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The Risks and Rewards of the Doctor-Patient Relationship

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This article will touch on two very different topics. The first is a brief review of, and commentary on, an article by Davis and Bove titled "The Chiropractic Healer." The article appeared in the May 2008 issue of *JMPT*. This is a fascinating piece. Very little of the work I have read on "healing" has been in Medline-referenced, peer-reviewed journals. This well-referenced article attempts to look at the healing side of our practices. They talk about the evolution of the concept of placebo effect to the understanding of the "meaning response," to the concept of the biopsychosocial milieu within which healing occurs. It's good to see a serious article about the healing aspects of our art.

I like articles that force me to confront and change my point of view. This article points out that it might not be useful for us as practitioners to change our patients' views of what we are doing for them. An example, the patient thinks "L5 is out of place," and the role of their DC is to put it back in. Even if we know the "bone out of place" model is archaic, it might not serve the patient or their healing process to try to convince them otherwise.

I also recognize that if I believe I am trying to create motion, it doesn't serve the patient to walk around stiff, trying to keep the joint "in." It's a fascinating dance to meet the patient where they live, treat and educate them, and enhance rather than downgrade the meaning of the interaction for them. I know I tend to err in using too many words when explaining complicated causal chains. It often is useful to "keep it simple, stupid."

Another aspect of this article describes moving from presence toward transcendent presence. Presence refers to how fully engaged you are with the patient. From there, we move up the chain toward a deeper connection with our patients and the healing inherent in the relationship. In transcendent presence, "an exchange of energy occurs between caregiver and patient in a spiritual-like quality." There is so much more to what we do than just the physical. So much we are just barely beginning to understand. I appreciate being part of the mystery of healing.

Be Careful Out There

Now, on to a different and darker topic. You can lose your license, be charged with a felony sexual assault and have your professional life suddenly end. Your patients might be litigious, the board of chiropractic examiners might look at your actions differently than you would and local prosecutors would love to get their name in the paper. I will assume a male doctor and a female patient. I know there are other situations with risks, but these are the players I know best.

I remember, early in my career, a patient storming out of my massage therapy room. She said, "I have back pain and your massage therapist is massaging my buttock!" In hindsight, the massage therapist (male) and I had both done an inadequate job of explaining why he was working on the gluteal muscles.

I have always said I am going to do what is needed for the patient. I will work wherever they need work. I will not be ruled by fear. That said, I am very cautious, and I have a protocol I attempt to

follow every time I touch a sensitive area. These include many areas we touch routinely. When you do a side-posture adjustment, the patient might perceive you as being "all over them with your body." Side posture of the pelvis requires one of your contacts to be on the ilium, which the patient might interpret as their buttock. Again, routine for you is not so routine for a new patient.

Sensitive areas include the sternochondral area and the whole of the anterior and lateral rib cage. Intra-oral work can be sensitive for certain patients, along with any touch of the lower belly. The whole of the anterior and posterior pelvis and the upper legs also are sensitive zones. Within these zones, there are obvious variations. Touching the upper sacroiliac probably is much less sensitive to the average person than touching the origin of the sacrotuberous ligament.

Here is a basic communication protocol for working on sensitive areas. One, explain what you are doing and why. It might be useful to name the structure you are working on, such as "I am checking the junction of your sternum, your breast bone, with the front of your ribs." Two, ask permission to touch the area. Three, have eye contact and a clear "yes" from the patient before you proceed. Four, use a statement such as, "If anything I do feels unsafe, inappropriate or not OK, let me know right away."

Let's explore further. When you ask permission, pay attention to nonverbal "no" or "maybe" cues, such as the patient hesitating or looking away. Stay awake and stay aware of the patient's nonverbal signals. Ask the patient what's up; you might need to explain further. You might need to adopt a completely different approach. If you know the patient has a history of abuse, this is an immediate yellow or red flag to be even more cautious.

If you are working directly on the skin, rather than through clothing, the encounter immediately has more charge. Check out the comfort level of the patient. Again, ask clearly, and cover the patient appropriately with a gown or drape. Decide which of your procedures needs an assistant (acting as a chaperone) in the room and which do not, and stick to your policy. If you don't have an extra assistant, another option to protect yourself is a Webcam or camcorder. Having a video takes any future legal situation out of the "he said, she said" arena. Certain procedures might benefit from a written release form.

Explore your own attitude. Can you talk to the patient in a clear and straightforward way, without embarrassment or hesitation? Can you say, "I need to work on the front of your rib cage," "I need to touch your pubic bones," or "I need to touch your tailbone." If these statements do not flow smoothly from you, you will make the patient uncomfortable. It's your whole "envelope" that is relevant here. What is your body language when you touch these areas? You need to be very clean here. That means your thoughts are only on the specific clinical area where you are focusing. If your thoughts have a sexual component, the patient will pick this up.

Most of our communication is nonverbal. How clean is your nonverbal communication? On the verbal level, don't tell dirty jokes. Flirting with your female patients also increases risk. These actions set up a sexual vibe; a nonclinical connotation that bleeds into your clinical encounter. Previously, I talked about presence. The patient knows when you are not fully present, and this is likely to make them uncomfortable.

I've attempted to include here both some of my limited knowledge of the medical-legal aspects of this arena and some common-sense guidelines. Be careful out there. Your career and your reputation are on the line.