

Patients who stalk doctors: their motives and management

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THERE IS PERSUASIVE anecdotal evidence that healthcare professionals have a heightened vulnerability to being stalked by their patients. This is supported by an overrepresentation of healthcare professionals in stalking-victim populations.¹ Some stalking behaviours constitute little more than minor irritations, but more serious cases can ruin a clinician's career. Rarely, but tragically, stalking has cost some doctors their lives.

Stalking refers to a constellation of behaviours encompassing repeated and persistent attempts to impose unwanted communications or contact upon another. While legal definitions of stalking do not specify time periods, it is increasingly apparent that harassing behaviours extending beyond two weeks constitute clinically significant stalking.² The behaviours include telephone calls, letters, email, unsolicited gifts, following, maintaining surveillance, making complaints of professional misconduct or initiating spurious legal action against the victim, ordering or cancelling goods or services on the victim's behalf, property damage, threats, and physical or sexual violence. Stalking has emerged as a significant social problem³ and now constitutes a specific criminal offence in many jurisdictions. Although the past decade has seen a virtual explosion of interest in this phenomenon, only in recent years has stalking begun to pique the interest of the medical profession. This attention relates in part to the observation that stalking behaviours are becoming more prolific³ and may be amenable to clinical intervention.⁴

Although the extent of the problem has yet to be quantified, it is timely to highlight pertinent issues relating to the stalking of medical practitioners by their patients. We searched the *Index Medicus/MEDLINE* and *PsycLIT* databases for articles pertaining to stalking and related behaviours perpetrated against medical practitioners by their patients, and we review the literature in this article. We also present strategies that can be used to discourage a patient's intrusions and minimise the impact of these behaviours on clinicians' professional and personal lives. Because there is a lack of empirical data on the efficacy of specific interventions, these management strategies are based on our experience of assessing and treating stalkers and their healthcare practitioner victims during the past decade.

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ABSTRACT

- The prevalence of stalking is increasing and healthcare professionals are overrepresented among stalking victims.
- The most common motivations for stalking are patients' developing a romantic attachment, due to delusional beliefs (as in erotomania) or misplaced expectations (often by socially inept patients), and patients' developing a resentment for some supposed injury.
- Strategies to prevent victimisation and minimise the impact of stalking include:
 - taking care to preserve privacy and security,
 - making clear to patients that the relationship will always be professional and what the boundaries are,
 - informing colleagues and other relevant parties,
 - transferring the patient's care to another doctor, and
 - considering legal action.

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Harassment and stalking in healthcare settings

Workplaces can be risky environments, as burgeoning reports of violence, bullying and sexual harassment attest.⁵ Clinicians cannot claim immunity from these abuses.⁶⁻⁸ One survey of 850 forensic psychiatrists found that 42% of the 480 respondents had been harassed in some way by patients:⁹ 17% reported threats of physical harm, 13% reported non-violent threats (such as a lawsuit), and 3% had been physically assaulted. A study documenting the nature of threats to clinicians¹⁰ observed that intimidation could continue after the patient's discharge from inpatient care.

Clinicians attending the 1994 annual meeting of the Oregon Psychiatric Society were surveyed about stalking.¹¹ Twenty-six of the 90 respondents had been subjected to behaviours that met the authors' definition of stalking, and 37 reported other forms of distressing intrusions. In Australia, healthcare professionals were overrepresented in a sample of 100 self-referred stalking victims (nine general practitioners, three psychiatrists, two gynaecologists, one rheumatologist, a medical resident, a psychologist, a nurse and an occupational therapist).¹

The vulnerability of medical practitioners to the unwanted intrusions of their patients is one legacy of a profession that comes into regular contact with lonely and disordered people. In some of these individuals, "sympathy and attention is easily reconstructed as romantic interest".¹² Despite this, little systematic research has been conducted on the abnormal attachments of patients to their doctors, and it is likely many incidents of stalking remain unreported.

This paucity of research relates in part to the nature of the profession. The authors of one study suggest that some staff may not have reported stalking behaviours because “denial and minimisation are common reactions to being the target of patients’ aggressive behaviour”.¹³ Denial enables clinicians to ignore threats and continue their work.¹⁰ Some doctors may fear that their victimisation will be equated with incompetence, or, in the current climate of sexual misconduct allegations, that their complaints of harassment will be met with scepticism. In popular depictions of doctor–patient liaisons, the emphasis is usually on the doctor exploiting the patient, with an implication that the imbalance in power precludes the patient from victimising the doctor.⁸ Resistance within the criminal justice system to prosecuting patients, especially when the patient is mentally ill,¹⁰ may also discourage reporting.

Patients who stalk

Stalking behaviours are the product of a number of different motivations and states of mind.¹⁴ The two most common motivations for stalking clinicians are:

- Patients’ developing romantic or child-like attachments that lead them to entertain hopes of a relationship. These hopes may arise on the basis of delusional beliefs (as in erotomania, a false conviction that one is loved by another), misplaced expectations in the lonely and desperate, or simply the unrealistic expectations of a would-be suitor. The last group is typically drawn from the socially incompetent or narcissistically self-absorbed.
- Patients’ developing a resentment against the professional, usually connected to some supposed injury or dereliction.

It has long been recognised that patients may transfer feelings of love or hate to their therapist as a consequence of the treatment situation and early experiences, a phenomenon known as transference.¹⁵ However, transference explanations for patients’ misplaced affections or anger foster in healthcare professionals an unhelpful sense of responsibility that can lead to feelings of guilt. They also foster the counterproductive assumption that the stalking and harassment can be managed within the doctor–patient interaction.

The impact of stalking on healthcare professionals

In one report, the authors noted that the harassing behaviours of their subjects had a disruptive impact on hospital staff, and consequently the functioning of the hospital.¹³ Staff became more vigilant and modified aspects of their work practices and lifestyle to ensure their safety. Some even changed their place of residence.

Another study also highlighted the disruption created in the professional and personal lives of physicians who experienced threats.¹⁰ Examples included modifying their treatment style or refusing certain referrals, reducing their practice size, and placing restrictions on family activities. Some expressed guilt for the intense family stress that resulted. Many of the doctors who participated in the

Anti-stalking strategies

- Don’t disclose personal details to patients.
- Don’t leave personal information where patients can access it.
- Don’t give home contact details to professional organisations that allow public access to the information.
- Beware of confidentiality and privacy issues associated with electronic patient data.
- Consider security measures: obtain an unlisted home phone number and post office box address; install deadlocks, window locks, peepholes and exterior motion sensor lights; trim trees and shrubbery.
- Ensure patients understand your relationship is a professional one and will never be otherwise.
- If concerned about a patient’s intrusions, set limits on proximity-seeking behaviours and ensure the patient is seen only when other people are nearby.
- Carefully document the patient’s intrusions.
- Retain all evidence of stalking.
- Inform a colleague and other parties as appropriate, including medical defence organisation.
- If unwanted contact or communication persists, discontinue the patient’s care and refer to another practitioner.
- If the patient poses an immediate risk to the practitioner or third parties, consider civil commitment (if mentally ill) or prosecution.

Australian survey¹ said that nothing in their medical training had prepared them for this and they had emerged feeling frustrated, helpless and disenchanted with their profession.

Management strategies

Many doctors have, or feel they are expected to have, a high tolerance for the criminal behaviour of patients, even when it induces fear and disrupts the lives of practitioners and their families. We believe such tolerance is misplaced, both in terms of the clinician’s health and the patient’s long term interests. The following strategies (summarised in the Box) can be used to discourage a patient’s unwanted intrusions and to minimise their impact on all concerned.

The first threat or declaration of love

Stalking behaviours can emerge gradually out of apparently appropriate behaviours, such as attending more frequently at the doctor’s rooms, phoning ostensibly for clarification of some aspect of treatment, or “chance” encounters outside of the work context. Alternatively, they may have a sudden onset, heralded, for example, by a declaration of love. Clinicians often respond awkwardly to these sudden declarations, giving polite disclaimers of interest on the basis of the professional nature of the relationship. All too often this results in patients’ discharging themselves from the practice and returning, hopeful that now all obstacles have been removed. Worse still, the clinician may suggest an intimate relationship is precluded on the basis that they already have a partner. The patient might hear this as, say, “I would be interested but for my wife”, with potentially dangerous repercussions.

Stalking behaviours will be more readily recognised and their emergence may be subdued when clinicians set clear boundaries for appropriate behaviour in their patients.¹⁶ It is important to state that their relationship is, and will only ever be, a professional one. While this message should be firm and unequivocal, the clinician must endeavour to preserve the patient's dignity, lest they give the patient further reasons, particularly anger and resentment, to continue their harassment.

The early stages of stalking

It is reasonable to confront the patient and set limits by restricting the duration and frequency of appointments and any other behaviours that are aimed at maximising contact with the doctor. However, this approach has most chance of succeeding with the socially incompetent would-be suitor. Stalkers driven by morbid infatuation or resentment seldom respond to these measures alone.

If a patient's intrusions continue despite the clinician's warnings, particularly when the behaviour persists beyond two weeks, there is a substantial risk of protracted harassment.² In these circumstances, the clinician is ill-advised to continue the therapeutic relationship and should resist any temptation to engage in endless debates and negotiations. Ongoing communication will only reward the patient's efforts to maintain contact. However, transferring such patients can be difficult,¹¹ both because of medicolegal abandonment implications and because prospective physicians may be understandably wary of accepting them. It is essential to document the termination process. In some instances it may be necessary to defuse the situation by hospitalising the patient.

It is essential that the clinician carefully document each incident, noting the time and date, a synopsis of the behaviour and the names of any witnesses. These records should be kept in a secure place, as they can be invaluable in any future legal proceedings. The victim should also retain any concrete evidence of the stalking, such as answering machine messages, gifts and letters. Correspondence should not be returned, as this perpetuates contact between victim and stalker and vital evidence is lost.

Affected professionals should not suffer in silence. They should inform a trusted colleague and discuss the case with a psychiatrist familiar with these issues. Other staff at the doctor's practice, particularly receptionists, must be apprised so that they do not inadvertently countenance the patient's pursuit and to enable them to adopt personal safety precautions. Spouses and other family members should be informed for similar reasons.

Established stalking

Stalking is a criminal offence and cases that do not respond to the above measures warrant a police report. This is particularly important when stalking involves threats or violence, or where there is a known history of sexual or physical aggression. Morbidly infatuated stalkers generally have a low incidence of threatening and violent behaviour,

and, although resentful stalkers often issue threats, they seldom proceed to actual personal violence.¹⁴ Nevertheless, threats should never be disregarded, particularly in a stalking context, and the clinician must take precautions to ensure his or her personal safety and the safety of others who may be at risk. If the stalker threatens to initiate spurious legal action against the practitioner, or there is a likelihood of future action, the doctor's medical defence organisation should be alerted.

Restraining orders or protective injunctions are frequently advised in stalking situations, but are not universally effective.¹² Erotomanic patients are likely to be impervious to legal sanctions, although these are often useful in dissuading the socially incompetent and less entrenched resentful stalkers. Erotomanic stalking patterns will not subside without definitive treatment, and referral for psychiatric evaluation is a priority.

It must be stressed that any escalation in stalking behaviours, particularly when it involves threats and overt hostility, should not be ignored or "worked through" in therapy. Threats are indications to seek advice. If a patient poses an immediate risk of harm to the therapist, he or she may require civil commitment or, for patients who are not mentally ill, prosecution under anti-stalking statutes.¹⁷

Preventive strategies

It is crucial that medical practitioners take steps to protect their privacy. They should be cautious about disclosing personal details to patients or leaving personal information where patients can access it, and avoid divulging home contact details to professional organisations or registries that appear in the public domain. With the introduction of electronic patient data, clinicians need to be familiar with the associated confidentiality and privacy issues.¹⁸

Office security is a priority in any medical rooms.⁹ Clinicians who practise in relative isolation without the support staff available in group practices or hospital outpatient departments are precariously placed to manage patients with a history of stalking or other threatening behaviours. It is wise to arrange a chaperone for physical examinations and, if the patient objects, to document this in the medical file. A doctor who is concerned about possible stalking behaviours by a patient should at the very least endeavour to see the patient when other staff are nearby.¹⁹

Conclusions

In studying stalking, we are constantly seeking more effective ways of identifying and protecting the victims. At a time when healthcare resources are a widespread concern, phenomena with the potential to end medical careers cannot be ignored. Studies to date indicate that stalking of medical practitioners occurs with sufficient frequency to warrant systematic attention. Research is currently in progress to empirically measure the extent of the problem in the medical profession. Future research efforts should be directed to developing specific management strategies and formulating workplace policies. Greater emphasis must be placed on

