

Practical Advances
in Primary Care

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From the Editor

E-mail-Enhanced Relationships: Getting Back to Basics

My relationships with patients are being quietly transformed. Rather than episodic interaction during hurried office visits, I now have continuous communication. I feel like Marcus Welby again.

I began exchanging e-mail addresses with patients simply for convenience, theirs and mine. I knew how frustrating my office's telephone system had become, and I wanted patients to get right back to me with questions and information. I also wanted to share lab results without having to chase them down on the phone. After using e-mail for about a year, I realized that my relationships with patients had fundamentally changed. Communicating through e-mail had brought me closer to them, as in the early days of my practice.

When I started my practice 21 years ago, I had the luxury of taking a lot of time with patients. If they were sick with the flu or another self-limited problem, I called them the next day to ask if they were feeling better. Then, like the rest of us, I got very busy. Twenty-five to thirty patients a day consumed my time and energy. Driving home at night, I often wished that I'd had more time with the five or six patients who really needed to see me that day, but I was too busy servicing the rest of my patients' needs to make that happen.

Today, electronic communication provides a vehicle for transforming office practices. I envision a future where primary care physicians and their staffs are able to answer the daily needs of most patients electronically, freeing precious time for doctors to interact with those who require a more intimate level of care.

Many common acute problems can be handled electronically. The sinus pressure that occurs during a cold can be monitored through e-mail, and a patient can be reassured that nothing more serious is wrong. It's much easier to avoid antibiotics for URIs or an unnecessary referral when a patient hasn't gone to the trouble of coming in for a visit. E-mail is also ideal for following up on acute problems that take time to heal. If a patient with plantar fasciitis is given detailed instructions to resolve the problem after an office visit, a periodic e-mail exchange can help monitor progress and provide reinforcement. Acute positional vertigo generally takes six weeks to six months to resolve. E-mail can be used to gauge improvement after an office visit and can help detect worsening, which may be an early warning that something more serious is going on.

Electronic communication can provide continuous online management of chronic disease, replacing the need for episodic visits. Obese patients can e-mail their weight and other data weekly, and can be coached online. Lipid disorder patients can receive periodic lab instructions and get feedback on their progress. L-thyroxine doses for patients with hypothyroidism can be adjusted easily through e-mail. Hypertension, diabetes, and asthma can all be monitored more closely, with less frequent visits, through electronic sharing of information. Patients with disabling chronic conditions, such as lupus, can communicate with their doctor and their consultant without the trouble of regular visits.

E-mail has also improved my relationships with consultants. I can send them messages introducing patients and providing important details about their conditions. This begins an electronic dialogue about their care. With the consultant's permission, I can copy these messages to patients, connecting them electronically with the consultant. This communication is especially helpful for postoperative care after early discharge.

Privacy and confidentiality are important issues with electronic communication. In the September issue of *Hippocrates*, our "Legal Brief" department reviewed the utility and pitfalls of e-mail communication with patients (see "You've Got Mail," September 1999). The cautionary guidelines of the American Medical Informatics Association (www.amia.org) outline the "informed consent" that should exist between physician and patient in the use of e-mail. These guidelines emphasize explaining the response time parameters for e-mail, being discreet, being careful, and, if in doubt, seeing the patient. I tell all my patients that e-mail with me is a warm line, not a hot line. They know I will see the message and respond in one to three days. Immediate access still requires the phone. I also tell patients I will treat our messages privately and confidentially, and that they will become part of the medical record. I tell patients that electronic communication is not guaranteed to be secure. However, password protected communication is probably as secure as phone lines and paper (which can readily be copied).

We all practice serious medicine on the phone at all hours of the day, with only partial documentation (or none at all), and under pressure to give immediate answers. If the phone were invented today, we would probably need to play an informed consent recording before talking to patients. If used wisely, electronic communication should improve quality and lower risk. It is essentially like the phone, but with a written record, and the freedom to respond more thoughtfully at a convenient time and place.

The critical enabling factors for an electronically enhanced practice are technology, financing, and control. Since information technology and usage are growing at an accelerated pace and Americans are comfortable with doing more things online, why shouldn't health care take advantage of the trend? I practice in Irvine, CA, and I haven't had any patients yet who couldn't give me an e-mail address, either their own or that of a trusted friend or relative — like in the early days of the phone. Colleen Connery at the University of Colorado in Denver told me that a survey of indigent patients at a community clinic showed 70% were able to provide e-mail addresses. Electronic communication will soon be as universal as television. A growing market of health care information technology will expand the sharing of information in

ways we can only imagine.

An electronically enhanced practice is less expensive if it saves office visits and provides more service. This should capture the attention of health care payers and purchasers. The challenge now is to free the physician from a strictly visit-based reimbursement. Capitation, panel-size reimbursement, or salaries can allow for this. Even in a strictly fee-for-service cash practice, patients could be asked to pay a monthly fee, which would be automatically deducted from a credit card, in order to have continuous e-mail communication.

Finally, primary care physicians need to be given control over their schedules, with the flexibility to care for their patients in the most efficient way, meeting current standards for quality.

In the future I envision, physicians will have a more executive schedule for managing the 2,000 or more patients they must take responsibility for to earn their keep. Imagine a schedule with five or six time-intensive office visits daily, time reserved for e-mail, and for brief visits in which a physical exam is necessary. Wouldn't this be a better routine for everyone? Some of my patients have become passionate in their testimonials about having direct electronic access to their personal physician. It reminds them, and me, of the good old days of Marcus Welby.

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