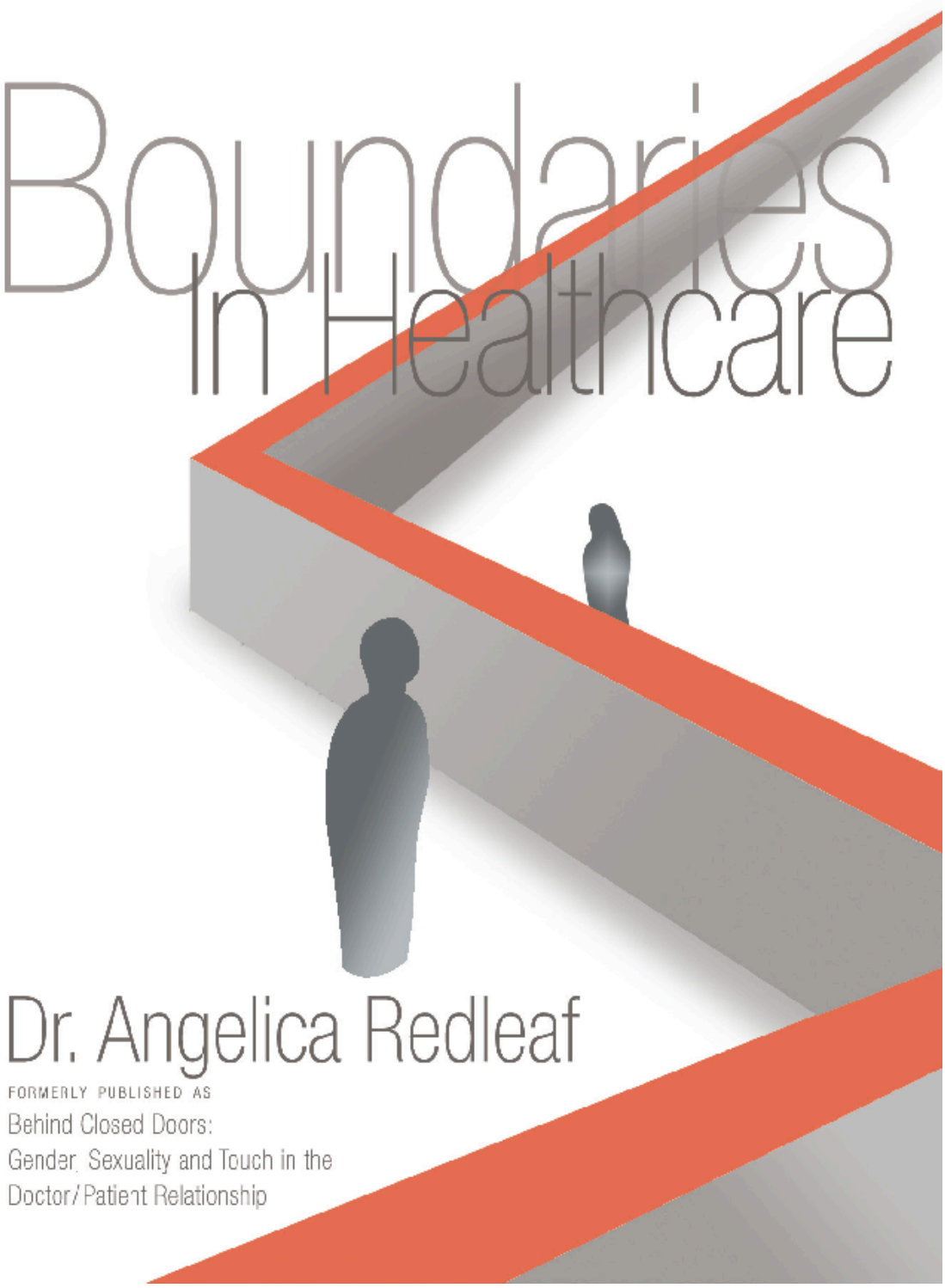
Boundaries
In Healthcare
Dr. Angelica Redleaf
FORMERLY PUBLISHED AS
Behind Closed Doors:
Gender, Sexuality and Touch in the
Doctor/Patient Relationship

NOTE: the following excerpt is from the book "BOUNDARIES IN HEALTHCARE", copyright 2008, Dr. Angelica Redleaf. For additional information an book purchase, please visit *angelicaredleaf.com*

The excerpt includes reviews of the book, portions of chapters 5 & 7, the table of contents and information about Dr. Redleaf, the author.

Reviews:

"This needs to be a part of medical education and not a subject to be learned because of ... lawsuits. [This book] obviously needs to be read by every healthcare professional." – Bernie Siegel, MD, *Love, Medicine and Miracles*

"This readable book has caused me to reconsider how I relate to patients in one-on-one settings and how my... methods could be improved to establish clear, consistent role boundaries; the author has accomplished her mission."
– William W. Weddington, MD, in *Journal of the American Medical Association*

"If healthcare providers could only read one book on the topic of professional boundaries, this one should be it!" – Elizabeth R. Becker, LCSW; innersolutionsforsuccess.com

"I had some questions about what is and is not acceptable in the doctor's office. This book made that very clear." – D. M. Torres, Amazon.com

CHAPTER 5

What is Misconduct?

Sexual misconduct is misconduct of a sexual nature…It includes in particular any sexual activity between [a leader] and one of his/her subordinates. This commonly includes teachers and their students, doctors and their patients, and employers and their employees. While such activity is usually not explicitly illegal, it is often against professional codes of ethics. For example, a teacher may be fired and a doctor may have his or her medical license revoked due to sexual misconduct. In addition, the person in the subordinate position may allege sexual harassment.

Wikipedia, July 2007

The number of sexual misconduct complaints against healthcare professionals is increasing at an alarming rate. A 1992 study by the Federation of State Medical Boards reported charges that year against 132 medical doctors in 42 states, compared with charges in 1990 against 84 doctors in 35 states[1]—and the tide of complaints continues to rise. This was also confirmed by a 1994 study performed by the Federation of Chiropractic Licensing Boards that likewise found misconduct complaints against chiropractors to be increasing.[2] Furthermore, in a 1997 study of sexual misconduct cases, researchers found the number of disciplinary actions in sex-related offenses rose from 34 to 162 between 1989 and 1994. Remarkably, the study also uncovered that about 40 percent of the doctors disciplined for sexual misconduct were permitted to keep their medical licenses.[3]

NOTE- The following is an excerpt from a 2006 press release of the Washington State Department of Health. [4] *This exemplifies our need to maintain appropriate boundary lines with our clients to avoid allegations being made against us – please be warned!!!*

For immediate release: March 10, 2006
Sexual misconduct allegations cause suspension of Tacoma healthcare provider.
OLYMPIA: A Tacoma massage therapist [who is also a] registered nurse has had both licenses suspended on allegations of sexual misconduct. The actions by the Washington State Nursing Commission and Massage Program mean Dale A. Neel of Tacoma cannot practice as a massage therapist or a registered nurse in our state until there is a hearing. Neel was employed as a registered nurse at Allenmore Hospital and was practicing massage out of his home. According to the statements of charges and summary suspensions, Neel engaged in inappropriate sexual contact with four clients during massage sessions.

Such accusations of sexual misconduct are creating casualties on all sides: providers who lose their licenses, practices, and/or reputations; clients who are traumatized by inappropriate or abusive behavior (or behavior they perceive as abusive); and healthcare professions that are publicly humiliated or singled out for unflattering media attention.

A FIDUCIARY FAILURE

Sexual misconduct is, to say the least, a very complex problem. It encompasses issues of sex, gender, power, and communication, as well as, in some cases, a real pathology on the part of the healthcare professional.

Sexual misconduct occurs when the fiduciary aspect of the healthcare relationship is compromised. “Fiduciary” is a legal term that is applied to a professional in whom a client places trust. Because such professionals are in positions of power relative to their clients, the law holds them to a higher standard of behavior. They are required to place the interests of their clients above and before their own. A comprehensive, even exhaustive, exploration of this and related topics is presented in the book *Sexual Abuse by Professionals: A Legal Guide*.[5]

All healthcare professionals have a fiduciary relationship with those who come to them for help. In other words, the professional is in a position of power, while the client is in a position of

weakness and vulnerability. Although the patient may not be directly aware of the power imbalance, the professional is nonetheless obligated to understand and control its limits.

AN ANCIENT TRANSGRESSION

A portion of the Hippocratic Oath concerning relationships with patients declares, "[R]emaining free…of sexual relationships with both female and male persons."

The problem of sexual misconduct has been with us for centuries. It was addressed by the Greek physician Hippocrates in the fourth or fifth century B.C., in the Hippocratic Oath that some members of the medical profession continue to use today: "Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief, and in particular, of sexual relationships with both female and male persons."[6] Similar admonishments to doctors, warning them against inappropriate sexual behavior toward their patients, have been found in European medical texts from the Middle Ages and the Renaissance.

AN EQUAL OPPORTUNITY PROBLEM

About 90% of sexual misconduct complaints are filed by females. Seventy-five percent of alleged perpetrators are males.

Statistics reveal that approximately seventy percent of sexual misconduct complaints against health professionals, psychotherapists, and clergy are filed by females against male professionals. Approximately twenty percent are from female patients or clients complaining about female professionals. Of the remaining ten percent of complaints, roughly five percent are from male patients or clients complaining about men, and the remaining five percent are from male patients or clients bringing allegations against women. Females, therefore, make up about ninety percent of the victims of sexual misconduct, and twenty-five percent of the alleged perpetrators.[7] It should be noted, however, that many of those working in the field "have speculated that male victims of professionals of either gender are underrepresented across the board because of particular male characteristics inhibiting both recognition and reporting [of abuse].[8]

Female caregivers may think they are immune to complaints of misconduct, but the statistics prove them wrong. What is more, women may be especially at risk from those who are obsessive. The client behavior that tends to be the most obsessive is that which occurs between a female client and a female provider.[9]

BREAKING THE SILENCE

People used to keep silent about improper behavior, but that is rapidly changing. Now they are speaking out in record numbers—and this is only the beginning.

Until very recently, the complaint process has been little-known, little-used, and far from impartial. To quote the organizers of the Third International Conference on Sexual Exploitation by Health Professionals, Psychotherapists and Clergy, "The tendency is to shoot the messenger, blame the victim and coddle the man."[10] However, as individuals become less afraid of complaining, as awareness of the complaint process rises, and as the complaint process itself becomes fairer and less humiliating for the person filing charges, the number of complaints will continue to increase.

As things now stand, it is up to clients and patients to monitor the behavior and the regulation of practitioners; and it is through their complaints that this monitoring takes place. Women, especially, have become increasingly sensitive to inappropriate or "old-style" behavior on the part of either male or female healthcare professionals.

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CHAPTER 7

Caring for the Abused Individual

Sexual abuse is an all-too-common phenomenon. The greatest of care must be exercised, because anyone who comes to you may be a survivor of rape, violence, or abuse. Remember the First Law of Medicine: "First, do no harm."

Those with a history of sexual abuse need to be treated with particular sensitivity and care since: (1) they have been traumatized, and (2) they are more vulnerable to future abuse.

Anyone previously abused needs to be treated with particular sensitivity and care, not only because they have been traumatized but also because, having once been abused, they have become more vulnerable to further abuse. "When a person has been abused and violated by caretakers…all relationships become infused with distorted sexual and aggressive elements."[1] Someone who has suffered abuse may have been left with a feeling of utter helplessness that makes it impossible to resist coercion, may have been led to believe that he or she is worthless except as a sexual plaything, or may have learned to think of sex as a currency with which to purchase affection and approval.

At least one in four Americans have been abused by the time they reach the age of eighteen. Thus, whether they know it or not, anyone caring for a significant number of people is going to have among them those who have been sexually abused. Since abuse survivors rarely identify themselves, however, it is difficult—if not impossible—to identify which patients have a history of abuse.

A SURVIVOR'S TALE

I heard a speaker at a conference I attended in Toronto, in Ontario, Canada who described his own experience of sexual abuse. [2]

He is a Cree Indian, from northern Canada. When he was a child, it was common for the government to remove Indian children from their families when they were about six years old. And this is what happened to him: He was sent to a Catholic residential school.

Naturally, there were priests there. These priests went around to each child's bed after the lights went out and proceeded to masturbate the children nightly. Imagine the terror. You're six years old, and away from your family. It's dark. And the priest is on you. What scars would that leave? And what would your experience be like in a doctor's office after that?

Will we know which of our clients have been abused, sexually or otherwise? How do we administer appropriate care for such individuals? They need special care.

Because so many people have been abused, all office procedures, behavior, and communication should take these large numbers of potential abuse survivors into account. And because statistics indicate that the overwhelming majority of those who abuse children are men, the care of abuse survivors is particularly problematic for male practitioners. Former victims, generally, will be the most vulnerable and the most anxious or fearful in the presence of those who most resemble their former abusers.[3]

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About the Author

Angelica Redleaf, D.C.

Dr. Angelica Redleaf is the president of Redleaf Chiropractic Center, Inc., in Providence, Rhode Island. A practicing chiropractor since 1978, Dr. Redleaf has served as president, vice president, secretary, and as a member of the Board of Governors for the chiropractic society in her home state. She earned her Doctor of Chiropractic degree from NY Chiropractic College. She graduated from Hunter College of the City University of New York with a Bachelor of Arts in education and anthropology. Her background includes teaching, social work, and studies in psychology as well as various languages.

Beginning in 1992, Dr. Redleaf has provided educational and consulting services to professional societies, state licensing boards, and individual doctors. She has been honored to speak at numerous conferences around the world, including the Foundation of Chiropractic Licensing Boards, Parker Seminars, and in Switzerland for the Touch for Health Association.

Dr. Angelica Redleaf became aware of the problem of physician sexual misconduct in the late 1980's when a number of doctors in her state had complaints made to the licensing board. Since then, she has arduously studied the topic and learned to understand the intricate issues involved. As a result of her research and consulting work, Dr. Redleaf created the Safe Practice Analysis to help other healthcare professionals steer clear of the potential landmines inherent in the provider/patient relationship. She has written numerous articles as well as the book: *BEHIND CLOSED DOORS: Gender, Sexuality & Touch in the Doctor Patient Relationship*. This book has now been updated and has a new title: BOUNDARIES IN HEALTHCARE, which came out in 2008.