Legal and Ethics Considerations in Reporting Sexual Exploitation by Previous Providers

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When a patient reports a sexual relationship with a prior provider during treatment, a psychiatrist or therapist must balance conflicting ethics principles of autonomy, confidentiality, and social justice in deciding whether to report this behavior to the proper authority. Many states have statutes regarding such reporting that are unclear or ambiguous; others lack laws entirely. We surveyed state laws and contacted state medical boards to clarify each state's position on mandatory reporting of sexually exploitive psychiatrists, specifically when the patient reveals the exploitation during treatment. Our results showed that only 5 state legislatures have explicitly addressed this matter. Of the remaining states, 18 require reporting through a patchwork of laws and policies, and the other 27 states and the District of Columbia have no laws that require reporting a colleague if a patient discloses a past sexual relationship. In this article, we examine the different approaches and considerations taken by state legislatures and medical boards in addressing this concern.

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The canons of medical ethics have restricted sexual conduct between a physician and a patient since ancient times. The Hippocratic oath states: "Into whatever homes I go, I will enter them for the benefit of the sick, avoiding any voluntary act of impropriety or corruption, including the seduction of women or men, whether they are free or slaves" (Ref. 1, para. 9).

The American Medical Association (AMA) considers a sexual relationship between a treating physician and a patient to be unethical, regardless of specialty.[2] The American Psychiatric Association (APA), American Psychological Association, and National Association of Social Workers view therapist–client sexual relationships as inappropriate.[3,4,5] While the AMA does not fully prohibit physicians from romantic relationships with former patients, the APA guidelines on medical ethics explicitly state "sexual activity with a current or former patient is unethical" (Ref. 3, section 2.1).

The same guidelines also require that psychiatrists maintain the confidences and protect the privacy of their patients. Furthermore, psychiatrists are expected to report others in the profession who are "deficient in character" (Ref. 3, section 2). Thus, a psychiatrist has a clear conflict when a patient discloses a sexual relationship with a past treatment provider. Although confidentiality is "essential to psychiatric treatment," (Ref. 3, section 4.1), these sexual relationships are unethical and potentially dangerous, with research showing detrimental outcomes for patients, sometimes compared with the effects of incest and rape.[6]

Sexual relationships between psychiatrists and patients are neither a new phenomenon nor particularly rare. It is difficult to provide an accurate estimation of the frequency of sexual violations because the data

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come from imperfect sources, i.e., self-reports or cases reported to authorities.[7] In a national survey of psychiatrists in 1987, 7.1 percent of male and 3.1 percent of female providers acknowledged sexual contact with at least one of their own patients during their careers. Just as concerning, 33 percent of those psychiatrists admitted to sexual relationships with multiple patients.[8] In another study, 80 percent of psychologists who had intimate relationships with patients reported encounters with multiple patients.[9] When pooling the data from multiple studies of the prevalence of sexual relationships between all types of psychotherapists (psychologists, social workers, and psychiatrists), 7 percent of male providers and 1.5 percent of female providers have had sex with at least one patient.[10]

The literature on rates of psychiatrist–patient sexual interactions mostly predates 2000. We could find no recent large-scale surveys on the topic, but data exist for all physicians. A review showed that 7.1 percent of all sanctions issued from 1994 to 2002 by the Federation of State Medical Boards were for sexual misconduct.[11] In a 2014 review, 11 percent of cases for disciplinary review by the AMA Council on Ethical and Judicial Affairs involved sexual boundary violations.[12] The Atlanta Journal-Constitution reviewed public records, from 1999 to 2015, from every state and found more than 2,400 physicians publicly sanctioned by medical boards for sexual misconduct.[13] In a study of physicians from all specialties referred to a physician health program from 1986 to 2005, 14 percent had sexual intercourse with a former patient, and 11 percent had sexual intercourse with a current patient. Of those, 10 percent committed further sexual boundary violations, and this was likely an underestimate.[14] Although these studies are not specific to psychiatrists, there are no data to suggest the frequency of offending or reoffending for psychiatrists would prove different.

A review of the literature suggests that a sexual relationship between a mental health provider and a patient brings significant risks to the patient. In one study, treating psychologists estimated that harm occurred in up to 95 percent of victims of psychotherapist sexual exploitation. In this study, 11 percent of victims required hospitalization due to the intimate relationship, 14 percent attempted suicide, and 1 percent completed suicide. Only 17 percent of patients eventually achieved complete recovery.[15] In another study of psychiatrists who had treated such patients, 87 percent of respondents felt prior sexual exploitation had been harmful.[16]

Some states offer civil, criminal, and injunctive relief to deter this misconduct, but data regarding efficacy are scarce.[17] Legal sanctions, however, can only be effective if the offense is reported.

Fifty percent of psychologists,[15] 17 percent of social workers,[18] and 65 percent of psychiatrists[16] have reported treating at least one patient who has had a prior sexual relationship with a psychotherapist. The data suggest that, in a long career of practicing, many therapists and psychiatrists will be faced with a patient who reports a prior sexual relationship with a previous provider, and the dilemma of reporting colleagues for sexual exploitation of a patient is likely to arise. Mental health professions face competing interests. Is it a provider's duty to protect the autonomy and confidentiality of an individual patient or to report the unethical behavior of another provider to protect other patients and further the social good?

Since the 1970s, following the California Supreme Court decision in *Tarasoff v. Regents* (1976),[19] many jurisdictions have recognized the right, and even obligation, of providers to breach confidentiality to warn or protect specific third parties who face imminent danger. In *Volk v. DeMeerleer* (2016),[20] the Washington Supreme Court expanded that duty to unnamed potential victims. The dilemma of ethics (for obligated reporters) is that the potential future victims are unidentified and might never exist, while the harm is likely to occur over a longer period of time.

In 2006, the Sexual Boundaries Work-Group of the Federation of State Medical Boards released general guidelines for how state boards should address sexual boundary violations, yet offered no recommendations regarding the reporting of such information; this group did, however, recommend medical boards consider calling mental health practitioners for both the accused physician and victimized patient as witnesses who "may provide insight into factors that led to the alleged sexual misconduct, an opinion regarding the level of harm incurred by the patient, and describe the physician's rehabilitative potential and risk for recidivism" (Ref. 21, Section IV). The APA ethics guidelines allow a provider to break patient confidentiality in specific circumstances, stating a provider may release information "under proper legal compulsion" (Ref. 3, Section 4).

Despite such guidelines, a practical problem remains unanswered. Reporting laws vary by state and licensing board and may not address at all the matter of reporting prior sexual misconduct between a psychiatrist and patient. There is no clear answer to this challenging legal and public policy question; persuasive arguments can be made both for and against the mandatory reporting of sexually exploitive physicians and psychiatrists. In a survey of psychiatrists, more than one third of psychiatrists knew of a psychiatrist who had been sexually involved with patients, but only 8 percent reported the exploitation; however, 56 percent of psychiatrists favored the mandatory reporting of therapist–patient sexual conduct.[16] This discrepancy highlights the complexity of this topic.

The aim of this article is to provide clarification regarding reporting obligations of psychiatrists when, during the course of treatment, they learn about a patient's prior sexual relationship with a previous treating psychiatrist. Based on the information, we provide guidance for future development of reporting laws to help balance the conflicting ethics principles at stake.

Methods

We first compiled a list of state laws that outlaw psychiatrist–patient or psychotherapist–patient sexual relationships. We reviewed each state law database for laws referencing practitioners (including "psychiatrist," "therapist," "psychotherapist," and "health care worker") and sex (including "sex," "sexual relationship," and "sexual exploitation").

We then compiled a list of state rules and regulations regarding reporting prior psychiatrist–patient sexual exploitation to the state medical board. We did this by reviewing each state law database for laws mentioning "physicians" or "psychiatrists" and reporting (including "reporting," "mandated report," and "mandated reporter"). Laws were also searched using the LexisNexis database. When no laws containing these search terms were available for a state, we contacted the medical board to see if there are policies or laws requiring reporting of unethical physician conduct. We inquired about mandatory reporting of sexually exploitive psychiatrists, including asking the question "Does your state medical board or state law have a policy stating whether or not psychiatrists or psychotherapists have any special reporting obligations if they learn or suspect that their patient has had a sexual relationship with a prior psychiatrist or psychotherapist?" We also clarified each medical board's position on this subject when laws were ambiguous.

If a state had a rule or law requiring physicians to report unethical conduct of other physicians and there was no explicit confidentiality law or the medical board stated that reporting laws supersede confidentiality laws, we assume this means a physician or psychiatrist must report a prior physician's suspected sexual relationship with a patient, even if learned from a patient in the course of treatment.

In several states, physicians are mandated to report any suspected unethical conduct of physicians, but laws also exist stating physicians cannot break patient confidentiality. As the latter requirement is more specific than the former, in the absence of contrary evidence, we interpreted this to mean that physicians cannot report sexual exploitation learned from a patient and do not have a mandatory reporting requirement. When we did not receive a response and no relevant law was found, we concluded our inquiry with the determination that there was no evidence of such a reporting requirement for that state.

Results

Therapist–Client Sexual Relationships

Twenty-six states and the District of Columbia have laws that specifically forbid sexual relationships between a psychotherapist and a patient (Table 1). These states use varying language to delineate the forbidden relationships. Most states specifically reference psychotherapists, mental health workers, or counselors. Alaska and Utah broadly mention health care workers, which is assumed in this article to include mental health care workers. Each of these laws, except for Colorado, provides language specifically including psychiatrists in the definition of providers banned from sexual relationships with patients.

Reporting Prior Sexual Relationships

Only five states have explicit laws to address reporting of a prior psychotherapist's sexual exploitation of a patient when learned during the course of treatment (Table 2). Each state law specifically covers psychiatrists or physicians.

Texas requires any psychotherapist to report the unethical behavior to the appropriate licensing board.[22] The definition of psychotherapist includes "physician who is practicing medicine."[22]

Table 1 States with Laws Outlawing Psychiatrist–Patient and Psychotherapist–Patient Sexual Relationships

State	Legal Statute Banning Relationship	Term Used in Law for Therapist
Alaska	AS § 11.41.420 (2018)	Health care worker
Arizona	Az. Rev. Stat. § 13-1418 (2019)	Behavioral health professional
California	Cal. Bus. & Prof. Code § 729 (2019)	Physician and surgeon, psychotherapist
Colorado	C.R.S. 18-3-405.5 (2018)	Psychotherapist
Connecticut	Conn. Gen. Stat. § 53a-71 (2019)	Psychotherapist
Delaware	11 Del C. § 761 (2019)	Health professional
District of Columbia	D.C. Code § 22-3015 (2019)	Professional services of a medical or counseling nature
Florida	Fla. Stat. § 491.0112 (2019)	Psychotherapist
Georgia	O.C.G.A § 16-6-5.1 (2018)	Practitioner of psychotherapy
Idaho	Idaho Code § 18-919 (2019)	Medical care provider, physician, psychotherapist
Illinois	740 ILCS 140 (2019)	Psychotherapist
Iowa	Iowa Code § 709.15 (2018)	Counselor or therapist
Maine	17-A M.R.S. § 253 (2019)	Psychiatrist, psychologist, or licensed as a social worker
Michigan	MCLS § 750.520e (2019)	Mental health professional
Minnesota	Minn. Stat. § 609.344 (2019)	Psychotherapist
New Hampshire	RSA 632-A (2019)	Actor provides therapy
New Mexico	N.M. Stat. Ann. § 30-9-10; 30-9-11 (2019)	Psychotherapist
New York	NY CLS Penal § 130.05 (2019); NY CLS Educ § 6530.44 (2019)	Health care provider or mental health care provider; in the practice of psychiatry
North Carolina	N.C. Gen. Stat. § 90-21.41 (2019)	Psychotherapist
North Dakota	N.D. Cent. Code § 12.1-20.06.1 (2019)	Therapist
Ohio	ORC Ann. 2907.03 (2018)	Mental health professional
South Dakota	S.D. Codified Laws § 22-22-28, 22-22-29 (2019)	Psychotherapist
Tennessee	Tenn. Code Ann. § 29-26-201 (2019)	Therapist
Texas	Tex. Penal Code § 22.011 (2017)	Mental health services provider
Utah	Utah Code Ann. § 76-5-406 (2018)	Health professional
Washington	WAC 246-16-100 (2019)	Health care provider
Wisconsin	Wis. Stat. § 940.22 (2019)	Physician, therapist

Virginia and California have no mandatory reporting law but require that the mental health provider discuss the criminal nature of the prior sexual relationship with the patient and provide information on the patient's right to report. Virginia requires providing the Department of Health's toll-free consumer complaint hotline, whereas California requires the provider to review a patient advocacy pamphlet "Professional Therapy Never Includes Sex," which is prepared by the state.[23,24,25]

Rhode Island and Wisconsin have no mandatory reporting but require a discussion with the patient about the nature of the violation and the patient's right to report. If the patient wishes to file a report or complaint, the practitioner is required by law to follow through and report to the appropriate licensing board.[26,27]

Reporting Rules and Laws

Thirty-three state medical boards responded with a policy, reference, or response to our inquiry. Eighteen states require a physician or psychiatrist to report a prior physician or psychiatrist for unethical conduct, even if learned from a patient in the course of confidential treatment. Indiana requires mandated reporting of unethical behavior of other physicians and psychiatrists to a peer review committee, but not directly to the medical licensing board.[28]

Several states have adopted distinctive, idiosyncratic policies. Florida,[29,30] Kansas,[31] Nebraska,[32,33] and Nevada[34,35] mandate physicians to report suspected unethical conduct of other physicians, but they do not allow physicians to break patient confidentiality to do so. According to state medical boards in Hawaii, South Dakota, and Maryland, physicians are encouraged, but not mandated, to report unethical behavior to the medical board. No recourse is available to patients to prevent such reports. As discussed earlier, two states, Rhode Island and Wisconsin, do not mandate reporting in all cases, but only if a patient requests that a psychiatrist file a report.

Two states, California and Virginia, have laws that explicitly do not mandate reporting. For the remaining 21 states and the District of Columbia, we found no evidence of any official mandated reporting for individual physicians or psychiatrists when a patient tells them of a colleague's prior sexual misconduct (see Table 3).

Table 2 Summary of Specific State Laws Addressing Reporting of Psychotherapist Sexual Exploitation Learned During the Course of Treatment

State	Legal Statute	Duty to Patient	Penalty for not Following the Law
California	Cal. Bus. & Prof. Code § 728. (2019)	Must provide and discuss with the patient a brochure published by the state that delineates the rights and remedies for patients who have been involved sexually with their psychotherapists.	Failure to comply with this section constitutes unprofessional conduct.
Rhode Island	RI Gen. Laws Ann. § 5-63.1-2 (2019)	Practitioner must ask if patients wants to make a report and must make a report if the patient says yes.	Any person required to make a written report under this section who fails to do so shall be punished by a fine of not more than five hundred dollars ($500) and shall be subject to discipline by the appropriate licensing board of registration or equivalent oversight authority.
Texas	Tex. Civ. Prac. & Rem. Code § 81.006 (2017)	Clinician has a duty to report. Clinician must inform the patient of this duty and determine whether the patient wants to be anonymous in the report.	Subject to disciplinary action by that person's appropriate licensing board and also commits an offense. An offense under this subsection is a Class C misdemeanor.
Virginia	Code of Virginia § 54.1-2400.4 (2019)	The clinician must advise the patient of the patient's right to report such misconduct to the Department of Health Professions. The clinician must provide the department's toll-free complaint hotline number for consumer complaints and explain how to file a report.	Civil penalty not to exceed $100.
Wisconsin	Wis. Stat. § 940.22 (2019)	The therapist must explain to the patient the violation that occurred and ask if the patient would like the clinician to file a report. If the patient would like to make a report, the therapist must file a report to the respective licensing department of the sexually exploitive therapist and the district attorney within 30 days.	Guilty of a Class A misdemeanor.

Discussion

Slightly over half of the states have specific laws banning sexual relationships between mental health providers, including psychiatrists, and patients. Only five state legislatures expand the definition to include all health care providers (Table 1). This speaks to the generally assumed heightened importance of trust in a psychotherapist–patient relationship.

Only five state legislatures created specific laws to address mandated reporting of sexually exploitive mental health providers, including psychiatrists. These states provide clear and unambiguous guidance for providers, but they take varied approaches to weighing the conflicting principles of confidentiality, autonomy, and public safety. These laws reflect three general approaches to balancing social welfare against patient autonomy.

The approach of the Texas legislature favors social welfare by striving to prevent further sexual exploitation of patients. This law favors a paternalistic approach because a report must be made even without the patient's consent or even if the patient requests the information not be made public. Patients hold the right to decide if they will be named in the report. Allowing the informed patient to remain anonymous may help mitigate questions of confidentiality, while offering the option to be named with the support of the treating therapist may encourage a sense of autonomy and self-determination. It is clear, however, that this is not a perfect solution. In many cases, such as those in which the offender has committed a transgression with only one patient, the offender will be able to deduce the identity of the patient with relative ease.

Table 3 Summary of the Medical Board Policies, Rules, and Laws by State Regarding Mandatory Reporting by Psychiatrists of Sexually Exploitive Therapists, as Discovered During Treatment of a Patient

State	Official Mandated Reporter Policy	Standard for Reporting According to the Statute
Alabama	No official mandated reporting, per medical board	N/A
Alaska	Mandated to report, 12 AAC 40.967 (2019)	Facts known to the licensee regarding incompetent conduct as defined by Alaska Stat. § 08.64.326 (2019)
Arizona	Mandated to report, A.R.S. § 32-3251 (2019)	Any information that appears to show that a doctor of medicine is or may be medically incompetent, is or may be guilty of unprofessional conduct or is or may be mentally or physically unable safely to engage in the practice of medicine
Arkansas	No official mandated reporting	N/A
California	No official mandated reporting, per medical board	See Cal. Bus. & Prof. Code § 729. (2019)
Colorado	Mandated to report, C.R.S. 12-36-118 (2018)	Duty to report to the board any licensee known, or upon information and belief, to have violated any of the provisions of C.R.S. 12-36-117(1)
Connecticut	Mandated to report, Conn. Gen. Stat. §20-13d (2019)	Has any information which appears to show that a physician is or may be unable to practice medicine with reasonable skill or safety for any of the reasons listed in Conn. Gen. Stat. § 20-13c
Delaware	No official mandated reporting, per medical board	N/A
District of Columbia	No official mandated reporting	N/A
Florida[a]	No official mandated reporting	N/A
Georgia	No official mandated reporting	N/A
Hawaii[b]	No official mandated reporting	N/A
Idaho	Mandated to report, Idaho Code § 54-1818 (2019)	Possessing knowledge of a violation of Idaho Code § 54-1814 (2019) by any other physician and surgeon licensed to practice medicine
Illinois	No official mandated reporting	N/A
Indiana[c]	Mandated to report, 844 IAC 5-2-8 (2019)	Personal knowledge based upon a reasonable belief that another practitioner holding the same license has engaged in illegal, unlawful, incompetent or fraudulent conduct in the practice of medicine
Iowa	Mandated to report, IAC § 653-22.2 (2019)	Knowledge means any information or evidence of reportable conduct acquired by personal observation, from a reliable or authoritative source, or under circumstances causing the licensee to believe that wrongful acts may have occurred.
Kansas[d]	No official mandated reporting	N/A
Kentucky	No official mandated reporting	N/A
Louisiana	No official mandated reporting, per medical board	N/A
Maine	Mandated to report, 24 M.R.S. § 2505 (2019)	Reasonable knowledge of acts of the physician . . . amounting to gross or repeated medical malpractice . . . that endangers the health or safety of patients, professional incompetence, unprofessional conduct, or sexual misconduct identified by board rule
Maryland[b]	No official mandated reporting	N/A
Massachusetts	Mandated to report, ALM GL ch. 112, § 5F (2019)	. . . shall report to the board any person who there is reasonable basis to believe is in violation of section five, or any of the regulations of the board
Michigan	Mandated to report, MCLS § 333.16222 (2019)	Knowledge that another licensee or registrant has committed a violation under § 16221, article 7, or article 8
Minnesota	Mandated to report, Minn. Stat. Ann. § 147.111 (2019)	Personal knowledge of any conduct which the person reasonably believes constitutes grounds for disciplinary action under § 147.01 to 147.22
Mississippi	No official mandated reporting	N/A
Missouri	No official mandated reporting	N/A
Montana[e]	Mandated to report, MCA 37-3-401 (2019)	. . . shall . . . report to the board any information that appears to show that . . . a physician is guilty of unprofessional conduct
Nebraska[f]	No official mandated reporting	N/A
Nevada[g]	No official mandated reporting	N/A
New Hampshire	No official mandated reporting, per medical board	N/A

Table 3 Continued

State	Official Mandated Reporter Policy	Standard for Reporting According to the Statute
New Jersey	Mandated to report, N.J.S.A. 45 1-37 (2019)	If that health care professional is in possession of information which reasonably indicates that another health care professional has demonstrated an impairment, gross incompetence, or unprofessional conduct
New Mexico	No official mandated reporting	N/A
New York	Mandated to report NY CLS Pub Health § 230 (2019)	Any information . . . which reasonably appears to show that a licensee is guilty of professional misconduct
North Carolina	No clear mandated reporting, per medical board	Per North Carolina medical board, reporting would "depend on each individual case."
North Dakota	No official mandated reporting	N/A
Ohio[h]	No official mandated reporting	N/A
Oklahoma	Mandated to report Oklahoma § 435 10-7-4 (2019)	Unprofessional conduct includes failure to report to the Board unprofessional conduct committed by another physician.
Oregon	Mandated to report, ORS § 676.150 (2018)	Reasonable cause to believe that another licensee has engaged in prohibited or unprofessional conduct
Pennsylvania	No official mandated reporting, per medical board	N/A
Rhode Island	Mandated reporting at the request of the patient	See Table 2 and RI Gen. Laws Ann. § 5-63.1-2 (2019)
South Carolina	No official mandated reporting, per medical board	N/A
South Dakota[b]	No official mandated reporting, per medical board	N/A
Tennessee	No official mandated reporting, per medical board	N/A
Texas	Mandated to report Tex. Civ. Prac. & Rem. Code § 81.006 (2017)	If the patient reports any sexual contact with a previous provider, clinician must report.
Utah	Mandated to report, as per Utah medical board citing Utah Code 26-23a-2 (2018) and Utah Rule R156–67 (2019)	Any health care provider who treats or cares for any person who has any . . . injury inflicted by . . . violation of any criminal statute of this state (referable to Utah Criminal Code 76-5-406 (2019)
Vermont	No official mandated reporting	N/A
Virginia	No official mandated reporting	See Code of Virginia § 54.1-2400.4 (2019)
Washington	No official mandated reporting	N/A
West Virginia	Mandated to report W. Va. Code § 30-3-14 (2019)	Report to the board any act of gross misconduct committed by another licensee of the board
Wisconsin	Mandated reporting at the request of the patient; see Wis. Stat. § 940.22 (2019)	See Table 2 and Wis. Stat. § 940.22 (2019)
Wyoming	No official mandated reporting, per medical board	N/A

[a] In Florida, a physician must report a sexually exploitive colleague if aware of misconduct, unless that information was uncovered during a treatment session as per Fla. Stat. § 456.059 (2018). Psychiatrists must maintain patient confidentiality.
[b] Practitioners in Hawaii, South Dakota, and Maryland are encouraged to report sexually exploitive colleagues and are by law allowed, but not required, to break patient confidentiality to do so.
[c] In Indiana, the law only requires mandated reporting to a peer-review committee, but not to the medical board.
[d] In Kansas, a physician must report a sexually exploitive colleague if aware of misconduct, but K.S.A. § 65-4923 (2019) specifically states "[t]his subsection shall not be construed to modify or negate the physician–patient privilege, the psychologist–client privilege, or the social worker–client privilege as codified by Kansas statutes." Furthermore, a report may only be made based on "direct involvement or observation of the incident."
[e] In Montana, only psychiatrists are mandated to report sexually exploitive behavior. A psychologist shall only report it with written permission of the client as per ARM 24.189.2305 (2019).
[f] In Nebraska, a physician must report a sexually exploitive colleague if aware of misconduct as per R.R.S. Neb. § 38-1,125 (2019); these reports, however, only apply to "first-hand knowledge of the facts," and Neb. Rev. Stat. § 27-504 (2019) protects information learned from a patient during a course of treatment.
[g] In Nevada, a physician must report a sexually exploitive colleague if aware of misconduct as per Nev. Rev. Stat. Ann § 630.3062 (2019), but NRS § 49.215 (2019) protects communication between the doctor and patient through a privilege held by the patient.
[h] While the state has no mandated reporting, Ohio § 4731.22(F)(S) says anyone "may" report.

Critics of anonymous reporting have suggested that this keeps an accused therapist from being able to face an accuser.[36] In a survey of psychologists who had a patient tell them about a prior sexual relationship with a therapist, only 4 percent of the allegations were believed by the new treating psychologist to be false.[15] Such reports may include those that stem from malicious intent, but also, if less frequently, those of patients with significant psychiatric illness under the delusion that such sexual contact has occurred. While 4 percent may appear to be a small number of cases, the consequences of a false report

can be quite serious. Such a false accusation risks damaging a provider's reputation and ability to earn a livelihood. Yet a false report, especially when managed appropriately and confidentially, is not the same as a sanction or penalty. State medical boards have a duty to investigate all such claims thoroughly, rather than merely accepting them at face value.

It remains a concern that if patients are aware of mandatory reporting laws, it may compromise their ability to engage in further treatment.[36] If patients feel confidentiality is limited, they may not share relevant intimate matters with their therapists. This could impair a therapist's ability to fully treat a patient. Reporting against patients' wishes may alienate patients from pursuing further mental health care.[36] Confidentiality concerns are important given that these patients likely already have diminished trust in the system due to the prior sexual exploitation. Furthermore, if patients do not bring up past exploitation, the sexually exploitive therapy cannot be reported.

The approach taken in California and Virginia considers the importance of social protections, but it heavily favors patient autonomy because there is no mandatory reporting. Patients are informed of their rights to file a complaint and are educated as to the nature of the sexual misconduct, but they have full autonomy to decide whether to file a report with a licensing board. There are many reasons patients might choose not to report a sexual relationship with a prior therapist on their own. These include self-blame and guilt, painful feelings about bringing up the exploitation, repression, and fear of repercussions in their own lives.[36–39] Though such laws do not ensure that the responsible agencies will be aware or warned of a psychotherapists' unethical behavior, they are in line with mental health trends toward patient empowerment and increased focus on patient rights because they provide increased patient education and fully protect patient autonomy.

The third approach, espoused in statutes in Rhode Island and Wisconsin, attempts to balance the first two approaches. Mandatory education about the inherent boundary violation in the sexual relationship and the right to report are followed by mandatory reporting if the patient wishes. Autonomy rests with the patient in these states because they have the ultimate decision-making power about whether a report will be made. This approach removes personal responsibility and action from the patient by requiring a provider to file the report if that is the decision the patient makes. This likely results in an increased rate of misconduct being reported.

Not reporting psychiatrists who may have had a sexual boundary violation with a patient can result in significant harm to subsequent patients. Although it remains true that trust and confidentiality are foundations of psychotherapy,[3] subsequent providers who do not report sexual exploitation risk maintaining a "conspiracy of silence."[36] As with mandatory reporting policies that exist for the sexual exploitation of children and for impairment of physicians, the public good requires special exceptions to absolute confidentiality. If not reported, sexually exploitive psychiatrists and physicians can engage in future harmful behavior, and appropriate regulatory boards may not have been warned or had a chance to intervene. Reporting encourages the profession to maintain integrity through self-policing and helps preserve public trust in the field of mental health.

Based on our research, it is common for medical boards to require physicians to report other sexually exploitive physicians, even if the information is learned during treatment sessions. It should be noted that medical board laws and policies apply to all physicians, not just psychiatrists. Therefore, psychiatrists would have to report any physician engaging in sexual misconduct with a patient, regardless of treatment setting. Given the significant risk of potential harm to a patient sexually exploited by a physician and given the prevalence of physicians who engage in sexual relationships more than once in a career, it makes sense that a medical board would adopt legal policies aimed at preventing future harm from occurring.

Still, many concerns exist with requiring reporting without a specific legislative statute. Medical board policies refer to physician misconduct while neglecting to distinguish details. They do not adequately define the standard for filing a report. Terms variably used by different states, such as "reasonable belief," "possessing knowledge of a violation," "reasonable basis to believe," "any information," "reasonably indicates," and "reasonable cause to believe," are open to interpretation in the absence of case law. This may cause physicians to be uncertain about what they should do or may lead to physicians making different decisions on a case by case basis. The policies offer little guidance to the physician. Is it enough to file a

report if a patient briefly mentions a prior sexual encounter with a prior physician, or does the patient need to be distressed by this experience? Does the patient's account of the events have to be objectively logical and consistent, or is simply arousing suspicion worthy of a report?

The complex and varied approach taken by states results in a confusing collection of laws for providers who may not practice in one state for an entire career. Even when specific and clear laws do exist, providers do not always know the rules. Despite the mandatory reporting law, a study of Texas social workers found that 34 percent of them did not know that they had to report suspected sexual exploitation by prior therapists, 29 percent did not know they could face criminal penalties for failing to report, and 46 percent were unaware that they could share the victim's identity without consent when reporting.[18]

Legislatures must balance considerations of autonomy and societal protection regarding mandatory reporting of sexually exploitive psychiatrists and other mental health providers to the state medical board. They must also work to develop consistent, clear, and unambiguous statutes, which is not always achieved. For example, in South Dakota, physicians are directed to "strive to report physicians deficient in character."[40] In Maryland, the medical board "strongly encourages individuals, including physicians, to report to the Board information of possible violations of the Medical Practice Act, including sexual misconduct" (Maryland Board of Physicians, personal communication, November 2018). No rule requiring or preventing such a disclosure when learned from a patient exists in either state, forcing the individual physician, without clear guidance, to decide whether to report. Indiana rules require reporting misconduct to a "peer review or similar body" but leave it up to the individual physician to decide whether to report the information to the medical licensing board.[28]

Florida,[29,30] Kansas,[31] Nebraska,[32,33] and Nevada[34,35] mandate physicians report suspected unethical conduct of other physicians, but they do not allow physicians to break patient confidentiality to do so. The patient holds the right to waive confidentiality, but there are no laws requiring the physician to educate the patient about their option to waive confidentiality to trigger a physician report. The physician would not be able to fulfill the reporting mandate if the patient chooses not to waive confidentiality. Only if the patient waives confidentiality can the physician fulfill the obligation to report the unethical conduct.

Laws requiring "first-hand knowledge" likely lead to more reliable reports because patient accounts can sometimes be substantially biased. They would theoretically negate the challenge of confidentiality laws because a patient report would not be first-hand knowledge of a physician's conduct. Yet this can be complicated. For example, in Iowa "knowledge" refers to evidence "acquired by personal observation" or "under circumstances causing the licensee to believe that wrongful acts may have occurred."[41] The latter could potentially include information disclosed by a patient during treatment despite it not being personal observation.

Legislative clarification could also limit reporting differences between mental health professions. For example, the Montana medical board informed us that psychiatrists would have to report misconduct, under medical board rules, but psychologists would only be able to report the same misconduct with the written permission of the patient.[42,43] Reviewing the reporting rules for non-physician mental health professionals in each state was beyond the scope of this article, but, given the variations in reporting requirements among the states, psychiatrists should remain informed about local reporting statutes and the case law that may determine the expected reporting practice in some states.

This article is not an exhaustive discussion of this complicated topic. We have limited ourselves to the consideration of providers and patients in therapeutic relationships. Forensic psychiatrists, worker's compensation evaluators, and other mental health professionals in purely evaluative or consultative roles face an equally complex, but fundamentally distinct, set of ethics questions and obligations. Even regarding therapeutic encounters, this review is not meant to be definitive; rather, our hope is to stimulate discussion among the psychiatric and legal communities on this important and often overlooked clinical dilemma and provide a helpful starting point for those who wish to conduct further research in this area. It is not feasible to communicate the exact details of every relevant statute in a brief article. We suggest that anyone with specific questions about statutes in their jurisdiction consult an attorney.

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