[J-10-2010] [MO: Castille, C.J.]
IN THE SUPREME COURT OF PENNSYLVANIA
MIDDLE DISTRICT

DAVID THIERFELDER AND JOANNE THIERFELDER, H/W	:	No. 97 MAP 2009
	:	Appeal from the Order of the Superior
v.	:	Court entered on May 19, 2009 at No 571
	:	EDA 2007, affirming the Order of the
IRWIN WOLFERT, M.D. AND MEDICAL CENTER AT GWYNEDD AND ABINGTON MEMORIAL HOSPITAL	:	Court of Common Pleas of Montgomery County, Civil Division, entered on February 5, 2007 at No. 04-03111 c/w 03-11978
APPEAL OF: IRWIN WOLFERT, M.D.	:	
	:	ARGUED: March 10, 2010

DISSENTING OPINION

MADAME JUSTICE TODD **DECIDED: September 28, 2012**

I respectfully dissent. Determining whether there should be a duty, and, thus, a cause of action in professional negligence, when the legislature has not spoken, presents challenging questions of social policy and protection from harm. As offered by the majority, quoting the late Dean Prosser, "*[i]n the end the court will decide whether there is a duty on the basis of the mores of the community*, always keeping in mind the fact that we endeavor to make a rule in each case that will be practical and in keeping with the general understanding of mankind." Majority Opinion at 24 (emphasis added). Ultimately, in this matter, the majority concludes that the mores of the community should not, for purposes of professional negligence, find any duty of care on the part of a general practitioner who, while providing mental health treatment, engages in sexual

relations with a patient — behavior already deemed to be unethical — causing the patient physical and psychological injury. Importantly, the majority not only rejects finding a duty in the matter *sub judice*, it completely shuts the door on placing a duty on a physician as a matter of law — regardless of the nature of the mental health treatment rendered. I disagree with this unfortunate determination.

Even more deleterious is the majority's alteration of the Althaus construct, which, as I explain below, will adversely impact future application of this test.[1] In my respectful view, even in the majority's application of the altered Althaus test, it takes an overstated approach in its analysis — finding each and every prong of the five-prong Althaus test to be unsatisfied — which, in my view, simply proves too much in the physician-patient realm. For the reasons that follow, I would affirm the Superior Court's order finding that this claim in professional negligence should move beyond the pleading stage, and would find that when a physician provides treatment for a mental health disorder such as alleged here — depression — and has a sexual relationship with that patient, if the sexual relationship causes injury, the patient has alleged a cognizable cause of action against the physician in professional negligence.

Initially, it is critical to note that this case comes to us at the preliminary objections stage. In reviewing a trial court's grant of preliminary objections in the nature of a demurrer, all material facts set forth in the complaint, as well as all inferences reasonably deducible therefrom, are admitted as true for the purposes of review. The question presented by a demurrer is whether, on the facts averred, the law states with certainty that no recovery is possible. Where doubt exists as to whether a demurrer should be sustained, the doubt should be resolved in favor of overruling it. MacElree v. Phila. Newspapers, Inc., 544 Pa. 117, 124, 674 A.2d 1050, 1053-54 (1996).

[1] Althaus ex rel. Althaus v. Cohen, 562 Pa. 547, 756 A.2d 1166 (2000).

While the majority provides great detail in the factual and procedural background of this matter, the core of this dispute is relatively straightforward. JoAnn Thierfelder contends in her complaint that she and her husband, David Thierfelder, were patients of Dr. Irwin Wolfert. Mrs. Thierfelder avers that the couple divulged to Dr. Wolfert details of their intimate relations so that Dr. Wolfert could provide appropriate medical care. According to Mrs. Thierfelder, Dr. Wolfert treated her for depression and anxiety and prescribed medication for her depression. Importantly, during the course of the physician/patient relationship, Mrs. Thierfelder claims that Dr. Wolfert's treatment and medication regimen caused her to believe that Dr. Wolfert had "cured" her, that she informed him that he was her "hero," and that she believed that she was in love with him. Third Amended Complaint, at ¶ 13. Mrs. Thierfelder alleges that, after she informed Dr. Wolfert of her feelings, and while treating her for depression, Dr. Wolfert began a sexual relationship with her. After the relationship became sexual, Mrs. Thierfelder maintains that she became increasingly anxious and depressed and attempted to break off the relationship, but that Dr. Wolfert convinced her to continue the relationship. Ultimately, Mrs. Thierfelder contends she ended the relationship with Dr. Wolfert and, later, informed her husband about the affair. Because of Dr. Wolfert's actions, Mrs. Thierfelder alleges that she suffered deterioration of her psychological condition, severe depression and psychological harm, was deprived of the opportunity to obtain relief from her psychological condition, and suffered severe physical pain and mental anguish.

Professional negligence, also referred to as medical malpractice, giving rise to liability in tort, consists of a "negligent or unskillful performance by a physician of the duties which are devolved and incumbent upon him on account of his relations with his patients, or of a want of proper care and skill in the performance of a professional act."

Quinby v. Plumstead Family Practice, 589 Pa. 183, 198, 907 A.2d 1061, 1070 (2006).[2] As medical malpractice is a form of negligence, to establish a case of professional negligence, (1) there must be a duty owed to the patient by the physician; (2) the physician must have breached that duty; (3) the breach must be the proximate cause of the patient's injury; and (4) the patient must suffer damages as a result of that harm. Stimmler v. Chestnut Hosp., 602 Pa. 539, 555, 981 A.2d 145, 154 (2009).

At issue in this appeal is the question of duty. Thus, for a patient to establish professional negligence under the circumstances of this case, the patient must establish that a general practitioner had a duty to not have sexual relations with a patient for whom he is providing treatment for a mental health disorder. Of course, if such a duty exists, a patient must also establish the physician breached that duty, the breach was the proximate cause of the patient's injury, and the patient suffered damages as a result of that harm, in order for the patient to be able to obtain relief under a professional negligence theory.[3]

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[2] In the context of physicians and patients, it is universally accepted that there already exists a duty on the part of a physician to conform to certain acceptable medical standards of reasonable medical care when treating a patient. Arguably, in the absence of legislative guidance defining the scope of this duty, such matters as presented in this case can be resolved according to the standards of the profession, as determined through the adjudicative process, and usually requiring expert testimony to establish the proper standard of care. Quinby, 589 Pa. at 199, 907 A.2d at 1070. Indeed, Mr. and Mrs. Thierfelder have offered a certificate of merit in support of their claims which provides that Dr. Wolfert's conduct departed from acceptable medical standards. In my view, however, and as discussed below, here, the standards of the profession are clearly articulated, and, thus, a determination of the existence of a duty under these circumstances may properly be undertaken by our Court.

[3] The majority progressively morphs the issue before us. We granted allocatur to determine "Whether, for purposes of determining professional negligence, a general practitioner who provides mental health treatment to a patient is held to the same higher duty as a specialist in psychiatry or psychology?" Thierfelder, 603 Pa. 430, 984 A.2d 935 (2009) (order). In its opinion, the majority begins that the question before us is "whether a medical general practitioner who provides *incidental* mental health treatment to a patient, with whom he then engages in a sexual affair, may be held to a

In determining whether a duty exists for purposes of professional negligence, our Court traditionally employs the five-factor Althaus test. Specifically, this determination involves the weighing of discrete factors, including: (1) the relationship between the parties; (2) the social utility of the actor's conduct; (3) the nature of the risk imposed and foreseeability of the harm incurred; (4) the consequences of imposing a duty on the actor; and (5) the overall public interest in the proposed solution. 562 Pa. at 553, 756 A.2d at 1169. Of course, as noted by the majority, the analysis is set against the backdrop of policy considerations of whether a plaintiff is entitled to protection from the harm she alleges, and, even more broadly, the mores of the community.[4] [5]

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particularized 'specialist duty,' applicable to mental health professionals, that prohibits consensual sexual contact with patients, such that the defendant general practitioner may be subject to medical malpractice liability in tort." Majority Opinion at 1 (emphasis added). Then, the majority begins its analysis by rephrasing the issue as follows: "The question here is whether to extend a mental health specialist's presumed duty to refrain from sexual activity with patients to general practitioners who provide *some degree* of mental or emotional counseling to a patient, or who prescribe *common medications* for depression or anxiety for that patient, and then engage in consensual sexual relations with that patient." Majority Opinion at 38 (emphasis added). Not only is the progressively evolving nature of the statement of the issue troubling, but the majority's characterization of the mental health treatment at issue as "incidental" and any prescriptions as "common medications" is divorced from the complaint, to which, at this stage of the pleadings, we are limited. We do not know the type of treatment rendered by Dr. Wolfert to Mrs. Thierfelder or the nature of the medication prescribed. Further, the majority asserts that its repeated use of the qualifier "incidental" to describe the mental health treatment under consideration distinguishes "the sort of treatment that arises during the course of a preexisting doctor-patient relationship, one not originally or usually involving mental health treatment from the sort of targeted treatment rendered by a mental health specialist." Majority Opinion at 40 n.21. Yet, the majority does not explain the relevance of when the treatment arises in the relationship or whether the treatment is for a first-time patient or a repeat patient. Indeed, as the focus is whether the patient is being treated for mental health disorders, it appears to me that these considerations are irrelevant. Nor does the majority's statement of the issue account for the distinction or suggest a duty with respect to more serious treatment by a general practitioner.

[4] The majority cogently offers that our Court has not addressed the seemingly predicate question of whether professional liability arises from a mental health professional's consensual sexual conduct with a patient; however, after scholarly analysis, the majority

In my view, fair application and proper weighing of the Althaus factors leads convincingly to the conclusion that a physician who is providing treatment for a patient's mental health disorder has a duty not to engage in sexual conduct with his patient, especially in light of the vulnerabilities of a patient with a mental health disorder and the fact that a physician, as discussed below, is already prohibited from sexual relations with a patient under professional medical standards.[6] Conversely, I find that the

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properly offers that courts in other states have overwhelmingly concluded a claim against a mental health professional for his consensual sexual conduct with a patient gives rise to a claim in professional negligence. Majority Opinion at 25-35.

[5] The majority further suggests, at some length, that courts have been reluctant to recognize a cause of action in professional liability when a general practitioner provides treatment for a physical injury, i.e., non-mental health treatment, and engages in consensual sexual conduct with a patient. I do not quibble with its characterization of the law, but simply emphasize this issue is plainly not before us. What I am concerned about is the majority's characterization of the circumstances before us as occurring "in the grey area between purely physical medical care and mental and emotional care, which may entail a broad range of treatments from simple counseling, to a single prescription by a general practitioner to treat a regular patient's occasional anxiety . . . , to comprehensive and sustained treatment *by mental health specialists* to address serious psychological illnesses such as schizophrenia and bipolar disorder." Majority Opinion at 36-37 (emphasis added). The broad range of treatment we consider today, however, is that given by a general practitioner — not a mental health specialist — who, as noted below, may fully engage in "comprehensive and sustained treatment" for "serious psychological illness." Thus, the majority's division between which type of practitioner may engage in differing levels of treatment is not only unfounded, but, properly understood, sharpens the point: today's holding fails to recognize a duty on the part of a physician, and, thus, a claim in professional negligence against not only general practitioners who give a "single prescription," and engage in sexual relations with their patients, but also those generalists who provide "comprehensive and sustained treatment" for "serious psychological illness," and engage in sexual relations as well.

[6] According to the majority, placing a duty on general practitioners would create an "absolute 'duty' in general practitioners to refrain from sexual relations with patients they have treated for mental health issues" and would create a *per se* cause of action. Majority Opinion at 37 n.20. First, the "absolute duty" to refrain from sexual relations with his or her patients is no different than the "absolute" ethical duty currently imposed upon physicians, with which they must abide. Thus, while I would recognize a duty on a physician when treating a patient for mental health disorders to refrain from sexual relations with that patient, doing so respects an unqualified prohibition already firmly in

majority's approach to the Althaus factors, as more fully explained below, is not only unpersuasive, but alters the Althaus test so as to unduly limit these factors in future applications. While I address each of the Althaus prongs separately, the majority's alteration of the test, and its overly-broad approach, can be best demonstrated by its analysis of the first Althaus factor — the relationship between the parties.

Relationship Between the Parties — Generally speaking, the relationship between a physician and a patient creates professional obligations and legal duties; and, as recognized by our Court for over 100 years, the relation is one of trust and confidence. See Smith v Blanchy, 188 Pa. 550, 554, 41 A. 619, 621 (1898). Moreover, a physician holds a position of superiority over a patient based upon his expertise and the patient's vulnerable position in seeking care, which as noted involves, at its core, trust in the physician and the primacy of the patient's well-being. This inequity is only exacerbated where a patient seeks care for mental health disorders, as did Mrs. Thierfelder. In my view, this close relationship and the heightened sensitivities in the context of treatment for mental health disorders logically counsels towards recognizing a legal duty to protect patients who suffer from mental health disorders from exploitation by a physician. Moreover, this approach to the first Althaus prong, and a conclusion that, at a minimum, this prong suggests the finding of a duty, is consistent with our Court's prior case law.

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place. Second, and contrary to the majority's assertions that "showing both treatment and sexual relations proves the [cause of action]," id., to be successful for a claim in professional negligence in these circumstances, a patient would need to establish not only treatment for a mental health disorder and sexual relations between physician and patient, but also that the sexual relations both caused and resulted in harm to the patient. Finally, while criticizing my approach as absolutist, it should be contrasted against the majority's own absolutist bar of any professional negligence liability for a general practitioner based upon sexual contact with a patient, regardless of the nature of the treatment or how severe the mental health disorder suffered by the patient.

Indeed, our landmark decision in Althaus emphasized the physician-patient relationship, in contrast to a therapist's relationship with the patient's *parents*: "Dr. Cohen's professional relationship with Nicole [her patient] simply does not create the type of relationship between Dr. Cohen and Nicole's parents to support the imposition of a duty of care. Thus, the therapeutic relationship between Dr. Cohen and Nicole created professional obligations and legal duties that related exclusively to her patient, Nicole." 562 Pa. at 554, 756 A.2d at 1169-70. Moreover, this Court when faced with a far less substantial relationship, has found this prong to weigh in favor of a duty. See, e.g., Sharpe v. St. Luke's Hosp., 573 Pa. 90, 96-97, 821 A.2d 1215, 1219 (2003) (finding a duty on part of hospital, which was under contract with employer regarding collection and handling of urine specimens as part of employer drug testing program, to employee undergoing drug testing, despite relationship factor between hospital and employee was neither professional nor contractual, and collecting cases regarding same).

Based upon the close relationship at issue and our prior precedent, finding this factor weighs in favor of a duty should be without controversy. Yet, contrary to our prior precedent and foundational authority, the majority comes to the remarkable conclusion that even the physician-patient relationship fails to support finding a duty of care. Rather than analyzing the relationship between the parties, the majority instead amends the factor to focus on the type of care provided. Specifically, the majority asserts that, because "it is increasingly common for primary or general care physicians to advise patients on relatively common matters of emotional or mental import, like stress or depression, and also to prescribe widely-used medications for such conditions," and because there is a "qualitative difference" between treatments by a general practitioner

and a "dedicated course of therapy provided by a mental health professional," this somehow changes the nature of the relationship of the parties. Majority Opinion at 40.

First, to be clear, the majority today finds that the physician-patient relationship, one of the closest recognized in our law, and one so regarded that it enjoys evidentiary privileges,[7] does not necessarily qualify as the type of relationship considered under Althaus to give rise to a duty of care. Rather, in the majority's view, it is the regularity and type of treatment rendered that defines the relationship. Second, the asserted "qualitative difference" in the treatment rendered by a general practitioner as compared to a mental health professional regarding any given malady suffered by a patient, or specifically the depression suffered by Mrs. Thierfelder in this matter, is rank speculation. As noted below, a general practitioner is licensed to provide mental health and psychiatric services, and, thus, the difference in treatment is immaterial to the analysis. Moreover, while the majority characterizes depression as "common matters of emotional or mental import" and suggests such conditions are treated by "widely-used medications," Majority Opinion at 40, it fails to tie its analysis to the particular averments made in the complaint before us. Mrs. Thierfelder has averred that she was suffering from depression, a mental health disorder, when being treated by Dr. Wolfert, and that he provided medications for her condition. There is no indication whether the type of depression from which she suffered was "common" or complex or severe. At this stage in the proceedings, it is unknown whether or not the medications Dr. Wolfert prescribed to his patient for her mental health disorders were "widely used."

The majority asserts the relationship analysis is different when considering treatment by a general practitioner and a mental health professional, offering this "is particularly so because a general practitioner is less likely than a mental health

[7] 42 Pa.C.S.A. § 5929; Pa.R.E. 501.

professional to recognize, understand, and employ transference as a conscious therapeutic method." Id. The majority provides no basis for this broad conclusion. Moreover, and importantly, we are at the preliminary objection stage, and Mrs. Thierfelder pleads indicia of transference, and Dr. Wolfert's mishandling thereof. Thus, the majority's reliance upon qualitative differences in treatment is not only divorced from the complaint, but, again, is in tension with the current state of the law where a general practitioner is licensed to provide mental health or psychiatric services. Consequently, any suggestion that general practitioners are limited in the type of care they can provide, or that they cannot provide a "dedicated course of therapy," akin to that of a mental health professional, is simply without foundation.

Even assuming, *arguendo*, there are differences in treatment, this does not change the essential relationship between the parties — that of a physician in a position of superiority over a patient, and one based upon trust and confidence. Unlike the relationship between a physician and a third party, where we have found against recognizing a duty, see Althaus, here, there exists a close relationship between a physician who is providing treatment for a mental health disorder and a patient, a relationship founded upon trust and confidence, which strongly weighs in favor of recognizing a duty of care. In sum, not only does the majority improperly alter the focus of this prong of the Althaus test, it comes to the remarkable conclusion that the physician-patient relationship, one of the most private and confidential recognized in our law, does not counsel towards finding a duty of care.

Social Utility of Physician's Conduct — While it is axiomatic that medical professionals contribute greatly to our society by providing care to those in need, the relevant inquiry regarding social utility is specific to the conduct in question. See, e.g., Lindstrom v. City of Corry, 563 Pa. 579, 585, 763 A.2d 394, 397 (2000) (analyzing

social utility factor not based upon value of police work universally, but on utility of police officer's attempt to apprehend a fleeing suspect); Forster v. Manchester, 410 Pa. 192, 197, 189 A.2d 147, 150 (1963) (cited in Althaus as foundation for social utility factor, focusing on specific type of investigation conducted by private detective, not social utility of private detectives in general). Thus, while the majority shifts the focus, the relevant and precise inquiry *sub judice* involves the social utility of a physician having sexual relations with a patient while rendering treatment for mental health disorders.

In Pennsylvania, sexual contact between physicians and patients is deemed to be unprofessional, and it is expressly prohibited by the State Board of Medicine; violation of this prohibition subjects a physician to disciplinary action including the loss of his or her license. 49 Pa. Code §§ 16.61, 16.110. Importantly, this prohibition is reserved not only for mental health professionals, but rather applies to all medical practitioners. According to the profession's ethical code, sexual relations between physician and patient "detract from the goals of the physician-patient relationship, may exploit the vulnerability of the patient, may obscure the physician's objective judgment concerning the patient's health care, and ultimately may be detrimental to the patient's well-being." American Medical Association Code of Medical Ethics § 8.14 ("Sexual Misconduct in the Practice of Medicine"). This is powerful, if not dispositive, evidence that the utilitarian value of a general practitioner having sexual relations with a patient, for whom he is providing mental health treatment, is minimal, if not non-existent. Thus, based upon the universal condemnation of sexual contact between a physician and a patient, in my view, the social utility of the physician's conduct at issue favors recognizing a duty of care.

While recognizing that sexual activity between a general practitioner and a patient has no social utility "in and of itself," Majority Opinion at 41, the majority attempts to address the obvious lack of social utility by again altering the proper focus of this prong, and recasts the analysis in terms of ready access to treatment. The majority offers that there is social utility in *not prohibiting* a physician from having sexual relations with a patient the physician is treating for mental health disorders, as, according to the majority, such a prohibition on a physician's sexual contact with his patient "burdens the social utility in general practitioners serving as first-stop medical providers for a litany of maladies, including mental and emotional issues that may not be so severe as to require a mental health specialist." Majority Opinion at 41-42. The majority fails to explain how this is so, especially in light of the pre-existing duty on a physician to refrain from such conduct by the State Board of Medicine. The majority further concludes that this is a "difficult balance" not particularly amenable for our common law consideration. Id.

In my view, it is difficult, if not impossible, to reconcile the majority's concern with "burden[ing]" these front line caregivers with the fact that, as noted above, sexual contact between physicians and patients is universally condemned, is deemed to be unprofessional, and is already expressly prohibited by the medical profession. Indeed, noticeably absent from the majority's analysis of any of the Althaus factors is mention of this blanket prohibition. The struggle the majority faces is that, in analogous matters, our Court has had to analyze equally valuable but competing kinds of conduct in deciding whether to impose a duty. See, e.g., Emerich v. Phila. Ctr. for Human Dev., Inc., 554 Pa. 209, 720 A.2d 1032 (1998) (weighing warning of third party against threat of immediate risk of serious harm or death against confidentiality of communications with patient). By contrast, here, we are considering conduct which is universally

condemned and proscribed by state regulation. There is little or no social utility in a physician having a sexual relationship with a patient for whom he is providing mental health treatment, and the "burdening" of the providing of care is a dubious proposition at best. Thus, in my view, this factor plainly weighs in favor of finding a duty.

Indeed, while the majority suggests the analysis is far more "nuanced" than this approach allows, distilled to its essence, the majority's analysis of this factor rests upon the assumption, if believed, that if general practitioners have a duty not to engage in sexual contact with their patients, it will burden their providing treatment for mental health disorders. I believe this conclusion strains credulity, especially in light of the already existing prohibition on this conduct. Respectfully, in this matter, the analysis is much less complex and nuanced than the majority purports.

Nature of the Risk and Foreseeability of the Harm — In my view, there is a significant risk that a physician, holding a superior position over a patient suffering from a mental health disorder such as depression, who engages in a sexual relationship with that patient, does so to the detriment of his charge. Obviously, one who suffers from a mental health disorder such as depression, and who engages in a sexual relationship while being treated for such malady, may suffer substantial harm. In this matter, Mrs. Thierfelder has pled such harm. Moreover, under Althaus, we look to see if the defendant created the harm or foresaw the possibility of the harm. Althaus, 562 Pa. at 554, 756 A.2d at 1170. While merely allegations at this point, it is clear that, if proved to be true, Dr. Wolford "created" the harm that was suffered by Mrs. Thierfelder.

While acknowledging that risk, as well as the harm that may ensue if a mental health professional exploits the physician/patient relationship, the majority nevertheless finds the harm is not foreseeable when a *general practitioner* engages in sexual relations with a patient he is treating for mental health disorders: according to the

majority, a general practitioner "unfamiliar with transference, or less familiar with the effects of the treatment, or who is not deliberately employing the technique . . . , is less likely to foresee that an apparently consensual sexual affair with the patient may risk worsening the patient's psychological problems and even create new doubts, anxieties, and agitations." Majority Opinion at 44. Thus, the majority apparently believes that such negative outcomes are simply too unforeseeable for the general practitioner, and, accordingly, finds it unreasonable to place a legal duty on a general practitioner to abstain from sexual relations with a patient who is suffering from a mental health disorder. I cannot agree. The possibility and import of harm concerning transference has been known for decades, see, e.g., Simmons v. U.S., 805 F.2d 1363, 1364-65 (9th Cir. 1986), yet the majority gives general practitioners a pass on knowing and understanding the possible ramifications and injury that could occur from their undertaking treatment of mental health disorders of their patients. Furthermore, the American Medical Association explains generally the potential for harm in giving its rationale for its prohibition on physician-patient sexual relationships: such relationships "exploit the vulnerability of the patient, may obscure the physician's objective judgment concerning the patient's health care, and ultimately may be detrimental to the patient's well-being." American Medical Association Code of Medical Ethics § 8.14.

Moreover, the majority's analysis is undermined by the fact that, in Pennsylvania, a general practitioner is licensed to practice mental health or psychiatric services, and to diagnose and provide psychiatric treatment, all without any residency or board certification in psychiatry or psychology. See Pennsylvania Medical Practice Act of 1985, 63 P.S. §§ 422.1 – 422.51a. In my view, when a general practitioner undertakes to render treatment to a patient for mental health disorders, which the physician is

legally permitted to provide, it is not unreasonable for that physician to understand and know the basic consequences of such care.

While, as noted above, social utility is set forth as a discrete factor, and is properly analyzed as such, we also weigh the social utility of the conduct at issue against the factor concerning the nature of the risk and foreseeability of harm.[8] Considering the minimal or utter lack of social utility of a physician having sexual relations with a patient while rendering mental health treatment, and the nature of the risk of harm and its possible foreseeability, these factors, viewed both individually and when considered collectively, weigh in favor of recognizing a legal duty of general practitioners to refrain from engaging in sexual relations with their patients whom they are treating for mental health disorders.

Consequences of Imposing a Duty on Physicians — As to the consequence of imposing a duty upon general practitioners to refrain from having consensual sexual relations with patients whom they are treating for mental health disorders, those physicians are in the best position to ensure that they bring no harm to their patients by refraining from such conduct, and, thus, physicians possess the ability to limit their liability by acting within already imposed state regulatory limitations with respect to their patients.

Similar to its discussion of the social utility factor, the majority offers that the duty to refrain from sexual contact with a patient would impose "significant consequences"

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[8] See Lindstrom, supra, where each discrete factor, including social utility was applied separately. Additionally, in Althaus, we considered social utility of a physician's actions as a discrete factor and then also weighed this factor against risk and foreseeability: "[h]ere, the social utility disfavors expanding therapist's duty of care to non-patients, especially where the non-patients are the accused victimizers. However, we must *also* weigh this factor against the potential risk and foreseeability of harm stemming from improper treatment of children who have been sexually abused." 562 Pa. at 554, 756 A.2d at 1170 (emphasis added).

and would "have the effect of discouraging general practitioners from rendering what appears to have become, by now, relatively routine attention to their patients' mental and emotional well-being." Majority Opinion at 44. Yet, the majority fails to explain why this is so. In addition to its contention that imposing upon physicians such a duty will be too burdensome, the majority offers that "free will and personal responsibility hold some sway." Id.[9] Ultimately, the majority believes that requiring physicians to refrain from sexual relations with such patients will negatively impact the doctor-patient relationship and general practitioners will cease to provide medical care for mental health maladies. Id. Essentially, the majority contends that, if a general practitioner is not free of the specter of professional liability for having sex with his patient who is in need of mental health treatment, he will not provide such care.

As discussed above, the difficulty with the majority's analysis is that its claimed chilling effect on a general practitioner's patient care is unsupported and dubious. In my view, the consequences of placing a duty on a physician who is rendering treatment for a mental health disorder to refrain from having sexual contact with his patient are not onerous, and I am unpersuaded that such a prohibition will discourage physicians from rendering appropriate mental health care, especially where physicians are highly-regarded and highly-trained professionals, and, as noted above, sexual conduct is already prohibited by the standards of the medical profession. Further, here we have a physician providing care for a mental health disorder to a vulnerable patient, and, thus, virtues of free will and personal responsibility simply do not resonate with their typical

[9] The majority repeatedly downplays the care provided by a general practitioner to a patient who suffers from a mental health disorder as "base-level" and "relatively routine" and suggests patients seek help from mental health professionals for only "serious mental and emotions problems." However, as noted above, a general practitioner is licensed to provide mental health and psychiatric services in Pennsylvania, and, at this stage, we simply do not know the type or level of care that Dr. Wolfert provided while treating Mrs. Thierfelder for depression.

force. The parties' free will may be honored should the mutual desire for a sexual relationship prove compelling: the physician may immediately terminate the professional relationship with the patient and, at some appropriate subsequent time, engage in the sexual relationship desired; or, in the alternative, the physician may continue treating the patient but refrain from having a sexual relationship. In my view, the consequences of burdening general practitioners with a duty of care not to engage in sexual relations with patients whom they are treating for mental health problems are minimal and weigh in favor of recognizing such a duty.

Overall Public Interest in the Proposed Solution — Again, invoking a chilling effect on patient care, the majority concludes that placing a duty on a physician to refrain from having a sexual relationship with a patient who suffers from mental health disorders comes at a "high social cost" and would "discourage general or primary care doctors from meeting their patients' manageable mental and emotional needs." Majority Opinion at 45. Again, I find this conclusion to be inexplicable. The majority accepts that general practitioners now provide a significant degree of mental or emotional care for their patients, including the prescribing of medication; yet, to a large degree, the majority reasons that such widespread caregiving justifies not imposing a duty. The opposite is true in my view: that the health care system has changed, that the distinction between general practitioners and mental health professionals has become blurred, and that it has become commonplace for general practitioners to treat patients for mental health disorders and to prescribe drugs to these individuals for these conditions, counsels *towards* protecting these patients, not *against* it. Insulating from liability general practitioners who decide to engage in sexual relations with their patients serves no public interest of which I am aware. Indeed, I find there to be a significant overall public benefit in recognizing a duty of general practitioners *not* to engage in

sexual relations with patients suffering from mental health disorders, as such a duty will reduce the chance of injuring or exacerbating the symptoms of a patient the physician has pledged to assist, will enhance the chance of recovery, and will discourage conduct by the physician that could result in professional disciplinary action and the loss of the physician's license.

I find that faithful application and weighing of the Althaus factors leads to recognizing a legal duty on a general practitioner to refrain from having sexual relations with a patient whom the physician is treating for mental health disorders, and should allow this claim to proceed beyond the pleadings stage. As we have recognized, "the concept of duty amounts to no more than the sum total of those considerations of policy which led the law to say that the particular plaintiff is entitled to protection from the harm suffered." Althaus, 562 Pa. at 552, 756 A.2d at 1168-69 (internal quotation marks omitted). Importantly, "the legal concept of duty of care is necessarily rooted in often amorphous public policy considerations, which may include our perception of history, morals, justice and society." Id. at 553, 756 A.2d at 1169. In light of our Court's understanding of the notion of duty, I have no hesitation in concluding that general practice physicians who provide treatment for mental health disorders to patients have a duty to abstain from sexual relations with their patients — conduct which is deemed to be unprofessional and prohibited by the medical community — and that these physicians may be potentially liable in professional negligence actions for any harm to their patients — patients they pledged to take no action to harm — as a result of engaging in such conduct.[10]

[10] I view as distinct the question of whether it would be appropriate to impose a duty where a physician has sexual relations with a patient who is being treated only for a physical condition, as such sexual contact could be viewed as unrelated to the patient's treatment and physical condition. As noted above, that question is not before us in the present case.

Here, Mrs. Thierfelder has pled, *inter alia*, that she was in a physician-patient relationship; that Dr. Wolfert was treating her for a mental health disorder, depression; that, during this relationship, Dr. Wolfert's treatment and medication caused her to believe that he was her "hero," that he had "cured" her, and that she was in love with him; that they began a sexual relationship; that she attempted to end the relationship but that Dr. Wolfert convinced her to continue the relationship; that Dr. Wolfert failed to treat her appropriately; that Dr. Wolfert practiced therapeutic techniques beyond the scope of his competence, and failed to properly recognize, diagnose, and treat her transference; and that, as a result of this conduct, she suffered harm. In my view, these averments are sufficient to allow this cause of action in professional negligence to proceed beyond the pleading stage and continue to discovery.

Thus, for the above reasons, I would affirm the order of the Superior Court.