

E-mails in a Psychiatric Practice: Why Patients Send Them and How Psychiatrists Respond

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ABSTRACT

Context: Little is known about what prompts patients to use e-mail with their physicians and how physicians respond to these e-mails.

Objective: To identify the main reasons why patients e-mail and to learn how psychiatrists manage these e-mails as part of these patients' overall care.

Design: One hundred patient-initiated e-mails to each of two psychiatrists in a group practice were studied retrospectively for primary reason for the e-mail and for psychiatrists' handling of each e-mail. Other data were collected to assess how representative the e-mailing patients were of the psychiatrists' patient panels.

Results: Age, sex, and diagnoses of the e-mailers were similar to our overall panels. The most common reasons for e-mailing were refill requests (19.5%), questions about prescribed medication (16.5%), and worsening of symptoms (11.5%). The modal e-mail was a patient with attention-deficit/hyperactivity disorder requesting a refill. The psychiatrists' most common responses were authorizing a refill (25%), reassurance (22%), and making or moving up a scheduled appointment (16%). For all patients who reported a worsening of symptoms, responses, communicated by e-mail or telephone, included a combination of an earlier appointment and/or change in medication or dose and/or referral for psychotherapy. Both psychiatrists found e-mail to be an efficient enhancement of their practice, and it was inferred that this was also a satisfying mechanism for patients.

Conclusion: Physician-patient communication via e-mail is timesaving for both, and the benefits to patient care should reassure physicians who are wary of using e-mail in their practice. Potential risks to patients without face-to-face or telephone contact appear to be minimal.

INTRODUCTION

Although the medical field has been slow to adopt new communication technologies, e-mail is playing an increasing role in health care delivery.¹ More and more patients have requested to have the option to communicate with their physicians and other clinicians via e-mail.^{2,3} This form of communication not only has been a more efficient process for some physicians and patients, but also has reduced the need for some face-to-face appointments, thereby improving access for those who do require such visits. One recent study found, somewhat counterintuitively, that increased use of e-mail was associated with increased utilization of other health services,

including telephone calls, office visits, emergency room visits, and hospitalizations.⁴ This suggests the need for greater understanding of how e-mail is used and what it means for patients. We are aware of no published research that attempts to identify the concerns that lead patients to e-mail their physicians or how physicians manage those e-mails.

There are other aspects of the physician-patient e-mail encounter that call for exploration. The nature of the practice setting (solo or group practice), the physician's own ease with using e-mail, and reimbursement issues likely play a role in the use of e-mail. Although some practitioners charge for e-mail, it is not the norm; as a result, there are concerns

about providing a clinical service for free. Development of professional standards for e-mail use is in its infancy, and legal and ethical factors are similarly worrisome to some.⁵⁻⁹

Whether any of these issues is more or less relevant to any particular medical specialties is not known. In the totality of a physician's work, e-mail takes time beyond the other tasks that are already part of that work. In our own practice setting, a large Psychiatric Department with four offices covering Orange County, CA, as part of the extensive services of Kaiser Permanente Southern California (KPSC), the role of e-mail has taken on major importance to the physicians. Integrating the use of e-mail with increased demands for productivity and service has been a challenge for both administrative and practicing physicians. With relatively little information as to the content of the e-mails, how they are handled, and the amount of physician (or other provider) time this involves, these issues cannot be addressed in a systematic way. We became interested in learning why our own patients send us e-mails. We also wanted to get some sense of how time-consuming e-mail was for us and what impact e-mail had, if any, on patients' need for appointments. Additionally, we wondered if there were any demographic or diagnostic factors associated with patients' use of e-mail.

METHODS

The methods for this study were approved by the institutional review board of KPSC. Because a purpose of the study was to learn the main reasons for patients' e-mails and this information was gathered by the patients' own

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physicians, neither the institutional review board nor we found there to be a need for informed consent or a concern for a breach of confidential information.

We first created a typology to capture the reasons why patients initiated e-mail contact with us, and between March and June of 2014, we collected information on 100 consecutive e-mails (200 total) sent to each of us. Because we also wanted to capture data on how we responded to them, we only recorded e-mails sent to us on days we were working; given that covering physicians might handle these differently, we wanted to avoid that as a confounding variable. All e-mails are sent through the Kaiser Permanente network (www.kp.org), in which patients are automatically informed that they may expect a response within 2 business days. Our own practice styles almost always lead to a response the same day, either from 1 of us or from our nurses. As has been noted in other settings,⁸ physicians handle e-mails in different ways, and in our practices, one of us prefers to handle e-mails directly, whereas the other prefers to have them initially addressed by nurses. That is to say, the first author directly handled the 100 e-mails that his patients sent to him; the second author had nurses initially field the 100 e-mails sent to him by his patients. There being no prior studies on e-mails from psychiatric patients, we captured the following data on each patient who e-mailed us: 1) age, 2) sex, 3) primary diagnosis, 4) most recent kept appointment, 5) most recent contact (eg, phone call or e-mail), and 6) presence or absence of an upcoming appointment. For each electronic correspondence, we identified a primary reason for the e-mail; for some, there was a second reason as well, not necessarily related to the primary reason. Then, we recorded our responses to the e-mails, using another typology we created for this purpose. This set of categories included, but was not limited to, any changes in the treatment plan and whether a new appointment was made or an existing one moved to earlier.

We were curious as to how representative our e-mailing patients were of each of our panels, (ie, whether there might

be sex, age, or diagnostic variables related to which of our patients were more likely to use e-mail), so we obtained a profile of our individual panels during the period of data collection. Another question related to how subjectively burdensome or time-consuming it was for us to address patient e-mails. We defined the end of an e-mail exchange (or series of exchanges) as the point at which the central concern of the e-mail was definitively addressed. Because patients may use e-mail as a kind of “continuing conversation,” it was necessary to identify when a given issue was handled.

Age range, years	No. of e-mailers ^a
18-30	30
31-40	52
41-50	47
51-60	46
61-70	19
> 70	6

^a Total < 200 because some patients sent > 1 e-mail.

RESULTS

Given the similarity of our clinical roles as general adult psychiatrists, the data presented combine both sets of 100 e-mails. Patients' ages ranged from 18 to older than 70 years (Table 1). Of the 180 patients who e-mailed us during the collection period, 66% were women and 34% were men. Most patients sent 1 e-mail during the period, but 20 sent more than 1, with a single patient sending 8 e-mails. This most frequent e-mailer is one of our more complicated patients, with substantial psychiatric and medical factors, and her psychiatrist did not find these e-mails inappropriate or burdensome, although they clearly

also reflected some of those factors. All age ranges (older than 18 years) were well represented, including 19 between the ages of 61 and 70 years, and 6 from those older than 70 years, suggesting that e-mail use is not unusual among older adult patients (Table 1). The proportion of patients older than 60 years who sent e-mails was only slightly less than the proportion of those in that age group in our patient panels.

The primary diagnoses of those who e-mailed were generally representative of the primary diagnoses in our patient panels, as shown in Table 2. In our panels, the most common diagnoses are depressive disorders, attention-deficit/hyperactivity-disorder (ADHD), anxiety disorders, and bipolar disorder. The most frequent diagnoses of those who e-mailed were depressive disorders, bipolar disorder, ADHD, and anxiety disorders. Psychotic disorders, dementia, obsessive-compulsive disorder, and other diagnoses were less common in both our panels and among our received e-mails. Not only did the diagnoses of those who e-mailed generally mirror those of our panels but also the age and sex mix of the e-mailers closely reflected those demographics in our panels. We concluded that the e-mailers reflect our panels quite well in those regards.

Almost all of those who e-mailed would be considered “active” patients in our panels. Eight (4%) of the patients who e-mailed had not been seen in the past year, even though they were being prescribed some medication by us. Although 11% had not been seen in the past 6 months, only 1.5% had no contact of any kind with us during that time. Of those who had not been seen in the past 6 months, 45% did have upcoming appointments.

Diagnosis	Percentage of patient panel	Percentage of e-mailers
Depressive disorder	33.1	30.0
Bipolar disorder	14.4	23.0
ADHD	13.3	20.5
Anxiety disorder	15.2	18.5
Other disorder	24.0	8.0
Total	100	100

ADHD = attention deficit hyperactivity disorder.

Primary reason for e-mail	No. of e-mails
Prescription refill request	39
Questions about prescribed medication	33
Symptoms worse	23
Symptoms better	16
No change in symptoms	14
Request for appointment	10
Problem getting refill from pharmacy	10
Side effects	10
General information	6
Problem related to medical (nonpsychiatric) care	5
Advice	4
Disability or sick leave	4
Forms	4
Laboratory results	4
Cancel or change existing appointment	3
Concern about another family member	3
From family member about patient	3
Request to change physician	2
Request for psychotherapy	2
Insurance issue	1
Other	4
Total	200

Table 3 illustrates the reasons for patients' e-mails. Most patients e-mailed for a single reason, but 28% had a second reason. The most common reasons for e-mailing were to request a refill, to ask a question about medication, or to report a worsening of symptoms or an improvement in symptoms. Among the more frequent of the remaining e-mails included pharmacy or refill problems, and requests for an appointment. As seen in Table 3, many other concerns prompted e-mails, but these were less common. The most common combination of diagnosis and reason for an e-mail was a patient with ADHD requesting a refill.

With regard to our handling of these e-mails, it should again be noted that one of us responds personally to all e-mails, and the other's practice is to have nursing staff initially review the e-mail and

the chart, and then either contact the patient to get additional information or pass the e-mail along to the physician for disposition. This reflects other studies, which document a natural variation in practice styles for handling e-mails and other patient communications.

Table 4 illustrates our responses to patient e-mails. Although not categorized by the reason for e-mails because of the relatively small numbers, it can be seen that responses addressed those reasons. The most common response was to provide a refill (25% of responses), followed by reassurance (22%), making an appointment (18.5%), changing the dose of a medication (11.5%), and changing medications (8%). In some circumstances, more than 1 action was taken.

Of greatest concern was the 11.5% of patients who e-mailed because of worsening of symptoms; we noted the actions taken for them as a subset of the whole. Such actions were either e-mails or telephone calls by the psychiatrist or telephone calls from a nurse. For some, there was more than 1 action taken. Of those 23 patients, some of whom had no upcoming appointment, 19 were given an appointment or had an existing one moved up; 10 of those 23 patients also were recommended to make dose changes in current medication. Four patients were referred for some form of psychotherapy, and 2 had their medication changed. In no case did we find that an e-mail signaled a psychiatric emergency situation requiring hospitalization or a same-day, in-person appointment.

DISCUSSION

We think that our study should provide some reassurance to psychiatrists (and perhaps other physicians) worried about how e-mail will affect their daily practice. Although we had some concerns about using e-mail with patients, our conclusions from the data as well as our subjective experience support the notion that e-mail can please patients and make the physician's workday more efficient and satisfying. We believed that, at the outset of the study, we were more comfortable with e-mail than some of our colleagues were, but we found that patients' use of e-mail

was, without exception, reasonable, judicious, and appropriate. Patients did not contact us expecting an ongoing exchange or that some informal therapy would be conducted electronically. They were respectful of our time, as evidenced by their short and to-the-point messages; we did not find that an initial reason for e-mail became a jumping-off point for a longer exchange. Most expressed some appreciation for our handling an item in this way.

As another form of work in the physician's workday, we found it advantageous to handle incoming e-mails as quickly as possible; as others have reported, some physicians have a sense of satisfaction in keeping the real and electronic desks as clean as possible. Also, e-mail exchanges seemed to take up less of our time, regardless of whether we handled them ourselves or had our nursing staff respond initially. Most commonly, a single response was sufficient.

In our system, there is time built into the physician's schedule for "patient management," during which time the physician addresses e-mail, phone calls, paperwork, consultation with colleagues, and non-face-to-face patient care. As a practical matter, many physicians use that time to see patients who need to be seen in person, so the pressures to manage these other aspects of patient care in a timely way are heightened. There is no added compensation for any of these other forms of care,

Response to e-mail	No. of responses
Prescription refilled	50
Reassurance	44
Appointment made	41
Change in medication dose	23
Change in medication	16
No action	8
Change to existing appointment	8
Referral for psychotherapy	5
Referral for other services	3
Forms completed	3
Existing appointment canceled	2
Total	203 ^a

^a Total is more than 200 because some e-mails received more than 1 action.

... the modal e-mailer was a patient with ADHD in need of a refill; such patients tend to be less complicated, and when their condition is stable, office visits can seem superfluous to both physician and patient.

and both time and the lack of extra compensation have been among the concerns physicians have had about e-mail. Given the organizational emphasis on direct service, some physicians may discourage the use of e-mail despite its obvious other advantages; that said, such discouraging would likely just add to the existing pressures for timely appointments.

In this study, we surveyed how we each, as individuals, manage e-mails in our practices, and as noted, we thought we handled them in an appropriate manner. We acknowledge there is no external check on this, and there is some risk that e-mail exchanges may result in suboptimal care, although we do not think this occurred. Certainly, by the very nature of e-mail, one cannot hear patients' voices or observe them directly. An e-mail message conveys in words only the words a patient chooses to write, and there is a greater risk of missing important clinical material that would more likely be detected in a phone call or an in-person visit. Depending on how well a physician knows a patient, and the nature of the e-mail, clinical judgment based on that e-mail needs to be tempered. This is, of course, more of a concern when a patient reports some worsening than if, say, there is only a request for a refill. It may also be true that some patients prefer the relatively impersonal nature of an e-mail to a phone call or an appointment; one can only speculate as to the clinical relevance of this. Even so, an e-mail from a patient who is struggling is much preferable to no contact at all. Given that most of our practice is psychopharmacologic management, such issues may be of lesser import than for a different kind of psychiatric practice.

Some patients admittedly e-mail as a means of avoiding the copay required for an appointment, and we found this a very reasonable use of e-mail in patients who were clinically stable. As noted earlier, the modal e-mailer was a patient with ADHD in need of

a refill; such patients tend to be less complicated, and when their condition is stable, office visits can seem superfluous to both physician and patient. It is interesting to consider whether there is a correlation between the frequency of recent appointments and the patients' use of e-mail; we did not systematically look into this, but as noted, most had been seen relatively recently.

We note that there are some advantages of e-mail over a phone call. Because e-mail is a written record of all such communication, whereas documentation of a phone call is not a transcript of that call, there is less chance of misunderstanding. E-mail allows time for both parties to think about what they wish to write and may facilitate more precision in the exchange. We have found e-mail to be surprisingly personal and have been able to write things that might be more difficult for a patient to otherwise hear. Another benefit of e-mail is that, as a direct line between physician and patient, it requires no clerical staff time in answering a phone call and transmitting the message. The patient can e-mail at his/her convenience and never gets put on hold, and telephone tag is avoided.

As an initial survey of psychiatrist-patient e-mails, our results answer some questions and raise others. We infer that e-mail is a satisfier for our patients, as evidenced by the diversity of the ages, diagnoses, and reasons associated with the e-mails, and our ability to respond to them promptly. We did not specifically ask patients about their satisfaction with e-mail. It would be useful to know more about what patients like and do not like about e-mailing us, as well as understanding more about those patients who do not e-mail. Because our study indicated that e-mailers were not substantially different from our panels regarding age, sex, and diagnoses, there may be other factors that deter some from e-mail when it could otherwise be of value to them. Some patients may be put off by having to log in to our organization's Web site or may be concerned about privacy; our organization does not permit e-mail communication in other modes because e-mails become part of the patient's health record.

Because this study looks at an adult psychiatry practice, we have no data as to how e-mail is used in a child-adolescent psychiatry practice. It seems likely that many teenagers would take advantage of e-mail, and, presumably, some parents would do so as well regarding the treatment of their children. This might raise some additional privacy and confidentiality issues that do not pertain to adult patients. We found in our study that we received some e-mails from relatives of patients with dementia, so even in an adult practice, e-mails may be generated by others with access to the patient's Kaiser Permanente e-mail account. These, although rare, do raise some concerns about the Health Insurance Portability and Accountability Act and related privacy issues.

As psychiatrists who have enjoyed using e-mail in our practices, we recognize that not all might feel similarly. Physician satisfaction with e-mail will naturally affect whether their patients are encouraged or discouraged from using it. There are still concerns about ethical and legal parameters regarding its use, although there are now some efforts in that direction. Except for the most straightforward of reasons, many health care organizations are rightfully uncertain about the limits of what can be handled by e-mail and what requires more direct contact. We suggest it would be helpful as well to attempt to measure the time involved in e-mail work and to learn from colleagues how that work is integrated into the already busy workday. Some attempts to measure this have suggested a range of two to four minutes per e-mail.⁸ In our system, physicians have the option of doing some of their work from home or other remote locations. Although this is not appealing to all, it does afford a way of doing some of this work outside the hectic office or hospital setting.

We acknowledge the small scale of this study and that generalizing to other practice settings, other medical specialties, or other patient populations should be done cautiously. Even so, we think that it is reasonable to anticipate that others would find e-mail a positive step forward for patient care. We suggest that

more systematic studies of e-mail use in different settings as well as satisfaction surveys of both patients and physicians would shed additional light. There will also be a need for more structured guidelines about the legal and ethical aspects of e-mail use, and to ensure that those who use it understand its limitations and benefits. We anticipate that, as more and more people rely on e-mail and other, newer technologies in other aspects of our lives, this will become part of a more seamless integration into future medical care. We note here that, in our own setting, video and telephone appointments are being introduced as additional ways to offer care.

CONCLUSION

Our study focused specifically on the use of e-mail by psychiatric patients with physicians who already had a comfort with and a positive stance toward its use. Although broad conclusions are difficult

to draw, we hope that these data, in combination with our subjective experience, will encourage more physicians to use e-mail communication as a regular component of patient care. ❖

Disclosure Statement

The author(s) have no conflicts of interest to disclose.

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Psychic Influence

I wish to call your attention to a well-known fact, namely, that certain maladies and particularly the psycho-neuroses, are more accessible to psychic influence than to any other remedies. It is no modern talk, but a dictum of old physicians, that these diseases are not cured by the drug, but by the doctor—to wit, by the personality of the physician in so far as he exerts a psychic influence.

— Sigmund Freud, DM, 1856-1939, Austrian neurologist known as the father of psychoanalysis