Education & Practice Online First, published on May 28, 2014 as 10.1136/archdischild-2013-305856

The benefits of encouraging patients to email their doctor: a review of individual practice

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Received 18 December 2013
Revised 18 March 2014
Accepted 5 May 2014

To cite: Cohn A. *Arch Dis Child Educ Pract Ed* Published Online First: [*please include* Day Month Year] doi:10.1136/archdischild-2013-305856

Paediatricians have a (hopefully) justified reputation for being accessible to their patients and responsive to their needs. In order to achieve this, various systems have been employed to encourage, or at least permit, patients to communicate with the medical team in between hospital appointments. Patients value being able to contact their doctors,[1–3] yet doctors are often concerned that if they make themselves too available they will be overwhelmed by patient requests (table 1).[4 5]

I am a paediatrician working in a general hospital in Hertfordshire, UK. The majority of my work is with children with continence issues, and in the overlap between health and psychology, for example, children with conversion disorders, school attendance issues and chronic fatigue. I am also the named doctor for safeguarding children. For the last few years, I have used email extensively to allow my patients to communicate with me. This article describes my journey to email and the challenges and benefits encountered on the way.

PROBLEM 1

Outpatient clinics suffer from appointment congestion. There is increasing demand for appointments, without the associated increase in provision. The inevitable consequence of this is that the system has limited flexibility and responsiveness. Follow-up appointments are arranged at a specific time in the future regardless of whether this will coincide with the time when the patient needs or wishes to be seen. Limited clinic time makes it difficult to schedule additional appointments. Unfortunately, there seems little determination to improve the system so that clinic appointments can be arranged by need rather than calendar.

Until this system changes, dealing with problems between appointments remains a challenge. If a treatment plan is not working as expected, if the patient wants some clarification or if there are test results expected, it seems unreasonable to ask them to wait for a distant appointment to get the help required.

Even if another face-to-face appointment were available, it is easy to underestimate the impact on the family of making a trip to the hospital, taking time off school and work when they only have a simple question to ask.

SOLUTION 1

I have always asked patients to contact me if there are any problems. In this context, 'me' meant my secretary who would take a message and then I would call back. Our Children's Community Nurses provided support for the family and acted as a means of communication between the patients and myself—but may have felt that they were shielding me. I relayed test results quickly by letter if they were normal or by phone call, sometimes arranging an urgent appointment, if they were not.

PROBLEM 2

Patients still frequently came to clinic without any improvement because they did not want to 'bother' me with a phone call. For those parents that called, I might have to spend many attempts trying to get hold of them. Parents would often receive calls when they seemed distracted, for example, while in the supermarket or more contentiously while driving, but would rarely ask me to call them at another time. It is unlikely that they would be able to focus fully on the conversation. Despite this, there is no such thing as a short phone conversation, and they were taking up an increasing

Table 1 Reasons why doctor patient email use may be limited[4 7 10 11]

Misplaced fears about patients emailing their doctors	Reality
Number of emails will be overwhelming	Manageable number of emails
▶ Inappropriate use ▶ Lengthy ▶ Excessively demanding ▶ Sensitive content ▶ Inappropriate requests	Patients use email sparingly and appropriately
Excessive time required answering emails	Emails take little time to answer

amount of the working day. In addition, our Community Nursing Team was unable to offer its previous support, which increased the number of requests for my opinion.

As far as results were concerned, I would not always know when a patient had had an investigation. In the absence of communication, patients could be worrying unnecessarily or falsely reassured thinking that I would have contacted them if the test result was abnormal.

SOLUTION 2

I began offering those patients that needed contact between appointments the opportunity to email me. Very quickly it became obvious that I should offer all patients this choice. The easiest way to do this is to send them an email with my contact details at the end of our first appointment so that they would have this in their inbox. I encourage patients to email me if they have any concerns, or a few days after they have had any investigations so that I can look up and send them the results. All the emails received are stored in a secure 'folder' on the trust email site.

RESULTS SO FAR

I recently audited all of the emails that I received over a 2-year period. During this time, I would have seen about 900 new patients. I received 779 emails (see table 2)—an average of 32.5/month. In the last month of the study, 36 emails were received, which suggests that use was essentially constant over time.

Table 2 Summary of the main content of each of the 779 emails received over 2 years

Primary nature of email	No (%) Total 779
Patient management	313 (40.3)
Providing medical update	160 (20.5)
Thanks	119 (15.2)
Administrative—changing appointments, etc.	77 (9.8)
Signposting advice—eg, go to the GP, ask the school nurse, etc.	71 (9.1)
Requesting results of investigations	39 (5.0)

There were 223 separate senders, so approximately 25% of patients used this service. One child sent 44 emails, one mother 25 and 22 parents sent between 7 and 12 emails each, so that the majority of correspondents sent only 1 or 2.

Of the emails received, 468 required a response, averaging little more than one email per working day. The remaining 311 may have received a polite response but required no significant action.

Reviewing the narratives of the emails a number of themes emerge (see box 1). It is clear that the patients value this method of communication with email appearing effective and acceptable. The flexibility of email means that patients can send them at any time, the sending presumably being therapeutic of itself.

The nature of patients' emails suggests that patients use email wisely and sensitively. There was no need to restrict email usage. The majority of emails were

Box 1 Patient emails

Recurring themes in emails from patients

Patients satisfaction with email:

"(I prefer) to write an email asking for advice directly rather than going through so many people"

"Really appreciate being able to email you"

"It is quite amazing and wonderful to be able to have a direct dialogue with you"

"(Can I) cancel the next appointment and discuss via email instead."

Clarification of consultation

"We forgot to mention when we saw you"

"My son took down the wrong number"

Requiring reassurance—especially at night

"I write to you now at 4:30am in a desperate plea for ur help"

"Dear Cohn… I'm currently sitting up with him in bed and feeling rather desperate for him—as well as exhausted!" sent at 04:02 followed immediately by "Apologies, email should read. Dead (sic) Dr Cohn" sent at 04:03. Later at 09:30 "Unfortunately, I was not sleeping when you sent this email…"

"Thank you for your email, it has put my mind at rest",

"Thank you, you have made me feel better about it, see you two months."

Update

"To dr Cohn I had dry Pants All day. From J Xxx"

Gratitude

"Thank you for providing your email address and for seeing D today."

"Thank you for your prompt replies—it's very much appreciated."

related to management issues, such as asking advice about modifying treatment plans, changing drug dosages, managing behaviour or reporting adverse effects of drugs. Emails also provided useful updates, including response to medication, reporting further events such as fits, returning symptom diaries and reporting back after visits to other doctors or health-care professionals.

There were a small number of administrative emails (more realistically classified as offering help to patients who did not know where else to find it) but these are easily handled, and it is hard to imagine anybody's time being so precious that they could not forward one email a week to the appropriate administrative staff. Most email conversations express a degree of gratitude and some even of flattery. Presumably unhappy patients complain by other means. An unintended, yet welcome benefit is that the emails can be used as evidence of good relationships with patients for appraisal and revalidation purposes.

I believe that email is also efficient in relation to time[6]—replying to an email takes only a few minutes at most—saves secretarial time and reduces letters and postage (see box 2).

PROBLEM 3

Although this is undoubtedly an improvement, there are still a number of challenges (see box 3). One of the major ones involves data protection. It is sensible to discuss using emails with the Trust Information Governance team to ensure that no laws—specifically the Data Protection Act 1998—are being breached. Although ideally the emails should be encrypted, this is usually not practical. There are general concerns about who receives the email. NHS correspondence needs to be addressed to specific individuals, so the sending of unsolicited emails may be problematic, as many family members could have access to the same email account. However, this is mitigated to some degree in that the emails I send are always sent as replies to the email account that I have received the correspondence from. Again, there may be some double standard, as there is no guarantee that a letter sent to one member of a household will not be opened by another.

The basic principles of information governance apply to email as well. Confidential information should only be used if it is absolutely necessary, and its use should be minimised as much as possible. This can be difficult when parents include their children's details in the text of their email, which will then be automatically included with the reply. It is realistically not possible to delete this information from every email that I send.

The MPS provides guidelines on the use of emails,[7] the GMC provides advice on confidentiality[8] but does not specifically comment on email use between doctors and patients, neither does the Health and Social Care Information Service.[9]

Box 2 Advantages of allowing patients to email their doctor

Improve patient satisfaction:
- Modify treatment regimens
- Alert/update doctor to changes in condition
- Provide information—eg, forgotten at clinic or "his grandfather mentioned…'
- Address ongoing anxiety uncertainty
- Receive results rapidly
- Reduce clinic appointments
- Email conversation can be 'filed' immediately in computerised records

Doctor satisfaction:
- Happy patients
- Effective use of medical time
- Impressive record of invariably positive patient feedback—useful in appraisal and revalidation.

Box 3 Unresolved issues with email[8 9 13]

Data protection/patient confidentiality.[7–9]
Unable to verify that intended message has been understood.
Ensuring patients do not use email when requiring emergency care or advice.
Recording clinical activity.
Dealing with any abuse or overuse.

SOLUTION 3

The MPS guidelines may be better suited to primary care. They recommend using email for mainly administrative matters and not for management of symptoms. Dealing with new symptoms by email is clearly precarious, but tailoring already established treatment seems safe. My personal practice is to receive emails on my own account and answer emails within a day of receiving them. If I am on leave, an out-of-office reply advises when they will be answered and directs patients who need emergency help to the appropriate source. The MPS recommend sending an acknowledgement that an email has been received with a time frame for when it will be answered. This is really only practical if using a dedicated patient email site. A disclaimer on each email indicating that it is not a secure form of communication is a further sensible safeguard alternatively, patients can be asked to sign, or better still, email their understanding that we are using non-

Table 3 Advantages and disadvantages of different methods of communication available to patients

Method of communication between clinic appointments	Patient advantages	Patient disadvantages	Hospital doctor advantages	Hospital doctor disadvantages
None (go to your GP)	None	Wait between appointments to solve issues	Normal flow of life uninterrupted by unexpected queries	Patients less satisfied and can now express this in surveys
Use of clinical nurse specialist	Speak to highly qualified individual with high accessibility	May be constrained by pathways, treatment may need more radical overhaul	As above and may also bask in reflected glow from effective nursing team	Patients may be satisfied with the nurse but not with the consultant
Patient can ask doctor to phone	Rapid access to consultant—allows optimising care. Presuming consultant is available	Many patients find this too intimidating, especially if spoken English is poor May be called back at inconvenient time	Problems can be solved before clinic—clinics run more effectively Increased patient satisfaction	Phone calls often quite lengthy Can be hard to update patient's records with details of conversation
Email	Rapid access to consultant Less threatening medium Replies can be read at leisure	Can be difficult to explain complex situations An email conversation may require numerous emails Need email access Patients with poor English or literacy issues may feel challenged	Allows rapid problem solving Increased patient satisfaction Emails can be answered at any time Reduced time spent while effective communication increases	Sometimes phone calls are required
Patient can use doctor's mobile phone	Supreme accessibility	Intimidating—do not want to worry a busy doctor	Extremely high level of patient satisfaction	Unexpected phone calls interrupting face-to-face clinical encounters
Flexible appointment system	Can be seen when necessary	Need to go to the hospital—take time off work (this could be somewhat overcome by phone/video consultations)	Only see those patients that need to be seen	Planning can be difficult—as appointments are for a purpose—appointment times may need to be longer

secure technology before conducting any correspondence. In my experience, no parent has been concerned about this.

A system should be in place for storing the correspondence in the patient records, again solved easily by effective IT, but probably a challenge in most hospitals. Printing and filing hard copies is likely to be the norm for the foreseeable future.[10] Other challenges include the difficulty of keeping general practitioners informed; allowing them to be included by 'cc'ing them in the emails should be an easy enough obstacle to overcome if there is sufficient interest. In the interim, general practitioners are no more 'left out of the loop', then they are after a telephone contact between hospital and patient.

It is somewhat ironic that telephone and conventional letters are used freely while texting and emailing is viewed with fear and suspicion. The greatest lapse of confidentiality that I am aware of occurred when one patient had to move house after a letter discussing their HIV treatment was delivered to, and read by the residents of, the wrong address.

There is always a chance that emails may be misunderstood, but I am not sure that this is more likely than in a verbal consultation. In many ways, the fact that the patient has a written record means that they can check to see what has been communicated. In some cases, email will not be sufficient and verbal communication either by phone or in person will be necessary.

For those who have literacy problems or do not speak or write English, email can present difficulties. The offer of telephone contact is always present as is the explicit understanding that perfect English is not required. There may be a family member or friend who can communicate via email, with the added advantage that an email can be composed and read at leisure, while a conversation may be pressurised. I suspect that I receive fewer emails from families who struggle with English, but I cannot remember the last phone call I received from such a family either. While email patently does not eliminate this disadvantage, it might reduce it slightly.

Computer access is now so ubiquitous that lack of access is rare. Families who offer a 'reason' as to why they do not have email access are usually only those suffering extreme poverty, and this admission by itself can trigger sensitive questioning about financial difficulties, which should be followed by useful 'signposting.'

PROBLEM 4

Currently my email correspondence is not recorded as clinical activity. Clearly, it does not take up a vast amount of time, but in a culture that measures everything and then charges for it, some recording system may need to be implemented so that this work can be 'recognised'.[11 12] I answer my emails during the occasional quiet moments during the day. If I was more organised I might try to have a fixed time for doing this, but in all honesty it takes so little of my time that this seems unnecessary.

It is possible to be overwhelmed; this usually occurs when one family send multiple emails over a short period of time. Remarkably, on each occasion the correspondence settles after a few weeks. Similarly, there is frustration when I cannot provide a solution to the patient's problem or respond to their requests. I have no answer to this; this is no different when placed in a similar situation in a formal clinic setting, but accessibility makes it harder to hide clinical impotence.

Another occasional problem is the unsolicited email. Most of these will be from families who get my address via the Trust website or the internet. My standard response to these is that I cannot offer medical advice without a consultation, but I can advise about getting a referral. Compared with the quantity and content of most unsolicited emails, receiving an occasional one from a potential patient is of little consequence.

THE FUTURE

There seems to be some reluctance among doctors to allow patients to email them freely, and much of this is to do with the beliefs that this would be time consuming and doctors would receive emails that were overwhelming in number and content. I hope that my personal experience can add further to the evidence that these concerns are unfounded.[13 14] Allowing patients to email their doctor is popular with patients, should be workable for doctors and results in better outcomes and improved patient and doctor satisfaction[15 16](see table 3).

DO TRY THIS AT HOME

Using email with patients works, but starting out may be difficult. Ideally it would be with permission of the hospital Information Governance Department and clinical leads. Recording the clinical activity should be no different to recording any other 'non-clinic patient contact episode'.

As with my experience, it probably helps to start small. I am sure that most paediatricians can immediately think of a few patients where this form of contact would be helpful while at the same time manageable. After a while, when the emails do not pour in may come the realisation that deciding who gets your email address and who does not seems arbitrary and unfair so that it might be expanded to all patients with a particular problem or those that you feel may need supporting with their management plan. Eventually, I suspect that you will hand out your email address willingly to all. Mine is anthony.cohn@nhs.net

Competing interests None.

Provenance and peer review Not commissioned; externally peer reviewed.

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Arch Dis Child Educ Pract Ed published online May 28, 2014
doi: 10.1136/archdischild-2013-305856