# Sexual contact in the doctor-patient relationship in the Netherlands

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## Abstract

*Objective*—**To obtain data on sexual contact between doctors and their patients.**

*Design*—**Anonymous questionnaire with 17 items sent to all working gynaecologists (n=595) and all ear, nose, and throat specialists (n=380) in the Netherlands.**

*Results*—**Response rate was 74%; a total 64 doctors gave a reason for not completing the questionnaire. 201 (59%) male gynaecologists and 128 (56%) male ear nose, and throat specialists indicated that sexual feelings are acceptable in the doctor-patient relationship; 286 (85%) and 186 (81%), respectively, had felt sexually attracted to a patient at some time, as had 14 (27%) female gynaecologists. More than half (59%) of the doctors who indicated that sexual feelings are unacceptable in the doctor-patient relationship had experienced these feelings, and 91% of this group had a negative attitude towards these feelings. 4% of respondents in each group had had actual sexual contact with patients. Most gynaecologists were in favour of having more attention paid to sexual problems during training; having their professional society take an official viewpoint; subsequent public support of this viewpoint; and taking on an impartial counsellor for the patients as well as the doctors.**

*Conclusion*—**Sexuality exists in the doctor-patient relationship. Gynaecologists have a higher risk of having sexual contact with their patients than do ear, nose, and throat specialists but compensate for this greater risk by a higher state of recognition and acknowledgement.**


## Introduction

Data on sexually tinted doctor-patient relationships are scarce, and very little is known about the true extent of the problem. We found only two publications in which doctors had been asked (by questionnaire) to provide information about sexual contact with their patients.

In 1973 Kardener *et al* approached 200 each of psychiatrists, gynaecologists, surgeons, internists, and general practitioners by post. The overall response rate was 46%. Of the 83 gynaecologists who responded, 13% admitted that they had had erotic physical contact; almost half had had intercourse. This rate was higher in gynaecologists than in other groups.[1]

In 1984, Henderikx and Van Son-Schoones studied 75 male general practitioners, 75 social workers, and 75 female district nurses. Of the 39% (29) of general practitioners responding 21% (six) stated that they had had erotic physical contact with a patient, 3% (1) of whom had had intercourse, compared with 36% (27) and 14% (4) for the social workers.[2]

Mental health care workers have more commonly been study targets, and 5-10% of the male and 0·5-1% of the female care providers had had sexual contact with a client.[3-6] The response rates, with the exception of the study by Holroyd and Brodsky, were low, averaging 40%. The sexual contact was generally initiated by an older, male care provider with a young, female client. On both sides, the motives were concealed in personal problems in the psychosexual sphere. A "crush" was also mentioned. From these and other studies it is clear that the consequences for the patient or client were predominantly negative.[3 5 7-9]

These publications give the impression that care providers are taking advantage of their situation, ignoring the difference in power and autonomy between the care provider and the client or patient.[3 10-13] The authors emphasise that care providers should be aware of their exceptional position. Professional limits exist in the relationship of care providers with clients or patients, and these may sometimes clash with a person's own limits or needs. From the principle of firstly, not doing harm (*primum non nocere*), it is never professional for care providers to indulge their own needs, and they should be aware of this occupational risk.

Are gynaecologists at more risk of having sexual contact with their patients than other medical specialists? Does the nature of this specialism play a part, as is often suggested by outsiders? These published reports do not provide a satisfactory answer to these questions, so we decided to make an inventory of data on gynaecologists in the Netherlands, with the ultimate intention of supplying data that would inform discussion on this topic within the professional society.

## Methods

To collect anonymous data, a questionnaire was sent to all working gynaecologists in the Netherlands who were members of the Society for Obstetrics and Gynaecology and to all the members of the Dutch Society for Ear, Nose, and Throat Specialists. Ear nose, and throat specialists were chosen for comparing gynaecologists to doctors whose work is not directly concerned with female genitals. The committees of both societies inspected the questionnaire and gave permission to use their lists of members.

Originally, it was the aim to include general practitioners in the study. However, the National Society for General Practitioners withheld its approval, giving the reason that the specific importance of the question was not "evident" for general practitioners.

The questionnaire contained three central concepts: (a) the doctor-patient relationship: all forms of contact between the doctor and patient which are meant to solve the patient's request for medical help in a professional manner. This concept emphasised the framework in which the relationship should take place; (b) sexual feelings: all the feelings which the doctor or patient experience as being sexually loaded. The subjective element in sexuality was emphasised; and (c) sexual contact: all forms of contact which are meant to bring about or satisfy sexual feelings. The subjective nature of sexuality was emphasised to prevent a specific

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form of behaviour, such as intercourse, from receiving too much emphasis.

The questionnaire comprised 17 items: sex, profession, four questions on permitting or averting sexual feelings, five items on the occurrence of sexual contact, five items on the amount of attention required on this subject during training and practice, and a last item on why the questionnaire had not been filled in if the respondent refused to cooperate. To assure anonymity, no information was asked about age, grade, or time in practice.

The questionnaire was mailed in May 1990. The first reminder followed two weeks later, and six weeks later the same questionnaire was sent to everyone with a second reminder. This procedure was chosen to guarantee anonymity and to achieve the highest possible response rate.

## Results

The total number of respondents was 720; 64 respondents refused to complete the questionnaire and gave a reason. The 656 respondents who filled in the questionnaire comprised 339 male gynaecologists, 52 female gynaecologists, 229 male ear, nose, and throat specialists, five female ear, nose, and throat specialists, and 31 respondents with unknown sex or profession. The group of female ear, nose, and throat specialists was considered too small for separate analysis. For simplicity, the results for each question are presented only for male gynaecologists, female gynaecologists, and male ear, nose, and throat specialists.

We aimed to perform a descriptive study and to make an inventory of data, so no statistical analyses of the differences between the groups were made.

### RESPONSE RATE

A total of 975 questionnaires were mailed, 595 (61%) to gynaecologists and 380 (39%) to ear, nose, and throat specialists. The response rate of 74% included 64 respondents who refused to complete the questionnaire and gave a reason. A total of 656 respondents (67%) answered the questions.

### QUESTIONS OF SEX AND PROFESSION

The questionnaire was completed by 397 gynaecologists (61%) and 239 ear, nose, and throat specialists (36%). In 20 cases, the profession was not specified. The ratio of gynaecologists to ear, nose, and throat specialists was similar in the total group and the respondent group: 1·57:1 and 1·66:1, respectively.

A total of 568 (87%) men and 57 (9%) women returned the questionnaire; in 31 cases the sex was not specified. Of the gynaecologists, 339 (86%) were men and 52 (14%) were women; of the ear, nose, and throat specialists, 229 (98%) and five (2%). The ratio between men and women within the professional societies was not known in advance, so we could not relate the response rate to the sex of the respondents.

### OTHER QUESTIONS

The table lists the questions asked and shows the doctors' responses.

A total of 326 (92%) of the 354 doctors who indicated that sexual feelings were acceptable (question 1) also indicated that they had felt sexually attracted to a patient (question 2). In the group of 259 doctors who indicated that sexual feelings were unacceptable, 153 (59%) had nevertheless felt sexually attracted to a patient.

Of doctors who thought sexual feelings were acceptable (question 1), 219 (62%) also indicated a positive attitude towards their own sexual feelings for patients (question 3); of those who thought sexual feelings were unacceptable, only 23 (9%) indicated a positive attitude.

*Doctors' experiences of and opinions on sexual contact in the doctor-patient relationships. Values are numbers (percentages)*

| | Male gynaecologists (n=339) | Female gynaecologists (n=52) | Male ear, nose, and throat specialists (n=229) |
|---|---|---|---|
| *Permitting or averting sexual feelings* | | | |
| 1 Do you think it is acceptable for doctors to have sexual feelings for their patients? | | | |
| Acceptable | 201 (59) | 25 (48) | 128 (56) |
| Unacceptable | 133 (39) | 26 (50) | 100 (44) |
| No answer | 5 (2) | 1 (2) | 1 (<1) |
| 2 Have you ever felt sexually attracted to a patient? | | | |
| Yes | 286 (84) | 14 (27) | 186 (81) |
| No | 52 (15) | 38 (73) | 42 (18) |
| No answer | 1 (<1) | 0 | 1 (<1) |
| 3 What is your attitude regarding the sexual feelings you have towards patients? | | | |
| Positive | 113 (33) | 7 (13) | 92 (40) |
| Negative | 168 (50) | 13 (25) | 97 (42) |
| No answer | 58 (17) | 32 (62) | 40 (17) |
| 4 Do you let it show to the patient that you have these feelings? | | | |
| Yes | 7 (2) | 1 (2) | 8 (3) |
| No | 289 (85) | 19 (37) | 200 (87) |
| No answer | 43 (13) | 32 (62) | 21 (9) |
| *Occurrence of sexual contact* | | | |
| 5 Do you have any experience of sexual contact with a patient in the doctor-patient relationship? | | | |
| Yes | 12 (4) | 2 (4) | 8 (3) |
| No | 326 (96) | 50 (96) | 219 (96) |
| No answer | 1 (<1) | 0 | 2 (1) |
| 6 If so, with how many patients have you had sexual contact? | | | |
| 1-2 | 8 (67) | 1 (50) | 2 (25) |
| >2 | 4 (33) | 0 | 4 (50) |
| No answer | 0 | 1 (50) | 2 (25) |
| 7 If so, did intercourse take place? | | | |
| Yes | 4 (33) | 0 | 5 (63) |
| No | 8 (66) | 1 (50) | 1 (13) |
| No answer | 0 | 1 (50) | 2 (25) |
| 8 How did you feel (afterwards) about sexual contact for yourself? | | | |
| Positive | 7 (58) | 1 (50) | 6 (75) |
| Negative | 5 (42) | 0 | 0 |
| No answer | 0 | 1 (50) | 2 (25) |
| 9 How did you feel (afterwards) about sexual contact for the patient? | | | |
| Positive | 7 (58) | 1 (50) | 6 (75) |
| Negative | 5 (42) | 0 | 0 |
| No answer | 0 | 1 (50) | 2 (25) |
| *Desirability of more attention to sexual issues in the doctor-patient relationship* | | | |
| 10 Do you think that during your training, more attention should be paid to sexuality in general and to sexuality in the doctor-patient relationship in particular? | | | |
| Yes | 257 (76) | 49 (94) | 104 (45) |
| No | 75 (22) | 3 (6) | 117 (51) |
| No answer | 7 (2) | 0 | 8 (3) |
| 11 Do you think that your professional society ought to have an official viewpoint about sexual contact in the doctor-patient relationship? | | | |
| Yes | 218 (63) | 38 (73) | 86 (34) |
| No | 110 (32) | 14 (27) | 135 (56) |
| No answer | 11 (6) | 0 | 8 (10) |
| 12 Do you feel that this official viewpoint should be held publicly? | | | |
| Yes | 215 (63) | 34 (65) | 82 (36) |
| No | 88 (26) | 15 (29) | 101 (44) |
| No answer | 36 (11) | 3 (6) | 46 (20) |
| 13 Do you think that an impartial counsellor ought to be appointed to whom patients can turn for support and guidance in the case of actual sexual contact? | | | |
| Yes | 277 (82) | 51 (98) | 156 (68) |
| No | 55 (16) | 1 (2) | 51 (22) |
| No answer | 7 (2) | 0 | 22 (10) |
| 14 Do you think that an impartial counsellor should be appointed within the professional organisation to whom doctors can turn? | | | |
| Yes | 277 (67) | 45 (87) | 118 (52) |
| No | 95 (28) | 3 (6) | 88 (19) |
| No answer | 17 (5) | 4 (8) | 23 (10) |

In addition to the 12 male gynaecologists, two female gynaecologists, and eight male ear, nose, and throat specialists who had had sexual contact with a patient (question 5), five others had answered yes but did not give their sex or specialty. Therefore 4% of the total group of respondents (27/656) had had sexual contact with a patient.

An unanswered questionnaire was returned by 64 respondents. The reasons given included no time (3), no point (41), the subject was too loaded (1), and 19 miscellaneous answers such as "aimed too one-sidedly at doctors," "concepts too poorly defined," "no sex in practice," "this problem is of more account in psychotherapeutic relationships," and "you ought to be ashamed of yourself for performing such a study."

## Discussion

A written survey sent to all Dutch gynaecologists and ear, nose, and throat specialists was most likely to guarantee anonymity and give all gynaecologists and ear, nose, and throat specialists a chance to participate in the study. We did not collect information about age, grade, or time in practice of the specialists so that anonymity could be maintained.

Although we stated the questions as clearly as possible, different people will make different interpretations of such a controversial subject, and this should be borne in mind. As the original Dutch version of the questionnaire has been translated into English for publication, some of the subtleties may have been lost in translation.

Because of these limitations, together with those imposed by the postal questionnaire format, we do not wish to put too much emphasis on numbers—the main target of the study was to supply material for discussion.

### RESPONSE

Various reasons can be given for our response rate (74%) being considerably higher than those previously reported. There may be a general need for discussion on the topic, or the topic may have been less heavily loaded than we had expected. It is doubtful whether the latter is true in view of the worried reactions we received shortly after sending off the questionnaires and particularly in view of the worried reactions regarding the presentation of the results. In any case, the surprisingly high response rate provides great impetus for discussions on this topic. Although it would be interesting to study the motives of the non-responders, this is unfortunately impossible owing to anonymity.

### PERMITTING OR AVERTING SEXUAL FEELINGS

Only a small majority of the male gynaecologists (59%) and male ear, nose, and throat specialists (56%) thought that sexual feelings towards the patient in the doctor-patient relationship were permissible, as did 48% of the female gynaecologists. Thus, many doctors rejected these feelings. The rejection fits into the classic medical model, in which the patient is more or less reduced to an object, and does not give any cause for (sexual) feelings or emotions from the doctor. The danger is that this denial leads to the attitude that what isn't allowed, doesn't exist. On the other hand, on theoretical grounds solving intimate problems, particularly in the doctor-patient relationship, can give rise to a (mutual) emotional bond between the doctor and patient.[14] This can form the basis for extreme intimacy and emotional excitement which, through eroticism, can lead to a sexually exciting situation. However, when these feelings and emotions are recognised as normal human behaviour—the doctor is only human after all—they can more easily be discussed.

At first glance it could be concluded from the large differences between men's and women's answers to the question, "Have you ever felt sexually attracted to a patient?" that men, within the doctor-patient relationship, are quicker to eroticise (emotional) situations than women, but it must be remembered that female gynaecologists would be dealing mainly with female patients.

Of the many respondents (42% (259/620)) who indicated that sexual feelings were unacceptable, 59% answered that they had experienced these feelings. The existence of this contradiction points out that regarding a patient as an object does not completely banish eroticism.

The answers to the question, "What is your attitude regarding the sexual feelings you have towards patients?" showed that the experience of sexual feelings must have given rise to an inner conflict for many of the respondents. It was not surprising that the percentage of respondents who experienced these feelings as negative was much larger in the group of doctors who had already indicated that they found sexual feelings unacceptable than in the group who found these feelings acceptable (question 1).

### OCCURRENCE OF SEXUAL CONTACT

Sexual contact in the doctor-patient relationship occurs among gynaecologists and ear, nose, and throat specialists alike. Besides the incidental cases which are publicised in the press, there are also signals that can sometimes be picked up in practice. Other indications can be found in the literature.[1,2,5-7] If we assume that a doctor as care provider does not behave any differently from other care providers, then on the basis of existing published reports on this topic perhaps 5-10% of male doctors have had sexual contact with one or more patients.

Determining exactly how common sexual contact is in the doctor-patient relationship is not possible in this study as the numbers of contacts reported are small. The specific load of the questionnaire might have led to underreporting, in particular for gynaecologists. Nevertheless, the frequency of 4% found in this study compares favourably with the percentages reported in the literature. Male gynaecologists and male ear, nose, and throat specialists had the same rate of contact, as did female gynaecologists, but one has to tread carefully because there were so few female gynaecologists among the respondents—8%—and so few of them had had sexual contact with a patient. The scarce data in the literature indicate that, for each female doctor having sexual contact with a patient, 10 male doctors would be expected to do so, which is very different from the ratio in this study of 1:1. The "professional risk," however, is not confined to male gynaecologists.

The lack of difference between male gynaecologists, female gynaecologists, and male ear, nose, and throat specialists in our study does not mean that the risk is the same for both professions. There are two possibilities: there really may not be any difference, or the greater risk for gynaecologists may be compensated for by more awareness. The latter assumption is based on the comparison between the male gynaecologists and male ear, nose, and throat specialists who actually had sexual contact with a patient. The differences between these specialists were small but consistent. Compared with male gynaecologists, the male ear, nose, and throat specialists had relatively more contacts with more (>2) patients, more often had intercourse with a patient, more often felt positive about the sexual contact afterwards for himself and for the patient, and more often omitted to answer the questions on this topic. This suggests that the perception of ear, nose, and throat specialists regarding the problem of sexual contact in the doctor-patient relationship is different from that of gynaecologists. An explanation for this could be that, due to the nature of their work, gynaecologists are more engaged in intimate issues than are ear, nose, and throat specialists and this indicates a higher degree of "risk awareness." The differences between the answers to the question on the desirability of more attention to this topic in the training, professional society, and practice (questions 10 to 14) provide extra emphasis on this point.

Most of the doctors who had sexual contact with a patient felt positive (afterwards) about it for the patient as well as for themselves. However, more gynaecologists felt negative. Data on the patients' feelings were not collected in this study, but published

reports show that the outcome of sexual contact with a care provider is negative in 90% of the cases and sometimes has far reaching consequences for physical and psychological functioning.[3 5 7-9] There is no reason why this should be any different for the patients with whom our respondents had sexual contact. The discrepancy between doctors' perception of the consequences for the patient and what the patient herself may feel indicates a misconception held by the doctors involved, which makes it possible for them to enter into sexual contact in the doctor-patient relationship without any qualms. Special attention will have to be paid to this issue.

DESIRABILITY OF MORE ATTENTION TO SEXUAL ISSUES IN THE DOCTOR-PATIENT RELATIONSHIP

Ear, nose, and throat specialists had a different attitude towards questions on sexuality than gynaecologists. Most ear, nose, and throat specialists indicated that they wished to let the point rest (questions 11 and 12). That a clear majority were in favour of taking on an impartial counsellor for the patients and (to a smaller extent) for the doctors seems to be a contradiction, but it can be seen to fit within the framework of "the conspiracy of remaining silent," in which the problem is recognised but ignored and everyone tries not to disrupt the display of (ideal) correct behaviour to the people outside. Gynaecologists both recognise the problem and acknowledge that their professional society should acknowledge it.

This study shows that there are strong arguments for paying more attention to the subject of sexual contact in the doctor-patient relationship in the Netherlands. In Britain, too, discussions on the topic would be welcomed.[15]


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# Symptoms after accelerated immunisation

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## Abstract

***Objective*—To document the incidence of symptoms after accelerated immunisation with diphtheria-tetanus-pertussis vaccine.**

***Design*—Controlled study of children immunised with adsorbed diphtheria-tetanus-pertussis vaccine at accelerated and standard schedules.**

***Setting*—Colchester and north Hertfordshire.**

***Subjects*—107 children scheduled to receive immunisation at 2, 3, and 4 months of age and 115 children scheduled to receive immunisation at 3, 4½ to 5, and 8½ to 11 months of age.**

***Main outcome measures*—Parentally recorded symptoms, axillary temperatures, and size of local redness and swelling at the injection site during the seven days after immunisation.**

***Results*—In general symptoms occurred less frequently with the accelerated schedule. Proportions of parents reporting axillary temperatures greater than 37·2°C or local redness or swelling greater than 2·5 cm after the third dose of vaccine were significantly reduced in the accelerated schedule group.**

***Conclusion*—Immunisation at 2, 3, and 4 months of age is likely to cause fewer reactions than immunisation at 3, 4½ to 5, and 8½ to 11 months of age.**



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## Introduction

In May 1990 an accelerated schedule of primary immunisation was introduced into the United Kingdom. The ages at which children received combined diphtheria-tetanus-pertussis vaccine and oral poliomyelitis vaccine were changed from 3, 4½ to 5, and 8½ to 11 months[1] to 2, 3, and 4 months.[2] It is known that adsorbed diphtheria-tetanus-pertussis vaccine given at the old schedule can cause fever, swelling, and redness at the injection site and symptoms such as crying and irritability.[3 4] The aim of this study was to document the incidence of mild systemic and local reactions to an accelerated schedule of primary diphtheria-tetanus-pertussis immunisation in the United Kingdom.

## Subjects and methods

Children born between June 1989 and January 1990 were referred by health visitors and doctors in five general practices in central Colchester. Informed consent was obtained by a study nurse at a home visit. Children were then immunised at the surgery according to recommended procedure[1] and at the preferred site of the immunising doctor or nurse. Adsorbed Wellcome diphtheria-tetanus-pertussis vaccine was administered, which had been distributed and stored according to routine practice in the district. Children who began the study were scheduled to receive their first dose at 8 weeks of age and subsequent doses at 12 and 16 weeks of age.

A historical control group was available of children born in north Hertfordshire between September 1986 and November 1987 who had taken part in a previous study to document reactions to Wellcome adsorbed diphtheria-tetanus-pertussis vaccine. These children were scheduled to receive immunisation at 3, 4½ to 5, and 8½ to 11 months. The immunisations were