

Unsolicited E-mails to Forensic Psychiatrists

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E-mail communication is pervasive. Since many forensic psychiatrists have their e-mail addresses available online (either on personal websites, university websites, or articles they have authored), they are likely to receive unsolicited e-mails. Although there is an emerging body of literature about exchanging e-mail with patients, there is little guidance about how to respond to e-mails from nonpatients. Therefore, we used a Delphi technique to develop a consensus about salient points for the forensic psychiatrist to consider regarding responding to e-mails from nonpatients and the risks entailed. Four scenarios are described, including e-mails from nonpatients and unknown others requesting advice or help. The potential ethics-related, legal, moral, and practical concerns for forensic psychiatrists are discussed. Finally, potential pitfalls for forensic psychiatrists are described.

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New forms of electronic communication have opened up many ways of contacting psychiatrists. E-mail and social media have increased the public visibility of practitioners. Medical protection agencies and professional organizations have delineated practice standards for communicating with patients using electronic methods.^{1–4} However, little consideration has been given to unsolicited e-mail commu-

nications. Both general and forensic psychiatrists are likely to receive unsolicited e-mails. Eysenbach noted that “Every physician who has published his email address . . . receives unsolicited emails from patients he or she has never seen before” (Ref. 5, p 3). Recupero wrote, “Unsolicited e-mail is likely to result in some of the greatest dilemmas in ethics for psychiatrists” (Ref. 6, p 472). Concerns for the psychiatrist who receives these e-mails may include whether it is from a real person and whether the correspondent is asking for advice. Is the psychiatrist at risk if he replies or at more risk if he does not? What if there is an apparent crisis or danger, either to the sender or to others? How is a physician–patient relationship defined? When is liability attached to e-mail replies? What are the legal versus the ethics-related concerns?

Despite the ubiquitous nature of the Internet and anecdotal reports from colleagues about receiving unsolicited e-mails from unknown persons, there is little guidance in the professional literature. It has become easier over time for nonphysicians who are seeking information on the Internet to obtain the e-mail addresses of forensic psychiatrists through Google Scholar searches of research articles or hospi-

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tal websites. Oyston noted that receiving e-mail from unknown patients “produces an ethical and legal dilemma, as the recipient of the message has to balance a natural and desirable human response to offer help to someone who has a problem against the medical, legal, and ethical pitfalls of providing advice to an unknown person . . .” (Ref. 7, p 3). The desire to help others and to relieve suffering that initially draws many physicians to medicine must be balanced against potential liabilities when replying to unsolicited e-mails.

There has been little research on medical professionals’ responses to unsolicited e-mails. Available data suggest that patients use e-mail in search of specific medical assistance. Wakelin and Oliver analyzed the 20 unsolicited e-mails received by an orthopaedic surgeon over a six-week period.⁸ Almost half of the writers (45%) requested advice, and 20 percent sought treatment. One-third pursued information with legal implications. Even after a boilerplate reply was sent, explaining that the surgeon did not respond to unsolicited e-mails, one-fifth continued to message him. Eysenbach and Diepgen reviewed 209 unsolicited e-mails sent to German dermatologists by nonphysicians.⁹ Three-quarters asked specific questions, including 11 percent who solicited a diagnosis or an opinion after listing symptoms.⁹

Many physicians, at their peril, reply to these requests. Oyston⁷ reported a study in which an e-mail message from a fictitious patient was sent to 108 anesthesiologists, requesting advice about anesthesia after ventilation. The majority (54%) responded. More than one-fifth of the physicians contacted offered the imaginary patient a potential diagnosis. In another study, researchers sent an e-mail to 58 academic dermatology websites from a fictitious patient who claimed to have a specific dermatological condition for which early treatment is essential to prevent severe complications or death.¹⁰ Half of the e-mails received a response. Of the replies, 93 percent urged the patient to see a doctor. Such studies, in which physicians reply to specific concerns without intending to create a physician–patient relationship, have been described as “demonstrating a surprising naiveté on the part of well-meaning physicians.” (Ref. 11, p 1).

Ignoring all unsolicited e-mails from strangers may give rise to ethics-related conflicts.¹² Recupero noted:

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 [Ref. 6, p 473].

The orthopedic surgery article noted:

Doctors should remember that they are not duty-bound to respond to unsolicited emails and when they do choose to do so it would be wise to tread carefully. . . . It is easy to envisage how the unsuspecting practitioner could inadvertently become embroiled in medico-legal disputes which are best avoided [Ref. 8, p 484].

Recupero described a hypothetical unsolicited e-mail in which a nonpatient claims he is “really suicidal” over the potential loss of a relationship (Ref. 6, p 472). She suggested sending a generic reply that reminds the recipient that there is no doctor–patient relationship and encourages the person to seek appropriate help. An e-mail that appears to be tailored to the individual seeking advice may appear to both the writer and the courts to establish a relationship. She noted: “As emails 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.” (Ref. 6, p 471). Regardless of the presence of a disclaimer in the e-mail, the patient’s perception of a relationship rather than that of the psychiatrist may be what matters.⁶ Eysenbach further recommended avoiding sending out personalized messages, such as referring to the sender by name in the text.⁵

As noted above, there is little guidance on how to approach unsolicited e-mails, although the studies of other professional groups raise many potential pitfalls. Arguably, forensic psychiatrists may be contacted about specific risk-related and legal matters more commonly than other physicians. To explore these questions, we sought to gain an understanding of how experienced forensic psychiatrists approach this ethically fraught area of modern forensic practice. Other forms of unsolicited contact, which include phone calls and letters, present their own particular problems and will not be covered in this article.

Methods

The Delphi technique, which is a qualitative iterative (systematically repetitive) process, was used. The method involves multiple stages, each building on the last. Systematic structured communication

with an expert panel is used. This method allows for independent thought, idea generation, and gradual consensus building.¹³ Structured rather than unstructured group decisions are more likely to be accurate.¹⁴ This method was considered most appropriate because of the dearth of consensus in the literature and because expert guidance could help future decision-making. Samples in the Delphi method are not meant to be generalizable.

In the first stage of the technique, expert panelists discussed the topic of unsolicited e-mails and related some of their personal experiences. Then, questionnaires were constructed including four sample case vignettes of unsolicited e-mails (based on personal experiences). The four types of e-mails that were considered were a request for nontraditional medical services, a private party's request for dangerousness assessment and advice about a relative, a request to do research on a private party, and a request for supervision. Unsolicited e-mails from attorneys were not considered in this project, because, although such messages are common, nonresponse poses minimal risk to either party.

Questionnaires were then distributed to the expert panelists. Responses were collected, with both commonalities and conflicting opinions noted. In the third stage, a nonpersonally identified summary of the expert panelists' opinions from the questionnaires, their rationales, and reasoning was provided to the panel. This relative anonymity and use of a questionnaire was selected to allow freer expression of opinions and nonconformity, decrease only favorable responses, and encourage critiques. Then expert panelists further considered their replies in light of others', and consensus was gradually built. This process was continued through the planned endpoint of reaching consensus on the guiding principles.

Members of the Group for Advancement of Psychiatry's (GAP) committee on Psychiatry and the Law made up the expert panel. GAP is a North American think tank of invited expert psychiatrists, seeking to offer careful objective perspectives on challenges currently facing psychiatry. Members are invited based on psychiatric expertise. GAP has been in existence since 1948 and has been a leader in psychiatric thought on many areas that relate to the profession. GAP's values include respect, honor, openness, quality, altruism, diversity, independence, and leadership to address emerging concerns in psychiatry. The GAP Committee on Psychiatry and Law

was considered well suited for the Delphi method, because it is a committee of experts working in their area of special interest and expertise, specifically forensic psychiatry.¹⁵

The 10-member expert panel had a mean length of forensic practice of more than 15 years. Expert panelists' knowledge ranged from being quite aware of their own hospital's and insurance carrier's policies about responding to e-mails to lacking awareness. Expert panelists varied regarding whether they open e-mails from unrecognized senders, or those with empty subject lines. A range of junk e-mail filters was reported. Most did not regularly exchange e-mails with their own patients. They described variable risk tolerances and most perceived of themselves as humanitarians.

Results and Emerging Themes

The four vignettes and expert panelists' responses are described below.

Vignette 1: "Please help me die!"

A psychiatrist who has written several Op-Ed pieces on palliative care and end-of-life decision-making for regional newspapers receives the following e-mail message:

Dear Dr. X:

I am writing to you because I do not know where else to turn. I am 71 years old and I have suffered from intermittent bouts of severe depression my entire life. At present, I am on medication and symptom free. However, I am unwilling to endure another episode of depression ever again. The truth of the matter is that I am not at all afraid of death, but I am terrified of suffering of the kind I have experienced in the past. I have resolved to end my own life at present, while I am happy, to avoid such a possibility.

I have read your thoughtful writing about "death and dying," and I believe you are the sort of physician who might understand my plight. (My own doctor says he is unable to help me.) Can you please offer me some guidance on what resources are available to a person in my circumstances? I understand that euthanasia may be available to people in my situation in Montana and Switzerland. Do you have colleagues there to whom you could refer me? Any suggestions you might have—even regarding available literature—would be much appreciated.

Sincerely,

John Doe

How, if at all, should Dr. X respond to this message? If this physician believes that assisted suicide should be available to a competent adult under such circumstances, can he ethically and legally provide the writer

with printed material about assisted suicide laws in five states, Switzerland, and elsewhere? If the writer actually reported suffering from a terminal illness such as amyotrophic lateral sclerosis or cancer, do ethics and law permit the physician to provide literature or even referral information?

Expert Panelists' Responses

The psychiatrist in this scenario faces significant ethics and legal conundrums that raise complex questions regarding the boundaries between advocacy and therapeutic engagement. The first decision that the psychiatrist must make is whether to acknowledge the e-mail at all. Some may feel that acknowledging such an e-mail in any way will raise false expectations in the writer or unnecessarily blur the boundary between a nonprofessional and professional relationship. They believe the most appropriate course would be to ignore the message. Responding to the e-mail also raises legal concerns: Having replied once, does the psychiatrist have an obligation to respond to future messages, especially if these messages become more desperate or overtly threaten self-harm? One solution might be for such a high-profile person to have an automated reply on his e-mail stating, "If you have contacted me for help with assisted suicide, I urge you to contact your own mental health clinician, as I am legally unable to respond to such messages; if you have contacted me on another matter, I will get back to you." It is worth noting that the Princeton University philosophy professor Peter Singer uses a similar automated message for those who wish to discuss his controversial positions on bioethics topics. On the other hand, offering a polite response, even if one refuses assistance, may strike the psychiatrist as more in line with human decency. By holding himself out as a public figure on the subject of aid in dying, he should have expected such messages, and to ignore them entirely seems a disservice to those in need who take the time to seek his assistance.

Assuming that the psychiatrist chooses to reply, he must decide how involved he wishes to become in the writer's situation. It is possible that the writer has active psychiatric symptoms, despite his denials, and these symptoms may be contributing to his desire to die. On the other hand, the writer may genuinely be in remission and may now be seeking help with what is often termed "rational suicide," without having diminished capacity. The psychiatrist is not likely to

be able to make such a determination unless he acquires additional information, including direct contact with the writer, in which he runs the risk of creating a physician–patient relationship. (Whether someone seeking assistance with suicide can be considered a patient is in itself an unresolved question in the literature; one might alternatively choose the term "client" or "recipient of services," but those states that have legal physician-assisted suicide have generally retained the word patient in their guidelines and case law and in fact stress the importance of an established physician–patient relationship.) Assuming that the psychiatrist does not wish to create such a relationship, he should take the following two steps:

Inform the writer explicitly that he is not willing to be the writer's physician.

Urge the writer to discuss his wishes with his current psychiatrist or to find a psychiatrist willing to engage in such discussions.

These steps help ensure that the writer will not go untreated.

Yet the writer has written seeking guidance, and so the question arises of whether the psychiatrist can ethically and legally take additional steps beyond those outlined above to offer some general wisdom on the matter of assisted suicide. At present, many leading professional organizations in medicine are opposed to assisted suicide. For example, Opinion 2.211 of the American Medical Association's Code of Ethics states, "Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks."¹⁶ Many states continue to prohibit physician assistance in suicide. Yet such sentiments are not universally held and attitudes among physicians may be evolving along with those of the general public. A reasonable person might consider referring the e-mailer to printed material online that describes the criteria and process for seeking aid in dying in jurisdictions where physician-assisted suicide is legal. (Currently, Oregon, Washington, Montana, Vermont, and recently, California allow physician assistance in dying.) In some of these states, the intervention is both legal and regulated, with screening processes and rules designed to filter out patients with significant mental illness. It is worth noting that this e-mail writer is unlikely to meet the established criteria for aid in dying in these

states. More problematic would be providing information about policies outside the United States, such as those in Switzerland, where patients are not screened as closely. Guiding the writer to any illegal means of ending his life would certainly be impermissible, as no such screening process would be involved. (We confine ourselves here to offering such guidance to a nonpatient.) However, it is important to note that even directing a nonpatient to publicly available information on programs for aid in dying that are legal in other jurisdictions may be a violation of the assisted-suicide statutes in some states. The physician would be exposed to criminal liability as well as civil sanction, so that even such conservative steps should be taken cautiously, with a full knowledge of the law where one practices.

Vignette 2: "Please advise me for free"

A forensic psychiatrist receives the following e-mail message:

Dear Dr. Y:

I looked you up on the Internet and I am hoping you can help me. I do not have any money to pay you, but I would be very grateful. Last year, I found out that my husband was involved with another woman and I ended our relationship and moved in with my parents across the state, taking our four-year-old son with me. My husband did not accept our breakup. Although I am the one with the legitimate grievances, he has been calling me late at night for the past few months and demanding that we get back together. His messages have grown increasingly desperate and paranoid, and he has made vaguely frightening remarks like, "This story won't have a happy ending if you refuse to meet with me," but he has not made any direct threats. You should also know that my husband used to have a serious alcohol problem and I fear he is drinking again. Once, while drunk, he hit a neighbor with a tire iron. I do not want to get the police involved unless absolutely necessary, because I recognize that my husband is suffering and because he is the father of my son. He also might still be on parole for the tire iron incident and I don't want him to return to prison. At the same time, I don't know how seriously to take his threats. I have tape recorded several of his phone calls and the messages that he left for me. Would you be willing to listen to them and offer some advice about how to handle this situation? Do you think I am in danger? Thank you in advance for any help you can offer. I trust, as a physician, you will honor confidentiality and not share this information with anyone.

With gratitude,

Jane Doe

What guidance, if any, should Dr. Y offer to this writer?

Expert Panelists' Responses

Assuming Dr. Y does not wish to enter into a physician–patient relationship with this writer, her first choice is whether to respond at all. It should be noted that there is little concern that the psychiatrist will unintentionally become involved in a physician–patient relationship with the husband in this case; rather, the concern is that in implicitly soliciting a risk assessment on a third party, the wife may believe she is herself entering into a therapeutic relationship with Dr. Y.

From a potential liability standpoint, a strong case can be made for ignoring these sorts of messages as a matter of policy; whereas some jurisdictions impose a duty to assist on witnesses to danger, such as automobile accidents, none extend that duty to remote solicitations for professional assistance. Good Samaritan laws are not protective in this case because an e-mail does not suggest an emergency. Dr. Y might even, as a matter of policy, choose not to read such messages, stopping as soon as the purpose of the message became clear. Some jurisdictions impose a limited duty on physicians to report very narrow varieties of wrongful conduct encountered outside the course of a physician–patient relationship, such as child abuse and physician impairment. Although these mandatory reporting duties do not appear to be implicated here (there appears to be no direct evidence that a child is endangered), providers should know whether their jurisdiction requires reporting of such matters discovered outside a physician–patient relationship. Some jurisdictions do and others do not. Dr. Y presumably faces the same time constraints as many physicians; she cannot be expected to solve all of the world's problems or to assist every stranger who seeks her help.

Yet Dr. Y may feel that human decency demands at least acknowledgment of this request for assistance; she may even believe that some rudimentary effort to make the writer aware of available resources is ethically required of her. If she does respond, she would be wise to clarify at the outset that she is not offering medical advice nor is she agreeing to become Ms. Doe's physician. She might even state politely that this will be her only response to the writer, attempting to forestall further communication. She should also clarify that the confidentiality of a doctor–patient relationship does not exist between them. Most important, Dr. Y should note that nothing in her response should be construed to be a determination of the degree of danger that Ms. Doe's

spouse poses. Once she has laid out these parameters, Dr. Y might urge the writer to contact law enforcement authorities, noting that the police are best equipped to determine the danger in such a situation. Dr. Y might also provide general guidance on how to find a psychiatrist to cope with the situation, such as dialing “LIFENET” (a mental health crisis service <http://800lifenet.org/>) in some American jurisdictions. Making the writer aware of the existence of emergency shelters for domestic violence victims might also be within the realm of one-time advice that Dr. Y chooses to offer. Needless to say, although there is no medical chart because this is not a physician-patient relationship, Dr. Y should record her actions carefully.

The challenge of this case is that the desperation of the writer has the potential to draw the physician into a complex situation that she is ill equipped to handle. Dr. Y should remind herself that without a physician-patient relationship, her ability to assist the writer is extremely limited. By partially involving herself in the writer’s life, even with the best of intentions, she may actually deter the writer from seeking the legal or medical care that her situation requires.

Vignette 3: “Please research me”

As a forensic psychiatrist who has published in the area of stalking, you receive a message from an unknown person who has found your e-mail address online. The correspondent writes a lengthy description of how he has been stalked and threatened by a group of “militant feminists” after he broke up with his “crazy girlfriend.” He would like to speak with you on the phone so that you can do research on his life and so that he can tell you more about these feminists. What should you do?

Expert Panelists’ Responses

Competing considerations in making the decision of whether to reply included regard for the person’s welfare, liability concerns regarding licensing in the state that the writer is in, and the troubling information provided in the unsolicited e-mail.

A possible course of action would be merely to state that one is not interested in performing the research. Another reply might be to thank the correspondent for his e-mail and decline further contact. If the person appeals again, the conversation could be closed more firmly. Both of these approaches acknowledge the efforts of the e-mail writer in reaching out, but are meant to end the correspondence. Sim-

ilarly, one could reply that the person may wish to speak to a local mental health professional, while explaining that one cannot be of direct service, unless the correspondent were to schedule an appointment. One might consider referring the request to a psychiatrist in the person’s area. Depending on whether the request is appropriate in the first place, this action may lead to unsolicited e-mails to another forensic psychiatrist and create an ethics-related dilemma for that clinician. As well, if the psychiatrist replies to the e-mail asking the location of the author, it may be seen as an entry to engage in a more lengthy conversation and initiate a relationship.

Even if one is an expert on a topic (stalking or another topic), one should keep in mind that psychiatrists are not expected to perform research projects merely in response to a request from a stranger. Further, if one were to wish to consider performing research related to an e-mail received from an unknown sender, it is advisable to get in touch with one’s institutional review board to clarify the ethics involved and obtain informed consent.

Vignette 4: “Please give me free collegial advice!”

As a forensic psychiatrist with expertise in the area of violence risk assessment, you receive an e-mail from an unknown person who tells you that she is a psychiatrist in a distant state. She notes that she heard you speak at an APA meeting and subsequently found your e-mail address online. The body of the e-mail includes a rather detailed six-paragraph patient description about a threatening outpatient, and the psychiatrist asks you what you think she should do. What is your response?

Expert Panelists’ Responses

This request is somewhat different in this scenario, because, when taken at face value, the correspondent is an unknown colleague rather than a member of the general public. One need also consider, however, that the unknown person may not be a colleague as purported. When someone is a purported colleague, expert panelists are more likely to respond because of a sense of brotherhood with colleagues. However, even after making the decision to respond to such an e-mail, the level of response bears consideration.

In general, it appears wise not to tell the psychiatrist what to do in a potentially volatile situation. One would generally not perform clinical supervision based only on a six-paragraph description and

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one cannot know the competence level of the unknown psychiatrist. General education of the unknown psychiatrist about *Tarasoff*¹⁷, or reporting to the police is one possibility. A referral to a local forensic psychiatrist who understands local context and law is another appropriate course of action. Some expert panelists might distill for the (supposed) colleague a few key themes from the e-mail for guidance, discuss violence risk factors and various options available, but still suggest a more formal consultation with a local expert. Such a referral helps remind the colleague that the forensic expert is not a partner in the care of the patient.

A common non-e-mail analogy might be when one is asked about specific clinical scenarios as a workshop speaker. In the case of a workshop, it is usually clear that one is not providing clinical consultation on a complicated case but rather is teaching. Alternatively, one might offer a phone consultation to the psychiatrist. Another expert panelist has replied in such cases when the matter was clear, based on the e-mail description, although there may be concerns about liability. Similar to the other scenarios, one has no ethics-related obligation to be a free consultant in any and all requests. It is nice to be collegial, but a formal supervisory arrangement accompanied by compensation may be more appropriate in some cases.

Discussion

A forensic psychiatrist who is known to be an expert may expect to receive unsolicited e-mails. The expert panel noted that there are intersecting moral, ethics-related, legal, and practical concerns. Human decency, desire to relieve suffering, and beneficence may lead a forensic psychiatrist to reply to e-mails from unknown persons.

Table 1 Considerations in Deciding Course of Action After Receiving Unsolicited Email From an Unknown Person

Determine whether the sender's identity can be verified. Could it be a person other than who the sender claims to be?
Potential for creation of doctor-patient relationship with duty of care if you reply, despite lack of ability to examine or obtain collateral information in a potentially complex case
Licensing and malpractice concerns if sender is not in state
Potential for the e-mailer to misinterpret your response
False expectations: potential for lack of appropriate action by e-mailer because he believes that he is following psychiatric advice, or alternatively, because he is waiting for a reply from the psychiatrist

Table 2 Potential Decisions Regarding Response to Unsolicited E-mail From an Unknown Person

Maintain a high junk-mail filter so as to avoid knowing that e-mails have been received
Do not open e-mails from unknown senders as a matter of policy
Set an automatic reply that unsolicited e-mails are not read or replied to
Read e-mail, but choose not to reply for various reasons
Read e-mail, acknowledge by thanking sender, politely stating that you are unable to assist and declining further contact
Read e-mail, give general reply and clarify that there is not a doctor-patient relationship and that you are unable to provide medical advice; encourage sender to seek help in sender's own area; and record your course of action

Factors that psychiatrists should consider in regard to course of action are reviewed in Table 1. Table 2 reviews the various decisions that are possible regarding responding to unsolicited e-mails.

Unsolicited e-mails should not be considered to be objective or reliable sources of data. Information may be inadequate, misrepresented, or omitted, making accurate assessment impossible.^{6,11} In an anecdotal report, one forensic psychiatrist had been e-mailed asking theoretical questions quite similar to those arising during a legal case in which he was involved. Forensic psychiatrists can never be certain who the sender of the unsolicited e-mail is. For instance, such a message might actually be the "bulk e-mail of a pharmaceutical company using a subtle method of praising their products." (Ref. 9, p 155).

A standardized policy for an automated reply should be considered. Finn and Krysik¹² suggested that social agencies adopt a standardized e-mail stating that services are not conducted by e-mail and providing emergency information. The orthopedic surgeon, Oliver, described an automated reply that might be adapted for the use of forensic psychiatrists:

I am sorry but I cannot answer unsolicited medical questions sent from patients or relatives to me either by email or through my website. Clinical advice must be obtained from your general practitioner or surgeon. Unsolicited email asking for medical advice, surgical or physician referrals, and sources of medical information will not be answered [Ref. 18, p 1433].

Kuszler noted:

[P]hysicians would be well advised to proceed with the utmost caution. . . . If the physician is unable to refrain from engaging in such a dialogue, he should be extremely circumspect in his responses, avoid engaging in differential diagnosis, and steer the patient to his or her own physician or an appropriate medical center. In the final analysis, this is not just an issue of potential liability, but of the judicious practice of good medicine [Ref. 11, p 3].

Replies that are not well considered may lead to a duty and liability risk to the psychiatrist. There is always the potential for misunderstanding with electronic communication. As well, the patient may heed the advice provided and may defer seeking help in person. General guidance, such as resources for seeking help, may well be given, with clarification that there is no doctor–patient relationship and no confidentiality. However, of concern, Eysenbach stated (and various studies in other disciplines have demonstrated) that “a significant number of physicians on the internet do not confine their interactions with patients to giving general advice, but also make diagnoses and give therapeutic hints” (Ref. 5, p 6).

People may use the Internet rather than their own doctor because of frustration, desire for anonymity, lack of trust, or feeling poorly informed, or the question is about a friend or relative rather than themselves.⁹ Furthermore, there is not a cost or availability barrier. Perhaps counterintuitively, people appear comfortable sending intimate clinical information to unknown professionals, whom they may find less intimidating than their own doctor.^{9,19} Similar to our second scenario, some e-mails received by expert panelists from unknown persons have included striking amounts of detail. Whether an unsolicited e-mail is about research, consultation, or clinical matters, one is not expected to assist every help-seeking stranger who comes across one’s e-mail address.

Telephone calls are the older parallel to e-mails. A phone call soliciting medical advice, in itself, can lead courts to recognize a physician–patient relationship.²⁰ New York State’s courts have examined this question thoroughly. In New York, as in most jurisdictions, a physician who agrees to examine or treat a patient assumes a degree of responsibility for that patient and may be sued for malpractice.²¹ Whether a relationship has been established will depend upon the particular details of the phone conversation. A case for malpractice may arise when it is “foreseeable that the prospective patient would rely on the advice [of the physician] and that the prospective patient did in fact rely on the advice.”²² Malpractice, needless to say, also depends on a deviation from the standard of care and damages.

Conclusions

Unsolicited e-mails from unknown persons can represent an ethics-related and legal conundrum.

Failing to consider the implications of replying to unsolicited e-mails may expose psychiatrists to liability. Free advice, offered with the best of intentions, may still unwittingly create a malpractice risk. One should consider the benefits and risks of not opening e-mails from unknown senders or of responding with an automatic message. If choosing to reply, one should be cautious about providing advice that could be taken as the beginning of a doctor–patient relationship. It is prudent to weigh the principles described herein before clicking “reply.”

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