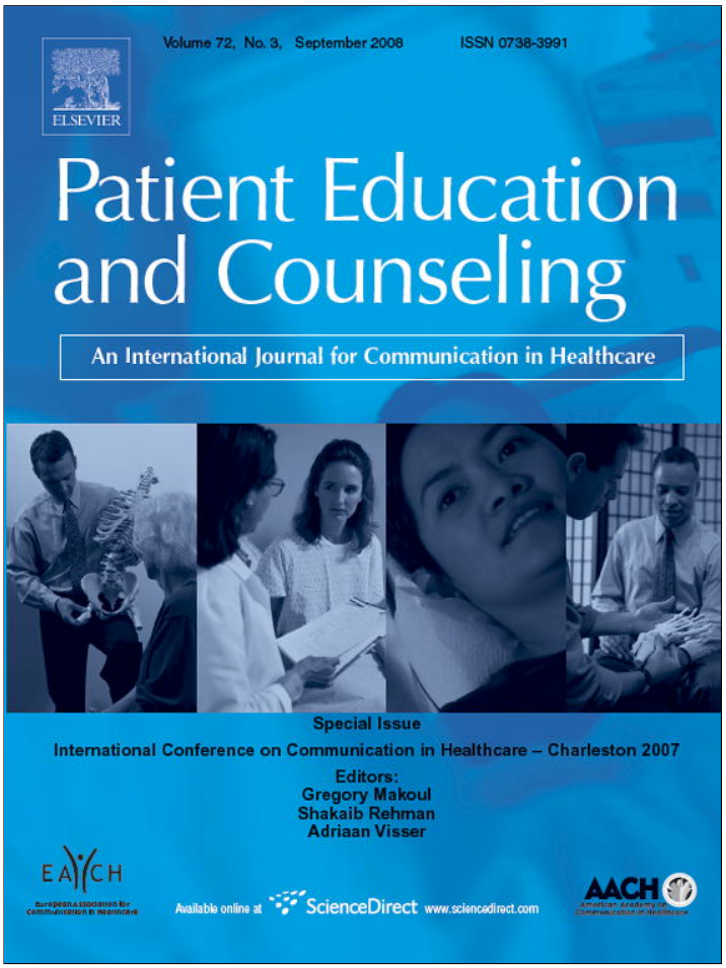

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Do patients respect the line? Transgression of boundaries reported by Swiss general practitioners

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Abstract

Objective: Transgression of boundaries in the relationship between physician and patient is commonly studied with patient as victim and physician as transgressor. A recent survey in the U.S. reported that almost 90% of physicians face transgression by patients over one year. Incidents happened mainly through verbal abuse, disregarding privacy, and overly affectionate behavior. Since this incidence seems to be alarmingly high, we were interested to analyze how often general practitioners in Switzerland experience transgression by patients.
Methods: 24% of the members of the Swiss Society of Internal Medicine (SGIM) and of the Swiss Society of General Medicine (SGAM) (n = 675/2781) responded to an internet-based survey which asked for experiences of transgression by patients and for physicians' responses to transgression in the last 12 months.
Results: 81% of responding physicians experienced transgression over the period of one year. Analyzing the frequency of incidents per physician per year, the most common forms of transgression were 'use of physician's first name' (7.7/y), 'asking personal questions' (1.8/y), 'being verbally abusive' (1.5/y), and 'being overly affectionate' (1.4/y). Calculated incidence of transgression was 3 per 1000 patient contacts. 39% of physicians decided to ignore the incident, 37% discussed the event openly. Transgression led to dismissal of patients in 13% of events.
Conclusion: Transgression even in mild and modest form is a rare phenomenon in Swiss practices.
Practice implication: The Swiss data do not suggest that there is a specific risk for Swiss practitioners to be exposed to major transgression for which they should specifically be prepared for example in communication skills trainings.
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Keywords: Transgression; Patient-centered communication; Physician–patient relationship; Professional health care attitudes

1. Introduction

Transgression in the physician–patient relationship defined as disrespect for professional boundaries has focused mainly on the patient as the potential victim. Previous literature on transgression describes incidence related to physicians' failure to maintain appropriate boundaries with patients [1–3]. Less is known about the frequency of patients' transgressing behavior and its subsequent impact on physicians. Following results of a recent analysis among member of the American Society of General Internal Medicine, a significant number of physicians encountered transgression by patients over a one year period: 43% of physicians surveyed verbally abusive patients; 39% faced inappropriate personal questions, and 31% met overly affectionate behavior. Moreover, patients attempted to socialize inappropriately with 27% of physicians [4]. Overall, 89% of physicians reported experiencing some type of transgression.

Interestingly, up to 30% of physicians chose to ignore the most significant transgression they had encountered, and they dismissed transgressive patients in only 11%. Similar results on transgression were found in Canada, where verbal sexual harassment was experienced by 44% of female general internists and by 20% of their male colleagues [5]. The high incidence in women points to a possibility of a rise of transgression in the future, since the proportion of female physicians is steadily rising in the U.S. and Europe [6–8]. Additionally, female physicians more likely invite patients to

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take over the role of active partners in medical care than their male counterparts [9,10].

There has also been a far-reaching shift in the patient–physician relationship that might foster transgression. Taking care for a patient is nowadays increasingly embedded in an egalitarian model of health care; physician and patient are considered partners [11]. If patients misunderstand this invitation to embark upon a partnership-like professional relationship, the risk to violation of boundaries between physician and patient could rise.

This study was undertaken to investigate the incidence of different types of transgression by polling General Practitioners and Internists in Switzerland via an internet-based survey. We further evaluated physician's reactions toward events of transgression. Since transgression by a patient is primarily based on physicians' perceptions of the situational context, we did not include any patient characteristics; nor did we question the validity of physicians' reports.

2. Methods

2.1. Participants and questionnaires

We contacted 2781 German speaking members of the Swiss Society of Internal Medicine (SGIM) and of the Swiss Society of General Medicine (SGAM) by e-mail in May 2004. Four weeks after the initial e-mail, members received a single reminder about the study. We used an Internet version of an already available and validated questionnaire in which participants could mark incidence of nine different types of transgression that occurred during the last 12 months [4]. We decided to use this already tested questionnaire because we were interested in comparing our results to data of Canadian and U.S. physicians.

To compare our sample to general characteristics of included associations, we analyzed demographic data of the Swiss Society of Internal Medicine (SGIM). Gender distribution in our sample mirrored the SGIM data with 79% male members. SGIM members are slightly older with 53 years (±13S.D.) than physicians in our survey (49 ± 8S.D. years).

The following categories of transgression were offered: (a) being overly affectionate, (b) using sexually explicit language, (c) attempting or engaging in sexual contact, (d) attempting to socialize, (e) using the physician's first name, (f) attempting to give expensive gifts, (g) asking the physician personal questions, (h) being verbally abusive, (i) being physically abusive. Additional types of transgression could be listed in a free text section. We further asked if physicians had responded to transgression by (a) discussion with patient, (b) ignoring event, (c) talked to a colleague, (d) got help from a third party, (e) dismissal of patient, or (f) other. Participants provided socio-demographic data and data on their professional background. Reports were treated confidentially.

2.2. Statistics

We used SPSS, version 12ff for Windows, for our analysis. Data of mode of transgression were used in absolute frequency and were recoded to yield categorical variables (0 = never, 1 = at least once) for relative frequency. The range of frequency accepted for the category 'using the physician's first name' was limited to 500 incidents to downsize counts of five physicians who reported up to 10,000 events. In order to reduce the number of multiple comparisons on item level single items on type of transgression and reactions to it, categories were grouped into larger dimensions using factor analysis (Principal component analysis (PCA) with Varimax-rotation).

Relationship between socio-demographic variables and practice characteristics and incidence of transgression and reactions to it was analyzed using one-way ANOVA and correlation analysis in a first step. Multivariate analyses testing simultaneously all predictor candidates emerging from the bivariate analysis were performed in a second step using multiple linear and logistic regressions. For all analyses $p < 0.05$ (two-tailed) was considered significant.

3. Results

3.1. Demographic characteristics

675 of the 2781 physicians (24%) responded to the Internet survey. The socio-demographic characteristics of participating physicians are shown in Table 1. Physicians were on average 49 years old, about 80% were male, and the majority was married. 45% of the respondents practiced in urban settings, 31% in a rural place, and 24% in a suburban area. Three out of four physicians worked full time in practice; respondents spent on average 75% of their working time treating patients.

3.2. Types and frequencies of transgression

Absolute, relative frequency and frequency of transgression per physician per year are shown in Table 2. The most common

Table 1
Demographic and practice characteristics ($n = 675$)

Gender	
Female (%)	130 (19)
Male (%)	545 (81)
Mean age (±S.D.)	49 ± 8
Mean years of profession (±S.D.)	21 ± 8
% of time spent in treating patients (±S.D.)	75.0 ± 20
Marital status *n* (%)	
Married	559 (83)
Divorced	28 (4)
Single	22 (3)
With partner	65 (10)
Practice local *n* (%)	
Urban	305 (45)
Suburban	160 (24)
Rural	209 (31)
Working schedule *n* (%)	
Full time in practice	502 (75)
Part time in practice	101 (15)
Other	71 (11)

Table 2
Absolute, relative frequency, and frequency per physician of reported transgression during 12 months per category

Mode of transgression	Absolute frequency	Relative frequency (%)	Frequency per physician (±S.D.)
(a) Being overly affectionate	913	39	1.4 ± 3.9
(b) Using sexually explicit language	259	16	4 ± 1.4
(c) Attempting or engaging in sexual contact	51	5	0.07 ± 0.48
(d) Attempting to socialize	732	41	1.1 ± 4.4
(e) Using the physician's first name	5124	33	7.7 ± 52.7
(f) Attempting to give expensive gifts	231	19	0.3 ± 1.2
(g) Asking the physician personal questions	1191	43	1.8 ± 5.3
(h) Being verbally abusive,	1030	45	1.5 ± 4.9
(i) Being physically abusive	38	4	0.06 ± 0.3

Table 3
Factor loadings: bold numbers refer to the variables retained for the construction of the factors minor transgression, sexual transgression, violent transgression

Mode of transgression	Factor 1: minor TG	Factor 2: sexual TG	Factor 3: violent TG
(a) Being overly affectionate	**0.57**	(0.34)	
(b) Using sexually explicit language		**0.69**	
(c) Attempting or engaging in sexual contact		**0.83**	
(d) Attempting to socialize	**0.74**		
(e) Using the physician's first name	**0.43**		
(f) Attempting to give expensive gifts	**0.62**		
(g) Asking the physician personal questions	**0.58**	(0.34)	
(h) Being verbally abusive,			**0.62**
(i) Being physically abusive			**0.85**

type of transgression in absolute frequency was 'using the physician's first name' ($n = 5124$), followed by 'asking personal questions' ($n = 1191$), and 'verbally abusive' ($n = 1030$). Considering relative frequencies, verbally abusive behavior was most common (45%) followed by personal questions (43%), and attempts to socialize (42%). Serious forms of transgression like physical abuse or attempted sexual contact were rarely reported (4 and 5%, $n = 38$ and 51, respectively).

Analyzing the number of incidents per year, physicians most commonly reported to be approached by patients using their first name (7.7/y). They further were asked inappropriate personal questions 1.8 times per year. They met verbally abusive patients 1.5 times per year and overly affectionate patients 1.4 times per year. 37% of participating subjects had experienced one or two types of transgression, 29% three to four and 15% of respondents had experienced five and more incidents. Overall, 123 respondents (19%) noted no experience of transgression in the preceding 12 months.

Categories of transgression were subjected to a factor analysis to analyze frequency of physician responses to transgression and to relate transgression to psychosocial characteristics. This resulted in a 3-factor solution explaining 51% of variance. A first factor with the categories (a), (d), (e), (f), and (g) summarizing less severe types of transgression was called ''minor transgression''. Factor 2 with category (b) and (c) combined ways of ''sexual transgression''; the third factor with category (h) and (i) was summarized as ''violent transgression.'' For factor loadings see Table 3.

3.3. Response to transgression

Data for analysis of physicians' response to transgression were gathered from 546 physicians who had experienced at least one event in the last 12 month. Most physicians decided to ignore the incident (39%). Almost the same amount of respondents (37%) chose to openly discuss the incidence with the patient. 21% talked about the event with a colleague or supervisor. Only 4 percent chose to call for assistance to address the situation. Transgression led to dismissal of the patient in 72 cases (13%).

Grouping the five response items by factor analysis led to a 2-factor solution with 56% of variance explained. The first factor with the items (a) and (b) (negative) was called ''communicating'' while the second with the items (c), (d), and (e) was called ''acting''. For factor loadings see Table 4.

3.4. Relations of transgression to socio-demographic variables

3.4.1. Type of transgression

According to socio-demographic parameters, possible differences in transgression modes analyzed on bivariate and multivariate level by linear regression showed that less transgression was experienced in married physicians and in physicians who have worked for more than 15 years in practice. However, prevalence of transgression was higher in full time workers. Age and gender had no statistically significant influence on the total number of transgression events.

The following significant results were found when the three transgression factors ('minor', 'sexual', and 'violent') were

Table 4
Percentage of physicians' reaction to transgression and factor loadings for the construction of the factors communicating with patients, taking action

Item	Mean (% reaction to TG)	Factor 1: communicating	Factor 2: acting
(a) Discuss transgression with the patient	37	0.89	
(b) Ignore the incident	39	−0.81	
(c) Talk about incident with colleagues/superiors	21		0.62
(d) Call assistance (nurse, security, etc.)	4		0.69
(e) Dismiss the patient from my practice	13		0.60

Table 5a
Percentage of physicians reporting transgression (TG) in the last 12 months by gender

Mode of transgression	Female physicians	Male physicians	Sig.
(a) Being overly affectionate	45	38	ns
(b) Using sexually explicit language	17	16	ns
(c) Attempting or engaging in sexual contact	2	6	ns
(d) Attempting to socialize	42	41	ns
(e) Using the physician's first name	34	33	ns
(f) Attempting to give expensive gifts	18	19	ns
(g) Asking the physician personal questions	45	43	ns
(h) Being verbally abusive,	39	46	ns
(i) Being physically abusive	1	5	*
Factor 1: minor TG	0.09	−0.02	ns
Factor 2: sexual TG	−0.05	0.01	ns
Factor 3: violent TG	−0.17	0.04	*

ns: not significant, $^{*}p < 0.05$, $^{**}p < 0.01$, $^{***}p < 0.001$ (all two tailed).

analyzed: minor transgression was more frequent in non-married and full time working physicians. Sexual transgression was more frequent in urban practices while violent transgression was more frequent in male physicians and less likely in older or part-time working physicians. Socio-demographic and practice characteristics of participating physicians had only minor impact upon transgression events since R^2 reached only values between 1% and 4%. Table 5a gives a detailed overview of gender effects upon transgression. Gender of physician did not matter except for the rare case of violent transgression.

3.4.2. Response to transgression

On the level of the response-factors, *communicating* (discussion, not ignoring) was more frequent in physicians working part-time, while all other parameters showed no significant multivariate influence. *Acting* (talking to colleagues, dismissal of patient, calling for support) was more frequent in younger physicians and those working in urban areas. Again, models reached only 2–3% of variance explained.

Table 5b
Percentage of physicians' responses to transgression by gender

Item	Female physicians	Male physicians	Sig.
(a) Discuss transgression with the patient	30	39	ns
(b) Ignore the incident	44	38	ns
(c) Talk about incident with colleagues/superiors	28	19	*
(d) Call assistance (nurse, security, etc.)	4	4	ns
(e) Dismiss the patient from my practice	13	13	ns
Factor 1: communicating	−0.13	0.03	ns
Factor 2: acting	0.09	−0.02	ns

ns: not significant, $^{*}p < 0.05$, $^{**}p < 0.01$, $^{***}p < 0.001$ (all two tailed).

As reported above, gender had neither an influence upon factors relating to the type of transgression nor on factors built from modes of reactions to over-stepping patients. There was only one single item where gender mattered: Female physicians reported significantly more often than males to discuss an incident of transgression with a colleague ($[F(1,454) = 4.04$, $p < 0.05]$, see also Table 5b).

4. Discussion and conclusion

4.1. Discussion

Eight of ten physicians in our sample reported to have experienced transgressions in the previous year. The most common types of transgression were minor forms, consisting of patients using physicians' first name and acting in a verbally abusive or overly affectionate behavior. Severe forms of transgression were rare and less frequent than in U.S. and Canadian samples reported [4,5].

The fact that only 19% of the physicians who responded to our survey practiced without facing transgression seems potentially alarming. However, the type of transgression that most physicians met was a minor transgression. The category most commonly reported was 'use of first name' with approximately 8 events per year. Using the first name within a professional relationship is quite common in Switzerland and should be interpreted as a very mild variant of a transgression. This was mirrored by comments of practitioners who responded to our survey with the comment that being addressed by their first name is a sign of a good working alliance between patient and physician. Besides this equivocal form of transgression, remaining categories of transgression were barely experienced twice a year.

Additionally, the impact of reported incidents seems to be insignificant when one compares the number of reported incidents with the absolute number of patients seen by an average Internist or GP per year. The mean of all reported transgression events in our sample was 14.4 (±74.6S.D.) for a 12 months observation period. If one assumes that physicians see on the average 20 patients per day in around 46 work weeks per year (data provided by SGIM), this mean has to be viewed against a background of 4600 patient contacts per year. Hence, the likelihood of experiencing an incident of transgression is 0.3% on average per year. Still, if one assumes that at least some events of transgression are difficult to handle for the physician there is a need for an improvement of physicians' ability to handle these problem situations. From our data it appears that two thirds are not practicing what one would advise them to do: talk about it with your patient!

A major limitation of the study is the low response rate of 24%. As we have only limited information on non-responding physicians we cannot rule out that results are biased. The fact that the U.S. survey succeeded in a response of nearly 40% by 'good old' mailing may show limits of an internet-based survey as unrequested e-mail generally tend to be put in a garbage/spam folder.

Another limitation of our study may be the fact that we did not study patient characteristics. Nonetheless, we were mainly interested in physicians' personal perception of patients' behavior and in the way they chose to address it. Whether or not an external observer would deem certain behaviors as overstepping or not, was not the focus of this study.

One of the most striking finding for us was the low percentage of physicians (37%) who reacted by openly discussing the incident with the patient. Since transgression rarely lead to dismissal of patients, discussing a transgression could offer a chance to clear the air especially for an ongoing and prospective relationship. Avoidance by physicians could be due to the somewhat unrealistic assumption that being ''patient centered'' means always agreeing with patient's requests and being accepting of all manner of patient behavior. Empirically this does not seem to be the case as data show that patients' expectations are not always met [11,12]. Another explanation is the lack of proper training how to deal with transgressing patients. If a future survey would demonstrate an increase in the numbers of these adverse events, appropriate modules should be included in the training of GP's.

4.2. Conclusion

Swiss general practitioners rarely face transgressions by patients over the period of one year. Most forms of transgressions are minor and lead to dismissal in 13 percent of patients. However physicians' response to events of transgression need improvement: Only 37% of physicians had openly discussed transgression with their patient, the majority had simply ignored the event.

4.3. Practice implication

Contrary to the US data that highlighted the potential harm of a patient-centered communication style our data do not suggest that this is the case on a large scale.

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Conflict of interest

All authors declare no financial, personal or other relationship with other people or organizations within three years of beginning the submitted work that could inappropriately influence, or be perceived to influence, their work.

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