

BREACHING THE SEXUAL BOUNDARIES IN THE DOCTOR-PATIENT RELATIONSHIP: SHOULD ENGLISH LAW RECOGNISE FIDUCIARY DUTIES?

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ABSTRACT

In this paper I argue that sexual exploitation in the doctor-patient relationship would be dealt with more appropriately by the law in England and Wales on the basis of a breach of fiduciary duty. Three different types of sexual boundary breaches are discussed and the particular focus is on breaches where the patient's consent is obtained through inducement. I contend that current avenues of redress do not clearly catch this behaviour and, moreover, they fail to capture the essence of the wrong committed by the doctor – the knowing breach of trust for self-gain – and the calculated way in which consent is induced. Finally, I demonstrate that the fiduciary approach is compatible with the contemporary pro-patient autonomy model of the doctor-patient relationship.

I. INTRODUCTION

A patient must be able to trust that their healthcare professional will provide the best possible care and act in their best interests... A breach of sexual boundaries can seriously damage this trust.¹

The central argument presented in this paper is that doctors' breaches of sexual boundaries would be most appropriately responded to through the recognition of fiduciary obligations. Whilst the argument has previously been made that sexual exploitation in certain relationships may be dealt with more fittingly at law on the basis of a breach of fiduciary duty, this claim has been made in the broader context of all professional relationships in which one party 'has responsibility for the [other's] emotional or psychological well-being'.² My concern is more specific. It is centred on the doctor-patient relationship for three reasons.

First, this professional relationship, which is so fundamental in our society, offers a considerable exploitative opportunity for the unscrupulous doctor. This is because of

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¹ Council for Healthcare Regulatory Excellence, *Clear Sexual Boundaries between Healthcare Professionals and Patients: Responsibilities of Healthcare Professionals* (CHRE: London 2008), 3.

² T Allen, 'Civil liability for Sexual Exploitation in Professional Relationships' (1996) 59 MLR 56, 75.

not merely the significant imbalance of power, but also the unique way in which the relationship will readily furnish opportunities for sexual exploitation.³ Other professional relationships – such as social worker-client or solicitor-client – will seldom if ever do likewise, for as Archard explains, ‘[a] patient... must open herself up, lay herself bare, share significant confidences with her doctor.’⁴ In such a relationship that is so dependent on trust, there is clear evidence that the sexual exploitation of patients has a deleterious effect on their mental well-being.⁵ Moreover, the sexual nature of the exploitation in the unequal relationship between the doctor and patient serves to render especially egregious the abuse of trust.⁶ Secondly, as I will demonstrate, a fiduciary duty not to breach the sexual boundaries can be grounded in the doctor’s professional responsibilities not to breach trust or to act out of self-interest, and is compatible with the contemporary pro-patient autonomy model of the doctor-patient relationship.

Thirdly, although the ethical obligation on doctors to refrain from breaching sexual boundaries with their patients is far from new, being traceable to the Hippocratic Oath,⁷ medical professionals’ adherence to this ethical imperative has been raising growing concern.⁸ Over the past twenty or so years, there has been a series of well-publicised cases in which doctors were alleged to have behaved in a sexualised way towards their patients. Initially, there was the Department of Health’s inquiry concerning GP Clifford Ayling, who was alleged to have committed indecent assaults on female patients over a period of thirty years.⁹ This was followed by a second inquiry into sexual abuse allegations made by female psychiatric patients against two male psychiatrists,¹⁰ and media coverage of allegations against GPs Oladapo Idowu¹¹ and Benjamin Deodhar.¹² More recently, a tribunal upheld a Primary Care Trust’s decision to bar GP Navin Zala from working in its area in 2012 following allegations that he had sexually abused patients over a twenty-year period. He was subsequently convicted of ten counts of indecent assault and sentenced to eleven years imprisonment.¹³ And, at the beginning of 2014, the Fitness to Practice of the Medical Practitioners Tribunal Service suspended Dr Srinivas Yenugula, having

³ See W Tschan, ‘Abuse in Doctor-Patient Relationships’ (2013) 178 *Key Issues in Mental Health* 129, 132.

⁴ D Archard, *Sexual Consent* (Westview Press: Oxford 1998), 61.

⁵ M Halter, H Brown and J Stone, *Sexual Boundary Violations by Health Professionals – an Overview of the Published Empirical Literature* (CHRE: London 2007) 53.

⁶ D Archard, ‘Exploited Consent’ (1994) 25 *J. Soc. Philos.* 92, 99.

⁷ D Anderson and others (eds) *Dorland’s Medical Dictionary* (WB Saunders Company: Philadelphia 1988), 768.

⁸ F Subotsky and others (eds), *Abuse of the Doctor-patient Relationship* (Royal College of Psychiatrists: Routledge 2010), 1.

⁹ Department of Health, *Committee of Inquiry - independent investigation into how the NHS handled allegations about the conduct of Clifford Ayling* (HMSO: London 2004).

¹⁰ Department of Health, *The Kerr/Haslam Inquiry: Full Report* (Cm 6640) (HMSO: London 2005).

¹¹ Minutes of the General Medical Council’s (GMC’s) Fitness to Practice Panel 19-30 November 2007 (copy on file with author); J Narain, ‘Nigerian doctor “fathered a secret love child with patient”’, *Daily Mail* 19 November 2007.

¹² Minutes of the GMC’s Fitness to Practice Panel 30-31 July 2007 (copy on file with author); P Stokes, ‘Doctor jailed for indecent assaults on women patients’, *The Telegraph* 25 August 2006.

¹³ The determinations of the GMC’s Interim Orders Panel in Navin Zala’s case are not available, but see B Leach, ‘Doctor barred after 20 years of sex abuse’, *The Telegraph* 19 February 2012; BBC News, ‘Former GP Navin Zala indecently assaulted patients’ (9 June 2013) <<http://www.bbc.co.uk/news/uk-england-kent-22975943>> accessed 23 December 2015.

ruled that he had provided ‘sexually motivated’ treatment to numerous female patients.¹⁴

This paper’s unique contribution lies in its detailed critical scrutiny of the synergy between fiduciary duties, the obligation to maintain sexual boundaries, and (the nature of) the doctor patient-relationship. The case for dealing with a doctor’s sexual misconduct through recognising fiduciary duties has previously been made by Tan.¹⁵ However, whilst I reach broadly the same conclusion regarding the appropriateness of fiduciary law to tackle this behaviour, this paper takes forward Tan’s briefer analysis in a number of significant respects. First, I consider the issue of prevalence to demonstrate the significance of the problem. Secondly, whilst Tan focuses on battery as an alternative cause of action for the patient, I consider the suitability of both battery and negligence. Thirdly, I subject the question of whether the case for fiduciary obligations is made out to greater critical and analytical scrutiny. Finally, I draw important connections between fiduciary obligations and the contemporary model of the doctor-patient relationship.

The paper unfolds as follows. I begin by exploring what sexual boundary breaches within the doctor patient relationship are and consider also their prevalence, before explaining why such breaches of sexual boundaries can be harmful and exploitative. I then differentiate between three different types of sexual boundary breaches. My particular focus is on breaches involving inducement. I do not address cases of rape or sexual assault, which would ordinarily be dealt with by the criminal law. Rather, I am concerned with instances where doctors engage in sexual behaviour with their patients when patients acquiesce, but whilst their consent might be questioned because they have been induced into sexual activity by the doctor, the question of whether their consent is invalid at law is not clear cut. Take, for instance, the case of cosmetic surgeon, Fabian Baez, who offered to provide a botox procedure for free to a patient in exchange for sexual favours.¹⁶ In such a case, the patient consents to the sexual activity; however, her only reason for so doing is to obtain the surgery she desires. The surgeon takes advantage of the patient, knowing that offering her the procedure is likely to be sufficient inducement to gain her acquiescence to sexual activity. Considering such wrongful and harmful breaching of the sexual boundaries by doctors, I explore what is available in terms of legal redress. I contend that the current avenues of redress do not lend themselves well to such sexual exploitation because it is not clear that they catch this behaviour. Moreover, they fail to capture the essence of the wrong committed by the doctor – his knowing breach of trust for self-gain, having allowed a conflict to arise between his duty to the patient and his self-interest - and the calculated way in which consent is induced. I thus argue

¹⁴ See ‘Minutes of the Fitness to Practise Panel of the Medical Practitioners Tribunal Service’, Dr Srinivas Yenugula, 5198308, 7 March 2014 (copy on file with author). For a further example, see the Record of Determinations relating to GP Alexander Rajendram, at http://www.mpts-uk.org/static/documents/content/Alexander_Hinsley_Yogaraj_Rajendram.pdf accessed 23 December 2015. Numerous other sexual misconduct cases can be found on the MPTS website.

¹⁵ D Tan, ‘Sexual Misconduct by Doctors and the Intervention of Equity’ (1997) 4 *Journal of Law and Medicine* 243.

¹⁶ *Health Care Complaints Commission v Dr Baez* [2014] NSWCATOD 3. The judgment is available at <http://www.caselaw.nsw.gov.au/decision/54a63cd63004de94513db887> accessed 23 December 2015.

that these cases would be more appropriately dealt with if the law recognised a doctor's liability for breach of fiduciary duty. Finally, I proceed to elucidate the way in which the fiduciary approach can be synthesized with the contemporary pro-patient autonomy model of the doctor-patient relationship.

II. BREACHING SEXUAL BOUNDARIES IN THE DOCTOR-PATIENT RELATIONSHIP

A. Nature and Prevalence of Sexual Boundary Breaches

According to General Medical Council (GMC) guidance, doctors 'must not pursue a sexual or improper emotional relationship with a current patient'.¹⁷ Although there is, therefore, no doubt that physicians have an ethical and professional obligation not to behave in a sexual manner with their patients, the cases I refer to in the introduction clearly evidence violations of this obligation.¹⁸ It has been noted that generally '[s]exual boundary violations are discussed but not clearly defined in the professional literature',¹⁹ and definitions may be inconsistent.²⁰ There is thus a lack of clarity as to what exactly constitute sexual boundary breaches. The description that is most commonly referred to in the professional literature in the UK comes from the Council for Healthcare Regulatory Excellence (CHRE). The CHRE's definition is an expansive one, encompassing the use of words intended to be sexually arousing or gratifying as well as sexualised acts:

A breach of sexual boundaries occurs when a healthcare professional displays sexualised behaviour towards a patient or carer. Sexualised behaviour is defined as acts, words or behaviour designed or intended to arouse or gratify sexual impulses or desires.²¹

My focus in this paper is on sexualised activity since, by and large, the reported cases and research relate to the occurrence of physical sexual activity rather than or alongside the use of words.

Although research data on sexual boundary breaches by physicians is limited, in surveys from the USA in 1986 and the Netherlands in 1992, some kind of sexual encounter with a patient was admitted by up to 10% of doctors.²² 9% of 10,000 doctors stated that they had had sexual contact with one of more patients in another study from the USA reported in 1992.²³ According to Subotsky's research in the UK,

¹⁷ GMC, *Maintaining a Professional Boundary Between You and Your Patient* (GMC: London 2013), para [4].

¹⁸ See also Subotsky and others (n 8).

¹⁹ TL Koenig and RN Spano, 'Sex, Supervision and Boundary Violations' (2004) 22 *The Clinical Supervisor* 3, 5.

²⁰ Halter and others (n 5).

²¹ CHRE (n 1) 3. See also S Penfold, *Sexual Abuse by Health Professionals* (University of Toronto Press: Toronto 1998), 19.

²² N Gartrell and others, 'Psychiatrist-patient sexual contact: results of a national survey' (1986) 143 *Am. J. Psych.* 1126; D Wilbers and others, 'Sexual contact in the doctor-patient relationship in the Netherlands' (1992) 304 *BMJ* 1531.

²³ N Gartrell and others, 'Physician-patient Sexual Contact: Prevalence and Problems' (1992) 157 *Western J. Med.* 139.

nineteen of the thirty six cases against psychiatrists decided by the Professional Conduct Committee of the GMC between January 2000 - November 2004 related to sexual misconduct, leading her to conclude that 'over this period, sexual misconduct was the major issue for serious professional misconduct (SPM) hearings at the GMC for psychiatrists'.²⁴ However, this does not appear to apply to this period only. Smith's research reveals that sexual misconduct has been a significant matter for the GMC for a much longer period,²⁵ thereby providing a clear indication that whilst the professional duty not to breach sexual boundaries is strictly enforced, it is commonly breached. It is of interest that the reported cases and research in the area reveal a significant gender issue: when sexual boundary breaches occur, they tend to be instigated by male doctors against their female patients. One study found that where the respondent doctors who acknowledged sexual contact with their patients specified their sex and their patient's sex, 89% of breaches occurred between a male doctor and female patient.²⁶

If there has been an increase in sexual boundary breaches over the last few decades, this has been attributed to the changing nature of the doctor-patient relationship brought about by the emphasis on greater informality and the end of the age of deference, leading to an increased likelihood that doctors may cross professional boundaries.²⁷ Whilst ethical training could play a role in reducing the occurrence of sexual boundary breaches, it is notable that, according to the recent literature, medical professionals continue to receive little education on this matter.²⁸ Indeed, we should be cautious that the available statistics reveal a true picture of the actual prevalence of sexual boundary breaches. As some respondents in one study noted, there are numerous reasons why doctors might not admit to such breaches when asked to participate in surveys on prevalence, including concerns about bringing the profession into disrepute and the fear of legal consequences should their breaches amount to a criminal offence.²⁹

B. Wrongful and Harmful: the Breach of Trust and its Effects

The primary reason that physicians' breaches of sexual boundaries are wrongful relates to the nature of their relationship with their patients. The doctor-patient relationship is a prime example of a relationship of unequal power and trust and the particular effects of the power imbalance and abuse of trust in the relationship are

²⁴ F Subotsky 'Psychiatry: Responding to the Kerr/Haslam Inquiry' in F Subotsky and others (n 8) 71.

²⁵ RG Smith, *Medical Discipline: the professional conduct jurisdiction of the GMC 1858-1990* (Clarendon Press: Oxford 1994), 8-9 (sexual behaviour was the third highest category of cases between 1989-1990) and 40-41.

²⁶ Gartrell and others (n 23) 140. 6% of cases occurred between female doctors and male patients, 4% between male doctors and male patients and 1% between female doctors and female patients (see also Halter and others (n 5) 60). Whilst noting that female doctors can perpetrate sexual exploitation against their patients, for the purposes of brevity, I refer to the doctor as 'he' and the patient as 'she' in the remainder of this paper.

²⁷ CA Galletly, 'Crossing professional boundaries in medicine: the slippery slope to patient sexual exploitation' (2004) 181 *Med. J. Aust.* 380.

²⁸ See, e.g., J Stone, 'Regulation and its Capacity to Minimise Abuse by Professionals' in F. Subotsky and others (n 8) 180.

²⁹ Gartrell and others (n 23) 142. Consider too the discrepancy in this study between the percentage of doctors who reported that they had sexual contact with patients (9%) and those who stated that at least one of their patients who reported sexual contact with another physician (23%).

heightened in the context of sexual exploitation.³⁰ The obligation upon doctors to maintain sexual boundaries can be clearly linked to the humanity formulation of Kant's second categorical imperative, the ethical responsibility to treat individuals as ends in themselves, rather than merely as means to an end and thereby failing to respect them as persons.³¹ Buchanan's Kantian account of exploitation seems particularly apt here: 'to exploit a person involves the harmful, merely instrumental utilization of him or his capacities, for one's own advantage or for the sake of one's own ends.'³² Although space to explore the concept of exploitation in this paper is limited, by this term I particularly have in mind a doctor's utilisation of his position of power wrongfully to take advantage of a patient for his own ends.³³ The doctor's sexual exploitation amounts to the *wrongful misuse* of the patient because his treating of her in an exploitative manner ignores what makes her human, infringes her dignity and right to demand respect equal to that paid to the doctor himself, and fails to recognise the value of her life. Moreover, the doctor takes advantage of the power entrusted in him by both patient and society, prioritises his own interest, and may also take advantage of some weakness, vulnerability or other characteristic that enables him to misuse the patient, such as a drug addiction.

Besides being wrongful, sexual boundary breaches by doctors can also be seriously harmful. Of course, sexual exploitation in any relationship can cause serious harm; however, in professional relationships such as that between doctor and patient, Koenig and Spano note that '[t]he result of this behavior is always devastating because the less powerful person experiences or re-experiences a fundamental violation of her or his trust, which is so essential to the professional relationship'.³⁴ A comprehensive review of the existing research on the effects on patients produced for the CHRE in 2007 revealed that '[s]ymptoms include post traumatic stress disorder, anger, a sense of betrayal and exploitation, guilt and self-blame'.³⁵ The Kerr/Haslam Inquiry Report refers to the devastating effects of the doctors' breach of trust on their patients,³⁶ and Ayling's patients' testimony revealed their inability to challenge his abusive behaviour: 'I was a bit shell-shocked. His attitude was so brusque - it was so businesslike ... You didn't like to argue with him ... I'd been brought up to trust my doctor.'³⁷ In such cases and, in part, because sexual activity is such private, intimate behaviour, patients find it difficult to disclose. For example, the records show that some of Ayling's patients felt unable to report his abusive behaviour or even discuss it with others.³⁸ Feeling shame at being unable to avoid the sexual exploitation and abuse would seem to be a common response amongst patients and has been noted as 'a massive obstacle to healing, and to breaking the silence'.³⁹ There is an interesting

³⁰ GMC (n 17).

³¹ I Kant, *Groundwork of the Metaphysics of Morals*, in I Kant and MJ Gregor (ed), *Practical Philosophy* (Cambridge University Press: Cambridge 1999), 37.

³² A Buchanan, *Ethics, Efficiency, and the Market* (Rowman and Allanheld: New Jersey 1985), 87.

³³ Drawing upon J Feinberg, *The Moral Limits of the Criminal Law: Harmless Wrongdoing* (Oxford University Press: Oxford 1988), chs. 31 and 32; A Wertheimer, *Exploitation* (Princeton University Press: Princeton 1996), 16; S. Wilkinson, *Bodies for Sale: Ethics and Exploitation in the Human Body Trade* (Routledge: London 2003), ch. 2.

³⁴ Koenig and Spano, op. cit., n.19, at 13.

³⁵ Halter and others (n 5) 60.

³⁶ Department of Health (n 10) 4.

³⁷ S Bosley, 'How did he get away with it for so long?', *The Guardian* 29 April 2002.

³⁸ Department of Health (n 9) 70.

³⁹ Penfold (n 21) 129-130.

question whether such a reluctance to disclose will remain following the spate of high profile historic sexual abuse cases that have been seen recently, and the criticism that has been poured on the failure to listen to victims in investigation reports.⁴⁰

C. Types of Sexual Boundary Breaches

Varying behaviour falls under the umbrella term of sexual boundary breaches. As I see it, there are three different types of such breaches. First, Type 1 breaches occur where a doctor engages in sexual activity with a patient without the patient's overt consent. This would include rape and sexual assault for example,⁴¹ and such a breach could occur when the patient is unconscious and thus unable to consent. As noted already, physicians' sexual boundary breaches without consent can (and should) be dealt with by the criminal law. Secondly, there are Type 2 sexual boundary breaches, where a doctor's conduct is less likely to be criminalised because the patient's consent has been obtained, albeit that this consent has been improperly induced.⁴² Such instances of sexual exploitation manipulate patients, causing them to act against their better judgement,⁴³ and are also clearly exploitative of their weaker positions in their relationships with their doctors, as the following examples demonstrate.

First, a gynaecologist offers to not charge for fertility treatments in exchange for sex, or to 'naturally inseminate' a woman who desires to have a child.⁴⁴ Secondly, in the Canadian case of *Norberg v Wynrib*,⁴⁵ the patient, Laura Norberg, was addicted to Fiorinal, a prescription drug which she had been obtaining from numerous doctors. When each of these doctors refused her request for more of the drug, she approached Dr Wynrib. He initially gave her a prescription but realised she was addicted after she

⁴⁰ See, eg, A Johnstone and C Dent, *An Investigation into the Association of Jimmy Savile with Stoke Mandeville Hospital* (HASCAS: London 2015). Inquiries into historic sexual abuse that have recently been set up include the Independent Jersey Care Inquiry, at <<http://www.jerseycareinquiry.org/>> and the Independent Panel Inquiry into Child Sexual Abuse <<https://childsexualabuseinquiry.independent.gov.uk/>> both accessed 23 December 2015.

⁴¹ The recent conviction of former paediatrician Michael Salmon for rape and sexual assault is a case in point. See <<http://www.thelawpages.com/court-cases/Michael-Salmon-14802-1.law>> accessed 23 December 2015.

⁴² Although in theory, inducement may mean that the patient does not give 'real' consent for the purposes of the criminal law, securing a conviction in this jurisdiction could well be difficult because this would not be a straightforward issue for the jury to assess under of s.74 of the Sexual Offences Act 2003 (SOA). For further discussion, see S Ost and H Biggs, "'Consensual' Sexual Activity between Doctors and Patients: A Matter for the Criminal Law?" in A. Alghrani and others (eds), *The Criminal Law and Bioethical Conflict* (Cambridge University Press: Cambridge 2012). See also the discussion in section III.A in relation to consent and the tort of battery.

⁴³ Feinberg (n 33) 201.

⁴⁴ Allegations which were the focus of a recent medical disciplinary hearing at Texas's State Office of Administrative Hearings involving a gynaecologist who subsequently had his license to practice revoked. See M Bryant, 'Medical board holds closing arguments in Shelton hearing', *Amarillo Globe-News* (27 December 2014) <<http://amarillo.com/news/local-news/2014-12-27/medical-board-holds-closing-arguments-shelton-hearing>> accessed 23 December 2015. See also M. Bryant, 'Judges push sanctions in doc's ethics case', *Amarillo Globe-News* (3 April 2015), <<http://amarillo.com/news/latest-news/2015-04-03/judges-push-sanctions-docs-ethics-case>> accessed 23 December 2015; M. Bryant, 'Board revokes Amarillo doc's license', *Amarillo Globe-News* (10 July 2015) <<http://amarillo.com/news/local-news/2015-07-10/gynecologist-loses-license>> accessed 23 December 2015. The judgment is at <<http://www.soah.state.tx.us/pfdsearch/pfds/503%5C13%5C503-13-4127-md-pfd1.pdf>> accessed 23 December 2015.

⁴⁵ [1992] 2 SCR 226.

made further requests for the drug. He then told her that if she was ‘good to’ him, he would ‘be good’ to her, the implication being that he would supply the drug in exchange for sexual favours. Norberg attempted to obtain further prescriptions from other doctors without success and desperation thus caused her to return to Dr Wynrib. On numerous occasions she provided him with sexual favours to gain access to Fiorinal. Subsequently, she went to a drug rehabilitation centre and was successful in overcoming her addiction. She brought claims against Dr Wynrib in battery for sexual assault, in negligence, and for breach of a fiduciary duty. The Supreme Court of Canada found in Laura Norberg’s favour, although there were differences of opinion as to the basis upon which her claim was successful. I discuss the Supreme Court’s judgment in the following section, where I am concerned with exploring potential legal remedies for such sexual boundary breaches involving inducement.

Notably, our moral objection to such sexual boundary breaches does not only relate to the doctor’s violation of trust, it also concerns the way in which consent is procured and the doctor’s violation of an essential professional obligation. First, the moral objection involving the means of obtaining consent can be shown by drawing a parallel with our response to consent in cases of blackmail, for ‘... blackmail in the broad sense encompasses all actions aimed at *inducing* the victim to give up something significant, something like... sexual favors...’.⁴⁶ Blackmail is, at bottom, a contract for silence. The person who is blackmailed into paying hush money appears to consent to pay quite genuinely: he or she wants the silence. Similarly, the patient in the first example above gives ostensible consent because she wishes to have a child and a patient in Laura Norberg’s situation gives apparent consent because she wants the drugs, despite the fact that they may well find sex with the doctor distasteful. Notwithstanding the presence of *seemingly* genuine consent in these cases and cases of blackmail, we object to the way that the consent is induced; we see reason to question how real this consent is because there is a telling presence of exploitation.

As Fletcher demonstrates in his analysis of blackmail, our objection stems from the fact that the blackmailer (or doctor) has created a situation in which he can exploit the other party’s weakness and thereby dominate the other party through blackmail or an inducement.⁴⁷ Fletcher comments that ‘... the essence of... blackmail [lies in] the relationship of dominance implicit in taking the first step of inducing the victim to pay money...’.⁴⁸ There could consequently be a distinction between blackmail and some Type 2 sexual boundary breaches, since there may be no continued relationship of dominance where the patient can walk away after consenting to one sexual act, such as where a doctor induces a patient to consent to sexual intercourse by offering to move them up on the waiting list for an operation, for instance. Once the operation has taken place, there might not be any continued weakness that the doctor can continue to take advantage of. However, as with blackmail, in Type 2 cases such as *Norberg* where the doctor takes advantage of a particular, continuing vulnerability such as a drug addiction or a long-term illness, once the patient has consented to provide the first sexual favour, the relationship of dominance and subordination is established, encouraging further sexual demands.

⁴⁶ GP Fletcher, ‘Blackmail: The Paradigmatic Crime’ (1993) 141 U. Pa. L. Rev. 1617, 1621 (emphasis added).

⁴⁷ *Ibid.*, at 1626-1629 and 1637. See also O O’Neil, ‘Between Consenting Adults’ (1985) 14(3) *Philos. Public Aff.* 252.

⁴⁸ Fletcher (n 46) 1627.

Alongside this issue of procured consent in the context of a relationship involving an unequal balance of power lies a powerful moral objection to such sexual boundary breaches based on the doctor's violation of an essential professional obligation. As put by McLachlin J in *Norberg v Wynrib*, a doctor 'pledge[s] himself - by the act of hanging out his shingle as a medical doctor and accepting [the patient] as his patient - to act in her best interests and not permit any conflict between his duty to act only in her best interests and his own interests - including his interest in sexual gratification - to arise.'⁴⁹ This obligation on doctors to avoid permitting a conflict to arise between their duty to act in their patients' best interests and their own self-interest is fundamental to upholding both the reputation of the medical profession and our trust in the profession.

Finally, Type 3 sexual boundary breaches are consensual without any element such as inducement manipulating the patient and causing her to act against her better judgement. They may be initiated by the patient and are not engineered by the doctor's exploitation of his more powerful position in the relationship.⁵⁰ Whilst the patient in a Type 3 case may not feel that the trust she places in her doctor has been breached by consensual sexual activity, there is still a breach of the trust that the public places in the medical profession to maintain purely professional relationships with patients and thereby avoid a potential conflict between the doctor's duty and self-interest. However, this breach is most appropriately dealt with through professional regulation.⁵¹ Since I am not advocating that there be some form of legal redress for patients in cases where consensual sexual activity absent any inducement takes place,⁵² Type 3 breaches will not be discussed further in this paper.

III. EXISTING POSSIBILITIES FOR LEGAL REDRESS FOR TYPE 2 SEXUAL BOUNDARY BREACHES

Tort... can provide a remedy for a physician's failure to provide adequate treatment. But only with considerable difficulty can [it] be bent to accommodate the wrong of a physician's abusing his or her position to obtain sexual favours from his or her patient.⁵³

⁴⁹ *Norberg v Wynrib* (n 45) [71], per McLachlin J.

⁵⁰ See further H Biggs and S Ost, '(I Love You!) I Do, I Do, I Do, I Do, I Do: Breaches of the Sexual Boundaries by Patients in Their Relationships with Health Care Professionals', in S Devaney and others (eds), *Pioneering Healthcare Law: Essays in Honour of the Work of Margaret Brazier* (Routledge: London 2015) 91. I reject the opposing argument that doctors *always* exploit their patients by engaging in sexual relationships with them, even if consensual (see, eg, P Coleman, 'Sex in Power Dependency Relationships: Taking Unfair Advantage of the 'Fair' Sex' (1988) 53 Albany L. R. 95).

⁵¹ This is not to say that doctors who commit Type 1 and 2 breaches should also not face professional disciplinary proceedings. However, since my focus in this paper is on providing the patient with redress for the wrong committed, I do not explore professional regulation any further here.

⁵² See also A Grubb, 'The Doctor as Fiduciary' (1994) 47 C.L.P. 311, 324-325; R Flannigan, 'Fiduciary Regulation of Sexual Exploitation' (2000) 79 Can. B. R. 301, 308; Tan (n 15) 250. Notwithstanding the above, I am not suggesting that the presence of consent without inducement necessarily means that there is *never* anything wrongful about a doctor engaging in sexual activity with his or her patient (for an illuminating (Kantian) discussion, see O'Neil (n 4)).

⁵³ *Norberg v Wynrib* (n 45) [96], per McLachlin J.

If the existing law in England and Wales can effectively bring a doctor to account for his or her sexual exploitation of a patient in Type 2 breaches and captures the essence of the wrong committed, the argument that the doctor's duties need to be seen through the fiduciary lens will be less persuasive. In this section, I thus explore the different avenues for redress which the law may offer and the limitations of these avenues when pursued in this context.

A. Battery

It is possible for an aggrieved patient to bring a civil law action for battery in Type 1 cases if the absence of consent to sexual touching is clear and there would be no need to establish the existence of any damage.⁵⁴ Also, if a doctor obtains a patient's consent to sexual activity through deception, this deception could vitiate consent.⁵⁵ But it seems that this deception would have to mean that the patient did not consent to the nature and the quality of the act.⁵⁶ Thus, turning to Type 2 breaches, a battery (under civil and criminal law) could occur if, for instance, the patient is induced to consent to sexual activity because her psychiatrist convinces her that it is medical treatment necessary for her recovery. Absent such deception, case law has suggested that consent could also be deemed less than real because of the doctor's more powerful position, albeit this is in the specific context of a prison setting. In *Freeman v Home Office*,⁵⁷ a prisoner alleged that his consent to the injection of prescribed drugs by a prison medical officer was not real because he was a prisoner in the defendants' custody. The judge at first instance, McCowan J, noted that 'in a prison setting, [where] a doctor has the power to influence a prisoner's situation and prospects a court must be alive to the risk that what may appear, on the face of it, to be a real consent is not in fact so'. However, he found no evidence that 'the plaintiff's capacity to consent was overborne or inhibited in any way'.⁵⁸ The Court of Appeal dismissed the plaintiff's appeal. I return to *Freeman* below.

Looking to the Canadian jurisprudence, one of the claims Laura Norberg brought against Wynrib was in battery for sexual assault. Favoursing this claim, La Forest J held, with Gonthier and Cory JJ concurring, that the notion of consent should be adjusted to take into account the constraint that can be placed upon freedom to consent, because of an imbalance of power in the parties' relationship.⁵⁹ Although this was not an action brought under criminal law for sexual assault, La Forest J made reference to the relevant section of the Canadian Criminal Code upon assault, which states that no consent is obtained where the complainant submits because of the exercise of authority.⁶⁰ In deciding whether legally effective consent to a sexual assault under the tort of battery has been given, La Forest J stated that a two-step

⁵⁴ The doctor could also commit the offences of rape, assault by penetration, sexual assault or causing sexual activity under ss.1-4 of the SOA if he engages in sexual activity with a patient without her valid consent (see further Ost and Biggs (n 42)). However, I explore this no further in this paper since my concern here is considering existing avenues for redress for the patient in Type 2 cases which are less likely to be caught by the criminal law.

⁵⁵ *Appleton v Garrett* (1997) 34 BMLR 23 and, under the criminal law, *R v Tabassum* [2000] 2 Cr App R 328 and s.76 of the Sexual Offences Act 2003.

⁵⁶ See *R v Tabassum*, *ibid*.

⁵⁷ *Freeman v Home Office* [1984] QB 524.

⁵⁸ *Ibid*, 535 and 542-543.

⁵⁹ *Norberg v Wynrib* (n 45) [27].

⁶⁰ *Ibid*, [35]. The relevant section of the Criminal Code is s.265(3)(d).

process is involved. The first step is to ascertain whether an inequality of power exists between the parties, the second is to determine whether exploitation has occurred. La Forest J held that Wynrib's medical knowledge and his authority to prescribe drugs meant that an imbalance of power existed. He found that exploitation had occurred because Wynrib had made use of Norberg's drug addiction, her weakness, to pursue his own interests. Meaningful consent, therefore, was absent.⁶¹ Moreover, even if it were accepted that there had been acquiescence, La Forest J negated a defence centring on consent by applying the equitable doctrine of unconscionable transactions.⁶²

La Forest J's finding that consent was absent has received academic support, with Grubb arguing that, in all likelihood, Norberg's drug addiction deprived her of the ability to give consent to sexual activity.⁶³ But this was a particular vulnerability, arguably capable of vitiating consent, which will not necessarily be present in other Type 2 cases. In such cases, we are left with the question of whether, absent such a vulnerability, offering an inducement in a relationship involving an imbalance of power can make any consent invalid. Notably, there is no equivalent criminal law provision regarding acquiescence in sexual activity due to an exercise of authority that could be looked to in this jurisdiction. Notwithstanding this, in the context of tort, Grubb has argued that '[i]t is certainly the case that the law would scrupulously examine the actual relationship between a doctor and patient to ensure that the patient's consent is not involuntary due to undue pressure, inducements etc', citing *Freeman* to support this.⁶⁴ In *Freeman*, the Court of Appeal emphasised that the question of whether the prisoner had given real consent to the administration of the drugs 'was essentially one of fact', taking into account 'the setting in which the events occurred'.⁶⁵ This does lend strength to the suggestion that, in a case involving a sexual boundary breach between doctor and patient where inducement in a dependent relationship is present, this could be enough to vitiate the latter's consent under tort law. Seemingly in contrast to Grubb, however, Allen has contended that since it was held that the significant influence a prison doctor exerts over an inmate was not enough to vitiate consent, *Freeman* indicates that any pressure stopping short of force or threats would be insufficient to make consent less than real in cases of sexual exploitation in professional relationships involving an unequal balance of power.⁶⁶

⁶¹ Ibid, [49].

⁶² Although see McLachlin J's challenge to the application of this doctrine, *ibid*, [81].

⁶³ A Grubb, 'Sexual Assault by Doctor: Breach of Fiduciary Duty, *Taylor v McGillivray*' (1995) 3 Med. L. R. 108, 109. A recent American case involving a doctor who prescribed female patients drugs to obtain their acquiescence to sexual acts, leading to a number of rape and sexual assault charges, is also of interest. One significant factor in this case was that the doctor over-prescribed the drugs, making the women dependent and then using their dependency as leverage to commit the assaults. This seemingly led prosecutors to conclude that any apparent consent was vitiated. See M Trimble, 'Midstate doctor prescribed narcotics like candy, sexually assaulted addicted patients, police say', PennLive (10 February 2015) <http://www.pennlive.com/midstate/index.ssf/2015/02/midstate_doctor_sexual_assault.html> accessed 23 December 2015. The doctor's death in November 2015 prevented the case from proceeding further. See M Trimble, 'Victims will not see day in court after accused "candy doctor's" death' (23 November 2015) <http://www.pennlive.com/news/2015/11/dr_jay_cho_court_charge_sexual.html#incart_related_stories> accessed 23 December 2015.

⁶⁴ Ibid, 109.

⁶⁵ At 555, per Sir Stephen Brown LJ.

⁶⁶ Allen (n 2) 62.

I submit that Grubb's interpretation is the most persuasive and demonstrate this by considering a parallel with undue influence under contract law. Grubb's interpretation reflects the position under contract law that undue influence is enough to vitiate consent,⁶⁷ for '...in each case of undue influence we are essentially concerned with a superior party who wrongfully provides an ordinarily free and rational person with what appears to be a reason for doing what the influencer desires'.⁶⁸ Where there is evidence of overt persuasion, the case would meet the criteria of actual undue influence; and where things were slightly hazier the case would meet the criteria for presumed undue influence (provided the patient could show that what occurred is explicable only on the basis that it was procured by the exercise of undue influence rather than being readily explained by the relationship between the parties).⁶⁹ Drawing a parallel with the position under contract law seems particularly apt because there is, in contract law, a presumed relationship of trust and influence between doctors and patients.⁷⁰ Moreover, there is a strong argument that even though contract and tort are different branches of the civil law of obligations, they ought nonetheless to be harmonious. Indeed, it is notable that La Forest J made reference to the doctrine of undue influence in contract law in substantiating his finding that Norberg's consent was absent:

The doctrines of duress, undue influence, and unconscionability have arisen to protect the vulnerable when they are in a relationship of unequal power... on grounds of public policy, the legal effectiveness of certain types of contracts will be restricted or negated. In the same way, in certain situations, principles of public policy will negate the legal effectiveness of consent in the context of sexual assault. In particular, in certain circumstances, consent will be considered legally ineffective if it can be shown that there was such a disparity in the relative positions of the parties that the weaker party was not in a position to choose freely.⁷¹

Furthermore, whilst not a case involving an action for battery and a professional relationship where there was an imbalance of power, *Re T*⁷² provides an example of a case where the concept of undue influence was applied in the medical law context and was part of the reason for the judgment that the patient's refusal of life-sustaining treatment was not effective.⁷³

⁶⁷ *Bank of Credit and Commerce International SA v Aboody* [1990] 1 QB 923.

⁶⁸ R Bigwood, 'Undue Influence: "Impaired Consent" or "wicked exploitation"?' (1996) 16 OJLS 503, 511. See also P Birks, 'Undue Influence as Wrongful Exploitation' (2004) 120 LQR 34: '...undue influence consists in unconscionable exploitation of influence' (34).

⁶⁹ See *Royal Bank of Scotland v Etridge* [2001] UKHL 443, [30].

⁷⁰ See *Goldsworthy v Brickell* [1987] 2 WLR 133.

⁷¹ *Norberg v Wynrib* (n 45) [28 and 34].

⁷² *Re T (Adult: Refusal of Treatment)* [1993] Fam 95 (CA).

⁷³ This parallel between inducement in Type 2 cases and undue influence gives rise to the interesting question of whether we are more likely to assume that a patient was 'not in a position to choose freely' (n 71) because of undue influence or an inducement when she makes a choice which we would otherwise not have expected her to make and a choice which is, in our view, against her interests. Whilst I do not have the space to discuss this matter here, the refusal of a blood transfusion in *Re T* does seem to be an example of such a choice.

That said, it is clear that the answer to the question of whether or not consent is vitiated when an inducement is offered in a relationship involving an imbalance of power is unsettled in tort law.⁷⁴ As La Forest J noted in *Norberg v Wynrib*, both the trial judge and the Court of Appeal found that Norberg gave voluntary consent to the sexual behaviour with Wynrib, and one of his fellow judges in the Supreme Court, Sopinka J, found that although Norberg did not wish to engage in sexual activity with her doctor, her capacity to consent was not affected.⁷⁵ Moreover, in the context of criminal cases, it has been argued that where there is ostensible consent then it is likely to be very difficult to persuade a tribunal of fact that this ostensible consent was vitiated.⁷⁶

What is more, although the tort of battery ‘carries connotations of intentional wrongdoing and harm’,⁷⁷ framing the behaviour in Type 2 breaches in this way fails to convey the fact that the particular characteristics of the relationship between doctor and patient make the doctor’s behaviour especially wrongful. As noted by McLachlin J in *Norberg v Wynrib*, ‘[i]n common with all members of society, the doctor owes the patient a duty not to touch him or her without his or her consent; if the doctor breaches this duty, he or she will have committed the tort of battery’.⁷⁸ Going down the avenue of the tort of battery would thus reflect the doctor’s breach of this obligation owed by all in society, but would not encapsulate the breach of his duty to act in the patient’s best interests rather than his own self-interest,⁷⁹ a duty premised on trust. Whilst it might be argued that part of the wrong inherent within a doctor’s Type 2 breach - the violation of trust and the procuring of consent through wrongful exploitation of a dependent relationship - could be dealt with through an award of aggravated damages, this still does not address my contention that the essence of the tort of battery fails to reflect the totality of the wrong committed.

B. Negligence

Outside the intentional torts, it may be possible to bring an action against a doctor in certain Type 2 cases in negligence. However, whilst nothing firmly rules negligence out, it is not the most appropriate action for a number of reasons. An action in negligence would most obviously be available in cases where, in addition to the sexual boundaries breach, the doctor’s performance of his professional duty towards the patient (the provision of treatment, for instance), was below the required standard.⁸⁰ The element of failing to meet the professional standard of care would be present in the example provided earlier of the gynaecologist who ‘naturally inseminates’ a patient seeking fertility services, since this would be a blatant failure to provide treatment in accordance with medical standards. And turning again to *Norberg v Wynrib*, Sopinka J held that Dr Wynrib was under a duty to follow

⁷⁴ See also Birks (n 68) 37: ‘...undue influence may be a wrong in aggravating circumstances. *That is largely unexplored territory.*’ (Emphasis added.)

⁷⁵ Ibid, [42 and 133].

⁷⁶ See n 42 above and L Ellison and V Munro ‘Jury deliberations and complainant credibility in rape trials’ in C McGlynn and V Munro (eds), *Rethinking Rape Law: International and Comparative Perspectives* (Routledge: London 2010) 281.

⁷⁷ I Kennedy, ‘The Fiduciary Relationship and its Application to Doctors’, in P Birks (ed), *Wrongs and Remedies in the Twenty-First Century* (Clarendon Press: Oxford 1986) 113.

⁷⁸ *Norberg v Wynrib* (n 45) [64], per McLachlin J.

⁷⁹ See also Tan (n 15) 252.

⁸⁰ See also Allen (n 2) 69.

professional standards and that he had breached this duty, committing negligence by failing to attempt to help Laura Norberg overcome her addiction. In his view:

While the appellant consented to the sexual encounters, she did not consent to the breach of duty that resulted in the continuation of her addiction... The fact that a patient acquiesces or agrees to a form of treatment does not absolve a physician from his or her duty if the treatment is not in accordance with medical standards.⁸¹

Outwith cases where the sexual boundaries breach is related to a failure to treat the patient in accordance with required standards, although the professional guidance from the GMC makes it clear that doctors breach their *professional* code of conduct if they engage in a sexual relationship with their patients,⁸² this is unlikely to amount to a breach of a *legal* duty not to engage in sexual behaviour with patients for the purposes of the tort of negligence. Ordinarily, the doctor's duty is framed in terms of the tasks that he undertakes and in respect of which he professes some special skill. And it is for this reason that a doctor's negligence is primarily measured in terms of his failure to meet 'the standard of the ordinary skilled man exercising and professing to have that special skill'.⁸³

One possibility is that the negligence action could be framed in terms of the doctor's breach of his broader professional duty to promote the patient's general health.⁸⁴ On this approach, a breach of the sexual boundaries in Type 2 cases would suffice to ground a negligence claim because of the harm such a breach might cause to the patient's mental health.⁸⁵ There would be no need, on such analysis, to establish an associated failure to provide appropriate treatment to the patient. It is no objection that the doctor's conduct is deliberate rather than inadvertent since negligence liability is ascribed on the basis of a failure to meet an expected standard of conduct, and it makes no difference whether this failure is attributable to a deliberate breach of duty or one that is accidental.⁸⁶ But this approach relies upon an entirely novel conception of the legal duty owed by doctors to their patients. The professional duty may well be amenable to such broad construction, but the legal duty – as the quotation above amply testifies – is firmly tethered to the tasks undertaken in the deployment of the doctor's particular, professional skills. Moreover, even if there were to be judicial support for extending the duty of care in negligence in this way, this would not necessarily help patients in Type 2 cases who, even though they have been induced to take part in sexual activity, have nonetheless consented to it, and may therefore face a defence of *volenti non fit injuria*.⁸⁷

A further factor which militates against the invocation of negligence law in this context is the fact that psychiatric harm – at least so far as that term is generally understood – would not be compensable in Type 2 Cases. The House of Lords has

⁸¹ *Norberg v Wynrib* (n 45) [156].

⁸² GMC (n 17).

⁸³ *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, 586, per McNair J.

⁸⁴ See Allen (n 2) 69.

⁸⁵ See section II.B, *ibid*.

⁸⁶ See C Gearty, 'The Place of Private Nuisance in the Modern Law of Torts' [1989] CLJ 214, 223.

⁸⁷ Or possibly contributory negligence. See RB Harper, 'The application of contributory negligence principles to the doctor/patient relationship' (2001) 9 Torts L. J. 180, 196.

twice insisted that in order for such harm to be recoverable, a risk of physical harm to a primary victim must have been foreseeable.⁸⁸ Yet in Type 2 cases which do not involve the negligent provision of treatment which could cause physical injury, the patient is not foreseeably the victim of physical harm.⁸⁹ This leans towards the conclusion that even if there is a breach of duty, there is seemingly no *actionable* damage because there does not appear to be a recognised head of damage.

In addition, for different reasons than those canvassed in relation to battery, an action in negligence would again fail sufficiently to encapsulate the wrong that the doctor intentionally commits. As noted above, the tort can be applicable to intentional acts, however, negligence fails to frame the nature of the wrong appropriately (it frames it as a failure to meet the requisite standard of care rather than *deliberate wrongdoing*). For what seems to make the wrong done to the patient especially grievous in Type 2 cases is the knowing breach of trust and the doctor's placing of himself in a position where his duty to the patient and his own self-interest conflict.

IV. A BETTER APPROACH: RECOGNISING FIDUCIARY OBLIGATIONS IN TYPE 2 CASES GROUNDED IN THE DOCTOR'S PROFESSIONAL RESPONSIBILITIES

... a physician takes the power which a patient normally has over her body, and which she cedes to him for purposes of treatment. The physician is pledged by the nature of his calling to use the power the patient cedes to him *exclusively for her benefit*. If he breaks that pledge, he [should be] liable.⁹⁰

The fiduciary analysis has a significant tactical advantage for the plaintiff because consent is not a defence... [it] has the ability to capture the dynamics of the relationship. It focuses on power and the abuse of power most clearly.⁹¹

I now turn to present my argument that English law would offer a more apposite forum for dealing with a doctor's breach of the sexual boundaries in Type 2 cases if the doctor's violation of trust were to attract fiduciary liability in this jurisdiction. As I will demonstrate, this fiducial duty can be grounded in the doctor's professional responsibilities not to breach trust and to act in the patient's (best) interests rather than his own self-interest.

'Of ancient pedigree, and somewhat shrouded in mystery',⁹² fiducial obligations arise in equity in relationships that have been recognised as fiduciary, such as that

⁸⁸ Whilst Lord Lloyd stated in *Page v Smith* [1996] AC 155, at 190 that '[o]nce it is established that the defendant is under a duty of care to avoid causing personal injury to the [claimant], it matters not whether the injury in fact sustained is physical, psychiatric or both', Lord Steyn said in *White v Chief Constable of South Yorkshire* [1999] 2 AC 455, that the claimant 'must at least satisfy the threshold requirement that he objectively exposed himself to danger or reasonably believed that he was doing so' (at 499).

⁸⁹ As there is no intermediary whom the patient witnesses being injured, it is difficult to see how she could be a secondary victim either.

⁹⁰ *Norberg v Wynrib* (n 45) [98], per McLachlin J (emphasis added).

⁹¹ P Peppin, 'A Feminist Challenge to Tort Law', in A Bottomley (ed), *Feminist Perspectives on the Foundational Subjects of Law* (Routledge Cavendish: London 1996) 82.

⁹² Kennedy (n 77) 120.

between trustee and beneficiary,⁹³ and director and company, in circumstances where one party (the fiduciary) is entrusted with a power related to the beneficiary's legal or practical interests. The interests in question will often be regarding property or confidential information and the power vested in the fiduciary is limited to acting on the beneficiary's behalf 'exclusively for the other-regarding purposes for which it is held'.⁹⁴ As noted by Grubb, however, providing a comprehensive definition of a fiduciary relationship is 'well nigh impossible'.⁹⁵ Indeed, Flannigan has critiqued the law of fiduciary accountability for its lack of clarity and consistency, while Miller has observed that 'the law has evolved absent a general theory of liability... [n]owhere is fiduciary liability principled.'⁹⁶ Judges have centred their attention, on different occasions and in various jurisdictions, on elements of power, vulnerability and reliance, and tests based on discretion and reasonable expectation when finding that fiduciary duties exist.⁹⁷ Moreover, Flannigan contends that confusion is exacerbated by the common allusion to fiduciary relationships because fiduciary 'relationships', as such, do not exist.⁹⁸ Rather, following his analysis, fiduciary accountability arises where access to a person's assets (or, in the context of this paper, *access to the patient*) occurs as a result of an undertaking to act in the person's interest (an other-regarding purpose).⁹⁹ Such accountability is imposed, therefore, to control opportunism.¹⁰⁰ Whilst Flannigan's scholarship brings the basis for recognising fiduciary obligations more sharply into focus, the jurisprudence in the area has not moved away from the vaguer, conventional language of fiduciary relationships.¹⁰¹ Yet, as I will argue later, there are compelling reasons for resisting the construal of the doctor-patient relationship as fiduciary in an all-encompassing way.

Before addressing this issue, for my argument that fiduciary obligations should be recognised in Type 2 breaches of sexual boundaries cases to have any chance of succeeding, I must first find a means of overcoming a seemingly major hurdle: the fact that our courts may be unwilling to find fiduciary obligations in the doctor-patient relationship in contrast to Commonwealth courts elsewhere.¹⁰² Significantly, the

⁹³ P Bartlett, 'Doctors as Fiduciaries: Equitable Regulation of the Doctor-Patient Relationship' (1997) 5 Med. L. R. 193, 195.

⁹⁴ E Fox-decent and E Criddle, 'The Fiduciary Constitution of Human Rights' (2009) 15 LT 301, 312.

⁹⁵ Grubb (n 52) 311.

⁹⁶ R Flannigan, 'The Boundaries of Fiduciary Accountability' (2004) 83 Can. B. R. 35, 76; P Miller, 'A Theory of Fiduciary Liability' (2011) 56 McGill L. J. 235, 237 and 239.

⁹⁷ Flannigan, *ibid.* Flannigan analyses Canadian and Australian cases. The Canadian cases include *Guerin v The Queen* (1984) 13 DLR (4th) 321 (discretion); *LAC Minerals Ltd v International Corona Resources Ltd* (1989) 61 DLR (4th) 14 (reasonable expectation and vulnerability); *Norberg v Wynrib* (n 44) (power); and *Hodgkinson v Simms* (1994) 117 DLR (4th) 161 (reliance).

⁹⁸ *Ibid.*, 48.

⁹⁹ *Ibid.*, 36-37; Flannigan (n 52) 311. I am less convinced by others' explanations of the essential elements of fiduciary liability. For instance, Miller's focus on the fiduciary's 'discretionary power over the significant practical interests of another' fails to convey that the fiduciary's exercise of this power is limited to acting in the beneficiary's best interests (Miller (n 86) 262).

¹⁰⁰ Flannigan (n 96) 47. See also HE Smith, 'Why Fiduciary Law Is Equitable', in AS Gold and PB Miller (eds), *Philosophical Foundations of Fiduciary Law* (Oxford University Press: Oxford 2014).

¹⁰¹ See the continued reference to fiduciary relationships in recent scholarship (eg L Rotman, 'Fiduciary Law's "Holy Grail": Reconciling Theory and Practice in Fiduciary Jurisprudence' (2011) 91 Boston University L. R. 921; Miller (n 96) 237 and 239).

¹⁰² Canada (*Norberg v Wynrib*), Australia (to a more limited degree in *Breen v Williams* (1996) 186 CLR 71), New Zealand (*Smith v Auckland Hospital Board* [1965] NZLR 191) and the US (*Moore v Regents of the University of California* (1990) 793 P. 2d 479).

nineteenth century Court of Appeal case of *Mitchell v Homfray*¹⁰³ suggests that such obligations could be found in the doctor-patient relationship. The case involved a gift made to Homfray, who had previously been the deceased's doctor. The question arose as to whether Homfray's 'standing in a confidential relation to the donor' made the gift impeachable.¹⁰⁴ Since there was no suggestion of undue influence or fraud, it was held that whilst the gift was originally voidable, because the deceased had elected to abide by it and the doctor-patient relationship had ended, the gift could not be impeached. The court drew analogies with the way in which the influence that can be exacted in the solicitor-client relationship may make a gift invalid in equity.¹⁰⁵ Whilst the term fiduciary is not actually used by the judges, they presented the doctor-patient relationship as a 'confidential relation',¹⁰⁶ which is unsurprising given that abuse of a confidential relation was the more common terminology historically employed to describe what we would now refer to as an abuse of a fiduciary obligation.¹⁰⁷

According to the academic literature, it would seem that the courts in this jurisdiction viewed the doctor-patient relationship as 'an epitome of the fiduciary relationship well into [the twentieth] century'.¹⁰⁸ More recently, Browne-Wilkinson LJ clearly (albeit implicitly) acknowledged the existence of a fiduciary obligation in the doctor-patient relationship in the Court of Appeal judgment in the *Sidaway* case when he opined that such a duty might be breached where a doctor 'abused his position of trust to make a personal profit for himself'.¹⁰⁹ However, in the same court, Dunn LJ considered that only an 'ill founded' analogy could be drawn between the law of fiduciary obligations and a doctor's performance of professional duties¹¹⁰ and, on appeal to the House of Lords, Lord Scarman rejected an attempt to present broadly the doctor-patient relationship as fiduciary in an *in obiter* statement. In his view, 'there is no comparison to be made between the relationship of doctor and patient with that of solicitor and client, trustee and cestui qui trust or the other relationships treated in equity as of a fiduciary character'.¹¹¹

This judicial reluctance to connect fiduciary law with the doctor-patient relationship can be explained in part because English law has tended to view the concept of fiduciary relationship as a function of property law and equitable limitations on ownership.¹¹² It comes into play, therefore, as the mechanism for controlling the abuse of property improperly obtained from relationships of trust and, as such, the concept primarily denotes a relationship with the property and/or economic interest rather than with the person.¹¹³ The approach I will now advocate

¹⁰³ (1881) 8 QBD 587.

¹⁰⁴ At 591, per Lord Selborne LC.

¹⁰⁵ *Ibid.*, 590 and 592.

¹⁰⁶ *Ibid.*, 591, per Lord Selborne LC.

¹⁰⁷ L Sealy, 'Fiduciary Relationships' (1962) 20 CLJ 69, 69-72.

¹⁰⁸ Bartlett (n 93) 196.

¹⁰⁹ *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1984] 2 QB 493, 519.

¹¹⁰ *Ibid.*, 515.

¹¹¹ *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871, 884. See also the first instance judgment of Popplewell J in *R v Mid-Glamorgan FSHA, ex parte Martin* (1992) 16 BMLR 81.

¹¹² JC Shepherd, *The Law of Fiduciaries* (Carswell: Toronto 1981) 52.

¹¹³ This explains Browne-Wilkinson LJ's acceptance of the possible existence of a fiduciary duty where there is an abuse of trust for the doctor's personal profit (n 99); the fiduciary relationship would exist over the profit through the imposition of a constructive trust.

may thus require a judicial willingness to move away from a conceptualisation of fiduciary law which is concerned primarily with property and economic interests¹¹⁴ in relationships of trust to one which imposes fiducial obligations to protect other *non-material* interests in such relationships. Reiterating the underlying objective of controlling opportunism could well assist in encouraging such a move since, as Smith has recently argued, '[s]ituations in which the potential for opportunism arise out of an important discretionary agency relationship of great dependence are not limited to ones involving a conventional property interest or other identifiable resource. Thus, the treatment of physicians as fiduciaries is understandable...'¹¹⁵ I now draw attention to the reasons why the doctor-patient relationship is conducive to the recognition of fiduciary obligations and the protection of non-material interests, and then explain why this should be limited (initially, at least) to the particular context of sexual boundary breaches.

Doctors epitomise what Moline has referred to as our paradigm professionals, individuals who act for the good of their clients, who are committed to take the trust placed in them seriously.¹¹⁶ Trustworthiness is one of the five virtues which Beauchamp and Childress consider to be particularly applicable to the medical professional and profession.¹¹⁷ The professional and ethical obligations to avoid an abuse of trust and power and to act in the patient's best interests rather than the professional's own self-interest, essential elements of the fiduciary duty,¹¹⁸ are fundamental to the requirement we place on doctors to uphold the reputation of the medical profession. Further, outwith the legal definition, a popular dictionary definition of fiduciary as 'held or given in trust' and 'dependent on public trust' can support the idea of the professional relationship between doctor and patient possessing such fiduciary characteristics by its focus on the private and public nature of the trust vested in the individual who owes the obligations.¹¹⁹ In both the private context (the trust the patient places in her doctor) and public context (upholding the public's trust in the profession),¹²⁰ the doctor-patient relationship is one in which, to use Harding's phrasing, a 'thicker form of trust' arises because of the doctor occupying 'a role to which specific social meanings and expectations attach'.¹²¹

It is possible to see the way in which these professional responsibilities and the social expectations we have of medical professionals can be translated into a legal fiduciary obligation by returning to *Norberg v Wynrib*. The final claim that Laura

¹¹⁴ See also the Australian case of *Paramasiviam v Flynn* (1998) 90 FCR 489.

¹¹⁵ Smith (n 100) 20.

¹¹⁶ J Moline, 'Professionals and Professions: a Philosophical Examination of an Ideal' (1986) 22(5) Soc. Sci. Med. 501.

¹¹⁷ TL Beauchamp and JF Childress, *Principles of Biomedical Ethics* (Oxford University Press: Oxford, 7th ed, 2013), 39-40.

¹¹⁸ *Bray v Ford* [1896] AC 44, 51-52. I note the traditional view, particularly in the Australian jurisprudence, that fiduciary duties are proscriptive rather than prescriptive in nature (see, e.g., *Breen v Williams* (n 102) 113), but this has not proved to be an obstacle in the Canadian jurisprudence (see, e.g., *McInerney v MacDonald* [1992] 2 SCR 138), and the proscriptive element is clearly present: the doctor's professional duty is both proscriptive (not to act out of self-interest) and prescriptive (to act in the patient's best interests).

¹¹⁹ *Oxford Compact Dictionary and Thesaurus* (Oxford University Press: Oxford 1997).

¹²⁰ Notably, GMC guidance on sexual behaviour refers to the need to maintain both 'the trust of patients and the public': GMC, 'Sexual Behaviour and Your Duty to Report Colleagues (GMC: London 2013), para. 3

¹²¹ M Harding, 'Trust and Fiduciary Law' (2013) 33 OJLS 81, 84.

Norberg brought against Dr Wynrib was for breach of a fiduciary duty and in this respect her counsel convinced McLachlin and L'Heureux-Dubé JJ. As recently argued by Chamberlain, the case provides an illustration of the way in which, at least in the context of these two judgments, '... the Supreme Court of Canada is simply less timorous than its counterparts elsewhere in the common law world, and has been willing to apply the spirit of fiduciary obligation in ways that appropriately meet the perceived needs of modern society.' Chamberlain proceeds to point out that protecting relationships considered valuable by society is a traditional rationale for recognising fiduciary obligations.¹²² Indeed, according to McLachlin J:

... the doctor-patient relationship shares the peculiar hallmark of the fiduciary relationship – trust, the trust of a person with inferior power that another person who has assumed superior power and responsibility will exercise that power for his or her own good and only for his or her good...¹²³

McLachlin J. continued by highlighting societal and personal interests reflected in the case, which she found constituted vital practical interests that the legal enforcement of fiduciary duties was designed to protect:

Society has an abiding interest in ensuring that the power entrusted to physicians by us, both collectively and individually, [should] not be used in corrupt ways... the plaintiff... has a striking personal interest in obtaining professional medical care *free of exploitation for the physician's private purposes...*¹²⁴

Although she acknowledged that these interests differed from the legal and economic interests which the law regarding fiduciary relationships traditionally protected, in her view, it would be wrong for the law to protect material interests whilst failing to protect human or personal interests.¹²⁵ She offered no definition of what constitutes such interests, however it appears clear from the quotation above that she had in mind the interest all patients have in placing their trust in the medical profession to receive medical care and treatment without exploitation. A broader interpretation moving beyond sexual or other forms of¹²⁶ exploitation would be that patients have an interest in obtaining medical care and treatment from doctors whose primary concern, and whose responsibility, is to protect their patients' interests rather than serving their own. This interpretation would, if accepted, lead to wider recognition of the doctor-patient relationship as fiduciary with more far-reaching consequences, as I will discuss shortly.

¹²² E. Chamberlain, 'Revisiting Canada's Approach to Fiduciary Relationships'. Paper presented at the Seventh Biennial Conference on the Law of Obligations, Hong Kong, 15 July 2014, 1 and 3.

¹²³ *Norberg v Wynrib* (n 45) [65], per McLachlin J. See also the judgment of the Supreme Court of Washington in *Lockett v Goodill* 430 P.2d 589 (Wash 1967), 591 that '[t]he relationship of patient and physician is a fiduciary one of the highest degree. It involves every element of trust, confidence and good faith'; *Lac Minerals Ltd v International Corona Resources Ltd* [1989] 2 SCR 574, 648.

¹²⁴ *Ibid.*, [74] (emphasis added).

¹²⁵ *Ibid.* Miller's definition of practical interests as those which are protected in the context of fiduciary liability clearly supports this (Miller (n 96) 276). See also Wilson J's (dissenting) judgment in *Frame v Smith* (1987) 42 DLR (4th) 81, 99-100.

¹²⁶ For example, the use of the patient's cells without his permission in potentially lucrative medical research in *Moore v Regents of University of California* (n 102).

So why, post *Mitchell v Homfray* and Browne-Wilkinson LJ's speech in *Sidaway*, have the courts in this jurisdiction shied away from an extension of fiduciary law to such interests? First, the context in which there has been very limited judicial consideration of whether the doctor-patient relationship should be recognised as fiduciary may be significant. *Sidaway* concerned a failure to inform the patient of inherent risks involved in a particular medical procedure. Notably, there is a degree of commonality between this context in which Lord Scarman refused to expand fiduciary law to doctors, and Type 2 sexual boundary breaches. The doctor's behaviour in both instances leads us to question the genuineness of the patient's consent and we consider the doctor's behaviour to be inappropriate, a violation of the trust that the patient has placed in him. There *may* be a failure to refrain from acting out of self-interest¹²⁷ and to protect the patient's interests in both contexts.¹²⁸

There are, however, a number of important differences.¹²⁹ First, the duty to disclose risks involved in a procedure relates to professional skill and thus an action in negligence is more apt. The duty in question would need to be the doctor's duty to disclose personal interests in order for there to be a fit with fiduciary obligations.¹³⁰ Secondly, and related to this, negligence provides an avenue for redress for the non-disclosure of risks, now well recognised by the courts, and it is thus unnecessary to offer the patient a remedy through extending fiduciary law to encompass this scenario. By contrast, as I have argued above, the existing law fails to offer a neat or obvious fit for doctors' Type 2 sexual boundary breaches; a legal remedy under tort law does not clearly exist. Consequently, applying the law of fiduciary obligations would '[complement] the laws of contract, tort, and unjust enrichment, and [offer] a meaningful, alternative cause of action for interactions that create implicit dependency and peculiar vulnerability' where other causes of action fail to bite.¹³¹ Thirdly, a failure to inform a patient of inherent risks can be the result of a doctor's negligence rather than an intentional omission, whereas Type 2 breaches of sexual boundaries are always intentional. Whilst I note that a breach of a fiduciary duty may be entirely innocent,¹³² the fiduciary obligation that I am calling to be recognised relates to deliberate wrongdoing. Finally, the underlying mischief of opportunism that the law of fiduciary obligations seeks to address is present in Type 2 sexual boundary breaches, whereas it is absent in (most) cases where the doctor fails to disclose risks.¹³³ As has been noted in another context, '[b]reach of fiduciary obligation... connotes disloyalty or infidelity. Mere incompetence is not enough'.¹³⁴ All of these differences could justify a more sympathetic judicial response to a claim that the law of fiduciary obligations should apply initially in the specific context of a doctor's sexual exploitation of his patient.

¹²⁷ See n 130 below.

¹²⁸ Although not in a non-disclosure case where a doctor relies on therapeutic privilege, for she would claim that the decision not to inform the patient of the particular risk was taken in order to protect the patient's interests. See, for example, Lord Scarman's judgment in *Sidaway* (n 111) 889-890.

¹²⁹ cf. Grubb (n 52) 335-338.

¹³⁰ Such as where, e.g., a doctor fails to disclose the risks involved in a new treatment because he has a particular interest in the patient receiving the treatment in question. See, e.g., C Dyer, 'Stem cell therapy doctor exploited desperate patients, GMC finds' 341 (2010) *BMJ* c5001.

¹³¹ Rotman (n 101) 925.

¹³² See *Boardman v Phipps* [1967] 2 AC 46.

¹³³ An exception being the situation outlined in n 130 above.

¹³⁴ *Bristol and West Building Society v Mothew* [1996] 4 All ER 698, 712, per Millett LJ.

Perhaps our judges are concerned that broader recognition of the doctor-patient relationship as fiduciary could give rise to attempts to extend the application of the law of equity to numerous other doctor-patient contexts, such as failing to allow a patient access to her medical records. If the law were to reflect the position that the doctor-patient relationship is, broadly speaking, a fiduciary one, it would take a status-based approach¹³⁵ to finding fiduciary obligations. Problematically and unnecessarily, this would extend the remit of fiduciary law to all areas of a doctor's interaction with a patient, making it both unwieldy and over-broad. A reluctance to see all of a doctor's obligations as fiducial rather than confining a doctor's potential fiduciary accountability to more limited contexts was clear in the High Court of Australia case of *Breen v Williams*.¹³⁶ And, as has been noted in a Canadian case, 'not all fiduciary relationships and not all fiduciary obligations are the same; these are shaped by the demands of the situation. A relationship may properly be described as "fiduciary" for some purposes, but not for others.'¹³⁷ Thus, again, the courts may be more receptive to recognising the doctor-patient relationship as a fiduciary one if this were to occur in the particular context of sexual boundary violations, thereby reflecting a fact-based approach to finding fiduciary obligations that does not create the broader precedent set by a status-based approach.¹³⁸ This is not to suggest that the application of fiduciary obligations should remain limited to sexual boundary breaches. An initial application to such breaches may help quell judicial reluctance to accept fiduciary obligations in the doctor-patient relationship, but once this first step has been taken, the judiciary may be amenable to incremental expansion to encompass other forms of exploitation such as the confluence of medicine with commercial and research interests and, possibly, mental abuse.¹³⁹

The argument that fiduciary obligations to patients should be limited to circumstances involving exploitation gains additional strength on the basis of Flannigan's analysis of the essential characteristic of fiduciary obligations. His detailed critical exploration of the Anglo-American and Australian jurisprudence has led him to argue that the courts have become confused as to the fundamental prohibition that a fiduciary obligation contains: not to act out of self-interest.¹⁴⁰ This would exclude any behaviour absent such self-interest (such as failure to inform the patient of risks because the doctor considers the risks to be negligible, refusal to grant patients access to their medical records, or the breaching of confidentiality in order to protect others¹⁴¹) from the purview of fiduciary law. It would also be in keeping with Meagher JA's view in the New South Wales Court of Appeal decision in *Breen v Williams* that the type of fiduciary duties which would usually occur in the doctor-

¹³⁵ Bartlett (n 93) 195-6.

¹³⁶ *Breen v Williams* (n 102) [14], per Brennan CJ.

¹³⁷ *McInerney v MacDonald* (n 118) 149, per La Forest J.

¹³⁸ These different approaches are explained elsewhere (see Bartlett (n 93) 196 and Miller (n 96) 270-272 for criticism).

¹³⁹ Provided the mental abuse is perpetrated for reasons of self-interest. See the text accompanying n 140 below.

¹⁴⁰ Flannigan (n 96) 52.

¹⁴¹ Note that whilst Flannigan argues that the function of the law of breach of confidence is akin to that of the law of fiduciary obligations, he is considering the context in which confidence is breached for reasons relating to opportunism (Flannigan (n 96) 71). However, this essential element of acting in self-interest is not present where confidentiality in the doctor-patient relationship is breached to protect others in cases such as *W v Egdell* [1990] Ch. 359 CA.

patient relationship are for doctors not to profit at their patients' expense¹⁴² and not to place themselves in a position where their own interests conflict with their patients.¹⁴³

I am thus advocating the adoption of a liberal approach to finding fiduciary obligations which draws upon the moral and social purposes fiduciary law can serve and utilises fiduciary law as an instrument of public policy,¹⁴⁴ as has occurred in the Canadian jurisprudence. For it is fiduciary law that most appropriately captures the elements in the doctor's behaviour in Type 2 cases that make the wrong and harm committed so egregious: the doctor allows a conflict between his duty of loyalty to the patient and his own self-interest to arise, gaining from the exploitation of his more powerful position and breach of trust. Fundamentally, the wrong is committed through allowing this conflict to arise¹⁴⁵ and this is what makes fiduciary law so apposite; whilst the afore-discussed action for battery might reflect the wrongful aspect of the doctor's exploitation of his more powerful position to acquire ostensible consent, it would not capture this essential element of the wrong. The broader moral lens incorporated by the law of fiduciary obligations and equity more broadly should be conducive to recognising the 'totality'¹⁴⁶ of this deliberate wrongful and harmful behaviour.¹⁴⁷ My position here is predicated on loyalty being an essential ingredient of fiduciary law, as Gold and Miller have recognised: '[t]he duty of loyalty is one of the most prominent features of fiduciary law'.¹⁴⁸ Whilst I acknowledge that there is debate as to whether the fiduciary obligation to avoid a conflict between one's duty and one's personal interest is grounded in morality,¹⁴⁹ the argument that the origins of fiduciary loyalty lie in moral values is supported by numerous authors.¹⁵⁰

Finally, I should address the issue of *when* a breach of the sexual boundaries in Type 2 cases should be actionable under fiduciary law and the matter of remedies. Should it be necessary to require that the breach cause a recognised psychiatric

¹⁴² See, e.g., *Moore v Regents of University of California* (n 102). That is, providing *profit* is not interpreted in strictly economic terms and thus the word *gain* may be more apt in my context.

¹⁴³ (1994) 35 NSWLR 522, 569-71.

¹⁴⁴ See P. Finn, 'The Fiduciary Principle' in T Youdan (ed), *Equity, Fiduciaries and Trusts* (Carswell: Toronto 1989), 26-27.

¹⁴⁵ See also Tan (n 15) 252.

¹⁴⁶ *Norberg v Wynrib* (n 45) [61], per McLachlin J.

¹⁴⁷ I note here that I have not considered whether the moral lens of the criminal law might also be conducive to recognising the wrong committed in Type 2 cases through, for example, the creation of a new breach of trust sexual offence or modification of the consent provisions under the SOA (see n.44 above). Under the Canadian Criminal Code (s. 273.1.(1)(2)(c)), for instance, there is no consent for the purposes of sexual assault where 'the accused induces the complainant to engage in the activity by abusing a position of trust, power or authority'. This matter is considered in Ost and Biggs (n 42).

¹⁴⁸ AS Gold and PB Miller, 'Introduction' in Gold & Miller (n 100) 5.

¹⁴⁹ Both Conaglen and Penner have countered that moral conceptions of the fiduciary obligation (that it is imposed to prevent a fiduciary from acting immorally in misusing their position) and the view that loyalty underpins the fiduciary duty are misconceived. Indeed, Penner goes so far as to argue that being a fiduciary involves no duty to avoid a conflict of interest and such a conflict is not in itself a wrong. See J Penner, 'Is Loyalty a Virtue, and Even if it is, Does it Really Help Explain Fiduciary Liability?', in Gold & Miller (n 100); M Conaglen, *Fiduciary Loyalty: Protecting the Due Performance of Non-Fiduciary Duties* (Oxford: Hart 2010), ch 5.

¹⁵⁰ It is notable that Penner's chapter is the only one of four in the same edited volume to conceive that loyalty is not a fiduciary duty or a juridical constraint upon fiduciaries. See I Samet, 'Fiduciary Loyalty as Kantian Virtue', in Gold and Miller (n 100); Smith (n 100); AS Gold, 'The Loyalties of Fiduciary Law' in Gold and Miller (n 100).

condition rather than (simply) mental distress? I argue that if a patient can establish that she suffered mental distress as a consequence of a breach in a Type 2 case, even if this does not lead to a psychiatric condition, this should constitute actionable damage. For, as Allen has observed, albeit in a broader context, '[t]he harm is real, even if it is not a psychiatric disorder'¹⁵¹ and in the context of a professional relationship so dependent on trust, the need to deter the abuse of power is clear.¹⁵² In terms of remedies, equitable compensation¹⁵³ could redress the harm caused. I note that the question of whether exemplary damages in particular are available for breach of a fiduciary duty is unsettled under the law in England and Wales.¹⁵⁴ Certainly in the breach of trust cases related to property and economic interests, it has been held that the issue of remedies should be settled by proprietary remedies (constructive trust principles) rather than awarding equitable compensation akin to exemplary damages.¹⁵⁵ However, whilst noting 'the absence of English authorities for awarding exemplary damages for an equitable wrong', the Law Commission has recommended the use of punitive damages under fiduciary law.¹⁵⁶ Commonwealth jurisdictions elsewhere do allow such awards to be made¹⁵⁷ and, indeed, McLachlin J's remedy for Laura Norberg included \$25,000 in punitive damages for Dr Wynrib's breach of his fiduciary duty. In explaining her reasoning behind the availability of punitive damages, she noted that where the fiduciary's behaviour is purposefully repugnant to the beneficiary's best interests and motivated by self-interest, this would establish the conditions precedent for awarding punitive damages in fiduciary law.¹⁵⁸ She also considered that the award was justified in particular on the grounds of deterrence.¹⁵⁹

The award of exemplary damages in that case has been supported by Duggan,¹⁶⁰ and such an award would offer an apt remedy in other Type 2 breaches if permitted in this jurisdiction. Indeed, equitable compensation offers a superior method of redress when compared to battery or negligence since it is better able to address the public policy concerns that Type 2 sexual boundary breaches raise. Tan has noted the 'flexibility of equitable compensation' to provide an appropriate award that takes into

¹⁵¹ Allen (n 2) 76.

¹⁵² Ibid and see the text accompanying ns 5 and 34-39 above.

¹⁵³ On the principles of which, see *AIB Group (UK) Plc v Mark Redler & Co Solicitors* [2014] UKSC 58.

¹⁵⁴ The position is clearer in the Australian jurisprudence, at least with regard to New South Wales, where it has been held that such damages are not available for breach of equitable obligations in *Harris v Digital Pulse Pty Ltd* (2003) 56 NSWLR.

¹⁵⁵ See the Privy Council decision in *A-G for Hong Kong v Reid* [1994] 1 AC 324, subsequently criticised by Lord Neuberger MR in *Sinclair Investments (UK) Ltd v Versailles Trade Finance Ltd* [2011] EWCA Civ 347, who was of the view that imposing damages to cover not only what the claimant has lost but also accounting for whatever profit the defendant has made by taking the property was a more appropriate way to deal with the unauthorised gain (at [80] and [88]-[90]). However, the Privy Council's decision was approved by the Supreme Court in *FHR European Ventures LLP v Cedar Capital Partners LLC* [2014] UKSC 45.

¹⁵⁶ Law Commission, *Aggravated, Exemplary and Restitutionary Damages* (Law Com No 247) (HMSO: London 1997), para 5.1.55.

¹⁵⁷ Such as New Zealand (*Cook v Evatt* (No 2) [1992] 1 NZLR 676 (HC)).

¹⁵⁸ *Norberg v Wynrib* (n 45) [112], per McLachlin J.

¹⁵⁹ *Norberg v Wynrib* (n 45) [113 and 120]: '... Dr. Wynrib's conduct is sufficiently reprehensible and offensive to common standards of decency to render him liable to such a punitive award... Dr. Wynrib is not alone in breaching the trust of his patient through sexually exploiting her; physicians... must be warned that society will not condone abuse of the trust placed in them'.

¹⁶⁰ A Duggan, 'Exemplary Damages in Equity: A Law and Economics Perspective' (2006) 26 OJLS 303, 316-7.

account the nature of the fiduciary obligation that has been breached and the particular circumstances of the case.¹⁶¹ Referring to precedent in *Norberg v Wynrib*, McLachlin J stated that ‘... equitable compensation, must continue to... be moulded to meet the requirements of fairness and justice in specific situations’¹⁶² and ‘[i]n awarding damages the same generous, restorative remedial approach, which stems from the nature of the obligation in equity, applies.’¹⁶³ She thereby differentiated equitable compensation from damages in contract and tort which would take account of any failure on the part of the claimant to mitigate or take appropriate care, emphasising equity’s concern to restore the claimant as fully as possible to the position she would have been in had the breach not occurred.

Thus, the flexibility of equitable compensation should enable recognition and remediation of the harm done to the trust placed in the doctor by the patient and collectively by society in the medical profession, alongside any psychological injury and mental distress suffered by the patient. As put by Joyce, ‘[f]undamentally... the benefit of applying fiduciary law... [lies] in the appropriate acknowledgement in law of the wrong done to the [patient]’.¹⁶⁴

Having made my case for the recognition of fiduciary duties in the context of Type 2 breaches of the sexual boundaries, I now consider how this fits with the prominent model of the doctor-patient relationship which centres on patient autonomy.

V. SYNTHESISING THE FIDUCIARY APPROACH WITH THE CONTEMPORARY MODEL OF THE DOCTOR-PATIENT RELATIONSHIP

I have argued that the fiduciary approach is grounded in the particular professional responsibilities to avoid an abuse of trust and power and to avoid a conflict arising between the duty to act in the patient’s interests and the doctor’s own self-interest.¹⁶⁵ However, fiduciary law’s emphasis on power and dependency has caused Peppin to question whether it can fit comfortably with the current model of the doctor-patient relationship which prioritises patient autonomy rather than physician paternalism.¹⁶⁶ This prioritisation in ethics and law¹⁶⁷ suggests that today’s patient is less dependent and more empowered, and therefore, less reliant than the beneficiary in a fiducial relationship. Moreover, for some patients, knowing that their doctor is legally obliged to respect their autonomy could also diminish (although not extinguish) the need for trust in the relationship, thereby calling into question the existence of an element so fundamental to fiduciary obligations.

¹⁶¹ Tan (n 15) 253.

¹⁶² *Norberg v Wynrib* (n 45) [101], per McLachlin J.

¹⁶³ *Norberg v Wynrib* (n 45) [104], per McLachlin J.

¹⁶⁴ R Joyce, ‘Fiduciary Law and Non-economic Interests’ (2002) 28 *Monash U. L. R.* 239, 266.

¹⁶⁵ See the text accompanying nn 118 and 140 above.

¹⁶⁶ Peppin (n 91) 82.

¹⁶⁷ See, eg, *Chester v Afshar* [2004] UKHL 41; *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; O O’Neil *Autonomy and Trust in Bioethics* (Cambridge University Press: Cambridge 2002).

Prioritisation of the patient's autonomy can only go so far, however. The doctor's obligations to act in the patient's best interests and consider appropriate treatment options remain, as does the patient's reliance on the doctor's expertise and her obligation to engage in responsible decision-making¹⁶⁸ with her doctor. This is evidenced by considering another established model of the doctor-patient relationship which overarches the patient autonomy model: the mutuality, or shared decision-making model.¹⁶⁹ This model is 'characterized by the active involvement of patients as more equal partners in the consultation... in which both parties participate as a joint venture and engage in an exchange of ideas and sharing of belief systems'.¹⁷⁰ The information provided by the doctor is technical and medical, the patient's relates to her preferences, values, and plans.¹⁷¹ As this model reveals, decisions as to the patient's treatment and care must be made within the framework of the medical evidence. The mutuality model sets the boundaries of the patient autonomy model, favouring principled autonomy, a concept that focuses on responsibilities and obligations to others,¹⁷² over individual autonomy. Significantly, trust is a vital component of the mutuality model.¹⁷³ Put simply, without trust, neither party will feel able to engage in the necessary exchange of ideas.

My synthesis of the mutuality model and a fiduciary approach to doctors breaching the sexual boundaries can essentially be expressed in the following way: the patient approaches the doctor for medical advice/treatment; her engagement with the doctor occurs with a view to gaining advice/treatment in her interests and she enters into the relationship with him on the basis that he can be trusted not to act primarily out of self-interest and to respect her autonomy and values. Because of the mutuality of the relationship and the need to respect the patient's autonomy, the doctor makes a fiduciary undertaking when entering into a professional relationship with the patient and the patient's acquiescence to being involved in this relationship and engaging in the shared venture of responsible decision-making is given on this (implicit) basis. A doctor who proceeds to breach the sexual boundaries has not only violated the patient's trust, he has also failed to respect the mutuality of the doctor-patient relationship, treating the patient not as an autonomous partner but as a means to achieve his own self-interest. Or, to put it another way, the doctor's exploitation of the patient for reasons of self-interest *prevents* the existence of a relationship of mutuality and this is thus a further reason to take a breach of a fiduciary obligation seriously. It is therefore possible to address Peppin's concern through the lens of the mutuality doctor-patient relationship model. For, as Harding has argued, fiduciary law assists in 'building a trusting relationship as a normative framework for cooperative action',

¹⁶⁸ J Coggon, 'Varied and Principled Understandings of Autonomy in English Law: Justifiable Inconsistency or Blinkered Moralism?' (2007) 15 *Health Care Anal.* 235.

¹⁶⁹ See further DH Smith and L Newton, 'Physician and Patient: Respect for Mutuality' (1984) 5 *Theor. Med.* 43; A Kon, 'The Shared Decision-making Continuum' (2010) 304 *JAMA* 903; G. Elwyn and others, 'Shared Decision-making in Primary Care: the Neglected Second Half of the Consultation' (1999) 49 *Brit. J. Gen. Pract.* 477.

¹⁷⁰ M Morgan, 'The Doctor-Patient Relationship', in G Scrambler (ed), *Sociology as Applied to Medicine* (Elsevier: London, 2008), 54.

¹⁷¹ C Charles and others, 'Decision-making in the Physician-patient Encounter: Revisiting the Shared Treatment Decision-making Model' (1999) 49 *Soc. Sci. Med.* 651.

¹⁷² O'Neil (n 167) 96: 'Principled autonomy... provides a basis for an account of the underlying principles of universal obligations and rights that can structure relationships between agents.'

¹⁷³ See RM Zaner, *Ethics and the Clinical Encounter* (Prentice Hall: Englewood Cliffs, NJ, 1988), 54-55.

thereby constituting ‘a powerful expression of the autonomy of the parties to the relationship’.¹⁷⁴

VI. CONCLUSION

The reported cases and existing research related to doctors behaving in a sexualised way towards their patients demonstrate that sexual boundary breaches continue to occur despite the clear professional ethical prohibition placed on such conduct. I have placed the various types of boundary violations into three categories, primarily on the basis of the absence of patient consent (Type 1 breaches involving criminal offences); the presence of the element of inducement which can cause us to question how real a patient’s consent is (Type 2 breaches); and the presence of patient consent absent such an element (Type 3 breaches). Whilst all of these breaches involve a breach of trust, Type 1 and 2 breaches are sufficiently wrongful and harmful to warrant bringing the doctor to account at law.

Type 1 breaches fall within the realm of the criminal law, however, Type 2 breaches are not always clearly caught by the existing law because of the difficulties associated with proving a lack of consent. Moreover, the possible available avenues for legal redress under the law of torts fail to capture the essence of the wrong committed; the abuse of trust and power which occurs because the doctor has allowed a conflict to arise between his duty and self-interest. Consequently, I have argued that English law should recognise fiduciary obligations in the doctor-patient relationship in this specific context. For, ‘[w]ithout characterizing the duty as fiduciary the wrong done to the patient [can] neither be fully comprehended in law nor adequately compensated in damages.’¹⁷⁵ The duty upon physicians to maintain the sexual boundaries with their patients reflects the essence of fiduciary obligations; the doctor who breaches this duty abuses his position of trust for self-gain, failing to put the patient’s interests first. Whilst I have suggested that the initial move to recognise fiduciary obligations in relation to Type 2 boundary breaches could then be expanded to encompass other instances of exploitation which the doctor perpetrates for reasons of self-interest, I have not advocated extending recognition of fiduciary obligations in the doctor-patient relationship beyond such exploitative contexts. I do not see this as necessary or, indeed, appropriate when other more suitable legal remedies exist for behaviour such as refusing to allow a patient access to her medical records, or breaching a patient’s confidentiality.

I have shown that the fiduciary approach I have called for in Type 2 cases is not at odds with the prominence attached to patient autonomy in the contemporary doctor-patient relationship, demonstrating how viewing the doctor as fiduciary reflects the nature of the interaction between doctor and patient under the mutuality model of this relationship. The patient’s relationship with her doctor involves a responsible, shared decision-making process regarding her health. She engages with her doctor in order to

¹⁷⁴ Harding (n 121) 102. The patient autonomy model was clearly favoured in *McInerney v MacDonald* (n 118), in which a fiduciary duty to provide patients access to their medical records was held to be owed by a doctor, providing further evidence of the compatibility of the contemporary model of the doctor-patient relationship and the concept of fiduciary.

¹⁷⁵ *Norberg v Wynrib* (n 45) [76], per McLachlin J.

gain advice and treatment in her interests on the basis that he can be trusted not to act out of self-interest and to respect her as a partner in this process. Ensuring that any conflict between his duty to the patient and his self-interest is avoided is fundamental to discharging his ethical responsibilities as a medical professional, including respecting the patient as an autonomous partner. The fiduciary approach is thus well suited to supporting and protecting a relationship grounded in trust in which both parties express their autonomy by working cooperatively together.