

### Clinicians and E-mail: Risks and Benefits

—by Reid Coleman, M.D., Medical Informatics Officer, Lifespan

The question “Should I use e-mail as part of my practice?” is becoming less frequent. The more commonly asked question today is “How should I use e-mail to communicate with my patients?” There is no single answer to this question, and changes in both technology and patterns of practice will lead to different answers in the near future. Several societies have issued recommendations which can be used as guides, but ultimately each physician or practice will have to make a decision based on an understanding of the nature of e-mail as a communication technique and the type of information to be sent and received using email. Once these questions have been answered, applying appropriate technology is straightforward.

E-mail is described as asynchronous communication. This simply means that the two parties communicating don’t need to be doing it at the same time. Regular mail (which is often now called snail mail), faxes, and other printed or written forms of communication are also asynchronous. Communication in which both parties are participating at the same time is called synchronous communication. Face to face conversation and telephone conversations are typical synchronous communications.

The advantage of asynchronous communication is also its weakness. A message

can be sent at any time that is convenient for the sender, without concern about the receiver’s availability. And the receiver can respond according to his or her schedule. This is ideal for communication that is simple and not urgent. Simple means that both parties are using a shared vocabulary, agreed upon concepts, and that responses do not require frequent clarification and/or many additional questions. Urgency is often in the eye of the beholder, but can be defined by the nature of the situation. The weakness of asynchronous communication is that it is not appropriate for complex or urgent communication.

One other note about the distinction between synchronous and asynchronous communication: the distinction is blurring. People who use e-mail heavily at their jobs often experience nearly synchronous communication. Hand held devices that send and receive e-mail allow swift back and forth communication regardless of where the parties are. Text messaging and “Instant Messengers” contribute to this sense of e-mail being synchronous. Patients have to be aware that this is not a reasonable expectation of their physicians. This “blurring” is made more difficult by the fact that voice mail and automated switchboards are making telephone conversation seem asynchronous.

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**Lifespan  
Risk Management**

www.lifespan.org/risk  
167 Point Street  
Suite 170  
Providence, RI 02903  
T: (401) 444-8273  
F: (401) 444-8963

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An understanding of the nature of e-mail should lead to decisions about what type of information should be communicated. Requests for routine appointments are simple and not urgent. A request for advice about crampy pain associated with heavy bleeding may be urgent. Some place in between is the right solution for most physicians. Remember that simple communication requires a shared vocabulary and mutually understood concepts. Many physicians start using e-mail for patients for appointments, referrals, and prescription refills. This type of communication can be very useful both for the patient, who can send an email after work, during lunch etc., and for the office staff who can respond when there are not patients in the office needing their attention.

The next step up in complexity is "simple" questions about test results or medications, or patient requests for information about a disease. Patients will often send links to web pages with a request for comments. Physicians (or staff) can send a brief "everything is normal" or "no change" or "your cholesterol is improved – keep taking the medication" quickly and easily and may reduce the time previously spent on phone calls. And a copy of the e-mail can be placed in the chart to document the communication. Just be sure that you are using a shared vocabulary. And remember that the documentation can be a two-edged sword. A poorly thought out note may be harder to defend than a casual comment made over the phone.

If e-mail is used for more complex issues, there is another consideration. For physicians who do not perform procedures, giving advice is a major source of reimbursement. Giving advice about complex issues via e-mail saves no time, reduces income, and could increase risk. There are some insurers (none in Rhode Island) that are experimenting with paying for non face-to-face encounters. If this becomes an option in Rhode Island, remember that synchronous communication is better suited to complex communication than e-mail.

The major technology question raised by physician-patient e-mail is privacy and security. Regular e-mail provides neither. Even the simplest communication has significant HIPAA implications. An appointment with - or a referral to - an oncologist reveals personal health information, as does a prescription for an anti-psychotic. All communication with patients should be considered PHI (personal health information.) Lifespan provides a "Private Messaging" system for any physician who uses Lifespan e-mail. An email sent to a patient with the expression "PHI" anywhere in the subject line is redirected to the message vault, and patients receive an email directing them to the "Private Messaging" vault where they can create a password protected account and "log in" to see the message and respond. After this account is created, all e-mail can be sent through this vault privately and securely. This option should also be used for any e-mail containing PHI that is sent outside the Lifespan e-mail system.

If a physician or practice chooses to use e-mail for patient communication, clear policies and procedures are a must. They should address the level of complexity appropriate for e-mail and what an acceptable response time should be. These policies need to be understandable, communicated to patients clearly, and this communication should be documented. "Managing expectations" is an overused phrase but patient expectations about e-mail have to be managed carefully. As important, once these policies are established and communicated the physician and/or practice must adhere to them. While risk and liability are issues that can be debated endlessly, there is no question that clear and logical policies and procedures that are communicated, documented, and adhered to, lessen risk and liability significantly.

E-mail is like any other technology - it should be used if it is appropriate, not because it is available.

## Q & A... from the Office Practice Setting

**Q** How do I reduce the risks associated with an increased patient load?

**A** Clinicians seeing an increasing volume of patients might consider:

- Reducing paperwork with electronic clinical information systems. Available systems automate processing of health insurance claims, produce medical outcomes information needed by managed care organizations, generate patient education materials, and generate reminders for routine and follow-up care for your patients.
- Meeting regularly with office personnel to assess existing office systems and develop protocols for streamlining routine activities such as follow-up on missed appointments and referrals, telephone call documentation, and scheduling of diagnostic tests.
- Employing continuous quality improvement and patient safety concepts that involve and educate office staff in changing requirements and procedures.

**Q** What should I do when patients do not keep appointments or follow-up?

**A** Make a reasonable effort to contact patients who miss scheduled appointments or tests. A "reasonable effort" depends on the clinical importance of the test or visit, the severity of the patient's medical condition, and the risk associated with the missed appointment. For patients at minimal risk, a single phone call or postcard following the missed appointment may suffice. For patients who need ongoing monitoring or treatment, a more concerted effort (e.g., certified mail) should be made to inform them about the specific risks of missing appointments. Document your attempts to obtain follow-up, as well as missed appointments, failure to follow up, failure

to follow care instructions, and any other examples of patient non-compliance, along with the patient's stated reason for missing the appointment.

**Q** What are the patient safety issues surrounding medical advice via telephone?

**A** One option is to decide not to provide advice over the phone, especially to unknown or unfamiliar patients. However, if phone advice is provided to known patients, the key areas of concern are the degree of medical advice offered and documentation of the exchange.

Mechanisms should be in place to respond to and record what was discussed during those calls from patients seeking treatment information. If not, the potential for patient dissatisfaction, missed diagnoses, delay in treatment, and possible serious medical consequences exists.

Staff should be supported with protocols including the questions they should ask and when a patient should be referred to a physician. The threshold for obtaining a physician's response should be relatively low. Staff training, telephone procedures, and protocols should be periodically reviewed to ensure that inquiries are being appropriately managed.

Documentation of all phone calls in which medical information is discussed is extremely important. The date and time of the call, patient's complaints, and advice given should all be recorded. The advice given should include the point at which the patient should seek medical attention. The few minutes taken to record this information will be valuable for ongoing patient care. In the event a patient challenges the quality of medical care they received by phone, or claims he or she made multiple calls and received no or inadequate advice, such documentation will prove worthwhile.

# Q & A... from the Office Practice Setting

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**Q** What are the patient safety issues surrounding prescribing over the phone?

**A** The decision about whether to prescribe over the phone depends upon the physician's relationship with the patient, the type of medication, and the circumstances of the call.

Prescribing new medications to known patients over the phone without a recent clinical evaluation is not recommended, especially when a drug's appropriateness cannot be readily assessed. If such prescriptions are made by phone, the physician should document that the patient's clinical status and other medications have been assessed, that possible side effects were discussed, and that the patient was told under what circumstances to call again.

For prescription renewals by phone, an assessment of clinical status to check for side effects and the appropriateness of continuing the medication is important and should be documented in the patient's medical record.

## Out-of-state

The circumstances of an out-of-state call is an important consideration. For the patient "caught" without his or her current medication, prescribing an amount to cover the limited time period may be appropriate. When the symptoms' description suggests the need for a new medication, referral to a local emergency room or clinic for assessment is advised.

Special circumstances may develop where patients are being followed out-of-state because of the nature of their illnesses and the expertise of the physician. However, the involvement of a local physician who can monitor the patient and prescribe the needed medications as well, would still be important in these cases.

## New or Lapsed Patients

Extreme caution should be exercised in prescribing medications over the phone to new patients or those who have not been clinically evaluated for some time. When suspicions of drug abuse are aroused, careful questioning, prescribing only alternative drugs, suggesting the patient be seen in a clinic or emergency room, and/or prescribing the smallest possible quantity are ways to deter inappropriate use.

**Q** What should I do if a patient requests that information be withheld from the medical record?

**A** Information necessary for providing proper care of the patient should always be documented in the record. Care may be compromised by incomplete medical information, such as known conditions or test results, to the extent that diagnoses may be missed and useful treatments delayed. In addition, hiding information from health or life insurance investigators could be deemed as abetting an act of fraud. On the other hand, omitting data that has no bearing on the patient's current care or condition, such as social history and history of distant past substance abuse, may be appropriate.

**Q** If the patient can give a current history, should I review prior medical records.

**A** Yes.

Reviewing prior medical records as part of a current office visit is good patient care. The patient should be asked to describe not only the current complaint (i.e., "what brings you to the office today?" or "this is your follow-up visit after..") but any concerns that may have led up to the current visit. With one or two skillful questions, you can

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ascertain what is troubling the patient. With an opportunity to talk (uninterrupted) for several minutes, the patient can relate a significant amount of useful information, and feel that you are listening.

However, relying only on the patient's memory is risky. For example, a patient may have presented over a period of time, with a series of symptoms that - taken one at a time - have been managed appropriately, but all together may indicate

a much more severe condition. Review of the past records is necessary to put those pieces together. In addition, a review of the record can refresh your memory about pending test results, the need for routine screening, results of referrals to specialists, or other matters that should be addressed.

*Adapted with permission from RMF website  
[www.rmhf.harvard.edu/faqs/index.aspx](http://www.rmhf.harvard.edu/faqs/index.aspx). Accessed 12/14/06.*

## Liability Issues With Equipment and How We Can Avoid Them

—by Joan Flynn, Director of Risk Management, Lifespan

*A patient recovering from a procedure pulls on the siderail of the stretcher she is lying on. The siderail releases and the patient falls from the stretcher, sustaining injuries serious enough to cause her to miss work for six weeks.*

*A patient is positioned on an operating room table with his head and chest on a homemade table extender. The table begins to tilt and the patient starts to slide off as the surgeon leans over to insert a line.*

*An infant suffers a severe burn when a chemical hot pack not intended for use on infants is placed directly against her skin.*

*Two patients suffer chemical burns in their throat following use of tubing not rinsed according to manufacturer instructions.*

Although equipment related issues represent a small proportion of our liability claims, they are claims that could be avoided. Equipment claims fall into three general areas:

- Equipment that is broken or not maintained,
- Equipment that is modified or not used as intended, and
- Equipment not used according to instructions.

### BROKEN/POORLY MAINTAINED EQUIPMENT

Equipment can fail unexpectedly, but often we find that staff knew that a piece of equipment was not working correctly, such as the stretcher siderail, but they continue to use it. Reasons may include lack of replacement equipment, or lack of knowledge on the correct process for obtaining repairs. Each department or physician's office should ensure that they have a process for maintaining and repairing equipment and that responsibility for these tasks is clear. Equally important is regularly reviewing the amount of equipment and/or knowing how to

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obtain a temporary replacement for broken equipment. Departments and offices should have a plan for preventive maintenance per manufacturer's instructions, and a schedule for replacing equipment that is at or beyond its expected "shelf life." In addition, all repairs should be done according to the manufacturer's specification.

## MODIFYING EQUIPMENT OR EQUIPMENT USE

Rhode Island Hospital developed a policy on the modification of equipment after a practitioner suffered a serious injury caused by modified equipment. The policy states that personnel should use commercially available equipment whenever possible and that equipment may only be made or modified by the hospital with approval of the Safety Manager. While staff may be tempted to modify equipment that does not quite meet their needs, the dangers of this practice must be considered. The modification may change the structural integrity of the equipment or may affect the performance of the equipment in ways that were not anticipated. Staff who have not been educated about the modification may not know how to use the equipment. And if an injury does occur, the original manufacturer will undoubtedly deem that any warranty or guarantees are no longer in effect due to the modification.

## FAILURE TO FOLLOW MANUFACTURER INSTRUCTIONS

Departments and offices must have a plan for the introduction of new equipment to ensure that everyone who uses the equipment is thoroughly trained. Again, responsibility and expectations for training must be clear. The responsible person should read manufacturer materials and instructions and be especially attentive to any differences between new equipment and what staff used previously. These differences may include cleaning or maintenance of equipment, as well as general use.

## REPORT PROBLEMS

A final way that staff can prevent injuries caused by equipment is to report promptly any problems that they encounter. These problems may include unclear labeling or instructions, unintended patient reactions to a device or premature failure of equipment. Reporting these issues, even if no patient is involved or injured, helps with both prevention and trending of problems. The Safe Medical Device Act requires reporting of equipment and device problems that lead to a serious injury or require a procedure, such as removal of the device, to prevent injury. However, reporting these issues before a patient is harmed is obviously preferable.

Too often when an injury occurs related to equipment, we hear staff say things like, "Oh, that's been broken for a long time" or "No one ever showed me how to use that" or "I don't have time to read instructions." Needless to say, these comments make a claim indefensible. More importantly, we owe our patients and colleagues a safe environment and each employee and practitioner bears some responsibility for ensuring safety.

# Schwartz Center Rounds

Schwartz Center Rounds is a multidisciplinary forum where caregivers discuss difficult emotional and social issues that arise in caring for patients. Discussions are relevant and open to all caregivers and departments. Dates, time, and place for 2007 are listed below.

11:45 AM -1:00 PM

**Nursing Arts 5  
Rhode Island Hospital**

March 13

May 15

July 17

September 18

November 20

For more information, see:

**<http://www.theschwartzcenter.org/programs/rounds> or call Sharon Clair at 444-5392.**

Rhode Island Hospital designates this educational activity for a maximum of 1 *AMA PRA category I credit*.™

Each physician should claim only those credits he/she actually spent in the educational activity.

This CME activity is also designated for a maximum of 1 category I credit in Risk Management.

## Risk Management Grant Award Program

Each year Risk Management Grants are awarded for funding of specific educational or research/action projects. The Grant must be related to professional liability (malpractice), general liability, or patient safety, and there must be an identified loss prevention benefit resulting from the proposal.

The process begins with completion of an on-line preliminary application. These applications will be reviewed and an invitation to submit a full proposal will be sent to selected applicants. Please look for an announcement concerning the preliminary grant applications on the Lifespan email and/or intranet, anticipated for March.

For further information about the grant program, contact Peggy Martin at Lifespan Risk Services, (401) 444-6491 or [pmartin2@lifespan.org](mailto:pmartin2@lifespan.org).

### Correction...

Correction to the Fall 2006 Edition (Vol. 7, No. 3) in Lessons Learned: In "The Patient" section, "Librium" is the medication used for treating the patient's alcohol withdrawal, not "Lithium".

# Risk Management Activities and Services

## The staff:

- Is available to provide risk management educational programs tailored to the schedule and needs of the audience,
- Conducts Risk Management Office Surveys for our affiliated physician groups, for hospital departments, procedure areas, and nursing units,
- Administers the Risk Management Grant Program, and
- Produces this newsletter. Back issues are available in a printable format from our website: [www.lifespan.org/risk](http://www.lifespan.org/risk)

For more information, questions, consultations, or suggestions, contact **Peggy Martin** at Lifespan Risk Services, by email at [pmartin2@lifespan.org](mailto:pmartin2@lifespan.org) or at **444-6491**.

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*Insights* is published by Lifespan's Risk Management Department. Submissions and ideas are welcome and may be submitted to **Peggy Martin** via e-mail: [pmartin2@lifespan.org](mailto:pmartin2@lifespan.org) or fax: **(401) 444-8963**.

*editorial committee chairperson:* Peggy Martin

*committee members:* Paul Adler, Joan Flynn, Rick Almeida, Joseph Melino and Valerie Till

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Please send address changes to Valerie Till, (401) 444-4595 or [vtill@lifespan.org](mailto:vtill@lifespan.org)

Nonprofit  
U.S. POSTAGE  
PAID  
Providence, RI  
PERMIT NO. 538

Lifespan  
Risk Management  
167 Point Street  
Suite 170  
Providence, RI 02903

