E-psychiatry: the patient–psychiatrist relationship in the electronic age

Mary V. Seeman,* MD CM; Bob Seeman,† BEng, MBA, LLB

Education

Éducation

Dr. Seeman is Professor and Tapscott Chair of Schizophrenia Studies at the University of Toronto and the Centre for Addiction and Mental Health, Toronto, Ont. Mr. Seeman is an e-commerce strategy consultant in Vancouver, BC.

This article has been peer reviewed.

CMAJ 1999;161(9):1147-9

Dear Dr. S: Thanks for the appointment. You always make me feel different from how I felt before. I can't wait to talk to you next week. I don't remember what you said I should do about my pills. Could you remind me?

Dear B: We agreed to keep the dose the same. See you next week.

Dear Dr. S: Thanks for your email. I love to correspond with you in this way. I had a dream last night about you and you seemed very sad. Please write and tell me you're all right.

Dear B: Let's keep our conversations limited to our appointments. See you next week.

Dear Dr. S: You're right about keeping our conversations to our appointments, but I have to tell you that I am feeling very suicidal. I thought you'd better know.

Correspondence by email between psychiatrist and patient, as in the example above, is still relatively rare.[1] But booking and checking appointment times, asking medical questions, describing symptoms and "keeping in touch" by email is coming into its own. This is problematic terrain.[2,3] Should a psychiatrist respond to such messages at all? Should a psychiatrist answer direct questions, give advice or offer psychological interpretations by email? Would the psychiatrist in this exchange be responsible if that last message from patient B were left unanswered and B went on to harm himself? In addition to the obvious moral and ethical dilemmas associated with psychiatry by email — e-psychiatry — there are also important legal, financial and privacy concerns associated with this mode of practice. In this paper we provide an overview of some of these issues.

The issue of email liability can be contrasted with liability associated with telephone exchanges. If a threat of suicide made by telephone were left unanswered and the suicide actually took place, the imprint of the message would be much more difficult to retrieve. The physician is unlikely, in that instance, to be charged with negligence. But email messaging leaves a permanent trace. Regular letters also leave traces, but they take more time to write and deliver; more deliberation is required. Email is instantaneous, spontaneous, impulsive. Messages cross miles in minutes. A patient such as B could dispatch 10 such messages an hour, every hour. What, then, should psychiatrists do — answer the messages or not?

Patients do and must have a right to sue their physicians for whatever they consider malpractice, and they or their legal representatives could construe nonresponse as malpractice. Alternatively, a rebuffing response ("Let's wait until our next appointment") could also be taken badly by a sensitive patient. Furthermore, the legal status of any advice proffered by email (e.g., "Double up on your antidepressant") varies from jurisdiction to jurisdiction.[4]

The psychiatric author of this article (M.V.S.) receives several messages a day from known patients, but more problematic are psychiatric queries from unknown persons whose whereabouts are also unknown.[5] Questions and personal complaints arrive by email from people living in other provinces, in the United States and elsewhere in the world. Because a physician's licence is usually limited to his or her jurisdiction, does dispensing medical advice to someone residing in Buffalo, Los Angeles or Hong Kong amount to practising without a licence? The emerging consensus is that the physician is practising in his or her own jurisdiction — that the patient is travelling along the information highway to visit the physician in his or her office much as he or she would travel to see a physician in another province.[6] That addresses licensing. What about negligence? If the physician provides a negligent recommendation by email to a person outside their jurisdiction, are legal

repercussions as likely? Probably not. Although it is possible to sue a doctor outside of one's own province, it is difficult to do so. The patient must hire a lawyer in the doctor's jurisdiction, a process that becomes costly and unwieldy. A climate is thus created in which medical advice provided by email can be flip, unchecked and inaccurate. The medium itself invites rapid, off-the-cuff responses, a situation that is reinforced by the relative immunity from prosecution.

Clearly, the most judicious course of action is not to respond to email queries.[7] But some are irresistible: "I have been told you are the best psychiatrist in North America. Thank you in advance for taking the time to answer this question." Or heartbreaking: "My daughter has been diagnosed with schizophrenia. I cannot believe this diagnosis is correct. The psychiatrist hardly spent an hour with her. She has always been high strung and I know she is under stress, but please tell me the diagnosis is wrong. I looked her symptoms up on the Internet. I think she may have Wilson's disease. Please tell me where I can go to have this checked."

Of course, telephone enquiries have existed for a long time, but they have never been extensive. Internet links seem to funnel email questions in from around the world. And because physicians tend to answer their own email (unlike the situation with telephone calls, which are usually intercepted by secretaries), a poorly thought out medical response is more likely.

Is e-psychiatry billable? Most health plans equate service with face-to-face sessions, and fee-for-service reimbursement is still the most common way in which North American psychiatrists are paid.[8] Provincial plans do not pay for telephone calls, for instance, but it is permissible to bill patients directly for such consultations. Would the same principle apply to e-therapy? There is a legal precedent in the state of California where, since January 1997, no health care service plan can any longer demand face-to-face contact. The intent is to reimburse telehealth providers to the same degree as face-to-face providers. Because it is customary to bill psychotherapy on the basis of units of time, is it fair to charge patients more if their therapists are slow typists? And how does the psychiatrist terminate an email session if the patient would prefer to carry on (or vice versa)? How do you "hang up"?

One advantage to electronic communication is that it is automatically recorded. No more time-consuming handwritten psychotherapy notes. No more imperfect recollection of what was said by whom and when. No more need for voice recordings, which must be laboriously transcribed. Both parties have ready access to the recorded sessions. No more miscommunications, no more mistaken impressions, no more ambiguities. Email sessions can be printed out and added to the medical chart. The Royal College of Physicians and Surgeons of Canada has not, thus far, published guidelines on when to retain email correspondence, but it seems self-evident that this should be done routinely.

Issues of privacy need urgent attention in the potentially burgeoning domain of psychotherapeutic email exchange. Strangers can gain access to private information divulged by the patient. Seemingly anonymous systems managers can read any message sent along a system. What is to prevent them from copying and disseminating confidential material? How safe is it to assume that mental health information contained in email correspondence will not be used to discriminate against patients trying to purchase life or disability insurance, as now happens when the results of genetic testing are made known?[9]

Privacy issues can be technically overcome by existing encryption methods, but it will take time for universal standards to be set. Current encryption methods will not deter the online industry from its dogged product-marketing pursuit of mailing lists, statistics and personal information. The *Journal of the American Medical Informatics Association* has addressed these issues and has issued guidelines.[7]

E-psychiatry is inevitable in the future. It will be particularly useful in preconsultation history-gathering and in the administration of paper-and-pencil psychological tests, questionnaires and rating scales before a first psychiatric appointment. It will help in the provision of services to people who speak languages known to only a small subset of clinicians and in consultations with sufferers of agoraphobia (those who fear leaving their homes) or others who cannot come to the office for physical, psychological or geographic reasons.[10] Prison populations might become a target group, and the hearing impaired are another obvious group who might benefit from this type of service provision.[11]

Quite apart from personalized therapeutic email exchanges, interactive computer-assisted therapeutic packages are available for individual disorders such as specific phobias.[12–14] For example, people with social phobia are already overcoming their fears of social occasions by meeting and interacting with others by means of bulletin boards and chat groups. A smart entrepreneur will certainly, in time, develop these ideas into prosperous Internet commodities. But can over-the-screen therapy ever be psychologically equivalent to face-to-face encounters, which register nuances of gesture and body language? Probably. High-speed networks now allow full-screen, full-motion video and voice over the Internet. When it comes to diagnosis, one recent study determined that interrater reliability between face-to-face and telephone assessment was excellent for anxiety disorders and very good for major depressive and substance abuse disorders, although problematic for adjustment disorder and depressed mood.[15] Whether a diagnosis made by email will be legally held to the same standards as one made in person will depend on several issues, notably patients' expectations and the accessibility of alternatives. The Canadian Psychiatric Association will need to develop standards for electronic practice, as has been done by the Canadian Medical Association.[16]

Psychiatrists tend to be technophobes. But they had better overcome their fears, because technologically assisted

diagnosis, transmission of referral information and consultation letters over the Net, electronic banking of progress notes and e-psychotherapy are all inevitably around the corner. Subject recruitment and research over the Net already exist. Psychiatrists of the future may be just as legally liable for *not* using technology as they may be now for applying it in novel and nontraditional ways:

Dear Dr. S: I emailed 50 psychiatrists in Toronto, and they all answered me except you. Your standards of practice are well below those of your peers. I have lodged a complaint.

Competing interests: None declared.

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Reprints requests to: *Dr. Mary V. Seeman, Centre for Addiction and Mental Health, 250 College St., Toronto ON M5T 1R8; fax 416 979-6931; mary.seeman@utoronto.ca*