Family Practice Grand Rounds

Management of the Multiproblem Seductive Patient

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A seductive gesture by a patient towards a physician is not uncommon in clinical practice, and presents a variety of problems in maintenance of the doctor-patient relationship and management of the patient's medical problems. Medical, psychological, and social factors must be considered in resolving these problems. This Grand Rounds presents such a case and discusses alternative approaches to patient management and the role of other health professionals in the care of such patients.

DR. RAYMOND O. WEST *(Director of Medical Education):* Today we will discuss a multiproblem woman who used her sexuality and other devices to manipulate her physicians. Before Dr. Mayer presents the case, permit me to say a few words by way of background.

The manipulation of others to gain one's own ends is one of the less attractive aspects of human nature. Manipulative patients are well known to every medical specialty. A modern prototype is the narcotics user who employs every imaginable artifice to con his physician into prescribing drugs.[1,2] Other examples include the often interminable demands of hypochondriasis, the intractability of burned children during convalescence,[3] unconcealed sexual self-stimulation on the part of mental and geriatric patients,[4,5] and the many other ways in which patients, both male and female, exploit their sexuality.

Patients' use of sexuality is a problem that lurks just below the surface in nearly every family practice. Some patients may express their sexuality toward a physician in subtle ways, others may flaunt it, and still others may be overtly seductive. How are such approaches best handled? Should the physician be cold and indignant, warm and understanding, or lukewarm and noncommittal? In any case, it is important that the young physician become desensitized to patients' sexuality.[6] In the event of seductive behavior, the physician should not feel threatened and should be able to keep the situation under control.

Since the time of Hippocrates, erotic contact between physician and patient has been an overriding cultural taboo. This probably derives from the societal roles of the male physician as father-image and healer. Even a young male physician plays the role of father-figure. As such, he uses his authority to educate the patient in health practices. As healer, he is one of the few persons outside the immediate family to whom society affords the special privilege of manipulating the person of others.[7] In actuality, two conventions have arisen here. The incest taboo is seen as arising from the role as father; another convention, which might be called the concept of "professional disinterest," permits intimate but nonerotic personal contact.

It is important to look at the other side of the coin. Taboos, like laws, are sometimes violated. This is evident from recent literature addressing the problem of physicians imposing their sexuality upon patients. A survey[8] in Southern California disclosed that 19 percent of responding physicians believed that erotic contact might benefit some patients; five to 13 percent had actually engaged in some kind of erotic behavior with their patients.

What have others had to say about this? Leon Saul[9] suggests that the physician must tread a narrow path between cold objectivity and sympathetic identification with the patient. A patient's feelings, either of sexuality or of hostility, may be transferred to the physician, and the patient may seek satisfaction through the physician. Saul points out, however, that the physician must provide treatment and guidance directed toward the patient's finding satisfaction not in the professional milieu but in the real world. Paul Chodoff[10] writes that the physician should be introspective when a patient manifests seductive behavior. He should ask himself, "Have I done anything to provoke this?" If the answer is "no," he should, in a firm but nonrejecting manner, get on with the business of the day – medicine. If "yes," the problem is his and the task is to increase his self-awareness. Solomon Papper[11] writes, "for a patient to be regarded by his physician as 'undesirable' can be catastrophic." Siassi and Thomas[7] suggest that a physician is never justified in being sexually indiscrete; otherwise he would violate both a public trust and his professional commitment of noninvolved objectivity.

DR. MELVIN L. MAYER *(second-year family practice resident):* Our patient is a Caucasian female, age 23, gravida nine, para four, and abortion five. She has had two marriages and is involved in various difficulties with the custody of her four children. She has been in the hospital about 15 times for a gastric ulcer and had two episodes in which she vomited blood. She had just had a Caesarean section and developed a postoperative wound infection and was having severe abdominal pain with a diagnosed gastric ulcer at the time of first contact. She was anxious and nervous and several times threatened to leave against our advice. After discharge she became concerned about becoming pregnant again. At the time of the Caesarean section a tubal ligation was advised. She refused, but two months later she changed her mind and asked to have her tubes tied. A gynecologist recommended the surgery

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be avoided because he felt that she had too many other problems, including the ulcer. We fitted her for a diaphragm until we could stabilize her gastrointestinal and emotional problems. About a week later she requested psychiatric consultation which I arranged for.

A little after that, she called me at the hospital and asked if I was a very religious person. I told her that I considered myself a moral person who tried to live by Christian principles. Then she asserted that she knew, "I felt toward her the same way that she did toward me." I told her that I was happily married, that my wife was expecting and that I wasn't looking for anything or anybody. I told her if that was the way she felt toward me it probably would be better for her to seek another physician. She told me she had just recently gotten a job as a dancer at a topless bar and said, "Why don't you stop by and see me after work sometime?" I declined. The whole conversation surprised me because she hadn't made any seductive overtures in the office.

I was in a dilemma. I went to Dr. West, our program director, and asked for his advice. He suggested that we send her a registered letter informing her that her care would be transferred to him for two weeks, after which she would have to find another primary care physician. By the way, a few days later she took an overdose – probably just a gesture – and was admitted to intensive care where she pulled out her IV and left.

DR. WEST: Dr. Mayer wrote a diplomatic letter. It is now part of her record. I do not know what she told her husband, but he makes it sound as if it was she, not Dr. Mayer, who terminated the doctor-patient relationship. Perhaps we can open the discussion with these questions: Was this patient seductive? If so, why?

DR. DAVID EPLEY *(Consultant in behavioral science):* The fact that she made contact by telephone may be an indication that she felt a risk was involved if she approached you directly. A telephone is more impersonal, and communication can be cut off more easily.

MR. RALPH WILLIAMS *(Director of Social Services):* In the doctor-patient relationship, a primary concern of the physician is to present a program which meets the physical and emotional needs of the patient. Dr. Mayer might have demonstrated such a sympathetic understanding of the patient's problems that she misunderstood his motives.

DR. WEST: Then you both feel that this was an overt approach to change the relationship to something more intimate.

MR. WILLIAMS: Yes, I feel it was an effort to seduce the physician.

DR. EPLEY: It certainly sounds like it, but there is always the chance that she meant something else. She said, "I know you feel about me the way I feel about you," and yet she didn't say how she felt about you. She was protecting her vulnerability, leaving it open to interpretation.

DR. WEST: Is there doubt in your mind as to whether seduction was her real intent?

DR. EPLEY: People often use their sexuality to express other feelings or other needs. This is a common occurrence in my practice. For her, this could be a customary way of expressing deeply felt needs. These might be needs for reinforcement of her self-esteem or they might be requests for help. For some people, a sexual overture is a way of communicating, "Help me!" It may be also a way of saying, "It seems to me you care for me by some of the ways you respond to me, so I am going to approach you in the way I know best in order to receive the caring that I need." In this context a sexual invitation would not require a sexual acknowledgment. For that matter, a sexual response from a physician might seem inappropriate to her. A caring reply might be enough, for example: a touch, a smile, a warm tone of voice or some other response that accepted her and showed appreciation of her offer. But whether this would indeed be an appropriate response would depend upon the interaction between the physician and the patient at that moment.

DR. VLADO GETTING *(Consultant in preventive medicine):* I am going to ask some questions which might follow up your leads, Dr. Epley. What do you know about her upbringing? Her educational background? Was she from a broken home? Did she have a sexual relationship in her home – maybe with her father? Were her pregnancies all with her two husbands or was she quite promiscuous?

DR. MAYER: I am not aware of any sexual relationship with her father. She comes from a religious background. She never finished high school. Her first pregnancy was at age 11; of course she was not married.

DR. ORRIS ROLLIE *(Associate Director, Family Practice Residency Program):* She must have been pregnant almost continuously – nine times since age 11.

DR. GETTING: I am wondering whether she feels insecure with the opposite sex. Maybe she was looking for a father image; a protector rather than a sexual partner.

DR. ROLLIE: I might be wrong but I am willing to bet that she had an early sexual relationship with her father.

MR. FRED OFFENBACH *(Director of Hospital Education):* How would you account for her invitation to visit her at the topless bar? This would seem to have a sexual overtone, would it not?

DR. GETTING: Not necessarily. Perhaps she was proud that she had a job and was earning money. In her judgment this could be normal behavior and not promiscuous.

DR. MAYER: I am not sure of several things. Maybe I should have told her that I would continue to be her family physician. Maybe I could have helped her to work out some of her psychological problems.

DR. WEST: That is an issue we should explore. Do I hear Dr. Epley and Dr. Getting saying that we have a duty to such a patient even if it is reasonably clear that she is being seductive? Did we do wrong in discharging her so promptly?

MR. WILLIAMS: Why did you elect to take her case for two weeks and then recommend that she find another physician?

DR. WEST: This is purely medicolegal self-protection. You cannot simply abandon a patient. You must give her time to find a new physician. We felt that two weeks was adequate.

DR. GETTING: Her sexuality was only one symptom of her many problems. The repeated pregnancies are, of course, a complication of her sexuality, but the facts of the gastric ulcer and the overdose both suggest serious emotional disturbances. Now why? Is it because of a parental pathology or maybe social pathology? And is she being thrown back into the same

environment where these things are going to recur? Can we in any way diagnose the environment in which she lives in an attempt to identify the social problem?

MISS JOANNE GORAL *(Health Educator, Family Practice Residency Program):* It seems to me that she is crying out for help. She is using her sexuality in an attempt to obtain the love and acceptance which she apparently feels are lacking in her life. I feel that she wants help and that is possibly why she approached Dr. Mayer in the way she did. She was turned down. She will probably go to some other physician and repeat a similar seductive approach and probably get turned down again. I understand that it must have been an awkward situation for Dr. Mayer, but I feel that something more could and should be done for her.

DR. WEST: Are we saying that we owe the seductive patient something even if we give it at some danger?

DR. EPLEY: I think the medical profession owes the patient something; I am not sure any individual practitioner does.

MR. WILLIAMS: The patient has had failures all her life. To be terminated by her physician was another crisis for her. It might have been helpful if you had decided to keep her in the system, perhaps involving our other professionals as well.

DR. WEST: She is still being cared for in our Family Health Center. When she became my charge she began calling my home. First she told me that their home had burned down. Her diazepam (Valium) was destroyed so she needed more. I knew a little about the suicide attempt so I suggested she see me in the office; she reneged. Several days later, another call; would I write her a letter saying that she should not take a lie detector test. I learned that the fire marshal was charging her and her husband with arson. She said, "You know very well that a lie detector test isn't going to be true when I'm so nervous." So I wrote a letter to the fire marshal saying that she had been under a great deal of stress. I do not know whether or not she took the polygraph test. Anyway, the arson charge was dropped. A few days later, another call; she needed more Valium and she was afraid she was pregnant again. So again an appointment was made at the Family Health Center for a pregnancy test. Later she called to say she would skip the appointment because she was having her period. And then last Monday she called again wanting a pregnancy test.

DR. GETTING: This young lady is looking for help. She knows she has problems but she does not recognize what is wrong. There is something basically wrong here which we have not discovered yet. What about her social and economic background? Are those children really the children of her husbands? How does she support them? What kind of a husband does she have? What does he do for a living?

I have an idea that she may be socially, economically, or educationally deprived.

DR. ROLLIE: I can tell you firsthand that she is still working as a go-go dancer. You know, I feel rather neglected here. I was very much involved in her total care and I have not had any phone calls.

DR. MAYER: I think that tells us she was not looking for a father image. Seriously, in retrospect it is fairly obvious that several mistakes were made in the handling of her case, and we as family physicians should be more willing to spend the time to get an in-depth social and family history.

DR. ROLLIE: When she was admitted with her overdose was she seen by a psychiatrist?

DR. MAYER: Not a chance; she ran out of Intensive Care even before she had time to sign an AMA form.

MR. OFFENBACH: Should she so desire, would you be willing to reassume her primary care, and if so, how would you go about treating her?

DR. MAYER: I think it would be awkward and probably not in her best interest. I could have continued her primary care up until the time we sent the letter.

DR. GETTING: It would appear that what we were doing was taking care of her chief complaint, but we did not really get to the basic problem and treat the whole patient.

DR. WEST: Do I hear you saying that there is no such thing as a seductive patient, but only a patient calling for help? If this is so, would you say that in similar circumstances physicians should not do as we did?

DR. GETTING: There surely are patients who are seductive and sexually overactive. I know of a girl who was 16 and could name ten men with whom she had had sexual relations; she was doing it just for the fun of it. But why? I think it is important to find out. In this instance the girl came from a broken home and all her sisters were promiscuous. It was the family norm to be promiscuous. I do not know if this was the situation with our patient, or whether she was using seductiveness in order to call for help.

DR. WEST: If it could be shown that this represented our patient's usual social behavior would you have approved of our turning her off?

DR. GETTING: Well, in retrospect one knows all the answers. I think it would be a mistake to say that we did wrong. I think what we did was, at the time, correct in our judgment. But with hindsight it probably would have been better not to have turned her off.

A word of caution: the physician must take special precautions not to put himself into a physical position where he could be accused of wrongdoing. Always have a witness in the office when examining or treating a woman, preferably another woman.

DR. WEST: Sage advice.

Could we take a moment to discuss the physician's family? Does Dr. Mayer owe anything to his wife on this? Such as protecting her from these telephone calls that invade their home?

DR. GETTING: It certainly is a disturbance to the household when a patient, especially a seductive one, telephones repeatedly. The wife must know what is happening; otherwise, there could be a serious misunderstanding.

DR. ROLLIE: I might add an incident that happened in my practice. I took care of an unmarried 16-year-old girl whom I had delivered and given primary care. This was some six years ago and to this date personal letters keep coming to my home almost monthly with pictures of her child and news about her boyfriends. I have not answered any of them but they continue to come, signed, "with love." My wife gets a bit disturbed each time.

DR. WEST: When I was about Dr. Mayer's age, I worked with an older physician. He told me that he had never had an approach of this nature, except for one rather attractive lady who, one day in the consultation room, spontaneously threw her arms

around him and kissed him full on the lips. Now what should be the physician's attitude in a situation like this? Thank her? Return the favor?

DR. EPLEY: Enjoy it if you can?

DR. WEST: He was very stern. He said, "Young lady, don't ever let that happen again." He did not discharge her and his wife did not like it at all.

DR. GETTING: Back to our patient; she is still in the system. What should we be doing for her? She certainly needs either psychological or psychiatric help and a thorough investigation of her social background. Now how can we get that? Do we send someone to her home?

DR. EPLEY: Well, if there were a female physician it might be different.

DR. WEST: How about a health educator? Perhaps a social worker? A visiting nurse?

MR. WILLIAMS: A nurse with adequate counseling skills could be more effective than a social worker due to the medical problems with which the patient is struggling.

DR. EPLEY: One issue we have not explored is the kind of messages which Dr. Mayer might have been sending to her. You are friendly and supportive to your patients. Maybe you were projecting an image you were not fully aware of.

DR. MAYER: She was certainly receiving something that I was not intending to send by either word or action.

DR. GETTING: There are other areas that we ought to discuss: her nutritional status and her hemoglobin. With that ulcer, is she supposed to be on a special diet? If she has been promiscuous, what about venereal disease? If she has had sexual contact with many men, she may have picked up gonorrhea and perhaps even syphilis. Were tests made for VDRL?

DR. MAYER: Her VDRL was negative and she was asymptomatic for gonorrhea so no test was carried out.

DR. WEST: Do you think, Dr. Mayer, that she was attractive enough to put out amorous feelers and expect to receive a positive response?

DR. MAYER: In my opinion, not at all.

DR. WEST: Could we close by going around the table and giving a brief summation of your reactions?

DR. EPLEY: I see the principal issue as whether the physician is able to respond to the patient only in a selective way in terms of her medical problems. Clearly, in this case Dr. Mayer felt it was appropriate to respond selectively. Perhaps as an outcome of this discussion it might be possible to respond in a more comprehensive way. But only you will know what is appropriate for you at a particular time. Face the patient and relate yourself to her.

MISS GORAL: In this particular situation I can see why Dr. Mayer saw no choice other than to respond as he did. His doctor-patient relationship had deteriorated through no fault of his own. However, I feel that it might have been better to consider an older or woman physician so as to avoid any further complications.

DR. GETTING: The young lady is obviously abnormal in many different ways. She presented with symptoms which we treated but we did not identify her fundamental problem. I would agree that an older physician would be better than a good-looking young fellow. But we need to investigate the basis of her behavior before we can really come up with a satisfactory treatment regimen.

I think this case raises many questions but answers few. For example, her past social history could have a material bearing on her present lifestyle. Her attitudes, values, and behavior patterns are certainly different from those of most middle-class family physicians. It is not surprising that a physician, applying his own value system, fails to understand her motivations. Did the patient misinterpret the doctor's motives? Maybe the doctor misinterpreted the patient's. Dr. Mayer quite understandably moved to protect himself; there surely must be other ways of doing this without rejecting the patient. In other words, how can the doctor help the seemingly seductive patient to meet her needs without himself being entrapped?

MR. WILLIAMS: The importance of maintaining the doctor-patient relationship cannot be overemphasized. For a physician to have allowed himself to be seduced would have been a triumph for the patient but a disaster for the relationship.[7,12]

DR. ROLLIE: I think Dr. Mayer handled this in a way that was the only way at the time. I agree that we should go into her situation more carefully. I would like to see Dr. Epley interview her and then follow through.

DR. MAYER: In retrospect, the question arises as to how I can satisfactorily delve into the social and psychological background of my patients in the family practice clinic in the ten to 15 minutes allotted to see each one. Or do I need to make better use of available ancillary personnel such as social workers and clinical psychologists? I think that busy family physicians need to be able to select out the patients early and refer them to the proper ancillary person or agency before a serious problem develops.

DR. WEST: Very good; I would like to add only this: what we talked about today is the epitome of what we are trying to accomplish in family practice. The family physician should discard the old idea of episodic or crisis care and learn to treat the whole patient. But not, I must add, at the cost of compromising his personal or professional standards.

EPILOGUE: Approximately two months later the patient underwent a tubal ligation. Her family situation appeared to be stabilizing; she elected not to undergo psychosocial counseling. She continued to obtain her primary medical care in the same family practice clinic; however, her visits remained episodic. Her gastric ulcer appeared to be quiescent. No new life-threatening crises had occurred.

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