Social and sexual contact between general practitioners and patients in New Zealand: attitudes and prevalence

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SUMMARY

Background. *Doctor–patient social and sexual contact is increasingly acknowledged as an issue of importance for the medical profession. However, there is little research concerning general practitioners on this topic.*

Aim. *A study was undertaken to obtain data on social and sexual contact between general practitioners and their patients.*

Method. *An anonymous questionnaire was mailed to a nationwide randomized sample of 217 general practitioners in New Zealand.*

Results. *A response rate of 86% was obtained. Dating and sexual contact with patients was considered to be sometimes or usually acceptable to 35% and 10% of general practitioners, respectively. Of respondents, 6% reported having dated a patient, 4% reported having had sexual contact with a patient at some point during their career and 2% reported having engaged in sexual contact with a former patient. General practitioners who had personally known of a colleague who had engaged in sexual contact with a patient were more likely to believe this behaviour had negative consequences than general practitioners who themselves reported having engaged in sexual contact with a patient.*

Conclusion. *The study results have implications for developing behavioural guidelines and educational interventions for general practitioners.*

Keywords: doctor–patient relationship; behaviour; sexual behaviour; personal misconduct; doctors' attitudes; patient attitude.

Introduction

THE General Medical Council of the United Kingdom has taken a serious view of the abuse of a doctor's professional position in order to pursue a personal relationship of an emotional or sexual nature with a patient,[1] and an editorial in the *British Medical Journal* generally endorses a position prohibiting sexual contact between doctors and their patients.[2] Medical associations have adopted similar policies prohibiting sexual contact between physicians and current patients.[3,4] However, research on physicians' attitudes and behaviours concerning sexual contact with patients and upon which these policies are based has been sparse[5] and has predominantly been conducted within American psychiatry.[6-8]

Information obtained from specific medical specialties may not be generalizable to other medical specialties. General practitioners have a unique and special relationship with patients in the community and are often privy to patient confidences that doctors in some other specialties are not. However, only two previous studies have involved general practitioners[9,10] including one where 11% of the general practitioner respondents acknowledged having had sexual contact with one or more patients.[10] In this latter study, as in other studies,[5,8,9] a definition of sexual contact was used that allowed the inclusion of a wide variety of behaviours including hugging when that contact 'arouses or satisfies sexual desire'. Where responding doctors reported that patients had had sexual contact with a doctor other than themselves, most thought that this had been harmful to the patients, and this notion has received general support.[2-4,7,11,12] Response rates of as low as 46%[9] and 19%[10] call into question the validity of results of the earlier studies involving general practitioners.

Given this paucity of research, the questionable validity of previous results, and the current interest in developing guidelines for doctors, it was decided to conduct a national survey in New Zealand on general practitioners' attitudes and behaviours concerning general practitioner–patient social and sexual contact.

Method

The study was undertaken in 1993. Two hundred and seventeen valid addresses were obtained from a randomized sample of 220 general practitioners selected from the national mailing list of 2363 general practitioners in New Zealand. The sample size of 220 gave a confidence interval that was sufficiently narrow for estimating prevalence. Prior to the questionnaire being mailed, a letter was sent to the selected general practitioners informing them about the study and its goals, ethics committee approval, the support of key professional organizations, independence from professional or disciplinary bodies, and the academic affiliation of the researchers. A four-page anonymous questionnaire was then mailed to each general practitioner along with a reply card which was returned under separate cover thus allowing the respondents to be identified without being linked to their responses. Non-respondents received up to two further mailings.

General practitioners were asked about the acceptability of sexual feelings towards patients including whether they had ever let such feelings show, the acceptability of dating and sexual contact between a general practitioner and his or her patient, whether or not they had dated or had had sexual contact with patients and with former patients (after treatment was terminated), and whether they had personally known of general practitioners who had engaged in sexual contact with their patients. They were also asked to specify the effect of sexual contact on both the doctor and patient concerned (whether positive, negative, mixed, no effect or unknown). There was space on the

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questionnaire for general practitioners to include comments. Questions asked but not reported here include general practitioners' attitudes to their own sexual feelings towards patients and their knowledge of colleagues who had engaged in sexual contact with former patients.

Sexual contact was defined as genital–genital, genital–oral or genital–anal contact. For all questions general practitioners were asked to exclude from consideration patients with whom there had been a prior relationship such as a spouse.

In order to protect anonymity, questions on demographic data were limited. The questionnaire was adapted from one used previously,[13] and was piloted with general practitioners, psychiatrists, and others. Results were analysed using the *SAS* statistical package; non-parametric statistics were used to compare differences between groups. All significance levels were calculated using two-sided tests of significance.

Results

Completed questionnaires were returned by 187 of the 217 general practitioners (86.2%). Seventeen general practitioners declined to participate and 13 general practitioners did not respond. Of 186 respondents, 74.2% were men. Eighty two respondents (44.1%) were aged less than 40 years, 25.8% were aged between 40 and 49 years and 30.1% were aged more than 49 years. Of 180 respondents, 24.4% worked in single-handed practices. There were no statistically significant differences in the age or sex of respondents compared with the population of all general practitioners practising in New Zealand.

Of 179 general practitioners 57.5% thought it acceptable for doctors to have sexual feelings towards their patients, and 62.5% of 184 doctors reported having felt sexually attracted towards a patient. Ten general practitioners (6.3%) indicated that they had let these feelings show to the patient by behaviours including 'a hug', 'mild flirtation', 'telling the patient', and 'giving flowers'.

General practitioners' attitudes towards dating and sexual contact with their own patients are shown in Table 1. That dating was acceptable was related to personal knowledge of colleagues' sexual contact with patients (reported later). Fifty per cent of 44 general practitioners with personal knowledge of colleagues' sexual contact with patients thought that dating was acceptable compared with 32.8% of 131 doctors who did not know of other colleagues' sexual contact with patients ($\chi^2 = 4.16$, 1 degree of freedom, $P<0.05$). That sexual contact was acceptable was not related to personal knowledge of colleagues' sexual contact with a patient. Age, sex and whether or not the practice was single-handed were not significantly related to attitudes towards dating or sexual contact.

The prevalence of dating and sexual contact by general practitioners with patients at any time during their career is shown in Table 2. All general practitioners who reported having dated a patient or having had sexual contact with a patient were men and the majority (10 of the 12 who had dated a patient and five of the seven who had had sexual contact with a patient) were now over 50 years of age. Most now practised in non single-handed practices. Three of the four general practitioners who had sexual contact with a former patient said that this was initiated within a year of terminating treatment.

Table 1. General practitioners' attitudes towards dating and sexual contact with their own patients.

Activity	% of GPs considering activity			% of GPs expressing no opinion
	Usually acceptable	Sometimes acceptable	Never acceptable	
Dating (*n* =187)	*2.7*	*32.1*	*59.4*	*5.9*
Sexual contact (*n* =183)	*0.5*	*9.3*	*89.1*	*1.1*

n = number of respondents.

Table 2. General practitioners reporting having dated or had sexual contact with their own patients at any time during their career.

Activity	% of 186 GPs (95% CI) reporting activity
Dated own patient	*6.5* (*3.0* to *10.0*)
Sexual contact with current patient	*3.8* (*1.1* to *6.5*)
Sexual contact with former patient	*2.2* (*0.1* to *4.3*)

CI = confidence intervals.

When describing the effect their sexual contact had on the last patient involved, five out of seven general practitioners saw this as positive for reasons including 'the attention made a patient feel more settled', the patient had found the relationship 'worthwhile and beneficial' and that it was a 'rewarding experience'. One thought that there was no effect on the patient and the other general practitioner did not know. When describing the effect on themselves, again five thought that this was positive for reasons including that it was 'enriching', 'beneficial' and 'brought great happiness'. Two thought the effects were mixed. One general practitioner eventually married his patient.

A quarter of the general practitioners (46/186) reported knowing of other general practitioners' sexual contact with current patients. In all cases, general practitioners known to have had sexual contact with patients were men. Respondents who knew of colleagues' sexual contact with patients reported their opinion of the effect of the last known contact on the patients involved. Thirteen per cent (six) thought it was positive, 28.3% thought it negative, 6.5% thought there was a mixed effect, and 45.7% did not know (the other three respondents reported it had no effect). Comments about a positive effect included that there was a 'resultant happy marriage', and comments on negative effects included that it 'devastated the patient', 'betrayed trust in the general practitioner and caused a loss of confidence in the medical profession', 'damaged a patient's marriage', and 'caused a patient's dependency on drugs and alcohol'. The effect of the last known relationship on the doctor involved was described as positive by 8.7% of respondents, negative by 34.8%, mixed by 10.9%, and was unknown by 37.0% (8.7% reported it had no effect). Comments about positive effects included that 'life took a new direction for the good', that a 'stable and ongoing relationship was developed', and comments on negative effects included 'marital strife', 'peer disapproval', 'disciplinary action', 'subjection to blackmail by the patient' and 'depression'.

Discussion

These data should be viewed in the light of several study limitations. As with other studies in this field the data are limited by the use of a self report questionnaire and possible bias towards socially desirable responses. How and when general practitioners had initiated or engaged in sexual contact was not addressed.

Questions were not asked about sexual orientation and behaviours such as hugging, kissing and fondling.

The vast majority of general practitioners in the present study had not dated a patient and had not had sexual contact with a patient. The prevalence estimates of 6% having dated a patient and 4% having had sexual contact with a current patient at some point in their careers are not readily comparable with the two earlier studies involving general practitioners because of the earlier studies' wider definitions of sexual contact and lower response rates.[9,10]

Of those general practitioners who acknowledged having had sexual feelings towards a patient, the majority did not report acting on those feelings by letting them show to patients. While most respondents thought that dating and sexual contact with their own patients was not acceptable, 35% suggested that dating patients was usually or sometimes acceptable. A smaller minority of 10% thought that sexual contact might be acceptable. These results exclude attitudes towards sexual relationships with patients with whom there had been a prior relationship such as a spouse, since many doctors do in fact treat family members.[14] More accepting attitudes towards dating patients was also weakly related to knowing of a colleague's sexual contact with a patient. This might suggest that in some cases doctors may be influenced by the perceived consequences of dating or may view this as acceptable or even normal when a colleague is involved. An alternative explanation is that doctors with more accepting attitudes are more likely to be entrusted with this personal information.

The consequences for both patients and doctors (and more widely patients' families and the medical profession) of doctor–patient social and sexual contact is relevant to the development of behavioural guidelines for and the education of general practitioners. Those few general practitioners who reported having engaged in sexual contact with patients perceived that mostly positive benefits occurred to both themselves and patients. However, it will be important to assess patients' perceptions of the consequences, particularly in light of the suggestion that doctors may rationalize their own sexual behaviours with patients.[7] This suggestion is supported by the finding that there were more perceived negative outcomes of doctor–patient sexual contact reported for colleagues than were reported for doctors' own involvement. A selective memory may lead doctors to report more positive outcomes resulting from sexual contact with their own patients. The differences may reflect bias: negative outcomes of doctor–patient sexual contact may be more likely to come to the attention of colleagues than positive outcomes, or colleagues may report or attribute more negative consequences because of professional jealousies. Nevertheless, these data reinforce the need for educating general practitioners as well as medical students about the possible negative consequences of doctor–patient sexual contact.

General practitioners may be faced with the dilemma of what to do on learning about colleagues who engage in sexual contact with patients.[15] A quarter of respondents had known of a colleague who had engaged in sexual contact with a patient demonstrating that such behaviour is not covert. However, in New Zealand as in American psychiatry,[16] only a few cases ever reach the attention of the medical council or ethics committees.

There appears to be a discrepancy between the 4% of practitioners who reported having had sexual contact with a current patient and the 25% who were aware of at least one such occurrence involving a colleague. A similar discrepancy has also been found in earlier studies.[10,16] This may reflect a bias towards under-reporting incidences of contact with practitioners' own patients, particularly given the highly sensitive nature of this research. However, more likely explanations include the lack of specificity about how personal knowledge was obtained, possible duplicate reporting by general practitioners about colleagues and the uncertain reliability of this information when not independently corroborated.

The small but nevertheless important number of general practitioners who reported having dated and having had sexual contact with their own patients, and the greater numbers indicating that dating and sexual contact was acceptable, demonstrate attitudes and behaviours in conflict with existing guidelines for doctors.[1-4] This also suggests a need for further discussion and education about acceptable professional behaviours. Future studies could evaluate the effectiveness of any interventions including educational interventions designed to modify general practitioners' attitudes and behaviour about sexual relationships with their own patients.

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