or health care setting and the disclosure of PHI outside of the office setting. It states that protected health information can only be used and disclosed for treatment, payment, or healthcare operations without a patient authorization. Any other uses require a patient authorization prior to the PHI being released. The rule also generally limits the release of information to the minimum necessary for the purpose of the disclosure so that irrelevant information is not released unnecessarily. This limitation of only releasing the minimum necessary information does not apply when the PHI is disclosed to another practitioner for direct treatment purposes. The rules make allowances with public health responsibilities as well to allow the collection of information used to prevent or control disease, injury, disability, including public health surveillance, investigation and intervention. The HIPAA limitations do not apply to information that is de-identified so that the patient can not be connected with their PHI. The following is a table listing what is considered identifiable information:

<table>
<thead>
<tr>
<th>Identifiable Information</th>
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<tbody>
<tr>
<td>1. Name</td>
</tr>
<tr>
<td>2. Any address specification such as street, city, county, precinct, and zip code</td>
</tr>
<tr>
<td>3. All dates except for the year including birthdates, admission date, discharge date, date of death and all ages over 89</td>
</tr>
<tr>
<td>4. Telephone number</td>
</tr>
<tr>
<td>5. Fax number</td>
</tr>
<tr>
<td>6. Electronic mail address</td>
</tr>
<tr>
<td>7. Social Security number</td>
</tr>
<tr>
<td>8. Medical record number</td>
</tr>
<tr>
<td>9. Health plan beneficiary number</td>
</tr>
<tr>
<td>10. Account number maintained by the healthcare provider</td>
</tr>
<tr>
<td>11. Certificate or license number such as driver’s license number</td>
</tr>
<tr>
<td>12. Vehicle identifier and serial number including license plate number</td>
</tr>
<tr>
<td>13. Medical device identifier and serial number such as pace maker serial number</td>
</tr>
<tr>
<td>14. Web site address</td>
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<tr>
<td>15. Internet protocol (IP) address number</td>
</tr>
<tr>
<td>16. Biometric identifier including finger and voice prints</td>
</tr>
<tr>
<td>17. Full face photographic images and any comparable image, and</td>
</tr>
<tr>
<td>18. Any other unique identifying number characteristic or code</td>
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</tbody>
</table>


Beyond limiting the practitioner’s ability to use or disclose PHI without a patient’s authorization, the Privacy Rule empowers patients to have more control over their health information. The first step in providing the patient with more control is the mandatory requirement of each health care provider to provide the patient with a copy of the “Notice of Privacy Practices.” If the initial contact with a patient is electronic, then an electronic copy of the Notice of Privacy Practices must be provided at that time. The Notice of Privacy Practices outlines the patient’s rights to privacy and how personal health information
will be routinely used for treatment, payment and healthcare operations within the healthcare setting. The provider must also obtain a written acknowledgment from the patient that a copy of the notice was received. [44]

Release of PHI for purposes other than treatment, payment or healthcare operations requires a signed authorization from the patient. This allows patients to make informed choices about how their individual health information may be used and/or disclosed. The HIPAA privacy rules go beyond requiring an authorization for release of information by requiring tracking what disclosures of PHI have been made. This enables patients to find out how their health information has been used or released. The patient also has the right to obtain a copy of their medical record and can review and correct or amend the PHI. There must be policies and procedures in place for patient review, correction or amendment of their PHI. The provider is not required to change medical records at the request of the patient, but they should be able to link the amended information to the original chart. Corrections or amendments to the health record requested by the patient can only be made with their physician’s approval.

To assure that the HIPAA privacy rules are enforced, health care providers are required to designate a privacy officer within the clinic. This person is responsible for implementing the privacy rules. There should also be a designated contact person, who may be the same individual, to receive complaints and provide information to the public related to the privacy policies. The final piece of the privacy rules relates to the need for staff education related to patient privacy and their responsibilities to comply with the HIPAA regulations. There should be documented education with all staff and appropriate policies and procedures in place to demonstrate that the office is doing their due diligence in assuring that the patient’s privacy is maintained. The office should also look at their routine operations and make a concerted effort to minimize the chance for inadvertent disclosure of PHI due to processes in place such as leaving patient records in plain sight at the receptionist’s desk or having computer screens with PHI easily visible in areas where patients are present.

The other rule HIPAA encompasses is the Security Rule which is composed of two major standards; the security standard and the electronic signature standard [45]

The Security Standard requires a secure electronic environment in which a covered entity would maintain, store, or transmit all PHI. The rule defines and requires a secure electronic environment as; an environment with physical, procedural, technical and administrative procedures, services, and mechanisms.
What is a Secure Electronic Environment?

A **Secure Electronic Environment** is an environment that has administrative procedures, physical safeguard and technical security services and mechanisms in place. It also includes the implementation of an electronic signature standard if the practice uses an electronic signature.

**Administrative Procedures** are formal, documented practices to protect PHI. This includes the selection and execution of security measures and the management of personnel as it relates to protecting PHI.

**Physical Safeguards** are procedures to protect computer systems, buildings and other equipment from fire and other natural and environmental hazards, as well as from intrusion.

**Technical Security Services** are processes that are implemented to control and monitor access to PHI such as passwords.

**Technical Security Mechanisms** are processes implemented to prevent unauthorized access to data that is transmitted over a communications network (Internet, Intranet, fax machine, etc.)


**The Electronic Signature Standard**
An electronic signature is a data component that is incorporated into an electronic document for the purpose of uniquely identifying the signer. Practices are not required to use electronic signatures, however if a provider uses electronic signatures, then the Security Standard Rule requires that HIPAA signature standards be used to verify the identity of the message sender, or the signer of a document. [46]

With the implementation of HIPAA regulation, the government has imposed national rules and standards that will greatly improve the security of a patient’s protected health information, while giving them more control over where and how it can be used. Securing and standardizing the electronic environment will greatly expedite and secure the transfer of data and Protected Health Information.
STANDARDS

1. The content of the medical record is owned by the patient; however, the physician has the obligation to maintain the record intact for the use of the patient and to copy it upon request.\(^{30}\)

2. Upon receipt of a properly executed release of records request, a chiropractic physician shall make available copies or summaries of medical records to the patient or third party within a reasonable time.\(^{25}\)

3. Clinicians must ensure that their documentation of a patient’s health status is understandable by others on the health care team.\(^{4}\)

4. The patient record must include documentation of informed consent.

5. Whether written or verbal, informed consent for evaluation and treatment should include a discussion with the patient and should be documented as a PARQ conference.

6. Recordable abbreviations and terminology should be internally consistent and a key for these abbreviations must be available upon request.\(^{9}\)

7. The record should never be backdated, erased, deleted or altered in any way.\(^{4,21}\) If corrections need to be made, a line should be drawn through the error and the change initialed and dated.\(^{4,15}\) If records are kept electronically, amendments should be made in such a way that preserves the original record.

8. All information regarding a patient must be kept confidential unless its release is authorized by the patient or is compelled by law.

9. The doctor is responsible for staff actions regarding record keeping. Any employee involved in the preparation, organization, filing, or discussion of records should fully understand professional and legal requirements, including the rules of confidentiality.\(^{4,10,28}\)

10. If a chiropractic office closes or changes ownership, secure retention of the health care record must be ensured.\(^{4}\)

11. When records are kept electronically, they must be protected by proper back-up, firewall and confidentiality/security procedures.

12. Reports with clinical findings received from external sources should be reviewed, initialed, and dated upon receipt.\(^{4,9,10}\)

13. The clinical impression or diagnosis must be recorded within the record.\(^{4,10,15}\) When more than one diagnosis is made (for example, biomechanical assessment and pathoanatomic diagnosis), these must be differentiated and recorded.\(^{14}\)
REFERENCES