See article by Scott et al

Should Blind Psychiatrists Be Paid Less?

Mark Zimmerman, MD[a,*]

I will address the question posed in the title at the end of this commentary.

The meta-analysis by Scott and colleagues[1] in this issue found that video-based telehealth treatment of posttraumatic stress disorder (PTSD) in primary care was as effective in reducing symptoms as face-to-face treatment. Moreover, the therapeutic alliance was as strong, and patient satisfaction as high, in telehealth as in-person treatment. These findings for PTSD are consistent with the results of other reviews and meta-analyses that found equivalent efficacy and patient satisfaction between telehealth and face-to-face treatment for insomnia,[2] substance use disorders,[3] obsessive-compulsive disorder,[4] depression,[5] and schizophrenia spectrum disorders[6] and in samples of patients with a mixture of psychiatric diagnoses.[5] Telehealth interventions as adjuncts to routine care have also been found to be effective in addressing other clinically important behaviors such as enhancing medication compliance.[7] In outpatient settings, appointment attendance is greater with telehealth versus in-person visits.[8–10] To be sure, telehealth interventions have not been limited to patients with psychiatric disorders and have been found to be effective in other areas of medicine.[11]

The literature on telehealth interventions, including both telephone and televideo, goes back decades. However, the recent COVID-19 pandemic, which spurred recommendations for social distancing and other precautionary measures, resulted in a rapid transition from in-person to telehealth visits, especially in behavioral health.[12] The change in how visits are conducted has been greatest in ambulatory care, though it also has occurred in emergency rooms[13] and inpatient units.[14,15] The widespread transition to telemedicine was economically feasible because reimbursement for services was not reduced. In part, equivalent compensation for telehealth treatment was compelled by government regulation.

The COVID-19 pandemic will not pervade society forever. Thus, the ongoing role of telehealth treatment in the delivery of treatment, particularly ambulatory behavioral health treatment, is uncertain. While some states have mandated an expansion of telehealth services and required private payers to continue to reimburse telehealth services at the same level as in-person treatment, other states have already rescinded, or allowed to expire, emergency orders that required equivalent telehealth reimbursements. What will the future hold?

Government regulatory agencies, at both the federal and state levels, will largely determine how widespread telehealth behavioral services will remain. To be sure, telehealth behavioral services will retain some presence because of the shortage of behavioral health providers in many areas. An as yet potential area of growth for telehealth treatment is the "expertise niche" in which clinical programs with renowned expertise in treating specific disorders expand their geographic reach. During the pandemic, programs with special expertise that heretofore had no experience with telehealth adapted and became comfortable with telehealth treatment delivery, and they might seek to expand services because the constraints imposed by physical space requirements will be lessened. Whatever the reason, telehealth will retain some future presence. To be determined is whether telehealth will be the norm (or near norm) of ambulatory behavioral health care, with patients having the choice of seeing clinicians in person or by telehealth, or whether telehealth will resume being just a small fraction of how care is delivered.

How will government regulators decide whether to maintain the expansion of telehealth services or return to the pre-pandemic status quo?

Undoubtedly, lobbyists, for and against, will attempt to exert their influence. What scientific-based arguments will be made? A lot of research had already been conducted pre-COVID. In fact, all of the treatment studies in Scott and colleagues' meta-analysis[1] were conducted prior to the COVID-19 pandemic. An explosion of science has occurred during the pandemic. A PubMed search conducted on November 30, 2021, with the terms *telemedicine* and *psychiatry* yielded 3,757 citations over the last 30 years, with more than 15% (n = 584) published already in 2021. The literature is near unanimous—almost all studies comparing telehealth and in-person treatment delivery have found equal efficacy, safety, and patient satisfaction.[5,16,17]

Equivalent efficacy is not surprising. Consider the following conceptual approach toward subtyping patients based on their response to treatment. When evaluating the response to two effective treatments, the key question is, how many and which patients will demonstrate *differential treatment response*? That is, how many and which patients would respond to one type of treatment but not the other?

There are 4 treatment response subtypes. Group 1 consists of patients who respond to the nonspecific

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aspects of treatment. This group can be thought of as placebo responders. The nonspecific aspects of treatment underlying the placebo response include the expectation of benefit, support from a clinician showing concern and attention, and symptom resolution due to the natural history of the disorder. Large placebo effects have been found for many psychiatric disorders, including in patients who are considered treatment resistant.[18] Group 1 patients would have a positive treatment response whether treated by telehealth or in person.

Group 2 includes patients who are chronically ill and treatment unresponsive regardless of the intervention. As with the patients in group 1, the approach toward providing care will not make a difference for the patients in group 2.

Group 3 includes patients who respond positively to the active ingredient(s) of the intervention whether the intervention is virtual or in person. The response rate in group 3 is additive to the group 1 nonspecific treatment response rate.[19]

Only the patients in group 4 will exhibit a differential treatment response. That is, it is only the patients in this group in whom the method of treatment delivery will make a difference. Some patients in this group will preferentially respond to in-person treatment. Perhaps subtle behavioral cues would be detected only in person, thereby leading to a positive treatment response. Observations of a patient's dress, grooming, physical appearance, gait, eye contact, dyskinetic movements, weight change, fidgetiness, body language, etc, are likely more accurate in person, and a more valid assessment of these elements of the mental status examination could increase the likelihood of a positive response. For some patients, the therapeutic alliance would be established and sustained only in person, and this too would result in greater efficacy of in-person treatment. Privacy might sometimes be difficult, and distractions at home could interfere with the therapeutic process during a telehealth appointment. And, of course, some patients may struggle with certain forms of technology. On the other hand, some patients in group 4 will preferentially respond to telehealth treatment. Obstacles interfering with travel to appointments are eliminated, and fewer missed appointments could improve treatment outcome. Some patients might feel more comfortable "opening up" and allowing themselves to be more emotionally vulnerable when they are not in the same physical space with their clinician, thereby increasing the likelihood of a positive outcome. Observing patients in their home environment might provide important clinical information that otherwise would not be ascertained. Thus, of all patients seeking behavioral treatment, only those in group 4 would show a differential treatment response, and this group includes an admixture of patients who preferentially respond to in-person treatment and who preferentially respond to telehealth.

The size of these 4 groups is open to debate, but I would hypothesize that no more than 20% of patients seeking behavioral health care belong to group 4. Thus, for 80% of patients, it would not matter if care was delivered in person or by telehealth, and for the minority of 20% who are differential treatment responders, some would respond preferentially to telehealth and some would respond preferentially when treated in person. Given the likely small size of the differential treatment response group, and the inclusion of a mix of patients who would preferentially respond to telehealth or in-person treatment, it is unlikely that a study randomly assigning patients to be treated in person or by telehealth will demonstrate the superiority of one approach. It is beyond the scope of this commentary to elucidate the list of potential advantages and disadvantages of each treatment approach. Rather, the point is that both have their respective strengths and weaknesses, and it would be difficult to demonstrate that one approach produces better outcomes. (A caveat to this conclusion is that it is based on patients seeking treatment. From a population-based public health perspective, one clear advantage of telehealth over in-person treatment is the provision of greater access to treatment.)

So, while calls for additional research to demonstrate equal efficacy and safety of telehealth compared to in-person treatment are likely to be made by those opposing telehealth expansion, the preceding conceptual analysis predicting equivalent efficacy has already been strongly supported by the empirical literature.[5,16,17,20] Additional research is highly unlikely to alter the conclusion of equal efficacy.

Let's now turn to the enigmatic title of this commentary. It has been proposed that equal compensation to in-person treatment be provided for televideo appointments but compensation for telephone-based treatment be reduced (or eliminated). In this context, consider the following question: how do telephone visits differ from treatment by a blind psychiatrist? To be consistent, those who support eliminating or reducing compensation for telephone visits because the patient is not assessed visually should also assert that blind psychiatrists/therapists receive reduced reimbursement (or no compensation at all). Do the opponents of equal compensation for telephone visits support this position? If not, the opponents to equal compensation should identify the important/critical/essential components of behavioral health treatment that distinguish telephone visits from treatment by a blind clinician. (To be clear, I do not support reducing compensation to blind psychiatrists.)

In conclusion, the research to date indicates that in-person and telehealth psychiatric treatment are equally effective and safe. Perhaps subgroups of patients will be identified that respond preferentially to one treatment approach, although I am skeptical that this will be consistently demonstrated empirically. Once pandemic-related issues have been resolved, patients should be given the choice of receiving treatment in person or virtually, and compensation should be equivalent.[21] The science already supports such a position. However, patient preference should not be absolute, and clinicians should use their judgment in considering whether some patient characteristics such as level of psychosis, safety risk, or need for a physical examination warrant in-person visits.

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