Telepsychiatry and Internet Prescribing: A Legal Overview and Case Investigation

By Jane J. Chee, Esq.

August 2010
Disclaimers

This publication was made possible by grant number G22RH20216 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS.

Information contained in this report is current up to the date listed on the report. Note that the information is subject to change following action taken by a state's legislature, state agencies, state medical boards, or other applicable state government agency or body. CTeL will make every effort to provide the most current information.

The views and opinions expressed in the forgoing publication are solely those of the author and do not necessarily represent the views and opinion of the Center for Telehealth & e-Health Law, its Board of Directors, or its staff.
Acknowledgements

Jane J. Chee served as a CTeL Legal Fellow in 2010. She received her L.L.M. with distinction in Taxation from Georgetown University Law Center; her J.D., cum laude, from Seattle University School of Law; and her B.A., cum laude, from Claremont McKenna College. Ms. Chee currently resides in Seattle, WA. Her primary legal interests include tax law, health law and regulation, and civil litigation, especially professional malpractice litigation. In addition, her current practice involves insurance defense and construction defect litigation.
Welcome To CTeL

The Center for Telehealth & e-Health Law (CTeL) was founded in 1995 to overcome the legal and regulatory barriers to the utilization of telehealth and related e-health services. CTeL, formerly known as the Center for Telemedicine Law, was created under the vision and leadership of a number of individuals and organizations, including Dr. Yadin David, Bob Waters, the Mayo Foundation, the Cleveland Clinic, the Midwest Rural Telemedicine Consortium, and the Texas Children's Hospital.

CTeL has established itself as a leader in the telehealth community and is known for its ability to compile and analyze complex legal, regulatory and public policy information. CTeL provides vital support to the community by providing critical analysis and information on legal and regulatory issues on topics such as reimbursement, licensure, telecommunications, FDA regulations, privacy, and accreditation.

For additional information about the Center for Telehealth & e-Health Law, please feel free to contact us at:

Center for Telehealth & e-Health Law
1500 K Street, NW
Suite 1100
Washington, DC 20005-3317
202.230.5090 | Fax 202.230.5300
info@ctel.org | www.ctel.org
I. Overview

a. Telehealth, Generally

Telemedicine involves the use of telecommunications technologies, ranging from the telephone to satellites and the Internet, to assist in delivering medical information and services to the public.\(^1\) The federal government has traditionally defined telemedicine as the “use of electronic communication and information technologies to provide or support clinical care at a distance.”\(^2\) Telemedicine encompasses “everything from a telephone consultation to the more sophisticated interactive video presentation,”\(^3\) and goes by many names, often referenced as “telehealth” or “care at a distance.”\(^4\) Telemedicine has offered a number of benefits to its users. Most notably, telemedicine has increased access to care, allowing individuals living in remote areas to receive the same medical care opportunities as those living in a large urban area. Telemedicine also helps to reduce hospital admissions and medical costs.\(^5\) One estimate predicts that the use of telemedicine could save as much as $15 to $20 billion per year.\(^6\)

At its inception, telemedicine was used as a means to assist astronauts in space, as well as to triage injured soldiers on the battlefield.\(^7\) Today, telemedicine is used in a variety of settings and has become a great convenience to doctors and patients alike. The use of telemedical technologies has spread like wildfire. As an example, in 2006,
17.1% of home health agencies reported using telemedicine; in 2009, that number increased to 23%.\(^8\)

Telemedicine commonly appears in situations where local physicians seek the assistance of non-local specialized physicians. Where these specialized physicians are unable to travel to offer consultative services to local physicians, they can instead appear via telemedicine technologies, such as a WebTV terminal.\(^9\) Telemedicine also aids those individuals needing continuous care. These patients can opt for in-home telemedical monitoring equipment, instead of relying on a live-in nurse to administer medications or conduct vitals testing.

While telemedicine began with the telephone, it has grown to include more specialized areas of medicine, and now can be seen in the form of telepathology, “teleradiology and other teleimaging diagnostics, telesurgery and robotics, video and Internet/e-mail conferencing, transmission of electrocardiographic and other physiological data by telephone, telecommunications, or Internet lines and ‘telehealth’ education via the Internet and cable television.”\(^10\)

This paper focuses on the practice of telepsychiatry, a specialized area of telemedicine. This paper begins with a discussion of telepsychiatry and its functions, followed by a summary of licensure requirements for telemedicine practitioners, including telepsychiatrists, seeking to practice medicine across state lines through telemedical technologies. Information on noteworthy federal legislation follows. The paper then addresses the controversial topic of Internet prescribing, and offers an analysis of the notable case of *Hageseth v. The Superior Court of San Mateo County*. 
Finally, this paper concludes with suggestions for the next important steps to promoting telepsychiatry.

b. Telepsychiatry, Generally

“Telepsychiatry” is the term that has been associated with the use of telemedicine technologies, like videoconferencing, to provide mental health services to individuals with limited access to care.\(^{11}\) This specialized area of telemedicine is not a new concept; in fact, “one of the first recorded uses of telemedicine was the provision of psychiatric services.”\(^{12}\) In 1955, the concept of telepsychiatry was invented.\(^{13}\) In the early 1960s, the National Institute of Mental Health and Dr. Cecil Wittson introduced audiovisual linkage to a network of seven state hospitals that began using telemedicine in the 1950s.\(^{14}\) The addition of audiovisual linkage to the preexisting telemedicine network provided many benefits to the patients and medical practitioners of these hospitals. Arguably the most important benefit was that researchers found that patients involved in group therapy sessions noted no change in effectiveness when the traditional in-person therapist was replaced with a telepsychiatrist, a psychiatrist isolated from the group.\(^{15}\)

Telepsychiatry plays a role in a number of settings. For example, prison inmates may have an immediate need for psychiatric treatment. This need can be fulfilled through the use of telepsychiatry, with psychiatrists offering treatment despite the fact that they are currently located hundreds of miles from the prison. Similarly, individuals in rural areas may find it difficult to visit a psychiatrist with any regularity.
With telepsychiatry technologies, a rural resident can receive the frequent treatment he or she needs.

i. Pros and Cons

Certain practices of medicine may be more suitable for telemedicine technologies than others. For instance, psychologists and psychiatrists find teleconsultations particularly beneficial to offering mental health services to patients in need.\(^{16}\) “Psychiatry, a specialty that does not require touch during examination of the patient, is a branch of medicine eminently suited to the use of telecommunications technology,” one author notes.\(^{17}\) Moreover, due to the nature of psychiatry, in which a relationship of trust between the patient and the health practitioner is supremely important, telepsychiatry provides a means to continue treatment when life circumstances such as relocation or child- or elder-care hardships may force a patient to end treatment too soon.\(^{18}\)

Telepsychiatry has seen much advancement since its inception. Most recently, researchers have examined the effectiveness of “asynchronous telepsychiatry.”\(^{19}\) Asynchronous telepsychiatry involves the use of patient information and prerecorded videos of patients, and allows primary care physicians to receive psychiatric consultations from distant psychiatrists. As the use of asynchronous telepsychiatry becomes more widely used and accepted, consulting psychiatrists will be able to offer their feedback to a patient’s primary care physician within 24 hours.\(^{20}\) While not appropriate for every patient, “asynchronous telepsychiatry could be suitable for up to 80 percent of patients requiring assessment.”\(^{21}\)
Telepsychiatry does have some pitfalls. Mental health patients often have a need to form a trusting relationship with and feel a connection to their health practitioners. Unfortunately, there may never be a way to completely replicate the connectedness that a patient may feel with his doctor when he sits in a room and has a face-to-face conversation. Videoconferencing depersonalizes the patient-physician relationship and may diminish a patient’s sense of connectedness.

Moreover, not every mental health patient may be suited for telepsychiatry. For example, patients suffering from paranoid schizophrenia may have their condition exacerbated if they have delusions involving television or other types of technology. Autistic patients with impaired social functions may need in-person contact to help develop their lacking social skills. High-functioning alcoholics and drug abusers may be capable of concealing their condition through the use of telepsychiatry. These are just a few examples of the many types of patients that should seek in-person care before opting for treatment via telepsychiatry.

ii. Empirical Studies

The effects of telepsychiatry have not been researched in great depth; however, two studies have had telling results. One study focused on the quality of care received by patients at a Fort Stockton prison. In that six-month study of a pilot telepsychiatry program, specialty psychiatrists in Lubbock, Texas provided consultative services via an interactive video program to the prison’s psychologist and inmates.22 That study revealed that 84 percent of the patient inmates did not need to be transferred to a
psychiatric hospital within 30 days of the telepsychiatric consultation, and 89 percent of the patients maintained, or were brought to, a medically safe level.\textsuperscript{23}

The second study focused on patient satisfaction and involved interactive video consultations. This study showed that patient satisfaction rates ranged from 89 percent to over 98 percent. Both the child patients receiving telepsychiatry treatments and their parents were surveyed, with the majority of the parents rating their satisfaction as a five on a five-point scale. Also, 29 out of 30 parents stated that they preferred these psychiatric teleconsultations to traveling to see their child’s psychiatrist.\textsuperscript{24} The child patients had similar satisfaction rates.

While telepsychiatry appears to be an open door for many patients living in remote or rural areas, or perhaps suffering from mental health issues that prevent them from leaving their homes, the number of studies about the effectiveness of telepsychiatry treatments remain practically nonexistent.\textsuperscript{25} There is little real data on the outcomes of telepsychiatry treatment, and thus the true effects of this seemingly helpful technology remain unclear.\textsuperscript{26} Without further research and studies evaluating the efficacy of the use of telepsychiatric technologies, telepsychiatry will not be able to establish a firm presence in the medical world.

\textbf{II. Administering Care Across State Lines: Jurisdiction and Licensure}

A look at even a single state alone reveals the need for telemedical technologies. For instance, over one million individuals live in Health Professional Shortage Areas (geographic regions designated by the Federal Government as lacking sufficient amounts of health care practitioners) in Pennsylvania, which has the largest number of
rural residents of any state. Due to this need, state legislators have been forced to recognize that a physician may need to administer care across state lines. As with telemedicine generally, telepsychiatrists must concern themselves with this jurisdictional question. The following discussion pertaining to licensure requirements and jurisdiction for physicians generally applies to all medical professionals, including psychiatrists specifically.

The states hold the power to regulate the professions, with medical practices like psychiatry included in that categorization. Medical licensure acts generally begin or end with a set of definitions, which attempt to clarify terminology within the act. The phrase “practice of medicine” often appears within these defined terms. Treatment by telemedicine is most often implied, if not explicitly stated, within each state’s definition of the “practice of medicine.”

As the argument goes, the practice of medicine in a telemedical situation is deemed to occur in the state where the patient is located because the patient has not chosen to accept treatment in another state, but has instead chosen to remain in his own state and rely upon his own state’s medical laws to protect him. When a physician chooses to “cross state lines” and practice telemedicine, that physician has turned his back on the laws of his own state in favor of the laws of the patient’s state.

Unfortunately, and not surprisingly, the question of jurisdiction is not so easily Answered, as this general guideline is not clearly accepted by every state. The best advice for physicians and psychiatrists seeking to practice in other states via telemedicine is to tread lightly. In general, where doctors have established “minimum
contacts” with another state, they can be subjected to that state’s jurisdiction and the laws of their own states may not protect them. As a result, telepsychiatrists treating and diagnosing patients at a distance should assume that they are forming minimum contacts in the states where that remote care is occurring. Telemedicine practitioners should also heed the guidance of the American Medical Association that physicians maintain “appropriate licensure in all jurisdictions where patients reside.”

For additional safety and to protect against liability, telemedical practitioners should also utilize informed consent forms and other written contractual documents, secure data transmission systems, and a strict procedure for terminating care. Moreover, telemedical practitioners should consult the rules of the state where their patients reside in addition to the rules of the state where they hold a license.

a. Licensure Exemptions

While some states require physicians practicing within that state to hold a “full” state-issued medical license, many states also have a number of exemptions to this general rule written into their medical professions act. One of the most common exemptions is the “consultative services” exemption. This exemption typically allows practitioners located outside of a licensing state to engage in the “practice of medicine” on a consultative basis. However, this exclusion is often limited by the requirement that the medical practitioner not open an office, nor have “ultimate authority over the care or primary diagnosis of a patient” who is located within the state where they are performing such consultative services. The consultation exception will likely not
benefit a telepsychiatrist who intends to practice telepsychiatry on any regular or continuous basis.\(^{37}\)

Endorsement and reciprocity are two additional exemptions to full state medical licensure offered by many states. Licensure by endorsement allows state medical boards to grant medical licenses to practitioners licensed in other states with equivalent licensure standards. Licensure by reciprocity is a similar exemption.\(^{38}\) This exemption works as follows: medical authorities from State A enter into negotiated agreements with medical authorities from State B so that practitioners from State A will be allowed to practice medicine in the State B (and vice versa) without the need to obtain additional licensure, qualifications, or any other form of documentation.\(^{39}\)

Other states offer special limited purpose licenses for physicians seeking to practice telemedicine within that state. However, this loophole to full licensure is not without its limitations. For example, states offering this limited license often require that a physician have a clean disciplinary record and that the physician first perform an in-person patient examination before that physician can treat via telemedicine. Oregon, Alabama, and Tennessee are examples of states that have created special limited purpose licenses for physicians that live outside of those states, but treat in-state patients.\(^{40}\) In addition, Texas has created a special limited purpose license for telemedicine practitioners, but maintains a consultative services exemption as well.\(^{41}\)

Some states recognize that one of the most common applications of telemedicine involves the use of a telephone or facsimile to transmit important medical information and documentation. Perhaps in an effort to assist the physicians licensed in their own
states, or perhaps to promote telemedicine in its most basic form, some states explicitly exclude such transmissions from the definition of telemedicine.\textsuperscript{42}

While telemedicine-specific legislation was in place in only a small handful of states a decade ago, such legislation is much easier to find today. For example, in 1997, only 11 states had telemedicine licensure laws.\textsuperscript{43} That number has steadily grown, and today well over half of the states have recognized the need to adopt telemedicine licensure laws of some sort. While these laws signify progress, state legislatures have much more work to do... and lawmaking takes time.

One saving grace for states seeking a faster means to utilize telepsychiatric practitioners is the use of interstate compacts. One such compact has been widely adopted by nearly every state. The Interstate Compact on Mental Health recognizes that providing treatment to mentally ill patients “bears no primary relationship to the residence or citizenship of the patient.”\textsuperscript{44} Importantly, this Compact informs adopting states of their responsibilities in meeting the goal of providing “a legal basis for the institutionalization or other appropriate care” for mentally ill interstate patients.\textsuperscript{45}

b. Federal Policies

As earlier noted, the states determine the means for issuing a medical license and regulating the profession. This regulation typically occurs via state medical boards, the entities granted with the authority to supervise physician licensure and enforce their established licensure requirements.\textsuperscript{46} However, the federal government also plays a role, albeit a small one, in medical regulation, holding the authority to establish federal
regulations such as those in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Currently, at least three federal laws have a direct impact on telemedicine. The Telecommunications Reform Act of 1996 holds the FCC responsible for ensuring that telecommunications services are available to medical providers in rural areas at the same costs as to those medical providers in urban areas. Through this Act, Congress recognized the disparity in health care treatment to individuals in remote areas, and "gave special consideration to health care providers in rural areas, maintaining that rural health care providers were to receive subsidies to the extent their rural rates were higher than urban rates."48

The Balanced Budget Act of 1997 followed. Due to this Act, the Secretary of Health and Human Services now makes Medicare Part B payments for telemedical consultations to Medicare patients living in rural areas, with this subsidy split between the referring practitioner and the consulting practitioner. This Act also required the Secretary to fund a four-year project to use "eligible health care provider telemedicine networks to improve primary care, and to prevent health care complications to Medicare beneficiaries with Diabetes Mellitus who are residents of these medically under-served rural or inner-city areas."51

Finally, the Food, Drug and Cosmetic Act established new regulations for telemedicine. This Act clarified that the U.S. Federal Food and Drug Administration ("FDA") has the authority to regulate telemedical devices and all other health care associated technologies.52
Telemedicine practitioners must also be concerned with how health care reform will change the practice of telemedicine. One can only hope that all current and future health care reform will encourage state medical boards and state and federal legislators to adopt necessary telemedicine legislation and shed more light on how to best, and most safely, provide health care through advanced telemedical technologies.

III. Internet Prescriptions

The narrow “subset of telemedicine practiced via the Internet” is often referred to as cybermedicine.53 “While cybermedicine also involves the distribution of health information, it primarily involves communication conducted on an Internet site without a previous or ongoing patient-physician relationship.”54 Similarly, “e-health includes telehealth and also encompasses Internet-based prescribing and dispensing, e-prescribing, health advice websites, online continuing medical education and health care procurement.”55

Internet prescribing falls within the categories of cybermedicine and e-health. Internet prescribing is described as “the practice of providing access to prescription drugs when the primary contact between patient and prescriber is Internet or e-mail-based.”56 Like Internet prescribing, Internet dispensing is another booming business. As the name indicates, Internet dispensing merely involves the distribution of medication for which a patient has already received a prescription. The instant portion of this paper will not discuss Internet dispensing and the pharmacists involved in Internet dispensing, but will remain focused on Internet prescribing and prescribing practitioners.
Not surprisingly, due to the convenience of the Internet, countless patients have flocked to their computers to search for health information and treatment options. In fact, “80 percent of, or 110 million, online adults use the Internet to access health information.”\textsuperscript{57} In 2001, “legal Internet and mail-order dispensing accounted for only $28 billion of the $164 billion in drugs sales, but it is the fastest growing segment of the pharmacy industry and is predicted to double each year in the near term.”\textsuperscript{58} In 2003, 18 percent of United States homes with Internet purchased prescription medications through an Internet website. That percentage was expected to grow to 27 percent only a year later.\textsuperscript{59} Today, not only has the number of homes with Internet grown, but so has the number of individuals who purchase their prescriptions through the Internet.\textsuperscript{60}

Currently, there are endless amounts of health related content on the Internet, and access to such information seems without limits. Unfortunately, the quality of such information varies, and the unsophisticated Internet-user could be led fatally astray. Specifically, the sale of prescription medications over the Internet has been a growing concern. State medical boards are often aware of the illegal Internet prescribing occurring in their state. For example, the California State Medical Board acknowledged receipt of approximately 20 complaints a year regarding Internet prescription.\textsuperscript{61}

Aside from California, many other states have adopted legislation that requires physicians to conduct in-person physical examinations before issuing medical prescriptions. Among those states are Alabama, Arizona, Florida, Iowa, Idaho, Kansas, Maine, Mississippi, Nebraska, New York, Ohio, and Virginia.\textsuperscript{62}
Many states also require a pre-existing provider-patient relationship before a physician can issue prescription medications electronically. The American Medical Association (AMA) has issued guidance on the use of telecommunication technologies in the patient-physician relationship. Specifically, the AMA allows for the use of e-mail between patients and physicians, but only as a supplement to, not a replacement of, the traditional in-person relationship.63

Illegal prescription and distribution websites have led state medical boards and legislatures to attempt to control this activity through strict regulation. This legislation often falls into three categories, with many states adopting more than one of these regulatory schemes.

First, some states rely on the regulatory changes that they have already made to accommodate telemedicine. Second, other states concentrate on the specifics of the physician-patient relationship, either by requiring a so-called “traditional” or “proper” relationship, or more transparently, by requiring face-to-face contact or prohibiting questionnaire-based prescribing. Third, some states have shifted their focus from physician to pharmacy regulation by concentrating on the product of an often out-of-state technologically-mediated relationship (i.e., the prescription) and seeking to control its in-state dispensing.

The second regulatory approach appears to be the most burdensome to Internet prescribers, in effect thwarting the ease of profit-making and forcing these questionably legal businesses to completely conform or face potentially criminal consequences. Many of these Internet prescription websites thrive off of the ability to provide a
medical prescription to a patient solely on the basis of that patient’s answers to an online questionnaire. This allows a physician to issue thousands of prescriptions a day and earn substantial amounts of money along the way.

Many state legislatures specifically address this type of prescribing, labeling it “unprofessional conduct.” For instance, Arizona lists “prescribing, dispensing or furnishing a prescription medication or a prescription-only device to a person if the licensee has not conducted a physical examination of that person or has not previously established a physician-patient relationship” as “unprofessional conduct.” Similarly, the California Business and Professional Code states that “prescribing, dispensing, or furnishing dangerous drugs... without a good faith prior examination and medical indication therefore, constitutes unprofessional conduct.”

Other states take a different approach, instead focusing on the establishment of a proper patient-physician relationship. For example, Delaware’s legislature specifically defined the type of patient-physician relationship required in order for a physician to issue a medical prescription. In that state, physicians “must conduct at least one in-person medical evaluation of the patient and perform a medical history and physician examination sufficient to establish a diagnosis and to identify conditions of, or contraindications to, the treatment recommended or provided.”

In a similar vein, other states categorize this type of Internet prescribing based solely on an electronic medical questionnaire as a “failure to practice medicine with that level of care, skill, and treatment which is recognized by reasonably prudent physicians
as being acceptable under similar conditions and circumstances, as well as prescribing legend drugs other than in the course of a physician’s professional practice.”

Many states rely on their state medical boards to discipline those individuals engaged in this type of unprofessional conduct. For example, Section 164.053 of the Texas Occupations Code authorizes the Texas Medical Board to sanction licensed Texas physicians who issue prescriptions to patients without previously conducting face-to-face examinations. Other state medical boards issue policy statements advising physicians to conduct physical examinations and take thorough patient histories before issuing prescriptions via the Internet or other means.

Not surprisingly, many patients and physicians agree and hold the same skepticism about Internet prescribing as state medical boards and legislators: “Some critics argue that it is inappropriate to diagnose a patient’s illness without a physical examination and at least simple tests such as blood pressure, and that a physician needs to touch, feel, and smell a patient to make an accurate diagnosis.”

A former United States President has even weighed in on this issue. During his term in office, President Clinton commenced the fight against the sale of prescription medications through the Internet. He called for “zero tolerance for prescription drug Internet sites that ignore federal and state laws and harm patient safety and health.”

The issuance of prescription medications sold over the Internet without an in-person physician examination by a licensed physician raises a number of safety, legal, and ethical concerns for the states, which are largely responsible for medical licensure and regulation, as well as the federal government, which has the authority to regulate
interstate commerce. The FDA has regulatory and oversight authority over the growing use of the Internet in telemedicine.\textsuperscript{71} The FDA is responsible for ensuring the safety of the public and should keep a close watch on Web sites offering prescription drugs without any in-person patient-physician contact, especially those which only require the submission of a medical questionnaire.

In spite of all these ostensibly deterring prohibitions and guidance, in 2000, a physician in Ohio appeared before a medical board and faced a criminal trial on 64 counts of selling prescription medications over the Internet. Ultimately, the physician was forced to relinquish his medical license.\textsuperscript{72} In that case, even though the physician was arguably practicing medicine in a jurisdiction where he did not hold a license, the court chose not to sanction him on those grounds. Instead, the novelty of this particular case was that the physician received the first criminal indictment for failing to personally examine his “patients.”\textsuperscript{73}

Fortunately, not all Internet physicians prescribe on the basis of a medical questionnaire. Many websites perform a more thorough patient investigation, requiring Internet consultations through e-mail with pre-existing patients or consultations using video teleconferencing.\textsuperscript{74}

One Web site, CyberDocs, has been discussed at length by Professor Ronald L. Scott of the University of Houston Law Center. The CyberDocs Web site utilizes advanced technology to offer medical services through the Internet. However, even Tom Caffrey, the founder and CEO of CyberDocs, encourages the site’s users to employ common sense when seeking information and assistance from his website.\textsuperscript{75} Moreover,
the Web site advises its users to seek an in-person visit with a physician, and not to replace traditional in-person treatment with the CyberDocs Web site.\textsuperscript{76} In addition, the site cannot be used for every purpose or to acquire any prescription. For example, CyberDocs has a list of prescription medications that its practitioners will not prescribe over the Internet, including muscle relaxants, narcotics, and sedatives.\textsuperscript{77}

As many state medical boards and legislators have declared that prescribing medications online without an in-person examination is a violation of ethical medical practices and is inappropriate conduct which may be sanctioned, the Center for Telehealth and E-Health Law advises practitioners to refrain from issuing prescription medications through Web sites who encourages Internet-savvy patients to walk away from their computers and visit a licensed medical professional in person when they need medication.

\textbf{IV. Case Investigation: Christian Ellis Hageseth v. The Superior Court of San Mateo County}\textsuperscript{78}

While considered by many as a great medical advancement, telepsychiatry is not without its problems. Specifically, telepsychiatry has received criticism due to the fatal consequences of the issuance of depression medication over the Internet. In 2005, John McKay, a student at Stanford University, bought a generic version of Prozac off of an Internet site.\textsuperscript{79} In the course of the medication’s purchase, Dr. Christian Hageseth, a Colorado-licensed psychiatrist, reviewed the online prescription request and authorized a pharmacy in Mississippi to fill and mail the medication to the student’s California
home. Shortly after receiving this prescription, the 19-year-old student committed suicide.80

While Dr. Hageseth was not charged with causing Mr. McKay’s death, his actions quite clearly were a contributing cause to the student’s suicide. As a result of this unfortunate incident, in May 2006, the San Mateo County District Attorney filed a criminal complaint against Dr. Hageseth for practicing medicine in California without a license. In that state, only a California licensed physician may issue prescription medications to a patient.81 Unlicensed practitioners may be subject to criminal sanctions.82 The allegedly negligent Web site, www.usanetrx.com, does not require any form of prescription verification from a licensed physician.83 The only requirement is the submission of an online questionnaire to be reviewed by a usanetrx.com physician.

In this case, that physician was Dr. Christian Hageseth, who approved McKay’s online application based on his assertions that he was previously prescribed the medication and that he was not suicidal.84 Interestingly enough, at that time, Dr. Hageseth’s medical license was restricted by the Colorado medical board and he was not authorized to prescribe medication.

Jurisdiction was one main question in the Hageseth trial. Although the initial complaint alleged that Dr. Hageseth practiced medicine in California, all evidence confirmed that Dr. Hageseth never physically entered California, instead remaining in Fort Collins, Colorado.85 Thus, the jurisdictional question could only be answered by clarifying the meaning of California Penal Code § 27. That statute provides that “persons are liable under the laws of this state... who commit, in whole or in part, any
crime within this state.” Defense counsel interpreted this provision to mean that “there has to be an act in California. That’s it.” However, the Court of Appeals ultimately determined that jurisdiction was proper in California, even if Dr. Hageseth never set foot in California, “either himself or through the intervention of an agent in the state.”

In arriving at this conclusion, the court first considered the “minimum contacts” analysis, wherein a court can assert jurisdiction over a foreign resident who has “purposefully availed” himself of the privileges of conducting activities within that jurisdiction. The court then recognized that “the rule is well settled that civil ‘minimum contacts’ analysis has no place in determining whether a state may assert criminal personal jurisdiction over a foreign defendant.” The court then considered laws “premised on the belief that a state should have jurisdiction over those whose conduct affects persons in the state or an interest of the state” and reviewed a number of cases involving foreign residents charged with committing crimes affecting residents of other jurisdictions and the “detrimental effects” theory of extraterritorial criminal jurisdiction. Specifically, the United States Supreme Court has held that acts performed outside of a jurisdiction, but “intending to produce and producing detrimental effects within it, justify a state in punishing the cause of the harm” and asserting jurisdiction.

After a lengthy analysis, the court held that “it is not necessary to the ‘detrimental effect’ theory of extraterritorial jurisdiction that the defendant be physically present in this state during some portion of the time during which his alleged criminal act took place, or that he act through an agent physically present in this state, or that there exist a statute or judicially declared exception extending the state’s
territorial jurisdiction for the particular crime with which the defendant is charged.”

Under this “detrimental effects” theory of jurisdiction, the court determined that Dr. Hageseth could not escape prosecution due to a question of jurisdiction.

Dr. Hageseth next argued that “extraterritorial jurisdiction over his Internet conduct is unreasonable because (1) he and others are not on notice of the unlawfulness of such conduct, and (2) the assertion of jurisdiction would not deter others from his allegedly unlawful conduct, but (3) it would deter physicians licensed in other states from providing residents of this state many useful forms of medical assistance over the Internet.” The court rejected the first and third arguments in short order, but addressed with more detail its reasoning for dismissing Dr. Hageseth’s second contention. In brief, the court explained that “the denial of state jurisdiction to punish the practice [of Internet prescribing without an in-person medical examination] would provide the unscrupulous physicians who engage in it even greater freedom to do so than they already possess.”

While sentencing was pending, Dr. Hageseth ventured into another Internet opportunity. He founded a non-profit corporation called Depression Care Access, Inc., which offers “support, information, and encouragement” to those suffering from depression through an Internet Web site.

Finally, in April 2009, Dr. Hageseth’s fate was decided. The San Mateo County Superior Court sentenced him to nine months in county jail for practicing medicine without a medical license. This term will follow with three years of probation. This is
the first instance of imprisonment of an out-of-state telemedicine practitioner for practicing medicine in California, and appears to be the first litigation of its kind.93

Fortunately, due to this case, many questions regarding the regulation of online prescriptions to out-of-state patients have at least partially been answered. Unfortunately, even with these answers, this surely will not be the last case of negligent online prescribing. With many more Web sites continuing to offer similar unsafe and potentially fatal services, it is more than likely that many more suits will follow.

Unlike Internet prescribing, telepsychiatry in general has rarely been discussed by the courts and, when telepsychiatry has made its way into the courtroom, judges have not specifically commented on it. For instance, in In re Division of Mental Health Services, the court reviewed “whether the Department of Human Services, Division of Mental Health Services, validly exercised its authority when it granted a waiver from the requirement imposed by N.J.A.C. 10:31-2.3(d) and N.J.A.C. 10:31-2.5(a) that a face-to-face psychiatric interview be conducted whenever individuals are being screened for involuntary psychiatric commitment.”94 In requesting waiver, the guidance center conducting the screening assessments contended that the telepsychiatry video/audio transmission allowed “for a patient-to-provider interaction that very closely replicates physically being present and allow[ed] for expert treatment to patients distant from the primary caregiver.”95 It also informed the Division that the use of these technologies “would not diminish the efficacy of its screening procedures or affect the quality of the screening services it provided.”96 The Division granted the waiver, finding that the use of telepsychiatry as a tool and as a supplement to the full component of psychiatric
services offered by [the guidance center] is consistent with the current trend of augmenting outreach of psychiatric services through live videoconferencing and links. The Division found that “no significant risk to the welfare and safety of individuals subject to screening services or the staff of designated screening centers or emergency services would result from the granting of the waivers.”

The Warren Hospital protested the grant of the telepsychiatry waiver, requesting that the Superior Court of New Jersey reverse the Division’s decision to issue the waiver to the guidance center. Although that court concluded that the Division’s decision to grant the telepsychiatry waiver was arbitrary and capricious, it did so based on procedural grounds. Importantly, the court offered no negative commentary on telepsychiatry and the quality of medical care involved.

V. Conclusion

The benefits of telemedicine and telepsychiatry are numerous: patients in remote areas have greater access to care and an opportunity to receive care from distant specialists, physicians are able to offer faster response times, both patients and physicians benefit from reduced travel time, and health care costs may be substantially reduced. Many states have taken advantage of these benefits by implementing their own telepsychiatry-specific telemedicine programs. For example, in the mid-1990s, Georgia adopted a telepsychiatry initiative involving state psychiatric hospitals and mental health centers. This initiative was more than necessary, as a majority of the counties in Georgia have no psychiatrists, and the entire state has only 63 child
The benefits can be felt by individual patients, as well as hospitals, ambulatory care centers, clinics, and prisons.

Texas also appears to be at the forefront of the telemedicine movement generally and the telepsychiatry movement in particular. In 2001, Senate Bill 553 was enacted to establish a task force to review the procedures for determining the proper usage of the insanity defense, and whether a defendant is competent to stand trial or to be executed. This task force was designed to specifically evaluate a number of factors related to mental health and the prison system, including “assess[ing] the potential use and benefits of telepsychiatry.

While proponents rave about the numerous benefits of telemedicine and telepsychiatry to patients across many states, these benefits must be balanced against the relative novelty of telemedicine technologies and the understanding that such new advancements take time and regulation before they are entirely safe for the public. Specifically, state and federal legislatures need to address the concerns of state medical boards and the American Medical Association and discipline the creators of Internet prescribing websites that fail to require a proper physician-patient relationship and physical examination before issuing prescriptions.

This paper discussed only a narrow portion of the bigger picture of telemedicine, telepsychiatry, Internet prescribing, and health care as a whole. Within that narrow portion, many stones remain unturned. Legislators and state medical boards need to move with haste to develop statutes and guidelines for the sake of public safety as well as for the sake of telephysicians, telepsychiatrists, and other medical practitioners.
While this paper discussed the harsh consequences of one telepsychiatrist’s actions, this author believes that it is quite appropriate to suggest that most psychiatrists seeking to practice through telemedical means hold the best of intentions, striving only to serve patients with mental distress and disease and not necessarily for their own financial gains.

An important next step in reaching the goal of the safe and legal practice of telepsychiatry is to focus on the research. The empirical studies necessary to determine the true effects of such technologies have yet to be conducted in any conclusive sense. Once conducted, studies revealing positive results for patients of telepsychiatry will help the telepsychiatry movement and pave the path for widespread use and benefits.

---

1 For purposes of this paper, the terms “telemedicine” and “telehealth” will be used interchangeably.


4 However, some authors have made a distinction between the terms “telemedicine” and “telehealth,” with telehealth involving nonclinical health services like education in addition to clinical services. See Mike Williams, Michael Pfeffer, Juliana Boyle, and Donald M. Hilty, Telepsychiatry in the Emergency Department: Overview and Case Studies, California HealthCare Foundation (December 2009), available at http://www.chcf.org/~media/Files/PDF/T/TelepsychiatryProgramsED.pdf (last visited August 13, 2010), hereinafter “Emergency Department.” The Federal government also offers a unique definition of “telehealth,” using the term more broadly as the “use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related

5 Id.


10 Integrated Health, supra note 8.


12 Emergency Department, supra note 5.

13 Risk Managers, supra note 4.


15 Id.


20 Id.

21 Id.


23 Id.


26 Id.


28 U.S. Const. amend. X.

29 See generally Cal. Bus. and Prof. Code § 2052.5.


32 “States must demonstrate a substantial connection ‘between the defendant and the forum state necessary for a finding of minimum contacts that must come about by an action of the defendant purposefully directed toward the forum state.’” Christopher J. Carlyl, Malpractice and Other Legal Issues Preventing the Development of Telemedicine, 12 J.L. & Health 173, 202-203 (1998).


34 See NRS 630.047; HRS 453-2; ORS 677.060; 225 ILCS 60/49.5.


36 Id.


38 U.S. Dept. of Health and Human Services, Health Resources and Services Admin., Office for Advancement of Telehealth, Telemedicine Report to Congress, p. 21 (January 2001), available at

39 Id. at 22.


43 Telemedicine Report, supra note 39, at 29.

44 See, e.g., N.Y. Mental Hyg. Law § 67.07(a) (McKinney 1988).

45 Id.


52 See 21 U.S.C. §§301-381; see also Center for Devices and Radiological Health Food and Drug Administration (July 11, 1996), available at http://www.fda.gov/cdrh (last visited August 18, 2010).

53 Cybermedicine, supra note 17, at 414.


56 Id. at 187.

57 Id. at 226.
58 Id. at 188.


60 Id. at 227 (noting that “six million U.S. adults have purchased prescription drugs online”).

61 Bob Egelko, Father blames son’s suicide on ‘telemedicine.’ SFGate.com (December 30, 2008), hereinafter “Father blames,” citing Executive Director David Thornton.


63 American Medical Association Policy H-478.997, available at http://www.ama-assn.org. This policy does have one exception however. AMA Policy H-120.949 allows for the use of email between patients and physicians if the state where the patient resides permits out-of-state physicians to prescribe electronically.


66 Delaware, 2008 HB 454.

67 Fla. Admin. Code r. 64B8-9.014.

68 Colorado Board of Medical Examiners, Policy 40-9, Guidelines for Prescribing for Unknown Patients (Nov. 16, 2003).

69 Cybermedicine, supra note 17, at 417.


72 See Lauren Campbell, State Battles Illegal Online Drug Sales, Cincinnati Post, 2000 WL 3374195 (May 9, 2000); also see Kevin Mayhood, Probation, Fine Given to Doctor after Plea Internet Drug Sales, Columbus Dispatch, 2000 WL 23917304 (Aug. 16, 2000).

73 Id.

74 Cybermedicine, supra note 17, at 414.

75 See id., citing Marissa Melton, Online Diagnoses, Finding More than a Doc-in-the-Box, U.S. News Online (June 21, 1999).


79 Barbara Feder Ostrov, Parents sue online pharmacy, doctor: Menlo Park teen’s suicide shine light on shadowy market. San Jose Mercury News (March 14, 2006), hereinafter “Parents sue.”

80 Hageseth, supra note 78.

81 Cal. Bus. and Prof. Code § 2052.

82 Id. (“any person who practices or attempts to practice… without having at the time of so doing a valid, unrevoked, or unsuspended [medical] certificate… is guilty of a public offense, punishable by a fine not exceeding ten thousand dollars ($10,000), by imprisonment in the state prison, by imprisonment in a county jail not exceeding one year, or by both the fine and either imprisonment”).

83 Id.

84 Parents sue, supra note 79.

85 Hageseth, supra note 78.


88 Hageseth, supra note 78.

89 Hageseth, supra note 78, citing Strassheim v. Daily, 221 U.S. 280 (1911).

90 Id.

91 Id.

92 http://dcausa.org/meet-the-doctor.html

93 Father blames, supra note 60.

94 In re Division of Mental Health Services, 2009 WL 1675502 (N.J. Super. A.D. June 17, 2009).

95 Id.

96 Id.

97 Id.

98 Id.


101 A Call to Action, supra note 55, at 1188.


103 Alison J. Meyers, Mentally Ill and Mentally Retarded Defendants in Texas may get a Chance at Justice: Recommendations to the Task Force Created by Tex. S.B. 553, 77th Leg., R.S., 43 S. Tex. L. Rev. 1233, 1235 (2002), citing Tex. S.B. 553, 77th Leg., R.S.