Letters to the Editor

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Editor, Letters to the Editor Section

Editor’s Note: Send letters to the editor to jscherger@ucsd.edu or to my attention at Family Medicine Letters to the Editor Section, University of California, San Diego, 2658 Del Mar Heights Road #604, Del Mar, CA 92014. 858-232-8858. Fax: 858-565-4091. Electronic submissions (e-mail or on disk) are preferred. We publish Letters to the Editor under three categories: “In Response” (letters in response to recently published articles), “New Research” (letters reporting original research), or “Comment” (comments from readers).

New Research

Teaching Physician-Patient E-mail Communication Skills in a Residency Program

To the Editor:

E-mail communication with patients is already a part of clinical practice. Surveys estimate that up to 75% of primary care physicians have used e-mail with selected patients. A majority of patients, including many people of low socioeconomic status, have e-mail access and would communicate with their physicians via e-mail if this option were available.

However, e-mail communication does expose patients to risks, including loss of confidentiality and poor communication of medical issues. There are also potential medicolegal risks to physicians. The American Medical Informatics Association and the American Medical Association have published guidelines for physician-patient e-mail communication. These guidelines recommend that physicians explain the limitations of e-mail communication to patients and encourage use of a consent form, signed by the patient, before beginning e-mail communications with patients.

Limited information is available on use of e-mail with patients by resident physicians. Although one study did survey faculty and residents in an internal medicine teaching clinic, the survey assessed only e-mail use, not knowledge about e-mail communication or guidelines. A Medline search found no published curricula for teaching e-mail communication skills during residency. This report shows the results of a survey of family medicine faculty and residents about e-mail communication with patients.

We conducted a cross-sectional survey study in an urban family medicine residency program in California. The program is in the process of implementing an electronic health record, but no formal platform or policy exists for electronic communication with patients. The residency does have a policy requiring residents to check their university e-mail accounts.

We received responses from 19 residents (59%) and seven faculty members (64%). Thirty-two percent of residents and 71% of faculty currently use e-mail communication with patients. Residents and faculty demonstrated variable levels of understanding regarding the concepts of confidentiality, HIPAA compliance, and encryption. Although some faculty did mention awareness of written guidelines, some of these guidelines either do not exist (for example, the American Academy of Family Physicians does not have guidelines) or are not specific for physician-patient e-mail (Netiquette). Only 50% of residents and 20% of faculty reported that they “always” or “usually” file e-mail communication in the patient’s chart. None of the respondents used a consent form with patients to review the risks and benefits of physician-patient e-mail.

Our survey of residents and faculty in one family medicine residency program found many gaps in knowledge related to appropriate and confidential use of physician-patient e-mail. Our study is limited in size and by the fact that the invitation to participate was sent by e-mail, potentially overestimating the proportion of physicians in our practice who use e-mail with their patients. Our study is confined to a single institution; expanding our survey to more residency programs would allow us to further refine the
physician-patient e-mail curriculum and increase its usefulness to others. We plan to repeat our survey of knowledge and behavior following full implementation of a physician-patient e-mail curriculum in our institution.

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REFERENCES

Family Medicine Resident Confidence With Screening for, and Communicating About, Genomic Susceptibility to Breast Cancer

To the Editor:
Advances in the genomic sciences are catalyzing the emergence of screening for genomic predisposition to breast cancer in primary care. Many practicing primary care physicians lack confidence in their capacity to assess the clinical relevance of their patients’ family history.1 More recent medical trainees who receive education in genomic risk assessment might enter their practice more prepared to address family history and genomic risk. However, little is available that describes current residents’ confidence or educational needs related to genomic risk assessment. Our family medicine program established a curriculum to address family history assessment and patient counseling in 2004. The curriculum includes three components. The first is a half-day workshop for all residents that occurs early in the academic year and is focused on assessing family history. Third-year residents each complete a standardized patient interviewing session focused on assessing and communicating with a woman about her heritable breast cancer risk and two 3-hour clinical sessions observing cancer genetic counseling. We evaluated resident confidence with aspects of genomic risk assessment and counseling after 2 years of this educational initiative.

Methods: A self-administered questionnaire was given to family medicine residents attending one regularly scheduled resident-only meeting during the winter of 2006. The questionnaire consisted of five questions with a common stem, “I feel confident in my ability to...,” and a common 5-item response option (strongly disagree to strongly agree).

Results: All 23 residents attending the meeting responded (60% of the total residents). Four out of five residents were confident in their ability to assess family history. Fewer residents reported confidence in their ability to engage shared decision making about whether or not to pursue genetic counseling for high-risk women (41%) and in their ability to reassure low-risk women (50%). Confidence in all dimensions was higher for PGY-3 versus PGY-1 residents.

Conclusions: With a family history assessment and patient counseling curriculum, family medicine residents in our program appear more confident assessing familial risk than using such information for counseling and shared decision making. Future curricula should target these needs.

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Comment

“I Could Never Just Take Blood Pressures All Day Long Like You Do in Family Medicine”

To the Editor:
I was caught off guard when one of my surgical colleagues made the above statement to the first-year medical school class we were addressing about career plans. I was surprised that some of my colleagues still have such a poor understanding of what family physicians actually do. I now use the statement as a springboard with student groups into a discussion about what it is I actually do.

To begin with, of course, the problem of hypertension in the United States is neither trivial nor particularly easy to treat. There are an estimated 58 to 65 million hypertensives in the adult population, with a 29%–31% incidence in the 18 year and older age group.1,2 Of those with the disease, the data from NHANES show that only 34% have their blood pressure under adequate control.3 The health burden of this disease in terms of premature car-