

A Duty to Protect Our Patients from Physician Sexual Misconduct

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In this issue of *The Journal*, MacIntyre and Appel have reviewed state laws and medical boards' policies to ascertain which states require reporting of sexually exploitive psychiatrists, specifically when the patient reveals the exploitation during treatment. They highlight the competing ethics duties faced by physicians who are in a position to report such conduct and provide guidance for future development of reporting laws to help balance the conflicting ethics principles at stake. In this commentary, I discuss the pros and cons of mandatory reporting laws and underscore the importance of physicians' ethics duty to report the sexual misconduct of other physicians even in the absence of a legal mandate. In light of recent high-profile cases that demonstrate a failure of medicine to self-regulate, I make the case for a cultural shift in our profession so that the subject of reporting physician sexual misconduct is viewed not from the lens of a duty to report, but that of a duty to protect.

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In their survey of state laws and medical boards, MacIntyre and Appel¹ find that a majority of states do not have laws that mandate physicians to report other sexually exploitive physicians, even if the information is learned during treatment sessions, but that state medical boards commonly have this reporting requirement.¹ They provide guidance for future development of reporting laws to help balance the conflicting ethics principles at stake.¹

The article by MacIntyre and Appel highlights the complex challenges related to regulating the salient problem of sexual misconduct by psychiatrists. This concern is further complicated not only by the fact that the professional role of psychiatrists overlaps in part with that of therapists from many other disciplines, but also because their ethics duties overlap with those of physicians from other specialties. Any discussion of these multifarious, albeit intertwined, legal and ethics obligations must first begin with taking a measure of the problem itself.

Therapist-Patient Sexual Involvement

Psychotherapist-patient sexual involvement is not a novel concern for psychiatry. It gained prominence in the early 1970s and, in 1973, the American Psychiatric Association (APA) explicitly condemned sexual contact with patients as unethical.² By 1989, the American Medical Association (AMA) had followed suit by deeming sex with a patient unethical for all physicians.² During this period, growing public concern about the problem led legislatures in many states to pass legislation criminalizing psychiatrists' sexual misconduct.² Surveys of psychiatrists in this era indicated that approximately seven percent had engaged in sexual misconduct at some time in their careers, and over a third of those psychiatrists had been involved with more than one patient.³ Subsequent studies of physicians disciplined for sexual misconduct revealed that psychiatrists were significantly more likely than physicians in other specialties to be disciplined for sexual relationships,⁴⁻⁶ though at least one study indicated that the overall percentage of psychiatrists implicated was on the decline.⁷ This was attributed to the formulation of strong policies in the 1990s regarding physician-patient boundaries.⁷ More recently, a 2012 review of clients referred to a physician health program between 1986 and 2005 reported that

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psychiatrists represented the greatest percentage of boundary violators, followed by family practice and internal medicine doctors.⁸ Sexual intercourse with a former patient, followed by sexual intercourse with a current patient, included the majority of cases in the patient sexual violation category, which made up 34 percent of all clients referred to the physician health program.⁸

Physician Sexual Misconduct

To be clear, the problem of sexual misconduct is neither limited to sexual intercourse, nor is it specific to the therapeutic environ of psychiatry. The expanded definition of physician sexual misconduct from the Federation of State Medical Boards (FSMB) includes not only grave behaviors that include sexual violation, but also misbehaviors that include sexual impropriety (i.e., behavior, gestures, or expressions that are seductive, sexually suggestive, disrespectful of patient privacy, or sexually demeaning to a patient).⁹ Surveys of physicians from multiple specialties have yielded physician-patient sexual involvement rates of 3.3 to 9.8 percent, which are comparable with rates for psychiatrists. Physicians in the fields of family medicine and obstetrics and gynecology have also been disciplined at higher rates for sexual misconduct compared with their peers.¹⁰ Additionally, a review of data from the FSMB between 1992 and 2004 indicated that 7.1 percent of all sanctions were issued for sexual misconduct irrespective of specialty.¹¹

This is important for two reasons. First, psychiatrists are expected to abide by the same code of ethics that applies to medicine at large. Second, apart from the few exceptions noted in the article by MacIntyre and Appel,¹ state legislatures and medical boards do not make a distinction between psychiatrists and other physicians who engage in sexual misconduct; therefore, laws and policies that are enacted for physicians apply to psychiatrists. For instance, MacIntyre and Appel¹ note that 18 states have created a duty to report unethical conduct of physicians irrespective of specialty, even if learned from a patient.

These data indicate that all of medicine, not just psychiatry, continues to grapple with this problem. A recent review described the factors that have allowed physician sexual misconduct to persist.¹² Disciplinary actions far underrepresent the actual prevalence of self-reported physician boundary violations, and

many cases of physician sexual abuse go unreported by the victims.¹⁰ Patients may not report such behavior because they may be shocked and consumed by feelings of disbelief, guilt, or shame; they may be fearful that they will not be believed due to the significant power imbalance between physicians and their patients; or they may be unwilling to publicly disclose the abuse.¹² Additionally, victims may not know how to navigate the regulatory system to seek redress for the harms of physician sexual abuse, such as filing a complaint with the state medical boards that licensed the physicians. When they do file complaints, victims can be further traumatized by the investigation and legal procedures, which may lead them to withdraw their complaints.¹²

But the obstacles do not end there. Even when complaints are filed, medical boards do not always act on them, or they may impose inadequate sanctions so that those physicians are often permitted to resume medical practice.^{13,14} Ultimately, physicians who are reported are permitted to self-regulate by state medical boards where physicians constitute the majority of members.¹¹

Mandatory Reporting of Sexual Misconduct

The review of literature above indicates that physician sexual misconduct continues to remain a pervasive problem and that psychiatrists are more likely to be disciplined for sexual boundary violations than their peers. Several factors could increase psychiatrists' risk of sexual boundary violations. They often work in isolation, out of view of other professionals. They have more personal contact and longer and more sessions with individual patients, hence more opportunity to become intimate with them. Patients may be more likely to report sexual misconduct for physicians of particular specialties, and psychiatric patients may be more vulnerable to inappropriate caregiver relationships.⁴ The APA has recognized that psychiatrists may be more vulnerable to such violations because "the necessary intensity of the therapeutic relationship may tend to activate sexual and other needs and fantasies on the part of both patient and therapist, while weakening the objectivity necessary for control" (Ref. 15, p 4). This raises the question: Will the creation of laws mandating a duty specifically to report psychiatrists who have engaged in sexual misconduct help reduce its occurrence? MacIntyre and Appel¹ note that the rate of recidivism among psychiatrists who engage

in sexual misconduct with their patients is high, and not reporting such psychiatrists can result in significant harm to subsequent patients. They note that the APA ethics guidelines allow a provider to break patient confidentiality in specific circumstances, under proper legal compulsion.¹ The authors call for special exceptions to absolute confidentiality in cases where a physician learns of sexual misconduct by a prior therapist, as with mandatory reporting policies that exist for the sexual exploitation of children and for impairment of physicians.¹

The results of the study by MacIntyre and Appel¹ indicate that even though 26 states and the District of Columbia have laws that specifically forbid a sexual relationship between a psychotherapist and a patient, only five states have addressed the specific topic of reporting such a relationship; of these five states, only Texas mandates reporting by the physician who learns of such misconduct even without the patient's consent. Another 18 states allow for reporting such incidents via reporting laws that cover a wide variety of physician impairments and unethical conduct.¹ Even in these states, the standard for reporting varies, and terms 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 and offer little guidance to the reporting physician (Ref. 1, pp 7–8). Reporting sexual misconduct of a patient's prior therapist or psychiatrist offers further challenges. Most instances of sexual misconduct occur behind closed doors, and objective third-party information that could validate the misconduct is not readily available. Additionally, as MacIntyre and Appel¹ note, it is a formidable task to determine the current and ongoing risk for harm from a practitioner who has engaged in such misconduct in the past. For a physician who has to make a decision about reporting a colleague, such a determination is much harder than, say, reporting a colleague who suffers from a substance-use problem and shows up intoxicated for work. Similarly, mandatory laws that permit breach of confidentiality (e.g., duty to warn, abuse or neglect of minors) are all predicated on the presence of imminent or current risk, which may be difficult if not impossible to establish to a degree that justifies a breach of confidentiality in cases with remote sexual misconduct.

Addressing mandatory reporting laws in 1995, an APA Work Group tasked with providing guidance

on legal sanctions for sexual misconduct against patients had observed that psychiatrists should not be placed in the position of inferring sexual misconduct from the behavior or conduct of patients, nor should they be required to rely on third-party reports.² The Work Group concluded that it is essential that such statutes allow patients to determine whether a report is to be made because, as MacIntyre and Appel¹ also note, some patients, although traumatized, may still not be willing to report, and future treatment may be threatened by reporting against the wishes of the patient. The Work Group also noted that victims who do not wish their current psychiatrist to report are unlikely to commit themselves to pursuing disciplinary action,² thereby defeating the purpose of any psychiatrist-initiated reports. Finally, the Work Group emphasized the importance of maintaining the confidentiality of such reports, called for penalties for failure to report, and advocated immunity for reporting.²

A Duty to Protect Our Patients

Even though state laws in a majority of states do not obligate physicians to report sexual misconduct of other physicians, both the APA¹⁵ and the AMA¹⁶ have codified an ethics duty to report incompetent or unethical behaviors by colleagues. At its core, the purpose of any duty to report a physician who has engaged in unethical conduct is the protection of patients from harm. MacIntyre and Appel¹ note the harrowing consequences of sexual exploitation of patients. Such behavior not only victimizes patients; it also discourages people from seeking psychiatric treatment and damages the profession of psychiatry by eroding the public trust.² Responsible discharge of this duty is essential to upholding the moral code of our profession that has long defended its ability to self-regulate. In 2015, the FSMB adopted the Essentials of a State Medical and Osteopathic Practice Act, which provides sample language for the reporting responsibilities of physicians.¹⁷ In 2016, invoking a duty to report, the FSMB noted that this duty is a fundamental way in which physicians and others can fulfill duties of beneficence by removing potentially harmful conditions.¹⁸ It also provided a sample of relevant categories of information that are reportable, including sexual misconduct with patients.¹⁸ Yet it was noted that despite similar language being included in most states' medical practice acts, there is evidence that reporting often does not occur.¹⁷

Indeed, MacIntyre and Appel¹ cite a survey of psychiatrists in which more than one third of respondents knew of a psychiatrist who had been sexually involved with patients, but only eight percent reported the exploitation even though 56 percent favored the mandatory reporting of therapist–patient sexual conduct.¹ Various factors may be at play that make it difficult for psychiatrists to report their colleagues' ethical breaches: not wanting to damage a colleague and risk retaliation or being seen as a betrayer; not knowing what is reportable or where to go with what was discovered; not wanting to acknowledge what one has become aware of; hiding behind imagined requirements of confidentiality; and not remembering what was perhaps insufficiently taught about boundaries.¹⁹ But this reluctance to report colleagues is not a phenomenon specific to psychiatry.

A 2007 survey of 3,504 practicing physicians revealed that physician behavior did not always reflect the standards they endorsed. For example, although 96 percent of respondents agreed that physicians should report impaired or incompetent colleagues to relevant authorities, 45 percent of respondents who encountered such colleagues had not reported them.²⁰ A 2010 survey of 2,938 physicians from many specialties, including psychiatry, indicated that only 64 percent of surveyed physicians agreed with the professional commitment to report physicians who are significantly impaired or otherwise incompetent to practice, and only about two-thirds reported being prepared to effectively deal with incompetent or impaired colleagues.²¹ The most frequently cited reason for taking no action was the belief that someone else was taking care of the problem, followed by the belief that nothing would happen as a result of the report and fear of retribution.²¹ This research is proof that individual physicians cannot always be relied on to report colleagues who threaten quality of care.²² Thus, it appears that the one of the biggest obstacles to reporting physicians who engage in unethical conduct to the state medical boards is physicians.

Conclusion

The harm inflicted on patients by physician sexual misconduct has been recognized for several decades, yet the problem has persisted. Remote studies indicate that psychiatrists were disciplined at higher rates, though it is unclear if the incidence of sexual misconduct is higher for psychiatrists compared with physicians from other specialties. One of the

main barriers to measuring the incidence of physician sexual misconduct is underreporting, both by victims and by other physicians who are made aware of such occurrences. As physicians we have a duty to protect patients from harm. Recent high-profile cases of Larry Nassar²³ and George Tyndall,²⁴ physicians who continued to sexually exploit their patients despite numerous reports and warning signs, indicate that, as a profession, we are failing in the discharge of this duty. In response, calls for mandatory reporting of any witnessed or suspected physician sexual misconduct have come from many quarters.¹² Some have argued that the field of medicine has self-regulated in a manner that protects self-interests above patient interests and that perhaps regulations enforced in response to the sexual scandal by the Roman Catholic Church need now be implemented in the field of medicine.^{25,26}

As discussed in this commentary, laws that mandate reporting of sexual misconduct by physicians are difficult to enact, provide ambiguous thresholds for reporting, run the risk of compromising confidentiality, and can put the reporting physician in a precarious position. But is a legal mandate always a prerequisite for reporting? In other words, will physicians report a colleague who has engaged in sexual misconduct only under the threat of penalty for not doing so? A vast majority of physicians agree in principle that unethical conduct is harmful and should be reported, yet so many fail to report it even when it occurs in plain sight. Although efforts have been made in recent years to improve trainee education regarding boundary violations and whistleblowing at an entry level, much remains to be done to improve reporting of unethical conduct. Collective efforts need to be made to change the culture in our profession so that clearly harmful conduct, especially sexual misconduct, is not buried or dismissed without action. Empowering the patient victims of physician sexual misconduct is important, but it is also essential that we arm our conscience with the courage necessary to do the right thing, lest the erosion of trust in our profession become the subject of intense public scrutiny and regulation by external agencies as has occurred with other noble professions in the recent past.

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