

Misinformed Regulation of Electronic Medicine Is Unfair to Responsible Telepsychiatry

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Telepsychiatry is an established, effective, and increasingly used component of modern mental health care. Recent legal developments designed to control the growth of more controversial practices, such as issuing prescriptions over the Internet, may have chilling effects on the continued provision of responsible telepsychiatry. Although the policies behind these statutory and regulatory changes frequently reflect ethical and responsible practice, they should be resisted when they may deter or create disciplinary traps for conscientious telepsychiatry practitioners.

Responsible telepsychiatry provides care for underserved populations and has several documented benefits. Equally, regulatory scrutiny is necessary “to protect the public against the unprofessional, improper, unauthorized, and unqualified practice of medicine.”¹ In this article, we suggest that recent legal developments may have chilling effects on the continued provision of responsible telepsychiatry.

At the outset, it is important to recognize that terminology is one of the major villains in this situation. Regulators and no small number of practitioners think of telemedicine (and hence telepsychiatry)

primarily as involving a consultation between a primary physician (with or without the patient in attendance) and a remote colleague. In contrast, cybermedicine (and hence e-therapy) describes a scenario in which a single physician diagnoses and treats illness in a remote patient. Prescriptions issued over the Internet may be an element of that second scenario, but it also frequently (and illegally) occurs in the absence of any professional relationship. To complicate matters further, telemedicine is more likely to occur on an intrastate basis and frequently is state-sponsored, as is the case when it is used in correctional facilities.² In contrast, cybermedicine and prescribing via the Internet more frequently involve interstate interactions. Although psychiatrists and psychologists are involved in telepsychiatry and e-therapy, unlicensed or lightly regulated counselors are responsible for most of the growth in e-therapy. Although those involved in e-therapy use basic technologies such as Web pages, e-mail, and, occasionally, Web cams, experienced telepsychiatrists more frequently rely on videoconferencing, using broadband connections.

History, Growth, and Current Practice of Telepsychiatry

In the 1950s, Wittson implemented the first use of telepsychiatry as a teaching aide at the Nebraska Psychiatric Institute.^{3,4} Ten years later, researchers at the University of Nebraska found that patients and their relatives were receptive to this form of telecommunication and that the physical isolation of the physician from the patient had no noted negative effects. Researchers at Dartmouth Medical School (Hanover, NH) found that two-way video consultations between community family physicians and psychia-

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trists at the medical school not only posed no problems in establishing rapport with patients but also improved the community family physicians' interview skills and the use and knowledge of psychotropic drugs.⁵ By 1994, telepsychiatry had been proposed or was in use in approximately 16 programs.⁶ By 1997, telepsychiatric consultations were in active use in 25 programs.⁷

Currently, there is extensive use of telepsychiatry to provide consultations and recommendations in child and adolescent, forensic, emergency, and community psychiatry. Juvenile and geriatric populations have received particular attention because of the limited number of individuals trained to deal with such populations in rural areas. Detained and incarcerated adults and children have a disproportionately high rate of mental illness. States can provide urgently needed services within secure settings, minimizing disruption in the operation of the facility and potential breaches in security.⁸ In addition, correctional employees may receive interactive training in mental health, as is required by many jail and prison reviewers, without significant loss of time in their jobs.

Costs and Benefits of Telepsychiatry

Telepsychiatry is a powerful tool to provide psychiatric services to underserved individuals who are geographically isolated, limited, or incarcerated. Using technology to mediate between doctor and patient virtually eliminates the barriers associated with the travel necessary for the patient or provider. The provider benefits from increased productivity, and the patient benefits from receiving enhanced care that would be inaccessible otherwise. There is no time lost in transit, and there are fewer unattended appointments. Collaboration with another provider or an entire treatment team may occur at the time of an encounter with a patient, so that the providers may exchange information and observations in a time-efficient manner. Encounters with patients in their local communities may be more frequent and of variable duration as dictated by clinical need rather than access to a provider.

Video telepsychiatry presents significant advantages over other forms of remote interaction, such as record review, e-mail, and telephony. An important advantage is the direct visual observation of an individual's facial expressions, motor movements, and overall physical status, which is necessary for

accurate assessment and adequate treatment. The ability to observe physical movements at a level equal to or greater than the ability to hear information depends on a number of factors worthy of further investigation, such as line speed and image quality.⁹

No significant differences in perceptions by patients and physicians were found in a study comparing telepsychiatry and face-to-face interviews.¹⁰ In a pilot study involving semistructured ratings in patients with obsessive-compulsive disorder, almost perfect concordance was obtained between patients with obsessive-compulsive, depressive, and anxiety disorders and the corresponding treatment providers.¹¹ Straker *et al.*¹² report using telepsychiatry to improve access and decrease travel for inner city children by using a link to a medical school, and Maxmen¹³ reports that televised sessions do not compromise the therapeutic relationship. These results suggest that the patient's satisfaction is not a barrier to the use of telemedicine.

Regardless of the relationship between the distance provider and the remote site, both have obligations. Turner¹⁴ stresses the importance of the relationship between the telepsychiatrist and the local physician for successful implementation of the technology. The service must be provided in a private setting with a digital line for videoconferencing for the best approximation of a face-to-face encounter. The patient must be educated about the nature and purpose of the session, the use and operation of the equipment, and any potential breaches of confidentiality inherent in the technology used. The patient should be queried as to level of satisfaction with the service.¹⁵ Staff development and periodic monitoring are essential to ensure that quality services are being provided. Credentialing and continuing education in telepsychiatry must occur at regular intervals. A local provider must be available to render emergency care in a timely fashion.

Although experiences in rendering and receiving telepsychiatry services are different, there is no current indication that the expanded services provided are inferior to traditional services.¹⁶⁻¹⁸

Trends in the Legal Regulation of Telepsychiatry

Psychiatrists, as do all doctors, face the key licensure inquiry as to whether their activities constitute

the practice of medicine within a given state. A positive answer triggers the requirement for state licensure and, thereafter, potential disciplinary scrutiny.

Traditional telemedicine and telepsychiatry generally have slipped under the regulatory radar. As a typically intrastate and often state-sponsored endeavor, they have been legally uncontroversial. In most cases, the question of licensure required for both providers is moot, given their (assumed) licensure in that state. An out-of-state consulting doctor engaging in interstate telepsychiatry typically has not had to be licensed in the primary doctor's state (location of treatment). If the consultation occurs at the behest of the primary provider and is limited to making recommendations, it may not be interpreted as the practice of medicine, or, more commonly, an explicit cross-border consultation exemption would apply to the consultation. For example, the Alabama statute provides: "A doctor of medicine or doctor of osteopathy licensed to practice medicine in any state of the United States or the District of Columbia who may be called into this state in order to treat a patient in consultation with a physician licensed to practice medicine in this state shall be allowed the temporary privilege of practicing medicine in this state. This privilege shall be limited to 10 calendar days in a calendar year."¹⁹

Controversy and scrutiny have increased considerably with the growth of interstate cybermedicine (and e-therapy). States have undertaken reforms of their licensure rules. These reforms seek to increase the regulation of interstate practice and, in particular, to bring prescribing via the Internet within the disciplinary ambit of the importing state. As operationalized, however, these reforms frequently implicate intrastate and responsible interstate telepsychiatry. Several new types of regulation require scrutiny. First, there are new definitions of telemedicine that may impose state regulations on what heretofore have been viewed as consulting relationships. Second, telemedicine, once newly defined, attracts additional layers of regulation, such as practice certificates and consent requirements. Third, some states are imposing new controls on prescribing in nontraditional physician-patient situations.

State regulation is now anything but uniform. In Arizona²⁰ and California²¹ the definitions of telemedicine capture both intrastate and interstate consultations. In contrast, the Montana statute²² applies telemedicine-specific regulation only to interstate ex-

changes between doctor and patient and the West Virginia definition of the practice of telemedicine and hence the practice of medicine is limited to diagnosis or treatment by out-of-state doctors.²³ Such differential treatment has the potential to trap unwary physicians who routinely engage in both intrastate and interstate or multistate work.

The discrimination between intrastate and interstate scenarios also suggests potential legal challenges to such regulation. Courts have construed the Commerce Clause of the Constitution not only as granting interstate powers to the U.S. Congress, but also as possessing what they refer to as a dormant aspect that limits the power of the states to regulate interstate commerce.²⁴ No court has considered the constitutionality of state statutes that seek to regulate interstate telemedicine and discriminate between intrastate and interstate practice. Nevertheless, recent decisions striking down state laws regulating interstate commerce in wine²⁵ and protected speech²⁶ suggest that overreaching legislative activity affecting cross-border telepsychiatry could face serious constitutional challenge.

The emerging telemedicine definitions also differ as to the types of interaction they seek to regulate. Whereas the Arizona law²⁷ applies broadly to all forms of technologically mediated health care, the California statute is limited to what it describes as "real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information."²⁸ The statute explicitly excludes telephone or e-mail.²¹ It is not immediately clear why regulators would make distinctions based on the technologies (e.g., videoconferencing rather than telephony) used. In practice, the more stringent regulation applied to synchronous interactions would disproportionately target psychiatrists who use technologically sophisticated and more professionally appropriate and secure technologies.

States that specifically define telemedicine do so either to include it explicitly within the practice of medicine or to apply additional regulatory requirements. For example, Montana²⁹ and Ohio³⁰ require an out-of-state physician to apply for a specialty-specific telemedicine practice certificate. The trend, exemplified by statutes in Arizona,³¹ California,³² Oklahoma,³³ Puerto Rico,³⁴ and Texas,³⁵ requires telemedicine-specific consent and correlated record-keeping. For example, California requires "verbal and written informed consent [including a] descrip-

tion of the potential risks, consequences, and benefits of telemedicine.”³² Oklahoma reinforces the idea that practitioners now face escalating complexity in navigating these regulations by excluding its detailed consent requirements in some cases of traditional telemedical interactions (consultations) or in cases involving a specific subpopulation of Department of Corrections clients.³⁶

The most obvious regulatory agenda is to slow the growth of prescribing over the Internet. States have tackled this in two ways. First, some have amended their licensure rules to deem “[p]rescribing, dispensing, or furnishing dangerous drugs. . . without a good faith prior examination and medical indication therefor[e], constitutes unprofessional conduct.”³⁷ There are indications that state disciplinary boards increasingly interpret good faith prior examination as requiring physical face-to-face interaction between doctor and patient.³⁸

It is not surprising that such direct regulation has not been effective in controlling the practices of unlicensed charlatans or out-of-state physicians associated with so-called pill mills. As a result, several pharmacy boards have introduced a second, more indirect form of regulation that requires their in-state pharmacists to verify that the prescriptions presented to them were written after physical (and hence usually in state) examinations. Thus, the Texas rule prohibits a pharmacist from dispensing a prescription drug if he or she “. . . knows or should have known that the prescription was issued on the basis of an Internet-based or telephonic consultation without a valid patient-practitioner relationship.”³⁹ California imposes a similar rule and backs it with fines up to \$25,000 per occurrence.⁴⁰

Indeed, recent enforcement activities make clear the seriousness with which states are treating prescribing drugs via the Internet. Alabama⁴¹ and Oklahoma⁴² recently imposed lengthy prison sentences for issuing prescriptions over the Internet. California has levied \$88 million in fines in a case in which prescriptions were filled without face-to-face physician-patient interaction. State regulators also are seeking more powerful tools with which to do battle with the Internet pill mills. For example, in addition to more traditional licensure-related injunctive relief, Kansas prosecutors sought to apply their state’s robust Consumer Protection Act against a Viagra-selling out-of-state doctor, a position not endorsed by the Kansas Supreme Court in what appears to be the

first (but undoubtedly not the last) case regarding prescribing over the Internet to go to a state high court.⁴³

Conclusions

A myriad of complex legal and professional issues already burden the responsible practice of telepsychiatry.⁴⁴ These include uncertainties about the creation of the physician-patient relationship and the availability or applicability of malpractice coverage, the definition of the standard of care, federal (and where not preempted, state) regulation of confidentiality,⁴⁵ the intricacies of reimbursement coding, the shifting sands of the scope of practice enjoyed by psychologists,⁴⁶ and the growth of on-line counseling.⁴⁷

It is appropriate that state legislatures target the worst excesses of unlicensed practice and crack down on prescribing drugs via the Internet. Few of the regulatory changes considered in this article can be criticized regarding their goals and, in many respects, their substance reflects ethical and responsible practice.⁴⁸

Generalized increased regulation of technology in the practice of medicine must be resisted when it has the potential to chill responsible practice or create disciplinary traps for conscientious practitioners. The fact that prescribing over the Internet is characterized by the absence of face-to-face consultation and that individuals with unknown credentials conduct e-therapy should not lead regulators to undue regulation of responsible therapy that no longer relies on physical presence. Psychiatrists are now routinely involved in both intrastate and interstate telemedicine and use a variety of technologies. It has never been more crucial for the profession to consult with regulators and legislators and educate them about the tools and practices associated with modern telepsychiatry. Only by minimizing inappropriate disincentives or regulatory traps will we guarantee the sustained growth of responsible services.

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Telepsychiatry and the Regulation of Electronic Medicine

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