“Consensual” sexual relationships between health practitioners and their patients: what do the data say and what can be done about it?

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- Side data collected and analysed as part of a 3-year Marden Fund exploring disciplinary tribunals in health, law, and education
- Important to consider in light of limited existing data

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NEW ZEALAND

Outline

- Prevalence
- Barriers to reporting
  - Profession ones
  - Patient ones
  - Regulatory/Code of Ethics ones
- Disciplinary responses in NZ
- The risk of stereotyping those at risk
- Time for discussion and questions

Front: Freud, Hall, Jung **Back**: Brill, Jones, Ferenczi (1909)

Sexual relationships with patients is an old problem

Carl Jung and Sabrina Spielrein (1904-1910)

His first psychoanalysis patient
Long relationship

She herself went on to become an analyst

‘harmful and beneficial’ with dissenting opinions well into the 1960s

"Destruction as the Cause of Coming Into Being“ (1912)

Carl Jung and Sabrina Spielrein (1904-1910)

He described relationship as providing him with a soul mate and inspiration

She was 19

Diagnosed with “psychotic hysteria”

She described relationship as tortorous and linked with bouts of depression

Sexual misconduct encompasses many classes of behaviour

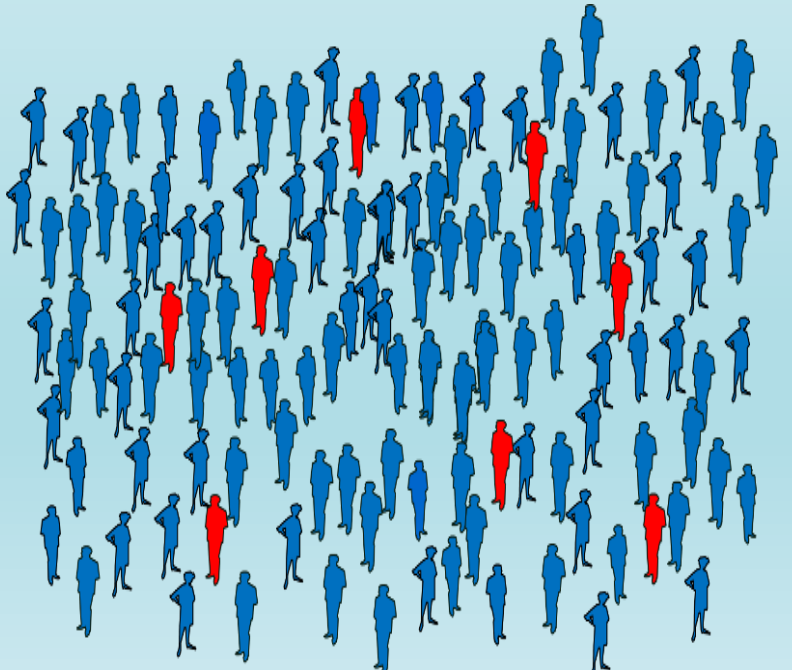
Assault/abuse:	Well described and little debate
Sexual exploitation:	Heightened social censure
Consensual relationships:	More fraught legal and ethical responses

Prevalence of sexual misconduct broadly

Claims about a “disturbing increase” (Harkner, 2015) are commonly made but are hard to substantiate

Diverse methods of research (surveys, “notification” databases, disciplinary databases)

Diverse definitions of what is included when researching sexual misconduct



Intense media attention almost certainly distorts understandings

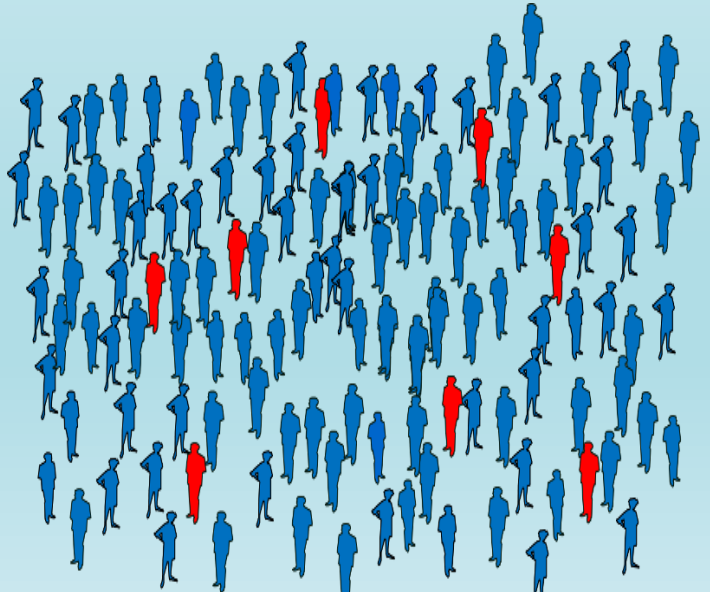
3-10% medical practitioners for all classes of misconduct
(Swiggert et al., 2002)

3.8% of general practitioners in NZ
(Elkin et al., 2011)

17% of disciplinary cases involve relationships with patients
(Coverdale et al., 1994)

4% of complaints about psychologists in Australia
(Grenyer et al., 2011)

9.4% of all charges for (UK) doctors, nurse and midwives
(Searle et al., 2017)



Types of misconduct[1] (5 most frequent) 2017-2021 (N = 538)

	LCDT (n = 94)	TDT (n = 325)	HPDT (n = 119)
Incompetent oversight/care in carrying out functions	50%	10.5%	31.1%
Misappropriating funds/pecuniary advantage	13.8%		
Negligent/misleading/forging communications	12.8%		11.8%
Criminal conviction	9.8%	22.5%	21.0%
Unethical business practices	9.8%		
Physical violence (pushing, hitting, disciplining)		38.5%	
Unprofessional communications (shouting, swearing etc)		20.3%	
Boundary violations		17.8%	21.0%
Illegal/unethical prescribing/writing certificates			13.4%

[1] more than one misconduct type can occur

Health professions are not alone in grappling with the wider problem

Legal Ethics

legal ethics

Routledge
Taylor & Francis Group

ISSN: 1460-728X (Print) 1757-8450 (Online) Journal homepage: www.tandfonline.com/journals/rlet20

The discipline of, and failure to sanction, sexual misconduct by Australian legal practitioners

Jennifer Sarah Schulz, Christine Forster & Kate Diesfeld

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Law firm partner guilty of misconduct after bad behaviour at Christmas parties

Catrin Owen

March 28, 2025 · 12:26pm

The lawyer has been found guilty of misconduct.
STUFF

Teacher's licence revoked after sexual relationship with her former student

Gabrielle McCulloch

October 31, 2022 · 2:54pm

Share

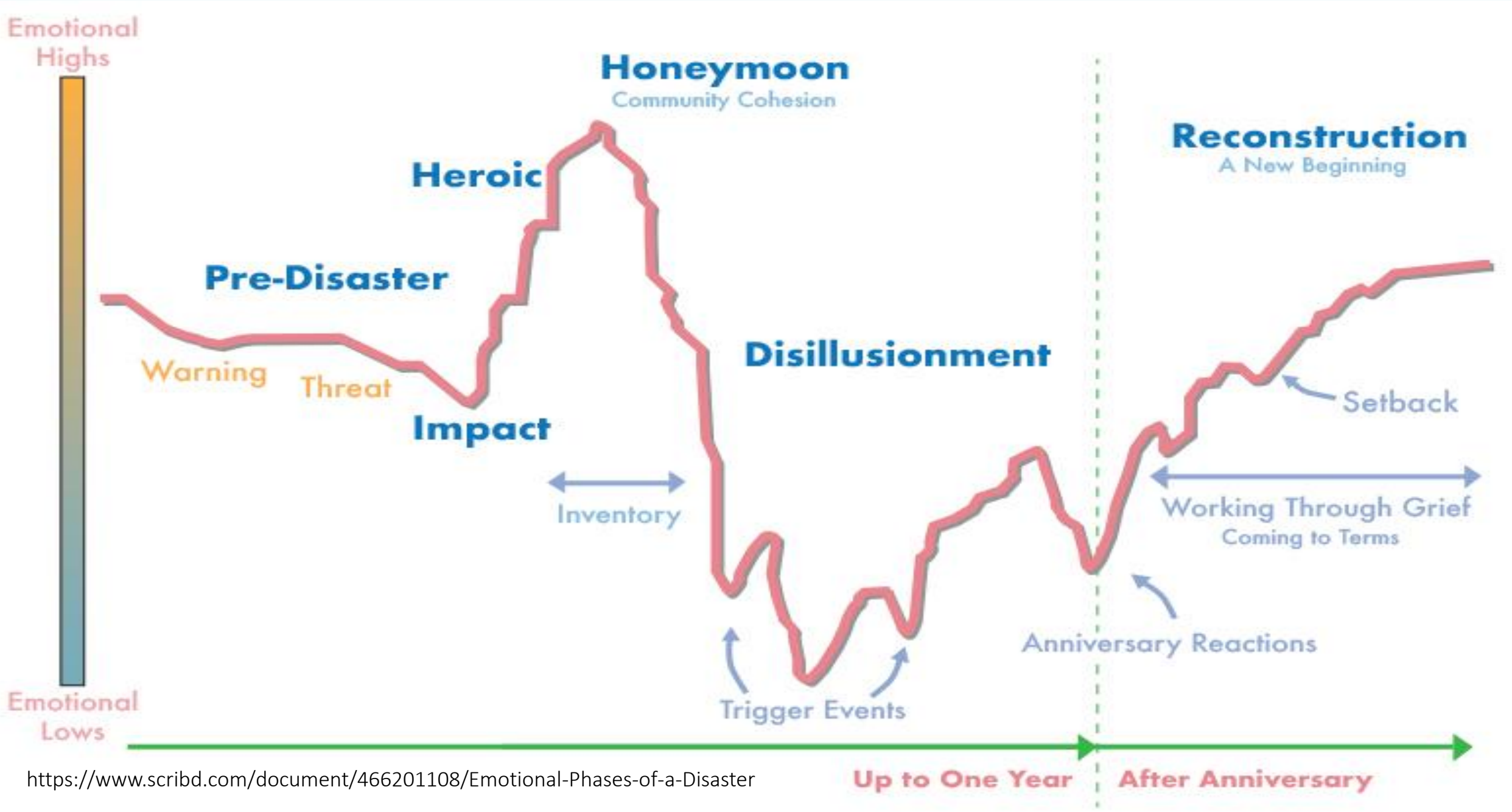
“Consensual” relationships: a different class of behaviour than sexual assault/abuse/criminal act

A complex psychological issue
A complex disciplinary issue

How so?

Under-reporting is assumed, with some particular barriers

Psychological barriers can be both practitioner and patient/client ones….



https://www.scribd.com/document/466201108/Emotional-Phases-of-a-Disaster

Barriers for reporting by practitioner colleagues…

It’s a bit awkward: Not knowing what to say, who to tell or what to do…

Isn’t it great our colleague seems so happy now….

This Photo by Unknown Author is licensed under CC BY-SA

Practitioners as “victims” (blame-shifting)

"she was a highly reprehensible individual”

“she was on the make, basically”

(McNulty et al, 2013)

Lack of understanding about the impact - might be especially true for some disciplinary/professional bodies as suggested by Schulz et al., 2022

…and as hinted at in recent discussions in the UK

The risks of ‘knowing’ but not reporting

2014 AHPRA (Australian Health Practitioner Regulation Agency): guidance on mandatory reporting obligations for the first time included definitional text on sexual misconduct (though don’t release data under the ‘sexual misconduct’ category)

Less clear in NZ (HPCA Act)

Patient barriers:

Patient in the midst of a relationship with their health practitioner resists thinking of a complaint, more or less in the same way that a betrothed person may resist thinking about divorce

(*to paraphrase Portman, 2000)*

The usual power and vulnerability differentials

Standards barriers……

Professional standards generally regarding relationships with current patients: statements vary

"Zero tolerance"

'Zero tolerance is a rigid and undifferentiated response'

"Appropriate professional standards" - without referring specifically to this issue

Professional standards also vary in regard to former patients

Ethical codes vary in their comment on this as well:

"it depends"
"only in the most unusual circumstances" (APA, 2017)
No comment

There are no objective measures of 'acceptable conditions' though this term has been used by some codes

Length of treatment is not a reliable indicator of power/impact.
(Emotional clock has a different concept of time)

American Psychological Association 2024

Former patients

Psychologists… do not engage in sexual or sexualized conduct (e.g., text messages, etc.) with former clients/patients/recipients of those services within two years of termination of services. Even after a two-year interval, psychologists are prohibited from engaging in sexual or sexualized conduct except in rare circumstances, and bear the burden of demonstrating that none of the following factors result in the client'/patients'/recipients' exploitation or vulnerability, continued power imbalance, conflict of interest, or loss of objectivity of the psychologist:

(1) the amount of time that has passed since services were terminated;
(2) the nature, duration, and intensity of the services;
(3) the circumstances of termination;
(4) the (client's) personal history;
(5) their current mental health;
(6) the likelihood of harm or adverse impact on them;
(7) any statements or actions made by the psychologist during the course of services suggesting or inviting the possibility of post termination sexual or sexualized conduct with them.

Q: would a clinician sit back and systematically work through all these issues before beginning the relationship

https://apps.apa.org/APACommentingPortal/attachments/Site125_Draft%20Revised%20Code_Final_Dec_2024.pdf
(accessed 4 August 2024)

Nursing Council NZ

Former patients

"…there is no arbitrary time limit that makes it safe''

"…must consider….

- how long the professional relationship lasted
- nature of the relationship…in terms of significant power imbalance…using previous influence
- vulnerability of the former health consumer
- whether exploiting knowledge because of previous professional relationship
- if likely to be taking care (of them) in future"

Guidelines: Professional Boundaries
NCNZ (2012)

Physiotherapy Board NZ

Former patients

”…in nearly all instances sexual contact with former patients would be regarded as unethical”

“It is acknowledged that in some instances the former patient-physiotherapist professional relationship may have been brief, minor in nature, or in the distant past. In such circumstances and where a sexual relationship has developed from social contact away from the professional environment, impropriety would not necessarily be inferred”

Code of Ethics and Professional Conduct (2018)

Medical Council NZ

Former patients

”…may be harmed by having a relationship with their former doctor”

“….it is difficult to have clear rules on when it is or is not acceptable

“…zero tolerance position…does not extend to doctor and former patients…but some circumstances when never acceptable:

- professional relationship included psychotherapy and/or long-term emotional support/counselling
- patient has condition/impairment likely to confuse their judgement
- patient has history of sexual abuse
- ending a professional relationship to initiate a sexual relationship

(silent on time issue)

(MCNZ Professional Boundaries Statement, 2018)

Some argue for discretion rather than a bright line rule in the situation of former patients/relatives of former patients

"affording too much 'protection' can deny [former] patients the right to choose their own relationships, associate freely, or even follow their hearts"

(Appel, 2023)

Academic legal debate in NZ

Professor Joanna Manning (2014)

Discipline for sexual misconduct may have relaxed because HPDT is increasingly considering mitigating and aggravating factors

Makes the argument that in some cases there is *“an apparently positive, sometimes long-lasting relationship”*

Risk factors research has tended to fall into the following broad categories

Practitioner typographies?

“Neurotic”

“Narcissistic”

(I suggest these are unhelpful depictions)

Risky fields with opportunities?

Psychiatry

General practice

O&G

Physiotherapy

Practitioner risk factors

?Age
Outpatient settings
Past transgressions of the same kind
?Gender bias

Preceding rationalizations

- “The rules don’t apply to me”
- “Look at everything I’ve already done to save this patient from suicide”

Patient risk factors

Gender
Psychological factors/symptoms/circumstances

Gender biases?

Some discussion in research that sanctions related to this type of misconduct may be influenced by **gender stereotypes**…

Women interpret boundary codes more strictly?

Men judged more severely when these boundary transgressions arise? - There is some evidence of this in transgressing teachers (Fromuth et al., 2016; Knoll, 2010)

NZ data

NEW ZEALAND HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL
TE RŌPŪ WHAKATIKA KAIMAHI HAUORA

In the relative absence of NZ research to explore these issues,
we reviewed HPDT decisions Sept 2005-Dec 2021 (>500 decisions)
N = 39 cases “Consensual” relationship misconduct

How does the disciplinary body (HPDT) evaluate these cases and justify the penalties.

Extracted decisions **where a consensual sexual relationship formed part of any formal charge**

(Excluded abuse/assaults/convictions)

Results

<7% of all decisions (n = 39)

Frequency:	Medical practitioners	34%
	Nurses	42%
	Psychologists	12%
	Physiotherapists	8%
	Midwives	4%

Male practitioners 62%/Female patients 62%

Current patients 73%

“Former” patients included some discharged within days/weeks of the relationship.

Three cases of relationships with partners of current patients

Context

Outpatient settings	92%
Mental health services (broadly defined)	65.3%

Disciplinary outcomes

Cancelled registration:	50%
Suspension (4-24 months):	30%
No suspension or cancellation:	20%
Censured	80%
Costs	100%
Fined ($500-$25,000)	31%
Conditions	73%

Case themes from 37 cases

1. Vulnerabilities when providing psychotherapeutic services
2. “Zero tolerance” but no suspension or cancelled registration
3. Risky areas for female practitioners
4. Rehabilitative conditions in all cases?

1. Vulnerabilities when providing psychotherapeutic services

Primary health settings rather than mental health service

8/Med/04/03P GP providing psychotherapy for “repressed memories”. HPDT determined that *“lacked the requisite skills and experience to undertake the counselling”*

487/Med/215P GP providing treatments for depression and substance addiction. Formally ended the patient relationship but continued to treat

2. “Zero tolerance” but no suspension or cancelled registration

Med13/258D –relationship with his patient who was another health practitioner

Name suppression but on condition that, for next 3 years, if asked by a patient if he was the practitioner who obtained this name suppression, he had to confirm this. Host of other conditions.
HPDT described his actions as *“not predatory”*
Early engagements with supports seemed to matter

“Zero tolerance” but no suspension or cancelled registration

Mid15/326D – relationship with patient’s partner. In effect, volunteered own crafted ‘suspension’ by withdrawing from practice before the Hearing.

This “time served” consideration is controversial (and not universally supported in other jurisdictions)

No suspension or cancellation:

838/Phys16/338D
Physiotherapist submitted *"she initiated it…confirmed with her …so there would be no misunderstanding…no longer seeing her in a professional capacity….she confirmed that"*

HPDT concluded still a power imbalance; who initiated it is irrelevant

Penalty took into account that he was a skilled and dedicated physiotherapist…ordered rehabilitative conditions (not to treat female patients or undertake direct contact research with female patients until completed conditions of [specified] professional development)

3. Risky area for female practitioners?

Correctional/Justice settings - Also found in USA prison settings (Rantala, 2018).

Nur05/25P – providing surgical dressing follow-up to prisoner

Psy08/84D – providing psychological follow-up to person on probation

Health practitioners working in justice settings…disproportionally women?

Case regarding “timing”

“Too soon…” said the Tribunal, but the High Court dismissed charges

Nur23/582P
Relationship with (father) inmate began 4 months after the last professional appointment with the child (and mother), albeit a follow-up appointment with child/mother was to be a year later

Preceded by the nurse accepting the mother’s offer of her husband’s building services (when out of jail)

“Immoral” and “unethical” conduct. On appeal, all charges dismissed

Summary

Regarding “consensual” relationship misconduct, rates and most frequently appearing professions concur with recent Australian research (Millbank, 2019; 8.4%). Psychologists disproportional; mental health settings disproportional

No evidence ‘on the face of it’ that men are being given more severe penalties

Permanent name suppression rates were disproportionally high (53.8%) when compared with all rates of HPDT name suppression (32%) over the same time.

Summary

Difficult area to do research: barriers to gaining information

Variable articulation of standards in the ethical codes

Variable “disruptions” to ongoing practice of the disciplined health practitioners when this form of misconduct occurs

Patients and former patients **are** harmed, as are the practitioners… inevitably

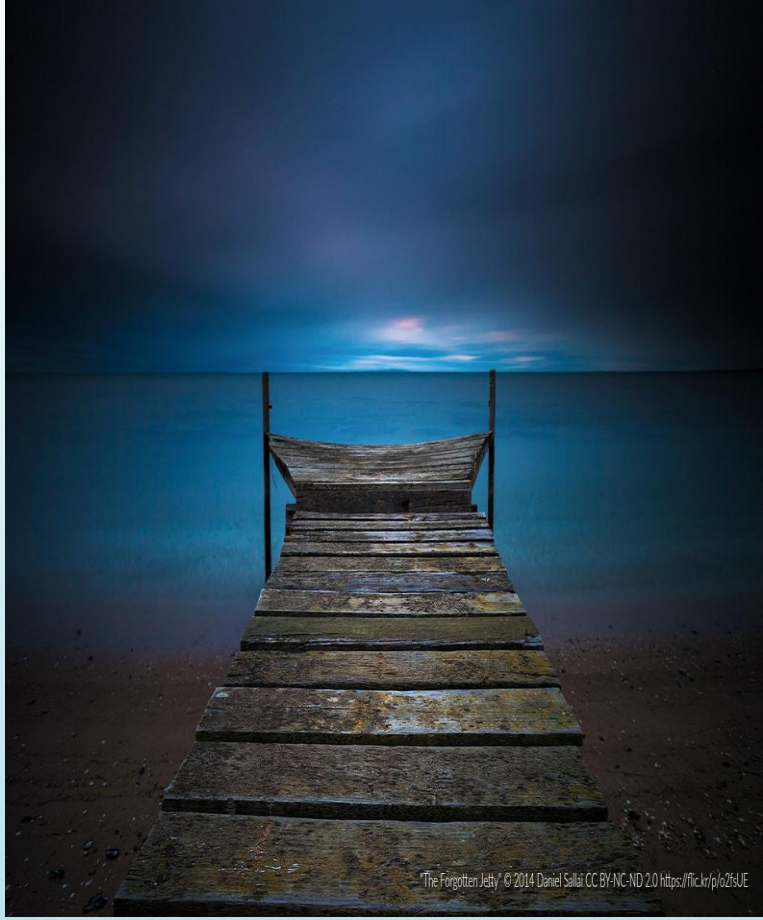
Analysis of cases helps explore where the ‘lines in the sand’ have been drawn and aid understandings (dispel myths) about any shifts in standards - as evidenced by the case law

What of the future?

Looking back on over 300 cases of this type, Gabbard (2017) concluded:

- *“doubt that much can be done to prevent this”*
- *there is “inability to predict who/when”*

though he supports ongoing efforts of professional education and strong efforts to rehabilitate most who transgress.



“given the low number of…tribunal decisions [of this type], it is possible that more interventions to prevent intimate relationships may not be necessary” *(Rietdijk & Renes, 2021, BMC Medical Ethics,22:60)*

Recent debate in UK

Sexual misconduct: UK medical practitioners tribunal service is not fit to practise

The current process for managing sexual misconduct perpetrated by doctors in the UK requires major reform, argue **Mei Nortley and colleagues**

Frances Dixon,, [1,2] Anna Louise Pouncey,, [3] Roshneen Ali,, [4] Parveen Vitish-Sharma,, [1,2] Martin Bengtzen,, [5] Mei Nortley[4,6]

BMJ 2025;390:e086867

"recent high profile cases have fuelled concerns about the consistency and adaquacy of....sanctions against doctors found guilty of sexual misconduct"

"Doctor knowingly entered into a sexual relationship with a 17-year-old, with whom he exchanged messages from the time she was as 13-year-old patient. He was suspended for 12 months"

Calls for **training and support for Disciplinary Tribunal members**

Recent debate in UK

News

Sexual misconduct of doctors: New tribunal guidance welcomed but experts say inconsistencies will remain

BMJ 2025 ; 391 doi: https://doi-org.ezproxy.otago.ac.nz/10.1136/bmj.r2105 (Published 07 October 2025)
Cite this as: *BMJ* 2025;391:r2105

But…."*We [Dixon et al] remain concerned that without formal recognition of aggravating factors like manipulation, grooming, and coercion, tribunal outcomes will remain inconsistent and overly lenient,*"

Areas for development in our own backyard too?

Clearer guidance and ethical statements needed in some instances?

Clearer statements about **this specific** class of misconduct to highlight its importance

Clearer guidance for Disciplinary Tribunal members on how to understand impacts (on patients, especially)

Insufficient cases in NZ to track significant change, emphasizing the importance of collaborating with ‘like’ jurisdictions, though this relies on misconduct data being fully reported.

Discussion and questions