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TELEPSYCHIATRY: IMPLICATIONS FOR LICENSING AND CREDENTIALING

by Dr. Harry Karlinsky

Telepsychiatry can be defined in many ways. In the following discussion, it is defined as the live, interactive audio and visual communication that is attained through videoconferencing and that appears to offer a reasonable alternative to the traditional face-to-face psychiatrist–patient encounter. Although telepsychiatry is an intuitively appealing means of increasing access to psychiatric expertise, especially in Canada's many underserved rural and remote communities, there are many obstacles to its widespread use. One of the consistently cited roadblocks is the issue of physician licensure—the formal process by which an official agency grants an individual the legal right to practise medicine. In Canada, this is a provincial or territorial responsibility (Pong and Hogenbirk 1999). The key question in the licensure debate surrounding the practice of telepsychiatry is whether the physician (in the case of this discussion, a psychiatrist) is considered to be practising in the province or territory where he or she resides or in the one where the patient is located.

Unfortunately, no consensus in Canada has been reached on where the site of care or locus of accountability is deemed to rest. In 1998, after two years of discussion and review, the Federation of Medical Licensing Authorities recommended to provincial and territorial licensing authorities that they adopt the positions "that when a physician provides a medical service by means of telemedicine, the service is deemed to occur at the patient's location" and "that physicians who wish to provide medical services by means of telemedicine in Canada must satisfy the licensing or registration requirement of the jurisdiction in which their intended patients reside" (Federation of Medical Licensing Authorities n.d.). The clear implication was also explicitly stated: that licensing authorities

> define professional misconduct in their jurisdiction as including practice by telemedicine by any member in respect of patients located in the jurisdiction of any other medical licensing authority in Canada in circumstances where the member has not obtained the necessary registration license or authority to do so from the medical licensing authority in whose jurisdiction the patient is located at the time such service is rendered.

As of October 2000, three provinces had declined to approve the recommendations, and efforts to resolve the issue have so far met with limited success (Carlisle 2000). For example, in a starkly opposing view, the Collège des médecins du Québec "considers that, in the practice of telemedicine, the medical act is performed in the place where the physician being consulted practises, and not in the place where the patient is" (Collège des médecins du Québec 2000).

Despite the lack of consensus on where a telehealth act is performed, it does seem to be clear that, if it is decided that the medical act occurs where the patient is located, then physicians who are providing telehealth from another province or territory will need to obtain licences in more than one jurisdiction. In these circumstances—and discussed from the broad perspective of telehealth activities in general rather than telepsychiatry per se—Pong and Hogenbirk have presented the various policy options related to addressing the dual or multiple licensure issue and have examined each in terms of its pros and cons (Pong and Hogenbirk 1999). Possible solutions cited include a national licensure system, telehealth practice under special licence, licensure by mutual or reciprocal recognition, licensure by endorsement, and telehealth practice under registration. In slightly differing ways, the intent of the latter four approaches is to allow physicians to avoid having to obtain a full licence from all jurisdictions in which they wish to practise telehealth, with the concomitant reduction in time, effort and cost. In a national licensure system, a physician would be required to obtain only one additional national licence, rather than a licence from every province or territory in which he or she might practise telehealth. Although this would be efficient for the individual practitioner, the time and expense involved in implementing a national program would likely be significant.

Interestingly, although physician licensure has been identified as one of the major obstacles to the implementation of telehealth, there is no compelling practical need to address the issue unless telehealth is practised on an interprovincial or international basis (Pong and Hogenbirk 1999).

However, even in the case of intraprovincial or intraterritorial telehealth activities—currently the most common form of Canadian telehealth practice—credentialing presents a policy issue that is as equally challenging, albeit underappreciated, as that surrounding licensure. Formally, credentialing refers "to the institutional policies and procedures that determine whether a healthcare practitioner has the qualifications to be employed or be granted privilege to practice" (Pong and Hogenbirk 1999). As with the uncertainty surrounding licensure, it remains unclear whether a telehealth consultant is required to be credentialed both at his or her base institution and at the remote institution that has requested the consultation service—particularly when only outpatients are involved.

There are several issues to consider. For example, a hospital corporation is legally obliged to ensure that those persons permitted to treat patients at its facilities are competent to do so. If there is no credentialing, one could argue that the hospital corporation risks liability for failing to discharge this duty in the event of a claim for damages. A hospital corporation is also obliged to ensure that patients' rights are protected and that patients have reasonable means to hold physicians treating them accountable. If a telepsychiatrist is not a staff member of a remote facility and does not formally hold privileges to practise, the means to hold that person accountable through the normal process of peer review and disciplinary proceedings might be lost (Wayne Chapman, personal communication). If it is decided that the consultant needs to be credentialed at the remote facility, several options are available to simplify an otherwise time-consuming, costly and cumbersome full-credentialing process. These options seem virtually to mirror the dual or multiple licensure approaches referred to above (Pong and Hogenbirk 1999). For example, a hospital receiving telehealth services might choose to credential by endorsing or recognizing a consultant's privileges obtained at his or her base hospital.

To complicate matters, some videoconferencing units in underserviced or rural communities are located in health units or mental health centres, where a formal credentialing process for physicians may not be in place. Videoconferencing units in public facilities, such as community colleges, could also conceivably be used for telehealth practice. Further, with excellent and affordable videoconferencing units now available for personal computers, a consulting telepsychiatrist no longer needs to use a videoconferencing room within a base hospital or, for that matter, to have hospital privileges in his or her base community. Given that patients could also have personal computer-based videoconferencing units, a clinical interaction could quite easily involve a private office-based psychiatrist in communication with a patient located in his or her own home. Although credentialing per se is not relevant to these latter cases, they do raise the issue of whether a provincial licence should specifically address the right to engage in telehealth practice.

In conclusion—and as usual when it comes to policy aspects related to the new technologies in healthcare—there are more questions than answers. Those in the field await final decisions so that they may know how to comply with the official policies and regulations (Filler 2000).

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