Sexual Abuse of Patients by Health Care Professionals

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Introduction

The ramifications to a physician accused of sexually assaulting a patient range from the catastrophic to the cataclysmic. Humiliation is the least of it. What lies ahead can be civil suits for hundreds of thousands of dollars, license revocation, family consequences, and, in some states, criminal charges. Almost unheard of -- or at least not spoken of -- a dozen years ago, charges of sexual abuse by health care providers, primarily psychiatrists and other psychotherapists, have resulted in one of the most rapidly growing categories of malpractice insurance claims payments.

Statistics reveal the tip of the iceberg. In Massachusetts, as an example, complaints of sexual misconduct made against physicians to the Board of Registration in Medicine, the state's licensing authority, numbered less than five per year during the early 1980s; by the end of the decade, the numbers were growing rapidly: in 1987, there were 17 such complaints; in 1988, there were 27, and in 1989, there were 55.(1) The 1990 total is not yet available, but is expected to be significantly higher than the prior year. In addition, several attempts to discover the scope of the problem by means of anonymous national surveys indicate that roughly 10% of psychiatrists responding admitted to having had sex with at least one patient.(2)

Jury verdicts against physicians accused of sexual abuse can be quite high; even a multimillion dollar verdict has been reported.(3)Compounding the potentially devastating financial consequences is a strong trend among professional liability insurers to attempt to deny liability for injuries caused by sexual contact between health care providers and patients, leaving physicians to pay their own legal expenses and, ultimately, any damages awarded to the patient.

At least seven states have passed legislation creating civil causes of action for sexual abuse by health care professionals.(4)Some states have adopted comprehensive legislative schemes establishing civil suits, license revocation proceedings, criminal sanctions, and mandatory reporting of information concerning sexual contacts by licensed professionals.(5) Additional states are considering similar legislation.

Sex between patients and psychotherapists is now uniformly deplored and unequivocally branded as wrong and unacceptable. The most comprehensive recent survey of psychiatrists reported that 98% of those responding felt sexual contact between psychotherapist and patient while the patient is in treatment is

always inappropriate. A similar number stated that such contact is usually or always harmful to the patient.[6] Moreover, the American Psychiatric Association flatly states that "[s]exual activity with a patient is unethical[7]" The cutting edge of legal and ethical inquiry now is focused on finer points, such as when, if ever, after the professional relationship ends is social and sexual contact acceptable.

This energizing of the legal, ethical, and medical communities around the issue is all the more remarkable when one considers that the first reported successful lawsuit by a patient against a physician for sexual contact was decided less than 20 years ago, and in that case, the trial judge reduced the jury's damage award of $153,679 to $25,000 because he felt the patient was not severely injured.[8] The evidence in the case showed that the psychiatrist had convinced his patient that "sexual treatment" would help her get well, and had even prescribed birth control pills before initiating intercourse, and that the patient was twice confined to a mental hospital as a result of the physician's sexual abuse.[9]

Susceptible physicians; susceptible patients

Leading psychiatric authorities on sexual relations between psychotherapists and patients have attempted to identify the personality types most likely to become sexually involved with one another. The "composite psychotherapist" is a man more than 40, usually ten to 25 years older than his patient (typically, a young female or a homosexual male), who is personally involved in a difficult heterosexual relationship, recently separated, or divorced. He is "rather withdrawn and introspective, studious, passive, shy," intellectual, perhaps intellectually but not physically adventuresome.[10] Among other things, this adds up to being unpopular with the opposite sex.

Just as certain personality types of health care professionals may be most susceptible to sexual involvement with patients,[11]a specific type of.patent is most likely to accuse physicians of sexual contact. According to Dr. Thomas G. Gutheil, who has written, testified, and lectured extensively on this topic, neither psychotic nor neurotic patients are likely to become sexually involved with their therapists since psychotics are not perceived as attractive and therapists would generally not wish to become involved with neurotics. The field is thus left open to patients with borderline personality disorders, who can exhibit such rage and be so controlling as to intimidate their therapists into breaking the rules by disclosing personal information or crossing professional boundaries.[12] Unfortunately, one form of intimidation exercised by patients with borderline personality disorders is the filing of specious lawsuits against their therapists.

In analyzing some 28 malpractice cases in which he was retained as an expert and dozens of cases in which he performed forensic consultations, all involving male therapists and female patients with borderline personality disorders, Dr. Gutheil found that every case, whether the allegations were true or false, was clinically mismanaged, primarily due to the therapist's failure to enforce

boundaries and meet the patient's need for clarity. Consequently, Dr. Gutheil recommends that once the patient-therapist relationship and the anticipated transference becomes eroticized, the therapist should present the case to a colleague, supervisor, or consultant for input and perspective.(13)

Based on this analysis, physicians are well advised to learn to identify both the characteristics in themselves that could lead to crossing the line with patients and the patients with whom they should be most careful to maintain professional boundaries. With the consequences of sexual misconduct allegations so severe, physicians should be especially careful to exercise restraint and should bring in a third party consultant in cases where the erotic level approaches the danger point.

The civil suit

In the 15 to 20 years that patients have been suing their physicians as a result of sexual encounters, the legal analysis of such suits has evolved from attempts to find a common-law niche, such as a suit for seduction, to a sophisticated examination of the role and consequences of the phenomenon of transference -- i.e., the emotional reaction the patient in therapy has toward the physician.(14) The early suits, often brought by discarded husbands of female patients, were wrongs looking for a legal name.(15) Physicians often won these suits, with plaintiffs either losing outright or failing to collect on any judgment they received. More recently, the pendulum has swung the other way. Creativity is now required to derive a defense, rather than to construct a legal ground on which to sue. In some states, particularly those in which a statutory cause of action has been created, there are only two issues at trial: Was there sex, and if so, how much money does the patient get?

Damage suits by patients claiming sexual abuse are based on one of two underlying allegations: (1) that the physician convinced the patient that engaging in sex was part of the medical treatment, or (2) that, although the physician never suggested that sex was part of the treatment, he failed to exercise self-restraint and thus breached his fiduciary duty to the patient.(16) The difference between these two scenarios is that in the first case, where the use of "therapeutic deception" is alleged, the physician's legal defense must be based on a head-on confrontation on the facts -- he must deny the sexual conduct, since he will not be able to present credible expert testimony that sexual encounters between a patient and a therapist are an accepted form of treatment.(17) The physician's only defense is to attempt to prove that the patient is fabricating.

Should the patient's allegation take the second form, however, the physician can assert a defense of consent. According to this defense, the physician admits to the sexual conduct, but portrays it as conduct between two consenting adults, outside of the therapeutic relationship and, hopefully, outside of his office.

The Defense of Consent: Is It Love or Is It Malpractice?

The legal foundations for a consent defense are eroding rapidly, however, to the point where, if the patient has competent counsel, the defense is barely viable. To counter consent as a defense, the plaintiff can assert counts for malpractice and breach of fiduciary duty based on the physician's failure to competently deal with the transference phenomenon. Boiled down to its essentials, the plaintiff's position is that in every therapeutic relationship the physician should expect the patient to idealize him and to transfer to him sexual desires and fantasies and, knowing this in advance, the physician should be able to deflect it. According to this theory, failure to adequately deal with transference is malpractice.

Whether or not the patient consented to the sexual activity, then, is irrelevant, since any sexual conduct is malpractice per se. Framed as malpractice, rather than as an intentional tort, the plaintiff's entire case on liability rests on proof of the sexual act; once that is proven, there is strict liability. Consent is not relevant to a malpractice count. Thus, consent is no more an issue in this case than in a case where a surgeon leaves a scalpel inside a patient. The only issues are whether the physician had a duty to treat the patient in accordance with accepted standards and, if so, whether those accepted standards barred sexual contacts.

The vast majority of cases stand for the proposition that any sexual contact between a therapist and a patient during the time the therapy continues are malpractice and a breach of fiduciary duty; in effect, the relationship is such a close and trusting one that it is the duty of the therapist to know better than to permit sexual contact.(18) One case that went against this trend involved a nonphysician - an alcohol abuse counselor. In this nonjury case, a federal trial judge rejected negligence and malpractice counts against the counselor, finding that the relationship between the counselor and the woman he was treating -- which included sexual intercourse in his office and led to the woman obtaining two abortions -- resulted from "private, mutual consent and attraction" and "did not constitute part of any treatment plan."(19)This case appears to be an aberration, however, possibly based on the fact that the defendant was a nonprofessional, rather than a psychiatrist or psychologist.(20)

Instructive on the difficulty of successfully asserting a consent defense against a malpractice claim is a case in which a physician treated a woman for "asthma and anxiety" for six years. During the last two years of that treatment, they "exchanged rings in anticipation of what their future might be together" and lived together.(21) However, the relationship ended with an altercation and the woman sued the physician for, among other things, malpractice in having sex with her while he was treating her. Despite the longstanding personal relationship, a jury found the physician negligent in his treatment and awarded the woman $665,000.(22)

Whether or not the allegations of sexual abuse are true, once a case reaches the trial stage, the only viable defense is often a direct confrontation on the facts, a dangerous roll of the dice. For tactical and emotional reasons, therefore, legal efforts should be directed at terminating the case short of trial.

The Statute of Limitations Defense

Persons who believe they have been harmed have a limited amount of time in which to sue the persons allegedly responsible for the harm. The statute of limitations sets the time limit by which a suit must be filed.

Statutes of limitations vary from state to state and from type of case to another. Statues for personal injury cases, which include most suits alleging sexual abuse, generally range from two to four years. Those states that have enacted statutes creating specific cause of action for sexual abuse by health care providers have generally prescribed a separate statute of limitations for that type of action, which can range from a short period, such as Illinois' two-year period,(23) to Minnesota's relatively long five-year limitations period.(24)

The length of the limitations period is easy to determine from the state's statute, and the cut-off date is absolute -- the date the complaint is filed with the court. Particularly in cases alleging sexual abuse by a health care provider, however, determining the date when the limitations period begins to run can be problematic, often to such an extent that establishing that date may be a crucial fact for a jury to decide at trial. This determination is made based on "the discovery rule," under which a statute of limitations period begins to run only when the plaintiff discovers that he or she has a cause of action. In a surgical malpractice context for example, the limitations clock begins running only when the patient first discovers the scalpel left in his or her abdomen after surgery, rather than on the date of the surgery. It is difficult to apply the discovery rule to a sexual abuse case. When does a patient "discover" that a cause of action exists against a physician with whom he or she had sexual intercourse? Since the patient was aware of the intercourse as it took place, it can certainly be argued that the date of the act is the date the statute of limitations commences. Alternatively, victims' advocates propose holding back the statute of limitations clock until the victim is psychologically capable of commencing an action, arguing that the person who caused the victim to be psychologically incapacitated should not benefit from his own wrongdoing. Courts have generally taken a middle ground. In a recent Massachusetts Supreme judicial Court decision, Riley v. Presnell,(25) the state's highest appellate court closely analyzed this issue. Robert Scott Riley was an epileptic who had been experiencing emotional difficulties, but was not suffering from any major psycho-pathology, when he began psychotherapy with Dr. Walter Presnell in 1975. Some months into therapy, Dr. Presnell introduced alcohol and marijuana into the sessions, and at least twice in the following four years of therapy, Dr. Presnell persuaded Riley to engage in various sexual acts with him, purportedly as a way to deal with Riley's feelings

toward his father. Dr. Presnell told Riley not to tell anyone of the nature of the therapy because it was "special," and the world would neither understand nor approve. During the therapy, Riley became totally dependent on Dr. Presnell, to the point of suggesting that Dr. Presnell might be "God."[26]

In 1979, Dr. Presnell abruptly terminated the sessions, leaving Riley with an addiction to Valium. Riley then saw another physician, who prescribed for him a one-month supply of Valium, but refused to issue further prescriptions, telling Riley he had become addicted as a result of Dr. Presnell's treatment. The following year, Riley began seeing a new psychiatrist. Riley told this psychiatrist of his emotional and psychological problems and his domestic difficulties with his wife and described Dr. Presnell's conduct in detail. The new psychiatrist told Riley that Dr. Presnell's treatment had been "substandard, bad, and essentially 'nontreatment.'"[27]

Nonetheless, according to Riley, it was not until 1984, five years after he last saw Dr. Presnell, that Riley realized there was a link between his present condition and the treatment he received from Dr. Presnell. The trigger for this realization, Riley said, was when he met another former patient of Dr. Presnell's, who said he had been similarly abused and suffered from many of the same psychological and emotional problems as Riley.[28] Riley subsequently filed suit against Dr. Presnell in March 1985, but a trial judge dismissed the case, holding that Massachusetts' applicable three-year statute of limitations for medical malpractice actions had expired.[29]

On appeal by Riley, the suit against Dr. Presnell was reinstated, with the appellate court stating for the first time the rule that the statute of limitations begins to run in such a case when "a reasonable person who has been subjected to the conduct which forms the basis for the plaintiff's complaint" would have been able to discern the cause of harm.[30] The court said an injury to the mind, as alleged by Riley, could have interfered with the discovery of the cause of action and prevented Riley from drawing a causal connection between the improper therapy and his psychological problems.[31]

The court placed on the plaintiff the burden of proving the circumstances that brought the case outside the statute of limitations.[32] To meet this burden, Riley offered expert testimony[33] that the type of therapy used by Dr. Presnell impaired Riley from making the causal link between his condition and the therapist's conduct.[34] As a final procedural twist to the case, the court stated that in this type of case it is the function of the jury, and not the judge, to determine when a statute of limitations began to run.[35]

Should the Riley decision be followed in other jurisdictions, one result for health care providers will be that the door will always be open to allegations of sexual misconduct, whether real or feigned.[36] The decision leaves open the possibility that 20 years after the last treatment, the patient may suddenly "discover" that his

or her psychological problems were really caused by sexual contacts with the physician and have a cause of action. The physician may or may not even remember the patient, and he may or may not have retained any of the patient's records. However, a defense of "I really don't remember ever seeing this patient, but if I did, I know I never had sex with him/her" is not likely to carry great jury appeal, especially when confronted with an opposing expert witness who testifies how the trauma of sexual abuse frequently causes memories to be totally suppressed for years. Another disturbing aspect of the Riley decision is that it forces the physician into a roll of the dice at trial on the statute of limitations issue, since it is only by submitting the case to the jury that he will know whether the patient's case may proceed or not. Following a well publicized trial, even a statute of limitations victory would be a pyrrhic one. Although a partial solution would be to bifurcate the trial by submitting the statute of limitations question to the jury before proceeding to other evidence, it is likely that most judges would just allow the trial to proceed to its conclusion. This is a serious issue for physicians and one that must be carefully considered. Statutes of limitations questions are likely to be the major battleground in future litigation over sexual abuse claims, particularly since there are precious few other defenses available to physicians faced with this type of allegation.

Insurance issues for the physician

One irony of this type of litigation is that the only common ground between the physician and his former patient is often a united front against the physician's professional liability insurer. Litigation between the physician and his insurer, and even between the patient and the physician's insurer, comprises a large body of the appellate case law in suits alleging sexual abuse by health care providers.

The typical scenario is for the former patient, through his or her attorney, to either file suit and serve it on the physician or for the attorney to notify the physician that suit will soon be filed. The physician then dutifully notifies his professional liability carrier, whose reflexive action is to deny coverage on the high moral ground that it does not insure against criminal acts. Sometimes the insurer provides a defense, but denies liability for damages.

Almost without fail, courts have rejected insurers' attempts to deny coverage except when the policy contains specific language limiting coverage for sexual misconduct. Typical is language from a Michigan case in which a patient alleged that her psychiatrist induced her to engage in sexual relations with him as part of her therapy.(37) The psychiatrist's insurer denied coverage and sought a declaratory judgment confirming its denial. In finding that coverage should not have been denied, the court noted that even though the psychiatrist's conduct could constitute a felony, it would also be malpractice, since the complaint alleged that the psychiatrist departed from proper standards of medical practice; although the complaint charged a unique form of malpractice, it was still malpractice(38). Besides, the court said, "[i]t is not the insured who will benefit

[from requiring insurance coverage], but the innocent victim who will be compensated for her injuries."[(39)]

In an interesting variation on this scenario, the New York Court of Appeals held that an insurer was obligated to pay for a physician's defense, but would not be liable for the judgment if the jury determined that the physician had intended to injure his patient by having sexual relations with her.[(40)] In that case, a dentist who allegedly assaulted a female patient in the course of delivering dental treatment was criminally convicted of sexual abuse in the third degree.[(41)]

In response to this almost universal trend of holding insurers liable at least for the costs of defense, and usually for liability for malpractice as well, many insurers have written specific exemptions into their policies for injuries arising from sexual contact with patients. For example, some policies provide a defense, but limit the dollar amount of coverage. Under such policies, the insurer typically will want to tender the policy amount early on in the litigation and will thereafter have no liability for defense costs. Obviously, then, it is in the physician's best interest for the insurer to refuse to tender its policy amount, so that the physician's legal fees continue to be paid by the insurer. To deal with this conflict, a physician covered by such a policy should obtain counsel of his choosing from the beginning of the suit to represent his interests exclusively.

Another type of insurance policy denies coverage for defense costs and damages if there is any claim of sexual contact.[(42)]In such circumstances, knowing a suit is about to be filed, it is in the best interests of both the physician and the former patient to ensure that the complaint is carefully drafted to allege malpractice in some form other than sexual abuse. The plaintiff's attorney will often be willing to cooperate, since it may be in the patient's best interests to withhold some of his or her most dramatic claims so as to maintain the insurance company in the litigation as a deep pocket out of which to collect a judgment. This practice is well illustrated by a recent New York decision in which a plastic surgeon sedated and then sexually abused and raped a patient. The physician was criminally convicted of first degree sexual abuse.[(43)]The woman then brought a declaratory judgment action against the surgeon's insurer seeking to compel the insurer to defend and indemnify the surgeon in a civil damage action she brought against him. In an effort to compel the insurer to provide coverage, the woman stated that the surgeon's "demonstrated active intention was to avoid damage or injury'" and, in the alternative, "that 'the sexual episode undertaken within the context of the medical treatment was consensual.'"[(44)]

In light of the permutations of insurance coverage, one of the first actions a physician should take when he learns a patient is likely to assert a claim of sexual abuse is to have his attorney carefully examine his professional liability policy and then make that policy available to the patient's attorney. Because of the wording of the policy, it might be in the patient's best interests to avoid direct allegations of sexual contact in the complaint. This can only work to the

physician's benefit in the litigation. However, experience has shown that a patient forceful enough to go forward with a lawsuit is likely to disclose the most flagrant allegations to licensing authorities, even if they are held back from a civil suit. This can lead to public disclosure of the charges and possibly disciplinary action, including license revocation.

Criminal charges and civil rights concerns

In addition to civil suits for money damages and disciplinary proceedings leading to license revocation, physicians who have sex with patients may be subject to criminal prosecution, usually for rape or sexual assault. The chief impediment to criminal prosecution, however, has been the patient's consent to the sexual acts. Criminal prosecutions of physicians thus usually have been restricted to cases in which the physician used force or drugs to incapacitate the patient.(45) No criminal case could be found where the coercive nature of the transference phenomenon was used to counter the patient's consent to engage in the sexual acts.

In response to this difficulty in bringing criminal prosecutions against physicians, those states that have enacted legislation making sexual abuse against patients a specific crime have included as a key element of the legislation a statement that consent by the victim is not a defense. For example, in California, where it is a misdemeanor for "any person holding himself or herself out to be a psychotherapist" to have any sexual contact with a patient or former patient, the statute specifically states that, "in no instance shall consent of the patient or client be a defense. "(46) North Dakota's criminal statute, which is similar to California's, but bars only sexual contact "during any treatment, consultation, interview, or examination," also states that consent by the complainant is not a defense.(47)

Some believe that a blanket prohibition on sexual contact between therapists and patients raises civil liberties concerns, because it assumes that no patient under any circumstances is capable of consenting to sex with his or her therapist, just as laws prohibiting sex with minors assume that no minor can consent to sex. In Massachusetts, where a statute that eliminates consent as a defense to a criminal charge has been proposed, the Civil Liberties Union of Massachusetts has expressed this concern:

It is clear that, by its literal terms [the proposed statute] criminalizes sexual acts between "consenting" adults, a course of action long condemned by civil libertarians and many court decisions. It is also clear that in some instances and to varying degrees, the.concept of "consent" is at best murky and at worst misleading in the actual context of therapeutic relationships....To uniformly, totally, and unequivocally rule out consent in all such circumstances, as we do in our statutory rape laws, seems inaccurate, ill-advised, and drastic.(48)

Constitutional challenges to such statutes, in an appropriate case, are likely, similar to challenges to statutes barring private sexual activities between people of different races and between people of the same sex.

Practical guidance for physicians accused of sexual abuse

The first indication that a patient is alleging sexual abuse can arise in a myriad of ways, from a threatening telephone call from a distraught patient to a deputy sheriff serving a summons and complaint. Because of the emotional and personal nature of such allegations, a physician's first reflex is to hide the existence of the charges and try to deal with it himself. This is a mistake, since any statements, threats, or offers of money made by the physician to the patient will be offered to the jury as admissions of guilt. The physician must involve his attorney from the start. As discussed above, experienced counsel may be able to convince the patient's attorney that discretion is also in the patient's best interests, in order to keep the physician's insurance available. Even when no insurance coverage is likely, however, quiet settlements can be reached if the physician's attorney can convince the patient's attorney that, for financial reasons, any settlement would involve payments over a number of years, and the only way the physician would be able to fund the payments would be to maintain his practice. In situations where the sexual misconduct cannot be denied, a ready admission of wrongdoing by the physician and voluntarily beginning a course of therapy and supervision, combined with monetary settlement, may satisfy a patient and prevent the allegations from going further. After all, a lawsuit can be as traumatic and difficult for the abused patient as it is for the physician.

The key to managing allegations of sexual abuse is early and active intervention, with the goal of preventing a lawsuit from being filed, preventing the allegations from being made public, and preventing a complaint to licensing authorities. Ideally, of course, the real key is for the physician never to become sexually involved with any patient, as all physicians should know. However, proof that this problem has existed throughout the history of medicine is found in the Hippocratic oath, which says:

In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill doing and all seduction, and especially from the pleasures of love with women or with men.

References

1. See, Boston Globe, June 18, 1990, at 29. Like physicians, psychologists have been hard hit. In fact, approximately 45% of the total money paid out over the past ten years by the American Psychological Association's professional liability coverage was for lawsuits involving sexual contacts with patients. Ethics Comm. of the Am. Psychological Ass'n, Trends in Ethics Cases, Common Pitfalls, and Published Resources, 43 Am. PSYCHOLOGIST 564, 567 (1988).

2. Obviously, any such survey has to be viewed carefully, as one can certainly question both the desire of physicians to respond to such a questionnaire and the honesty of the responses. With that in mind, the surveys show relatively consistent results. In a 1972 random survey of psychiatrists, 7.2% admitted having had intercourse with a patient, and an additional 13% admitted to sexual contact short of intercourse. Interestingly, 18% of obstetricians, 13% of general practitioners, and 12% of internists admitted to sexual contact with patients. Kardener, Fuller & Mensh, A Survey of Physicians' Attitudes and Practices Regarding Erotic and Nonerotic Contact with Patients, 130 Am. J. PSYCHIATRY 1077, 1079-80 (1973). A 1986 nationwide survey of psychiatrists showed 7.1% of male psychiatrists and 3.1 % of female psychiatrists admitting having had intercourse with a patient. Gartrell, Herman, Olarte, Feldstein & Locatio, Psychiatrist-Patient Sexual Contact: Results of a National Survey, I: Prevalence, 143 Am, J. PSYCHIATRY 1126, 1126-31 (1986). In addition, a 1977 survey of psychologists reported that 6.1 % admitted having had intercourse with a patient. Holroyd & Brodsky, Psychologists' Attitudes and Practices Regarding Erotic and Nonerotic Contact with Patients, 32 Am. PSYCHOLOGIST 843 (1977).

3. The largest reported jury verdict against a physician for sexually abusing a patient is $4.6 million. See Malpractice: More Patients Suing Their Psychiatrists, 68 A.B.A. J. 1353 (1982) (discussing Walker v. Parsons (Cal. App. Dept Super. Ct. July 7, 1981)). In another case, a teenage schizophrenic who sued her psychiatrist was awarded $650,000 by a Virginia jury after the defendant admitted to some 60 sexually related incidents. Nat'l L.J., Jan. 29, 1985, at 1, col. 1.

4. See CAL. BUS. & PROF. CODE § 729 (West 1990) (prohibiting psychotherapist-patient sexual relationships); COLO. REV. STAT.§ 18-3-405.5 (Supp. 1992) (psychotherapist-patient relationships); id.§ 18-3-403(g), -404(h) (1986) (prohibiting sexual intercourse under the guise of medical treatment); FLA. STAT. ANN. § 491.0112 (West 1991) (psychotherapist-patient relationships); ME. REV. STAT. ANN. tit. 17-A, § 253(2)(I) (West Supp. 1992) (psychotherapist-patient relationships); MICH. COMP. LAWS ANN.§ 750.90, .520b(1)(f)(iv) (West 1991) (pretext of medical treatment); MINN. STAT. ANN. § 609.344(h), .345(h) (West Supp. 1993) (psychotherapist-patient relationships); N.H. REV. STAT. ANN. § 632-A:2(I)(g) (Supp. 1992) (pretext of medical treatment); N.D. CENT. CODE § 12.1-20-06.1 (Supp. 1991) (therapist-patient relationships); R.I. GEN. LAWS § 11-37-2(C) (Supp. 1992) (pretext of medical treatment); WIS. STAT. ANN. § 940.22(2) (West Supp. 1992) (therapist-patient relationships); WYO. STAT. § 6-2-303(a)(vii) (1988) (pretext of medical treatment).

5. See, e.g., Mass. H4298 (1991) (Criminal Justice Committee), H4375, H4376 (1991) (Judiciary Committee), H4341 (1991) (Health Care Committee).

6. Herman, Gartrell, Olarte, Feldstein & Locatio, Psychiatrist-Patient Sexual Contacts: Results of a National Survey, II: Psychiatrists' Attitudes, 144 AM. J. PSYCHIATRY 164, 165 (1987).

7. Am. Psychiatric Assn, The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry, 130 AM. J. PSYCHIATRY 1058, 1061 (1973). The American Psychological Association takes a similar unequivocal position. AM. PSYCHOLOGICAL ASS'N, ETHICAL STANDARDS OF PSYCHOLOGISTS, principle 6a (1977 rev.).

8. Roy v. Hartogs, 85 Misc. 2d 891, 381 N.Y.S.2d 587 (Sup. Ct. 1976). The Hollywood movie based on this case ends with a courtroom filled with the psychiatrist's victims applauding the jury verdict. Several earlier cases, particularlyZipkin v. Freeman, 436 S.W.2d 753 (Mo. 1968), hinted at sexual improprieties, but were not based on sexual contact as an explicit violation of the physician-patient relationship. Other early cases were generally brought by husbands who alleged therapists had induced their wives to divorce them. See, e.g., Anclote Manor Found. v. Wilkinson, 263 So. 2d 256 (Fla. Dist. Ct. App. 1972); Horak v. Biris, 130 Ill. App. 3d 140, 474 N.E.2d 13 (1985); Nicholson v. Han, 12 Mich. App. 35, 162 N.W.2d 313 (1968).

9. See Roy, 85 Misc. 2d at 892, 381 N.Y.S.2d at 588.

10. Dahlberg, Sexual Contact Between Patient and Therapist, 6 CONTEMP. PSYCHOANALYSIS 107,117-20 (1970).

11. Gary Richard Schoener and John Gonsiorek, who have extensive experience treating both victims of sexual abuse and therapists who have been sexually involved with patients, describe six categories of therapists who sexually exploit patients:

1. Uninformed and naive -- trainees or people with substandard training who .have difficulty distinguishing personal relationships from professional relationships.

2. Healthy or mildly neuratic -- professionals involved in situational stressors for whom the sexual contact is limited or an isolated circumstance.

3. Severely neurotic-professionals with longstanding, significant emotional problems, especially depression and low self-esteem. Work tends to be the center of their lives and most of their personal needs are met in the work setting.

4. Character disorders with impulse control problems -- therapists with longstanding impulse control problems. They usually have a history of legal problems and inappropriate behavior and poorly controlled sexual behavior.

5. Sociopathic or narcissistic character disorders -- similar to the previous group, these therapists are more deliberate and cunning in their exploitation of clients. They are typically expert at seducing a wide range of clients and covering their tracks.

6. Psychotic or borderline disorders -- people with poor social judgment and impaired reality testing.

Schoener & Gonsiorek, Assessment and Development of Rehabilitation Plans for Counselors Who Have Sexually Exploited Their Clients, 67 J. COUNSELINC; & DEV. 227, 227-28 (1988)

12. Gutheil, Borderline Personality Disorder, Boundary Violations, and Patient-Therapist Sex: Medicolegal Pitfalls, 146 Am. J. PSYCHIATRY 597, 597-602 (1989).

13. Id.

14. In transference, "[t]he patient 'unconsciously attributes to the psychiatrist or analyst those feelings which he may have repressed toward his own parents. [I]t is through the creation, experiencing and resolution of these feelings that [the patient] becomes well.'" L.L. v. Medical Protective Co., 122 Wis. 2d 455, 362 N.W.2d 174, 177 (Ct. App. 1984) (quoting D. DAWIDOFF, THE MALPRACTICE OF PSYCHIATRISTS 6 (1973)). "'Inappropriate emotions, both hostile and loving, directed toward the physician are recognized by the psychiatrist as constituting ... the transference. The psychiatrist looks for manifestations of the transference, and is prepared to handle it as it develops.'" Id. (quoting Heller, Some Comments to Lawyers on the Practice of Psychiatry, 30 TEMP. L.Q. 401, 401-02 (1957)). Many cases have discussed transference at great length, with the general goal of finding that any sexual contact between a patient and a therapist during the course of therapy is malpractice. For discussions of the transference phenomenon, see, e.g., Worsham v. United States, 828 F.2d 1525 (11th Cir. 1987); Vigilant Ins. Co. v. Employers.Ins., 626 F. Supp. 262 (S.D.N.Y.1986); St. Paul Fire & Marine Ins. Co. v. Mitchell, 164 Ga. App. 215, 296 S.E.2d 126 (1982).

15. See supra note 8.

16. Throughout this discussion, the physician or therapist is referred to as male, since no reported case could be found of a male patient suing a female therapist.

17. In the more open atmosphere of the 1960s and early 1970s, there were suggestions that sexual encounters between patients and therapists were not necessarily harmful to patients. James McCartney supported sexual intimacy between patient and therapist. McCartney, Overt Transference, 2 J. SEX RES. 227 (1966). For advocating that position, and for admitting that he had utilized

that type of therapy with female patients, he was expelled from the American Psychiatric Association.

18. Interestingly, the same rationale has been advanced to prohibit sexual contact between an attorney and a client. California, once again, has been in the forefront in this effort.Tthe California legislature recently added the following provision toits Business and Professions Code: The Legislature further finds and declares that it is difficult to separate sound judgment from emotion or bias which may result from sexual involvement between a lawyer and his or her client during the period that an attorney-client relationship exists, and that emotional detachment is essential to the lawyer's ability to render competent legal services. Therefore, in order to ensure that a lawyer acts in the best interest of his or her client, a rule of professional conduct governing sexual relations between attorneys and their clients shall be adopted. CAL. BUS. & PROF. CODE @ 6106.8(a) (West 1990). This legislative action eventually resulted in a rule specifically prohibiting attorneys from requiring or demanding sexual relations with a client incident to or as a condition of professional representation, from coercing or intimidating a client into a sexual relationship, and from continuing to represent a client with whom they are having a sexual relationship if that relationship will adversely affect the quality of legal representation. CAL. RULES OF PROFESSIONAL CONDUCT Rule 3-120 (Deering 1992).

19. Worsham v. United States, 828 F.2d 1525, 1526 (11 th Cir. 1987); cf. Jacobsen v. Muller, 181 Ga. App. 382, 385, 352 S.E.2d 604, 607 (1986) (plaintiff was able to consent to sexual relationship with job counselor and thus condoned legal breaches by him).

20. For example, in Hoopes v. Hammargren, 725 P.2d 238 (Nev. 1986), the Supreme Court of Nevada rejected a physician's request to limit to psychiatrists claims for breach of fiduciary duty because of sexual intimacy. The court did note, however, that a medical patient is capable of consenting to a sexual relationship and that consent is a jury question in such circumstances. Id. at 242-43. In that case, a neurosurgeon misdiagnosed a woman as having multiple sclerosis and prescribed massive doses of central nervous system depressants, which he usually delivered to her house, at which times they engaged in intercourse. Id. at 239-40.

21. Aetna Life & Cas. Co. v. McCabe, 556 F. Supp. 1342, 1346, 1349 n.2 (E.D. Pa. 1983).

22. Id. at 1347 (judgment later reduced by court).

23. ILL. ANN. STAT. ch. 70, § 806 (Smith-Hurd 1989).

24. MINN. STAT. ANN. § 148A.06 (West 1989). Statutes of limitations for criminal offenses are usually longer than for civil actions. For example, whereas

Massachusetts has a three-year statute of limitations for a civil action for assault and battery, Mass. Gen. Laws. Ann. Ch. 260, § 2A (West 1990), usually a component of sexual abuse complaint, the statue of limitations for criminal assault and battery is six years, Id. ch. 277, § 63. Thus, while a former patient may be locked out of a monetary recovery by the civil statute of limitations, retribution through a criminal action often remains available.

25. 409 Mass, 239, 565 N.E.2d 780 (1991)

26. Id. at 241, 565 N.E.2d at 783.

27. Id. at 241-42, 565 N.E.2d at 783.

28. Id. at 242, 565 N.E.2d at 784.

29. See Id. at 240, 243, 565 N.E.2d at 783, 784.

30. Id. at 245, 565 N.E.2d at 785.

31. Id. at 246, 565 N.E.2d at 786.

32. Id. at 243-44, 565 N.E.2d at 785.

33. Riley's expert, in fact, was Dr. Thomas Gutheil.

34. Riley, 409 Mass. at 246, 565 N.E.2d at 786.

35. Id. at 248, 565 N.E.2d at 787. In a strongly worded dissent, Massachusetts Supreme judicial Court Justice O'Connor criticized the court for establishing a subjective standard, rather than an objective one, and argued that no other case even suggests that a plaintiff's intellectual or psychological deficit is to be considered for statute of limitations purposes. Id. at 251-55, 565 N.E.2d at 789-91. The result, he said, will be "unfair litigation." Id. at 254, 565 N.E.2d at 790.

36. See supra, note 12 and accompanying text for discussion of patients making specious allegations of sexual abuse against therapists as punishment for terminating treatment or other perceived wrongs.

37. Vigilant Ins. Co. v. Kambly, 114 Mich. App. 683, 319 N.W.2d 382, 384 (1982).

38. Id., 319 N.W.2d at 385.

39. Id. The dissent, however, noted the incongruity of the physician asserting as a defense to the patient's malpractice case that the sexual relationship had nothing to do with treatment but was "a love affair which did not have a blissful ending," while at the same time claiming to his insurer that his malpractice policy

covered his liability. Id., 319 N.W.2d at 386 (Cynar, J., concurring in part & dissenting in part).

40, Public Serv. Mut. Ins. Co. v. Goldfarb, 53 N.Y.2d 392, 399-402, 425 N.E.2d 810, 814-15, 442 N.Y.S.2d 422, 426-27 (1981).

41. Id. at 396, 425 N.E.2d at 812, 442 N.Y.S.2d at 424.

42. At least one court has stated that the insurer has the right to specifically state in its policy that it will not cover sexual activity between a psychiatrist and a patient. Vigilant Ins. Co. v. Employers Ins., 626 F. Supp- 262, 266 n.2 (S.D.N.Y. 1986).

43. Snyder v. National Union Fire Ins. Co., 688 F. Supp. 932, 933 (S.D.N.Y. 1988).

44. Id. at 936.

45. See, e.g., id. at 933 (plastic surgeon who sedated, then raped patient convicted of first degree sexual assault); Public Serv. Mut. Ins. Co. v. Goldfarb, 53 N.Y.2d 392, 425 N.E.2d 810, 442 N.Y.S.2d 422 (1981) (dentist who sexually abused patient during dental treatment convicted of third degree sexual assault).