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Calling Dr. Love: The Physician-Patient Sexual Relationship as Grounds for Medical Malpractice - Society Pays While the Doctor and Patient Play

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“CALLING DR. LOVE”: THE PHYSICIAN-PATIENT SEXUAL
RELATIONSHIP AS GROUNDS FOR MEDICAL MALPRACTICE
- SOCIETY PAYS WHILE THE DOCTOR AND PATIENT PLAY

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I. INTRODUCTION

Sex. A simple word encapsulating a plethora of emotions. By now everyone is familiar with the President Clinton-Monica Lewinsky scandal, or ZipperGate as it is more affectionately labeled by the press. The President was caught literally “with his pants down” in a series of indiscreet sexual encounters with a young, female intern. The scandal rocked his administration and nearly cost him his job. The average citizen was left questioning his motives and lack of judgment. The *Wall Street Journal* even contemplated whether President Clinton might be a “sex addict.”¹ Had the President unscrupulously used his power and influence for sexual gain? Or did he simply succumb to the wily charms of a youthful nymphet? These are questions to which no one (other than the affected parties) knows the answer. The ramifications of his boorish behavior, however, are unfortunately shared by the American public. The sanctity and prestige of the Presidential office may never recover. Future generations may be forced to examine a candidate’s sexual peccadilloes along with his or her political proposals. But one thing is very clear.

¹Sally Satel, *Is Clinton Out of Control?*, WALL ST. J., Sept. 21, 1998, at A28. Dr. Jennifer P. Schneider lists three key factors for determining sex addiction. These factors include (1) preoccupation with sex, (2) frequent engagement in sex, and (3) continuation of sex despite recurrent problems caused by it. Sex addiction, which is not recognized as a medical term by the American Psychiatric Association, may just be another example of society looking for an excuse to justify morally unacceptable behavior. *Id.*

Sex, in the wrong place, or at the wrong time, or even with the wrong person, can have serious, serious consequences. Nothing about sex is simple.

This note examines “consensual” sexual relationships between non-mental health physicians and patients.² More specifically, it examines whether such relationships ever amount to medical malpractice. Generally, a non-mental health physician would be liable under the rubric of medical malpractice only if the sexual relationship was commenced under the guise of “medical treatment.”³ Recent cases, however, have expanded liability in certain circumstances when the physician-patient relationship has involved “counseling matters.” “Counseling matters” describes talking to patients about their feelings, or discussing personal problems not necessarily related to their proposed treatment. Medical treatment supplemented by “counseling” purportedly requires greater scrutiny due to the higher levels of trust and confidence necessary to protect the patients’ interests.⁴ These cases adopt the more rigorous legal approach applied to mental health physicians. Mental health physicians (psychologists and psychiatrists) have routinely been held liable for medical malpractice based on sexual relationships with their patients. This liability arises out of mishandling the “transference phenomenon.”⁵

The “transference phenomenon,” a Freudian discovery⁶, involves the creation of a father-son, mother-daughter relationship between the doctor and patient which is ultimately necessary to promote psychological healing.⁷ Patients who experience such a phenomenon tend to be sexually vulnerable to their therapists.⁸ Sexual contact with a patient, therefore, may cause irreparable harm to the patient’s psyche.⁹ A good psychiatrist/ psychologist will avoid acting on this vulnerability and apply techniques to lessen it.¹⁰ A bad psychiatrist/ psychologist will initiate a sexual

²Compare Victoria J. Swenson, *A Proposal for Texas Re: Non-Psychiatric Physicians Who Engage in Sexual Conduct with Their Patients*, 19 T. MARSHALL L. REV. 269 (1994). Swenson states “a ‘voluntary’ relationship is suspect because it presumes that the patient is capable of giving an ‘informed consent.’ Given the asymmetric nature of the relationship, it is doubtful that this can occur.” *Id.* at 270 n.5.

³See, e.g., *Atienza v. Taub*, 239 Cal. Rptr. 454, 457 (Ct. App. 1987).

⁴See, e.g., *McCracken v. Walls-Kaufman*, 717 A.2d 346, 1998 WL 574763 (D.C. 1998).

⁵See, e.g., *Simmons v. United States*, 805 F.2d 1363,1365 (9th Cir. 1986).

⁶Michael Waldholz, *Thinkers Who Shaped the Century - Head Doctor: Doubted and Resisted, Freud’s Daring Map of the Mind Endures*, WALL ST. J., Dec. 2, 1991, at A1. Freud discovered transference when treating a young woman who displayed intense hostility and anger towards him. Freud realized these emotions were not related to his conduct, but instead reflected her attitudes about her father and men in general. Through the transference process the “patient unconsciously begins to repeat troublesome behaviors from childhood with the therapist.” *Id.* The therapist’s job is to assist the patient in dealing with transference so that any conflicts in life may be successfully resolved. *Id.*

⁷See *Simmons*, 805 F.2d at 1365.

⁸*Id.*

⁹*Id.* A clinical psychologist claimed that “were a therapist to be sexual with a client it would be replicating at a symbolic level the situation in which a parent would be sexual with a child. The kinds of harm that can flow from those sorts of violations of trust are similar.” *Id.*

¹⁰*Id.*

relationship, or through "countertransference" project his or her unhealthy feelings onto a client.¹¹ Transference issues arise, to some degree, in all relationships when perceived authority figures exist.¹² Psychologists, psychiatrists, counselors, physicians, lawyers, and the clergy all deal with transference issues.¹³ Consequently, it is not surprising that all these professions view sex with a client in an unfavorable light.¹⁴

The main question this article addresses is whether sexual relations between two consensual adults in the physician-patient relationship constitutes medical malpractice. Such a relationship may be unethical.¹⁵ Such a relationship may also result in severe civil or administrative penalties.¹⁶ Such a relationship may even be criminal.¹⁷ However, this author asserts that in no circumstances does the behavior ever rise to medical malpractice. It would be quite a stretch indeed to hold that a physician's sexual relationship with a patient was substantially related to the qualifications, functions, or other duties logically associated with being a doctor. Nor would it be logical to presume that such relations arose while in the scope of the physician-patient relationship, or that such activities constituted rendition of any health care services. Sexual acts also do not involve the requisite levels of skill and care promised to the patient. And the possible presence of the transference phenomenon, by itself, is simply not enough to impose liability for medical malpractice onto the non-mental health physician.

Why debate whether a sexual relationship creates grounds for medical malpractice? Medical malpractice is typically covered under professional-liability insurance policies.¹⁸ Adverse medical malpractice judgments or settlements increase insurance costs. Increased insurance costs are spread to society as a whole in greater health-care costs. Or in other words, society pays while the doctor and patient play. If the relationship is truly consensual, then BOTH parties must bear the brunt of their irresponsibility. Sex, like crime, comes with a cost and imposes societal burdens.

Part II of this note examines the issues involved in building a fiduciary relationship based on trust and confidence. Medical malpractice will be defined and broken down into its relevant parts. Transference and countertransference will be

¹¹See Rhoda Feinberg & James Tom Greene, *Transference and Countertransference Issues in Professional Relationships*, 29 FAM. L.Q. 111, 114 (1995).

¹²*Id.* at 111.

¹³*Id.* at 111-12.

¹⁴Swenson, *supra* note 2, at 272-73.

¹⁵*The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry* (visited Jan. 12, 1998) <<http://www.psych.org>>. Section 2, Annotation 1 states "inherent inequality in the doctor patient relationship may lead to exploitation of the patient. Sexual activity with a current or former patient is unethical." *Id.*

¹⁶Sandra H. Johnson, *Judicial Review of Disciplinary Action for Sexual Misconduct in the Practice of Medicine*, 270 JAMA 1596, 1597 (1993).

¹⁷*Id.*

¹⁸Christopher Vaeth, Annotation, *Coverage of Professional-Liability or -Indemnity Policy for Sexual Contact with Patients by Physicians, Surgeons, and Other Healers*, 60 A.L.R.5th 239 (1998).

discussed as it relates to physicians. Part II also suggests how to avoid compromising situations, and lists factors of which every doctor should be aware.

Part III of this note explores the case law surrounding the sexual relationship as grounds for malpractice. Part III first examines mental health care physician liability, and then considers non-mental health care physicians who had sexual relations under the guise of treatment. Part III concludes with a review of the most recent cases which discuss liability for physicians who undertake "counseling matters."

Part IV involves the underlying analysis on why the physician-patient sexual relationship should not constitute medical malpractice. Specifically, Part IV focuses on the significance of medical malpractice to the insurance agencies, as well as addresses other avenues which can be used to successfully discourage such conduct.

Finally, this note concludes with some general public policy arguments. In its rush to eliminate any and all things unfair (such as relative bargaining power), American society has become overly litigious. People no longer accept responsibility for their own conduct. The blame always falls soundly upon someone else's shoulders. This author contends that any rational, semi-intelligent human being should know, in advance, that sleeping with his or her doctor may create a potential conflict of interest. This recognition does not mean that doctors should have a free pass to avoid their moral obligations. It simply means that BOTH parties have a duty to be responsible. As the old saying goes "it takes two to tango."

II. BACKGROUND: A FIDUCIARY DUTY BASED ON TRUST AND CONFIDENCE

The nature of the physician-patient relationship is complex. As a fiduciary relationship, it is grounded in mutual trust and confidence. The physician is required, in good faith, to perform his or her duties at the level of knowledge, skill, and standards applicable to the medical profession as a whole.¹⁹ The physician is "represented to the public as possessing superior knowledge, being worthy of public trust, and bound to act in the best interests of patients."²⁰ The patient, on the other hand, enters the relationship at his or her most vulnerable moment.²¹ The patient's physical and mental well-being depends upon the physician's competence.²² Detailed physical examinations along with the patient's personal revelations and insights often accompany most courses of treatment.²³ Patients' vulnerability compounded with their obvious dependence on the physician to "cure their ills" places the physician in a position of dominance.²⁴ It is this position of dominance, or relative disparity of power in the relationship, which has led the American Medical

¹⁹61 AM. JUR. 2D *Physicians, Surgeons, and Other Healers* § 167 (1981).

²⁰Catherine S. Leffler, *Sexual Conduct Within the Physician-Patient Relationship: A Statutory Framework for Disciplining This Breach of Fiduciary Duty*, 1 SPG WIDENER L. SYMP. J. 501, 508 (1996).

²¹*Id.* at 509.

²²*Id.*

²³*Id.*

²⁴*Id.* at 511.

Association (the "AMA") to conclude that having sexual relations with a current patient is unethical.²⁵

The prohibition against sexual relationships with patients dates back over one thousand years to the Hippocratic oath.²⁶ A 1992 survey of practicing physicians revealed that nine percent acknowledged sexual contact with one or more patients.²⁷ And because of the strong and often complex emotions (affection, admiration, understanding, and empathy among others) evoked by the physician-patient relationship, it is not uncommon or abnormal that sexual attraction between the two parties develop.²⁸ This sexual attraction, which by itself may not be deleterious to the relationship, can under the right situation lead to sexual contact.²⁹ Sexual contact, or a sexual relationship, is viewed as gratifying the physician's needs at the patient's expense.³⁰ Objectivity of treatment is lost, or at least jeopardized, by placing the physician's focus elsewhere.³¹ Almost all researchers agree that the consequences of a physician-patient relationship are "universally negative or damaging to the patient."³²

The issue of "informed consent"³³ also arises.³⁴ If the disparity of the physician-patient relationship is so great, and its effects so harmful, can a patient or would a patient be able to voluntarily consent to such sexual activity? Physicians have been known to exploit their positions to gain sexual favors under the guise of treatment, or to take advantage of unconscious or incompetent patients.³⁵ Physicians have also abused patients by improperly performing medical procedures or dispensing drugs.³⁶ Logically, taking it one step further, it may not seem unreasonable due to this inequality in bargaining power to presume that in ANY physician-patient sexual

²⁵*Sexual Misconduct in the Practice of Medicine*, 266 JAMA 2741 (1991).

²⁶Swenson, *supra* note 2, at 271. The Hippocratic oath states "Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief, and, in particular, sexual relations with both female and male persons, be they free or slaves." *Id.*

²⁷Leffler, *supra* note 20, at 505. "The incidence by specialty broke down as follows: family practice, 11%; obstetrics/ gynecology, 10%; internal medicine, 6%; and surgery, 9%." *Id.*

²⁸*Sexual Misconduct in the Practice of Medicine*, *supra* note 25, at 2742.

²⁹*Id.*

³⁰*Id.* at 2743.

³¹*Id.*

³²*Id.* at 2742.

³³JOHN W. WADE, ET AL., *CASES AND MATERIALS ON TORTS* 99 (9th ed. 1994). "The doctrine of 'informed consent' requires a physician or surgeon to disclose to the patient the risks of proposed medical or surgical treatment." *Id.*

³⁴Swenson, *supra* note 2, at 287. Swenson notes "if a patient were given full, informed consent, why would she knowingly engage in such harmful conduct with her physician?" *Id.*

³⁵Glen O. Gabbard & Carol Nadelson, *Professional Boundaries in the Physician-Patient Relationship*, 273 JAMA 1445, 1446 (1995).

³⁶*Id.*

relationship the doctor is unfairly taking advantage of the patient.³⁷ Seduction of the patient occurs through the use of the physician's status and unfettered authority (rather than his or her personality) as an illicit "aphrodisiac."³⁸ True consent may never be gained because consent implies a knowing and informed willingness to participate.³⁹ Patients under the influence of their doctors cannot knowingly (by realizing the repercussions) "choose" to enter a sexual relationship.⁴⁰ In effect, the relationship has been chosen for them, and the consent is "illusory."⁴¹

The question then ensues whether a sexual relationship between a physician and a patient can occur concurrently BUT independently of treatment. Some courts still recognize the validity of a patient's consent.⁴² Some studies even go further and claim that sexual contact between the physician and patient can be advantageous.⁴³ The *Journal of American Medicine* recognizes that "it is of course possible for a physician and a patient to be genuinely attracted to or have genuine romantic affection for each other."⁴⁴ And of course in most romantic relationships, one party tends to have a disproportionate amount of authority over the other.⁴⁵ The Ohio Court of Appeals has stated that "private sexual contact between consenting heterosexual adults is protected [by the Constitution] thereby. Governmental entities . . . must act carefully at such times as they seek to sanction or penalize the bedroom conduct of consenting adults."⁴⁶

The courts and the AMA seem to be at odds; while the courts recognize consensual physician-patient sexual relationships, the AMA does not. The AMA recommends, at a minimum, that the physician terminate the professional relationship.⁴⁷ At this point sexual misconduct only arises if the physician continues to use his or her prior professional advantage inappropriately.⁴⁸ This solution, unfortunately, tends to overlook the obvious. Beginnings and endings of romantic endeavors are often fluid and cannot be easily placed along a time continuum.⁴⁹ All

³⁷Leffler, *supra* note 20, at 517.

³⁸*Sexual Misconduct in the Practice of Medicine*, *supra* note 25, at 2742.

³⁹*Id.*

⁴⁰*Id.*

⁴¹Leffler, *supra* note 20, at 518.

⁴²*Id.* at 524.

⁴³Steven R. Smith, *Mental Health Malpractice in the 1990's*, 28 Hous. L. Rev. 209, 227 (1991). The author mentions this view is rejected by most mental health professionals, and represents a "small 'school of thought.'" *Id.*

⁴⁴*Sexual Misconduct in the Practice of Medicine*, *supra* note 25, at 2743.

⁴⁵Feinberg & Greene, *supra* note 11, at 112.

⁴⁶*In re Pons*, No. 91AP-746, 1991 WL 245003, at *1 (Ohio Ct. App. Nov. 14, 1991), *rev'd on other grounds*, 614 N.E.2d 748 (Ohio 1993).

⁴⁷*Sexual Misconduct in the Practice of Medicine*, *supra* note 25, at 2743.

⁴⁸*Id.*

⁴⁹Johnson, *supra* note 16, at 1598.

patients are not alike, and all scientific findings are not absolute.⁵⁰ And because the possibility of a consensual relationship cannot be completely ruled out, it must be subsequently recognized.⁵¹ A consensual sexual relationship between the physician and patient does not necessarily violate the trust and confidence upon which the professional relationship is grounded.

A. Medical Malpractice

Medical malpractice is a particular form of negligence which applies when a physician fails to exercise the degree of skill and care which is ordinarily employed by similar members of the medical profession.⁵² Typically a cause of action based on malpractice may be brought in either contact or tort.⁵³ A plaintiff in a malpractice suit must successfully prove four key elements: (1) the physician owed the patient a duty; (2) the physician breached that duty; (3) the patient was harmed; and (4) the physician's breach was the proximate cause of that harm.⁵⁴ Liability only surfaces when "the professional has failed to provide the same care as would a reasonably prudent professional."⁵⁵ The average standard of the profession is used as the measuring stick.⁵⁶ This standard means that the physician is bound to exercise the "ordinary care, skill, and diligence as physicians and surgeons in good standing in the same neighborhood, in the same general line of practice, ordinarily have and exercise in like cases."⁵⁷ Only a departure from this standard, by performing a service that a similarly-situated physician would not have performed, or by failing or omitting to perform a service that a similarly-situated physician would have performed, results in negligence.⁵⁸ The burden of proof and persuasion ultimately rests with the plaintiff.⁵⁹ Expert testimony is typically required to prove these elements by the preponderance of the evidence.⁶⁰

Establishing a claim of medical malpractice based on a consensual patient-physician sexual relationship is contravened by one simple premise. A physician, by

⁵⁰*Id.* at 1596. The findings in this area "rel[y] extensively on empirical research relating to sexual contact between psychotherapists and patients as a justification." These findings were then extended to *all* physicians. *Id.*

⁵¹Leffler, *supra* note 20, at 517. "The College of Physicians and Surgeons of British Columbia has stated that "[e]ven though we could envision relationships which are consensual, do not hold the potential to compromise medical care, and do not involve exploitation, we concluded that these cases will be rare and it is better to absolutely prohibit all sexual contact between physicians and patients.'" *Id.*

⁵²61 AM. JUR. 2D *Physicians, Surgeons, and Other Healers* § 200 (1981).

⁵³61 AM. JUR. 2D *Physicians, Surgeons, and Other Healers* § 202 (1981).

⁵⁴Leffler, *supra* note 20, at 522.

⁵⁵Smith, *supra* note 43, at 214.

⁵⁶61 AM. JUR. 2D *Physicians, Surgeons, and Other Healers* § 205 (1981).

⁵⁷*Id.*

⁵⁸*Id.*

⁵⁹*Id.*

⁶⁰Leffler, *supra* note 20, at 524.

engaging in an act of a sexual nature, is in no way, shape, or form rendering a professional service.⁶¹ The Supreme Court of South Carolina has stated that

[T]he scope of professional services does not include all forms of a physician's conduct simply because he is a physician. . . . A "professional" act or service is one arising out of a vocation, calling, occupation, or employment involving specialized knowledge, labor, or skill, and the labor or skill involved is predominantly mental or intellectual, rather than physical or manual. In determining whether a particular act is of a professional nature or a "professional service" we must look not to the title or character of the party performing the act, but to the act itself.⁶²

In an effort to circumvent this common sense approach, and in conjunction with the prevailing public policy towards this issue (favoring an absolute prohibition against physician-patient sexual contact), the judicial system has manipulated the definition of "professional services" by concluding that the sexual acts were inseparable and intertwined with the other services provided, or by finding the transference phenomenon present.⁶³ Such an approach is contrary to sound legal fundamentals, since other avenues (such as criminal prosecution or loss of the license to practice) exist which can be used to foster the public policy prescribing a ban against all physician-patient sexual relationships. In these circumstances the law has clearly overstepped its bounds and fit inappropriate conduct into a type of action which cannot legally or logically support it. Call it judicial fiction, or "wishful-thinking," but medical malpractice based on a consensual physician-patient sexual relationship is just bad law premised on faulty logic.

B. Transference Phenomenon

Each party to a new relationship, whether professional or not, brings with him or her some degree of emotional baggage.⁶⁴ Emotional baggage, which consists of the parties' "wishes, fears, anxieties, hopes, pressures, and psychological defenses," may not be conducive nor appropriate to the new relationship.⁶⁵ Transference, as it relates to the professional relationship, exists when "the client has expectations not

⁶¹Willy E. Rice, *Insurance Contracts and Judicial Discord over Whether Liability Insurers Must Defend Insureds' Allegedly Intentional and Immoral Conduct: A Historical and Empirical Review of Federal and State Courts' Declaratory Judgments 1900-1997*, 47 AM. U. L. REV. 1131, 1177 (1998).

⁶²South Carolina Med. Malpractice Liab. Ins. Joint Underwriting Ass'n v. Ferry, 354 S.E.2d 378, 380 (S.C. 1987) (quoting Marx v. Hartford Accident & Indem. Co., 157 N.W.2d 870, 872 (1968)).

⁶³Rice, *supra* note 61, at 1177-79. The author notes that many courts have "refused or failed to employ various legal doctrines to help determine whether 'deviant' physicians and medical technicians are 'rendering professional services.' Instead these tribunals have permitted some generalized notion of public policy to influence whether some insurers . . . must defend their insureds in cases involving sexual assaults." *Id.* at 1177-78.

⁶⁴Feinberg & Greene, *supra* note 11, at 111.

⁶⁵*Id.*

grounded in current reality but on past personal history, self-image, adopted role in life, naive hopes and expectations of a fairy tale outcome of self-validation, or perhaps a self-fulfilling prophecy of defeat."⁶⁶ Transference issues arise and become more pronounced as the degree of neediness, level of stress, and threat of either financial, social, or emotional turmoil escalates.⁶⁷ For these reasons, psychiatrists, psychologists, lawyers, and members of the clergy (each in their capacity as counselors) all deal with the transference phenomenon to some extent, and may, as a consequence, be exposed to potential liability.⁶⁸

In a typical physician-patient relationship, one which promotes the patient's quick and full recovery, the physician acts to insulate the patient from his or her worries by listening to and addressing any concerns he or she may have.⁶⁹ The physician's undivided attention enables the patient to develop a sense of security (though perhaps a false one) and comfort amenable to the healing process.⁷⁰ The patient, as a result of this attention, begins to either consciously or subconsciously look at the physician "as a child would to a caring parental figure."⁷¹ Based on this new found level of personal intimacy, idolization of the physician may germinate into unrequited feelings of love and affection.⁷² The magnitude of these feelings may even prompt the patient to initiate sexual advances, an aspect of the transference phenomenon which Freud traced to the Oedipus complex.⁷³ It is in this context in which the sexual relationship is often analogized to an incestuous relationship between father and daughter.⁷⁴ "Just as the father must deny his daughter, the therapist [or physician] must refuse to engage in sexual intercourse with his patient."⁷⁵ The doctor, in reality, may neither be responsible for nor ultimately advance these feelings.⁷⁶ The patient is simply transferring his or her feelings towards a parent or other "significant person" onto the doctor by mere association.⁷⁷

The mishandling of the transference phenomenon (upon which the medical malpractice claim based on a sexual relationship is predicated) has largely been

⁶⁶*Id.*

⁶⁷*Id.*

⁶⁸*Id.* at 111-12.

⁶⁹Leffler, *supra* note 20, at 513.

⁷⁰*Id.*

⁷¹*Id.*

⁷²*Id.*

⁷³Phyllis Coleman, *Sex Between Psychiatrist and Former Patient: A Proposal for a 'No Harm, No Foul' Rule*, 41 OKLA. L. REV. 1, 8 (1988). The Oedipus complex is described as when "children often have fantasies of killing the same-sex parent and marrying the parent of the opposite sex." *Id.* at 8.

⁷⁴*Id.*

⁷⁵*Id.* at 11.

⁷⁶*Id.* at 6.

⁷⁷Coleman, *supra* note 73, at 6.

limited to the psychotherapeutic context alone.⁷⁸ Judicial opinions have attributed this limitation to the uniqueness of the psychiatrist-patient relationship.⁷⁹ The patient pays the psychiatrist or psychologist a fee for listening to his or her deepest thoughts, fantasies, and desires, and the psychiatrist or psychologist in return promises to assist in resolving any emotional dilemmas.⁸⁰ Honesty and complete openness are requirements for effective treatment.⁸¹ As a result of this interaction, the patient's problems are identified and analyzed to discover workable solutions.⁸² Recognizing and utilizing the transference phenomenon is essential to recovery.⁸³ Unresolved issues and patterns of repeated behavior affecting "significant others" are uncovered to reveal "valuable information about the patient's pathology."⁸⁴ And because the patient's emotional dependence on the mental health professional is so strong, and because the negative effects of an "incestuous" sexual relationship are so great, medical malpractice based on a sexual relationship between the mental health professional and patient was viewed as justified within the law.⁸⁵

Of course, the typical non-mental health physician incurs no such responsibilities and undertakes no such obligations. A patient's pathology is not at issue. Effective treatment does not revolve around displaced feelings affecting significant others. While honesty and openness still remain essential to treatment, "complete" openness is probably unnecessary. It is true that transference exists in some form in every relationship.⁸⁶ It cannot be said, however, that the degree of transference that exists in every relationship is equal.⁸⁷ Applying the mishandling of the transference phenomenon to non-mental health physicians, as well as to other professionals in a fiduciary relationship, involves prescribing a code of conduct which is not based on reality.

The courts which have taken this approach (by presuming physicians who undertake "counseling matters" are acting as mental health specialists) have missed the point. It is not the mishandling of the transference phenomenon which should be the underlying basis for medical malpractice based on a sexual relationship. The key issue determinative of liability should revolve around the unlimited potential for the exploitation and abuse of the patient.⁸⁸ The proper question to ask should be whether the physician has inappropriately used his or her status or the transference

⁷⁸Johnson, *supra* note 16, at 1599.

⁷⁹*Id.*

⁸⁰Coleman, *supra* note 73, at 5.

⁸¹*Id.*

⁸²*Id.*

⁸³*Id.* at 7.

⁸⁴*Id.*

⁸⁵Johnson, *supra* note 16, at 1599.

⁸⁶Coleman, *supra* note 73, at 9.

⁸⁷*Id.*

⁸⁸*Id.*

phenomenon for sexual gain.⁸⁹ If the answer is no, medical malpractice is not an appropriate cause of action. Non-mental health physicians simply do not foster nor encourage the type of emotional bonding that psychiatrists and psychologists demand.⁹⁰ And unless the sexual relationship occurs under the guise of treatment, vitiating any implied or explicit consent, the non-mental health physician should not be held liable under the doctrine of medical malpractice for a consensual sexual relationship.

C. Countertransference

The physician-patient relationship is not dissimilar from other human interactions which involve emotional attachment.⁹¹ Physicians and patients alike both react to environmental stimuli and experience complementary emotional responses.⁹² Emotions such as anger, sorrow, anxiety, helplessness, empathy, aversion, joy, and fear may all be triggered through the close social contact which defines the physician-patient relationship.⁹³ Physicians are not immune to these emotions despite their best efforts to maintain a clinical distance and preserve scientific objectivity.⁹⁴ In fact, it is because of this strong emotional interplay that physicians often find themselves highly susceptible to a phenomenon Freud called "countertransference."⁹⁵

Countertransference describes a physician's distorted perception of his or her patient's psychic or emotional state.⁹⁶ Countertransference exists when "a physician with personal psychological problems may personalize the patient's transference reaction, and be unable to resist the strong reciprocal feelings of attraction."⁹⁷ The phenomenon induces "the psychiatrist to experience intense feelings for his patient in a manner similar to the way he responded to other significant people in his life."⁹⁸ As a result, the physician may find it difficult to abstain from or avoid acting on any implicit sexual overtures.⁹⁹ The phenomenon may also become more pronounced if the physician unduly suffers under the burdens of substance abuse, abnormal pressure, or a recent trauma.¹⁰⁰ Once believed to be detrimental to the psychological treatment process, the countertransference phenomenon is now considered beneficial

⁸⁹*Id.*

⁹⁰Johnson, *supra* note 16, at 1599.

⁹¹William M. Zinn, *Doctors Have Feelings Too*, 259 JAMA, 3296 (1988).

⁹²*Id.*

⁹³*Id.*

⁹⁴*Id.*

⁹⁵Coleman, *supra* note 73, at 12.

⁹⁶Feinberg & Greene, *supra* note 11, at 111.

⁹⁷Leffler, *supra* note 20, at 514.

⁹⁸Coleman, *supra* note 73, at 12-13.

⁹⁹Leffler, *supra* note 20, at 514.

¹⁰⁰*Id.* at 514.

if identified and used correctly.¹⁰¹ Studying physicians' emotional responses to patients may even provide "important diagnostic insights."¹⁰²

Psychiatrists and psychologists are trained to recognize the phenomenon and resolve any inappropriate or improper sexual urges without acting on them.¹⁰³ Non-mental health professionals, however, may be circumscribed by their inability to perceive the countertransference phenomenon at work.¹⁰⁴ Awareness, then, may be the sole and limiting factor differentiating a healthy physician-patient relationship from one destined to constitute medical malpractice.¹⁰⁵ Regardless of his or her specialty, the physician is expected to acknowledge the phenomenon and act appropriately by avoiding sexual contact, a duty which precludes gratification of any sexual countertransference feelings.¹⁰⁶

In a recent study less than fifty percent of responding non-mental health professionals had confronted the issue of physician-patient sexual conduct in medical school or residency.¹⁰⁷ Only three percent had encountered the issue in continuing education classes.¹⁰⁸ Part of the disparity in the physician-patient relationship deals with the "differential in awareness and knowledge of the transference/countertransference phenomenon."¹⁰⁹ Accordingly, mental health professionals (those members of the medical profession trained to recognize and treat the phenomenon) have been entrusted with the responsibility of using this advantage constructively.¹¹⁰ Non-mental health professionals, however, cannot be held to such idealistic standards. Because both phenomena are largely (if not always) limited to the therapeutic relationship alone, non-mental physicians lack the necessary competence to diagnose or discern them.¹¹¹ Failing to recognize the phenomena is succinctly different from choosing to exploit them. Without any physician exploitation (which can only come from a fundamental awareness of the phenomena), no medical malpractice can exist. Non-mental health physicians are simply incapable of illicitly benefiting from a course of treatment which is foreign to the skill and care to which they normally provide. A lack of the requisite training, and a severely limited awareness of the transference/ countertransference phenomenon, make exploitation not only highly impractical, but also nearly impossible to fathom. As such, the non-mental health physician should not be held

¹⁰¹Coleman, *supra* note 73, at 13. "It has even been suggested that 'in many cases, the analyst's dreams about his patients have a diagnostic/ therapeutic function.'" *Id.* at 13 n.75.

¹⁰²Zinn, *supra* note 91, at 3296.

¹⁰³Leffler, *supra* note 20, at 513-14.

¹⁰⁴*Id.* at 515-16.

¹⁰⁵Zinn, *supra* note 91, at 3296.

¹⁰⁶Coleman, *supra* note 73, at 13.

¹⁰⁷Leffler, *supra* note 20, at 516.

¹⁰⁸*Id.*

¹⁰⁹*Id.* at 515.

¹¹⁰*Id.*

¹¹¹*Id.* at 516.

liable for medical malpractice based on his or her inability to effectively recognize or resolve the countertransference phenomenon.

D. Boundaries and Violations

Society has always attempted to define and distinguish acceptable standards of behavior for its citizens. These standards are often reflected in the laws, customs, and practices adopted by civilized nations. Attitudes towards marriage, family relations, sexual freedom, gender equality, and religious expression are among the many issues debated and legislated regularly. The nature of the physician-patient relationship is not unusual in that it too has undergone some degree of societal circumspection. As a result, various medical organizations and governmental bodies have taken it upon themselves to further delineate the proper parameters of physician conduct. Beginning with the Hippocratic oath, which expressly prohibited any sexual contact between the physician and the patient, organizations such as the American Medical Association Council on Ethical and Judicial Affairs, Medical Council of New Zealand, and the College of Physicians and Surgeons of British Columbia have all addressed the issue of sexual impropriety within the physician-patient relationship.¹¹² Concluding that all sexual conduct is highly detrimental to any course of treatment, these organizations have prescribed "boundaries" or codes of conduct onto all applicable physicians.¹¹³ Conduct which falls outside of any permissible "boundary" is viewed as a breach of the physician's fiduciary duty, irrespective of any mitigating circumstances.¹¹⁴ In this context the "boundary" becomes a powerful regulatory tool capable of conforming the physician's attitudes and beliefs with recognized societal norms. Boundaries, then, are simply another means of governing consensual adult behavior within the professional medical relationship.

Boundaries are described as the "limits of a fiduciary relationship in which one person (a patient) entrusts his or her welfare to another (a physician), to whom a fee is paid for the provision of a service."¹¹⁵ Boundaries serve to put the public and the physician on notice as to what constitutes acceptable professional conduct in the practice of medicine.¹¹⁶ "In the physician-patient relationship, these boundaries are 'derived from ethical treatise, cultural morality, and jurisprudence.'"¹¹⁷ Topics such as the acceptance of gifts, mishandling of fees, types of physical contact, length, location, and duration of appointments, and language are examined in relation to the "inherent power differential" prevalent in the physician-patient relationship.¹¹⁸ Sexual contact is considered "the most extreme form of boundary violation" due to its potentially devastating impact on patients.¹¹⁹ Psychiatrists and psychologists have

¹¹²Gabbard & Nadelson, *supra* note 35, at 1446.

¹¹³*Id.*

¹¹⁴*Id.*

¹¹⁵*Id.* at 1445.

¹¹⁶*Id.*

¹¹⁷Leffler, *supra* note 20, at 510.

¹¹⁸Gabbard & Nadelson, *supra* note 35, at 1445.

¹¹⁹*Id.*

jointly recognized the need for boundaries in a therapeutic setting.¹²⁰ Non-mental health professionals, though, have been slower to consider and adopt such measures.¹²¹ With the inclusion of such boundaries into licensing and disciplinary procedures, it becomes necessary (in order to avoid civil or administrative liability) to examine their applicability to the non-mental health physician who unwittingly takes on “counseling matters.”

Much of the increased attention placed on boundaries stems from the medical professions’ increased interest in prohibiting sexual contact.¹²² Based on a “slippery slope” argument, sexual exploitation is usually preceded by a series of non-sexual boundary violations.¹²³ “In this regard, what appear to be trivial violations may in reality be considerably more serious when viewed in the context of a [time] continuum.”¹²⁴ By addressing non-sexual boundary violations as well as sexual ones (both of which may cause the patient harm), patient exploitation can be at least minimized, if not prevented entirely. Research directed at psychologists and social workers has revealed that sexual exploitation “is a pervasive problem in fiduciary relationships.”¹²⁵

The ideal physician-patient relationship attempts to strike a delicate balance “between caring intimacy and objective, professional attachment.”¹²⁶ Many aspects of this relationship, though, make maintaining such a balance difficult.¹²⁷ Understanding this important trade-off is essential in determining whether or not a physician is guilty of medical malpractice. Not all boundary violations arise under unethical auspices and corrupt motives.¹²⁸ Some arise due to honest misunderstandings, while other minor violations (such as holding and comforting a grieving spouse) may be appropriate or even forgivable.¹²⁹ The AMA has identified several examples of nonprofessional sexual behavior which may violate professional boundaries: (1) predatory physicians who suffer from serious psychological disorders and continually attempt to seduce patients; (2) physicians who claim sex is for therapeutic purposes; (3) physicians who abuse the physical examination procedure; (4) physicians who ask patients out on a date during an initial visit; (5) physicians who have long-standing patient relationships which develop into infatuation; (6) rural physicians who are the only practitioners in town and must treat any potential romantic partner; (7) physicians who rape or fondle patients; and (8) physicians who initiate sexual harassment or makes suggestive comments.¹³⁰ This list is not intended

¹²⁰*Id.*

¹²¹*Id.*

¹²²*Id.* at 1445.

¹²³Gabbard & Nadelson, *supra* note 35, at 1445.

¹²⁴*Id.*

¹²⁵*Id.*

¹²⁶Leffler, *supra* note 20, at 512.

¹²⁷*Id.*

¹²⁸Gabbard & Nadelson, *supra* note 35, at 1445.

¹²⁹*Id.*

¹³⁰*Id.* at 1446.

to be exhaustive nor all-inclusive, but rather illustrates conduct which the AMA believes breaches the fiduciary duty.¹³¹ The AMA considers education as the primary tactic in combating and preventing such undesirable conduct.¹³²

In examining the list of potential sexual boundary violations, several flaws in its reasoning and purpose become readily apparent. Obviously some of the examples represent more serious violations than others. Categorizing them together, and punishing them equally, only re-emphasizes the need for examining each alleged violation individually. A per se rule (one prohibiting all physician-patient sexual relationships) is not only overinclusive, but also infringes on the privacy and personal freedoms of both the physician and the patient. Nor can a prohibition against a consensual physician-patient sexual relationship be advanced solely on the basis of judicial expediency or economy (meting out the same punishment for differing boundary violations). Unless the physician "exploits" his or her position for sexual gain, no medical malpractice arises. The AMA must realize that both physicians and patients are "real people experiencing a 'real' relationship."¹³³ Inevitably, strong feelings or a sexual attraction may arise between the physician and his or her charge.¹³⁴ Just because these feelings grew from the physician-patient relationship does not make them illegitimate.¹³⁵ "It is possible that both parties will discover that shared interests would have made them friends, or lovers, had they met under other circumstances."¹³⁶ For these reasons, a boundary violation might not be a "violation" after all. Free will cannot, and should not, be factored out of the physician-patient equation. Therefore, "boundaries" should only be demonstrative, rather than determinative, in helping to prescribe and to advance socially acceptable patterns of behavior.

III. CASE LAW: THE SEXUAL RELATIONSHIP AS GROUNDS FOR MALPRACTICE

The courts have identified three categories of cases which examine the sexual relationship as grounds for medical malpractice. The first category of cases deals with sexual relationships between the mental health professional and the patient. Courts have routinely held mental health professionals (psychiatrists or psychologists) liable for engaging in sexual conduct with their patients.¹³⁷ This

¹³¹*Id.*

¹³²*Id.* at 1448.

¹³³Coleman, *supra* note 73, at 14.

¹³⁴*Id.*

¹³⁵*Id.*

¹³⁶*Id.* at 15.

¹³⁷*See* Cotton v. Kambly, 300 N.W.2d 627 (Mich. Ct. App. 1980). *See also* Johnson v. Arkansas Bd. of Exam'rs in Psychology, 808 S.W.2d 766 (Ark. 1991); Waters v. Bourhis, 709 P.2d 469 (Cal. 1985); Dresser v. Board of Med. Quality Assurance, 130 Cal. App. 3d 506 (Ct. App. 1982); Anclote Manor Found. v. Wilkinson III, 263 So. 2d 256 (Fla. Ct. App. 1972); Vigilant Ins. Co. v. Kambly, 319 N.W.2d 382 (Mich. Ct. App. 1982); Noto v. St.Vincent's Hosp. and Med. Ctr., 537 N.Y.S.2d 446 (Sup. Ct. 1988), *aff'd*, 559 N.Y.S.2d 510 (App. Div. 1990); Roy v. Hartogs, 366 N.Y.S.2d 297 (Civ. Ct. 1975); Morris v. State Bd. of Psychology, 697 A.2d 1034 (Pa. Commw. Ct. 1997).

liability is based on the “mishandling of the transference phenomenon” which includes gratification of the physician’s sexual impulses at the expense of the patient’s therapeutic treatment.¹³⁸ The second category of cases focuses on the non-mental health professional who induces sexual relations with the patient under the guise of treatment.¹³⁹ In this category of cases, courts have also customarily found liability when the sexual relationship was proven to be entered into under false pretenses and for illegitimate medical purposes.¹⁴⁰ Finally, the third category of cases examines the non-mental health professional who in his or her regular course of treatment “undertakes counseling matters.”¹⁴¹ Courts who have analyzed cases in this area have been less absolute in finding liability. Sometimes the decision has rested on the issue of “whether professional services were involved.”¹⁴² Other courts have scrutinized the nature of the physician’s fiduciary duty (the trust and confidence factor), and delved into the inherent differential in the parties’ bargaining power (making the patient’s ability to consent dubious).¹⁴³ Still other courts have addressed public policy concerns ranging from the AMA’s recommendation of an absolute ban on physician-patient sexual relationships to the right of individuals to privacy within their bedrooms and the freedom of sexual expression.¹⁴⁴ It is in this last category of cases in which the most potential for societal harm exists. Defining a consensual sexual relationship between the physician and patient as medical malpractice violates sound legal fundamentals and promotes judicial activism at the expense of increased health care costs. As long as other more appropriate legal remedies exist (in the form of criminal sanctions and administrative penalties), this avenue need not be judicially explored.

A. Mental Health Professionals and Patients

Mental health professionals who engage in sexual relationships with their patients may be held liable for medical malpractice. The basis for this liability first arose under *Zipkin v. Freeman*.¹⁴⁵ In *Zipkin*, the patient (Ada Zipkin) sought

¹³⁸See *Seymour v. Lofgreen*, 495 P.2d 969 (Kan. 1972). See also *MacClements v. LaFone*, 408 S.E.2d 878 (N.C. Ct. App. 1991); *Greenberg v. McCabe*, 453 F. Supp. 765 (E.D. Pa. 1978), *aff’d*, 594 F.2d 854 (3d Cir. 1979); *L.L. v. Medical Protective Co.*, 362 N.W.2d 174 (Wis. Ct. App. 1984).

¹³⁹See, e.g., *Atienza v. Taub*, 239 Cal. Rptr. 454, 457 (Ct. App. 1987).

¹⁴⁰*Id.*

¹⁴¹See, e.g., *McCracken v. Walls-Kaufman*, Nos. 97-CV-193, 97-CV-209, 1998 WL 574763 (D.C. Sept. 10, 1998).

¹⁴²See *Collins v. Covenant Mut. Ins. Co.*, 604 N.E.2d 1190 (Ind. Ct. App. 1992), *opinion vacated*, 644 N.E.2d 116 (Ind. 1994). See also *St. Paul Fire and Marine Ins. Co. v. Hirst*, 683 P.2d 440 (Idaho Ct. App. 1984); *St. Paul Fire and Marine Ins. Co. v. Quintana*, 419 N.W.2d 60 (Mich. Ct. App. 1988); *Smith v. St. Paul Fire and Marine Ins. Co.*, 353 N.W. 2d 130 (Minn. 1984); *Washington Ins. Guar. Ass’n v. Hicks*, 744 P.2d 625 (Wash. Ct. App. 1987).

¹⁴³*McCracken*, 1998 WL 574763, at *5.

¹⁴⁴*Pons*, 1991 WL 245003, at *6.

¹⁴⁵*Zipkin v. Freeman*, 436 S.W.2d 753 (Mo. 1968).

treatment from Dr. Freeman for persistent diarrhea and headaches.¹⁴⁶ After two months of psychological treatment, Mrs. Zipkin's medical conditions completely disappeared.¹⁴⁷ Afraid she might suffer a relapse, Mrs. Zipkin agreed to continue her therapy (with her doctor's support and encouragement).¹⁴⁸ As part of her "therapy," Mrs. Zipkin and Dr. Freeman engaged in sexual relations, attended nude swimming parties, skating parties, and other social gatherings, discussed potential joint business ventures, filed unmeritorious lawsuits, performed manual labor on a farm (based on Dr. Freeman's belief that Mrs. Zipkin "desired to be a male"), and eventually cohabited together (after she left her husband).¹⁴⁹ When the relationship soured, and because of the tremendous feelings of humiliation and guilt from which she suffered, Mrs. Zipkin filed suit against Dr. Freeman for medical malpractice based on the "mishandling of the transference phenomenon."¹⁵⁰

The Supreme Court of Missouri denied Dr. Freeman's claim that the activities in which he and Mrs. Zipkin participated in consisted of "matters extraneous to receiving professional treatment."¹⁵¹ Relying on expert testimony, the court also recognized the significance of the transference phenomenon to therapeutic treatment, and the potential damage which may flow from its misuse or exploitation.¹⁵² Noting that psychiatrists have a responsibility in avoiding social relationships with their patients, and that treatment should be "handled in the office," the court recognized that "there must have been horrible things going on with her [Mrs. Zipkin] during this period."¹⁵³ Based on the overwhelming evidence presented at the trial, and the damages sustained by Mrs. Zipkin in her negligent treatment (sleepless nights, continuing headaches, distrust of her family, and feelings of inadequacy), the court held Dr. Freeman liable for medical malpractice.¹⁵⁴

*St. Paul Fire & Marine Ins. Co. v. Love*¹⁵⁵ is another example of a case which details the "mishandling of the transference phenomenon." In *Love*, Mrs. Anderson sought the psychological services of Dr. Love, an expert in marital counseling and behavior modification.¹⁵⁶ Mrs. Anderson had been sexually abused as a child and was experiencing marital difficulties.¹⁵⁷ After five months of treatment, Dr. Love and Mrs. Anderson had sexual relations in the counseling center, at an apartment

¹⁴⁶*Id.* at 756.

¹⁴⁷*Id.* at 757.

¹⁴⁸*Id.*

¹⁴⁹*Id.* at 755.

¹⁵⁰*Zipkin*, 436 S.W.2d at 756.

¹⁵¹*Id.*

¹⁵²*Id.* at 760.

¹⁵³*Id.*

¹⁵⁴*Id.* at 762.

¹⁵⁵*St. Paul Fire and Marine Ins. Co. v. Love*, 459 N.W.2d 698 (Minn. 1990).

¹⁵⁶*Id.* at 699.

¹⁵⁷*Id.*

maintained by the doctor, in a car, and at her home.¹⁵⁸ This behavior continued until Mrs. Anderson's husband caught them in "the act."¹⁵⁹ As a result, Mrs. Anderson and her husband filed suit alleging negligence, breach of contract, medical malpractice, and intentional infliction of emotional distress.¹⁶⁰ In response, Dr. Love tendered defense of the lawsuit to his professional liability insurer (St. Paul Fire & Marine).¹⁶¹

The insurance company denied coverage on the grounds that the claims did not result from the performance of professional services.¹⁶² The Supreme Court of Minnesota, however, rejected this argument after closely examining the influence of the transference/countertransference phenomenon in the psychotherapeutic relationship. Explaining that the therapist has a duty to reject the patient's erotic overtures, and must, in severe cases, discontinue treatment and refer the patient to another therapist, the court found that Dr. Love "used his professional role and authority status as an occasion and pretext to take advantage of his patients."¹⁶³ Because the therapist alone elicits the transference/countertransference phenomenon as part of the therapeutic treatment, an aberrant and unacceptable use of it falls within the scope of professional services covered by the insurance agency.¹⁶⁴ The supreme court found that the insurance policy covered the Anderson's claims.¹⁶⁵

Both *Zipkin* and *Love* show the courts' willingness to find medical malpractice based on a sexual relationship when a mishandling of the transference phenomenon occurs. The need for the patient to reveal his or her innermost thoughts, the psychiatrist's or psychologist's awareness and expertise in this area, and the potential for exploitation and infliction of emotional damage to the patient all make this decision a prudent course of action. Unlike non-mental health professionals, whose services normally do not entail any handling of the transference phenomenon, mental health professionals are uniquely aware of the ramifications involved in providing negligent treatment. Anytime that sexual conduct arises within the context of the patient's problem and prescribed treatment, courts will necessarily find psychiatrists or psychologists liable for medical malpractice. The case law in this area is relatively clear, and the courts have taken a position of zero tolerance.

B. Non-Mental Health Physicians Under the Guise of Treatment

Courts have also held non-mental health physicians liable for medical malpractice when sexual relations with the patient come under the guise of treatment. In *Dillon III v. Callaway*,¹⁶⁶ Mrs. Callaway was hospitalized for multiple joint

¹⁵⁸*Id.*

¹⁵⁹*Id.*

¹⁶⁰*Love*, 459 N.W.2d at 699.

¹⁶¹*Id.*

¹⁶²*Id.*

¹⁶³*Id.* at 701.

¹⁶⁴*Id.* at 702.

¹⁶⁵*Love*, 459 N.W.2d at 702.

¹⁶⁶*Dillon III v. Callaway*, 609 N.E.2d 424 (Ind. Ct. App. 1993).

pain.¹⁶⁷ Dr. Chambers, her treating physician, recommended therapy (even though he was not a practicing psychiatrist) after being unable to ascertain a physical cause for her injuries.¹⁶⁸ The conversations between Mrs. Callaway and Dr. Chambers revealed that Mrs. Callaway was having sexual problems in her marriage and had been sexually abused by her father.¹⁶⁹ Under the guise of treatment, Dr. Chambers and Mrs. Callaway entered into a "bizarre" and "sodomasochistic" sexual relationship.¹⁷⁰ After several years of this "treatment," Mrs. Callaway conferred with another physician.¹⁷¹ Under the new physician's care she was hospitalized and diagnosed as suffering from severe depression, anorexia, and agoraphobia, all determined to be a result of Dr. Chambers's "medical activities."¹⁷² Consequently, Mrs. Callaway filed a medical malpractice action.¹⁷³

Dr. Chambers and his insurer settled their liability with Mrs. Callaway, and she sought excess damages payable from the Indiana Patient's Compensation Fund.¹⁷⁴ The Indiana Second District Court of Appeals found she was entitled to such funds based on Dr. Chambers's use of therapy as a pretext for engaging in sexual relations, thus defeating the Compensation Fund Administrator's argument that the injuries did not result from the provision of health care services.¹⁷⁵ The court acknowledged the undue influence Dr. Chambers had exerted over Mrs. Callaway, and accordingly held she was entitled to be fully compensated for the nature of her injuries.¹⁷⁶

In *Wall v. Noble*,¹⁷⁷ Texas courts again found medical malpractice liability when a physician-patient sexual relationship was commenced under the guise of treatment. Ms. Noble consulted Dr. Wall in response to a medical condition that caused her breasts to sag.¹⁷⁸ Dr. Wall, a plastic surgeon, performed three breast-lift surgeries to alleviate this disquieting condition.¹⁷⁹ After the first surgery, Ms. Noble and Dr. Wall began a sexual liaison.¹⁸⁰ This pattern of sexual behavior was premised on Dr. Wall's promise that "I am your doctor—trust me," a statement which he repeated frequently when initiating a sexual advance.¹⁸¹ After the condition of her breasts

¹⁶⁷*Id.* at 425.

¹⁶⁸*Id.*

¹⁶⁹*Id.*

¹⁷⁰*Id.* at 428.

¹⁷¹*Dillon III*, 609 N.E.2d at 425.

¹⁷²*Id.*

¹⁷³*Id.* at 426.

¹⁷⁴*Id.*

¹⁷⁵*Id.* at 426.

¹⁷⁶*Dillon III*, 609 N.E.2d at 428.

¹⁷⁷*Wall v. Noble*, 705 S.W.2d 727 (Tex. Ct. App. 1986).

¹⁷⁸*Id.* at 729.

¹⁷⁹*Id.*

¹⁸⁰*Id.* at 731.

¹⁸¹*Id.* at 731.

failed to improve, Mrs. Noble filed a medical malpractice action claiming that Dr. Wall had negligently performed her surgeries, and had negligently engaged in a sexual relationship with her causing a breach of his fiduciary duty.¹⁸²

The Texarkana Court of Appeals affirmed the trial court's judgment for Ms. Noble.¹⁸³ Claiming that "the evidence of the sexual liaison was relevant, competent, and material in determining the physician's compliance with the standards of care," and concluding that the issue of when "treatment ended and a consensual sexual liaison began" was best left with the jury, the court found Dr. Wall liable on both grounds for medical malpractice.¹⁸⁴

Callaway and *Wall* represent the types of physician exploitation should always be actionable. Physicians who use their office or status for sexual gain are illicitly benefiting from the advantages placed upon them by society. In misusing their positions of authority and perverting the nature of their care, these physicians are demeaning the medical profession. A physician-patient sexual relationship undertaken in this manner can never be deemed consensual, because it will always be fraudulently induced. And because the sexual relationship is entered into under the guise of treatment, the sexual conduct becomes indistinguishable from the other legitimate services the physician may provide. Courts, again, have had little difficulty in holding physicians liable for medical malpractice when they engage in such tactless behavior.

C. Non-Mental Health Physicians Who Take on Counseling Matters

The non-mental health physician who undertakes "counseling matters" may also be held liable for medical malpractice based on a sexual relationship. "Counseling matters" describes behavior in which the physician "enters into a relationship of trust and confidence with a patient and offers counseling on personal matters to that patient, thus taking on a role similar to that of a psychiatrist or psychologist."¹⁸⁵ Courts examining cases in this area have reached strikingly dissimilar conclusions, finding liability in some instances and determining non-suits in others. To provide guidance in formulating this "new" area of medical malpractice liability, the courts have weighed a variety of factors including, but not limited to, public policy concerns, the scope of the physician-patient relationship, and the right to privacy and personal autonomy.

Liability has often rested on the courts' determination of whether the services provided were truly professional in nature (versus personal), or alternatively, whether in the courts' opinion the physician has grossly exploited his or her superior authoritative position for mere sexual advantage and personal gain (versus mutual consent and willing participation). The courts who have expanded liability in this area, regardless of any beneficent motives, are guilty of overlooking the obvious. Not every act performed by the physician arises out of the physician-patient relationship. And consequently, not every action taken by the physician represents adequate legal grounds for asserting medical malpractice. Failing to recognize such

¹⁸²*Wall*, 705 S.W.2d at 729.

¹⁸³*Id.* at 734.

¹⁸⁴*McCracken*, 717 A.2d at 352.

¹⁸⁵*McCracken*, 717 A.2d at 352.

an important distinction ignores sound legal principles and punishes the physician for his or her status rather than for his or her undesirable behavior. The courts must come to the realization that consensual physician-patient sexual relationships are simply beyond judicial scrutiny and societal intervention.

One of the first cases to deal with a physician who undertakes "counseling matters" is *Hoopes v. Hammargren*.¹⁸⁶ In *Hoopes*, Mrs. Hoopes sought treatment from Dr. Hammargren, a neurosurgeon, for multiple sclerosis.¹⁸⁷ Recognizing the emotional liability associated with the disease, which affects the nervous system, Dr. Hammargren prescribed quaaludes, valium, elavil, triavil, meprobamate, chloral hydrate, phenobarbital, seconal, and talwin to combat her anxiety.¹⁸⁸ These drugs are depressants with the "recognized potential for physical and psychological dependence."¹⁸⁹ Three months after Mrs. Hoopes' initial visit, Dr. Hammargren invited her out to dinner and then back to his office to "see his iguanas."¹⁹⁰ Mrs. Hoopes and Dr. Hammargren then commenced a sexual relationship lasted nearly five years until she relocated to get married.¹⁹¹ After consulting with another doctor, Mrs. Hoopes learned that she exhibited no signs of multiple sclerosis, and even if she had, Dr. Hammargren's prescriptions were not a typical course of treatment.¹⁹² Upset by Dr. Hammargren's apparent deception based on the improper prescriptions, the misdiagnosis of her condition, and the breach of the applicable standard of care based on the resulting sexual relationship, Mrs. Hoopes filed a medical malpractice action.

The trial court granted summary judgment to Dr. Hammargren.¹⁹³ The Supreme Court of Nevada reversed the trial court, holding that substantial evidence supporting Mrs. Hoopes's mistreatment and sexual advantage claims precluded summary judgment.¹⁹⁴ Examining the fiduciary nature of the physician-patient relationship, which is built on trust and confidence, and the duty of good faith imposed on Dr. Hammargren, the court concluded that taking "sexual advantage of the physician-patient relationship can constitute malpractice."¹⁹⁵ The court determined that for Mrs. Hoopes to prevail at trial, she must prove by a preponderance of the evidence that one, Dr. Hammargren held a superior authoritative position in the relationship; two, her medical condition left her mentally and emotionally "vulnerable"; and three, Dr. Hammargren unethically and illicitly exploited this vulnerability.¹⁹⁶ Mrs. Hoopes

¹⁸⁶*Hoopes v. Hammargren*, 725 P.2d 238 (Nev. 1986).

¹⁸⁷*Id.* at 239.

¹⁸⁸*Id.*

¹⁸⁹*Id.* at 239 n.2.

¹⁹⁰*Id.* at 240.

¹⁹¹*Hoopes*, 725 P.2d at 240.

¹⁹²*Id.*

¹⁹³*Id.* at 241.

¹⁹⁴*Id.* at 243.

¹⁹⁵*Id.* at 242.

¹⁹⁶*Hoopes*, 725 P.2d at 243.

must also show that Dr. Hammargren's actions were the proximate cause of her injuries.¹⁹⁷ By treating Mrs. Hoopes's psychological needs as well as her physical injuries, Dr. Hammargren's conduct in the form of a sexual relationship created new grounds for medical malpractice.

The District of Columbia Court of Appeals in *McCracken v. Walls-Kaufman*¹⁹⁸ applied a similar rationale when it examined as a matter of first impression whether a chiropractor could be held liable for malpractice for engaging in sexual activity with a patient. Dr. Walls-Kaufman provided chiropractic treatment to Mrs. McCracken.¹⁹⁹ During the course of her treatment she discussed personal matters with Dr. Walls-Kaufman, and he in return offered advice and counseling.²⁰⁰ Mrs. McCracken alleged that Dr. Walls-Kaufman sodomized her on approximately six occasions, and was unable to fend off these "assaults" due to a valium addiction of which Dr. Walls-Kaufman had prior knowledge.²⁰¹ Accordingly, Mrs. McCracken filed a medical malpractice claim.²⁰²

The District of Columbia Court of Appeals held that Mrs. McCracken stated a viable claim for medical malpractice.²⁰³ The court concluded that if a non-mental health physician enters into a relationship of trust and confidence with a patient, and takes on a role similar to that of a psychiatrist or psychologist by offering counseling on personal matters, the physician would be bound to "the same standards as would bind a psychiatrist or psychologist in a similar situation."²⁰⁴ The court required Mrs. McCracken to demonstrate on remand that one, the two engaged in a sexual relationship; two, during the course of the chiropractic treatment a psychologist-patient relationship had developed; and three, by engaging in a sexual relationship, Dr. Walls-Kaufman breached the applicable standard of care.²⁰⁵ Expert testimony would be necessary to establish these elements conclusively.²⁰⁶ In reaching this determination, the District of Columbia Court of Appeals creatively circumvented two barriers preventing Mrs. McCracken's tort recovery. First, the court ruled that the same course of conduct (i.e. the "assaults") may support both a medical malpractice (professional negligence) and an intentional tort claim.²⁰⁷ Second, by characterizing Dr. Walls-Kaufman's conversations as "counseling," the court could apply the more rigorous medical malpractice standard typically confined to members

¹⁹⁷*Id.*

¹⁹⁸*McCracken*, 717 A.2d 346 (D.C. 1998).

¹⁹⁹*Id.* at 348.

²⁰⁰*Id.*

²⁰¹*Id.* at 350.

²⁰²*Id.* at 348.

²⁰³*McCracken*, 717 A.2d at 352.

²⁰⁴*Id.* at 352.

²⁰⁵*Id.*

²⁰⁶*Id.*

²⁰⁷*Id.* at *4.

of the mental health profession.²⁰⁸ The *McCracken* decision represents the pinnacle of judicial activism in medical malpractice liability.

Hoopes and *McCracken* are both examples of court decisions aimed at broadening traditional notions of physician malpractice liability and prohibiting consensual physician-patient sexual relationships. Other courts, however, have been less willing to apply such strict legal standards.²⁰⁹

In *Odegard v. Finne III*,²¹⁰ the Minnesota Court of Appeals affirmed summary judgment in favor of Dr. Finne on Mrs. Odegard's intentional infliction of emotional distress and medical malpractice claims.²¹¹ Dr. Finne performed eleven surgeries on Mrs. Odegard to alleviate the ulcerative colitis from which she suffered.²¹² This medical condition caused her to experience eating difficulties, and negatively affected her self-esteem.²¹³ After her medical condition significantly improved following the last surgery, Mrs. Odegard and Dr. Finne initiated a sexual relationship.²¹⁴ As a result of this relationship, Dr. Finne asked Mrs. Odegard to marry him, contingent upon both parties obtaining a divorce from their present spouse.²¹⁵ The relationship ended when Dr. Finne decided to return to his wife and child.²¹⁶

The Minnesota Court of Appeals refused to recognize Mrs. Odegard's claim that a psychologist-patient relationship (based on the presence of the transference phenomenon) had developed, stating "transference is not a recognized component in the medical treatment of physical conditions."²¹⁷ The court further held that non-mental health physician liability would be restricted to situations in which the sexual relationship was commenced under the "guise of treatment."²¹⁸ Finding no facts to support a claim that the relationship was anything other than "consensual," the court reasoned that "essentially appellant [Mrs. Odegard] complains that she had an unhappy affair with a man who happened to be her doctor. This [complaint] is plainly insufficient to make out a cause of action for professional negligence."²¹⁹

²⁰⁸*McCracken*, 1998 WL 574763, at *5.

²⁰⁹*See* *Gunter v. Huddle*, No. 2970984, 1998 WL 802673 (D.C. Sept. 10, 1998). *See also* *Gromis v. Medical Bd. of California*, 10 Cal. Rptr. 2d 452 (Ct. App. 1992); *Wadsworth v. ABC Ins. Co.*, No. 98-C-0486, 1998 WL 934428 (La. Ct. App. 1998); *Mindt v. Winchester*, 948 P.2d 334 (Or. Ct. App. 1997), *review denied*, 966 P.2d 222 (Or. 1998).

²¹⁰*Odegard v. Finne III*, 500 N.W.2d 140 (Minn. Ct. App. 1993).

²¹¹*Id.* at 144.

²¹²*Id.* at 141.

²¹³*Id.*

²¹⁴*Id.*

²¹⁵*Odegard*, 500 N.W.2d at 141.

²¹⁶*Id.*

²¹⁷*Id.* at 143.

²¹⁸*Id.*

²¹⁹*Id.* (quoting *Atienza v. Taub*, 239 Cal. Rptr. 454 (Ct. App. 1987)).

*Newland v. Azan*²²⁰ provides another example of a court refusing to expand non-mental health physician malpractice liability. In *Newland*, Dr. Azan performed a root canal and other related procedures for Ms. Newland.²²¹ While she was sitting in the dental chair, and after being given several painkiller shots, Dr. Azan “touched her pubic area, kissed her, caressed her cheek and hand, rubbed his own genital area, and made sexually suggestive comments.”²²² Following treatment, Ms. Newland filed a petition claiming professional negligence (medical malpractice), battery, and intentional infliction of distress.²²³

The trial court granted summary judgment to Dr. Azan on the professional negligence claim.²²⁴ The Missouri Court of Appeals affirmed concluding “it must be a dental act or service that caused the harm, not an act or service that requires no professional skill.”²²⁵ The court also found no evidence linking the sexual contact to any “course of dental treatment,” nor to the presence or commencement of a psychologist-patient relationship.²²⁶ Finding that “unlike the therapist-patient relationship, there is nothing inherent in the typical relationship between a patient and a dentist that makes the patient unusually susceptible to accept the sexual advantages of the dentist,” the court refused to apply the more rigorous malpractice liability standard applicable to mental health physicians.²²⁷

Odegard and *Newland* illustrate sound judicial reasoning. By recognizing the lack of professional services implicated in a sexual relationship, and the absence of any psychologist-patient relationship in the typical course of medical treatment, these courts have refused to allow malpractice recovery for patients suffering from “broken hearts.” Because this policy is socially advantageous (it makes both parties responsible for their “bedroom antics”), as well as legally and economically practical, *Odegard* and *Newland* should be embraced by the judiciary. Physician-patient consensual sexual relationships are simply that, consensual. Punishing one party (the physician) for the lack of good judgment shown by BOTH parties reflects an outdated view of humanity and promotes gross social irresponsibility. The costs of a physician-patient sexual relationship should be borne by the parties involved, at no expense to the average everyday citizen who recognizes the need for approaching such a situation with extreme care and prejudice. The non-mental health physician’s liability for medical malpractice based on a sexual relationship must be limited to

²²⁰*Newland v. Azan*, 957 S.W.2d 377 (Mo. Ct. App. 1997).

²²¹*Id.* at 378.

²²²*Id.*

²²³*Id.*

²²⁴*Id.*

²²⁵*Newland*, 957 S.W.2d at 379. The court stated “In the present case, we also note the absurd precedent that would be set by allowing *Newland* to sue Dr. Azan under the theory of malpractice for sexual assault that did not involve dental care. For example, under the rule proposed by *Newland*, if a dentist shot his patient or tied the patient to a chair in the dentist’s office, this would also fall within the realm of malpractice.” *Id.* at 379 n.1.

²²⁶*Id.* at 379.

²²⁷*Id.* at 379.

those rare situations which involve exploitation of the patient under the "guise of treatment."

IV. ANALYSIS

The effects of the physician-patient sexual relationship permeate numerous facets of American life. The patient, the physician, hospitals, insurers, insureds, the judiciary, the legislature, the AMA, the APA (American Psychiatric Association), state licensing boards, and medical ethics committees all assert legally recognized interests in defining the proper parameters of physician-patient conduct. Conflicts, therefore, are certain to arise. To resolve these conflicts it becomes necessary to complete a cost-benefit analysis, one aimed at balancing society's interest in adequate medical treatment with an individual's right to privacy and autonomy in personal relationships. Three parties, however, the patient, the physician, and the insurers, warrant special attention. Because these parties stand to gain or lose the most by maintaining or changing the status quo, any such analysis must first begin by examining their rights and duties in retrospect to each other. Only then may a proper distinction be drawn between legally permissible behavior (a consensual physician-patient sexual relationship), and behavior which is potentially unethical or criminally suspect (sexual relationships occurring in therapeutic settings or under the guise of treatment).

The benefits resulting from judicial recognition of physician-patient consensual sexual relationship, are largely intangible. As anyone who has ever experienced a romantic relationship will be able to tell you, love can be a glorious thing. With it flows all of the emotions and intimate associations necessary to create a lifetime of fulfillment. Principles such as honesty, dedication, and mutual trust serve as bridges bringing people closer together, and also act as barriers insulating partners from the harshness of society. A romantic relationship between a doctor and a patient is no different. A relationship is no less "real" because its parties consist of a doctor and his or her patient, than one whose members consist of a baker and a cabinetmaker. It is of course true that a physician-patient relationship encourages a close bond to facilitate healing.²²⁸ It is also true that initially the physician maintains a superior position in the relationship.²²⁹ But like all relationships based on "chance circumstances," nothing prevents the parties involved from altering or modifying their current "bargaining" positions. In fact, most valid relationships will undergo long-term changes to better reflect the parties' mutual needs and wants. Love, no matter where you find it, simply cannot be trivialized.

Another intangible benefit springs from the physician's and patient's fundamental rights to privacy.²³⁰ Physicians are expected to work long and arduous hours curing disease and treating the sick and injured. The longer hours the physician works, the less time that exists for pursuit of social endeavors. By effectively banning fraternization with certain classes of patients (the AMA has banned sexual relationships with current patients, as well as considered bans on former patients and relatives of patients), the nature and quality of the physician's

²²⁸*Leffler, supra* note 20, at 508.

²²⁹*Id.*

²³⁰*Pons*, 1991 WL 245003, at *6.

life is negatively affected. Through such regulation the AMA is essentially eliminating the physician's ability to "choose" among certain prospective romantic partners and potential spouses. Instead of "narrowly tailoring" its prohibitions to physicians who exploit their patients by commencing a sexual relationship under the guise of treatment, the AMA attempts to abridge the rights of consenting adults to privately engage in constitutionally-protected behavior. Physicians, as well as patients, deserve the opportunity to pursue intimate associations free of any unfair and unmeritorious impositions based solely upon their status in the professional relationship. Undoubtedly, the "right to happiness" falls outside of the AMA's regulatory capabilities.

Limiting medical malpractice to non-consensual physician-patient sexual relationships also benefits insurance companies. "Each year in America, consumers, homeowners, small businesses, corporations, directors and officers, private individuals, professionals, private and public institutions, and associations spend an estimated \$200 billion purchasing third-party liability insurance from property and casualty insurers."²³¹ Physicians purchase liability insurance to protect themselves from adverse judgments resulting from damages sustained in "providing or withholding professional services."²³² Purchasing insurance also provides third-party victims, or the patients in this instance, a viable means of economic recovery for their injuries. Accordingly, to limit their liability and maintain price controls, insurance agencies often try to exclude coverage for "intentional and immoral" acts.²³³ Physicians who engage in sexual conduct with their patients would logically fall within this exclusion. But unfortunately, time and time again, insurers are asked (or ordered by the courts in duty-to-defend declarations) to defend policy-holding physicians who engage in such behavior.²³⁴ "Insuring" consensual sexual conduct, and forcing insurers to provide legal defenses for non-professional acts, unfairly imposes the "costs" associated with the romantic relationship onto society. These "costs" include acquiescing to potentially unethical and undesirable behavior (the physician-patient sexual relationship), and ultimately are reflected in greater health care expenditures and rising malpractice premiums.

Courts who have been faced with this moral dilemma have not surprisingly reached inconsistent judgments. Notions of public policy, and overriding concerns regarding the health and welfare of the patient, have influenced courts to restrict or to ignore the language limiting insurance coverage to the "rendering of professional services." Courts have also confusingly drawn legal distinctions between certain types of physicians (the gynecologist versus the medical technician) in determining whether the sexual conduct has become "intertwined with and inseparable from the other services provided."²³⁵ Courts reaching either conclusion have largely abused their judicial discretion. A consensual physician-patient relationship can never constitute the rendering of professional services. In examining the nature of the sexual act, the courts should focus not on the physician's specialty or presumed

²³¹*Rice, supra* note 61, at 1133.

²³²*Id.* at 1177.

²³³*Id.* at 1136.

²³⁴*Id.*

²³⁵*Id.* at 1179.

authoritative position in the relationship, but instead on whether the physician has used his or her professional status to "sexually exploit" the patient. "Exploitation" of the patient would be limited to situations which involve commencing a sexual relationship under the guise of treatment, mishandling of the transference phenomenon in the therapeutic setting, and taking advantage of unconscious or incapacitated patients unable to physically or mentally fend for themselves. All of these situations arise under the auspices of the professional relationship, and consequently, insurers would have a duty to defend such claims. By limiting insurer liability to physician "exploitation," consensual physician-patient sexual relationships fall outside the scope of insurable behavior. With no duty to defend these relationships, insurers are provided with the legal certainty and economic wherewithal necessary to maintain reasonable premiums and to promote efficient resolution of outstanding claims. The benefits to insurers, therefore, are more tangible (monetary) than intangible.

Finally, the most tangible benefit results from clarifying the structure of physician regulation. Other avenues exist to deter unwanted and undesirable physician behavior. Criminal penalties such as rape, statutory rape, and sexual assault exist to prevent "the most egregious instances of physician sexual misconduct - involving minor patients, or the use of drugs, anesthesia, or force to prevent or overcome resistance."²³⁶ Four states (Colorado, Michigan, New Hampshire, and Wyoming) have also criminalized sexual contact under the "guise of treatment."²³⁷ Additionally, thirteen states have adopted some form of criminal sanctions governing physician sexual misconduct.²³⁸ Nine of these statutes "cover sexual contact both within and outside actual treatment sessions during an ongoing professional relationship."²³⁹ Two statutes are limited to sexual misconduct occurring during the medical treatment or examination, and the other two statutes apply to sexual misconduct occurring outside of the actual treatment sessions when the patient has become emotionally dependent upon the physician or therapist.²⁴⁰ The majority of these statutes are worded broadly enough to encompass both mental health and non-mental health physicians, and have withstood constitutional due process and equal

²³⁶*Leffler, supra* note 20, at 527.

²³⁷*Id.*

²³⁸*Id.* at 528. *See also* CAL. BUS. & PROF. CODE § 729 (West 1998); COLO. REV. STAT. ANN. § 18-3-405.5 (West 1999); CONN. GEN. STAT. ANN. § 53a-71 (West 1998); FLA. STAT. ANN. § 491.0112 (West 1998); GA. CODE ANN. § 16-6-5.1(c)(2) (1998); IOWA CODE ANN. § 709.15 (West 1998); ME. REV. STAT. ANN. tit. 17-a, § 253(2)(I) (West 1998); MINN. STAT. ANN. § 609.344(h) (West 1998); N.H. REV. STAT. ANN. § 632-A:2(g) (1998); N.M. STAT. ANN. §§ 30-9-10 to 30-9-12 (Michie 1998); N.D. CENT. CODE § 12.1-20.06.1 (Supp. 1993); S.D. CODIFIED LAWS §§ 22-22-29 to 22-22-30 (Michie 1998); Wis. Stat. Ann. § 940.22(2) (West 1999).

²³⁹*Id.*

²⁴⁰*Leffler, supra* note 20, at 528. The North Dakota and New Hampshire statutes are limited to sexual contact occurring during the medical treatment or examination, while the South Dakota and Connecticut statutes apply only when sexual misconduct occurs outside of treatment, and the patient has become emotionally dependent on the physician. *Id.* at 528 n.149-150.

protection challenges.²⁴¹ Criminal sanctions obviously present a substantial deterrent to physician misconduct.²⁴²

Administrative penalties also exist. "The practice of medicine is a privilege granted by the states via licensing procedures."²⁴³ States through medical boards enforce statutes and regulations governing physician conduct.²⁴⁴ The medical boards have a duty to protect the public and prevent physician exploitation at the expense of the patient.²⁴⁵ Administrative regulation of physicians also provides "substantial advantages and benefits to the victim over civil and criminal controls."²⁴⁶

The rules of evidence and burdens of proof are generally more relaxed in an administrative hearing.²⁴⁷ Typically no statute of limitation exists, and the patient's prior sexual history is protected (by not being disclosed) under victim-shield provisions.²⁴⁸ Medical boards also have a wide range of available sanctions at their disposal.²⁴⁹ These sanctions include license suspension, license revocation, practice restrictions, mandatory counseling, and compulsory state monitoring.²⁵⁰ Physician misconduct is also judged by those members of society most capable of determining its presence, i.e., other similarly-situated physicians. Peer review and damage to one's professional reputation also serve as strong behavioral restraints. Administrative sanctions, including the potential loss of the physician's livelihood, afford patients another option to redress their alleged injuries.

Limiting medical malpractice to situations which involve physician "exploitation" does not leave patients "out in the cold." If the conduct rises to criminally prosecutable behavior, or violates a specified provision in the physician's license to practice medicine, the physician's conduct will not go unpunished. Indeed, the only fundamental change results in the type of "compensation" the patient is entitled to. In truly consensual physician-patient sexual relationships, the patient is entitled to no recovery. In situations in which the nature of the relationship is less definitive, the patient may receive satisfaction in knowing the physician's conduct will be reviewed by others. In the most extreme cases, including those instances in which the physician engages in sexual relations under the guise of treatment, both criminal and civil remedies will be available and appropriate. This author simply contends that the punishment should correspond to the nature of the crime. The regulation of physicians must reflect the same traditional notions of "fair play" recognized in other areas of the law.

²⁴¹*Id.* at 528.

²⁴²*Id.* at 529.

²⁴³*Id.* at 530.

²⁴⁴*Leffler, supra* note 20, at 530.

²⁴⁵*Id.*

²⁴⁶*Id.*

²⁴⁷*Id.* at 531.

²⁴⁸*Id.* at 530-531.

²⁴⁹*Leffler, supra* note 20, at 531.

²⁵⁰*Id.*

The costs of recognizing a consensual physician-patient sexual relationship fall primarily upon the patient's not-so-broad shoulders. These costs are not insignificant nor insubstantial. Medical studies have shown that 85-90% of patients who engage in sexual contact with their physicians consider it as "damaging."²⁵¹ "Similar to the reactions of women who have been sexually assaulted, female patients tend to feel angry, abandoned, humiliated, mistreated, or exploited by their physicians."²⁵² Patients may also suffer from "depression, anxiety, sexual disorders, sleeping disorders, and cognitive dysfunctions and are at risk for substance abuse."²⁵³ These feelings and emotions lead patients to eventually distrust their own judgments, and breed mistrust and resentment towards physicians in general.²⁵⁴ Physicians who initiate sexual contact for simple self-gratification, or who aim to humiliate or exploit patients, are also acting contrary to the duties and ethical obligations imposed upon them by society. A physician's moral obligation to his patient dictates that the physician act responsibly at all times, and encourages physicians to proceed both personally and professionally with due caution and considerable foresight. The sanctity and prestige of the entire medical profession reflects the judgments and actions of its individual members.

It is important to recognize that the above-mentioned medical studies are based on patients who have initiated disciplinary actions against physicians or therapists.²⁵⁵ Patients not harmed by consensual sexual relationships "may have escaped the attention of researchers."²⁵⁶ And at the termination of all romantic relationships (regardless of the professional make-up of its constituents) feelings of anger, abandonment, humiliation, and mistreatment are not uncommon or unusual. The patient's solution is simple. Just say no. Just say no to the physician, or be willing to accept the social, moral, and legal consequences stemming from willful participation. Just say no.

A recognition of the physician-patient consensual sexual relationship comports with reality. Relationships of this nature do exist, and prospective partners enter such relationships voluntarily. Perhaps society would be better off by prescribing an absolute ban on all physician-patient sexual relationships. The AMA certainly thinks so. Medical studies tend to support this conclusion. Judicial decrees and medical ethics committee resolutions promulgate such behavioral prohibitions. Proponents are also quick to point out the presence of the transference phenomenon and the physician's authoritative status in the relationship. Certainly, a relationship with so many "negatives" must be contrary to the public "good." The analysis, however, must not stop here. The physician's conduct should be evaluated in its entirety under a "totality of the circumstances" test. No exploitation, no violation. Consensual physician-patient sexual relationships are a fact of life. While such relationships

²⁵¹*Sexual Misconduct in the Practice of Medicine, supra* note 25, at 2742.

²⁵²*Id.*

²⁵³*Id.*

²⁵⁴*Id.*

²⁵⁵*Id.* at 2742-2743.

²⁵⁶*Sexual Misconduct in the Practice of Medicine, supra* note 25, at 2743.

may not be desirable, nor medically conducive, allowing patients to recover under the rubric of medical malpractice denotes strong judicial improvidence.

V. CONCLUSION

Nothing about sex is simple. People who regularly engage in sex often do so without fully comprehending the emotional and psychological consequences which are sure to follow. Physician-patient sexual relationships differ from conventional sexual relationships in only one aspect - they involve a physician and a patient. The presence of the transference or countertransference phenomenon, the physician's authoritative status, the providing of professional services, the inherent conflicts and obligations implicated by the Hippocratic oath, and the creation of boundaries to deter physician misconduct all become irrelevant when the patient implicitly consents to a sexual relationship. True consent can be fully given even though neither party initially recognizes the social undesirability and high obstacles which must be overcome to make such a relationship a "success."

Once the physician and the patient enter a consensual sexual relationship, the judiciary must take a "hands-off approach." While inappropriate non-voluntary sexual conduct will continue to be harshly punished and severely scrutinized, voluntary sexual conduct cannot and should not fall under the doctrine of medical malpractice. Allowing patients to recover, and insurers to pay, and physicians to be held liable for conduct which occurs outside of the professional relationship makes little sense. People must learn to accept responsibility for their actions. Subsidizing stupidity, and discounting common sense are "bad" public policies for the judiciary to promote. Malpractice recovery *must* be limited to those circumstances which involve physician "exploitation." Otherwise, society pays while the doctor and patient play.

Sex, in the wrong place, or at the wrong time, or even with the wrong person, can have serious, serious, consequences.

SCOTT M. PUGLISE