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Clinical Landscape of Telepsychiatry in Japan: A Psychiatric Case Report from the "Shadow Side" toward the Creative Development of Telepsychiatry in Japan

Satoru OGURA
Mizuekai Clinic Medical Corporation
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At the dawn of telemedicine in Japan, we are slipping into Galapagos syndrome. The main reason for this is that telemedicine remains considered an inferior substitute for in-person practice. As a result, the creative aspect of telemedicine is omitted and it is forcedly incorporated into the national health insurance system with heavy restrictions, making it useless. This occurred in 2018, and was coined "new telemedicine (bright side)" by the author, in contrast to "old telemedicine (shadow side)", which existed beforehand. The remedy for this syndrome lies in the "shadow side" of telemedicine, which vividly retains the creative aspect of its art. The author presents several psychiatric case reports from the "shadow side", followed by analysis of the characteristics of videoconferencing as a media, and in conclusion, suggests that the "hybrid model" of telemedicine, which utilizes in-person practice and videoconferencing flexibly, will be the future of telepsychiatry.

Keywords：telemedicine, telepsychiatry, case report, videoconferencing, health IT

Introduction

The author has been practicing online psychiatric treatment since March 2017, and has been employing telemedicine in

clinical practice to the present, when it is rapidly gaining social recognition, driven by the coronavirus pandemic. Based on this experience, we have strong concerns. If nothing is done, telemedicine in Japan will become Galapagosized. This means that the potential of telemedicine will be downsized by trying to integrate it into the current Japanese healthcare system, and Japan will be left behind in the global trend to fully utilize the potential of telemedicine.

This article is based on the author's presentation at the 116th Annual Meeting of the Japanese Society of Psychiatry and Neurology, with an editorial summary that adequately conveys his concerns and adds information on the trend of online psychiatric treatment (telepsychiatry) in the United States. The purpose of this article is to point out the problems of telepsychiatry in Japan and outline the future of clinical psychiatry as pioneered by telepsychiatry.

I. Problems of Telemedicine in Japan

1. Demerits of Rapid Introduction in the Midst of the Coronavirus Pandemic

In April 2020, initial consultations using online medical services were permitted as a time-limited measure against the backdrop of the spread of new coronavirus infection[5]. Furthermore, in October of the same year, a government policy was announced to lift the ban on telemedicine, including initial consultations, in principle, even after the coronavirus had been eradicated[6]. In other words, the introduction of telemedicine in Japan is accelerating, driven by the coronavirus pandemic. However, the usefulness of telemedicine for infection risk management is only one aspect of its unique and diverse appeal. It is unfortunate for both users and providers that the innovative aspects of online medical services are not fully recognized, and that telemedicine has taken root in Japan as an unavoidable next-best alternative to face-to-face medical services.

2. Confusion in Telemedicine Covered by Health Insurance

Currently, telemedicine services are confusing in terms of their operation. The biggest factor is the new online medical fee in the revision of the medical service fee in fiscal year 2018. As a result, the pre-revision online medical examination (where the re-examination fee by telephone is calculated) and the post-revision online medical examination (where the online medical examination fee is calculated) coexist.

The author distinguishes the former from the latter as "telemedicine (old)" and "telemedicine (new)", respectively.

The former was positioned as a transitional measure until all cases were shifted to the latter. The impression is that telemedicine (new) has become the "light" and telemedicine (old) has been relegated to the "shadow". However, telemedicine (new) has significant operational restrictions, making it difficult to fully utilize the potential of telemedicine. On the other hand, the creative elements of online medical services have been fully developed in telemedicine (old). Promoting telemedicine (new) without taking this situation into account will not only add to confusion in the field, but will also close the door to any possible future that telemedicine could open up.

3. "Light" of Telemedicine

As mentioned above, the online medical fee was newly established in the revision of the medical fee schedule for fiscal year 2018. However, the calculation requirements limit the patients and subjects who are eligible for calculation of the psychiatric home patient support management fee. That is, patients who receive a home visit once a month[4]. Medical institutions that do not provide psychiatric home-visit treatment cannot participate in the telemedicine (new) system at this point. This is a significant operational limitation.

Furthermore, the fee for telemedicine is reduced in comparison with that for face-to-face medical care. In addition, operational rules are added to the calculation requirements, such as the requirement that regular face-to-face consultations be mixed with online consultations. This indicates that telemedicine is viewed as an unavoidable alternative to face-to-face medical care. This viewpoint had led to Galapagosization. Incidentally, in the U.S., reimbursement for both is equivalent.

Of course, they are not identical. However, by knowing the advantages and disadvantages of each and using them differently, they can both be of equal clinical significance. If you are aware of this, you will understand how arguments such as "Is telemedicine possible from the first visit?" and "Show non-inferiority to face-to-face medical care" are based on an inadequate recognition.

4. "Shadow" of Telemedicine

In telemedicine (old) practiced before fiscal year 2018, the re-consultation fee was calculated using re-consultation fee by telephone, as a substitute. However, one restriction*1 and one condition*2 were added to this fee in the revision of the medical service fee in fiscal year 2018. Since the revision, it is no longer possible for new patients to receive

regular consultations within the framework of telemedicine (old). The actual situation in this area is extremely complicated. For details, please refer to my article[7].

Thus, the "shadow" of telemedicine seems doomed to extinction, but it is precisely in this shadow that the creative potential of telemedicine, which is distinct from face-to-face medical care, is realized. Unless this clinical sense is rescued, Japanese (psychiatric) telemedicine will become Galapagosized. The reality of this situation will be presented in III.

II. Implementation of Telemedicine in Our Hospital

The author is engaged in daily clinical psychiatric practice as the director of a psychiatric clinic in Kyoto City. Our clinic started telemedicine (old) in March 2017 and is still continuing it. The number of cases has generally remained at about 30 per month, and as of July 2020, the total number of cases was about 900.

Most of the patients live in the Kinki region, with some in the Kanto, Chubu, and Shikoku regions, and some are from overseas. Mood disorders are the most common disorders, and developmental disorders, neurosis, and schizophrenia are also seen in some cases.

All of the cases described in the next section received telemedicine (old). It should be noted that it is difficult to start new cases like these at present.

In addition, for the sake of protecting personal information, these cases are fictitious, combining the characteristics of several actual cases to the extent that they do not lose their clinical significance.

III. Presentation of Cases

1. Case A (30s, female, depression)

[Progress] A patient who had been working in the Kanto area developed depression and returned to her hometown of Kyoto City to consult our clinic for the first time in person. After her depression improved, she returned to the Kanto area, but she wanted to continue coming to our clinic, which was familiar with her progress, and so we followed her up from rework to return to work in the Kanto area through telemedicine.

[Discussion] Even if the patient's geographical medical care environment changes, telemedicine can maintain consistency of treatment. For example, one of the key points of treatment during rehabilitation is the prevention of relapse. Case A was treated by a conventional doctor who was familiar with the signs of relapse, rather than a new face-to-face doctor in the Kanto area, and the doctor was judged to be more beneficial in preventing relapse.

2. Case B (30s, male, bipolar II disorder)

[Progress] The patient had difficulty seeing a doctor periodically due to depression. We introduced telemedicine with the intention of intervening in this situation, where he was unable to see a doctor despite needing support the most. While the patient was lying in bed in a depressed state, we asked him to place his smartphone next to him and taught him breathing exercises. The patient commented: "Now I know what to do when I feel depressed."

[Discussion] In face-to-face consultations, there is a high risk that patient visits will be interrupted if the patient falls into a depressive or hypomanic state. Telemedicine can be provided when the patient needs support the most.

3. Case C (Male, 20s, depression)

[Progress] After graduating from high school, the patient became socially withdrawn. Although he had a history of psychiatric consultation with a diagnosis of depression, he had stopped visiting a psychiatrist because of the burden of visiting the hospital. He subsequently made his first face-to-face visit to our clinic, hoping that online care would allow him to continue receiving treatment. Thereafter, we continued to see the patient again via telemedicine. We shared information about the state of his room and interests, and promoted the development of rapport. As a result, his volume of speech gradually increased, and he was able to take a walk around his home with his smartphone when we asked him to. The patient was able to come to the clinic for face-to-face consultation when he was in a good mood.

[Discussion] Telemedicine is generally regarded as less informative than face-to-face medical care because the information obtained is limited to visual and auditory data, and this is often viewed as a disadvantage. However, as this case clearly shows, telemedicine provides a wealth of information about the patient's daily life that cannot be obtained in the unusual time and space of the doctor's office. What constitutes a wealth of information, and how should this information be utilized? Without this perspective, it is stereotypical to assume that online care is less informative than face-to-face medical care. In addition, telemedicine is less physically demanding and psychologically invasive than face-to-face medical care. This creates a completely new research theme in psychiatric interviewing, as described below.

4. Case D (30s, female, complex PTSD)

[Progress] The patient had been visiting a clinic for face-to-face medical

care in the Kanto region but had an initial online interview with our clinic for self-pay counseling to get a second opinion. She found the psychoeducational therapy, listening to her traumatic experiences, specific rehabilitation design, and lifestyle guidance meaningful, which her outpatient attending physician at that time did not provide. Although there were some occasions when the patient showed manipulative behavior toward the outpatient doctor, the moderate online distance (i.e., lack of physical presence of the doctor) naturally suppressed the patient's illness and allowed her to maintain focus on her own issues, and as a result, her trauma-related illnesses also eased.

[Discussion] The quantity and quality of information produced by one person in front of another person is overwhelmingly greater than that produced by video and audio of the same person. However, the stimuli can sometimes be intimidating and confusing to patients. In other words, there are situations in which the low volume of information in telemedicine is not necessarily a disadvantage. It has been reported that it is easier to talk about traumatic experiences online rather than during face-to-face care[1].

5. Summary of Case Studies

The message conveyed by the four case studies is that online care is not a next-best alternative to face-to-face medical care, but a new form of care that deserves to be considered as an equal option to face-to-face medical care in a clinical context.

Certainly, in countries such as the United States and Australia, where vast parts of the country are underpopulated, online care is an essential means of providing medical care in these areas as an unavoidable next-best alternative to face-to-face care. However, in an environment such as Japan, where patients can choose between face-to-face and telemedicine, the various characteristics of telemedicine that differ from those of face-to-face care suddenly come to the fore.

Let us enumerate these characteristics.

The first is the physical ease of access to medical care. It makes access to medical care possible across geographical barriers (Case A), or in situations where face-to-face medical care is difficult due to physical conditions (Case B).

The second point is the psychological ease of access to medical care. The psychological invasiveness of medical examinations is low, making continuous visits possible (Case C), and the absence of extra information that distracts the patient's attention makes it easier to concentrate on the task at hand (Case D).

Third, while including the above-mentioned points, it has marked significance in allowing patients to regain control of their medical care. Seizing the moment when they truly need medical care (Case B) and communicating their true self (Case C) support patient autonomy.

These characteristics will never be appreciated as long as online medical care is perceived as an unavoidable next-best alternative to face-to-face medical care.

However, when considering online care as an equal option to face-to-face care in a clinical context, one issue that cannot be avoided is the clinical competence of the psychiatrist who provides the care. In face-to-face consultation, the psychiatrist keeps staring at the electronic medical record monitor, interrupts the patient's conversation within 30 seconds like a timer, and forces the patient to leave the room by saying: "Same prescription is fine"; or in online consultation, the psychiatrist listens to the patient's complex symptoms and modifies the prescription while keeping a close eye on the patient. It is clear from the first glance.

In other words, being face-to-face is no guarantee of quality care, and being online does not always mean it is destined to be poor care. Tools are what they are. Of course, basic safety control of tools is essential, but clinical outcomes are determined by one's choice of which tools to use and how proficient one is with those tools. In the midst of this pandemic, we Japanese psychiatrists have a new tool in our hands: telemedicine, but we will never learn how to use it simply by practicing telemedicine in the "light." With this concern in mind, we present a case report of practice from the "shadow" side of telemedicine.

IV. Characteristics of Videoconferencing as Medium

The medium used in telemedicine is called videoconferencing, and usually consists of a video of the frontal upper body of both parties and audio of the conversation. In order to understand the characteristics of this medium, we attempted to compare the three by discussing telephone and face-to-face consultations.

1. Telephone Consultation

The advantage of telephone consultation is that this medium places the least physical and psychological burden on the patient. There are sometimes cases in which patients do not wish to undergo online consultation because the other party can see what is going on at home. Telephone consultation is less psychologically invasive due to the lack of visual information.

The disadvantage of telephone consultation, being two sides of the same coin, is that it is impossible to view the facial expression and posture, which are extremely important clinical findings.

2. Face-to-face Consultation

The advantage of face-to-face consultation is that the patient's momentary confusion and changes in atmosphere can be detected in a way that is not possible with a videoconference. The same is true for the patient, and the experience of sharing the same time and space has a significant positive impact on medical treatment.

The disadvantage of face-to-face consultation is that, of the three, the physical and psychological burden on the patient is the highest, although this is also the flip side of the coin. Therefore, the risk of interruption of outpatient visits is marked.

3. Telemedicine

The advantage of telemedicine is that clinical findings such as the patient's facial expressions and posture can be obtained, which is not possible with a telephone consultation. In addition, the patient's living environment, such as his or her room, can be observed. It is also easier to observe a relaxed patient than in a face-to-face consultation.

A more in-depth analysis of this would require a separate chapter. The reason for this goes beyond simply being at home or in one's own room, as the hierarchy of the doctor-patient relationship, both latent and manifest, can be changed at the initiative of the patient. Imagine that the doctor appears in a small smartphone screen and the patient can control where the smartphone is placed at will. The patient can look down at the doctor with the smartphone on his/her desk, depending on their mood that day. In a face-to-face consultation, the doctor is on home turf, but in telemedicine, the patient is on home turf. From another perspective, telemedicine via a smartphone heralds the birth of a new structure of psychiatric interviewing, comparable with the development of the couch in psychoanalysis (in this case, the patient has regained the initiative). This point alone opens up a new research theme in clinical psychiatry, and shows how shallow it is to view online care as the unavoidable next-best thing to face-to-face consultation.

Furthermore, it is easier to form a rapport than with a telephone consultation (if we may return to the topic). In particular, patients who place greater importance on intellectual information from their doctors may be more satisfied with telemedicine than face-to-face consultations, which are

more physically and psychologically demanding.

On the other hand, a disadvantage of online consultation is that if the patient continues to be treated without ever having met the doctor face-to-face, there is a concern that the doctor in charge may construct an image of the patient that is devoid of the unique atmosphere created by his/her physical presence. In a simple example, a patient who looks small and rounded on the screen during telemedicine may be unexpectedly taller in a face-to-face encounter, which may significantly change the image of the patient. During telemedicine, the patient's complexion may appear somewhat pale and his/her energy level may seem low, but when met in person, we may be surprised to find that his/her energy level may be unexpectedly high.

There is also a concern that patients who place a great deal of importance on the physical presence of their physicians may remain dissatisfied. Furthermore, if the face-to-face consultation is for rehabilitation to maintain socialization, there is a concern that it may deprive the patient of this opportunity.

4. Conclusion

Comparing the three media, it can be said that a short-sighted viewpoint such as: "videoconferencing is a medium that is more than a telephone call and less than a face-to-face meeting", does not fully grasp the reality of the situation.

In other words, psychiatrists must be familiar with the characteristics of each medium and be able to use them flexibly. Such an era has already arrived.

V. Telemedicine Overseas

In order to avoid the Galapagosization of telemedicine in Japan, it is essential to collect information on trends in other countries. For information on the situation in the U.S., a book published by the American Psychiatric Association[8] is a good reference. The following is a summary of the information that is useful to us.

1. Case Presentation

This book describes the use of telepsychiatry in a variety of settings, from child psychiatry to PTSD in military veterans. The primary purpose of introducing telepsychiatry is often to provide support in areas lacking psychiatric services, and in this sense, it is the next-best alternative to face-to-face treatment; however, during treatment, the clinical practice is well communicated, with the child's condition at home and relationship with his/her parents known by fully utilizing the unique features of telemedicine.

In the context of this paper, the clinical practice shown there is the "shadow" of telemedicine. In other words, the cases

presented in this paper are not specific to our hospital, but are more general in nature, in line with overseas trends.

2. Reform of Work Style

A psychiatrist not only treats his/her own patients online, but also provides consultation to an internist at an internal medicine clinic via videoconferencing, and then conducts a psychiatric interview with the patient, or conducts an interview with a child at a juvenile reformatory in the afternoon, etc. The book introduces the practice of such a way of working, in which one's skills are freely provided through videoconferencing.

If applied in Japan, this would be a situation where telepsychiatry is provided on a regular or on-demand basis to general hospitals where it is difficult to have a psychiatrist on site.

3. Hybrid Model

In Japan, the term "online medical care" is understood to mean medical care via videoconferencing. However, the term telepsychiatry in the U.S. includes not only videoconferencing, but also all online information, such as phone calls, emails, chats, SNS posts, and information from wearable devices. The hybrid model refers to a model of care that freely combines face-to-face care with all such online information. It has been predicted that the hybrid model will become the standard for clinical psychiatry in the near future as a practice of patient-centered care.

On the other hand, the Japanese guidelines for online medical care[3] stipulate that, in principle, e-mails and chats are not to be included. Here, too, we recognize Galapagosization.

On the other hand, in March 2020, we began developing a psychiatric community collaboration application ("molMIP") as an infrastructure for this hybrid model. Patients upload their consultation details to a bulletin board in advance, and the doctor in charge checks them before the consultation (in person or online). The content of the consultation is shared with local staff via the bulletin board, and the doctor in charge and staff communicate via chat. At night, in the case of emergency, patients can chat with a clinical psychologist.

Telepsychiatry will not be the unavoidable next-best thing to face-to-face care, but a basic feature embedded in such a hybrid model and provided by default.

Conclusion

The following points are essential for developing telepsychiatry in Japan while fully realizing the potential of telemedicine:

(i) Be aware that Japan has both telemedicine (old: "shadow") and

telemedicine (new: "light").

(ii) Recognize that Galapagosization is inevitable even if the target diseases of "light" are expanded.

(iii) It is necessary to continue to disseminate clinical experience of the "shadow".

(iv) We should continue to question what psychiatric interviewing is, taking advantage of the characteristics of the videoconferencing medium.

(v) We should seek telemedicine that integrates "light" and "shadow" in collaboration with the Ministry of Health, Labour and Welfare, and position it within a hybrid model to help patients regain control of their care.

This will be a blueprint for the future of telepsychiatry.

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Notes

1. One limitation is that: "the fee cannot be calculated if it is performed on the premise of regular medical management"[2]. This means that telemedicine (old) cannot be provided on a regular basis. This is significant. For example, it will no longer be possible to prescribe a four-week supply of prescriptions by setting the next session of telemedicine (old) for four weeks later. Those who were practicing telemedicine (old) at that time were not only shut out of telemedicine (new) but also prohibited from practicing telemedicine (old).

2. One condition is: "However, for patients whose medical management was conducted by telephone or videophone before March 31, 2008, and for whom the consultation fee was calculated, the consultation fee may continue to be calculated until the series of medical management is completed"[2]. Currently, this condition is the only basis on which a patient can be seen regularly via telemedicine (old). The patients are limited to those who were already using telemedicine (old) before the revision.