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Risk Management in the Digital World

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The literature is replete with articles addressing how the electronic age has created new and improved ways to deliver health care services. This change, however, has raised many questions regarding how professionals can utilize this new technology in a fashion that is consistent with both ethics and law. In this article we attempt a point in time survey of the problems created by practicing psychotherapy in the digital age focusing on a conceptual overview of two specific areas. We review various perceptions of the current state-based regulation of digital interstate practice by psychologists and provide an overview of some basic ethical and risk management principles that have to be addressed by practitioners before proceeding to offer these services given an uncertain regulatory environment.

Keywords: telepsychology, law, ethics, licensing, liability, risk management

European commerce during the Dark Ages was limited and stifled by the existence of a multitude of small kingdoms that were independently regulated and who suppressed the movement of goods across their borders through a confusing and inconsistent morass of taxation, tariff, and regulation. This forced merchants to find another solution to move their goods, one that would avoid the strangulation that resulted from this cumbersome regulatory model. These merchants chose to move their goods by sea without being subject to the problems that were created by this feudal and archaic design, a move that changed the world. The little kingdoms took hundreds of years to catch up.

Most of us have heard about the dual meanings of the Chinese ideograph for crisis: danger and opportunity. This is a great descriptor of the situation psychology finds itself in with regard to the rapid development of digital technologies that will likely revolutionize the way psychological services are delivered. The provision of remote psychological services electronically is developing rapidly and has been identified as a priority by several federal agencies, including the Office for the Advancement of Telehealth in the Department of Health and Human Services. Insurance companies and health care reimbursement programs such as Medicare and Medicaid are already reimbursing these services in limited circumstances, and psychologists are already involved in this process (American Psychological Association [APA] Practice Organization, 2010). In addition, 12 states have already mandated that health insurers reimburse for telehealth services (Baker, 2011). Consequently, it makes both professional and economic sense for psychologists to take full advantage of this use of technology.

Although several forces are moving forward to facilitate the use of technology in provision of psychological services, there remain limitations to be overcome. Most state-based professional licensing boards are conservative and geared to protect consumers within the state's borders, and a major hurdle to resolve is the absence of information from the regulatory system in this area—a system that was developed on the basis of the model of the provider of psychological services and the recipient being in the same room. Unfortunately, then, because the standards for providing psychological services remotely have yet to be established (APA Practice Organization, 2010), psychologists who want to do so will expose themselves to a risk that others will question as ethical and/or legal.

In this article, we review various perceptions of the current state-based regulation of digital interstate practice by psychologists. We also provide some specific ethical and risk management principles that have to be addressed by practitioners before they

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offer these services that will minimize ethical and licensing board risk in an uncertain regulatory environment. Finally, we provide some suggestions of what a successful collaborative solution to this problem might look like to avoid outside and potentially unnecessary federal regulation. We hope that this article will serve to encourage discussion in the psychological community toward a meaningful solution to many of the problems created by psychology's entrance into the electronic world of health care delivery.

History

The practice of psychotherapy is founded on a belief that the most efficacious way to provide clinical services is in person, a position that is reflected in the current opinions of some licensing boards (Office of Consumer Affairs & Business Regulation, 2006). The belief that the relationship between the client and psychotherapist is one of the major factors facilitating therapeutic progress has created an almost unquestioned assumption that regular in-person meetings are essential for therapeutic progress. The evolution of psychotherapy, however, has challenged these traditional assumptions, and many types of treatment currently exist that are neither consistently delivered nor professionally administered, nor do they occur face to face (e.g., bibliotherapy, coaching, consultation). In addition, several research studies have begun to evaluate the assumption that in-person psychotherapy is superior to remote treatment, and, to date, there is not a single study that has found a measurable difference in efficacy, even in cases in which the remote services are delivered through a medium that does not utilize real-time audio–video technology (Germain, Marchand, Bouchard, Guay, & Drouin, 2010; Hyler, Gangure, & Batchelder, 2005; Kroenke et al., 2009) One can also see the changing professional perceptions about remote service delivery in the decision of the American Psychoanalytic Association to create a project to train Chinese psychiatrists as analysts, including providing training analysis through Skype (Arehart-Treichel, 2010).

The electronic revolution is arguably a time of great challenge that may provide an opportunity for psychologists to deliver services remotely, eliminating many of the limitations imposed by an office-based environment. It may allow psychologists to broaden the focus of their interventions from that of a medically based approach to more of a problem-solving approach directed at problems in effective living, many of which do not fit into a medical model. That being said, if psychology is going to be a part of this new type of service delivery, it is going to have to resolve several legal and administrative problems that have their genesis in the current regulatory environment.

Intrastate and Interstate Remote Service

As previously mentioned, the regulatory structure of professional psychology by individual states was designed for a different era when remote practice was not a viable option and intrastate practice was more easily defined. Most state legislators have recognized some situations where out-of-state licensed psychologists can provide temporary services in the state, but these regulations were designed to deal with in-person services. The digital revolution has challenged the efficacy of the current regulatory model.

All the major professions, including psychology, arguably must now recognize the need to find a way to allow reasonable remote practice, including practice across state lines, and to do so making use of technology. Although there is a strong argument to be made that the ability to provide services in this fashion is in the best interest of those who receive psychological services, no profession has yet solved the problem regarding how to provide service without violating state laws and existing standards of practice. The profession that has made the most progress in addressing these types of issues is nursing. Nursing has developed a model that allows any nurse licensed in a state to practice, whether in person or remotely, in any state affiliated with their program. It only requires nurses to be aware of the laws of the states in which they practice and provides disciplinary jurisdiction to the state within which the nurse is licensed. The only disciplinary option a forum state (the one that does not license the nurse) has is to prohibit future practice by the nurse in that jurisdiction. There are now 24 states that participate in this program (https://www.ncsbn.org/158.htm). In addition, medicine has created a model statute and has recognized the need for national standards but has not yet moved beyond this (Center for Telemedicine Law, Office for the Advancement for Telehealth, Health Resources and Services Administration, 2003).

Psychology has fallen in addressing problems created by interstate practice, much less in the delivery of professional services through electronic means. The Association of State and Provincial Psychology Boards (ASPPB) has created two credentials that would greatly increase psychologist mobility: the Certificate of Professional Qualification and the Interjurisdictional Practice Certificate (IPC; ASPPB, 2011), but state licensing boards have been slow to accept them. In fact, to date, only five states even recognize the IPC.

Coaching has addressed the legal complexities created by interstate jurisdictional issues through the creation of a national credentialing organization with its own ethics code and ethics enforcement practices. In so doing, it is attempting to brand coaching as something that is not regulated by state professional licensing laws (Williams & Anderson, 2006). It has accomplished this by defining itself as a type of psychoeducational consultation service in which the problems addressed are strategic and performance related and in which the coach's role is facilitative rather than advisory. The International Coach Federation (ICF) has 15,000 members, many of whom are licensed mental health professionals. It has certified numerous training programs that are considerably less rigorous than those required of any licensed mental health providers (ICF, 1999), despite the fact that many of the competencies required of those who call themselves "coaches" overlap with the competencies that are taught in clinically focused doctoral programs in psychology and are arguably regulated by state licensing laws. To avoid allegations of unlicensed practice, most coaching and interstate therapy organizations recommend that extensive written disclaimers be used to alert the client to the differences between the services they regulate and health care. This is done to protect the client but also to protect the service providers. At this point, many psychologists feel the need to seek ICF credentialing to practice both coaching and industrial–organizational consultation, despite the fact that they already have a credential that allows them to provide these services.

Digital Psychology: Ethical and Regulatory Perspectives

One of the most significant issues affecting the future of electronic practice is who gets to regulate the provision of professional services when the practitioner, in the state where he or she is licensed, provides services to an individual in another state where the practitioner is not licensed. Legal regulation of transactions has traditionally been based on the geographic location of the transaction. Electronic transactions, however, do not have a geographic location as they occur in cyberspace. To determine who gets to regulate the transaction and how it is regulated, the legislatures and courts have to decide where the transaction is occurring from a regulatory perspective.

As has been stated, in the United States, legal regulation of professional transactions has been traditionally assigned to the states (Holland, 2004). This was, in part, due to the fact that most professional transactions took place in person; therefore, it made sense to have local control. State laws and regulations are designed to establish minimum acceptable training standards designed to protect consumers from incompetent or negligent practices. States cannot exercise their protective responsibility if individuals from outside the jurisdiction can provide service outside of their regulatory authority.

Recognizing that some interstate practice makes sense, most state legislatures have passed laws that allow temporary practice by an individual who is licensed in another jurisdiction (APA Practice Organization, 2010), but these laws all assert state control over temporary practice. Conversely, these legislatures all have argued that, to protect their citizens and enforce their laws, states must have the authority to regulate interstate transactions that affect their citizens. Many regulators and other commentators believe that these laws, and the social policy principles that underlie them, allow the consumer's state of residence the power to regulate services provided by an out-of-state provider. This also seems to be the opinion that is held by state psychology licensing boards. For example, Massachusetts, California, and Minnesota, among others, have taken the position that their consumer protection laws and temporary practice laws are binding. In fact, the California Board of Psychology has gone further and has taken the position that such practice would be considered practicing psychology without a license, which is a criminal act (http://www.psychboard.ca.gov/consumers/Internet-thrpy.shtml).

The belief that regulatory authority is established by the location of the consumer is not new in administrative law opinions and is clearly reflected in the beliefs of the ASPPB. As noted in the minutes of the Board of Psychology of the State of Minnesota, the position of ASPPB is that the "Counselor should be licensed in the Consumer's state of residence." (Minnesota Board of Psychology, 2009, p. 10). This belief is likely an extension of a licensing board's responsibility to regulate a profession and to protect the public. However, it does not address how one regulates a profession when the service provider is out of its statutory territory.

The State of Massachusetts has taken the issue of treatment of patients by electronic means a bit further than California. An official statement published by the Massachusetts Board of Psychology, addressing the delivery of psychological services electronically, concluded that services conducted in this fashion lose "much of the richness of interaction which, as any psychologist knows, comes with traditional face-to-face contact in an individual session with a client" (Office of Consumer Affairs & Business Regulation, 2006). In addition, it was the Board's position that "the practice of psychology occurs both where the psychologist who is providing therapeutic services is located and where the individual (patient/client) who is receiving the service is located" (Office of Consumer Affairs & Business Regulation, 2006). Thus, a Massachusetts practitioner must be licensed in both states.

Fortunately (or unfortunately), the issue of jurisdiction regarding out-of-state providers is arguably beyond the regulatory authority of a licensing board, which is limited to reasonable interpretations of its enabling act. Under existing laws, boards would have to convince state attorney generals to take action against out-of-state providers. At this point, state attorney generals are somewhat divided about their regulatory authority but have given little serious consideration to the issue, which suggests that it is a very low priority (Koocher & Morray, 2000).

Problems With the Regulatory System

As noted previously, the current regulatory system was designed for a very different model of health care delivery. There are several logical issues from the digital age with which the current regulatory system cannot deal. Consequently, the positions taken by licensing boards are often reductive, reflective of a type of "least common denominator thinking," and are not necessarily in the best interests of the consuming public. It is understandable that states want to protect consumers and want their own formulations in law of social policy questions and answers to govern conduct within their borders, but that needs to be balanced with what is best for the consumer. The approach that a license in the patient's location is required to conduct psychotherapy eliminates several treatment interventions that are not possible in an in-person world, severely restricts legitimate consumer choice, and may prevent many consumers from accessing the best services available.

It is easy to generate a list of clinical issues that current state-level regulatory models would deal with in a fashion that is not in the best interests of those who consume psychological services. For example, take the case of a therapy patient who has to travel for his or her work but wants to continue to get treatment while away by remaining in contact with the psychologist through regular phone sessions that would cross state lines. The position taken by many boards of psychology is that the psychologist who is treating this patient would be required to obtain a license or permission to treat the client in the state to which the client is traveling. Otherwise, and no matter how brief these trips are, the patient would have to eschew treatment or the treating psychologist would have to locate another psychologist in the state of residence to treat the patient regardless of the reality that the temporary local provider would not know very much about the client. This is simply a jurisdictional position that arguably is a misplaced attempt on the part of these boards to protect the public.

Another example would be when a therapist is treating the child of an acrimoniously divorced couple. Let's further assume that one of the parents lives in another state where the psychologist does not have a license to practice. If the psychologist was not allowed to provide services to and with the out-of-state parent, he or she would end up having a close working relationship with the in-state parent and have no treatment relationship with the out-of-

state parent. Not only is this design likely to make treatment much more difficult, but it could also actually contaminate the treatment relationships, create a perception of clinical bias on the part of the out-of-state parent and damage the efficacy of the treatment.

Judicial Approaches to Interstate Practice

The U.S. courts have a long history of resolving jurisdictional disputes between states and the federal government, and their positions have been relatively consistent and more nuanced than the position taken by state boards. The courts have recognized that this is a complex area and has the potential for consequences that could harm the development of the digital revolution and the potential benefits that it will offer to society. The courts have therefore decided against a set of rigid rules, opting instead for a case-by-case model that will allow the standards and rules to develop over time with appropriate experience. They have developed a basic decision-making rationale to assist them, called the *minimum contacts rule* (Wright v. Yackley, 1972). According to this rule, the state where the patient resides (forum state) can assert jurisdiction only when the out-of-state individual has made a purposeful attempt to promote or provide services in that state (Hageseth v. The Superior Court of San Mateo, 2007). The courts have said that jurisdiction can only be decided on the basis of a careful analysis of the facts and circumstances of each case.

One can better understand the judicial approach by looking at a representative case, Prince v. Urban (1996). In this case, a California resident traveled to Illinois to seek specialty help from a medical practice that specialized in treatment of chronic headaches. The treatment did not have the desired results, and the patient returned to her home in California. She had many follow-up telephone calls with her physicians in Illinois, and she was still dissatisfied. Eventually, she decided to bring suit but chose to do so in California. Her theory was that the telephone calls made by the doctors to her in California constituted medical practice in California; therefore, California had jurisdiction.

Not so, said the court. To determine whether California had jurisdiction, the court enunciated three principles that had to be considered on a case-by-case basis: Was the doctor–patient relationship created because of a systematic and continuing effort of the Illinois doctors to provide services in California, or was the location of the client incidental to the services provided? Were the doctors' services grounded in any relationship they had with California? Finally, the court then had to balance the state's interest in securing good medical care for its citizens against the potential and severity of anticipated harm.

There are several cases in which this doctrine has been applied to medical practice where the forum state was ruled to have jurisdiction. However, they all involved a real attempt by the provider in question to market or promote his or her services in the forum state before services were actually provided (Bullion v. Gillespie, 1990; Jones v. Williams, 2009).

The most relevant of the cases that deal with interstate practice is Hageseth v. Superior Court of San Mateo County (2007). Hageseth was a Colorado psychiatrist who was only licensed to perform research and who was a consultant for an Internet prescription company. He prescribed antidepressant medications through the service to a California teenager whom he never met, talked to, or medically evaluated in any way. That prescription was filled by a Florida pharmacy and shipped to California. The teenager later committed suicide. The state of California decided to prosecute Hageseth criminally for practicing medicine in California without a California license and sought to extradite him to stand trial. He appealed, saying that because he had never been in California and that none of the elements of the crime had taken place in California, California courts had no jurisdiction to prosecute him. Confusingly, the same California Court of Appeals that decided Prince v. Urban (1996) ruled that California had jurisdiction regardless of whether the charged conduct took place in cyberspace rather than in real space. Although the results of these two cases are different, the principle is the same: Hageseth was a part of a business that actively marketed itself on the Internet and was clearly soliciting the business of California citizens.

These cases and the contrarian and inconsistent policies coming from some state licensing boards, led to the beginnings of an ethical approach to electronic interjurisdicitonal practice which will substantially reduce risk if there is a complaint to either the practitioner's or consumer's state psychology licensing board. This is true because, despite what state boards have opined, they would likely not be able to gain jurisdiction over an out-of-state psychologist who was approached by a client to provide remote services unless the psychologist had taken direct actions to market or promote their services in the state where the client resides. Consequently, if a psychologist was providing continuing services to an existing or former client, working with an out-of-state parent, providing consulting services sought by an out-of-state client because of particular expertise, or providing services to individuals who do not have access because of geographic location, the only substantial risk to the psychologist is a complaint to the board by which he or she is licensed. It is important to note that the level of marketing required to provide jurisdiction to the forum state has not been clearly delineated, but the cases suggest that it would have to be more than merely making one's name and credentials available on one's own Web site. This would be true even if the Web site was intended to generate business as long as there are no direct solicitations of interstate business. Problems could arise, however, if the psychologist lists his or her name with an Internet referral service that is intended to be national and is designed to solicit referrals for interstate services. Under this circumstance, the forum state might gain jurisdiction and be able to bring charges against the psychologist.

Truly, however, the lines that divide these issues are gray. Regardless, there are several factors that still make the risks of being prosecuted quite low even if one goes so far as to seek interstate business. This is because, for a state licensing board to discipline an unlicensed practitioner who resides out of state, the charge would have to be practicing psychology without a license, which is a criminal offense. In addition, the board could only prosecute the case if the state was willing to physically extradite the psychologist from the state of residence. This is because criminal offenses cannot be tried in the United States in absentia. Making this even more unlikely, extradition is a very complex, expensive, and time-intensive process. Although the state of California was willing to do this in the Hageseth case, it is important to remember that the consequence of the psychiatrist's behavior in Hageseth was the death of the patient, and the conduct of the psychiatrist involved was deemed to be egregious. We know of no

other case in which a health care provider was extradited regardless of health care specialty.

The negatives that go with interstate unlicensed practice include the reality that defending against this charge could be very expensive for the provider and could lead a malpractice carrier to deny coverage since the charges are criminal in nature. In addition, the state could gain jurisdiction if the psychologist had to return to the state to complete services that were contracted for or if the psychologist entered the state for other professional reasons. As a practical matter, in the immediate future, the primary disciplinary exposure for psychologists engaging in interstate practice will be from the board that licenses them, a conclusion that is supported by the Health Resources and Services Administration report: "In the absence of specific agreements . . . states may not discipline health care professionals not licensed in their state if patient harm occurs as a result of the provision of [remote] health care services by an out of state practitioner" (Center for Telemedicine Law, Office for the Advancement for Telehealth, Health Resources and Services Administration, 2003, p. 7).

Risk Management in the Digital Age

Having established that, at this point, the main risks to a psychologist of interstate practice will be complaints to his or her own licensing board rather than the board where the consumer is located, we now turn to how to manage the risk of conducting telehealth services, both within a state and across state lines. Consistent with the risk management model put forth by the APA Insurance Trust, which focuses on avoiding licensing board disciplinary actions (Bennett et al., 2006), those who use technology in their practices to provide remote services must carefully evaluate this type of practice through an analysis of the risks and benefits of providing the services as compared with the other options available for the consumer. The authors (Bennett et al., 2007) have previously written about the optimal basic risk management strategy for psychologists on the basis of developing effective, ethically based strategies for addressing the problems the patient brings to psychotherapy, focusing on both potential risks and potential benefits. This should be followed by careful documentation of the pros and cons of each, consultation with peers (and, when necessary, specialists), and the use of comprehensive informed consent throughout the process. In what follows, we focus on the supplementary issues presented by electronic interstate practice.

Generically, a proper analysis of risk should lead to a delivery model that is ethically sound, consistent with standards of professional practice, and respectful of the law. Thus, the first step is to look at the Ethical Principles of Psychologists and Code of Conduct (Ethics Code) (APA Practice Organization, 2010). The psychologists who drafted the current version of the Ethics Code recognized that electronic services were the wave of the future and that the efficacy, techniques, benefits, and risks were actively being explored and debated in the literature but that there was, as yet, no real consensus. The Committee understood that these standards would likely be developed during the time when the current Ethics Code was in effect and wisely decided not to create rules that might later prove problematic (Fisher, 2008). The Ethics Code does not specifically address the issue of remote electronic practice, but the Ethics Committee has issued the following opinion to provide guidance:

> The APA has not chosen to address teletherapy directly in its ethics code and by this intentional omission has created no rules prohibiting such services. The APA Ethics Committee has consistently stated a willingness to address any complaints regarding such services on a case-by-case basis, while directing clinicians to apply the same standards used in "emerging areas in which generally recognized standards for preparatory training do not yet exist," by taking "reasonable steps to ensure the competence of their work and to protect patients, clients, students, research participants, and others from harm" (American Psychological Association, 2002, 2.01e). Aside from another general caution about reviewing "the characteristics of the services, the service delivery method, the provisions for confidentiality, and licensure board rules," no clear professional consensus or detailed ethical guidelines currently exist. (APA Ethics Committee, 1997, as cited in Koocher, 2009, p. 340)

Without specific guidance, practitioners must first look to the basic ethical principles underlying the current code. The best place to start a risk management analysis in this area is to evaluate the situation in terms of General Principle A of the Ethics Code, "Beneficience and Nonmaleficence." This principle requires the practitioner to conduct what is essentially a risk–benefit analysis of the proposed intervention that comparatively assesses the proposed remote intervention against what is available as an alternative. To evaluate this, the psychologist has to obtain adequate information about the client and his or her condition. Obviously, the more information about the client the psychologist possesses, the easier it will be to make a reasoned judgment. Because successful therapy is thought to depend largely on the quality of the relationship (Norcross, 2011), some personal contact is obviously preferable, even if it is only an initial evaluative session. If the psychologist already has a long-standing relationship, he or she is in a better position to assess whether continued progress is likely if the relationship becomes remote and whether there are risks to the patient of this form of communication. How much personal contact is required likely depends in part on the nature of the service provided. Psychodynamic psychotherapy would seem to require more than cognitive–behavioral and other short-term therapies. Coaching and other consulting services, within which a personalized connection is less crucial, would arguably require less in-person contact, providing that other sources of information can be accessed. Theoretically, for many assessment purposes, face-to-face services may not be required. It is important to remember that if there is no advantage to providing remote services over in-person services, the risk-managing psychologist will choose in-person services, even if it means referring the prospective client to someone else.

There are many situations within which a case can be made for remote services that are consistent with both good ethics and standards of practice to include the following:

1. Where the services are provided in the context of, and/or in service of, an existing treatment relationship (e.g., if a patient travels regularly for a job, if a college student is going home for the summer, if a patient is moving to a different location, or if both parties feel that continuation is better than transfer);

2. Where in-person treatment is either difficult or impossible to access where the patient resides (e.g., where the patient is a resident of a foreign country where English-speaking therapists are rare; where a provider is treating a child of divorced parents and one parent lives

far away; where the provider has a particular specialty or expertise that the client, after appropriate research, has determined is well suited to their particular needs; or where the patient has great difficulty traveling to the provider's location);

3. Where remote services offer practical advantages over in-person treatment (e.g., where progress is facilitated by short, regular interactions rather than weekly hourly sessions; where clients feel more comfortable communicating remotely than they do in person; or where clients have very busy lives, making remote sessions more efficient); and

4. Where the client desires remote treatment and the psychologist has sufficient information about the client to assess whether this is a rational, informed decision (e.g., where a client feels more comfortable in sharing personal information that is embarrassing or shameful through electronic technology).

The psychologist who provides remote services must also assess the risks created by the provision of those services. Until more research is conducted, it would be prudent to assume that patients who present high risk in more traditional contexts may not be good candidates for remote treatment. Clients who are highly dysfunctional, who have Axis II diagnoses, who have conditions that require team approaches or intensive care, who are at risk of self-harm, and who are likely to be noncompliant with the commitments necessary for treatment to be effective are probably not good candidates for remote treatment.

All this has to be balanced against the available alternatives to the evolving world of remote therapy. If the consumer has no past relationship with the therapist and lives in an area where there are many psychologists with similar skill sets, then referral to local resources is both logical and prudent from a professional and risk management perspective.

There are also questions about which technology is most appropriate for teletherapy. Intuitively, the closer a technology can come to simulating in-person sessions, the more likely it is to be seen as a successful approximation of person-to-person treatment (Holland, 2003). It is interesting that there is comparative research that suggests that audiovisual, audio only, and text communication all provide comparable, if not equal, benefits when compared with in-person therapy and that they have several advantages in certain situations (Anthony, Nagel, & Goss, 2010; Pergament, 1988).

Competence

If there are complaints filed, psychologists who provide remote services will be required to demonstrate competence in both the services they provide and the technology they are using to provide it. At this early developmental stage, standards of competence are fluid and unclear. Therefore, this is not easy to accomplish because the standards of practice logically remain unclear when an area of practice is this unexplored. At this point, practitioners will have to utilize and adapt their own clinical experiences to make decisions about practicing in this area. Consultation with colleagues will be particularly important in thinking through remote interventions in certain cases because it supports that the decision to engage in this type of practice was reasonable and consistent with what others would have done under similar circumstances. The psychologist who uses remote services will need to look for supportive written materials and continuing education offerings in the area. Several professional groups, including the Ohio Psychological Association (Ohio Psychological Association, 2008), have offered guidelines for electronic practice with which a practitioner should be familiar.

Competence in remote interventions will require considerably more knowledge of electronic communication portals than that used in traditional psychotherapy practice. It also requires a frank assessment of one's understanding of, comfort with, and competence to understand the electronic technologies one is utilizing. The digital-age psychologist also has to anticipate potential problems that unsophisticated consumers might encounter, including what happens when the technology does not operate reliably. A discussion of these issues is an essential part of the informed consent process, particularly when the psychologist and patient are evaluating whether remote therapy is the right choice.

Particularly important will be confidentiality and privacy concerns. If one is practicing remotely across state lines, state laws about confidentiality and privilege will differ between the respective states, and the interstate nature of transactions is likely to raise real issues about which rules apply. At this point, it is safe to assume that the laws of the psychologist's home state would apply, but this is by no means certain. The difference in state confidentiality laws necessitates a more thorough discussion between the psychologist and the patient than would occur when psychologist and patient reside in the same state. It is likely that psychologists who intend to engage in interstate practice will have to have some familiarity with the laws of the patient's state of residence.

A Cooperative Solution

Short of some federal regulations, the only meaningful path to reasonably regulate interstate psychological practice is a voluntary agreement among state licensing boards or legislatures to establish appropriate credentialing through some type of consortium. It would require a set of uniform rules between adjudicatory bodies so that practitioners could know what is expected of them in interstate practice. It would also require the development of a method by which out-of-state consumers could more conveniently file complaints against psychologists in their home jurisdictions where those complaints could be effectively and economically investigated and prosecuted. Only in this way can a meaningful set of rules be established that would honor and protect the current state-level licensure system but would not stifle the development potential of remote services.

Discussion

This review demonstrates how applying the current regulatory design to treatment in the digital age is arguably not in the best interests of the consuming public or of the profession. The well-intended regulatory position of licensing boards to limit service delivery does not fit well with the rapid changes occurring in the electronic delivery of health care services either now or in the future. A review of the clear differences between the positions taken by many licensing boards, which are managed by administrative law and those taken by civil courts regarding jurisdiction, reflects a lack of consistency in the law, which generates strong legal argument that the boards' interpretations about interstate practice are incorrect. That aside, what is clear is that the boards, through the establishment of a conservative position on this matter, have placed both the practitioner and the consumer in a difficult

circumstance. In fact, it could be argued that a psychologist facing any of the previously mentioned conflicts who chooses to follow the boards' position that out-of-state practice is illegal and consequently denies the benefits of an already successful treatment alliance is selecting, in certain circumstances, the unethical option.

We feel that the solution to the dilemma created by various licensing boards regarding interstate practice and telepsychology lies in their adopting a more flexible position, such as those taken by the courts. This would be one within which boards would examine complaints individually and not generically. In this solution to the dilemma, licensing boards would look at compliance with the standards developed by various external bodies for remote and interstate practice and assess the psychologist's competence to engage in this new area of practice. Boards would also consider whether the interventions were well thought out, well managed, and well administered. Finally, it is our hope that the boards' initial perspective in dealing with this evolving area would be exploratory and educational rather than overtly prosecutorial. To do otherwise makes them like small, isolated kingdoms that have confusing regulations and who do not relate well with each other. That being said, the reality is that eventually the federal government will have to address the issue of how to deal with differences in state laws and regulations, and state boards will have to develop the technology to regulate and, where necessary, discipline their licensees' work with out-of-state clients. Although it is obvious that some negative outcomes will occur, within which clients might be harmed, this was true with the development of most areas of psychotherapy over the past 50 years. That said, the end result will benefit all and will expand and improve psychologists' ability to provide assistance and care to those in need.

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