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Tanya J. Dobash

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NOTES

PHYSICIAN-PATIENT SEXUAL CONTACT: THE BATTLE BETWEEN THE STATE AND THE MEDICAL PROFESSION

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 of sexual relations with both female and male persons.
—Hippocratic Oath¹

Throughout history, the medical profession has forbidden sexual contact between medical practitioners and their patients.² The Hippocratic Oath has prohibited sexual contact between doctors and their patients since 460 B.C.³ Today, the medical profession continues explicitly to condemn sexual relations in physician-patient relationships.⁴

1. See Maura L. Campbell, *The Oath: An Investigation of the Injunction Prohibiting Physician-Patient Sexual Relations*, 32 PERSP. IN BIOLOGY & MED. 300, 300 (1989) (setting forth entire text of Hippocratic Oath); see also *infra* note 3 and accompanying text (discussing Hippocratic Oath).

2. See GARY R. SCHOENER ET AL., PSYCHOTHERAPISTS' SEXUAL INVOLVEMENT WITH CLIENTS: INTERVENTION AND PREVENTION 332-33 (1989) (describing historical development of ethical prohibition).

3. See Hippocrates, *Physician's Oath*, in STEDMAN'S MEDICAL DICTIONARY 579 (3d lawyers' ed. 1972) ("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."); 23 THE NEW ENCYCLOPEDIA BRITANNICA 889 (15th ed. 1990) (providing slightly different translation of Oath); see also Campbell, *supra* note 1, at 304-07 (discussing reasons for inclusion in Hippocratic Oath of injunction against sexual contact with patients and outlining continuing concern of Western medical authors for this injunction). In *Andrews v. United States*, 732 F.2d 366 (4th Cir. 1984), the United States Court of Appeals for the Fourth Circuit noted that, although the Hippocratic Oath is not a basis for liability, it is indicative of the medical profession's historic knowledge of and concern about the potential for sexual abuse in the physician-patient relationship. *Id.* at 368 n.2.

4. See COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AMERICAN MED. ASS'N, *Opinion 8.14: Sexual Misconduct in the Practice of Medicine*, in CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS OF THE AMERICAN MEDICAL ASSOCIATION 40, 40 (1992) [hereinafter AMA CURRENT OPINIONS] (defining sexual misconduct as sexual contact that occurs concurrent with physician-patient relationship). Opinion 8.14 states:

Sexual contact that occurs concurrent with the physician-patient relationship constitutes sexual misconduct. Sexual or romantic interactions between physicians and patients detract from the goals of the physician-patient relationship, may exploit the vulnerability of the patient, may obscure the physician's objective judgment concerning the patient's health care, and ultimately may be detrimental to the patient's well-being.

If a physician has reason to believe that non-sexual contact with a patient may

Despite the medical profession's clear proclamation, whether courts will recognize the public's right to rely on physicians to execute faithfully their ethical obligation to refrain from engaging in sexual activity with patients depends on how much weight they place on the medical profession's ethical standards.⁵ Uncertainty results from a fundamental anomaly in the structure of physician regulation.⁶ The medical profession retains autonomy based on its promises to self-regulate and rigorously apply its ethical standards to its members.⁷ However, when a physician's conduct falls below professional standards, the primary avenues of redress available to a patient all involve action by the state, which enforces its own standards rather than the medical profession's standards.⁸

This anomaly becomes especially apparent in medical licensing board disciplinary actions. A primary justification for states' delegation of regulatory power to medical licensing boards is that the physicians sitting on the boards presumably know the ethics of their profession better than the

be perceived as or may lead to sexual contact, then he or she should avoid the non-sexual contact. At a minimum, a physician's ethical duties include terminating the physician-patient relationship before initiating a dating, romantic, or sexual relationship with a patient.

Sexual or romantic relationships between a physician and a former patient may be unduly influenced by the previous physician-patient relationship. Sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions or influence derived from the previous professional relationship.

Id.

See also AMERICAN PSYCHIATRIC ASS'N, THE PRINCIPLES OF MEDICAL ETHICS WITH ANNOTATIONS ESPECIALLY APPLICABLE TO PSYCHIATRY § 2, at 4 (1993) (stating that sexual contact with current or former patients is unethical); Council on Ethical and Judicial Affairs, American Medical Association, *Sexual Misconduct in the Practice of Medicine*, 266 JAMA 2741, 2745 (1991) [hereinafter *AMA Report*] (explaining rationale for conclusion that sexual contact or romantic relationship concurrent with physician-patient relationship is unethical and that sexual contact or romantic relationship with former patient may be unethical under certain circumstances); Brian McCormick, *Canadians Vow "Zero Tolerance" for Sex Abuse by Doctors*, AM. MED. NEWS, Aug. 10, 1992, at 6 (reporting Ontario College of Physicians and Surgeons' independent task force recommendation of reforms, including adoption of policy that sexual abuse of patients is never acceptable); Beverly Merz, *House Just Says No to Sex Between Doctors, Patients*, AM. MED. NEWS, Dec. 14, 1990, at 10 (describing American Medical Association House of Delegates' adoption of report defining sexual contact within doctor-patient relationship as breach of medical ethics).

5. See *infra* notes 6-13 and accompanying text (describing fundamental anomaly in structure of physician regulation, which results in uncertainty regarding right to rely on physicians to execute their ethical duties).

6. See *infra* notes 7-8 and accompanying text (discussing abnormality in structure of physician regulation that allows medical profession autonomy in exchange for promise to self-regulate according to its strict ethical standards but provides only state avenues of redress for misconduct).

7. See *infra* notes 48-59 and accompanying text (discussing justifications for medical profession's autonomy).

8. See *infra* note 64 and accompanying text (discussing avenues of redress available to patients).

rest of the public and can identify conduct that renders a physician unfit to practice medicine.⁹ However, despite the states' recognition that the medical profession possesses the greatest ability to evaluate the conduct of physicians, the medical boards are bodies created by state governments, and as such they must confine their activities to investigations of violations of the laws promulgated by the state legislatures rather than violations of standards promulgated by the medical profession.¹⁰ Therefore, breaches of professional ethical standards that the state legislature has not codified remain outside of the jurisdiction of the licensing board. In short, states give medical licensing boards the power to discipline physicians because the boards know the ethics and standards of the medical profession, yet the states do not give the medical boards the power to apply those very same ethics and standards.

This fundamental anomaly reveals that professional medical ethics are in competition and conflict with law as embodied in the pronouncements of courts and legislatures.¹¹ With regard to physician-patient sexual contact, the states have, in some instances, maintained a vision of what constitutes disqualifying unethical conduct that is quite different from the medical profession's view.¹² The medical profession and the states are embroiled in an ongoing struggle over normative space,¹³ and this struggle causes public uncertainty over the standards to which physicians must adhere. The public has received mixed messages regarding what constitutes unethical conduct and whether a firm basis exists for relying on the pronouncements of the medical profession on this subject.

9. See *Coe v. United States Dist. Court for the Dist. of Colo.*, 676 F.2d 411, 414 (10th Cir. 1982) (stating that state board of medical examiners is presumed to know better than laymen ethics of medical profession and what renders one unfit to engage in practice of medicine).

10. See ROBERT M. DERBYSHIRE, *MEDICAL LICENSURE AND DISCIPLINE IN THE UNITED STATES* 76 (1969) (describing medical boards as state entities); see also *Pons v. Ohio State Med. Bd.*, 614 N.E.2d 748, 753 (Ohio 1993) (Pfeifer, J., dissenting) (explaining that, although state grants medical board power to discipline physicians because board is more able than courts to determine what constitutes acceptable medical practice, board's disciplinary action based on violation of professional ethical standards is unlawful because beyond statutory constraints).

11. See *infra* notes 80-111 and accompanying text (describing conflict between medical profession and state regarding proper standards of physician conduct).

12. Compare *supra* notes 2-4 and accompanying text (describing medical profession's absolute prohibition of physician-patient sexual contact) with *infra* notes 88-111 and accompanying text (describing diverse manners in which states handle issue of physician-patient sexual contact).

13. See Susan P. Koniak, *The Law Between the Bar and the State*, 70 N.C. L. REV. 1389, 1392 n.13 (1992) (defining use of term "normative"). For the purposes of this Note, the terms "normative" and "norm" describe an ideal standard of conduct or ethical rule binding upon the members of a group and serving to guide, control, or regulate proper and acceptable behavior. WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY OF THE ENGLISH LANGUAGE 1540 (1986). A norm is a principle of right action. *Id.* Thus, a struggle over normative space is a struggle over the ability to assert or deny that something ought to be done or has value in a particular arena or for a particular group.

Some courts have noted the inherent contradiction in telling the public, on the one hand, that the ethical obligations of physicians require the physicians to refrain from having sex with patients, and, on the other hand, telling the public that patients have no right to rely on physicians to execute those ethical obligations faithfully.¹⁴ However, despite this contradiction, other courts and legislatures continue to send this mixed message to the public.¹⁵

Courts evaluating medical licensing board disciplinary actions based on physician-patient sexual contact increasingly have considered what importance to place on the medical profession's code of ethics, the fiduciary nature of the physician-patient relationship, and the power dynamics within the professional relationship that deprive the patient of the ability to give true consent to sexual contact with the physician.¹⁶ This Note considers issues involved with, and the balance among, the public's and individual

14. See *Petrillo v. Syntex Lab., Inc.*, 499 N.E.2d 952, 960 (Ill. App. Ct. 1986) (stating that it would be contrary to common sense for public to be told that physicians have ethical obligation to obtain patient's consent before disclosing patient's medical confidences but that patient has no right to rely on physician's faithful execution of ethical obligations), *appeal denied*, 505 N.E.2d 361 (Ill.), *cert. denied*, 483 U.S. 1007 (1987); see also *Yates v. El-Deiry*, 513 N.E.2d 519, 522 (Ill. App. Ct. 1987) (citing *Petrillo* for proposition that public policy is reflected in medical profession's code of ethics, which consists of Hippocratic Oath, AMA Principles of Medical Ethics, and Current Opinions of Judicial Council of AMA), *appeal denied*, 520 N.E.2d 394 (Ill. 1988); *Humphers v. First Interstate Bank*, 684 P.2d 581, 587 (Or. Ct. App. 1984) (stating that civil right of recovery against physician for breach of ethical duties is created by public's right to rely on widespread public knowledge of ethical requirements of medical profession), *aff'd in part and rev'd in part*, 696 P.2d 527 (Or. 1985).

15. See *infra* notes 88-111, 123-91 and accompanying text (discussing diverse manner in which legislatures and courts handle issue of physician-patient sexual contact). The media and the entertainment industry exacerbate the mixed messages received by the public. Sexual relationships between physicians, especially psychiatrists, and their patients form the standard plot line for a variety of popular films, such as *THE PRINCE OF TIDES* (Columbia Pictures 1991) and *BASIC INSTINCT* (TriStar 1992). See Melinda Beck et al., *Sex and Psychotherapy*, *NEWSWEEK*, Apr. 13, 1992, at 53 (describing examples of psychiatrist-patient sexual contact in history and in popular films). To the film industry's credit, the psychiatrist played by Richard Gere in *FINAL ANALYSIS* (Warner Bros. 1992) checked the Code of Ethics before entering into a sexual relationship with a patient's sister to ensure that such conduct was not unethical. Syndicated advice columns further reflect indications of the public's perception of the prohibition against physician-patient sexual contact. See Ann Landers, *Barbara Noel's Ordeal Stirs Intense Reaction*, *CHI. TRIB.*, Oct. 11, 1992, *Tempo*, at 3 (publishing letters from public and responses regarding issue of physician-patient sexual contact). Landers' widely-read column included letters to the public from the medical profession, including representatives of the American Psychiatric Association, Southern California Psychoanalytic Institute, and the Meninger Clinic. *Id.* The communications from the medical profession informed the public that the profession universally prohibited sexual contact within the physician-patient relationship. *Id.* Unfortunately, other syndicated columnists understate the serious implications of physician-patient sexual contact. See JUDITH MARTIN, *MISS MANNERS' GUIDE FOR THE TURN-OF-THE-MILLENNIUM* 540 (1989) (advising optometrist, who was concerned about propriety of soliciting romantic dates from female patients, about proper method of propositioning patients).

16. See *infra* notes 123-91 and accompanying text (discussing cases in which courts either recognized or rejected medical profession's code of ethics, fiduciary nature of profession, and power disparity as relevant factors).

patient's rights, the medical profession's autonomy, the states' dominion over the medical field, the judiciary's application of professional ethics codes in board disciplinary actions, and the judiciary's recognition of the power imbalance within the physician-patient relationship.

Part I of this Note discusses the problem of sexual contact between physicians and patients and why the medical profession prohibits such contact. Part II examines the ability of both the state and the medical profession to govern physician conduct. Part III considers the relationship between law and medical ethics—the medical profession's normative vision and how it contrasts, competes, and coexists with state law governing physicians. Part IV discusses the current judicial application of the medical profession's code of ethics, specifically the provision prohibiting physician-patient sexual contact, and examines how the judiciary handles the issues of fiduciary duty and power dynamics in the professional fiduciary relationship. Part V contrasts courts' application of the medical code of ethics in actions involving confidentiality issues with how courts apply the medical code of ethics in matters involving sexual contact issues. This contrast illustrates that courts are allowing the public to rely on the medical profession's ethical standards in some circumstances, but not in others. Finally, this Note concludes that courts and legislatures should make greater use of the medical profession's ethical code to define standards of conduct and public policy regarding physician-patient sexual contact. Judicial indifference towards the medical profession's prohibition of physician-patient sexual contact denies the public its "benefit of the bargain" in granting occupational autonomy to the medical profession.¹⁷

I. THE PROBLEM WITH SEXUAL CONTACT BETWEEN PHYSICIANS AND PATIENTS

The term "sexual misconduct" often triggers debate over the precise type of sexual activity that rises to the level of "misconduct."¹⁸ Sexual contact that occurs as a result of the physician's exertion of physical force over the patient or that occurs under the "guise of treatment" has been widely discussed and is universally condemned.¹⁹ However, "consensual" sexual contact between physicians and patients of unequal power status has been addressed less adequately.²⁰ This Note focuses on the latter type of

17. See *infra* notes 48-59 (discussing bargain between medical profession and society in which medical profession gains autonomy in exchange for promise to regulate itself).

18. See *SEXUAL EXPLOITATION OF PATIENTS BY HEALTH PROFESSIONALS I* (Ann W. Burgess & Carol R. Hartman eds., 1986) (observing that term "sexual misconduct" triggers debate over precise type of sexual activity that constitutes misconduct).

19. See *id.* (commenting that sexual victimizations in which one person exerts force over another person have been well documented in crime statistics, national surveys, and studies). In addition, courts and legislatures universally condemn rape by physicians and sexual contact that the physician achieves under the "guise of treatment," without the patient's knowledge or consent. See *Atienza v. Taub*, 239 Cal. Rptr. 454, 456 (Ct. App. 1987) (discussing cases in which courts condemned sexual contact achieved under "guise of treatment").

20. See Burgess & Hartman, *supra* note 18, at 1 (commenting that sexual victimizations

sexual exploitation, in which a physician in an authority position takes advantage of the patient's relative powerlessness.

The attitudes of both society and the law toward intervention into the private lives of individuals has changed substantially over time. In early American society, courts scrutinized sexual and marital practices.²¹ Today, courts ordinarily consider an adult's decision to enter into a sexual relationship with another consenting adult to be a privacy interest outside the scope of legal intervention.²² The right to privacy, however, is not absolute,

characterized by one person exerting dominance over person of unequal power status have been less adequately addressed than other types of sexual victimization). Burgess and Hartman remark that most of the clinical literature on the subject deals primarily with either incest or child sexual abuse. *Id.* Both incest and child sexual abuse involve child-adult sexual activity, which is already proscribed by federal and state statutes. *Id.* Sexual activity between adults in disparate power positions has received considerably less attention. Despite the gravity of the issue, researchers have encountered a great deal of resistance to the investigation and study of sexual misconduct by physicians. See generally Nanette K. Gartrell et al., *Institutional Resistance to Self-Study: A Case Report*, in *SEXUAL EXPLOITATION OF PATIENTS BY HEALTH PROFESSIONALS*, *supra* note 18, at 121-23 (describing American Psychiatric Association's resistance to internal committee's investigation of sexual abuse of patients by psychiatrists). Of the reasons offered for the lack of investigation of physicians' sexual misconduct, concern for the reputation of the medical profession is perhaps the most problematic. See *id.* at 123 (stating that American Psychiatric Association resisted internal study because some members were "concerned that the survey data could damage the public image of psychiatry"); S. Michael Plaut & Barbara H. Foster, *Roles of the Health Professional in Cases Involving Sexual Exploitation of Patients*, in *SEXUAL EXPLOITATION OF PATIENTS BY HEALTH PROFESSIONALS*, *supra* note 18, at 5, 6 (stating that reluctance to discuss or investigate sexual misconduct in depth results, in part, from fear that open discussion will damage reputation of profession). Resisting self-study out of fear for the reputation of the medical profession is untenable because the profession's reputation and autonomy are based on the profession's promise to regulate and discipline itself. See *supra* notes 48-59 and accompanying text (explaining that medical profession attained esteem and autonomy by promise to public to self-regulate).

21. See Eduardo Cruz, Comment, *When the Shepherd Preys on the Flock: Clergy Sexual Exploitation and the Search for Solutions*, 19 FLA. ST. U. L. REV. 499, 499 (1991) (describing early American scrutiny of sexual and marital practices and prevalence of "amatory actions" during that time period). Cruz explains, "The trend toward elimination of amatory actions is directly linked to changes in society, including increasing societal interest in personal choice, decriminalization of sexual activities in many states, and growing skepticism about the law's role in protecting feelings and in enforcing personal morality." *Id.* at 499-500 (citing *DAN DOBBS ET AL., PROSSER & KEETON ON THE LAW OF TORTS* § 124, at 930 (5th ed. 1984)).

22. See *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972) (interpreting right to privacy as granting individuals, married or single, right to make fundamentally private decisions free from unwarranted governmental intervention); *Griswold v. Connecticut*, 381 U.S. 479, 483-84 (1965) (commenting on freedom of association element of right to privacy); *Carey v. Population Servs. Int'l*, 431 U.S. 678, 684 (1977) (stating that one aspect of "liberty" protected by Due Process Clause of Fourteenth Amendment is right to certain zones of privacy); *Roe v. Wade*, 410 U.S. 113, 152 (1973) (recognizing that zone of personal privacy exists under Constitution); *Stanley v. Georgia*, 394 U.S. 557, 564 (1969) (stating that right to be free from government intrusions into private life is fundamental right). See generally Jeffrey A. Barker, Comment, *Professional-Client Sex: Is Criminal Liability an Appropriate Means of Enforcing Professional Responsibility?*, 40 UCLA L. REV. 1275 (1993) (analyzing sexual privacy cases and discussing constitutional implications of limiting sexual privacy right in context of professional-client sex).

and the government retains the power to limit privacy rights in some instances.²³

One of the situations warranting government intervention is the controversial area of sexual activity between physicians and patients.²⁴ The medical profession, by trying to apply its ethical standards through state licensing boards, tacitly takes the position that such sexual activity is a matter for state intervention. State legislatures that either adopt the American Medical Association (AMA) standards by statute or adopt their own standards on such sexual activity necessarily make this activity a matter for state intervention. The courts, however, are in conflict.

The medical profession has consistently taken the position that physician-patient sexual relations warrant special consideration for two reasons. First, the physician-patient relationship is fiduciary in nature, and a sexual relationship violates the physician's fiduciary duties. Physicians serve as medical trustees of their patients' lives and health; the special responsibility accorded to physicians by virtue of their unique healing skills and the need for patients to be able to trust in physicians' dedication to patient welfare result in a prohibition against physician-patient sexual contact.²⁵ Second,

23. See *Carey*, 431 U.S. at 686 (noting that sufficiently compelling state interest will validate regulation that burdens right of privacy); *Roe*, 410 U.S. at 155 (stating that compelling state interest may limit right of privacy); see also *Planned Parenthood v. Casey*, 112 S. Ct. 2791, 2824 (1992) (stating that exercise of constitutional rights within context of practicing profession is subject to reasonable licensing and regulation by state); Cruz, *supra* note 21, at 500 (citing cases for proposition that laissez-faire attitude toward most sexual relationships between adults does not mean that government is powerless to intervene in certain situations); John M. O'Connell, Note, *Keeping Sex Out of the Attorney-Client Relationship: A Proposed Rule*, 92 COLUM. L. REV. 887, 919 (1992) (stating that government can limit right to privacy only if legislative enactments are narrowly drawn to express only legitimate state interests at stake). In discussing a proposed rule prohibiting attorney-client sexual contact, O'Connell observes that the privacy argument against such a rule might be that attorney-client sexual activity is "consensual activity of the kind protected in the line of cases that has defined the right to privacy, and that no compelling state interest can be advanced to justify proscribing the autonomy of two adults who want to enter into a sexual relationship." *Id.*

24. See *Barker*, *supra* note 22, at 1335 (stating that state has compelling interest in preventing professional-client sexual relationships if they are inherently harmful). *Barker*, however, believes that harmless professional-client sexual relationships do not justify governmental intervention. *Id.* *Barker* concedes that in particular contexts, such as the therapist-patient relationship, the risk of harm is so high that empirical evidence could stand in the place of actual proof of harm to a particular patient. *Id.* However, with other professions, such as general medical practitioners and lawyers, it is impossible to read inherent harm into the professional-client sexual relationship. *Id.* at 1335-36. *Barker* concludes that a blanket prohibition based solely upon professional status would fail a strict scrutiny test and that professionals should not be penalized by having to accept a significant, state-imposed burden upon their rights to choose sexual partners. *Id.*

25. See NORMAN S. BLACKMAN & CHARLES S. BAILEY, *LIABILITY IN MEDICAL PRACTICE: A REFERENCE FOR PHYSICIANS* 52 (1990) (discussing fiduciary nature of physician-patient relationship). The medical profession recognizes that a "fiduciary" is one who holds something in trust for another; thus, in the patient-physician relationship, the physician acts as the medical trustee of the patient and the patient's life and health. *Id.* In setting forth its absolute prohibition of physician-patient sexual contact, the AMA explained the special responsibility

according to some, patient consent is not possible.²⁶ The medical profession has concluded that the risk of coercion is so high that true and authentic consent on the part of the patient in this type of relationship is usually lacking.²⁷

The disproportionate distribution of power within the physician-patient relationship deprives the patient of the ability to give meaningful consent to a sexual relationship with the physician.²⁸ Despite the medical profession's attempts to promote patient autonomy and eliminate medical paternalism,²⁹

accorded to physicians by virtue of their unique skills of healing and the need for patients to be able to trust the physician's dedication to the patient's welfare. *See AMA Report, supra* note 4, at 2743 (discussing trust integral to physician-patient relationship and society's need for physicians to use their knowledge, expertise, and influence solely for welfare of patients).

See also Carl Sherman, *Behind Closed Doors: Therapist-client Sex*, *PSYCHOLOGY TODAY*, May 1993, at 64 (describing fiduciary nature of professional relationships in which client places trust in professional and professional is sworn to act in client's best interests). Sherman compares professional-client sexual relationships to incest due to the power imbalance and trust between the parties, and he states that it can have the same effects such as guilt, shame, anger, and despair. *Id.*

26. *See AMA Report, supra* note 4, at 2742 (explaining why patients cannot give true consent to sexual contact with physician). The AMA Report provides:

When a physician acts in a way that is not to the patient's benefit, the relative position of the patient within the professional relationship is such that it is difficult for the patient to give meaningful consent to such behavior, including sexual contact or sexual relations. It is the lack of reliable or true consent on the part of the patient that has led researchers to compare physician-patient sexual contact with other sexually exploitative situations such as sexual assault and incest. It is noteworthy that several states specify that consent of the patient or client cannot be used as a defense to charges of sexual misconduct.

Id. (citations omitted).

27. *See id.* (discussing lack of true or reliable consent on part of patient in physician-patient sexual relationship).

28. *See infra* notes 29-38 and accompanying text (discussing power dynamics of professional relationship that render patient unable to give meaningful consent to sexual relationship); *see also AMA Report, supra* note 4, at 2742 (discussing power dynamics as factor in physician-patient sexual contact). The AMA Report provides:

[I]nstances of sexual contact with patients do seem to occur most commonly where there is considerable disparity in power, status, and emotional vulnerability between physician and patient. Physicians who engage in sexual contact with patients are typically older and male, while patients are typically younger and female. Studies among psychiatrists indicate that approximately 85% to 90% of sexual contact involves a male psychiatrist and a female patient. . . . [P]atients who were involved in sexual contact with their psychiatrists were also the ones most likely to be particularly vulnerable emotionally . . . [and] were more likely than other patients to consider exploitative relations with an authority figure to be normal.

Id.

See also Nanette Gartrell et al., *Psychiatrist-Patient Sexual Contact: Results of a National Survey, I: Prevalence*, 143 *AM. J. PSYCHIATRY* 1126, 1128 (1986) (reporting that studies among psychiatrists indicate that approximately 88% of sexual contact involves male psychiatrist and female patient and that majority admitted that sexual contact with patient was for their own emotional or sexual gratification). *See generally* PETER RUTTER, *SEX IN THE FORBIDDEN ZONE* (1989) (discussing why people in positions of power betray trust of patients and clients and contemplating relationship between power and exploitation).

29. *See* ROBERT M. VEATCH, *A THEORY OF MEDICAL ETHICS* 158-62 (1981) (discussing

society continues to accord high status to physicians as the omnipotent interpreters of medical truth and knowledge,³⁰ and individual patients often unquestioningly submit to the physician's authority.³¹ Physicians wield three types of power.³² First, physicians possess the power of superior knowledge by virtue of their medical training.³³ Second, they have charismatic power based on their own personal qualities.³⁴ Third, and most importantly, physicians command great social and cultural power, arising in part from an implied contract between the medical profession and society which entrusts the profession with the authority to determine medical truth and knowledge.³⁵ The three inextricably intertwined types of power work together

paternalism and patient autonomy in medical ethics); HOWARD BRODY, *THE HEALER'S POWER* 44-55 (1992) (same).

30. See BRODY, *supra* note 29, at 17-18 (1992) (describing how society accords high status to those it entrusts to define medical truth and knowledge).

31. See *id.* at 15 (stating that people who are under particular stress or threat will seek safety in authority). Brody explains that most people, when well, are fully capable of assuming freedom and responsibility; but these same people, when sick, can be comforted only through subjugation to miracle, mystery and authority. *Id.* A fictitious Chief of Medicine described by Brody explains physician-patient power dynamics:

The millions fear sickness and death and want the doctor to abolish those fears. . . . They have no confidence in their own wisdom, their own resources, to pull them through. They look to the doctor to have all the power, to make all the choices, to be free to act for them. . . . [R]eligion and medicine issue ultimately from the same source. Do you really think that we have advanced that much beyond primitive society, in which priest, soothsayer, and medicine man were all embodied in the same person? Can you look at recent examples of contagious epidemic diseases in our society—the society that thought it had outgrown epidemics and contagion—and seriously say that we are not ready to burn witches at the stake, to sacrifice victims to appease the gods, once the fear is upon us? . . . [Both medicine and religion] try to address the most profound fears of humanity, and ultimately there are two ways to do this—through meaning and magic. . . . [I]n times of great need and fear, the millions do not want meaning; they want magic, and the more potent the better. . . . And so we who would accept the priesthood of healing the sick must have our magic too. The magic comes in three forms—miracle, mystery, and authority. . . . [When patients] think they stare death in the face or think their wives or children or parents do, they want miracles, and they want doctors who look and talk like people who perform miracles.

Id. at 4-7. Cf. ROBERT ZUSSMAN, *INTENSIVE CARE: MEDICAL ETHICS AND THE MEDICAL PROFESSION* 2 (1992) (criticizing some medical ethicists for ignoring nonrational matters that account for patients' willingness to give consent to medical procedures, including imbalance of influence between patients and doctors and social forces that shape patients' values).

32. See BRODY, *supra* note 29, at 16-18 (discussing three types of power that physicians possess: Aesculapian/knowledge power, charismatic power, and social/cultural power); cf. O'Connell, *supra* note 23, at 889 (discussing two types of power, societal and relational, that lawyers possess).

33. See BRODY, *supra* note 29, at 16 (describing power of knowledge, or "Aesculapian power," as arising from knowledge of obscure and complex body of facts and theories, as well as from practical skills).

34. See *id.* at 16-17 (describing physicians' charismatic power as personal qualities, including courage, decisiveness, firmness, and kindness).

35. See *id.* at 17 (stating that physicians' social and cultural power arises from status that society accords them and explaining "implied contract" between medical profession and society).

and enhance each other.³⁶ However, many of the concerns about potential power abuse in physician-patient relationships arise primarily from physicians' social power and the other social roles physicians play in our society, which can clearly be separated from their roles as healers.³⁷ As a consequence of these acquired and endowed powers, physicians necessarily stand in a position of power in relation to their patients, who have entered into a fiduciary and trusting relationship with their physicians.³⁸

Prior to 1990, the AMA recognized the potential for power abuse in physician-patient relationships and declared "sexual misconduct" in the practice of medicine to be unethical.³⁹ However, after criticism that this prohibition against sexual misconduct did not define "misconduct" and merely begged the question, in 1990 the AMA amended its Code of Medical Ethics to clarify what type of sexual conduct is proscribed.⁴⁰ Today the Code expressly provides that sexual contact that occurs concurrently with the physician-patient relationship constitutes sexual misconduct.⁴¹ Sexual relationships that predate the physician-patient relationship, such as sexual contact with a spouse, are an exception to this general rule.⁴² In most other

36. See *id.* at 32 (stating that it is impossible to separate charismatic and social power from power of knowledge).

37. See *id.* at 31 (stating that problem of power abuse arises from multitude of social roles physicians play that are distinguishable from their roles as healers).

38. See O'Connell, *supra* note 23, at 889 (stating that power imbalance is inevitable consequence of entering into fiduciary or confidential relationship); see also Nanette K. Gartrell et al., *Physician-Patient Sexual Contact*, W.J. MED., Aug. 1992, at 139, 142 (describing power imbalance that results when patient enters into fiduciary relationship with physician).

39. See Telephone Interview with David Orentlicher, Office of General Counsel, American Medical Association (Feb. 16, 1993) (describing pre-1990 opinion declaring "sexual misconduct" to be unethical).

40. See *id.* (stating that questions regarding specific conduct that constituted "misconduct" prompted AMA to clarify that all physician-patient sexual contact concurrent with professional relationship constituted "misconduct"); see also AMA CURRENT OPINIONS, *supra* note 4, at 40 (setting forth current version of Opinion 8.14).

41. See AMA CURRENT OPINIONS, *supra* note 4, at 40 (prohibiting all sexual contact that occurs concurrently with physician-patient relationship).

42. See Gartrell et al., *supra* note 38, at 139 (excluding from definition of "physician-patient sexual contact" spouses, significant others, and sexual partners who later became patients). Providing an exception for sexual relationships that predate the professional relationship is sensible in light of the rationale supporting the AMA's rule prohibiting physician-patient sexual contact. Physician-patient sexual contact is prohibited because the patient's consent to the sexual relationship may be affected by the patient's emotional or psychological vulnerability resulting from the professional relationship. See *AMA Report*, *supra* note 4, at 2742 (discussing reasons for prohibition against physician-patient sexual contact). If the sexual relationship predates the professional relationship, the patient's consent to sexual contact with the physician obviously was not affected by the professional relationship because the professional relationship did not exist at the time consent was given. Therefore, sexual relationships with spouses, significant others, or sexual partners who later became patients fall outside of the prohibition against physician-patient sexual contact concurrent with the professional relationship. However, even in these exceptional situations, the physician should keep in mind the professional obligation to serve the needs of the patient. The emotional factors that accompany sexual involvement may affect the physician's medical judgment, thus jeopardizing the patient's

cases, the AMA has explained that sexual contact between a physician and patient is almost always detrimental to the patient⁴³ and is unethical because the physician's self-interest inappropriately becomes part of the professional relationship.⁴⁴ Because a fiduciary relationship exists between a patient and physician,⁴⁵ physicians have a fiduciary obligation to act solely for the welfare of patients by refraining from engaging in sexual activity with patients.⁴⁶ In the view of the medical profession, patients must be able to rely on physicians' faithful execution of their ethical and fiduciary obligations in order for the physician-patient relationship to succeed.⁴⁷ In sum, because physician-patient sexual contact has great potential to harm the patient and because patients cannot give true consent, almost all physician-patient sexual contact is per se sexual exploitation and sexual misconduct. Although the AMA forcefully maintains that physician-patient sexual relationships are ethically impermissible, whether a physician who enters such a relationship can be subject to discipline, and whether a patient can rely on the medical profession's ethical position, are a matter of a complex interplay between the power of the state to regulate medicine and the status of medical practice as a profession.

II. THE POWER OF THE STATE AND THE MEDICAL PROFESSION TO GOVERN PHYSICIANS' CONDUCT

A. *The Power of the Medical Profession to Regulate Itself*

The medical profession, like other professions, has assumed a dominant position in our society, and its members are part of the occupational elite who have a unique opportunity to achieve prestige, influence, and wealth.⁴⁸

diagnosis or treatment. *Id.* at 2743. One study concluded that although treating intimates for major medical problems is not unethical, it is unwise because it is difficult for physicians to be objective when they are emotionally involved. See Gartrell et al., *supra* note 38, at 143 (discussing finding that many respondents to study indicated that they had treated their spouses, significant others, and former sexual partners).

43. See Gartrell et al., *supra* note 38, at 142-43 (setting forth detrimental effects of physician-patient sexual contact and discussing serious harm to patients caused by sexual contact with physicians); *AMA Report*, *supra* note 4, at 2742 (stating that most researchers agree that effects of physician-patient sexual contact are almost universally negative or damaging to patient).

44. See *AMA Report*, *supra* note 4, at 2743 (explaining that physician's professional obligation to serve needs of patient and disregard own gratification means sexual contact with patient is unethical).

45. See *id.* (describing fiduciary responsibility and trust that are integral to physician-patient relationship).

46. See *id.* (stating that health of individuals and society depends on physicians' willingness to employ their knowledge, expertise, and influence solely for welfare of patients, and that sexual contact with patient seriously compromises patient's welfare).

47. See *id.* (stating that patients who seek medical treatment must be able to trust in physician's dedication to patient's welfare in order for physician-patient alliance to succeed).

48. See Criton A. Constantinides, Note, *Professional Ethics Codes in Court: Redefining the Social Contract Between the Public and the Professions*, 25 GA. L. REV. 1327, 1327 (1991) (describing professionals' unique position of favor in society).

One of the most crucial characteristics of any profession is the degree of autonomy its members are able to maintain over their work.⁴⁹ A profession's freedom from externally imposed standards, regulations or influence implies that it is a responsible, self-contained body capable of and willing to regulate itself.⁵⁰ The medical profession's primary justification for self-regulation is that, by nature, medical professionals operate from a distinct and esoteric body of knowledge that the lay public is incapable of evaluating.⁵¹ Only individuals who have mastered that specialized body of knowledge are capable of accurately evaluating the performance of other medical professionals.⁵² As a result, the medical profession has emerged as an autonomous, self-regulating body that, despite not being entirely free of state control, remains formally free to control the content of its own work.⁵³

The AMA's Code of Ethics, which outlines the medical profession's obligations to the public, is the primary means by which the medical profession broadcasts its image to the public in an effort to justify its regulatory autonomy.⁵⁴ The medical profession promises to monitor its

49. See *id.* at 1333 (citing James R. Elkins, *Ethics: Professionalism, Craft, and Failure*, 73 KY. L.J. 937, 941-42 (1984-85) for proposition that autonomy is profession's crucial characteristic); see also ELIOT FREIDSON, *PROFESSION OF MEDICINE* 77 (1970) (listing formal criteria of profession cited by analysts); PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 15 (1982) (defining "profession" as "occupation that regulates itself through systematic, required training and collegial discipline; that has a base in technical, specialized knowledge; and that has a service rather than profit orientation, enshrined in its code of ethics"). Freidson identifies two "core characteristics" of professions, a "prolonged specialized training in a body of abstract knowledge, and a collectivity or service orientation." FREIDSON, *supra*, at 77 (citing William J. Goode, *Encroachment, Charlatanism, and the Emerging Profession: Psychology, Sociology, and Medicine*, 25 AM. SOC. REV. 902-14 (1960)). In addition, there are "derived characteristics" that result from the core characteristics: The profession determines its own standards of education and training; professional practice is often legally recognized by some form of licensure; licensing and admission boards are manned by members of the profession; most legislation concerned with the profession is shaped by that profession; and the practitioner is relatively free of lay evaluation and control. *Id.*

50. See Constantinides, *supra* note 48, at 1333 (stating that freedom from external standards implies self-contained body capable of regulating itself).

51. See BARRY R. FURROW ET AL., *HEALTH LAW* 41 (2d ed. 1991) (describing medical profession's justification for control over licensing, discipline, and health care delivery).

52. See Constantinides, *supra* note 48, at 1334-35 (citing Arlene K. Daniels, *How Free Should Professions Be?*, in *THE PROFESSIONS AND THEIR PROSPECTS* 39, 40 (Eliot Freidson ed., 1973) for proposition that only professional's peers are qualified to evaluate professional performance); see also Richard Leahy, Comment, *Rational Health Policy and the Legal Standard of Care: A Call for Judicial Deference to Medical Practice Guidelines*, 77 CAL. L. REV. 1483, 1510-13 (1989) (arguing that medical societies are best suited to promulgate practice guidelines to which courts should give legal force).

53. See FREIDSON, *supra* note 49, at xx (stating that medical profession has achieved special status, autonomy, and control over own work even when not free of state control). See generally *id.* (analyzing how practice of medicine gained special status of profession).

54. See Constantinides, *supra* note 49, at 1372 (discussing professions' use of codes of ethics to justify autonomy); see also MICHAEL MORAN & BRUCE WOOD, *STATES, REGULATION AND THE MEDICAL PROFESSION* 58-59 (1993) (describing AMA's claim to be "the voice of American medicine").

members to insure a high standard of medical care in exchange for the right to be free from external intervention.⁵⁵ In return, the public delegates regulatory power to the medical profession.⁵⁶ Because the perceptions that the medical profession transmits to society through its Code of Ethics induce public acceptance of the medical profession's demand for autonomy,⁵⁷ the public should have the right to rely on the members of the medical profession to execute faithfully their ethical obligations.⁵⁸ Allowing the medical profession autonomy to determine its own ethical standards while denying the public the right to rely on physicians' adherence to their ethical code denies the public the benefit of its bargain.⁵⁹

The medical profession receives much criticism for failing to police its members adequately.⁶⁰ Although part of this perceived failure may be attributed to physicians' reluctance to discipline "one of their own,"⁶¹ a more problematic reason for the medical profession's failure to discipline itself may be that the structure of the disciplinary system deprives the medical profession of the ability to police its members sufficiently.⁶² The contradictory structure of the medical disciplinary system, in which the public relies on physicians sitting on state medical boards to uphold their ethical standards but in which the boards can uphold only state standards, necessarily deprives the public the benefit of its bargain. Although the public

55. See Constantinides, *supra* note 49, at 1340-41 (describing profession's promise to self-regulate in "social contract" between public and professions); see also MORAN & WOOD, *supra* note 54, at 24-25 (stating that self-enforcement of rigorous standards of ethics and competence is hallmark of profession and that status of profession gives professionals opportunity to control their occupation).

56. See Constantinides, *supra* note 49, at 1340-41 (describing public's delegation of power to state according to "social contract" between public and professions); see also MORAN & WOOD, *supra* note 54, at 2 (stating that recognition by public of professional status is reflected in expectation that doctors will be members of professional organization that has ethical code, disciplinary rules, and control of entry and training standards).

57. See Constantinides, *supra* note 49, at 1371-72 (stating that public accepts medical profession's demand for autonomy based on code of ethics).

58. See *infra* notes 59 and accompanying text (describing rationale for argument that public has right to rely on physicians to execute their ethical duties).

59. See Constantinides, *supra* note 49, at 1371 (arguing that public loses "benefit of its bargain" if courts do not acknowledge professional ethics codes in establishing duties or standards of care).

60. See *AMA Report*, *supra* note 4, at 2744 (stating that commentators have expressed concern that disciplinary bodies have not been sufficiently effective in dealing with sexual misconduct).

61. See Marilyn Beck & Lori Long, *Gynecologist-Patient Sexual Abuse: I. A Medical Board's View*, in *SEXUAL EXPLOITATION OF PATIENTS BY HEALTH PROFESSIONALS*, *supra* note 18, at 66, 66 (stating that one reason for delay in official board action is that medical colleagues will not confront offender). Beck and Long state that other reasons for official delay are that victims are reluctant to lodge complaints, avenues of complaint are lacking or unknown, physicians tend to disbelieve such complaints, and identifiable forums or guidelines for dealing with the issue have not been established. *Id.*

62. See *infra* notes 63-64 and accompanying text (discussing structure of disciplinary system and available remedies as causes for medical profession's perceived failure to discipline physicians).

grants the medical profession autonomy based on the profession's promise that its members will adhere to the professional ethical code, the public can look only to the state for a remedy when physicians behave unethically. The discovery and investigation of sexual misconduct is unlikely unless victims of sexual misconduct initiate actions and pursue adequate state remedies.⁶³ Victims of sexual abuse by physicians have four primary avenues of redress, which all rely on the state's power to discipline physicians: criminal complaints, common-law civil actions, statutory civil actions, and professional board complaints.⁶⁴ This Note will focus on the last of these remedies, discipline by state medical boards.

B. *The States' Power to Regulate Medical Practice*

The state's power to regulate health care originates in the police power, which the individual states retain according to the United States Constitution.⁶⁵ The state, however, only became involved in the regulation of medicine in the 1880s at the request of the medical profession, which was unable to prevent untrained practitioners from competing with trained physicians.⁶⁶ Thus, the medical profession attained its dominant position by acquiring power and authority from the state.⁶⁷

Since the state began licensing the practice of medicine, courts consistently have held that states have a legitimate interest in regulating the practice of medicine and maintaining the quality of medical care provided within their borders.⁶⁸ The United States Supreme Court has long recognized

63. See *AMA Report*, *supra* note 4, at 2744 (citing Nanette Gartrell et al., *Reporting Practices of Psychiatrists Who Knew of Sexual Misconduct by Colleagues*, 57 AM. J. ORTHOPSYCHIATRY 287 (1987), and discussing avenues of detection and reporting of sexual misconduct by physicians).

64. See generally Linda Jorgenson et al., *The Furor Over Psychotherapist-Patient Sexual Contact: New Solutions to an Old Problem*, 32 WM. & MARY L. REV. 645, 666-728 (1991) (discussing remedies available to both direct and secondary victims of abuse).

65. See FURROW, *supra* note 51, at 78 (discussing source of states' power to regulate medicine).

66. See STARR, *supra* note 49, at 102 (1982) (describing medical profession's attempts to win licensing laws to protect against untrained practitioners). See generally *id.* (describing rise of medical authority and shaping of medical system).

67. See FREIDSON, *supra* note 49, at 23 (1970) (describing state's aid in establishing profession's preeminence); MORAN & WOOD, *supra* note 54, at 26 (stating that modern professions accomplish dominant position by acquiring power and authority from state).

68. See, e.g., *Bigelow v. Virginia*, 421 U.S. 809, 827 (1975) (noting that state has legitimate interest in maintaining quality of medical care provided within borders); *Barsky v. Board of Regents*, 347 U.S. 442, 451 (1954) (holding that state has plenary power to regulate practice of medicine and maintain professional standards, which power includes discretion to suspend license on basis of criminal conviction in foreign jurisdiction); *Lambert v. Yellowley*, 272 U.S. 581, 598 (1926) (Sutherland, J., dissenting) (noting power to restrict physicians belongs exclusively to states); *Linder v. United States*, 268 U.S. 5, 18 (1925) (recognizing that direct control of medical practice in states is beyond power of federal government); *Dent v. West Virginia*, 129 U.S. 114, 122 (1889) (observing that power of state to provide for welfare of people authorized it to prescribe all medical regulations).

that the state has the right to regulate generally in order to protect the health and welfare of its people.⁶⁹ The Court also has recognized that the nature and extent of mandatory physicians' qualifications depended primarily upon the judgment of each state as to the necessity of such qualifications.⁷⁰ The Court has maintained that there is perhaps no other profession more properly open to state regulation than the medical profession.⁷¹ Accordingly, the Supreme Court has refrained from interfering with the states' regulation of the field of medicine.⁷²

The states, through their courts, legislatures, state medical boards, and prosecutors, involve themselves with almost every aspect of complaints against physicians, no matter what avenues of redress patients choose.⁷³ Despite the civil and criminal remedies available and the high degree of physician policing efforts by other groups,⁷⁴ physician discipline remains primarily the responsibility of the state medical boards.⁷⁵ As grantors of medical licenses, the boards are the only entities empowered by states to sanction doctors, restrict their ability to practice, or revoke their medical licenses.⁷⁶ States, because they have exercised their power to regulate medicine through the medical boards, have a duty to protect the public; states carry out this duty by putting the public in a position to make informed choices among physicians.⁷⁷ Some commentators posit that, through licens-

69. See *England v. Louisiana State Bd. of Medical Examiners*, 263 F.2d 661, 666 (5th Cir.) (per curiam) (citing *Dent*, 129 U.S. at 121-22), cert. denied, 359 U.S. 1012 (1959).

70. See *Dent*, 129 U.S. at 121-22 (stating that each state determines medical regulations based on necessity for such regulations in that state).

71. *Watson v. Maryland*, 218 U.S. 173, 176 (1910).

72. See *England*, 263 F.2d at 668 (discussing Supreme Court's reluctance to interfere with states' regulation of medical field).

73. See *Jorgenson*, supra note 64, at 666-728. (discussing remedies available to patients). The courts, state legislatures, state medical boards, and prosecutors are all state entities or agents, so the state is necessarily involved in any remedy.

74. See James Gray, *Why Bad Doctors Aren't Kicked Out of Medicine*, MED. ECON., Jan. 20, 1992, at 126, 128-40 (describing uncoordinated, ineffective efforts of hospital peer review committees, Medicare PROs, various impaired-physician rehabilitation programs, federal Drug Enforcement Administration, and informal colleague and partnership review).

75. *Id.* at 128.

76. *Id.*

77. See *Eatough v. Albano*, 673 F.2d 671, 676 (3d Cir.) (discussing states' interest in allowing public to make informed decisions about physicians), cert. denied, 457 U.S. 1119 (1982); see also *Geiger v. Jenkins*, 316 F. Supp. 370, 373 (N.D. Ga. 1970) (stating that state may regulate practice of medicine in order to perform its duty to safeguard public health), *aff'd*, 401 U.S. 985 (1971); *Aitchison v. Maryland*, 105 A.2d 495, 498 (Md.) (stating that state, in performance of its duty to protect public health, can regulate practice of medicine), cert. denied, 348 U.S. 880 (1954). *Geiger* and *Aitchison* refer to the states' "duty" in the medical field. However, most opinions refer to the states' "right" or "power" to regulate health care. See supra notes 68-72 and accompanying text (describing courts' recognition of states' right to regulate practice of medicine). The fact that the states have the right to govern the medical field does not necessarily lead to the conclusion that the states have a duty to take any particular action. Cf. *New York v. United States*, 112 S. Ct. 2408, 2414 (1992) (observing that, in matters reserved for states, federal government can encourage, but cannot compel, states to take particular actions).

ing, state medical boards create legitimate expectations by the public that licensees will behave ethically.⁷⁸ However, due to inconsistencies in the states' actions, the public does not know what kind of behavior to expect, and physicians do not know what behavior warrants penalties.⁷⁹

III. THE COMPLEX RELATION BETWEEN THE STATE'S LAW AND MEDICAL ETHICS AND ITS CONFUSING RESULTS

As traditionally and perhaps incorrectly conceived, the domain of any kind of professional ethics begins where state law leaves off. According to this understanding, ethics addresses only obligations above and beyond the requirements of law.⁸⁰ The traditional understanding suggests that a consensus exists on the authoritative position of state law where state law exists.⁸¹

However, these traditional assumptions about the relationship between law and medical ethics conceal the competition and the dynamic interplay between the states' and the medical profession's norms. The medical profession asserts that, in light of its unique expertise and esoteric knowledge, substantial areas of the medical field should be reserved for the profession to govern with its own rules.⁸² The state itself has sanctioned the profession's autonomy by deferring to the profession on matters of physician regulation.⁸³ Physicians control entry into the medical profession, disciplinary actions against their colleagues, and the delivery of medical care.⁸⁴ However, this control results from the states' allocation of these functions to the medical

78. See Mary Ellen Waithe & David T. Ozar, *The Ethics of Teaching Ethics*, HASTINGS CENTER REP., July-Aug. 1990, at 17, 21 (stating that boards' licensing of physicians allows public to expect that physicians will behave ethically); see also BLACKMAN & BAILEY, *supra* note 25, at 50 (1990) (noting that legal standards of medical care are based on reasonable expectations of patients, and these in turn are based on code of ethics that physicians have set for themselves).

79. See *infra* notes 98-191 and accompanying text (describing inconsistencies among states regarding legal standards to which physicians must adhere).

80. See Koniak, *supra* note 13, at 1395 (describing traditional understanding of relationship between law and professional ethics).

81. *Id.* at 1398.

82. See FREIDSON, *supra* note 49, at 45 (observing that medical profession bases its claim for autonomy on possession of skill so esoteric and complex that nonmembers of profession cannot evaluate it); MORAN & WOOD, *supra* note 54, at 30 (stating that medical profession's control over field is due, in part, to its role as custodian of medical knowledge).

83. See FREIDSON, *supra* note 49, at 33 (stating that, although state has ultimate authority in matters of licensing and prosecution of physicians, the state has given much of its authority to AMA resulting in medical profession's control over quality and terms of medical practice); VEATCH, *supra* note 29, at 103 (explaining that in most states "professional misconduct" is violation of state licensing laws, but that definition of professional misconduct is often made by profession itself). Veatch offers Maryland as an example of a state that has ceded to a private professional organization not only the definition of the standards governing grounds for suspension of the publicly granted license, but also the authority to judge whether those standards have been violated. *Id.*

84. See FURROW, *supra* note 51, at 41 (describing physician's control over licensing, discipline, and delivery of care within medical profession).

profession.⁸⁵ Although the states have allocated these areas to the medical profession to govern, the profession must govern with the state's statutes rather than with its own ethical standards.

Therefore, the traditional assumptions about the relationship between law and medical ethics minimize the interplay between the two. The medical profession is inextricably connected to the state and its laws—the profession is dependent on the state for much of its power, but the state must defer to the medical profession's expertise and rely on the profession to carry out its normative vision. Problems arise at critical points where the medical profession's normative vision diverges from the state's. The matter of consensual intercourse between physicians and patients concurrent with the professional relationship has emerged as a critical point of disagreement. The medical profession has declared its view of the issue in its ethical rules.

Under the traditional understanding, one hurdle for the medical profession is that the state treats rules of ethics as "law" only to the extent that the ethical rules are incorporated into the state statutes.⁸⁶ Therefore, the state relegates medical ethics to a relatively low status.⁸⁷ However, to allow the public the benefit of its bargain, the state needs to accommodate the medical profession's alternative vision of law, which is expressed through AMA ethical standards.

The state treats the medical profession's standards inconsistently, from full recognition in some state statutes to total rejection by some courts. The inconsistency arises from the fact that the state is not monolithic. Several elements of the state, particularly the state legislatures and courts, may be working at cross purposes. Moreover, a third element, the medical boards, straddles the line between the state and the medical profession because it is both part of the state and made up of members of the medical profession.

This inconsistent treatment of the medical profession's standards is manifested in several ways. First, although most state legislatures have codified some sort of legal prohibition against physician-patient sexual relationships,⁸⁸ the types of physician-patient sexual activity that individual state statutes proscribe differ markedly.⁸⁹ Second, the sixty-three⁹⁰ state

85. See MORAN & WOOD, *supra* note 54, at 26 (observing that professionalism is form of state-sanctioned regulation and that profession's control over itself is established by state).

86. See Koniak, *supra* note 13, at 1411 (stating that state treats ethics rules as "law" only to extent and form in which state adopts those rules).

87. See *id.* (observing that in state's "hierarchy of norms" professional ethics occupy relatively low status).

88. See, e.g., COLO. REV. STAT. ANN. § 18-3-405.5 (West 1992) (stating that sexual contact with patient is sexual assault in certain circumstances); FLA. STAT. ANN. § 458.331 (West 1992) (stating that physician-patient sexual activity is unprofessional conduct in certain circumstances); MINN. STAT. ANN. § 609.344 (West 1992) (defining criminal sexual conduct in third degree as including various types of physician-patient sexual contact); S.D. CODIFIED LAWS ANN. § 36-4-30 (1992) (stating that physician-patient sexual activity is unprofessional conduct in certain circumstances); WIS. STAT. ANN. § 940.22(2) (Supp. 1992) (stating that sexual contact with patient is felony regardless of consent).

89. See *infra* notes 98-109 and accompanying text (describing different types of conduct

medical boards in the United States are as diverse as the states they serve.⁹¹ The Federation of State Medical Boards has asserted that both the level of sanctions and the aggressiveness with which state medical boards pursue sexual misconduct cases vary widely.⁹² Third, the courts, both in reviewing board disciplinary actions and in hearing private claims by patients, approach the issue of physician-patient sexual contact in widely different manners.⁹³ Critics have expressed concern that existing disciplinary bodies have not dealt effectively with physician sexual misconduct;⁹⁴ however, these

proscribed by state statutes); *cf.* *Coralluzzo v. Fass*, 450 So. 2d 858, 859 (Fla. 1984) (noting that if professional ethical standards are not codified by state legislature, courts have no jurisdiction over violation of such standards and violation can be addressed only by profession itself).

90. See Gray, *supra* note 74, at 126, 128 (stating that some states have separate osteopathic and allopathic boards).

91. See *id.* at 146 (commenting on disparate performances and lack of uniformity of state medical boards despite lack of evidence that physician competence or impairment varies from state to state at all).

92. See McCormick, *supra* note 4, at 6 (stating Federation of State Medical Boards' assertion that level of sanctions and aggressiveness with which state medical boards pursue sexual abuse cases vary widely); Tim Friend, *Urging Tougher Pursuit of Bad Doctors*, USA TODAY, Jan. 13, 1993, at 1D (stating that, according to 1993 report by Public Citizen Health Research Group, state medical boards vary widely in their aggressiveness in disciplining physicians and that people who live in states with "better boards" are better protected).

The 1993 report titled "Comparing State Medical Boards" by Public Citizen Health Research Group, a Ralph Nader-founded consumer watchdog group based in Washington, D.C., concluded that state medical boards still do too little to discipline negligent or incompetent physicians. Elizabeth Neus, *Incompetent, Negligent Docs Still Escape Punishment*, GANNETT NEWS SERVICE, Jan. 12, 1993, available in LEXIS, Nexis Library. The group especially chastised the boards for disciplining fewer than one percent of the nation's physicians. *Id.* However, the report itself has received a great deal of criticism for relying solely on the number of physicians disciplined as an accurate indicator of the effectiveness of the boards. See *id.* (quoting Dr. James Winn, executive vice-president of Federation of State Medical Boards, as stating, "Public Citizen continues to focus on a numbers game. They still say that the number of scalps shows the effectiveness of the board.').

93. See *infra* notes 123-91 and accompanying text (examining different approaches courts take when deciding physician sexual abuse issues).

94. *AMA Report*, *supra* note 4, at 2744; see Gattrell et al., *supra* note 63, at 293 (finding that, as result of inadequate disciplinary actions, psychiatrists are avoiding censure by ethics committees for sexual exploitation of patients).

Critics of the disciplinary boards cite rising complaints about physicians, a rate of disciplinary actions that is not keeping pace with the number of complaints, and a lack of uniformity in those disciplinary actions that do occur. See Gray, *supra* note 74, at 126 (describing inadequacy of physician policing effort).

Some commentators suggest that if state medical boards do not sufficiently improve their systems of physician discipline, their jobs should be delegated to a federal agency. See Gray, *supra* note 74, at 146 (suggesting that federal agency might perform physician discipline more efficiently than state medical boards). However, in light of the states' traditional power to regulate the medical field, a federal agency would probably not take over the boards' duties of disciplining physicians.

The federal government, through its role as a purchaser of medical care, exercises some degree of control over health care. See FURROW, *supra* note 51, at 87 (discussing purchasing power as source of federal government's authority to control medical field). As a purchaser

critics have identified only the medical boards' role in physician discipline without recognizing that other actors, such as courts and legislatures, contribute to the problem.

Each state has the right and power to impose conditions on the right to practice medicine and may revoke a license for good cause.⁹⁵ The legislatures of each state delegate the power to regulate the medical profession to medical licensing boards. The legislatures delegate their power to the boards because they presume that the boards, in light of their superior knowledge of professional standards, can better evaluate and discipline physicians' conduct.⁹⁶ However, this delegation of regulatory power is limited; the state sets the standards, and professionals merely apply them. Despite the states' recognition of the medical profession's expertise in evaluating physicians' conduct, the medical boards are state entities that must confine their activities to investigations of violations of the laws promulgated by the state legislatures rather than those promulgated by the medical profession itself.⁹⁷

The standards of conduct promulgated by the state legislatures vary. Some states, such as Oregon, incorporate the medical profession's standards into the state statutes so that the legal standard corresponds with the professional standard. Oregon's statutes provide that the medical board may discipline a physician for "unprofessional or dishonorable conduct."⁹⁸ More importantly, the Oregon statutes include in the definition of "unprofessional or dishonorable conduct" any conduct contrary to recognized standards of ethics of the medical profession.⁹⁹ The Oregon Court of Appeals has held

of medical care, the federal government regulates the medical field through provider certification. *Id.* In order to receive Medicare or Medicaid payments, an institutional provider must be certified and must sign a provider agreement. *Id.* Although the federal government wields considerable power to control health care in light of the immense sums it spends on medical care, the federal government usually defers to the states. *Id.* at 88.

95. *Coe v. United States Dist. Court for the Dist. of Colo.*, 676 F.2d 411, 414 (10th Cir. 1982).

96. *See id.* (stating that state board of medical examiners is presumed to know better than laymen ethics of medical profession and what renders one unfit to engage or continue in practice of medicine).

97. *See DERBYSHIRE, supra* note 10, at 76 (describing medical boards as state entities).

98. *See OR. REV. STAT. § 677.190* (1991) (providing that "[t]he Board of Medical Examiners for the State of Oregon may refuse to grant, or may suspend or revoke a license to practice issued under this chapter for any of the following reasons: (1) Unprofessional or dishonorable conduct . . .").

99. *See OR. REV. STAT. § 677.188(4)* (1991) (including violation of professional ethical standard in definition of "unprofessional or dishonorable conduct"). Section 677.188(4) provides:

"Unprofessional or dishonorable conduct" means conduct unbecoming a person licensed to practice medicine or podiatry, or detrimental to the best interests of the public, and includes: (a) Any conduct or practice contrary to recognized standards of ethics of the medical or podiatric profession or any conduct or practice which does or might constitute a danger to the health or safety of a patient or the public or any conduct, practice or condition which does or might impair a physician's or podiatrist's ability safely and skillfully to practice medicine or podiatry

Id.

that these statutory provisions incorporate ethical standards recognized by the medical profession.¹⁰⁰

Utah,¹⁰¹ North Carolina,¹⁰² Ohio,¹⁰³ and Wyoming¹⁰⁴ include language similar to the provision in Oregon's statutes that allows the state medical

100. See *McKay v. Board of Medical Examiners*, 788 P.2d 476, 479 (Or. Ct. App. 1990) (holding that legislature intended to incorporate by reference ethical standards recognized by organized medicine). In *McKay*, the Oregon Court of Appeals responded to a physician's contention that the medical board could find a violation of ethical standards only after rulemaking defining "unprofessional conduct." *Id.* at 478. After reviewing the statutes and the legislative history, the court decided that the statutory framework did not mandate rulemaking before the medical board could find that a physician violated ethical standards. *Id.* at 479. The board, therefore, was not required to define "recognized standards of ethics" by rulemaking, and could rely on the medical profession's standards. *Id.*

The *McKay* court's opinion is especially interesting in light of its background. Prior to amendment in 1975, the Oregon statute did not include the language incorporating the medical profession's standards into the definition of unprofessional conduct. In 1980, the Supreme Court of Oregon in *Megdal v. Oregon State Board of Dental Examiners* refused to interpret the old statute as incorporating external professional standards by reference because so doing would create needless difficulties and bring up the question of the medical profession's authority to impose rules to be enforced by governmental power. *Megdal v. Oregon State Board of Dental Examiners*, 605 P.2d 273, 280 (Or. 1980). The *Megdal* court found that the medical profession's views, like any other entity's views, might raise interesting issues of policy and values. *Id.* at 281. However, the medical board should not look to the medical profession in order to determine professional standards. *Id.* at 280. In 1981, the Oregon Court of Appeals, in *Spray v. Board of Medical Examiners*, relied on *Megdal* for the proposition that "'ethical standards' may be unlike 'professional standards' and might have to be established by rulemaking." *Spray v. Board of Medical Examiners*, 624 P.2d 125, 125 (Or. Ct. App.), *modified*, 627 P.2d 25 (Or. Ct. App.), *review denied*, 631 P.2d 341 (Or. 1981). Although the amendment incorporating the medical profession's ethical standards became effective in 1975, both the *Megdal* and *Spray* courts applied the pre-amendment version of the statute.

101. See UTAH CODE ANN. § 58-12-36(15) (1990) (defining "unprofessional conduct" to include violation of medical profession's ethical standards). Section 58-12-36(15) provides:

"Unprofessional conduct" as relating to the practice of medicine includes . . . any conduct or practice contrary to the recognized standards of ethics of the medical profession, or any conduct or practice which does or might constitute a danger to the health, welfare, or safety of the patient or the public, or any conduct, practice, or condition which does or might impair the license holder's ability to practice medicine safely and skillfully

Id.

102. See N.C. GEN. STAT. § 90-14(a)(6) (1990) (providing that medical board can discipline physician for unprofessional conduct, including violation of medical profession's ethical standards). Section 90-14(a) provides:

The Board shall have the power to deny, annul, suspend, or revoke a license, or other authority to practice medicine in [North Carolina], issued by the Board to any person who has been found by the Board to have committed . . . [u]nprofessional conduct, including, but not limited to, any departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice, or the ethics of the medical profession, irrespective of whether or not a patient is injured thereby, or the committing of any act contrary to honesty, justice, or good morals, whether the same is committed in the course of practice or otherwise, and whether committed within or without North Carolina

Id.

The District Court for the Western District of North Carolina held that the language of

boards to look to, and to incorporate, the medical profession's ethical standards when licensing and disciplining physicians.¹⁰⁵ These types of statutes avoid the disparity between the professional standard that the public expects to be upheld and the legal standard applied by the state boards.

Several other states, however, have articulated substantially different standards of conduct that do not expressly incorporate the medical profession's standards. Most state statutes provide that "unprofessional conduct" provides grounds for physician discipline.¹⁰⁶ However, states differ in how they define "unprofessional conduct." Some states use a "reasonable physician" standard.¹⁰⁷ Some states specifically address physician-patient sexual

§ 90-14(a)(6) itself and in conjunction with established medical ethics sufficiently informs physicians of the standards by which they are to conduct themselves and their practice. *Hoke v. Board of Medical Examiners*, 395 F. Supp. 357, 362 (W.D.N.C. 1975).

103. See OHIO REV. CODE ANN. § 4731.22(B)(18)(a) (Baldwin Supp. 1991) (providing that state medical board can discipline physician for violation of medical profession's code of ethics). Section 4731.22(B) provides:

The board . . . shall, to the extent permitted by law, limit, revoke, or suspend a certificate, refuse to register or refuse to reinstate an applicant, or reprimand or place on probation the holder of a certificate for . . . [t]he violation of any provision of a code of ethics of a national professional organization. "National professional organization" means the American medical association, the American osteopathic association, the American podiatric medical association, and such other national professional organizations as are determined, by rule, by the state medical board. . . .

Id. § 4731.22(B).

104. See WYO. STAT. § 33-26-402(a)(xxvi)(A)(I) (1977) (providing that medical board can discipline physician for unprofessional conduct, including violation of medical profession's ethical standards). Section 33-26-402(a) provides:

The board may refuse to grant or renew, revoke, suspend or restrict a license or take other disciplinary action on the following grounds: . . .

(xxvi) Unprofessional or dishonorable conduct not otherwise specified in this subsection, including but not limited to:

(A) Any conduct or practice:

(I) Contrary to recognized standards of ethics of the medical profession;

(II) Which does or may constitute a substantial risk of:

(1) Danger to the health or safety of a patient or the public; or

(2) Impairing a physician's ability to safely and skillfully practice medi-

cine. . . .

Id. § 33-26-402(a).

In addition, Wyoming also specifically provides that the medical board can discipline a physician for "sexual exploitation of a patient." *Id.* § 33-26-402(a)(vii).

105. See *supra* notes 98-104 and accompanying text (describing language in Oregon, Utah, North Carolina, Ohio and Wyoming statutes that incorporates medical profession's ethical standards as legal standards of conduct).

106. See, e.g., ALASKA STAT. § 08.64.326(a)(9) (1962 & Supp. 1992) (providing that state medical board can impose disciplinary sanction on physician for engaging in "unprofessional conduct . . . in connection with the delivery of professional services to patients"); CAL. BUS. & PROF. CODE § 2220 (West 1990) (prohibiting unprofessional conduct); MO. REV. STAT. § 334.100(2)(4) (1989 & Supp. 1992) (providing that state medical board may discipline physician for "misconduct, fraud, misrepresentation, dishonesty, unethical conduct or unprofessional conduct . . .").

107. See OHIO REV. CODE ANN. § 4731.22(B)(6) (Baldwin Supp. 1991) (providing that state medical board can discipline physician for "departure from, or the failure to conform

contact.¹⁰⁸ Other states allow discipline for acts of moral turpitude, dishonesty, or corruption.¹⁰⁹ Although the same statutes do not specifically include violation of a professional ethical standard as a prohibited act, some courts have held that violation of a professional ethical standard does constitute unprofessional conduct.¹¹⁰ Other courts, however, have declined to uphold disciplinary action if it was not based on conduct specifically prohibited by statute.¹¹¹

IV. JUDICIAL RECOGNITION OF THE MEDICAL PROFESSION'S CODE OF ETHICS, PHYSICIANS' FIDUCIARY DUTIES, AND POWER DYNAMICS

In light of the problems inherent in physician-patient sexual contact,¹¹² modern public policy should strongly favor a prohibition against all physician-patient sexual contact regardless of the patient's consent. This prohibition involves recognition of three important factors: the power imbalance between physician and patient, the medical profession's code of ethics, and the fiduciary nature of the professional relationship. All three factors suggest an affirmative right of the public and individual patients to be able to rely on physicians to refrain from engaging in sexual relations with their patients.

The medical profession clearly recognizes these three significant issues. The fiduciary nature of the professional relationship serves as part of the

to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established . . ."). Ohio also incorporated the medical profession's code of ethics into its statutes. *See supra* note 103 (discussing § 4731.22(B)(18)(a)).

108. *See* MO. REV. STAT. § 334.100(2)(4)(i) (1989 & Supp. 1992) (providing that "[e]xercising influence within a physician-patient relationship for purposes of engaging a patient in sexual activity" constitutes "misconduct, fraud, misrepresentation, dishonesty, unethical conduct or unprofessional conduct," for which medical board can impose discipline); WASH. REV. CODE § 18.130.180(24) (1991) (providing that "abuse of a client or patient or sexual contact with a client or patient" constitutes "unprofessional conduct").

109. *See* ALASKA STAT. § 08.64.326(a)(9) (1962 & Supp. 1992) (providing that state medical board can impose disciplinary sanction on physician for engaging in "lewd or immoral conduct in connection with the delivery of professional services to patients"); WASH. REV. CODE § 18.130.180(1) (1991) (providing that "commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession" constitutes "unprofessional conduct"). In *Haley v. Medical Disciplinary Board*, the Washington Supreme Court found that this particular statute was rendered more specific by reference to purposes of professional discipline, and common knowledge and understanding of members of a particular profession. *Haley v. Medical Disciplinary Bd.*, 818 P.2d 1062, 1074 (Wash. 1991). In *Haley*, the medical board disciplined a physician for engaging in sexual contact with a patient; however, the board relied on § 18.130.180(1) rather than on § 18.130.180(24), which specifically prohibits physician-patient sexual contact. *Id.* at 1075.

110. *See infra* notes 155-91 and accompanying text (discussing how professional ethical standards are incorporated into statutory standards by courts).

111. *See infra* notes 123-54 and accompanying text (discussing cases in which courts refused to uphold disciplinary action based on violation of professional ethical standard unless conduct was specifically prohibited in statute).

112. *See supra* notes 18-47 and accompanying text (describing problems with sexual relationships between physicians and patients and reasons for prohibition).

foundation for the medical profession's prohibition against physician-patient sexual contact.¹¹³ The medical profession's recognition of the disparity in power between physician and patient provides a further basis for the medical profession's active stance against physician-patient sexual contact.¹¹⁴

The extent to which the states recognize power imbalance, fiduciary duty and the medical profession's ethical standards varies. The various degrees to which state legislatures recognize the medical profession's standards is reflected by the way in which states incorporate or refuse to incorporate the medical profession's code of ethics into the state statutes.¹¹⁵ Some legislatures have also acknowledged the considerable difference in power between physicians and patients,¹¹⁶ and the vulnerability of the patient.¹¹⁷

Judicial recognition of the three factors seems to vary from state to state.¹¹⁸ Courts generally recognize that a fiduciary relationship exists "where

113. See BLACKMAN & BAILEY, *supra* note 25, at 52 (discussing fiduciary nature of physician-patient relationship); *supra* note 25 and accompanying text (same).

114. See AMA Report, *supra* note 4, at 2742 (discussing combination of physicians' knowledge, expertise, and status with patients' physical and emotional vulnerability). The AMA explained that these elements of the physician-patient relationship combine to give the physician disproportionate influence over the patient. *Id.* Due to the relative power position of the patient within the professional relationship, the patient is unable to give reliable or true consent to sexual contact with the physician. *Id.*

115. See *supra* notes 98-105 and accompanying text (discussing states' incorporation of medical profession's code of ethics).

116. See FLA. STAT. ANN. § 458.331(1)(j) (West 1992) (stating that physician's exercise of influence within patient-physician relationship for purposes of engaging patient in sexual activity is grounds for disciplinary action by medical board).

117. See ILL. REV. STAT. ch. 70, para. 801 (1992) (defining "emotionally dependent" as nature of patient's or former patient's emotional condition and nature of treatment provided by physician such that physician knows or has reason to believe that patient or former patient is unable to withhold consent to sexual contact by physician).

As a result of this inability to give meaningful consent, several state legislatures have specified that psychiatrists and psychotherapists's cannot use the consent of the patient as a defense to charges of sexual misconduct. See COLO. REV. STAT. § 18-3-405.5(3) (1992) (stating that consent by client to sexual penetration, intrusion, or contact shall not constitute defense to sexual contact by psychotherapist); MINN. STAT. ANN. § 609.344(1)(h-j) (1992) (stating that consent by patient is not defense to sexual contact by psychotherapist when penetration occurred during psychotherapy session, when patient or former patient is emotionally dependent upon psychotherapist, or when sexual penetration occurred by means of therapeutic deception by psychotherapist).

The degree to which states disallow the consent defense also varies. Some statutes presume that patients are never capable of giving full and informed consent to sexual contact by their physicians. See FLA. STAT. ANN. § 458.331(1)(j) (West 1992) (stating that patient shall be presumed to be incapable of giving free, full, and informed consent to sexual activity with physician); ILL. REV. STAT. ch. 70, para. 801 (1992) (stating that consent of patient or former patient is irrelevant to determining whether prohibited sexual contact by physician occurred). Other states narrow the prohibition of the consent defense to certain situations. See MINN. STAT. ANN. § 609.344(1)(k) (1992) (prohibiting patient consent defense when sexual penetration is accomplished by means of false representation by health care professional that penetration is for bona fide medical purpose).

118. See *infra* notes 119-91 and accompanying text (observing that courts differ greatly

there is a special confidence reposed in one who in equity and good conscience is bound to act in good faith and with due regard to the interests of the one reposing the confidence."¹¹⁹ However, when the courts are evaluating cases involving physician-patient sexual misconduct, they do not always look to the inherent fiduciary nature of the physician-patient relationship. Not all courts recognize the existence of a power differential between physicians and patients. Some courts recognize patients' inability to give meaningful consent to sexual contact by their physicians,¹²⁰ while other courts reverse board disciplinary actions on the basis of patient consent to the sexual activity.¹²¹ Finally, courts express different opinions regarding the significance of the medical profession's ethical code.

Public policy, reflected in these three factors, suggests treating physician-patient sexual contact in a careful, thoughtful manner because the activity is much different from sexual relations between two consenting adults with presumptively equal power. Whether courts make use of the medical profession's ethical code and whether they acknowledge power dynamics and the fiduciary nature of the physician-patient relationship often determines how courts handle cases involving physician-patient sexual contact, especially how they construe statutes.¹²²

A. Cases That Narrowly Construe the Prohibition Against Physician-Patient Sexual Contact

*Yero v. Department of Professional Regulation*¹²³ and *Gromis v. Medical Board of California*¹²⁴ exemplify in different ways how some courts deny the public the benefit of its bargain with the medical profession—the affirmative right to rely on physicians to execute faithfully their ethical obligations to refrain from having sexual contact with patients regardless of consent.¹²⁵ In each of these cases, the court failed to regard fully the medical profession's ethical code, the fiduciary nature of the physician-patient relationship, and the power differential between the parties.

In *Yero v. Department of Professional Regulation*,¹²⁶ the Florida District Court of Appeal reversed a disciplinary action imposed by the Board of

regarding recognition of fiduciary aspect and power imbalance in physician-patient relationships).

119. *Neagle v. McMullen*, 165 N.E. 605, 608 (Ill. 1929).

120. See *infra* notes 155-91 and accompanying text (discussing cases in which courts acknowledge patients' inability to give meaningful consent to sexual contact by their physicians).

121. See *infra* notes 123-54 and accompanying text (discussing cases in which courts do not consider patient's inability to consent to be relevant factor).

122. See *infra* notes 123-91 and accompanying text (contrasting cases in which courts recognized medical profession's ethical code and unique nature of professional relationship with cases in which courts did not).

123. 481 So. 2d 61 (Fla. Dist. Ct. App. 1985).

124. 10 Cal. Rptr. 2d 452 (Ct. App. 1992).

125. See *supra* notes 48-59 and accompanying text (discussing public's "bargain" with medical profession).

126. *Yero v. Department of Professional Regulation*, 481 So. 2d 61 (Fla. Dist. Ct. App. 1985).

Medical Examiners against a psychiatrist who engaged in sexual activity with a patient one month after the termination of the professional relationship.¹²⁷ In *Yero*, after terminating treatment, the psychiatrist "succumbed" to the demands and threats of his patient, whom he diagnosed as having a borderline personality structure.¹²⁸ The court acknowledged that termination of the physician-patient relationship prior to the occurrence of sexual activities with the patient would not necessarily insulate the psychiatrist from disciplinary action.¹²⁹ However, the court found that the psychiatrist's license could be suspended in only two statutorily-described situations: (1) if the physician used the physician-patient relationship to engage in sexual activity, or (2) if the physician exercised influence within the physician-patient relationship for purposes of engaging the patient in sexual activity.¹³⁰ The court found that no basis existed for the suspension of the psychiatrist's license because the evidence failed to establish either of these conditions.¹³¹

The *Yero* court based its test on two Florida statutes that specifically prohibited physician-patient sexual contact in the two situations described by the court.¹³² However, the court did not consider another statute that prohibited the failure to practice medicine with the level of care, skill, and treatment that would be recognized as being acceptable under similar conditions and circumstances by a reasonably prudent physician.¹³³ The *Yero* court could have taken the approach of other jurisdictions by construing this general prohibition to include the psychiatrist's sexual conduct in this situation. In fashioning its narrow test, the *Yero* court considered neither the fiduciary nature of the professional relationship nor the medical profession's strict prohibition against sexual relations with patients even after the termination of treatment.

In determining the standard of conduct to which physicians must adhere, the California Court of Appeal, in *Gromis*,¹³⁴ employed an even narrower approach than the *Yero* court. In *Gromis*, the court reversed a disciplinary action imposed by the Medical Board of California, and affirmed by the trial court, against a physician who engaged in a sexual relationship with a

127. *Id.* at 63.

128. *Id.* at 61-62.

129. *Id.* at 63.

130. *Id.*

131. *Id.*

132. See FLA. STAT. ANN. § 458.329 (West 1993) (prohibiting sexual misconduct in practice of medicine and defining sexual misconduct to include physician's use of physician-patient relationship to induce patient to engage in sexual activity); FLA. STAT. ANN. § 458.331(1)(k) (West 1981) (current version at FLA. STAT. ANN. § 458.331(1)(j) (West 1992)) (providing as ground for disciplinary action physician's exercising influence within patient-physician relationship for purposes of engaging patient in sexual activity).

133. See FLA. STAT. ANN. § 458.331(1)(t) (West 1992) (providing as ground for disciplinary action physician's failure to practice medicine with that level of care, skill, and treatment recognized by reasonably prudent similar physician as acceptable under similar conditions and circumstances).

134. *Gromis v. Medical Bd.*, 10 Cal. Rptr. 2d 452 (Ct. App. 1992).

patient concurrent with the physician-patient relationship.¹³⁵ Specifically, the court considered whether the physician violated *California Business and Professional Code* section 726, which prohibits a physician from engaging in sexual relations with a patient if the conduct is "substantially related to the qualifications, functions, or duties" of the physician.¹³⁶

In reviewing the board's disciplinary action, the trial court found that the physician took advantage of a position of trust and introduced the sexual relationship into the existing professional relationship, causing injury to the patient.¹³⁷ The trial court concluded that the section 726 "substantially related to the functions and duties" test was satisfied in this case because the entire intimate relationship arose out of the physician-patient relationship, and the relationship subsequently caused injury to the patient.¹³⁸

The California Court of Appeal accepted the trial court's factual findings, including the finding that the physician took advantage of a position of trust and the patient suffered injury, but concluded that those findings were "insufficient to support the legal conclusion that the sexual relationship had a bearing on the functions and duties of a physician."¹³⁹ The Court of Appeal explained that no evidence proved that the physician's status as the patient's doctor actually caused the injury.¹⁴⁰ The Court of Appeal determined that, in order to uphold the disciplinary action, the trial court must find that the physician abused his status as the plaintiff's doctor to induce the patient's consent to sexual activity.¹⁴¹

135. *Gromis*, 10 Cal. Rptr. 2d at 459. Dr. Gromis acted as the patient's primary care physician and treated the patient for various physical ailments; however, the patient also went to Gromis to discuss her emotional and marital problems. *Id.* at 454. Gromis continued to treat the patient after he initiated a date and during the period in which he had sexual intercourse with the patient. *Id.* On at least two occasions, the patient asked Gromis if she should see another physician, and Gromis advised her that such action was unnecessary. *Id.* at 454-55. Gromis explained the ethical implications of their sexual relationship by stating that "he could treat her for anything above the waist, and she should see another physician for anything below the waist." *Id.* at 455.7

136. *Id.* at 454. CAL. BUS. & PROF. CODE ANN. § 726 (Bancroft-Whitney 1992) states: "The commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer which is substantially related to the qualifications, functions, or duties of the occupation for which a license was issued constitutes unprofessional conduct and grounds for disciplinary action. . . ."

137. *Gromis*, 10 Cal. Rptr. 2d at 458.

138. *Id.*

139. *Id.*

140. *Id.* The court acknowledged that the patient suffered injury as a result of the sexual relationship with her physician, but the court stated that the patient suffered harm simply because "she had an unhappy affair with a man who happened to be her doctor." *Id.*

141. *Id.* at 459. The court further noted that the record was susceptible to contrary inferences on the point of whether the physician abused his status to induce the patient's consent. The court stated, "[o]n the one hand, it might be found that Dr. Gromis took advantage of information gained through his status as Ms. M.'s physician, namely, her marital problems, and initiated an extra-marital affair. On the other hand, it might be found that the sexual relations arose from the mutual friendship and affections that formed outside the office." *Id.* However, the trial court previously determined that Dr. Gromis took advantage

In coming to its decision, the Court of Appeal in *Gromis* relied on an earlier California case, *Atienza v. Taub*,¹⁴² which considered whether an allegation that a physician initiated a sexual relationship with his patient during the time he was treating her stated a cause of action for malpractice.¹⁴³ Although *Atienza* involved a malpractice claim rather than a board disciplinary action, the *Gromis* court found the *Atienza* court's interpretation of *California Business and Professional Code* section 726 to be relevant. The *Atienza* court interpreted the language in the statute which prohibited sexual contact that was "substantially related to the qualifications, function, or duties" of the physician to mean that the physician's liability turned solely on whether the sexual relationship was initiated by the physician under the guise of treatment.¹⁴⁴ The *Atienza* court came to this extremely narrow definition by looking at four cases in which courts found a basis for a malpractice action based on patients' allegations that the physicians induced sexual relations as part of therapy.¹⁴⁵ The physicians had been held liable for their actions when they engaged in sexual conduct on the pretext that it was a necessary part of treatment.¹⁴⁶ From this, the *Atienza* court concluded that the *only* situation in which a physician can be held liable for sexual relations with a patient is when the physician has engaged in such conduct under the guise of treatment.¹⁴⁷ The *Atienza* court explained that because the physician's actions in that case were not a "modality of treatment," they were not "substantially related to the qualifications, function, or duties" of the physician; therefore, the *Atienza* court concluded that no breach or violation occurred.¹⁴⁸

The *Gromis* court acknowledged two situations in addition to the "under the guise of treatment" situation described in *Atienza* in which physician-

of his position of trust in initiating the sexual relationship. *Id.* at 458. The California Court of Appeal itself previously held that "when two or more inferences can be reasonably deduced from the facts, this court is without power to substitute its deductions for those of the trial court." *Shea v. Board of Medical Examiners*, 146 Cal. Rptr. 653, 662 (Ct. App. 1978).

142. 239 Cal. Rptr. 454 (Ct. App. 1987).

143. *Atienza v. Taub*, 239 Cal. Rptr. 454, 456 (Ct. App. 1987).

144. *Id.*

145. *See id.* at 456-57 (discussing *Waters v. Bourhis*, 220 Cal. Rptr. 666 (Cal. 1985); *Cotton v. Kambly*, 300 N.W.2d 627 (Mich. Ct. App. 1980); *Zipkin v. Freeman*, 436 S.W.2d 753 (Mo. 1968); *Roy v. Hartogs*, 381 N.Y.S.2d 587 (Sup. Ct. App. Term 1976)).

146. *Id.*

147. *Id.* at 457. The *Atienza* court's reading of "substantially related" to mean that § 726 prohibitions come into play only when the sexual contact occurs under the pretext of treatment is clearly an extremely narrow interpretation of the section. Furthermore, the court's analysis is suspect; the fact that courts have prohibited certain types of conduct does not necessarily lead to the conclusion that all other types of conduct are permissible. Lastly, the *Atienza* court not only disregarded the patient's right to rely on the physician's faithful execution of his ethical duty to refrain from sexual contact, but it refused to recognize any kind of fiduciary nature of the physician-patient relationship. To the *Atienza* court, the patient simply was complaining that "she had an unhappy affair with a man who happened to be her doctor." *Id.*

148. *Id.* at 457 n.3.

patient sexual activity should be proscribed: when the physician uses his status to induce the patient's consent and when the sexual relationship compromises the physician's medical judgment.¹⁴⁹ However, the *Gromis* court explicitly refused to consider the AMA ethical standards and disapproved of the trial court's reliance on expert medical testimony based on AMA ethical standards.¹⁵⁰ In addition, the Court of Appeal in *Gromis* criticized the trial court's ruling that a doctor's sexual misbehavior with a patient would adversely affect the doctor's fitness to practice medicine.¹⁵¹ The Court of Appeal reasoned that this ruling begged the question by not defining misbehavior.¹⁵² Although the AMA does define misconduct as any sexual contact that occurs concurrent with the physician-patient relationship,¹⁵³ the Court of Appeal stated that the trial court's reliance on this blanket prohibition to determine the medical standard of care was incorrect.¹⁵⁴ Like the *Atienza* court, the *Gromis* court refused to acknowledge the patient's legal right to rely on the physician's faithful execution of ethical duties. The court therefore implicitly held that the physician's ethical duties had no bearing on the legal duty of care.

B. Cases That Consider the Ethical Prohibition and the Fiduciary Aspect of the Professional Relationship

In contrast to the cases discussed in the previous section, the cases in this section, *Haley v. Medical Disciplinary Board*,¹⁵⁵ *Perez v. Missouri State Board of Registration for the Healing Arts*,¹⁵⁶ and *Pons v. Ohio State Medical Board*,¹⁵⁷ exemplify decisions in which courts recognize that sexual contact with a patient during the professional relationship, or even after the termination of the professional relationship, is a clear violation of the duty of care a physician owes a patient. *Haley*, *Perez*, and *Pons* allow the public the benefit of its bargain with the medical profession.¹⁵⁸ These decisions uphold the right of the public and of individual patients to rely on physicians to execute faithfully their ethical obligations to refrain from having sexual contact with patients regardless of consent. In each of these cases, the court, in evaluating the physician's conduct, regarded the medical

149. *Gromis v. Medical Bd.*, 10 Cal. Rptr. 2d 452, 458 (Ct. App. 1992).

150. *Id.* at 455, 459.

151. *Id.* at 458.

152. *Id.* at 459. The court also criticized an outdated version of the AMA rule because it declared sexual misconduct to be unethical without defining "misconduct." *Id.* at 455 n.3. However, it should be noted that the current AMA opinion explicitly defines sexual misconduct as sexual contact that occurs concurrent with the physician-patient relationship. AMA CURRENT OPINIONS, *supra* note 4, at 40.

153. AMA CURRENT OPINIONS, *supra* note 4, at 40.

154. *Gromis v. Medical Bd.*, 10 Cal. Rptr. 2d 452, 459 (Ct. App. 1992).

155. 818 P.2d 1062 (Wash. 1991).

156. 803 S.W.2d 160 (Mo. Ct. App. 1991).

157. 614 N.E.2d 748 (Ohio 1993).

158. See *supra* notes 48-59 and accompanying text (discussing public's "bargain" with medical profession).

profession's ethical code, the fiduciary nature of the physician-patient relationship, and the power differential between the parties. Rather than giving a narrow reading of the statutes, these courts look to physicians' professional ethical duties and the unique nature of the physician-patient relationship.

In *Haley*,¹⁵⁹ the Supreme Court of Washington affirmed a disciplinary action imposed by the state medical board against a physician who engaged in sexual activity with a former teenage patient three months after the termination of the professional relationship.¹⁶⁰ The physician's actions violated a provision of the state's Medical Disciplinary Board Act, which broadly prohibited any act involving moral turpitude, dishonesty or corruption relating to the practice of medicine.¹⁶¹

Just as in the *Atienza* and *Gromis* cases,¹⁶² the principal question that arose in applying the statute in *Haley* concerned the relationship between the practice of the profession and the conduct alleged to be unprofessional.¹⁶³ The *Haley* court first established that, to serve as grounds for professional discipline under the statute, the physician's conduct must be "related to" the practice of medicine.¹⁶⁴ The court then construed the "related to" requirement to mean that the conduct must indicate unfitness to bear the responsibilities of, and to enjoy the privileges of, the profession.¹⁶⁵ The Supreme Court of Washington interpreted the "related to" requirement much differently than both the *Atienza* court, which narrowly read the "substantially related to" requirement to mean under the guise of treatment, and the *Gromis* court, which read the statutory requirement to mean conduct affecting the physician's treatment of the patient.¹⁶⁶

The *Haley* court asserted that conduct that may constitute unprofessional conduct under the statute need not directly relate to specific skills needed

159. *Haley v. Medical Disciplinary Bd.*, 818 P.2d 1062 (Wash. 1991).

160. *Id.* at 1066.

161. See *id.* at 1068 (citing WASH. REV. CODE § 18.130.180(1) (1991)). Revised Code of Washington § 18.130.180(1) provides that for any person under the jurisdiction of the uniform disciplinary act, "[t]he commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession" constitutes unprofessional conduct. WASH. REV. CODE § 18.130.180(1) (1991). The state medical board in *Haley* found that the physician also violated § 18.130.180(24) of the Revised Code of Washington, which provides that sexual contact with a patient constitutes professional misconduct. *Haley*, 818 P.2d at 1066. However, the Supreme Court of Washington disagreed with the board's application of this statutory provision because the patient in this case was not a current patient. *Id.* at 1067-68.

162. See *supra* notes 134-54 and accompanying text (describing how California Court of Appeal in *Atienza v. Taub* and *Gromis v. Medical Board of California* interpreted "substantially related to" requirement of statute in reviewing board discipline of physicians).

163. *Haley*, 818 P.2d at 1068.

164. *Id.*

165. *Id.*

166. See *supra* notes 134-54 and accompanying text (describing how California Court of Appeal in *Atienza v. Taub* and *Gromis v. Medical Board of California* construed "substantially related to" requirement of statute).

for practice, and need not occur during the actual exercise of professional skills.¹⁶⁷ According to the *Haley* court's interpretation of the statute, conduct may indicate unfitness to practice medicine if it raises reasonable concerns that the individual may abuse the status of being a physician in such a way as to harm members of the public, or if it lowers the standing of the medical profession in the public's eyes.¹⁶⁸

Applying its interpretation of the statute, the Supreme Court of Washington concluded that the board's finding that the doctor's relationship with the former patient constituted exploitation of the patient for sexual gratification was sufficient to conclude that the physician's conduct constituted unprofessional conduct under the statute.¹⁶⁹ In addition to finding that the doctor's status as physician served as the basis for the initiation of the sexual relationship, and that the doctor used the trust and confidence he had achieved when serving as the patient's physician in order to establish the sexual relationship, the court concluded that the physician's conduct indicated unfitness to practice in two ways. First, his actions raised concerns about his propensity to abuse his professional position. Second, his actions tended to harm the standing of the profession in the eyes of the public. The court found that both of these results lead to reasonable apprehension about the public welfare.¹⁷⁰ Unlike *Yero*, *Atienza*, and *Gromis*, the *Haley* court looked to public expectations that physicians will execute their ethical duties,¹⁷¹ and recognized the psychological power and authority physicians have over their patients solely by virtue of the physicians' relative powerfulness within the physician-patient relationship.¹⁷²

In *Perez*,¹⁷³ the Missouri Court of Appeals evaluated a statute that broadly prohibited a physician from "engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm

167. *Haley v. Medical Disciplinary Bd.*, 818 P.2d 1062, 1069 (Wash. 1991). The court further explained the "majority rule" that disciplinary action may be taken against a physician because of acts or offenses which are not directly connected with the physician's technical competence to practice but which only evidence weaknesses of character which are regarded by the licensing authorities and the courts as "inconsistent with the general standards of the profession." *Id.* at 1070 (citing Francis Dougherty, Annotation, *Physician's or Other Healer's Conduct, or Conviction of Offense, Not Directly Related to Medical Practice, as Ground for Disciplinary Action*, 34 A.L.R.4TH 609, 613 (1984)). The court cited as illustrating the majority rule *Windham v. Board of Medical Quality Assurance*, 163 Cal. Rptr. 566 (1980); *Erdman v. Board of Regents of Univ. of State of N.Y.*, 261 N.Y.S.2d 634 (App. Div. 1965); *In re Kindschi*, 319 P.2d 824 (Wash. 1958); *Standow v. Spokane*, 564 P.2d 1145 (Wash. 1977). *Haley*, 818 P.2d at 1068-70.

168. *Haley*, 818 P.2d at 1069.

169. *Id.* at 1070-71.

170. *Id.* at 1071.

171. *See id.* (observing that public expects physician to decline flirtations of adolescent patient rather than taking them as opportunity for sexual exploitation).

172. *See id.* at 1070 (stating that physician exercised psychological power and authority over patient solely by virtue of relationship he had established as patient's surgeon).

173. *Perez v. Missouri State Bd. of Registration for the Healing Arts*, 803 S.W.2d 160 (Mo. Ct. App. 1991).

the public."¹⁷⁴ Like the *Haley* court, the *Perez* court held that a physician violated this statutory prohibition by engaging in a sexual relationship with a patient.¹⁷⁵

The facts in *Perez* closely resembled those in *Gromis*. The Missouri State Board of Registration for the Healing Arts disciplined a physician for engaging in a consensual sexual relationship with a patient concurrent with the professional relationship.¹⁷⁶ However, the *Perez* court's approach to the case differed remarkably from the *Gromis* court's reasoning. Despite a clear public policy concern about physician-patient sexual contact voiced by the California legislature in its statutory prohibition against physician-patient contact,¹⁷⁷ the *Gromis* court decided that the statute did not apply to the physician's conduct because the sexual relationship did not have a "bearing" on the functions and duties of the physician.¹⁷⁸ The *Perez* court, on the other hand, determined that the physician's sexual relationship with a consenting patient did violate a much more general statutory prohibition against dishonorable, unethical, or unprofessional conduct.¹⁷⁹

Although the *Perez* court did not expressly mention the AMA's prohibition against physician-patient sexual contact, the *Perez* court took the medical profession's ethical standards into consideration by finding that the physician's conduct fell below the statutory standard because it was "dishonorable, unethical and unprofessional."¹⁸⁰ In contrast, the *Gromis* court found that professional ethical standards were irrelevant.¹⁸¹ The Missouri statute's broad language and references to ethics and professionalism allowed the *Perez* court to uphold the medical board's disciplinary action. The different outcomes of the *Gromis* and *Perez* cases may be attributed to the differences in statutory text; however, the deeper problem is the different attitudes of the courts toward professional self-regulation, which determine the interpretation that the courts give to statutory language.

174. See *id.* at 164 (citing MO. REV. STAT. § 334.100.1(10) (1978)). Section 334.100.1(10) provided that the state medical board could undertake disciplinary proceedings against a physician for "engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public." *Id.*

175. *Perez*, 803 S.W.2d at 165.

176. *Id.* at 162-63.

177. See *supra* note 136 and accompanying text (discussing California statute prohibiting sexual contact between physicians and patients).

178. See *Gromis v. Medical Bd.*, 10 Cal. Rptr. 2d 452, 458 (Ct. App. 1992) (explaining why statute prohibiting physician-patient sexual contact was not applicable to defendant physician's conduct).

179. See *Perez v. Missouri State Bd. of Registration for the Healing Arts*, 803 S.W.2d 160, 164-65 (Mo. Ct. App. 1991) (reasoning that physician's sexual relationship with patient was dishonorable, unethical, and unprofessional conduct likely to harm public, thus constituting statutorily prohibited conduct).

180. See *id.* at 165 (finding that physician breached statute because conduct was dishonorable, unethical, and unprofessional).

181. See *Gromis*, 10 Cal. Rptr. 2d at 455 n.3 (stating that court need not consider whether physician violated AMA ethical standards because discipline is based solely on statutory standards).

Finally, in *Pons*,¹⁸² the Ohio Supreme Court evaluated a board disciplinary action in light of an Ohio statute that, like the Missouri statute in *Perez*, prohibited physicians from departing from, or failing to conform to, "minimal standards of care of similar practitioners under the same or similar circumstances."¹⁸³ The *Pons* court also applied another section of the Ohio code that authorized the state medical board to discipline physicians for violating ethical standards adopted by national professional organizations such as the AMA.¹⁸⁴ The *Pons* court found that the physician had violated these two statutory prohibitions by engaging in a sexual relationship with a patient.¹⁸⁵

In applying the "minimal standards of care" provision of the statute, the *Pons* court noted that the majority of the board members were licensed physicians who possessed the specialized knowledge needed to determine the acceptable standard of general medical practice.¹⁸⁶ The court found that a physician's standard of care extends beyond surgical skills and general medical knowledge; the care that a doctor renders to a patient consists of the entire treatment relationship between the doctor and patient.¹⁸⁷ The court upheld the board's findings that the physician violated the Ohio statute because he exhibited extremely poor medical judgment and was not acting in the patient's best interest when he entered into a sexual relationship with a patient who placed a great deal of trust in him.¹⁸⁸

With regard to the second part of the statute, the prohibition against violations of professional ethical standards, the *Pons* court upheld the board's finding that the physician's sexual relationship with his patient violated the AMA's Code of Ethics.¹⁸⁹ The Ohio Court of Appeals had previously overturned the board's action, in part because the physician's activities in this case occurred prior to the AMA's prohibition against physician-patient sexual contact.¹⁹⁰ The Ohio Supreme Court and the medical

182. *Pons v. Ohio State Med. Bd.*, 614 N.E.2d 748 (Ohio 1993).

183. *See id.* at 751 (citing OHIO REV. CODE ANN. § 4731.22(B)(6) (Baldwin Supp. 1991)).

184. *See Pons v. Ohio State Med. Bd.*, 614 N.E.2d 748, 752 (Ohio 1993) (citing OHIO REV. CODE ANN. § 4731.22(B)(18)(a) (Baldwin Supp. 1991)). Section 4731.22(B) provides: The board . . . shall, to the extent permitted by law, limit, revoke, or suspend a certificate, refuse to register or refuse to reinstate an applicant, or reprimand or place on probation the holder of a certificate for . . .

(18)(a) The violation of any provision of a code of ethics of a national professional organization. "National professional organization" means the American medical association, the American osteopathic association, the American podiatric medical association, and such other national professional organizations as are determined, by rule, by the state medical board. . . .

Id. § 4731.22(B).

185. *Pons*, 614 N.E.2d at 752.

186. *Id.* at 751-52.

187. *Id.* at 751.

188. *Id.*

189. *Id.* at 752.

190. *In re Pons*, No. 91AP-746, 1991 WL 245003, at *7 (Ohio Ct. App. 1991) (explaining that no sanction specifically tied to sexual activity between patient and physicians was in effect from 1976 to 1983, when sexual activity occurred in this case).

board, however, looked to other provisions in the AMA Code of Ethics that generally required a physician to uphold the dignity and honor of the medical profession.¹⁹¹ The court upheld the board's determination that the physician failed to uphold the dignity and honor of the profession when he maintained a sexual relationship with his patient and that he had exploited the patient's trust.

V. JUDICIAL RECOGNITION OF MEDICAL ETHICS IN PHYSICIAN-PATIENT CONFIDENTIALITY MATTERS

As discussed above, some courts have been reluctant to consider the medical profession's ethical standards regarding physician-patient sexual relationships; however, courts have not expressed this reluctance regarding other aspects of the doctor-patient relationship. In cases involving breaches of physician-patient confidentiality, courts have been more willing to look to the physician's ethical and fiduciary duties than in cases involving physician-patient sexual relations. In breach of confidentiality cases, courts have increasingly recognized that patients have a right to rely on physicians to execute their ethical duties so as to protect the confidential relationship.¹⁹² In these confidentiality cases, courts have recognized that the public is aware of both the medical profession's ethical code provisions and the Hippocratic Oath, which prohibit a physician's breach of confidentiality.¹⁹³ Many courts have concluded that, based on this widespread public knowledge of the profession's ethical obligations, the public has a right to rely on those ethical codes in making private civil claims.¹⁹⁴

Courts' reluctance to consider the ethical and fiduciary aspects of the physician-patient relationship in cases involving sexual relationships and their willingness to consider these aspects in confidentiality cases raise some questions. The reason for the judiciary's inconsistency in applying the profession's ethical standards to determine proper conduct for physicians remains unclear. Once the courts have established that the public has a right to rely on physicians' faithful execution of their ethical obligations, it would be inconsistent for the courts then to select which particular ethical obligations will translate into legal obligations.

191. *Pons v. Ohio State Med. Bd.*, 614 N.E.2d 748, 752 (Ohio 1993).

192. See *Hammonds v. Aetna Casualty & Surety Co.*, 243 F. Supp. 793, 801 (N.D. Ohio 1965) (stating that patients' expectations and trust in physicians arise from fiduciary nature of relationship and patients' awareness of medical ethics); *Petrillo v. Syntex Lab., Inc.*, 499 N.E.2d 952, 959 (Ill. App. Ct. 1986) (finding that public has affirmative right to rely on physicians to execute their ethical duties), *cert. denied*, 483 U.S. 1007 (1987); *Humphers v. First Interstate Bank*, 684 P.2d 581, 587 (Or. Ct. App. 1984) (finding that private cause of action exists because medical ethical principles are public knowledge and public has right to rely on these principles), *aff'd in part and rev'd in part (on other grounds)*, 696 P.2d 527 (1985).

193. See *Petrillo*, 499 N.E.2d at 960 (discussing public awareness of medical ethical code and Hippocratic Oath).

194. See *supra* notes 192-93 and accompanying text (discussing causes of action created by public knowledge of medical profession's standards).

Judicial unfamiliarity with the medical profession's 1990 prohibition against physician-patient sexual contact may provide some insight as to why not all courts have adopted the medical profession's standard. However, a deeper cause may exist. Courts hold different views about the role of the medical profession's ethical codes in society. Some courts entirely dismiss professional ethical codes, finding that they are inapplicable in a court of law.¹⁹⁵ Others find that professional ethical codes give patients and the public an affirmative legal right to rely on physicians to execute the ethical obligations set forth in the code.¹⁹⁶ One source of the different views of state courts regarding the role of medical professional ethics may be the degree to which states desire to exercise control over the practice of medicine within their borders.¹⁹⁷ Although states traditionally possess the power to regulate medicine, they must acknowledge the medical profession's standards in order to insure that the public receives the benefit of its bargain with the medical profession.¹⁹⁸

VI. CONCLUSION

The fundamental anomaly inherent in the current structure of physician regulation works to the detriment of the general public and individual patients by depriving them of the benefit of their bargain with the medical profession. Legal standards of medical care are based on reasonable expectations of patients, which, in large part, are based on the medical profession's code of ethics.¹⁹⁹ Therefore, the legal standards, as promulgated by the state legislatures and interpreted by the courts, should reflect the medical profession's ethical standards. In determining legal standards of medical care, courts and state legislatures should especially take into account the medical profession's concerns about the power differential inherent in the physician-patient relationship and the fiduciary duty owed by physicians to patients.

One way to achieve an alignment between legal standards of medical care and the medical profession's rules would be for all state legislatures to follow the lead of states such as Oregon by providing that violations of

195. See *Bryant v. Hilst*, 136 F.R.D. 487, 492 (1991) (finding medical code of ethics inapplicable to issues before court because it is not binding law).

196. See *Petrillo v. Syntex Labs., Inc.*, 449 N.E.2d 952, 959 (Ill. App. Ct. 1986) (stating that ethics of medical profession grant public, specifically patients, affirmative right to rely on physician to execute faithfully those ethical obligations).

197. See *supra* notes 65-73 and accompanying text (discussing traditional power of states to control and regulate medicine).

198. Cf. Nicole Baer, *Court Upholds Ottawa Doctor's Suspension*, OTTAWA CITIZEN, Apr. 23, 1993, at B1 (citing proposition that allowing courts to interfere with professional medical standards and establish different standards is not consistent with society's views about physician discipline).

199. See BLACKMAN & BAILEY, *supra* note 25, at 50 (noting that legal standards of medical care are based on reasonable expectations of patients, which in turn are based on code of ethics that physicians have set for themselves).

professional ethical standards constitute misconduct. In this way, the medical profession could regulate its members according to its own rules with the states' authority supporting it, rather than competing with it. However, as the cases discussed above exemplify, courts are free to interpret statutory language in a variety of ways. Thus, even if all state legislatures adopted the medical profession's ethical standards, particular courts could engage in a restrictive reading and thereby defeat the purpose of the profession's standards. When reviewing medical board disciplinary actions, the judiciary itself needs to give adequate weight to the prohibition of physician-patient sexual relationships.

Courts' recognition of the medical profession's prohibition would allow the public and individual patients to rely on physicians' faithful execution of all of their ethical duties, rather than just a particular few. Regardless of the particular ethical duty in question, courts' review of board disciplinary actions should reflect the public's right to rely on physicians to fulfill their ethical obligations. It is not enough for legislatures to codify the public's right to rely on physicians' ethical behavior. Courts must not read the statutes so restrictively that the purpose of the statutes is defeated. Judicial recognition of physicians' ethical obligations would provide well-defined standards by which to evaluate physicians' conduct. A lack of well-defined standards retards enforcement.²⁰⁰ Equally important, enforcement without adequate standards produces injustice.²⁰¹

TANYA J. DOBASH

200. DERBYSHIRE, *supra* note 10, at 86.

201. *Id.*

