

E-mail and the Psychiatrist-Patient Relationship

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E-mail correspondence between psychiatrists and patients raises numerous legal concerns with respect to the ethics of the doctor-patient relationship. Case law has shown that a doctor-patient relationship may be established in the absence of face-to-face contact. Despite this, a surprisingly high number of physicians respond to unsolicited e-mails, some even going so far as to suggest diagnoses or to offer advice. Courts may decide that a doctor-patient relationship exists where a psychiatrist has corresponded with a patient by e-mail. Psychiatrists may be faced with difficult ethics-related decisions regarding unsolicited e-mails from members of the public as well as e-mail from current patients and third parties, such as family members of patients. This article addresses relevant law and ethics guidelines and seeks to assist psychiatrists in making sound, ethical decisions about the professional use of e-mail.

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The popularity of the Internet among patients increases demands on doctors. Today's patients are often better educated about their health than were previous generations, and many prefer to be treated by Internet-savvy physicians.^{1,2} It may be detrimental to a physician-patient relationship for a physician to respond negatively to a patient's interest in the use of Internet technology in her health care.³ For example, one study⁴ found that 54 percent of patients indicated that they would switch doctors if they could communicate with the new doctor through e-mail. Many physicians whose e-mail addresses are available through Internet Web sites have found that they receive a large amount of unsolicited e-mail from prospective patients or consumers seeking advice or information.^{5–7} The Internet has placed many physicians in the difficult position of deciding whether to correspond with patients by e-mail, possibly increasing liability. Even when psychiatrists choose not to use e-mail, the Internet and e-mail are likely to change the nature of the physician-patient relationship.⁸

A distinction should be made between psychiatrist-patient e-mail and e-therapy. Psychiatrist-patient e-mail encompasses all types of e-mail communication between a psychiatrist and a patient,

including, but not limited to, prescription refill requests, appointment setting, and similar matters of business. E-therapy is, in some cases, a type of psychiatrist-patient e-mail, when the therapist is a psychiatrist and the therapy is conducted, at least in part, through e-mail. While e-mail may be considered incidental, e-therapy may constitute the practice of medicine online. Numerous additional risks are created by the provision of medical treatment (e.g., prescribing medicines, conducting psychotherapy or psychiatric examinations) on the Internet. Not least among these are the complicated legal status of interstate practice and regulatory jurisdiction. This discussion deals generally with the topic of psychiatrist-patient e-mail and does not address the multiple potential medico-legal and ethics-related factors associated with the provision of e-therapy.

Uncertain Legal Status of Physician-Patient E-mail

E-mail between psychiatrists and patients raises new legal and ethics-related questions surrounding the existence of a physician-patient relationship. While there is considerable case law on the physician-patient relationship in telephone interactions, there is no known case law regarding the physician-patient relationship and e-mail. Legal scholars predict that courts will use precedents involving telephone calls in defining the extent to which a physician-patient relationship exists in an e-mail case.^{9,10}

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Uncertainty regarding the complex legal implications of physician-patient e-mail may be a factor contributing to the low percentage of physicians exchanging e-mails with patients. A recent study¹ showed that while 90 percent of those who used e-mail to share and obtain medical information reported satisfaction, only 7 percent of e-mail users have corresponded with doctors or health care personnel. Several study participants reported a desire for doctor-patient e-mail. Psychiatrists may be wary of potential breaches of confidentiality, as security concerns are among the primary reasons for physicians' decisions not to use e-mail with patients.¹¹ Some physicians worry that they may become inundated with e-mails once they begin to use the medium,¹² and some worry that they may not be adequately reimbursed for time spent on e-mails.^{13,14}

Risks Associated With E-mail in Psychiatric Practice

For several reasons, e-mail communications may be treated differently, both legally and ethically, from telephone-based interactions. Unlike telephone calls, e-mails create a permanent written record of the communication, eliminating doubt as to the actual words communicated, but perhaps leaving as many questions as to the meaning of the words. E-mails are subject to discovery,¹⁵ subpoenas, and search warrants, particularly in cases in which a court may decide that the e-mails were not privileged communications. There may be significant lag time between the moment when a patient sends an e-mail and the moment when the physician responds, which greatly increases risk in crisis situations. The perception of confidentiality may differ from the actual confidentiality (or lack thereof) of doctor-patient e-mail, just as it may differ in other settings.¹⁶

Some commentators suggest that physicians print and save e-mails in a patient's medical record.^{17,18} If a psychiatrist fails to save e-mails in a medical record, the patient may be harmed because of incomplete information in the medical record, even though an electronic record might exist on the physician's computer. The psychiatrist who fails to save e-mails in the medical record may be held liable for malpractice if another caregiver relies only on the paper record, and harm results.^{15,19} As electronic medical records become more common, e-mail may be automatically saved into a patient's electronic medical record,

thereby avoiding the extra step of maintaining both a paper and an electronic record.

Psychiatrists should utilize safeguards such as firewalls and password protection to protect patient data confidentiality and security. E-mail raises concerns about the risk of a breach of confidentiality and potential violations of federal and state laws. The Health Insurance Portability and Accountability Act (HIPAA) of 1996²⁰ includes requirements for covered entities concerning the security and privacy of personally identifiable health information (PHI). Because e-mail may contain PHI, it is protected under HIPAA. In addition to the security and privacy requirements of HIPAA, some states have adopted additional safeguards to further protect patient health information, particularly for mental health records. A psychiatrist planning to use e-mail with patients should become familiar with HIPAA and state law and adopt appropriate procedures to ensure adequate security and privacy of patients' health information.

The chance of misdirecting an e-mail to an unintended recipient or even the intentional interception of e-mails by third parties increases potential liability exposure for the psychiatrist. This risk is significantly increased in wireless e-mail transmission. An unintentional misdirection by a physician or office staff of an e-mail containing PHI may become the basis of a civil action by the patient or an administrative proceeding for a HIPAA violation. Analogous cases in legal malpractice lawsuits involving documents misdirected by facsimile or other means may offer clues as to how misdirected e-mails may be handled by the courts.²¹⁻²⁴

In *Aerojet-General Corporation v. Transport Indemnity Insurance*,²² an attorney for a law firm representing Aerojet-General Corporation received a set of documents that had apparently been misdirected from the opposition's counsel. The documents contained information about a witness whom the attorney for Aerojet then contacted and deposed. The opposing counsel for Transport Indemnity Insurance sought sanctions against the attorney who had received the misdirected documents for his failure to notify that he had received them. The Court of Appeal of California reversed the sanction order that had been granted, stating:

The attorney-client privilege. . . is not an insurer against inadvertent disclosure. Further, not all information that passes privately between attorney and client is entitled to remain confi-

dential in the literal sense. . . . [T]he problem would be no different if [the attorney] had obtained the same information from someone who overheard respondents discussing the matter in a restaurant or a courthouse corridor, or if it had been mistakenly sent to him through the mail or by facsimile transmission. . . . [H]is professional obligation demands that he utilize his knowledge about the case on his client's behalf [Ref. 22, pp 1004, 1006].

As the Court decided in favor of the recipient, rather than the sender, of the misdirected communications, it is possible that a court would not rule in favor of a doctor who misdirects an e-mail containing PHI. On the contrary, a court may hold the doctor liable for the misdirection, possibly even deciding that the doctor-patient privilege has been waived in such communications.

E-mail communications may be analogous to tape-recorded conversations. In *Menendez v. Superior Court*,²⁵ the Supreme Court of California decided that tape recordings of psychotherapy sessions obtained by police pursuant to a search warrant in a murder investigation were not protected by psychotherapist-patient privilege when they contained threats of harm. Recognizing his duty to warn potential victims of a dangerous patient, the therapist in this case had disclosed information from the tape recordings to two women whose safety had been threatened in the recordings. The court reasoned that the psychotherapist had a right to disclose the threats to warn potential victims, under the dangerous patient exception. Applying this finding to e-mail communications, if a psychiatrist's patient indicates, through e-mail, fantasies of harming another individual, these e-mails may lose confidentiality. When a patient expresses fantasies of harming other individuals, verbalizing these fantasies may have a therapeutic effect for the patient; however, such communication may be misperceived by courts or juries as direct threats to the safety of other individuals.

In addition, transcripts of e-mails may contain scandalous or defamatory material—for example, "My boss, Joe Smith, is a crook." A chart note might only record generally, "Suspicious at work." If the transcript of the e-mail were wrongfully revealed to the outside world, Mr. Smith could be harmed, and the doctor, as well as the patient, might be sued for defamation.^{26,27}

To the psychiatrist, all avenues of communication are of importance for an accurate assessment. Assessment of physical bearing and gestures, assessment of the tone as well as the content of spoken words, and

the relationship between the visual and auditory communications are all relevant factors in making an assessment. Telephone conversations are once-removed from these avenues of communication; e-mail interactions are twice-removed. In e-mail communication, assessment of affect and mood is more difficult, and a psychiatrist may not be able to evaluate visual information such as psychomotor retardation or agitation. Because e-mail does not transmit visual or aural cues, the risk of a misdiagnosis may increase,²⁸ depending on the overall nature and history of the psychiatrist's relationship with a particular patient. Furthermore, the time delay in e-mail communication creates an additional barrier to risk assessment. The patient should be informed and understand the various risks, benefits, and alternatives to the use of e-mail as a frequent mode of communication with a psychiatrist.

Safeguards

Despite these obvious risks, some mental health professionals successfully use e-mail in their practice with available safeguards. One important and popular safeguard is encryption. Encryption technology uses algorithms to secure an e-mail. The sender from whom the e-mail originates possesses an encryption "key" that he uses to transform the e-mail text into an unintelligible sequence of characters. The e-mail is then sent, and the recipient must use a decryption key to obtain the original text of the e-mail message. A doctor may make the decryption key available to patients so that they can unscramble encrypted e-mail messages. While the process is mathematically complicated, user-friendly software is available that facilitates encryption and decryption by requiring users merely to enter the encryption or decryption key (a text phrase).²⁹ For attorneys, the American Bar Association has issued an ethics opinion that unencrypted e-mail "affords a reasonable expectation of privacy from a technological and legal standpoint."³⁰ For physicians, AMA has issued e-mail guidelines suggesting that ethically, there is no absolute prohibition against the use of unencrypted e-mail with patients.³¹ However, the AMA recommends that physicians make an effort to use encryption in e-mails unless patients waive encryption. CMS, the Center for Medicare and Medicaid Services, requires physicians to use encryption and authentication or identification in electronic communications regarding patients covered by Medicaid or Medicare.³²

Other safeguards include the use of a Web-based e-mail interface that allows a patient to log into the doctor's secure Web site and compose a message. The chance of misdirection and interception on this secure network is substantially less than in the case of e-mail accounts hosted by Internet service providers. Various companies offer secure, encrypted, Web-based messaging to physicians,³³ aiming to ease compliance with HIPAA and other regulations concerning data security and privacy. Even if the patient interacts via a secure Web site, the doctor's response, if e-mailed outside the Web site, carries the same risks. Increased security would be achieved by requiring the patient to sign in again to read the physician's response. Electronic signatures,³⁴ audit trails,³⁵ firewalls, password-protected screen savers, authentication tools, return receipts, encryption, and secure, Web-based messaging increase the security and privacy of Internet-based communications.

Many professional organizations recommend obtaining a patient's informed consent prior to initiating e-mail communication with existing patients.^{17,18,31,36} Informed-consent procedures help patients to assess risks, benefits, safeguards, and alternatives to particular forms of treatment. Because e-mail carries unique risks, patients should be given the opportunity to make an informed decision about the use of e-mail with their psychiatrists. With respect to the use of the Internet in psychiatry, the American Psychiatric Association has stated that ". . . patients must be informed of any risk to their confidentiality" (Ref. 37, Section 4-KK). The American Psychiatric Association (APA) produced a sample e-mail consent form for psychiatrists to use as an example.³⁸ It is important to note, however, that informed consent must be a process, allowing discussion between a physician and a patient, rather than merely a form the patient reads and signs. Psychiatrists should discuss with their patients reasonable expectations of staff access, relevant privacy and security risks, and the reasonable amount of time that may elapse before e-mails receive replies. Patients should be instructed to use the telephone to communicate emergency situations to the psychiatrist or simply to seek treatment at an emergency room or urgent care facility. The psychiatrist and patient should agree on what safeguards will be employed and discuss a procedure to follow with respect to emergencies, vacations, and sensitive topics.

Risks are inherent in any form of communication. It is generally presumed that patients know how to use telephones and how to protect themselves from telephone-based breaches of confidentiality. However, not all psychiatrists and physicians go through a detailed informed-consent procedure with their patients regarding the use of telephone technology. Many patients may be unaware of the risks associated with cordless telephones. How much can a psychiatrist assume that patients know about the risks, benefits, and safeguards associated with e-mail technology, and how much of a burden is on the psychiatrist to inform patients fully of all possible risks? This informed-consent procedure may vary from case to case, as some patients will be more technologically literate than others. Even when e-mail communication is initiated by the patient, can the doctor assume that the patient understands the risks? Once the practice of e-mail communication has been initiated, the content of the information may become more personal. Informed consent for the use of e-mail with patients should therefore be ongoing. Patients should be periodically reminded of existing and potentially developing risks associated with disclosure of more personal information in e-mail, such as defamation, duty to report child or elder abuse, and so forth.

"Matters of Business" E-mail With Current Patients

This article is concerned primarily with e-mail between a psychiatrist and a patient, prospective patient, or third party. Psychiatrist e-mail with current patients occurs when the psychiatrist-patient relationship is already in place. These e-mails are exchanged usually after an initial face-to-face psychiatric examination has been conducted. Existing-patient e-mails can be grouped into two categories: (1) "matters of business" e-mails concerning prescription refills, appointment rescheduling, and so forth, and (2) e-mails offering advice or discussing psychological topics. The latter category of e-mails may be considered a form of treatment.

Matters-of-business e-mails may be considered "incidental," like telephone calls, and they typically involve appointment confirmations, reminders, or rescheduling; information about on-call physicians, contact information, and refill requests. When the content of these e-mails becomes advice or delves into personal or psychological matters, the commu-

nication becomes more treatment-oriented and less administrative. Although psychiatrists do not usually charge for administrative-type phone calls, the APA in an ethics opinion explains that it is ethical to charge for telephone calls if the charges are agreed on in the initial contract for services between the psychiatrist and patient (Ref. 37, Section 2-F). Prior to charging a fee for e-mails, psychiatrists should discuss the charges with the patient in the informed-consent procedure, so that the patient understands and agrees to the fees.

There are key differences between telephone interactions and e-mail interactions, even concerning matters of business. E-mail in a doctor's office may be seen by office staff, whereas in a telephone conversation, the patient knows whether she is speaking with the doctor or a member of the office staff. Furthermore, while employers are unlikely to eavesdrop on employees' phone calls and rarely record them, employers do often read employee e-mails stored on company servers or computers. Patients who send e-mails from work should expect their e-mails to be read by their employer. Even in the home, numerous family members may have access to the computer used by the patient for e-mail. There is a risk that family members may read messages that were not intended for their review. Similar risks arise when sending mail, using answering machines, or leaving telephone messages with family members, but many doctors use precautions to protect their patients' confidentiality. For example, letters may be sent with blank return addresses, and answering machine messages may be vague. Equivalent safeguards should be applied to e-mail communications. Even the mere connection of a patient to a therapist may itself be sensitive. Patients may not always notify family members that they are seeing a psychiatrist.

Unsolicited E-mail

Unsolicited e-mail may come from prospective patients or third parties. While some of these unsolicited e-mails take the form of matters-of-business e-mails requesting appointments or inquiring whether the psychiatrist is accepting new patients, some messages may be requests for professional advice or information. While there is not yet much published literature about unsolicited e-mails received by psychiatrists, a look at unsolicited e-mails received by other members of the medical community may be illustrative of the issues raised by such

e-mail. Two studies published in the October 21, 1998 issue of the *Journal of the American Medical Association (JAMA)* examined the practical aspects of e-mail from noncurrent "patients." One study followed e-mails sent to a pediatric gastroenterology and nutrition unit at a university medical center over a period of several years.⁵ This study found that most (97%) of the e-mailed requests for medical advice originated from patients using search engines to locate medical information online. Some participants in the study claimed that e-mail consultations were more comfortable than in-person meetings with busy doctors, and that the medium of e-mail encouraged more forthright questions from the participants.

The other study in the same issue of *JAMA* explored e-mails sent by physicians in response to an unsolicited e-mail request for medical advice on dermatological symptoms of a serious condition.⁶ The researchers in the study sent an e-mail to physicians, describing symptoms of a serious herpes zoster infection, including a fever, headache, and burning pain associated with blisters on the patient's chest. The e-mail went on to mention that the patient was taking cyclosporine after having undergone a kidney transplant. The "patient" e-mail did not mention a suggested diagnosis, but several of the physicians who sent replies suggested the correct diagnosis. However, only 50 percent of the physicians responded to the request. Of those who responded, 93 percent suggested that the patient see a physician, and 26 percent of these would not give additional advice. Of the remaining physicians, 90 percent suggested a diagnosis, most naming a herpes zoster diagnosis. Five of the respondents in the study offered treatment advice to the patient, including recommendations of specific medications. It is perhaps most interesting to note that only 50 percent of the physicians responded to the e-mail, considering that the symptoms described an urgent medical condition. The researchers pointed out, as well, that the response time for replies was significantly delayed, up to 10 days. As the researchers explained: "For a real immunosuppressed patient experiencing herpes zoster, waiting 10 days for advice could have been fatal" (Ref. 6, p 1335).

A 2000 study in the *Journal of Medical Internet Research* found results similar to those of the dermatology study when an unsolicited e-mail request for advice was sent to anesthesiologists.³⁹ The fictitious patient explained that he had been put on a breathing

machine following a previous surgery, because of a problem with the way his body handles anesthesia, and he requested advice for an upcoming surgery. In this study, a 54 percent response rate was noted, and 48 percent of those who responded recommended seeing a physician. In this study, 41 percent of those who responded suggested a diagnosis. Ten percent included a disclaimer, with one disclaimer stating that e-mail was not the appropriate forum for medical advice.

E-mail solicitations for advice may pose significant ethics-related dilemmas for the psychiatrist who has an earnest desire to help those in need but seeks to avoid the development of a psychiatrist-patient relationship between himself and the sender of unsolicited e-mail. Prior to the development of Internet technology, a patient seeking medical advice would typically telephone a physician's office and schedule an appointment to speak with the doctor regarding his concern. The possibility that one may receive a professional medical opinion without paying office fees may entice an increasing number of patients to seek advice through sending e-mails to professionals whom they have never seen in person. Because the APA Guidelines have stated: "Without the direct contact in a face-to-face initial evaluation, it is difficult for a physician to provide competent medical or psychiatric evaluation and treatment" (Ref. 37, Section 1-FF), a replying psychiatrist may permissibly refrain from suggesting a diagnosis or treatment advice and probably should decline to do so in most cases.

When Does E-mail Initiate the Psychiatrist-Patient Relationship?

In *Miller v. Sullivan*,⁴⁰ the court noted that advice given by a physician to a patient during a telephone call can be sufficient to establish the physician-patient relationship when it is foreseeable that the patient would follow the physician's advice. In *Miller*, a dentist who was experiencing symptoms of a heart attack contacted a physician friend who advised him to come to the physician's office immediately. Instead, the dentist waited several hours to finish his work for the day and did not arrive at the physician's office until the afternoon, whereupon he suffered cardiac arrest. The patient was resuscitated but sustained brain damage and died several years later. Affirming a trial court order granting the defendant physician's motion for summary judgment dismiss-

ing a malpractice complaint, a New York appellate court ruled that:

A telephone call affirmatively advising a prospective patient as to a course of treatment can constitute professional service for the purpose of creating a physician-patient relationship. . . . Thus, it must be shown that it was foreseeable that the prospective patient would rely on the advice and that the prospective patient did in fact rely on the advice. . . [Ref. 40, p 823].

Applying *Miller* to e-mail in psychiatry, one may consider the hypothetical example of an individual e-mailing a psychiatrist to complain of severe anxiety. If the psychiatrist offers advice that the patient ignores, the psychiatrist may not be held liable. However, if the patient follows the psychiatrist's advice, this may establish a doctor-patient relationship. Suppose the psychiatrist offers advice similar to that given in *Miller*: "Come to my office at once." In a hypothetical worst-case scenario, suppose that the patient's anxiety attack was so severe that upon driving to the psychiatrist's office, the patient suffered a loss of consciousness due to shortness of breath and crashed into another car. The psychiatrist may be found liable to both the patient and other drivers for failing to assess the patient's condition accurately and thoroughly. A jury may decide that the psychiatrist should have told the patient to call an ambulance and go to an emergency room rather than come to the psychiatrist's office.

If a patient contacts a physician by e-mail to initiate treatment, the existence of a physician-patient relationship and duty of care may be a question of fact for a jury to determine.⁴¹ As Law Professor Nicholas Terry points out, courts are likely to give more weight to perceptions held by the patient than to those of the psychiatrist regarding the status of the relationship between the provider and patient,⁴² disclaimers (e.g., "this e-mail does not constitute a consent to provide treatment") notwithstanding.

One case commonly referenced on the existence of the physician-patient relationship by telephone is *Adams v. Via Christi Regional Medical Center*.⁴³ In *Adams*, the court described the physician-patient relationship as follows: "A physician-patient relationship is consensual. Thus, where there is no ongoing physician-patient relationship, the physician's express or implied [emphasis added] consent to advise or treat the patient is required for the relationship to come into being" (Ref. 43, p. 140). The jury in the trial court had been instructed of the following: "A physician-patient relationship may be created in any

number of ways, including the act of a physician agreeing to give *or giving advice* to a patient in person *or by telephone* [emphasis added] (Ref. 43, p 140). The court found that a doctor's recommendations, over the telephone, to the mother of a critically ill young woman were sufficient to establish a physician-patient relationship between the physician and the daughter. He was thereby found to owe a duty of care to the young woman, despite the fact that the communications occurred between himself and a third party (namely, the patient's mother) and over the telephone. One can easily see the same rules applying to e-mail communications.⁴⁴

As e-mails save written records of exactly what was communicated by the physician to the patient, a jury may interpret any word or clause as "advice" and therefore an agreement to form a doctor-patient relationship. Indeed, some level of professional responsibility may arise from consent to provide treatment at a future date.⁴⁵

E-mail and Third Parties

A psychiatrist may receive e-mailed inquiries from third parties, such as family members of patients. Just as with phone calls from third parties, the psychiatrist has a duty to exercise caution in the handling of these contacts, particularly if he wishes to avoid initiating a psychiatrist-patient relationship between himself and the third party.

In *Ramona v. Ramona*,⁴⁶ a father brought a lawsuit against his daughter's therapists when he was accused by his daughter of having sexually molested her. After seeking treatment for bulimia and depression,⁴⁷ the young woman underwent an Amytal Sodium interview and came to believe that her father had sexually abused her. She later met with her father and her therapist to confront her father about the alleged sexual abuse. Following the confrontation, the father lost his marriage and his job and subsequently brought a lawsuit against the therapists involved in his daughter's care. The court ruled "that therapists owe a duty to third parties to whom they direct their interventions. . ." (Ref. 48, p 297).

Applying this logic from the *Ramona* court to e-mail in psychiatry, we see that the psychiatrist must exercise caution when handling e-mails with third parties, particularly if these third parties are, or may become, actively involved in the patient's care and treatment. Even a seemingly harmless suggestion

(e.g., "Just be there to listen if your son needs to talk with you about his drug abuse.") could be construed as advice, functioning as part of the patient's treatment, possibly even increasing the likelihood that the third party would believe himself to have a doctor-patient relationship with the psychiatrist. In both *Bienz*⁴¹ and *Adams*⁴³, third parties (the patient's wife and the patient's mother, respectively) had played active roles in the patient's treatment and had later become plaintiffs in the malpractice lawsuit against the physician. If a patient has not given his psychiatrist explicit permission to discuss his case with third parties, e-mails providing patient-specific information from the psychiatrist to third parties are strong documentation of a breach of confidentiality and a violation of HIPAA, not to mention questionable ethical judgment on the psychiatrist's part.

Unavailability and Unanswered E-mails

The APA ethics guidelines state the following:

Ethical psychiatrists are obliged to render competent care to their patients. That competent care would include either being available for emergencies at all times or making appropriate arrangements. Certainly, a message telling patients to call an emergency room is not adequate coverage. Even in rather stable practices, including analytic practices with relatively stable patients, emergencies do arise. Care must be taken that, if and when such emergencies do arise, the patient is not abandoned [Ref. 37, Section 1-AA].

While the APA indicates that doctors should be available at all times, some test of reasonableness must apply. The need to be available to patients at all times may be satisfied by the use of an answering service. Answering services are staffed 24 hours a day, but e-mail is not always checked hourly or even daily. In psychiatry, e-mail may actually allow patients to communicate more effectively than answering services, as some patients may not be comfortable relating their questions or problems to strangers staffing an answering service, but may feel more comfortable doing so through e-mail or electronic voice mail to their psychiatrists. Patients should be informed absolutely that e-mail is not to be used for urgent matters unless the psychiatrist is available for a quick response.

A duty to a patient and subsequent breach constituting negligence may be established through the unavailability of a physician who was expected to be available.⁴⁹ A psychiatrist may be found liable

for breach of contract for failing to return a phone call for a significant length of time. In *St. Charles v. Kender*,⁵⁰ a physician was found to be in breach of contract when she failed to return a new patient's phone call for two days while the patient was suffering a miscarriage. In this case, the plaintiff did not make a claim of medical malpractice, but rather of breach of contract. The patient was not awarded monetary damages, as she was already having a miscarriage and suffered no monetary loss. However, applying the court's finding to the field of psychiatry brings to light the possibility that a psychiatrist who fails to respond promptly to patients' e-mails may be found liable, not only for medical malpractice, but perhaps also for a breach of contract, if a patient grows desperate and harms himself or others. Psychiatrists should inform patients of the reasonable amount of time that may elapse before e-mails receive replies. Patients should be instructed to use the telephone to communicate emergency situations to the psychiatrist or to seek treatment at an emergency room or urgent care facility.

A psychiatrist may set up his e-mail account so that a patient who sends an e-mail automatically receives a reply from the psychiatrist with predetermined contents, reminding the patient that e-mail is not a suitable forum for emergencies, listing the psychiatrist's phone and/or pager number, other emergency contacts, and reminding the patient of the risks and safeguards of e-mail communication, including the frequency with which the doctor checks his e-mail and sends replies. This information should be only a reiteration of the issues discussed by the psychiatrist and patient during a prior informed-consent procedure. A sample autoreply may appear as follows. (Names and anecdotes are fictional and hypothetical; any similarity to real persons or events is accidental.)

Dr. Z. has received your e-mail but may not have read it yet. Dr. Z. checks his e-mail at least twice a day on weekdays and sporadically on weekends. Replies may take several days. If you have not received a reply within 72 hours, please call Dr. Z.'s office at [phone number]. E-mail is not a suitable forum for communication of emergencies or crisis situations. E-mail communication carries risks to confidentiality and security of the e-mail contents. Although Dr. Z.'s e-mail is encrypted, this does not mean that confidentiality and security may be guaranteed. Dr. Z.'s staff may periodically read e-mails sent to him. IF THIS IS AN EMERGENCY, OR IF YOU ARE HAVING THOUGHTS OF HURTING YOURSELF OR HURTING OTHERS, PLEASE CALL DR. Z. IMMEDIATELY AT [re-

peat phone number], GO TO AN EMERGENCY ROOM, OR DIAL 911 FOR EMERGENCY SERVICES.

Ethics-Related Considerations

Psychiatric or psychoanalytic correspondence with patients is by no means a new phenomenon. Sigmund Freud corresponded with colleagues and patients and even replied to unsolicited requests for advice from members of the public.⁵¹ Following Freud's example, other psychoanalysts also engaged in correspondence with their patients, sometimes using letters as an adjunct to traditional psychiatric treatment. While correspondence with patients has fallen out of vogue in the psychiatric community, it shows signs of possible revival as a therapeutic modality to supplement more traditional care.⁵²

The use of e-mail raises additional concerns with respect to the standard of care owed to the patient. When examining negligence claims against psychiatrists, courts are likely to apply professional standards of ethics to the conduct of individual psychiatrists. As one scholar points out: "It makes little sense, from an ethics perspective, to talk as if an electronic encounter does not create a patient-physician relationship. The issue is the extent of the relationship and, thus, the nature and extent of the physician's obligations" (Ref. 8, p 64). No psychiatrist or other mental health professional should assume that a disclaimer in an e-mail will be a shield from liability or that e-mail communications cannot initiate a physician-patient relationship. Indeed, as the AMA has indicated: "Disclaimers alone cannot absolve physicians of the ethical responsibility to protect patients' interests."³¹

Unsolicited e-mail is likely to result in some of the greatest dilemmas in ethics for psychiatrists. Consider the following hypothetical example:

Dear Dr. Z.,

I know you don't know me, but I'm feeling really suicidal, and I hope you can help! My girlfriend said she's going to leave me, and I don't know what I'll do if she leaves. I'd kill myself if I lost her. I'm not going to see a psychiatrist, because I know I'm not crazy. I know, you'll tell me to go to the emergency room or to call a doctor here, but I'm not going to do that, so don't tell me to. I hope maybe you can tell me what I can do so my girlfriend doesn't leave me, because if she leaves me, I'm going to kill myself.

Thanks,

John Doe

When a psychiatrist decides not to respond to such an e-mail from a suicidal person who subsequently

commits suicide, is the psychiatrist legally liable?⁵³ A psychiatrist who ignores an e-mailed suicide threat simply out of fear of liability may not be rising to the highest standard of ethics but would be unlikely to be found liable in malpractice for any ensuing suicide, as no doctor-patient relationship would have been established. What if the psychiatrist does respond, however? Would he or she be held blameless for an unfortunate outcome? In normal emergency situations, physicians may be entitled to protection under “Good Samaritan” statutes when they render care at the scene of an accident.^{9,44} It is unclear, however, whether the same protection would apply to cases in which a patient e-mails a psychiatrist during a moment of crisis.

The hypothetical psychiatrist in our scenario may decide that she has an ethics-based responsibility to help the sender of the e-mail to obtain the treatment he evidently needs. The psychiatrist may believe that if she corresponds with the sender for a brief time, she may persuade him to seek help in person. There is also a very realistic possibility that seriously suicidal patients may e-mail psychiatrists as a final “cry for help” before attempting suicide and that, in such cases, the psychiatrist’s response may deter action.

If, in our hypothetical scenario, the psychiatrist replies, and it becomes clear that the patient is unwilling to seek help at an emergency room or in face-to-face treatment, should the psychiatrist attempt to have the patient involuntarily committed? Furthermore, if the patient has provided only an e-mail address with no further contact information, the task of seeking involuntary commitment becomes extremely complicated.

A reply from the psychiatrist to the hypothetical e-mail may attempt to remind the sender that he (the psychiatrist) is not his doctor and therefore cannot help him but nonetheless is referring the sender to sources that may be able to steer him toward help. Consider the following hypothetical reply:

Dear John,

I cannot undertake your care or provide advice for you personally. I am not your doctor. People who are suicidal should seek help immediately. For example, they can call 911, go to an emergency room, or call their own physician.

Sincerely,

Dr. Z.

Particularly in crisis situations such as that of the hypothetical suicidal man, it would be imprudent for

the psychiatrist to include advice in an e-mail to a member of the general public. Advice that is tailored to a particular individual or a particular individual’s situation (e.g., “John, you may wish to see a marriage and family therapist for your relationship troubles or a psychiatrist for your suicidal thoughts.”) is likely to be viewed by the individual and by the courts as medical or psychotherapeutic treatment, rather than simply information disseminated for educational purposes. The decision to provide advice to an unknown individual greatly increases the risk to both the individual and the psychiatrist. Had the e-mail originated from a known patient, with whom the psychiatrist already has a treatment relationship, the psychiatrist would have an additional level of responsibility. As discussed previously, an autoreply feature may be a positive, ethical step, reminding patients of the most appropriate procedures to reach the doctor in times of crisis.

A sender of an unsolicited e-mail to a psychiatrist may omit vital information or misrepresent other information. Inadequate information from the sender could lead to inappropriate advice from the psychiatrist. In the hypothetical example, the suicidal man has given very little information about his situation. Suppose the hypothetical Dr. Z. had sent him a general but vague message, such as: “I can’t be your doctor, but don’t lose hope. People can often work things out” and then received this response:

Dear Dr. Z.,

I did what you suggested. I tried talking to her. She said she has a restraining order now, and if I ever try to see her again, I’ll get arrested. Guess I really blew it this time. Thanks for the lousy advice. There’s nothing left for me to live for now that I’ve lost her. I won’t bother you again. Thanks anyway.

Your dead patient,

John

Ultimately, the doctor’s response to an e-mail may be left for a jury to consider when ascertaining whether the physician owed a duty of care to the patient and whether the physician-patient relationship was in place.

E-mail in Psychiatry: Conclusion

For some individuals, mental illness and various psychological concerns may be sources of stigma or embarrassment. In these cases, the perceived anonymity of e-mail communications may be the only forum in which the patient is comfortable seeking

help. This poses a complicated dilemma in ethics for the psychiatrist. One patient has written of her positive experiences communicating by e-mail with her mental health provider, outlining how e-mail contact between herself and a clinician when she was in crisis led to eventual face-to-face meetings and significant improvement in her situation.⁵⁴ Recognizing that one may be able to help a patient who is initially only willing to communicate by e-mail, a psychiatrist is faced with a difficult choice between increasing liability through such contact and refusing help to a patient in crisis.

E-mail between psychiatrists and known existing patients may affect the nature of the psychiatrist-patient relationship. E-mail between psychiatrists and prospective "patients" who are not currently receiving face-to-face treatment is likely to establish a physician-patient relationship in which the psychiatrist agrees to provide advice or treatment and the patient relies on the advice or information provided by the psychiatrist. Just as psychiatrists have established techniques to deal with telephone messages, they must develop procedures to follow when handling e-mail communication with patients. Psychiatrists intending to implement e-mail with existing patients should develop a procedure to inform patients of the risks, benefits, and safeguards associated with the medium. Patients should be required to indicate their consent to these risks, benefits, and safeguards prior to the psychiatrist's implementation of e-mail contact with them. When dealing by e-mail with nonpatients, the psychiatrist must take particular care to ensure that a doctor-patient relationship is not inadvertently created.

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