BEFORE THE

BOARD OF CHIROPRACTIC

EXAMINERS STATE OF OREGON

In the Matter of	)	
	)	Case # 2019-1013 and 2019-5013
	)	
Ann Griffin, D.C.	)	STIPULATED FINAL ORDER
	)	
License No.: 5669	)	(SUSPENSION)
	)	

The Oregon Board of Chiropractic Examiners (Board or OBCE) is the state agency responsible for licensing, regulating, and disciplining chiropractic physicians in the State of Oregon. Ann Griffin, D.C. (Licensee), is currently licensed by the Board to practice as a chiropractic physician in Oregon and is subject to the jurisdiction of the Board

1. Findings of Fact; Current Cases

Case 2019-5013

On June 5, 2019, the Board received a self-report of "unprofessional relationship with patient [Patient 2] after termination of care" from Licensee, stating that the date of the first incident was February 4, 2019. Licensee stated that she began treating Patient 2 for a shoulder condition on November 7, 2018, as a referral from Patient 3, Patient 2's employer. Licensee stated that she saw her for a total of 8 treatments, the last one being January 27, 2019.

Within her self-report, Licensee stated that she became aware that Patient 2 had developed personal feelings toward her. Licensee's self-report stated that based on this inclination, she terminated the doctor-patient relationship with Patient 2 by letter, signed January 30, 2019.

Licensee stated that she had Patient 2 come to the office to sign the letter. Licensee's letter to the Board further described Licensee's subsequent commencement of a romantic relationship with Patient 2 following a February 4, 2019 social engagement. Licensee also had a

doctor-patient relationship with Patient 1 and Patient 3. Patient 1 and Patient 3 are married. Patient 3 employs Patient 2. Patient 2 had a sexual relationship with Patient 1 that was known to Patient 1's husband, Patient 3. Upon discovering Licensee's relationship with Patient 1, Licensee further reported in her letter to the Board, that Patient 1 confronted her (on 5/24/19) outside her office, threatened to "make her life hell" and followed her vehicle on occasion. Licensee further disclosed that just prior to her self-report, that she, her husband, Patient 1 and Patient 3, met to discuss the relationship between Licensee and Patient 2.

Case 2019-1013

On June 6, 2019, the Board received a complaint alleging that Licensee engaged in inappropriate conduct, contact, crossed doctor/patient boundaries, and that she was having a sexual relationship with a patient. The complaint expressed awareness that Licensee allegedly stated that she had "turned herself in" to the Board (on June 5, 2019) preemptively to mitigate any discipline against her.

2. Patients Records Reviewed/Patients Involved

Patient 1

Patient 1, a 48 year old woman, was a patient of Licensee's. Licensee conducted an initial evaluation and treatment on November 25, 2018, to address low back and right shoulder pain.

There was one follow up visit on December 2, 2018. Licensee failed to record Patient 1's height, weight, blood pressure, or pulse for this initial evaluation or the follow up visit, in violation of OAR 811-015-0005(1)(C)(i). The record included a document entitled "Notice to Patient of Doctor's Discontinuance/Termination of Chiropractic Treatment," dated August 8, 2019, and signed by Licensee.

Patient 2

Patient 2, a 32 year old woman, was a patient of Licensee's. Licensee conducted an initial evaluation and treatment on November 15, 2018, to address right shoulder pain. Licensee failed to record Patient 2's height, weight, blood pressure, or pulse, in violation of OAR 811-

015- 0005(1)(C)(i). At that time, Patient 2 was in a sexual relationship with Patient 1 and was employed by Patient 3. In addition to the initial evaluation and treatment, Licensee consulted Patient 2 on the following dates of service: 11-07-2018, 11-15-2018, 11-29-2018, 12-06-2018, 12-16-2018, 12-23-2018, 01-20-2019, and 01-27-2019. The record included a document entitled "Notice to Patient of Doctor's Discontinuance/Termination of Chiropractic Treatment," dated January 30, 2019, signed by both Licensee and Patient 2. The termination notice cited boundary issues as the reason for termination.

Patient 3

Patient 3 was a patient of Licensee's. Licensee conducted an initial evaluation and treatment on October 29, 2018, to address right shoulder, right gluteal, and sciatica/leg pain. Licensee failed to record Patient 3's date of birth, age, height, weight, blood pressure, or pulse for this initial evaluation, in violation of OAR 811-015-0005(1)(C)(i). In addition to the initial evaluation and treatment, Licensee consulted Patient 3 on the following dates of service: 11-08- 2018, 02-21-2019, and 03-06-2019. On the last date of service, March 6, 2019, Patient 3 sought treatment for left hip pain and Licensee rendered an assessment that he had an abdominal aortic aneurism of 5 millimeters (record later amended to state 5 centimeter aneurism). This assessment was based on palpation of the abdominal compartment. No other physical assessment, such as blood pressure, extremity pulse, or further diagnostic tests were done or ordered. Licensee did not consult Patient 3's primary care physician and no differential diagnosis was performed to rule out other possible conditions. Licensee referred Patient 3 to his medical doctor for evaluation and baseline and indicated an ultrasound should be perform within 60 days.

3. Licensee's Contact with the Board

On May 24, 2019, Licensee left a voice message with the Board Investigator, expressing that she had a procedure or policy question about an interaction with a client and another client. The Board Investigator staff called her back on May 29, 2019. Licensee stated that she had "a situation with two patients," one of whom was the wife [Patient 1] of the other

patient's [Patient 2] employer [Patient 3]. Licensee stated that Patient 2 had made romantic overtures to her (Licensee) while she (Licensee) was rendering care to Patient 2. Licensee stated that Patient 1 ("wife of employer") confronted Licensee in her office's parking lot on or about May 24, 2019, stating that

she had overstepped her boundaries with Patient 2. Licensee framed the boundary she was overstepping as regarding an employee/employer situation, not that of a doctor/patient relationship boundary. Licensee stated that she had been "social with both patients." Licensee alleged that Patient 1 told her that she "will make your [Licensee] life very uncomfortable" or something to that effect. Licensee requested the protocols on how she should discharge both patients to comply with the Board's laws and rules. The Board Investigator provided Licensee the Board protocol, statutes, and rules.

Licensee re-contacted the Board Investigator on June 5, 2019 by telephone to make a self- report. Licensee admitted to the Investigator that she shared a "mutual attraction" to Patient 2 so she discharged her as a patient "a few weeks earlier" and, shortly thereafter, started an intimate and romantic relationship with Patient 2. She further stated that Patient 1 and Patient 2 had a prior romantic relationship. Licensee stated that Patient 1 became increasingly threatening, promising to file a complaint with the Board, and asked if she (Licensee) had a duty to report herself. The Investigator's recommendation was for Licensee to file a report on herself. Licensee filed a written self-report that same day.

Relationship Between Patients and Licensee

Patient 1 and Patient 3 are married to each other. During times relevant to these issues, Patient 3 employed Patient 2. Patient 1 and Patient 2 had a sexual relationship that predated Licensee treating any of the patients mentioned above.

4. Board Interviews

Board's Interview with Patient 1

On August 21, 2019, the Board interviewed Patient 1. Patient 1 reported that Licensee had a sexual relationship with Patient 2. Patient 2 and Patient 1 were then in an intimate

relationship. Patient 2 was a current patient of Licensee, having recently received chiropractic treatment from Licensee. Patient 1 reported that Patient 2 had conveyed to Patient 1 that Licensee provided a "very thorough buttock massage." Patient 1 reported to the Board concerns regarding this statement, and the belief that the conduct between Patient 2 and Licensee was sexual in nature.

In January or February 2019, Licensee invited both Patient 1 and Patient 2 to a local concert in their community. Patient 1, and others present at the concert, witnessed Licensee and Patient 2 engage in flirtatious conduct and sexually suggestive physical contact at the public event.

Patient 1 further reported having witnessed behavior between Patient 2 and Licensee that she understood indicate sexual activity at Patient 2's home in May 2019. Patient 1 reported that she and Patient 2 ended their intimate relationship at that time.

Patient 1 also provided information to the Board regarding a subsequent conversation that occurred on June 2, 2019. On that date, Licensee met with Patient 1, Patient 3 (Patient 1's husband), and Licensee's husband at Licensee's home. Patient 1 reported that during this meeting, Licensee admitted that she had engaged in a sexual relationship with Patient 2.

Patient 1 was discharged as a patient of Licensee on August 8, 2019.

Board's Interview with Patient 3

On August 22, 2019, the Board interviewed Patient 3 (Patient 1's husband). Patient 3 explained that he employed Patient 2 and was aware that Patient 2 and his wife (Patient 1) had an intimate relationship during times relevant to these issues. Patient 3 received treatment from Licensee from October 29, 2018, until March 6, 2019. On the last day of treatment, Licensee diagnosed Patient 3 with a 5 mm aneurism, later amended to a 5 cm aneurism, in his abdomen.

Patient 3 related that Licensee explained that such a diagnosis was potentially life threatening and he should go to the doctor and get an ultrasound within 60 days. Patient 3 reported that he was greatly emotionally affected by Licensee's diagnosis. As a result, Patient

3 reported purchasing life insurance and health insurance coverage to plan for impending catastrophic and end of life needs. Once his health insurance was in place, Patient 3 reported having gone to a different physician for a physical examination in July 2019. Patient 3 explained that no aneurism was found, and that the physician told Patient 3 he was in perfect health. Patient 3 also reported having later learned that Licensee had told Patient 2 (his employee) that he had an aneurism, without his consent or knowledge, in violation of his HIPAA privacy and confidentiality rights.

Licensee terminated Patient 3 from care effective August 8, 2019, via Licensee's "Notice to Patient of Doctor's Discontinuance/Termination of Chiropractic Treatment" which cited boundary issues and which Licensee signed but did not date the signature or mail the termination to Patient 3. Patient 3 obtained the termination as a result of requesting medical records from Licensee.

Unknown to Patient 3, at the time Licensee diagnosed him with the abdominal aneurysm, Patient 1 (who is Patient 3's wife) was beginning to suspect Licensee and Patient 2 were in a sexual relationship. Patient 1 had begun asking questions of Patient 2 due to unusual behavior displayed by Licensee and Patient 2. Licensee was fully aware at the time of Patient 3's treatment and diagnosis, that Patient 3 was married to Licensee's lover's sexual partner (Patient 2), and that Patient 3 employed Patient 2.

Patient 3 also shared the upheaval caused by Licensee's sexual relationship with Patient 2. Patient 3 explained that the relationship effected his business relationship with Patient 2, but more importantly to him, greatly distressed his wife, Patient 1. By extension, Patient 3 explained that he had to deal with the emotional impact of his wife losing her girlfriend to their doctor. Patient 3 had been the referral source for both Patient 1 and Patient 2 to originally seek chiropractic care from Licensee.

Board's Interview with Licensee

On September 16, 2019, the Board interviewed Licensee regarding these issues.

Licensee reported having terminated the doctor-patient relationship with Patient 2 on January 30, 2019.

Licensee reported that she then commenced a sexual relationship with Patient 2 beginning February 4, 2019. Licensee saw Patient 2 for 7-8 treatments.

Licensee stated that Patient 2's behavior toward her (Licensee) in treatment was overly familiar, that Patient 2 made flattering comments toward her, but that she did not have any intention of starting a romantic or sexual relationship with Patient 2. Licensee observed that she was married to a man and had no interest in women. Licensee reported terminating the doctor-patient relationship due to Patient 2's behavior during treatment.

On February 4, 2019, Licensee attended a concert with both Patient 1 and Patient 2. During this social event, Licensee began kissing Patient 2, and thereafter, developed a sexual relationship with Patient 2. Licensee reported learning of the existing intimate relationship between Patient 1 and Patient 2 when she started the sexual relationship with Patient 2 in February 2019. Licensee was also aware that Patient 2 was employed by Patient 1's husband, whom she was also treating (Patient 3).

Patient 2 was allegedly terminated as a patient by Licensee via Licensee's Notice to Patient of Doctor's Discontinuance/Termination of Chiropractic Treatment, dated January 30, 2019, signed by both Licensee and Patient 2. Licensee reported having Patient 2 come to the office to sign and receive the document. The document included a line for a witness signature. Licensee stated that no staff were present in the office when Patient 2 arrived to sign the document. Licensee explained that this was why the witness signature line was blank. The termination notice cited boundary issues as the reason for termination. This termination notice was provided in support of Licensee's claim that she terminated the doctor-patient relationship with Patient 2 on January 30, 2019.

Prior to receiving either her self-report or the complaint in this matter, Licensee contacted the Board on two occasions seeking advice. In her interview with Board Investigators, Licensee stated that the first time she contacted the Board Investigator, May 29,

2019, was because she was afraid of Patient 1 who was confronting her at her office. Licensee stated that the second time she contacted the Investigator, June 2, 2019, was because the situation had escalated and Licensee had begun a relationship with Patient 2, "a former patient." She stated that Patient 1 and Patient 1's husband (Patient 3) were going to "use that as ammunition" so she called the Board Investigator.

During the interview, Licensee acknowledged that when she called the Board Investigator the first time, she did not divulge to the Investigator that she had already started a personal relationship with Patient 2. Licensee also acknowledged that in her prior conversation with the Investigator, she was not telling the entire truth about her relationship with Patient 2.

5. Conclusions of Law Unprofessional Conduct in the Chiropractic Profession: Sexual Conduct

A chiropractic physician in the State of Oregon is expected to maintain appropriate professional boundaries with patients at all times. Chiropractic physicians are prohibited from engaging in sexual relations with a patient unless a consensual sexual relationship existed between them before the commencement of the doctor-patient relationship. The Board finds that Licensee pursued and engaged in a sexual relationship with Patient 2 following Patient 2 seeking treatment with Licensee and after the doctor-patient relationship was formed, in violation of ORS 684.100(1)(f)(A) and OAR 811-035-0015(1)(a)-(e). The Board finds that there was a doctor/patient relationship between Licensee and Patient 2 prior to sexual contact and that the doctor/patient relationship had not been appropriately terminated prior to sexual contact, pursuant to OAR 811-010-0005(4).

Unprofessional Conduct in the Chiropractic Profession: Emotional Injury

Licensee diagnosed Patient 3 with a life-threatening condition. This diagnosis was provided to Patient 3 during a time when Licensee was attempting to conceal her sexual relationship with Patient 2, Patient 3's employee who was also Patient 3's wife's lover, and

was done so as a deflectionary response. Despite these overlapping relationships and allegiances, Licensee, during her interview with the Board, disagreed that her clinical judgment was clouded in any manner, and denied diagnosing Patient 3 with possible aortic aneurysm to intentionally harm him.

Licensee prepared an August 8, 2019, "Notice to Patient of Doctor's Discontinuance/Termination of Chiropractic Treatment," citing boundary issues which Licensee signed but did not date or mail to Patient 3. Patient 3 obtained the termination as a result of requesting medical records from Licensee.

The Board finds that Licensee's disregard for the purpose of appropriate doctor-patient boundaries violated ORS 684.100(1)(f)(A),(1)(q), and OAR 811-035-0015(6).

Unprofessional conduct in the Chiropractic Profession: Truthfulness During Investigation

Licensee provided the Board with a written notice terminating her doctor-patient relationship with Patient 2, her then girlfriend. The Board doubts the veracity of this document for the following reasons:

(a) The form is the same format at those provided to Patient 1 and Patient 3;Licensee called the Board following her allegedly providing Patient 2 with the termination of doctor-patient relationship, inquiring as to the form and requirements of such a notice. If she had already provided such notice to Patient 2, those calls, and questions would have been unnecessary;

(b) Licensee stated that the document would have been witnessed by office staff but for office staff's absence when she called patient 2 to the office to sign the document; and

(c) The documentation is in direct conflict with the telephone conversations Licensee initiated with the Board Investigator on May 29 2019 and June 2, 2019, wherein she requested information on the protocol and procedures of how to terminate Patient 1 and Patient 2 as patients, and in direct conflict with statements made by Licensee during her interview.

The Board finds that these calls, and Licensee's self-report, were not made in good faith but in an attempt to mitigate the severity of any pending Board complaint or action that she anticipated was forthcoming. Providing untruthful and/or inaccurate information to the Board investigators in May and June 2019, and during her September interview with Board investigators, are violations of ORS 684.100(1)(f)(A) and OAR 811-035-0015(21).

6. STIPULATIONS

Therefore, pursuant to ORS 183.417(3) and ORS 684.100(9)(e), the OBCE orders:

1. The parties have agreed to enter this Stipulated Final Order. Licensee agrees that she is aware of her right to a hearing with her attorney present to contest the charges and hereby waives that right and agrees to entry of this order. Licensee agrees to waive any right to appeal. The parties wish to settle and resolve the above matter without further proceedings.

2. Licensee agrees to be suspended from practicing chiropractic in the state of Oregon for a period of six months beginning October 1, 2020 through March 31, 2021. Licensee is prohibited from practicing chiropractic during that time period. If Licensee is absent from the state of Oregon for any time period during suspension, except **vacations (with a 10 day limit),** the time away is tolled.

3. Licensee agrees that she will take and unconditionally and successfully pass all aspects of PROBE within six months of the date of this order. Licensee is required to cover the expense of the program and test and to provide proof of successful completion to the Board in writing. Licensee will not be released from the suspension until verification is provided to the Board.

4. Licensee is responsible to prominently post in the clinic a suspension notice as required by OAR 811-015-0080.

5. Licensee agrees to an assessment of a civil penalty of $5,000 within 60 days this order becomes final.

6. If Licensee violates any of the terms of this order, the Board may consider further discipline up to and including revocation.

7. This is a public document and reportable to all national and state databanks.

8. This order is considered a disciplinary action.

9. This order is effective on the date signed by the Board and is a public record.

BOARD OF CHIROPRACTIC EXAMINERS
State of Oregon

DATED this 1st day of October, 2020

Original signatures are available in OBCE administrative office.

By:_____

Cassandra C. McLeod-Skinner, J.D. Executive Director

DATED this 30th day of September, 2020

Original signatures are available in OBCE administrative office.

By:_____
Ann Griffin D.C.