With the worldwide COVID-19 pandemic, it’s the end of the world as we knew it. The necessary lockdowns to suppress the spread of the virus by physical distancing has forced psychiatry to pivot quickly toward telepsychiatry in lieu of in-person visits. As we pivot, with millions of clinicians and patients turning to telepsychiatry, we have an opportunity to not only provide continued care, but also an opportunity to question our assumptions. It always seemed to me that telepsychiatry, especially with easy to use two-way video interfaces, was not that big of a deal. Not only could you talk with a patient, but you could also see them while making almost good-enough eye contact, and perhaps not quite the same level of nonverbal communication through body language and hand gestures but good enough to obtain sufficient information. Not only that, but as we all have been forced to try to maintain our own social networks in the absence of in-real-life (known in gaming worlds as IRL), we, too, have become used to Zooming for tele-dinners and tele-happy hours to at least continue tele-relationships. Somehow, the insurance companies pivoted faster than I would have expected and embraced payments for telepsychiatry, albeit frequently paid at lower rates than IRL visits.

Why should telepsychiatry visits be paid less than IRL visits? What are the underlying assumptions that IRL visits are better?

The major assumption is that a patient must show up physically, and that the clinician has to meet face-to-face IRL with a patient to provide quality psychiatric care. Embedded in this assumption is that anything less than IRL is not as valuable. Yet, no data exist to show that telepsychiatry results in inferior outcomes or takes less expertise or interferes with shared decision-making. Quite the opposite, many of my patients have found it a relief to avoid the trip through the notoriously bad Boston traffic to get to my office and instead communicate with me via a secure portal from a computer or smartphone from the convenience of their homes. It saves them time and hassles. It reminds me of the early 1980s when I was in training at NYU/Bellevue at the time that psychoanalysis was still the dominant paradigm. The assumption was that psychoanalytic psychotherapy was the first tool one should use and if that did not work, then consider psychopharmacology—an attitude with no data to back it up. In contrast, telepsychiatry appears to be effective. One major issue is access, especially for those who do not have computers or Internet access capability. We will have to be diligent in finding creative solutions (eg, using platforms that can be used with smartphones), as well as providing phones and data plans for those without resources.

Telepsychiatry is here to stay and we should advocate to be reimbursed at the same IRL rates.

REFERENCES