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Neil S. Kaye, MD, DFAPA and Graham Glancy, MB, ChB, FRC Psych, FRCP (C), will answer questions from members related to practical issues in the real world of Forensic Psychiatry. Please send questions to nskaye@aol.com.

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Q: Can you provide some advice on the forensic aspects/applications of telemedicine?

Kaye:

Telemedicine typically refers to the use of telecommunications technology to assist in the practice of medicine. It is a broad term and encompasses telephone, teleconferencing, video-chatting, e-mail, text messaging, and instant messaging. The benefits of telemedicine are obvious including: convenience for patients, greater availability of services (especially rarer specialty consultation to rural areas and underserved populations including forensic settings) and potential cost/time savings for doctors, patients, insurers, and institutions.

Most states, and the federal government through Medicare, regulate the practice of telemedicine. Most of these laws are similar and include at least three key provisions of which all physicians must be mindful. These include: 1) defining the practice of medicine to be occurring where the patient is located; 2) noting that reimbursement is to be the same for in-person services; and: 3) and noting that treatment and consultation recommendations, including issuing of a prescription, will be held to the same standard of care (SOC) as those in a traditional in-person encounter (including the same degree of medical record keeping). Because of these requirements, it is imperative that the doctor know the patient's location during the interaction and that the doctor have a license to practice medicine in that State. Even a phone call to an active patient residing in an adjoining state could be a criminal activity (practicing medicine without a license) or result in sanctioning by the state medical licensing board.

Traditionally, medical malpractice suits require an examination of 4 specific elements often referred to as the 4 D's: was there a **D**ereliction of **D**uty that **D**irectly caused **D**amages? More specifically, the dereliction refers to a breach of the applicable standard of care (SOC). Two variables determine the traditional standard

of care within a given jurisdiction: (1) the means of comparison between the conduct of the defendant–physician and other physicians, and (2) the pool of physicians to which the defendant–physician is compared. These variables can be outcome determinative in any given medical malpractice case. Under the means of comparison variable, jurisdictions are divided between the custom-based standard and the reasonable-physician standard. Traditionally, courts applied the custom-based standard, which compares the defendant–physician's actions to medical custom. Under this standard, the fact finder determines whether the defendant has complied with the industry norms. However, many states have moved away from the custom- based standard and adopted the reasonable-physician standard. The reasonable-physician standard requires the fact finder to determine if a reasonable physician would have followed the defendant–physician's course of action in the same or similar circumstances.

It is the conflict between the "doctrine of sameness" and the traditional medical malpractice approach that opens the door to significant liability for practicing doctors. Most telemedicine laws state that the care delivered via telemedicine will be exactly the same, and held to the same standard, as that delivered in face-to-face or in-person patient encounters. In other words, the law states that any diagnosis made remotely, and any treatment or consultation advice rendered via telemedicine, must be indistinguishable from the usual practice of seeing a patient in person.

More simply said, the effect of these laws is in declaring that the "similar training-similar circumstances" approach is now being altered to be interpreted as similar training-different circumstances. In other words, it appears that the jury will be asked to decide whether or not the defendant doctor did what a similar doctor would have done in a face-to-face encounter. In proving this, expect the plaintiff to call nice, personable, possibly older doctor experts who will testify that they would have laid on hands as millennia of doctors have always done. The plaintiff's experts will likely opine that had an in-person, face-to-face encounter occurred, the diagnosis would have been more accurate or different, or that a physical examination would have yielded a different conclusion and treatment intervention, avoiding the claimed injuries. At that point, the defendant doctor (and insurer) can take out their checkbooks.

In addition, the law requires the same documentation for both types of visits. The need to go back to the file or EMR and complete a note after each telemedicine encounter must be stressed. Too many medical malpractice cases are indefensible, not because of actual malpractice, but rather because the documentation is insufficient to show the doctor's thinking, rationale, deliberations, and actions. Telemedicine, by its very nature, makes contemporaneous documentation more challenging, but that is neither an excuse nor a defense for non-compliance with the SOC regarding documentation. Perhaps something that may help is an addendum that an examination was "limited" due to the fact that the encounter was via telemedicine, although a savvy plaintiff's expert will dispute that this is a basis to

change the SOC applicable to the case. Therefore, it is important that the documentation indicate what was done, why it was done, and how the diagnosis was made, even with telemedicine, so that an appropriate defense can be made if there is a lawsuit at a later point.

So far, most of these cases are being settled by the insurers, as they are extremely difficult to defend. The reality is that most lay people (jurors) will simply never believe that telemedicine and face-to-face are the same, and they will continue to believe that telemedicine, while convenient, is simply inferior.

Glancy:

I would like to offer her some tips on a practical day-to-day level with the following caveat. There are many areas where, when members write in to 'ask the experts', I can give an answer based on my 38 years practicing forensic psychiatry and involvement with various organizations. I confess in this case that I am not an expert in telemedicine and so I consulted a friend and colleague, Dr. Pam Hoffman at Yale, who gave me some pointers to pass on to you.

First, as Dr. Kaye has advised, look up and understand the relevant licensure requirements, keeping in mind that these requirements vary from state to state. And, you must be sure you know the location of the person and how they can be contacted at that location. Also be aware that if you are considering prescribing controlled substances there may be different rules and regulations. It is important that you prepare the environment for any telemedicine encounter. This includes consideration of a background. Some virtual backgrounds problematic due to blurring and fuzziness that is difficult to tolerate. You can also buy a background, such as a bookshelf full of academic books, which can be hung behind you and gives a professional appearance. You should consider how you dress, keeping in mind this is a professional encounter. You may want to rehearse the encounter to ensure that the technology works and perhaps ask for help from a friend or colleague about your presentation.

Second, consider patient selection. This would include consideration about whether the patient has both access to the technology and at least a minor degree of literacy regarding the technology. The patient may need help from a family member (usually their 15-year-old kid) setting up and starting the interview. This does raise the issue of confidentiality. It is within your power to ensure that no others are in the room at your end, except in specified circumstances, but you can only attempt to control whether friends and family members, or even lawyers, are in the room at the other end. Ask the person if they are recording and if this is npt okay with you, specify that you are not allowing any recording.

Full and informed consent to the session is as important as it would be for an in person interview. You have to give consideration about whether this is given in

writing, presenting logistical problems, or verbally. If you are recording the interview/encounter, than the disclaimers and consents should be made part of the video record. This should include any usual warnings about mandatory or discretionary duty to warn or disclose. Insure that you document this carefully. One issue that could conceivably arise is whether you are actually interviewing the intended patient or evaluee, or if another person has slipped him for the interview. If you have any doubts it is probably best not to proceed. This issue may be particularly apposite if there is an issue of potentially prescribing controlled substances. Asking to see an ID and taking a screen shot is possible.

Another issue that may arise is what you would do if the patient reveals suicidal or homicidal thoughts to you, or whether as any other emergency arising during the interview. You should have a procedure in mind prior to the interview. This could involve calling emergency services, or contacting friends or relatives. Whatever you choose to do, you should have the means to contact these people prepared in advance should this situation arise. More commonly, there are technological emergences. This involves problems with Wi-Fi or sound. In this case also you should have some phone numbers ready to see if the problem can be easily resolved. You may want to do some asking around and research about possible platforms. First, they have to be HIPAA compliant. Second, it may be important that they can integrate easily into an existing EMR system, which might include appointment scheduling. Perhaps most importantly is that you may require 24/7 technical support.

There are certain things that appear on a video that are more noteworthy than in real life. For instance, it is helpful to make an effort to look into the tiny light of the camera, rather than the image on the screen. It can also be important to measure the space between you and the camera as we sometimes appear bizarre or even frightening if we move right into the camera. When stage actors are moving to television or film they have to be trained to tone down their expressions and movement, because everything seems "bigger" on a video or film. You may also want to cut down on hand gestures, if this applies to you, as your hands are sometimes enormous on the camera. On some platforms you can test out the camera and the sound in rehearsal and this can give you an idea of how you are perceived by others.

Take Home Points:

The alarm bell has been sounded. Doctors need to decide if they want to continue to use telemedicine in either the clinical or forensic arena or both, and if so, what special precautions must be taken to protect the doctor. Prior to making any diagnosis, the doctor must be certain of their opinion and certain that an in-person examination wouldn't be likely to provide any additional information that might be beneficial in making a diagnosis or in guiding treatment. Ask yourself, if the patient were in front of you, would you check vitals or do any type of physical examination?

If the answer is yes, this may not be a good telemedicine encounter. For a psychiatrist, this might mean that checking for cogwheel rigidity as a side effect of medication isn't possible; for medications that have specific recommendations from the FDA for ocular exams, that these can't be done; and for eye exams, it is not really possible to look for saccadic eye movements via an iPad/cell phone camera.

Telemedicine is not going away and offers substantial benefits to patients, doctors, and society. However, if doctors are held to the same SOC as in-person encounters, they need to be vigilant as to what cases they are willing to accept. Patients, legislators, and the public need to educated as to the reality of the differences between in-person medical encounters and telemedicine "visits" and should be warned and taught that they are not really the same. Every patient should be given the opportunity for in-person consultation when possible. The doctor should note the patient's consent to proceed with the telemedicine approach, but still be ready to admit that they cannot reach a diagnosis or prescribe a treatment if the information learned during the electronic appointment suggests an in-person visit is needed.