

Managing E-mail Interactions with Patients: A Discussion with Clinicians in Evaluating the Personal Health Link Project

By Carl A Serrato, PhD; Sally Retecki, MBA

Abstract

One software feature in the Personal Health Link (PHL) Project allows members of Kaiser Permanente to send secure e-mail messages to clinicians and staff. As an early step in the PHL evaluation process, a group of primary care physicians met to discuss their opinions and experiences with e-mail interactions with patients and to suggest strategies for effectively managing these e-mail interactions. Most clinicians spoke from their experience with e-mail interactions with patients in a conventional e-mail environment; only one clinician in the group was using PHL.

Introduction

Growing evidence indicates that e-mail communication between clinicians and patients is increasing. About 60% of adults in the United States have access to the Internet,¹ and 90% of this population would like to be able to communicate with their clinician online.² In a 2002 survey of adults who use e-mail, nearly 40% indicated that they would be willing to pay to communicate with their doctors through e-mail.² More Kaiser Permanente (KP) clinicians are communicating with their patients through e-mail. For example, one third of primary care clinicians in the Kaiser Permanente Northwest (KPNW) Region recently reported e-mail exchanges with their patients, although most report sending only one e-mail per day.³

However, some clinicians fear that online communication could add to an already full workload. Clinicians may also need to set boundaries and policies about patients' more extreme expectations or e-mail communication behaviors that may include urgent messages, long and complex messages containing open-ended questions, or frequent messages. Use of e-mail may empower mem-

bers who are attempting to self-manage but who may have complex medical questions, pain, or fear; some of these patients may not use e-mail communication appropriately. This raises the question, "What is appropriate e-mail communication?"

At least three distinct categories of e-mail exchanges occur between members and clinicians:

- *Brief acute need:* Intermittent brief e-mail use associated with an episode of an acute health care need for a person whose condition is stable or who is otherwise healthy
- *Prolonged care management:* High use of e-mail during a defined time period which is associated with a new diagnosis or destabilization of an existing condition
- *Ongoing high (excessive) use:* Prolonged high use of e-mail which is driven by a mix of objective medical need and other drivers of members' need for repeated contact.

How should one characterize

patients whose e-mail communication behavior is in the ongoing-high-use category? What do these patients really want? When can their needs appropriately be met by e-mail? How does one distinguish between objective medical need and subjective need for repeated e-mail contact?

This article begins to address these questions by reporting the findings of a discussion with clinicians who are already exchanging e-mail messages with patients. The organizing principle for this discussion about potential problems with clinician-patient e-mail communication was a focus on patient behaviors that require a creative response to address the question: What strategies and infrastructure support can best assist clinicians in managing e-mail interactions with patients?

Discussion Group

The discussion group was created early in the evaluation of the MyChart feature in the Epic software suite (Epic Systems Corp, Madison, WI) and as part of the Personal Health Link (PHL) Project, which is sponsored by KPNW Region, Kaiser Permanente National Clinical Systems Planning and Consulting Department, and the Kaiser National Internet Services Group. The MyChart feature provides members with Web access to portions of their medical record and the ability to send secure messages to clinicians and staff. The PHL project is ad-

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Carl A Serrato, PhD, (right), is a manager in Kaiser Permanente's National Market Research Department. Carl, a health economist, conducts research on a range of topics including evaluation of clinical innovations, member satisfaction with KP's services and product development. E-mail: carl.a.serrato@kp.org.
Sally Retecki, MBA, (left), is a project manager in The Permanente Federation's Performance Assessment Department. She led the PHL work as evaluation manager in Kaiser Permanente's National Clinical Systems Planning and Consulting Department. E-mail: sally.retecki@kp.org.



Table 1. Personal Health Link (PHL) Project Team

<p>Project Leadership: Sharon M Fox, E-clinical Services Program Manager, Clinical Information Systems (CIS), Portland; PHL Project Manager David E Schmidt, MD, Pediatrics, Northwest Permanente; PMG Physician Lead</p>
<p>Evaluation and Reporting Team: Sally Retecki, MBA, PHL Evaluation Lead, National Clinical Systems Planning & Consulting Yvonne Zhou, PhD, Clinical Systems Planning & Consulting, KP Northern California; PHL Reporting Lead and Data Analyst Carl A Serrato, PhD, Manager of External Scanning, National Market Research, Program Offices Jack Bookbinder, PhD, Senior Analyst, National Market Research, Program Offices; PHL Survey Coordinator Kyle Longmuir, Clinical Systems Planning & Consulting, KP Northern California; PHL Database Developer Colin F Bell, Senior Analyst, Clinical Systems Planning & Consulting, KP Northern California; PHL Data Analyst</p>

addressing key questions regarding MyChart's value to members and clinicians and the potential influence on clinic workload and practice efficiency as well as on clinic culture and practice style. PHL Project Team members are listed in Table 1.

In April 2002, a facilitated two-hour discussion group was conducted with KPNW primary care clinicians who are actively using e-mail to communicate with some of their patients. Four of the participants were physicians, and one was an affiliated clinician. One of the invited clinicians was using MyChart, and the other clinicians were interacting with patients in the conventional e-mail environment.

The discussion group also included Dr David Schmidt, Physician Lead of the E-Clinical Services Group for KPNW Region, who identified and extended invitations to the participating KPNW clinicians, and John Guzman, Chair of the Sub-Chiefs of Behavioral Medicine, The Permanente Medical Group (TPMG). Mr Guzman contributed expertise regarding meeting and managing the mix of subjective and objective clinical needs of members as well as experience in addressing these needs in e-mail interactions with members. A structured discussion guide was developed in preparation for the meeting with input from Dr Schmidt and Mr Guzman. (The discussion guide is available upon request).

Managing Inappropriate E-mail Use

As one clinician stated: "Some patients are better office visit patients than e-mail patients." E-mail frees patients from some of the constraints which are normally imposed during an office visit (eg, time allotted for visit, clinicians' control of the agenda). Relaxing these constraints may improve the ability of some patients to communicate with their clinician and may result in inappropriate behaviors in other patients.

This discussion focused on the following inappropriate e-mail communication behaviors: ongoing high (excessive) e-mail use, long and complex messages, nonmedical e-mail messages, complex message threads, prescription refill requests, and redundant messages.

Excessive E-mail Use

A concern expressed by some clinicians in the PHL Project was that providing e-mail access to members may attract that small cohort of patients who have a preference for a lot of interaction in excess of objective medical need. These patients may be expressing a need that would be hard to manage in any care setting but one that may be especially difficult to manage with the more direct access provided by e-mail.

Clinicians in the discussion group hypoth-

esized that use of e-mail will probably not induce new behaviors from members but will provide another channel, and perhaps more freedom, to manifest existing behaviors. The patients who overuse e-mail are very likely to be the same small population of patients whose behavior is a challenge in other settings. For example, there are patients who contact their clinician repeatedly by telephone or who bring extensive typed notes or a diary/calendar documenting their health conditions to an appointment. For these patients, e-mail provides another mode for them to display their anxiety and concern.

Sending e-mail messages to their health care provider may serve as therapy for very anxious patients. These patients may frequently e-mail long, stream-of-consciousness messages whose content reflects the patients' high level of anxiety about their medical conditions.

Clinicians were concerned that some important information about the patient's condition may be buried within long e-mail messages. The clinician may need and want to know this buried information but could miss it while skimming long messages or could discover it too late if insufficient time was available to read long messages immediately.

The legal implications and risk of malpractice suits from clinicians missing important information embedded in long e-mail messages was considered. This was an especially important factor because MyChart automatically adds all e-mail communications into the patient's medical record. The discussion group recommended that KPNW seek legal advice in this matter.

The opportunity for members to exchange e-mail with clinicians may simply function as an alternative channel of communication for patients who would have expressed their anxiety through another channel, such as the telephone. Medical assistants often handle a significant share of members' telephone communications, but the introduction of e-mail could shift to clinicians the burden of managing members' communications.

A general consensus of the participating clinicians was that establishing rules or guidelines for patients on how to use e-mail would not alter excessive e-mail use driven by abnormal anxiety.

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How substantial is the burden from patients who overuse e-mail? Do they represent an impediment to primary care practice and to the use of e-mail in particular, or do physicians' anecdotes about these patients represent the rare (if memorable) exception? The group's general consensus was that patients who overuse e-mail to an extreme degree are exceptions but that all clinicians have had patients who display similar behavior to a lesser degree.

Several clinicians expressed a sense of concern and protectiveness for patients in their panel who may be considered difficult: "... They're your patients and you love them, but everyone is, like, 'Oh my god, that's your nightmare patient!' Yeah, but they're *my* patients; I know them. We have this understanding. I know them; they know me ... they were a nightmare when they came, but now we've worked it out ... But when a colleague covers for me without knowledge or understanding of what works, the patient looks like and becomes a problem again."

Strategies suggested for managing this behavior involved recognizing that these patients need to express their concerns but establishing parameters and boundaries on how the clinician responds to these patients' e-mail messages. The group's suggestions to clinicians included the following:

- Acknowledge the patient's concerns, but let the patient know that you will not be able to respond to every e-mail: "I care, and I hear you. I can see that you are having a lot of pain. These are things that I can do Feel free to write; I won't always respond." "Thanks for keeping me informed. At the end of the week, I'll get back to you with some ideas." "Thanks for sharing this. It helps to put things into perspective and know where you are coming from. It will work for me if I can respond to you once every week."
- Try to clarify whether patients expect you to act on the information in the message or if the patient just wants to share their concerns with you. Ask the patient: "Are you telling me this because you want me to do something about this, or do you just want to tell me about this?" or "What would you like me to do?"

- For "difficult" patients who call or e-mail frequently, one clinician recommended quick responses. "Don't hide from [these patients] and don't let it sit all day ... answer immediately."
- Another clinician took the opposite strategy: "I just don't respond." This clinician expressed the belief that members accommodate a doctor's style or search until they find a doctor whose style is compatible with their preferences.
- Although the two preceding strategies appear contradictory (respond immediately versus don't respond at all), the opinion was expressed that room exists for both of these approaches, because "... patients choose you [their physician] for a reason, and they reflect your style."
- Patients may need to be referred to a behavioral psychologist or case manager. However, the discussion group clinicians acknowledged the limited number of behavioral psychologists and the difficulty in making timely referrals.

Long and Complex Messages

Patients sometimes send lengthy messages that lack focus or clear questions for the clinician, long, wandering messages, a series of branching questions, or just too much information. Clinicians may not be able to discern the patient's medical concern or fundamental question. One clinician, who was familiar with the e-mail capabilities of MyChart, explained why this type of e-mail message poses such a problem. Because clinicians often write responses to e-mail messages between patient appointments or during other brief breaks in their schedule, they have only five or ten minutes to compose an e-mail response before returning to other clinical work. MyChart does not currently allow the clinician to save incomplete responses without sending.

The discussion group's suggestions to clinicians for managing long and complex messages:

- One clinician preferred

not to reinforce this type of e-mail use. This clinician will respond to patients that their long message contains much to talk about and asks whether they wish to come in for a visit: "You have a lot of issues—let's talk in person." This strategy shifts responsibility back to the patient: Is their medical concern of sufficient seriousness and urgency for them to want to make an appointment?

- Another strategy to encourage a narrow scope of inquiry is to respond: "It's difficult for me to respond to the number of issues that you are raising. Can you please break this up into smaller pieces and ask me one at a time?"
- Alternatively, clinicians may choose to deal with one or two of the issues and ignore the rest ("It sounds like one question you have is ..."). The expectation is that the member will either forget the other items or assume that they are not important enough to repeat in a subsequent e-mail. Responsibility shifts to the patient to prioritize and raise additional questions.
- If the patient's questions are vague, you can define (ie, restate) one or two questions, as you understand them, and answer those questions.

Nonmedical E-mail Messages

Several clinicians indicated that they received nonmedical, personal e-mails from patients. In these cases, patients appeared to be using e-mail in an attempt to build a personal relationship with their clinician. Two clinicians reported being included on some of their patients' general distribution lists for chain letters, jokes, and notes about personal events, for example, news about a vacation. However, this type of personal communication cannot occur with MyChart because the patient must log on to a secure Web site to send their clinician an e-mail message.

One clinician observed that some patients use e-mail for general discussions about health and

Try to clarify whether patients expect you to act on the information in the message or if the patient just wants to share their concerns with you.

health care instead of discussions on issues related to their own medical condition. “I’m spending a lot of time being WebMD. I don’t want that. I want e-mails to pertain to them and to their conditions.”

Two strategies suggested for managing non-medical e-mail messages were:

- Deleting the message without reading it or replying to it. Clinicians suggesting this strategy indicated that they did not ask the patients to stop because they did not want to disrupt the relationship with the patient.
- Gently reminding the patient that e-mails sent to their clinicians via MyChart will be part of their medical record.

Complex Message Threads

Sometimes a patient sends messages about a medical condition that require the clinician to respond with a series of questions and follow-up questions to determine the appropriate response or treatment. Alternatively, a patient’s e-mail responses to questions may be so terse as to require the clinician to send numerous follow-up questions. The discussion group had the following suggestions for managing this type of behavior:

- Change the communication mode from e-mail to telephone: “This is going to be difficult to go back and forth. When would be a good time to call you?” or “Are you available tomorrow at (specify a time) when I could give you a call to talk about this?” or “This is too complicated [for e-mail]; I’ll call you in the next day or two.”
- Respond with a phone call on the clinician’s timetable, for example, after appointments are over at 6:30 pm. The surprise element enables the clinician to set the boundaries and “control the conversation better” and address items chosen by the clinician.
- Call patients to address their questions and medical condition. While on the phone or immediately after the call, type notes into an e-mail response to the patient: “To confirm the call we just had, I

Clinicians should receive training in using and managing e-mail communication.

would like you to” The e-mail message is automatically entered into the patient’s medical record and can be done instead of opening a phone encounter in EpicCare. It also has the advantage of sending the patient a reminder of the clinician’s instructions and advice (a strategy similar to an After-Visit Summary).

Prescription Medication Refill Requests

A common misuse of e-mail to clinicians is to request refills for prescription medication. The discussion group clinicians recommend setting boundaries by reminding members that refill requests are to be made directly to the pharmacy:

- “Refills go through the Pharmacy, please contact them.”
- One clinician indicated that the first time such requests come in, it is quicker for a clinician to take care of the refill process, but this clinician responds by reminding patients that for the next refill request, the patient needs to contact the Pharmacy directly.

Redundant Messages

Patients may send one or more follow-up e-mails which repeat questions or observations on issues that the clinician addressed in previous e-mails. Clinicians should

consider the underlying reason for a patient’s repetition. Was the patient confused by the clinician’s earlier e-mail message, or has the patient forgotten the message? Or is the patient expressing an unspoken (unwritten) physiological or psychological need? Clinicians need to be aware and to inquire as to the motive for the repetition.

For repeated questions from a patient, the group suggested clinicians may respond with one or more of the following:

- Restate the previous answer.
 - “Were you uncomfortable with or confused by my previous answer to this question?”
 - “I thought I answered this; wasn’t I clear?”
- Use this response with caution because

it may sound condescending. Clinicians have to be aware that the tone of a spoken message may be very different when the same message is written; large potential exists for the tone of an e-mail (ie, written) message to be misunderstood.

Discussion Group Recommendations

The discussion group had the following recommendations for implementation of MyChart.

Clinician Training

Clinicians should receive training in using and managing e-mail communication. Modular training meetings are best because the whole staff is required to be there—clinicians, medical assistants, and registered nurses. People who are in the module together can discuss and share their learnings and personal experiences.

Training should be given in at least two sessions which are separated by several weeks. Training sessions should cover communication skills as well as technical skills and should include topics such as the technical features and use of MyChart, how to communicate using e-mail, and how to manage patients’ inappropriate use of e-mail.

Infrastructure

Clinicians will need infrastructure support to efficiently manage inappropriate e-mail use. Support should include communication training, access to behaviorists, improved access to case managers, and fast-access consultation with clinicians who have experience with MyChart.

Suggested “dot” (sample or boilerplate) phrases should be provided. Although clinicians often make their own dot phrases, it would be useful to distribute a list of sample phrases which may be used to manage problematic or inappropriate e-mail messages from patients. Clinicians could modify and customize these phrases to suit their personal style and needs.

Standard organizational disclaimers should be provided to set boundaries and expectations for members regarding content, complexity, and best use of e-mail.

Because MyChart automatically adds all e-mail communications to the medical record, legal advice and support should be sought to protect clinicians from malpractice suits about overlooking important information embedded in long, complex e-mail messages.

Clinicians need to be able to have the e-mail access privileges revoked for any member who consistently and grossly misuses e-mail communication. A standing quality review group could be set up to review clinicians' requests to revoke member privileges, to send a letter informing the member about the review, to recommend action steps, and to approve e-mail privilege deactivation. Issues about access privileges to be considered include the following:

- Establishing parameters for reasonable e-mail use
- Supporting clinician judgment if parameters are exceeded
- Acknowledging that variation exists in clinicians' tolerance for excessive or inappropriate e-mail use and their skill and comfort in confronting difficult patients: "Different clinicians need different levels of support."
- Establishing procedures to counsel and advise patients who consistently and seriously misuse e-mail
- Creating opportunities and procedures to rematch a member with a primary care physician who has a similar communication style
- Establishing parameters to determine when e-mail privilege deactivation is reasonable and appropriate
- Establishing procedures for notifying a member that e-mail privileges have been revoked

- Establishing criteria and procedures for "emergency" (ie, temporary) deactivation when a member seriously violates e-mail privileges.

Conclusions

The initial intent for the discussion group was to consider this common concern among clinicians: Providing e-mail access to members will generate a new workload that is an expression of unmet patient demand. In particular, providing e-mail access will attract that small cohort of patients who have a preference for a lot of interaction in excess of objective medical need. However, as the discussion developed, it became clear that this facet of excessive e-mail use is only one concern facing clinicians. The focus of the discussion shifted to how clinicians manage excessive use of e-mail, long and complex messages, nonmedical messages, complex message threads, prescription refill requests, and redundant messages.

The clinician group hypothesized that e-mail will probably not induce new behaviors from members but will provide another channel, and perhaps more freedom, to manifest existing behaviors. For example, the clinicians observed that the patients who overuse e-mail are very likely to be the same small population of patients whose behavior is a challenge in other settings. For these patients, e-mail provides another mode for them to display their anxiety and concerns.

The clinicians who participated in this discussion shared the conviction that clinician

... patients who overuse e-mail are very likely to be the same small population of patients whose behavior is a challenge in other settings.

behavior can influence and manage this kind of patient e-mail behavior. These clinicians strongly embrace accountability for the overall quality of care and the care experience of their panels. With this understanding, the clinicians spoke frankly about their approaches to balancing members' needs and practice sustainability. They discussed the kinds of approaches that can successfully meet patients' objective medical needs and

contribute to resolution of other subjective elements of demand. ❖

Acknowledgments

We are grateful to the clinicians participating in the discussion group.

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A Wish Come True

I have always wished that my computer would be as easy to use as my telephone.
My wish has come true. I no longer know how to use my telephone.

— *Bjarne Stroustrup, b 1950, computer science professor, designer of C++ programming language*