1997

Sex on the Wards: Conundra for Clinicians

Douglass Mossman

Michael L. Perlin
New York Law School, michael.perlin@nyls.edu

Deborah Dorfman

Sex on the Wards: Conundra for Clinicians

Douglas Mossman, MD, Michael L. Perlin, JD, and Deborah A. Dorfman, JD

Should psychiatric inpatients be allowed to engage in sexual activities? Do clinicians have a *right* to prevent them from doing so? If so, when may sexual interaction be restricted? What sorts of clinical issues and problems are posed for nursing staff, and how should psychiatrists and administrators respond to these? These and related questions have received little attention from either medical or legal scholars, in sharp contrast to the extensive analysis devoted to other issues affecting the lives of psychiatric inpatients, and in especially sharp contrast to our culture's inundation with media messages about sex. This article summarizes the modest body of scholarship concerning sexual interactions among hospitalized patients, the clinical and administrative questions faced by psychiatrists who work with inpatients, and the potential medicolegal problems that inpatients' sexual activities can create. It concludes with a conceptual framework that clinicians can use to devise solutions to the problems arising from inpatients' sexuality.

American culture inundates its citizens with media messages about sex. Yet the issue of psychiatric inpatients' sexual activity has received only modest attention from medical and legal scholars, in sharp contrast to the extensive analysis devoted to other issues affecting the lives of mentally disabled persons. Inpatient sexual activity is not mentioned in the index of any major psychiatric textbook. However, the authors' experience and our contacts with practicing mental health professionals strongly suggest that responding to inpatients' expressions of sexuality is a common issue in clinical practice.

Should psychiatric patients be allowed to engage in sexual activities? When many psychiatrists are asked this question, they respond, "Not in my hospital!"[1] and cite potential liability risks—physical and emotional injuries, unanticipated pregnancy, and especially, in recent years, the spread of HIV—as a major concern. But doctors' worries about liability risks do not stop patients from being sexually active. Moreover, inpatient

Dr. Mossman is Professor and Director of the Division of Forensic Psychiatry, Wright State University School of Medicine; and Adjunct Professor, University of Dayton School of Law, Dayton, OH. Dr. Perlin is Professor of Law, New York Law School, New York, NY; and Dr. Dorfman is Staff Attorney, Washington Protection and Advocacy System, Seattle, WA. Portions of this article were presented at the May 1994 Annual Meeting of the American Psychiatric Association, Philadelphia, PA, and at the October 1995 Annual Meeting of the American Academy of Psychiatry and the Law, Seattle, WA. Address correspondence to: Dr. Douglas Mossman, Wright State University Department of Psychiatry, P.O. Box 927, Dayton, OH 45401-0927.

sex generates many other clinical puzzles, administrative quandaries, and legal questions:

- If psychiatrists wish to deter patients from sexual interaction to reduce liability risk, do they have an *unlimited* right to do so?
- If not, may sexual activity be restricted only because of a patient's own treatment needs, or do the feelings and needs of other patients and staff members count?
- How should hospitalization affect a patient's sexual autonomy and privacy needs?
- Does it matter whether sexual activity between two inpatients is likely to benefit them or be countertherapeutic?
- How do the kinds of serious psychopathology that lead to hospitalization affect patients' expression of sexual desires, patients' judgment and decision-making about sexual issues, their rights to engage in sexual activity, and the meaning of sexual activity?
- Do state statutes, state constitutions, or the Americans with Disabilities Act[2] create or protect a right to engage in sexual activity?
- Are there important differences with respect to type of hospital, voluntary or involuntary status, sexual orientation, gender status, forensic status, or length of stay?
- What sorts of clinical issues and problems are posed for nursing staff, and how should psychiatrists and administrators respond to these?

This article summarizes the modest body of clinical scholarship on the sexual behavior of adult psychiatric inpatients, the clinical questions faced by psychiatrists who work with these persons, and the potential liability issues that their sexual activities can create. We offer a conceptual framework that clinicians can use to devise solutions to the problems arising from inpatients' sexuality, and a model policy for long-term patient that addresses the above-listed questions. Our discussion will not touch two related, important, but very different topics: sex among mentally retarded persons who received long-term institutional care (discussed by Sundram and Stavis)[3]; and sex among psychiatrically hospitalized minors.

Background: What Do Professional Publications Tell Us?

Incidence The incidence of inpatient sexual interaction depends on how one defines it, on the hospital setting, on how long patients stay, and on who the patients are. In a prospective study[4] conducted in the early 1980s on an acute care ward, about 11 percent of the patients became involved in interpersonal relationships, but only 3 to 5 percent of these relationships—so far as staff members were aware—included "physical behaviors, such as kissing and fondling" (p. 168). In the mid-1970s, Akhtar and colleagues[5] found that the staff of their relatively short-term ward (average length of stay was "about three weeks") recalled "overt sexual behavior" (intercourse,

kissing, public masturbation, and "homosexual behavior") in 3 percent of their patients. Sexual interaction seems more common on units where length of stay is longer, perhaps because patients have more time to get to know each other.[6] Published reports thus suggest that the vast majority of persons do not engage in sexual interaction while psychiatrically hospitalized. Those patients who do are younger, single, and are not suffering from major mood or thought disorders.[4, 5]

Professionals' Responses and Attitudes Professional publications describe a variety of "official" responses to inpatients' sexual activity. Masturbation is generally viewed to be a harmless, reasonable, permissible behavior for inpatients,[7] if it is done "privately and appropriately."[5] Most authors have recommended that sexual interaction between patients be discouraged,[5, 8–10] but some have suggested that hospitals might promote appropriate sexual behavior by providing private settings[11] and education,[12] and by assessing competence to make sure that sexual interaction is informed and consensual.[13] A recent Quebec survey[7] showed that nearly 90 percent of hospital staff members thought that consensual kissing was acceptable, and 78.3 percent thought that private, consensual, heterosexual contacts between patients should be permitted.

Relative permissiveness or prohibitiveness may be expressed through explicit written policies about whether sexual interaction is allowed.[9, 10] Facilities that provide contraceptives[8] or private space for patients to engage in sexual relations[13] convey implicit messages about how sexual activity is viewed, as do those facilities that provide contraceptives on demand (e.g., condoms) only to male patients.[14]

Two recent questionnaire studies have evaluated attitudes about sexual interaction among hospital staff. Respondents in a Massachusetts survey[15] included mental health staff "holding positions ranging from mental health aide to psychiatrist" (p. 575). The "therapeutic impact" (p. 577, not further defined) of a sexual encounter was more important to staff than whether the encounter was consensual. Mental health staff were less disapproving of sex that occurred in conventional places (e.g., a bedroom) than sex taking place on hospital grounds. These findings suggested to the authors of the study that mental health professionals, like most citizens, judge inpatients' behavior based on conventional social norms and prejudices rather than by legal standards such as competence and consensuality. In their survey of professional, nursing, and ward staff at a Quebec facility, Trudel and Desjardins found that lower tolerance for inpatient's sexual behavior correlated with being older, less educated, and more religiously observant.[7]

Psychiatrists urge their colleagues to take a leadership role in managing responses to patients and providing guidelines for dealing with sexual interaction.[10] Still, the response of the staff of a ward or a hospital will also reflect its concerns about how the public will view the inpatients' sexual activity. Staff may assume that they have a "moral responsibility to

assure the spouses of married patients that the patient [*sic*] will be protected while in the hospital," and may perceive similar obligations to families of elderly demented patients (p. 124).[9]

In many circumstances, sex between patients may be a crime. In Ohio, for example, a person who has intercourse knowing that "the other person's ability to appraise the nature of or control his or her own conduct is substantially impaired" is guilty of a felony[16] and sexual contact with a similarly impaired person is a misdemeanor.[17] Hospital personnel who allow such activity might be indicted for facilitation of a crime.[18] In some states, sex between unmarried persons is still a crime; in others, homosexual sodomy is still a crime.[18a]

When hospital officials learn about a possibly incompetent patient's sexual activity, they may incur a legal obligation to report what "appears" to be a crime to law enforcement officials, and failure to do so might be "tantamount to a cover-up and malfeasance of office" (p. 76).[19] Responding both to the potential legal implications of sexual activity and to unfavorable media publicity, one New York State hospital developed a policy such that patients discovered having sex might be questioned by nursing staff, hospital safety officers, administrators, psychiatrists, police officers, detectives, and the district attorney; they also were not allowed to change clothes or bathe until physically examined (lest "evidence" be disturbed), and were asked to undergo physical examinations "including checking for possible bleeding and rectal tears, taking blood samples, and using nasal and throat swabs" (p. 77).[19]

Even without extra-hospital provocation, staff may be concerned about condoning or providing space for sexual activity. In the words of one nurse, "Are you suggesting that a tax-supported state hospital should provide facilities for coital activities when such acts are illegal? Are you proposing that the state should operate a brothel?" (p. 11).[12] As one of the authors' colleagues sarcastically paraphrased this viewpoint, "We're running a warehouse, not a whorehouse."*

The authors' informal contacts with clinicians across the nation confirm what anecdotes in legal[20] and journalistic[21] publications strongly suggest: actual reporting on and decision-making about inpatients' sexual behavior often depends on the tastes and whims of ward staff and is influenced by a variety of emotional, moral, and practical issues that have not been discussed in professional publications. Many commentators have recommended the use of written policies to address inpatient sex.[4] However, these policies may have unintended effects: if they are too complicated, ward staff ignore them; if they impose odious paperwork burdens, ward staff will ignore sexual behavior or tell patients to engage in it elsewhere.

The Impact of AIDS Clinicians' worries about sexual interaction reflect their worries about outcomes. Articles written when psychopathology was understood dynamically, when lengths of

*Personal communication, J. William McIntosh, May 11, 1994.

hospitalization were longer, and before the advent of AIDS express concern about undesired pregnancies, transmission of venereal disease, and whether sexual activity might be "therapeutic," an "acting out" of conflicts or transference issues, or an exhibition of the pathology that led to hospitalization.[5, 6, 22]

Recent publications on inpatient sexuality reflect the current trend toward ever briefer hospitalizations for stabilization of biomedically conceptualized disorders and changes in the medicolegal milieu surrounding psychiatric hospitalization. But an even more important factor dictating how psychiatrists currently think about inpatient sex is the recognition that psychiatric inpatients may have high rates of HIV seropositivity[23–25] and may engage disproportionately in AIDS-risk behavior.[26–29] Although the risk of transmitting HIV in any single act of needle sharing or intercourse with an infected individual is less than one percent,[30] the cumulative risk of transmission quickly rises if such behavior occurs repeatedly.[31] Recent articles about inpatient sexuality thus focus on assessment of patients' objectively verifiable mental states, their competence and appreciation of the risks associated with their actions, their need for protection from consequences of their own and other patients' behavior, their right to control their circumstances, their need for protection, and their right to have their HIV status remain confidential.[8, 13, 32]

By itself, however, making sure that patients are competent and informed does not address the contextual issues that affect patients' behavior and decision-making, or the day-to-day dilemmas posed for clinicians by patients' sexual behavior. Because of concerns about stealing from and mistreatment of copatients, most hospital wards have rules about patients' entering each others' rooms. Because they lack more dignified, private settings for sexual activity, patients have intercourse in bathroom stalls and stairwells. What appears to be consensual sex between competent patients may actually be sex in exchange for cigarettes or sex in response to a threat. One clinician told us of an incident in which the discovery of a sexually transmitted disease in one patient led to the need to screen 10 other inpatient contacts of the index patient. Hospital policies that allow condom distribution appear prudent, but what should a nurse say when a patient asks for a condom and names the prospective sex partner, and the nurse knows the partner is HIV-positive?

Related to this last issue are the official guidelines of the American Psychiatric Association (APA) concerning AIDS on inpatient units.[33] Those guidelines deem inpatient sex *per se* to be high-risk behavior. Noting that many inpatients "may be particularly vulnerable to unwanted sexual advances or cannot make free and informed choices regarding sexual activity," the guidelines urge psychiatrists to:

> develop strategies for safeguarding patients while they are in the hospital ... Adequate supervision must be available to ensure that all patients, regardless of serologic status, are not able to engage in behavior likely to transmit HIV in the inpatient setting. If a patient engages, or threatens to engage, in behavior that places other individuals at risk for HIV infection, the responsible physician should assure

that appropriate steps are taken to control the behavior and, if necessary, isolate and/or restrain the patient (p. 853).[32]

Potential Liability Resulting from Inpatients' Sexual Behavior

Concern about liability for HIV transmission figures prominently in clinicians' thoughts about sex among inpatients. If the APA's position about appropriate hospital practice is correct, then an instance of HIV transmission caused by inpatient sexual activity might generate a lawsuit claiming negligent supervision. Of course, HIV transmission is not the only potential reason for litigation related to inpatient sexual activity, and in fact HIV-related issues have not figured in most cases to date concerning sex between patients. Moreover, the limited and ambiguous case law in this area makes it difficult to know whether any suit would actually result in payment of damages. In this section, we describe some of the scholarly writings and case law that might affect the outcome of litigation arising from inpatients' sexual activity.

HIV Transmission Many commentators have staked out positions concerning ethical obligations and potential for liability in situations where HIV-positive psychiatric patients were either unable or unwilling to cease risky behavior or inform sexual contacts about their HIV status.[31, 34, 35] Psychiatrists have three main sources of guidance in anticipating and dealing with the liability risks associated with potential HIV infection: professional ethical guidelines, statutes, and case law.

Ethical Guidelines The APA has revised its AIDS policies over the past decade to reflect psychiatrists' experience in treating patients with HIV, knowledge about patients' high rates of risk behavior and seropositivity,[24, 26] treatment advances, and changing views about the balance between patient confidentiality and the well-being of third parties. The 1993 APA guidelines permit psychiatrists to notify patients' sexual contacts (either directly or through public health authorities) of their risk for infection, but third-party notification should be a "last resort" option reserved for cases in which seropositive patients will not cease risk-creating behavior or inform contacts themselves. Psychiatrists may protect third parties through the use of involuntary hospitalization, but this is applicable only for those patients who have a mental illness and who need hospital treatment.[32]

Under the APA guidelines,[33] counseling about HIV risk reduction should be a regular feature of inpatient care, both to protect patients in the hospital and to prepare patients to protect themselves after discharge. Hospital clinicians should respond to behavior that could cause HIV transmission with verbal interventions and medication, and if these measures fail, by secluding and/or restraining patients.[33] Not all psychiatrists approve of these guidelines. Those who do believe that the APA policy sets out a sensible approach that limits breaches of confidentiality while allowing psychiatrists to fulfill their overriding duty to protect third parties.[34, 36] The APA has established separate guidelines concerning HIV infection in children and adolescents.[37]

Other organizations have taken different positions on the balance between clinicians' confidentiality obligations and the duty to warn. The American Medical Association's Council on Ethical and Judicial Affairs feels that when patients will not stop HIV-risk behavior and public health authorities will not take protective action, a physician should inform a vulnerable third party.[38] The American College of Physicians and the Infectious Disease Society of America have merely urged that clinicians respect the confidentiality of HIV-infected patients "to the greatest extent possible, consistent with the duty to protect others."[39] The American Bar Association's (ABA) Model Policy stresses that clinicians who warn third parties face potential legal liability for breaching confidentiality; the ABA suggests that when infected patients will not inform contacts or cease risky behavior, caregivers should obtain legal advice or a judicial ruling before notifying a vulnerable third party.[40]

Some writers assert that there are no circumstances under which clinicians should disclose HIV status to a third party. These commentators emphasize that disclosing a patient's seropositivity can have devastating emotional and social consequences. They also believe that failure to assure absolute confidentiality may promote the spread of HIV by deterring infected individuals from getting tested and from discussing their status or behavior with caregivers.[30, 35]

Statutes The previously cited policies all recognize that clinicians must adhere to applicable laws in their jurisdictions. Laws in several states address physicians' duty to warn third parties about possible risk of HIV infection, and these laws supersede any common law principles concerning liability.[41] In all states, physicians must report AIDS cases to public health authorities, but most states do not require physicians to report the test results of persons who are HIV-positive but do not have AIDS.[42] In no state is a physician *required* to notify contacts of HIV-positive persons. However, several states allow such notification[41] and grant physicians immunity from liability whether or not they decide to inform third parties.[42] In some states the physician will satisfy the duty to protect by reporting HIV-seropositive patients to the health department, which bears the burden of notifying contacts.[41, 42] State statutes vary greatly in how they define the circumstances that require warnings and the persons who should or may be warned. States variously allow warnings to spouses, current sexual partners, past sexual partners, needle-sharing partners, jail or prison personnel, emergency medical personnel, persons who handle corpses, and guardians. In some states, clinicians may warn a third party only with the patient's consent.[36, 41, 42] Physicians therefore should consider the limitations or responsibilities imposed by their jurisdictions' statutes when deciding whether to warn a third party.[41]

Case Law Recently, a Wisconsin jury awarded $420,000 to a woman who was raped by a patient with AIDS while she was staying at a Minneapolis psychiatric hospital, despite the fact that she still tested HIV-negative three years later.[43] To date, however, no U.S. court has yet

ruled on whether a psychiatrist could be liable for HIV transmission following *consensual* sex between an inpatient and a third party. Should a case ever raise this issue, several existing precedents may influence the outcome.

The *Tarasoff* court[44] based its finding of a duty to protect on laws that require physicians to report contagious diseases and on decades-old cases concerning physician liability for transmission of infections such as smallpox and typhoid fever to third parties.[45] The standard interpretation of these cases is that they establish a physician's duty to protect by warning family members or close contacts about the risk posed by an infectious person.[46]

At least three decisions reached after *Tarasoff* have held physicians liable for third-party injuries caused by infectious disease transmission:

- A 1976 Florida court held that a man who shared a hospital room with a surgeon's infected patient could sue the surgeon for damages that resulted from failing to take necessary infection control precautions.[47]
- In a 1990 decision,[48] the Pennsylvania Supreme Court found that a man who contracted hepatitis could sue his female sexual partner's physicians for failing to give proper advice. The woman, a phlebotomist, stuck herself with a needle from a hepatitis patient. Her physicians erroneously advised her that if she did not contract hepatitis in six weeks, she was not infected. Acting on this information, she refrained from sexual relations for eight weeks. She developed hepatitis B three months after the needle stick, and three months later, her partner was also diagnosed with hepatitis B.
- Finally, a January 1995 California intermediate appellate ruling[49] directly addressed a doctor's duty to a third party who contracts HIV through consensual intercourse. The day after performing an operation at the UCLA Medical Center, a surgeon learned that his 12-year-old patient, Jennifer Lawson, had received HIV-tainted blood. No one told the girl or her parents. Three years later, the girl began dating and became intimate with Daniel Reisner. Two years after this, Lawson was diagnosed with AIDS; she told Reisner, who then found that he was HIV-positive. Reisner sued Lawson's surgeon and associated defendants, who attempted to have the suit dismissed by arguing that they did not know Reisner and owed no duty toward him. Relying heavily on *Tarasoff* and the above-cited Pennsylvania decision, the court ruled that the caregivers could be liable for Reisner's injury. The breach of duty consisted in the defendants' failure to issue a warning to the Lawson and/or her parents. "Once the physician warns the patient of the risk to others and advises the patient how to prevent the spread of the disease, the physician has fulfilled his duty—and *no more (but no less) is required*" (p. 1203, emphasis added).

These three cases stemmed from gross failures to perform basic medical tasks—make a diagnosis, inform a patient about a condition, or give accurate medical advice to persons requesting it. The following recent decisions did not involve such blatant errors, and no liability was found:

- A 1984 Colorado decision found that a physician was not liable for hepatitis contracted by babysitters of an infected patient's daughter (who was also infected) because the doctor was not aware of the specific risk to the sitters.[50]
- In 1986, a New York court ruled that a nurse who contracted scabies from a hospitalized patient and transmitted it to her husband and children could not sue because the hospital did not have a duty to warn the public about the exposure.[51]
- In 1990, an Illinois court found no physician liability in a case in which a doctor failed to diagnose a man's tuberculosis and the man transmitted the infection to his ex-wife and children, because Illinois does not recognize the duty to warn family members.[52]
- Another 1990 Illinois case held that a nurse who contracted tuberculosis from an infected patient did not have a cause for malpractice action against the patient's doctor, because Illinois recognizes physician duties to a nonpatient third party only when negligence toward a patient would necessarily result in injury to the third party.[53]

Extrapolating from these precedents to cases involving HIV transmission by hospitalized mental patients is tricky. No case in which physicians were found potentially or actually liable established a duty to control the patient or take other action to protect a third party; courts presumed that if the patients had received correct information, they would have behaved responsibly. Yet it would be a mistake to conclude that psychiatrists will avoid liability for HIV transmission to third parties simply by giving patients accurate information about the diagnosis and its implications. Courts may decide that psychiatrists have heightened obligations to protect third parties because of their patients' presumed impairments. Rightly or wrongly, courts (and the public) often have taken a distinct view of psychiatric patients and their caregivers' responsibilities. Courts have often ruled as though mental illnesses globally impair understanding and judgment, and they have held that in agreeing to work with mental patients, psychiatric caregivers assume a duty to control those individuals (who are not themselves responsible). The APA's HIV guidelines implicitly endorse this view when they acknowledge the vulnerability of many inpatients and sanction physical restraint to prevent HIV transmission where other measures fail.[33]

Liability for Other Consequences of Inpatients' Sexual Behavior. *Sexual Assaults in Hospitals* In several instances, psychiatrists have been sued because of sexual assaults committed in hospitals. The result is a collection of mixed and even conflicting opinions. Some examples follow.

Decisions favoring plaintiffs

- A woman sued the Ohio Department of Mental Health (ODMH) for exacerbation of her mental condition after she was raped by fellow inpatient Michael Preston.[54] Preston, who occupied the same hospital ward as the victim, had sexually assaulted a nurse at another hospital, and ODMH treatment "records indicated that he was excitable and violent" (p. 136). The court said that "it was foreseeable that Preston would attack and rape not only patients but members of the staff," (p. 137) and that ODMH "knew it was assigning the plaintiff to a place of danger" (p. 137). Although Preston was convicted for the assault, which implies that he was responsible for the act, the court said "that Preston's presence on the same ward . . . presented a dangerous condition and, thus, constituted negligence and the proximate cause of plaintiff's rape and injury" (p. 137).
- A female inpatient who was sexually assaulted by male inpatient tried to sue the hospital where she had stayed. A trial court dismissed her suit based on its interpretation of Colorado law, which immunizes mental health professionals from *Tarasoff*-type liability unless a patient makes a specific threat against a specific person. However, an appeals court overturned the lower court's dismissal because the woman alleged that the treatment staff knew of the assailant's "dangerous proclivities and his prior aggressive behavior toward" the victim (p. 234).[55] The appeals court held that such findings, if true, would constitute specific communication of a threat.
- A profoundly retarded patient brought a Section 1983 action (i.e., a lawsuit alleging a violation of constitutional rights while the defendant acted under color of state law) against hospital employees (including his primary physician) after an unidentified assailant sexually abused him twice in a 12-day period.[56] The defendants asked that the case be dismissed. Although the court believed that a single incident might have been an "isolated mishap," it found that the hospital's failure to institute—or even consider—additional protections before the second incident amounted to "deliberate indifference," and was therefore potentially actionable.
- During psychoanalytic treatment, a psychiatry resident had said he was a pedophile. The analyst, who also was a residency faculty member, knew that the resident planned to specialize in child psychiatry. Later, when a boy and his parents alleged that the resident sexually assaulted the boy while he was hospitalized, they sued (among others) the psychiatry resident's analyst. The analyst sought dismissal of the suit against him, but the court concluded that the analyst's faculty status gave him "official control or authority over" the resident (a condition for vicarious liability), and that the boy had

grounds to sue (p. 40).[57] The analyst could have redirected the resident's career without compromising confidentiality, said the court; "a self-confessed pedophiliac who intends to practice child psychiatry presents a foreseeable risk of harm to future minor patients" (p. 41).

Decisions finding no psychiatrist liability

- A woman who alleged that a male patient had attacked, kissed, and fondled her brought a Section 1983 action against Colorado state hospital officials. Both patients were fully clothed. The district court dismissed the suit, finding that the man's act was not an unconstitutional deprivation of rights because it had been an isolated incident.[58]
- A Pennsylvania woman was hospitalized for an acute exacerbation of schizophrenia but was judged not to need special observation. On her third hospital day, she said that another patient had raped her on the day of admission. Her condition worsened and required antipsychotic medication; later, she underwent a therapeutic abortion because of concern about possible effects of the medication. Her suit for negligent supervision resulted in a trial court verdict for the hospital, which the appellate court and State Supreme Court affirmed: state law required that patients receive the "least restrictive" treatment, and the decision not to order special observation conformed to this requirement and was therefore immune from suit.[59]
- A psychiatrist who provided consultative care to a plastic surgery patient was sued after the patient attempted to sexually assault a hospital staff member. California statutory law[60] (passed after *Tarasoff*) immunizes psychotherapists from liability for patients' violent behavior unless a patient has communicated a specific threat of physical violence toward a specific third party. Before the attempted assault, the patient had followed, grabbed, and tried to fondle nurses on the floor where he was hospitalized. However, the court said that this behavior did not constitute a "serious threat" of violence; the psychiatrist was therefore immune from liability.[61]
- An inpatient alleged that another inpatient raped her. She sued several hospital staff members, including her psychiatrist, claiming violation of her civil rights and negligence supervision. The court dismissed the claim against the psychiatrist, who did not train of supervise the staff who were supposed to be monitoring patients. But because previous incidents at the hospital had potentially put staff supervisors "on notice" about problems with patient supervision, the patient was allowed to go forward with her civil rights action against those persons.[62]

Consensual Sex in a Hospital Just one case, *Foy v. Greenblott*,[63] has dealt with alleged damages stemming from

consensual intercourse between hospitalized patients. Virgie Foy and her son alleged that the boy's "wrongful birth" resulted from negligence in controlling her behavior and sued her guardian, her physicians, and the mental health facility where she had resided. A California appeals court held that a hospital need not prevent a patient from procreating simply because of the patient's incompetence, and that not preventing the voluntary act of intercourse that led to the boy's birth was not grounds for a suit. If Foy could show she would have made use of reproductive counseling and contraceptives, then failure to make such assistance available to her might be actionable. The court noted, however, that case law and statutes have established a policy preference for maximizing reproductive choice and patient autonomy. "The threat of liability for insufficient vigilance in policing patients' sexual conduct . . . would effectively reverse these incentives and encourage mental hospitals to accord mental patients only their minimum legal rights" (pp. 91, 92).

Discussion

The traditional professional recommendation for dealing with inpatient sex has been simply to discourage it.[9] Although psychiatrists may have good reasons to insist on abstinence, inpatients still engage in sexual activity, sometimes surreptitiously, and sometimes with full knowledge of line staff. Policies, practices, and treatment planning that do not recognize how inpatients actually behave are unrealistic. When hospital administrators and professionals avoid discussing patients' sexual behavior, they leave ward staff members with little guidance (but much confusion) about how to handle issues arising from sexual interaction. The absence of policies increases the likelihood that staff members will act arbitrarily and randomly in responding to "sexual incidents." Hospital personnel may respond to consensual sexual activity in ways that violate patients' rights to liberty and reasonable interaction, yet fail to investigate or report potentially criminal incidents such as rape and sexual assaults. They also may not develop institutional practices and procedures to reduce sex-related risks.[3]

Protecting and safeguarding persons with impaired decision-making ability are among the primary functions of a psychiatric hospital. However, a patient's ability to consent to sexual interaction is likely to be a key issue is determining a hospital caregiver's legal responsibility for the patient's sexual behavior. What constitutes competence to consent to sexual activity varies across jurisdictions: some courts (in cases dealing with mentally retarded persons) have required only that the participant understand the nature of the activity; in other jurisdictions, participants must understand the nature and factual consequences of the activity; in still other jurisdictions, participants must understand the nature and factual consequences as well as the moral or social significance of the activity.[3]

Although potential sexual activity is just one of many factors to consider in making treatment decisions, a patient's

capacity to consent to appropriate sexual behavior and to refrain from inappropriate sexual behavior should influence plans for supervision and ward placement. Expected length of hospitalization will also influence how clinicians and hospitals accommodate patients' sexual behavior. On a short-stay ward where acutely ill, voluntary and/or involuntary patients are hospitalized for at most a few weeks, it is reasonable to ask patients to refrain from sexual interaction and to design ward policies with this expectation. Such an expectation is consistent with our culture's social expectations about sexual behavior, and clinicians can endorse these expectations even when sexual interaction would pose no health or liability risk.

What caregivers view as appropriate sexual behavior in part reflects social definitions about what is public and private, and about what kinds of sexual expressions our culture defines as belonging to the public or private sphere. Our culture defines certain aspects of sexuality, including those that involve genitalia and ejaculation, as personal and private. Therefore, we believe that respect for patients' dignity justifies intervention by hospital staff when disturbed patients masturbate publicly or engage in indiscriminate sexual interaction with others, even if no one will be harmed by the behavior. Even if the patients are (by whatever criteria the reader chooses) "competent" to engage in such sexual activity, sensible persons would advise and want them to stop anyway, for two related reasons. First, such actions among inpatients probably are indicative of judgment problems that psychiatric treatment should address. Second, patients with impaired judgment need help in understanding that they should not masturbate in public areas and that the hospital is not the place for indiscriminate sex. Ultimately, hospital treatment should (among other things) help patients develop the ability to get their interpersonal needs met in more appropriate circumstances; lack of this ability is a problem deserving clinical attention.

Our culture does not condone persons' having intercourse at the ballpark (even if they are married to each other), and restricting people from doing this does not violate anyone's privacy rights. Persons who live in civil society agree tacitly to constrain their behavior in a variety of public circumstances in order to reap benefits of sharing facilities with their fellow citizens. Of course, hospitals are not public places in the way that ballparks are, and patients in hospitals retain a variety of privacy-related rights.[14] Yet hospitals are more public than individuals' homes, and our expectations about sexual behavior in hospitals should reflect our expectations about appropriate personal restraint in public areas.

Inpatients who engage in sexual interaction may place themselves at risk for contracting HIV, may be charged with crimes, and may be enacting and exacerbating the very sorts of problems that led to admission. It is reasonable to ask inpatients to accept some carefully circumscribed limits on their freedom if doing so will allow them to benefit from treatment in a facility they share with other patients. It is reasonable to expect

patients to follow sensible behavioral guidelines concerning regular bathing, smoking restrictions, ward schedules, expected attendance at activities, use of alcohol and drugs, or sexual interaction. It is reasonable for hospital staff to ask patients (explicitly, if necessary) not to complicate their own difficulties and others' difficulties. It is also reasonable to ask patients to adhere to society's normative expectations concerning the time and place for sexual behavior. It is reasonable, finally, to ask patients to obey general ward rules that reflect reasonable expectations about the well-being and safety needs of all patients, that protect patients who may be incompetent or be harmed by sexual activity (either emotionally or physically), and that allow staff to attend to the job of helping patients deal with the problems that brought them into the hospital.

But it is *not* reasonable to apply the same sets of rules and policies to patients in short-term and long-term facilities (bearing in mind that some "short-term" facilities house patients who sometimes stay for months or years, and that some patients leave "long-term" facilities after a few days). The notion of the hospital as a "public place" applies to facilities where patients come together for relatively brief periods in their lives—at most several weeks—because they cannot tolerate the demands of life at home. Most psychiatric hospitalization nowadays is of this brief sort. In a long-stay setting (e.g., a hospital where patients spend years confined, or a supervised community group living facility to which patients are assigned during lengthy periods of civil commitment), an expectation of sexual abstinence is not reasonable and may not even be desirable. For long-stay patients, the institution becomes their home. One cannot ask them to make the same sacrifices expected of persons undergoing short hospitalizations. Long-term facilities must respond to different needs and conditions to allow patients dwelling there some opportunity for dignified living.

Long-stay psychiatric patients may even have a qualified right to be allowed to engage in sexual interaction. The treatment standards established in *Wyatt v. Stickney*[64] included granting patients "suitable opportunities for . . . interaction with members of the opposite sex" (p. 381). Only four of the states that based their Patients' Bills of Rights on *Wyatt* included this portion of *Wyatt* in their statutes, and no follow-up litigation based on these statutes has interpreted the just-quoted phrase as establishing a right to *sexual* interaction.[65] However, in 1942, the U.S. Supreme Court recognized that individuals have a right to procreate,[66] and more recent cases have recognized individual privacy rights involving reproductive decisions,[67] contraception,[68] marriage,[69] and family relationships.[70]

If the living conditions of long-stay institutionalized patients are governed by the Americans with Disabilities Act,[2] then it is quite possible that the *blanket* prevention of sexual activity may constitute unlawful discrimination. Institutional policies that prohibit sexual activity—where such policies apply simply because

the covered persons are members of the class of "mental patients"—may represent the very sorts of "overprotective rules and policies"[71] that invidiously discriminate against persons with mental disabilities and that are therefore outlawed by the ADA.

Staff who work in long-stay settings should develop policies and procedures that address sexuality and privacy, consistent with applicable local laws concerning consent. To carry out such policies, staff members need training in helping patients handle sexual issues, in recognizing and responding to patients' sexual problems, and in reporting incidents of possible criminal behavior.[3] Institutional policies that address patients' sexual behavior and their capacity to consent to sexual activity provide (at least in theory) some protection against liability. Evidence that a hospital has trained and supervised its staff members can suggest that the hospital has taken steps to make sure that "isolated mishaps" do not evolve into a pattern of neglect. The Appendix to this article provides a model policy concerning inpatient sexuality; an earlier version of this policy was adopted by Board and Care home operators in Santa Clara County, CA.

Despite the recommendations of the previous paragraph, we believe that policies and procedures will not, by themselves, resolve the clinical problems and administrative dilemmas posed by inpatients' sexual interaction. Policies, as we pointed out earlier, can have pitfalls: complicated or burdensome policies may understandably lead staff members to ignore sexual behavior or patients' sexuality; policies promulgated without discussion and training can generate staff resentment and resistance. We believe that policies such as the one contained in the Appendix should serve merely as a starting point for more sensitive clinical responses to a complicated set of perplexing, emotion-laden, commonly encountered, but under-discussed matters. Our model policy is not intended or offered as a solution; rather, we hope that the policy, along with the rest of this article, will help clinicians recognize and respond more thoughtfully to patients' sexual behavior and intimacy needs.

Appendix:
Model Policy Concerning Consensual Sexual Relations Among Long-Term Psychiatric Inpatients

I. Introduction
Human beings have an innate need and desire for emotional and sexual intimacy. This model policy offers psychiatric facilities guidelines to balance the rights and needs of patients with health and safety concerns.

II. General Policies and Standards
- A. Competent patients who reside in intermediate- and long-term care facilities should not be prevented from engaging in consensual sexual relations.
- B. All mental health facilities should offer patients sex education and contraceptive counseling services, and should make contraceptive devices reasonably accessible to their patients.

III. Admission and Screening
Upon admission, all patients will:
- A. Be interviewed and assessed to learn about their sexual history and whether they have been exposed to any sexually transmitted diseases (STDs), including infection with HIV.
- B. Receive a written copy of this policy, and this policy will also be explained

verbally to each patient. Each patient's chart will contain documentation showing that this information was given and whether the patient appeared to understand the policy.

C. Receive written information explaining safe sex practices. This information will also be explained verbally to each patient. Each patient's chart will contain documentation showing that this information was given and whether the patient appeared to understand the policy.

IV. Ability to Consent

A. Lacking information to the contrary, patients will be assumed to be able to consent to consensual sexual interaction.

B. If it appears that a patient does not understand the facility's sex policy or information on safe sex practices, members of the patient's treatment team should assess the patient to find out whether the patient can consent to sexual relations.

1. If the patient is found able to consent, the patient will not be prevented from engaging in appropriate consensual sexual activity.
2. If the patient is deemed unable to consent, the patient may be denied the right to consensual sexual relations.
   a. This will not necessarily prevent the patient from engaging in other consensual physical interaction, such as hugging or kissing.
   b. The patient's capacity will be reviewed by the treatment team each month throughout the patient's stay at the facility. If the patient later becomes able to consent, he or she will no longer be prevented from engaging in appropriate and consensual sexual relations.
   c. A patient has the right, after a determination of inability to consent, to request a review of this decision by the medical/program director or the director's designee. The patient may seek the assistance of a patients' rights advocate in preparing for and presenting evidence at the review.

V. Sex Education and Contraceptive Counseling

A. All patients will have the opportunity to participate in sex education. Such education should include instruction regarding: sexuality and relationships (including sexual preference); personal body awareness (including pregnancy and contraception, prevention of sexually transmitted diseases including AIDS, and safe sex practices); awareness of and respect for others people's feelings.

B. All patients will be offered individual contraceptive counseling to learn which type of contraceptive is desirable and appropriate. Medical examinations will also be offered depending upon the contraception used.

C. Contraceptive devices will be made readily available to all patients who can give informed consent and wish to engage in sexual relations.

VI. Masturbation

Patients may masturbate at appropriate times and places if they do so privately and if their behavior does not infringe upon the rights of others.

VII. Consensual Sexual Relations

A. Privacy

Patients who engage in consensual sexual interaction have the right to have such relations in a private setting. Staff will work with patients to help them find a private setting for sexual relations without compromising the rights of others. Staff will help patients to work with their roommates to arrange time for patients to use the room privately.

B. Dignity

Staff members will:

1. Provide a dignified setting for patients to engage in sexual relations.
2. Treat all patients expressing a desire for sexual interaction with respect and dignity.
3. Discuss any issues regarding the patient's decision to have sex and any questions openly and frankly.

4. Not act in manner causing the patient to feel ashamed, embarrassed, or intimidated for wanting to have sex or for having questions or concerns regarding sexual interaction.

C. Flexibility
Staff members should be flexible in allowing patients to engage in consensual sexual relations. Staff may require that such activity not interfere with groups and other facility activities. However, patients should have a reasonable amount of time for sexual relations and should be allowed to engage in such activity at various times of the day.

D. Confidentiality
All information regarding a patient's sexual activity will remain confidential unless there is justification to release this information. Release of such information may occur only to protect the patient or others.

E. Counseling regarding emotional issues resulting from sexual relationships should be available to all patients.

VIII. HIV and AIDS

A. Patients who are or who may become sexually active should receive education about HIV transmission, infection avoidance, and safe sex techniques.

B. Patients should be encouraged to use condoms to avoid HIV exposure and other sexually transmitted diseases. Condoms should be readily available to patients, at several locations throughout the facility. Patients should be able to obtain condoms without having to speak to staff members.

C. Staff members should periodically inform and remind patients that they may elect to receive HIV testing to learn their HIV status so that they may receive prompt medical treatment and care when necessary. Staff members will comply with state confidentiality laws concerning revelation of patients' HIV status.

D. Patients who are HIV-positive or who are diagnosed with AIDS will be treated with dignity, respect, and compassion.

IX. Sexual Assault

A. All allegations of sexual assault will be immediately reported to the medical/program director and to any other appropriate authorities pursuant to state statutory and regulatory law.

B. All allegations of sexual assault will be investigated by medical/program director or designee.

C. Staff members will provide or arrange for any necessary medical treatment and counseling to an alleged victim of sexual assault. Additionally, staff will insure that the patient remains safe and segregated from the alleged perpetrator of the assault until a final disposition regarding the alleged assault is made.

X. Restriction of Sexual Interaction

A. Patients may be restricted from engaging in sexual activities when such activities create a present danger or substantial risk to the patient or others, or they infringe upon the rights of others.

B. The following are examples of instances in which restricting a patient is appropriate.

1. The patient has inappropriately touched or has sexually assaulted another individual.
2. The patient is engaging in sex in exchange for cigarettes, money, or other valuables.
3. The patient is engaging in sexual relations resulting from coercion or duress.
4. The patient has engaged in sexual behavior that infringed upon the rights of others.

C. If a patient's sexual interaction is restricted, the following steps will be taken.

1. Staff will tell the patient the specific reason for the restriction.
2. The restriction will be documented in the chart. Documentation should include the date and time the restriction was implemented, the reason for the restriction, and a signed physician's order.
3. The treatment plan will be amended to address the problem.
4. The patient's ability appropriately to engage in consensual sexual interaction will be assessed weekly after

that to decide whether continuing the restriction is necessary.

5. When the restriction is no longer necessary, the patient will be permitted to engage in consensual sexual interaction.

XI. Staff Training

Staff members will receive training in the following subject areas to insure that patients' rights to privacy and social interaction are not violated and that the safety and health of all patients are protected:

A. Screening procedures;
B. Acceptance of patients' emotional and sexual needs and wants;
C. Instruction on providing sex education and contraceptive counseling;
D. Dealing with sexual assault;
E. Restriction of sexual interaction.

References

1. Sadoff RL: Liability issues, in Sex in Hospitals: Do Patients Have a Right to . . .? Symposium chaired by Mossman D and presented at the Annual Meeting of the American Psychiatric Association, Philadelphia, PA, May 23, 1994
2. Americans with Disabilities Act, 42 U.S.C. §12101 et seq. (1994)
3. Sundram CJ, Stavis PF: Sexual behavior and mental retardation. Ment Phys Disabil Law Rep 17:448–57, 1993
4. Keitner GI, Baldwin LM, McKendall MJ: Copatient relationships on a short-term psychiatric unit. Hosp Community Psychiatry 37:166–70, 1986
5. Akhtar S, Crocker E, Dickey N, Helfrich J, Rheuban WJ: Overt sexual behavior among psychiatric inpatients. Dis Nerv Syst 38:359–61, 1977
6. Morgan R, Rogers J: Some results of the policy of integrating men and women in a mental hospital. Soc Psychiatry 6:113–16, 1971
7. Trudel G, Desjardins G: Sexualité en milieu psychiatrique. Can J Psychiatry 39:421–8, 1994
8. Zonana H, Norko M, Stier D: The AIDS patient on the psychiatric unit: ethical and legal issues. Psychiatr Ann 18:587–93, 1988
9. Binder RL: Sex between psychiatric inpatients. Psychiatr Q 57:121–6, 1986
10. Keitner G, Grof P: Sexual and emotional intimacy between psychiatric inpatients: formulating a policy. Hosp Community Psychiatry 32:188–93, 1981
11. Welch S, Meagher J, Soos J, Bhopal J: Sexual behavior of hospitalized chronic psychiatric patients. Hosp Community Psychiatry 42: 855–6, 1991
12. Wasow M: Sexuality and the institutionalized mentally ill. Sex Disabil 3:3–16, 1980
13. Lichtenberg PA, Strzepek DM: Assessments of institutionalized dementia patients' competencies to participate in intimate relationships. Gerontologist 30:117–20, 1990
14. Perlin ML: Hospitalized patients and the right to sexual interaction: beyond the last frontier? NYU Rev L & Soc Change 20:302–27, 1993–94
15. Commons ML, Bohn JT, Godon LT, Hauser MJ, Gutheil TG: Professionals' attitudes towards sex between institutionalized patients. Am J Psychother 46:571–80, 1992
16. Ohio Rev. Code Ann. §2907.03 (Anderson 1993)
17. Ohio Rev. Code Ann. §2907.06 (Anderson 1993)
18. Ohio Rev. Code Ann. §2923.01 (Anderson 1993)

18a. Bowers v. Hardwick, 478 U.S. 186 (1986)

19. Holbrook T: Policing sexuality in a modern state hospital. Hosp Community Psychiatry 40:75–9, 1989
20. Rogers v. Okin, 478 F. Supp. 1342 (D. Mass. 1979) aff'd in part, rev'd in part, 634 F.2d 650 (1st Cir. 1980), vacated *sub nom* Mills v. Rogers, 457 U.S. 291 (1982)
21. Sheehan S: Is There No Place on Earth for Me? New York: Vintage Books, 1982
22. Hartocollis P: Hospital romances: some vicissitudes of transference. Bull Menninger Clin 28:62–71, 1964
23. Empfield M, Cournos F, Meyer I, *et al*: HIV seroprevalence among homeless patients admitted to a psychiatric inpatient unit. Am J Psychiatry 150:47–52, 1993
24. Sacks M, Dermatis H, Looser-Ott S, Perry S: Seroprevalence of HIV and risk factors for AIDS in psychiatric inpatients. Hosp Community Psychiatry 43:736–7, 1992
25. Cournos F, Empfield M, Horwath E, *et al*: HIV seroprevalence among patient admitted to two psychiatric hospitals. Am J Psychiatry 148:1225–30, 1991
26. Cournos F, Guido JR, Coomaraswamy S, Meyer-Bahlburg H, Sugden R, Horwath E:

Sexual activity and risk of HIV infection among patients with schizophrenia. Am J Psychiatry 151:228–32, 1994
27. Kelly JA, Murphy DA, Bahr GR, *et al*: AIDS/HIV risk behavior among the chronic mentally ill. Am J Psychiatry 149:886–9, 1992
28. Baker DG, Mossman D: Potential HIV exposure in psychiatrically hospitalized adolescent girls. Am J Psychiatry 148:528–30, 1991
29. Sacks MH, Perry S, Graver R, Shindledecker R, Hall S: Self-reported HIV-related risk behavior in acute psychiatric inpatients: a pilot study. Hosp Community Psychiatry 41:1253–5, 1990
30. Wiseman M: Hey Doc, can you keep a secret?: an Ohio physician's right to warn third parties that they may be at risk of contracting HIV. J Law Health 6:199–221, 1991–92
31. Simon RI: Clinical Psychiatry and the Law (ed 2). Washington, DC: American Psychiatric Press, 1992
32. American Psychiatric Association Commission on AIDS: AIDS policy: Position statement of confidentiality, disclosure, and protection of others. Am J Psychiatry 150:852, 1993
33. American Psychiatric Association Commission on AIDS: AIDS policy: guidelines for inpatient psychiatric units. Am J Psychiatry 150:853, 1993
34. Zonana H: Warning third parties at risk of AIDS: APA's policy is a reasonable approach. Hosp Community Psychiatry 40:162–4, 1989
35. Perry S: Warning third parties at risk of AIDS: APA's policy is a barrier to treatment. Hosp Community Psychiatry 40:158–61, 1989
36. Appelbaum K, Appelbaum PS: The HIV antibody-positive patient, in Confidentiality Versus the Duty to Protect: Foreseeable Harm in the Practice of Psychiatry. Edited by Beck JC. Washington, DC: American Psychiatric Press, 1990, pp 121–40
37. Commission on AIDS: position statement on HIV infection and psychiatric hospitalization of children and adolescents. Am J Psychiatry 151:631, 1994
38. Council on Ethical and Judicial Affairs: ethical issues involved in the growing AIDS crisis. JAMA 259:1360–1, 1988
39. American College of Physicians Health and Public Policy Committee, Infectious Diseases Society of America: The acquired immunodeficiency syndrome (AIDS) and infection with the human immunodeficiency virus (HIV). Ann Intern Med 108:460–9, 1988
40. Rennert S: AIDS/HIV and confidentiality: model policy and procedures. 39 Kansas L Rev 653 (1991)
41. Taub S: Doctors, AIDS, and confidentiality in the 1990s. 27 John Marshall L Rev 331 (1994)
42. Hermann DHJ, Gagliano RD: AIDS, therapeutic confidentiality, and warning third parties. 48 Md. L Rev 55 (1989)
43. Hospital held liable in patient's rape. Washington Post. February 2, 1997, A25
44. Tarasoff v. Regents of Univ. of California, 108 Cal. Rptr. 878 (Cal. Ct. App. 1973), rev'd, 529 P.2d 553 (Cal. 1974), modified, 551 P.2d 334 (Cal. 1976)
45. Mossman D: Potential liability for patients' sexual behavior. Psychiatr Malpract Risk Management, in press
46. Tracy A Bateman, Annotation, Liability of doctor or other health practitioner to third party contracting contagious disease from doctor's patient. 3 A.L.R. 5th 370 (1992)
47. Gill v. Hartford Accident & Indem. Co., 337 So.2d 420 (Fla. Ct. App. 1976)
48. DiMarco v. Lynch Homes-Chester County, Inc., 583 A.2d 422 (Pa. 1990)
49. Reisner v. Regents of Univ. of California, 37 Cal.Rptr.2d 518 (Cal. Ct. App. 1995)
50. Gammill v. United States, 727 F.2d 950 (10th Cir. 1984)
51. Knier v. Albany Med. Ctr. Hosp., 500 N.Y.S.2d 490 (N.Y. Sup. Ct. 1986)
52. Britton v. Soltes, 563 N.E.2d 910 (Ill. Ct. App. 1990)
53. Heigert v. Riedel, 565 N.E.2d 60 (Ill. Ct. App. 1990)
54. Knoll v. Ohio Dep't of Mental Health, 577 N.E.2d 135 (Ohio Ct.Cl. 1987)
55. Halverson v. Pikes Peak Family Counseling & Mental Health Ctr., Inc., 795 P.2d 1352 (Colo. Ct. App. 1990)
56. Shaw v. Strackhouse, 920 F.2d 1135 (3d Cir. 1990)
57. Almonte v. New York Medical College, 851 F. Supp 34 (D. Conn. 1994)
58. Knight v. Colorado, 496 F. Supp. 779 (D. Colo. 1980)
59. Farago v. Sacred Heart Gen. Hosp., 562 A.2d 300 (Pa. 1989)
60. Cal. Civil Code §43.92 (West Supp. 1986)
61. Barry v. Turek, 267 Cal. Rptr. 553 (Cal. Ct. App. 1990)
62. Rogers v. Alabama Dep't of Mental Health, 825 F. Supp. 986 (M.D. Ala. 1993)
63. Foy v. Greenblott, 190 Cal. Rptr. 84 (Cal. Ct. App. 1983)
64. Wyatt v. Stickney, 344 F. Supp. 373 (M.D. Ala. 1972)

65. Perlin ML: "Make promises by the hour": sex, drugs, the ADA, and psychiatric hospitalization. 46 DePaul L Rev 947 (1997)
66. Skinner v. Oklahoma ex rel Williamson, 316 U.S. 535 (1942)
67. Roe v. Wade, 410 U.S. 113, 152 (1973)
68. Griswold v. Connecticut, 381 U.S. 479, 485 (1965)
69. Loving v. Virginia, 388 U.S. 1, 12 (1967)
70. Moore v. City of East Cleveland, 431 U.S. 494, 503 (1977)
71. 42 U.S.C. §12101(a)(5)