Suggested Guidelines for E-Mail Communication in Psychiatric Practice

Kenneth R. Silk, M.D., and Joel Yager, M.D.

Background: Physicians and patients are increasingly communicating with one another by e-mail concerning administrative issues, medications, and other aspects of care. The objective of this article is to review existing guidelines for general physicians communicating with patients by e-mail as the basis for developing more specific guidelines for psychiatric practice.

Method: We review e-mail guidelines previously developed by the American Medical Informatics Association, subsequently promulgated by the American Medical Association, and consider each suggestion for clinical and administrative practice from the perspective of psychiatric practice. Case vignettes illustrate several of these issues.

Results: We suggest expansion and/or modification of existing guidelines to address more directly issues of specific concern in psychiatric practice.

Conclusion: Existing general guidelines concerning the use of e-mail in medical practice are useful starting points for psychiatric practice. Psychiatrists must pay particular attention to issues of confidentiality, communicative tone, and professional boundaries. With cautious application, e-mail may provide a useful tool for enhancing communication and treatment options for psychiatrists and their patients.

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Received Oct. 22, 2002; accepted Jan. 23, 2003. *From the Department of Psychiatry, University of Michigan Health System, Ann Arbor, Mich. (Dr. Silk) and the Department of Psychiatry, University of New Mexico School of Medicine, Albuquerque, N.M. (Dr. Yager).*

The authors report no financial affiliation or other relationship relevant to the subject matter of this article.

Corresponding author and reprints: Kenneth R. Silk, M.D., University of Michigan Health System, Psychiatry CFOB Box 0704, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0704 (e-mail: ksilk@umich.edu).

Communication by electronic mail (e-mail) has increased rapidly. In 2000, the Pew Internet & American Life Project Survey found that on an average day, 30 to 60 million people use e-mail with reasonable frequency.[1] In addition, the Internet and the World Wide Web are resources for information about all facets of medicine, including disease chat rooms and support groups for patients and families that can be readily accessed by virtually anyone. Guides are available to help consumers evaluate the quality and reliability of medical Web site information.[2,3]

Coincident with these trends, patients are increasingly using e-mail to communicate with their physicians. Still, patients send e-mail to their physicians much less frequently than the total number of e-mail users might predict.[4] A WebMD poll found that while almost 85% of patients use e-mail daily, only 6% had ever e-mailed their physicians; over 50% said they would like to do so but did not know their provider's e-mail address.[4] Among 950 patients surveyed in 6 different outpatient clinics in central Texas, 33% to 75% (average 54%) had access to e-mail. These patients wished to use e-mail to contact their physicians for prescription refills (90%), nonurgent consultations (87%), and routine laboratory test results (84%).[5] E-mail offers the potential of allowing more frequent communication between physician and patients—a sort of "high-tech house call."[6] As e-commerce and other forms of electronic communication grow, patients will increasingly expect electronic communication with physicians.

The *Consumer Reports*' guide on the advantages and pitfalls of e-mailing one's doctor[7] suggests that patients need to know (1) how private the communication will be and whether others beyond the identified physician will read the e-mail, (2) to send health-related e-mails only from one's home computer, and (3) not to send sensitive material via e-mail. Further, they suggest that patients (1) determine whether their doctor is willing to communicate by e-mail, (2) determine whether the e-mail is automatically acknowledged by the physician, (3) keep the messages short and limited to important matters, (4) identify themselves and the issue in the subject matter line, and (5) acknowledge answers when they are received from the physician. The guide reminds patients not to request or to expect diagnoses to be made via e-mail and that e-mail does not replace needed periodic visits to their physician.

Table 1. Summary of the American Medical Informatics Association Guidelines for the Clinical Use of Electronic Mail With Patients[a]

Establish turnaround time for messages.
Do not use e-mail for urgent matters.
Inform patients about privacy issues. Patients should know:
1. Who besides addressee processes messages: during addressee's usual business hours, vacation, or illness?
2. The message is to be included as part of the medical record.
Establish types of transactions (prescription refill, appointment scheduling, etc.) and sensitivity of subject matter (HIV, mental health, etc.) permitted over e-mail.
Instruct patients to put category of transaction in subject line of message for filtering: "prescription," "appointment," "medical advice," "billing question."
Request that patients put their name and patient identification number in the body of the message.
Configure automatic reply to acknowledge receipt of messages.
Print all messages, with replies and confirmation of receipt, and place in patient's paper chart.
Send a new message to inform patient of completion of request.
Request that patients use autoreply feature to acknowledge reading provider's message.
Maintain a mailing list of patients, but do not send group mailings where recipients are visible to each other. Use blind copy feature in software.
Avoid anger, sarcasm, harsh criticism, and libelous references to third parties in messages.

[a]Reprinted with permission from Kane and Sands.[8]

Table 2. Summary of the American Medical Informatics Association Medicolegal and Administrative Guidelines for the Clinical Use of Electronic Mail With Patients[a]

Consider obtaining patient's informed consent for use of e-mail.
Written forms should:
1. Itemize terms in Communication Guidelines.
2. Provide instructions for when and how to escalate to phone calls and office visits.
3. Describe security mechanisms in place.
4. Indemnify the health care institution for information loss due to technical failures.
5. Waive encryption requirement, if any, at patient's insistence.
Use password-protected screen savers for all desktop workstations in the office, hospital, and at home.
Never forward patient-identifiable information to a third party without the patient's express permission.
Never use patient's e-mail address in a marketing scheme.
Do not share professional e-mail accounts with family members.
Use encryption for all messages when encryption technology becomes widely available, user-friendly, and practical.
Do not use unencrypted wireless communications with patient-identifiable information.
Double-check all "To:" fields prior to sending messages.
Perform at least weekly backups of mail onto long-term storage. Define "long-term" as the term applicable to paper records.
Commit policy decisions to writing and electronic form.

[a]Reprinted with permission from Kane and Sands.[8]

In 1998, the *Journal of the American Medical Informatics Association* (AMIA) published the "Guidelines for the Clinical Use of Electronic Mail with Patients,"[8] a product of the AMIA Internet Working Group Task Force on Guidelines for the Use of Clinic-Patient Electronic Mail. Two sets of guidelines were presented: one devoted to communication and the other to medicolegal and administrative concerns. Broad areas addressed include privacy, permissible content, turnaround time, and tone of the e-mail, as well as the handling of messages with respect to automatic replies, acknowledging messages, saving and archiving of messages, and confirming action taken in response to e-mail (e.g., prescription called in or faxed to pharmacy) (Tables 1 and 2). The Guidelines and concerns have been reiterated in somewhat different forms in other medical journals.[9–13] These are easily accessible on the American Medical Association (AMA) Web site.[14]

Despite increased use of e-mail between patients and physicians, little has been written as to its use in psychiatry. A MEDLINE search in March 2002 produced only 1 reference to e-mail in a letter to the editor by Rothchild[15] in the *American Journal of Psychiatry*. Further, a MEDLINE search cross-referencing keywords "e-mail" or "electronic mail" with keywords "mental health" and "psychiatry" produced 6 references in each of the cross categories that specifically address e-mail communication between psychiatrists and their patients. In addition, "e-therapy," the practice of a therapist and a patient interacting online, has attracted little attention in the professional literature.[16] Though not a medical journal, a newsletter published by the American Psychiatric Association's Office of Healthcare Systems and Financing[17] devoted a major part of an issue to e-mail in psychiatry and reiterated in that publication the AMIA's, now also the AMA's, guidelines.[14,17,18]

In her analysis of e-mail communication in psychiatric practice, Rothchild[15] differentiates brief communications from more extensive e-mail communications. Brief communications may involve appointment scheduling, medication checks, and even an "emotionally needy patient with low tolerance for intervals between appointments [who] may be encouraged to commit thoughts to the word processor and e-mail them as an alternative to frequent telephoning."[15, p. 1476] More extensive e-mail communications can blend into therapeutic, dynamically complex, and boundary-related issues that may raise medicolegal and other concerns that not only can complicate the treatment but also can potentially put therapists, patients, and/or the treatment at risk. E-mail messages lack the subtle, nonverbal, emotive cues[19] that are so important in the psychotherapeutic practice of psychiatry.[20] While other specialties have been moving forward in trying to define specialty-specific guidelines for e-mail communication between physicians and patients,[4,12,13,21–23] psychiatry has just begun to enter the conversation.[24,25]

This article reviews the AMIA Guidelines and elaborates on them to address issues that we believe apply to the practice of psychiatry. The elaboration for psychiatry will be preceded by the notation "PP." In particular, these elaborations refer to clinical situations where a relation-

ship between psychiatrists and patients exists and where the relationship involves some form of ongoing psychotherapy. The elaborations also apply to situations in which a patient, initially unknown to the psychiatrist at the time of the e-mail, may shortly thereafter engage the psychiatrist in some form of treatment. Vignettes illustrate the possibilities and pitfalls of e-mail in the practice of psychiatry.

AMIA COMMUNICATION GUIDELINES ELABORATED FOR PSYCHIATRIC PRACTICE

At the beginning of treatment, physicians might wish to provide patients with instruction sheets and informed consent forms regarding the use of e-mail. The instructions should address the following issues, based on our elaboration of the AMIA Guidelines (an illustrative information sheet and consent form appear in Appendix 1).

Turnaround Time

Patients need to know the expected turnaround time, i.e., how frequently the physician goes online and answers e-mails. PP**:** Turnaround time should be clarified explicitly at the beginning of the treatment. Patients need to know if their clinician regularly reads and answers e-mail (e.g., in the evening, on weekends) and when replies can be expected as standard operating procedure. Patients must understand that e-mail should never be used for emergencies but only for communicating routine inquiries and information. (With today's increasingly sophisticated technology, it is actually now possible for a patient to send e-mail from a laptop while perched on a ledge threatening to jump).

Privacy

Patients need to know how much privacy can be guaranteed, and this information should be provided even if patients do not specifically inquire. Is the e-mail encrypted, and how? Who besides the physician might see the e-mail? If a physician uses a health care institution's e-mail system, patients need to know that even encrypted e-mail is not fully protected from institutional monitoring or from others using the e-mail system. Breaches may be rare, but patients need to know that such possibilities exist.

PP**:** Privacy issues are particularly pertinent because, depending on state laws, more stringent confidentiality requirements often apply for psychiatry, especially if substance abuse is involved. If the relationship is primarily psychotherapeutic, ordinarily no one other than the psychiatrist should have access. Depending on content, e-mails may have to be kept in a separate private medical record. If the relationship is restricted to medication management, depending on how that is interpreted by the patient and psychiatrist,[26] then a nurse clinician or medical assistant might also have access to e-mails. If patient and clinician agree that certain e-mails may be shared with third parties, for example other clinicians who are part of the patient's treatment team, the patient should sign specific consent forms to release information to those individuals. As an additional precaution, clinicians should log off e-mail when they are not sitting at their computers. Alternatively, an automatic logout can be activated if the screen is inactive even for a short length of time. Clinicians should be cautious both in the office and at home so that other individuals do not inadvertently see these messages.

Types of Transactions Via E-Mail

Before embarking on e-mail communication, clinicians and patients need to establish what is and is not appropriate with respect to topics and content. E-mail cannot be used for urgent or emergent issues. PP**:** Topics related to psychopharmacologic treatment such as dosages, side effects, and renewal of prescriptions may be quite appropriate for e-mail communication if the patient is on a stable medication regimen; otherwise, phone calls or office visits should take place during which suitable matters are discussed. Patients with significant comorbid substance use or possible nonadherence or inappropriate use of medications should be followed with face-to-face or telephone meetings to assess more closely the patient's clinical condition.

Most definitely, psychodynamic psychotherapy should not be conducted via e-mail. In psychodynamic psychotherapy, patients communicate thoughts, concerns, feelings, fantasies, and wishes verbally and nonverbally, and the clinician's perception and assessment of all types of cues derived from body posture, facial expression, tone of voice, and various inconsistencies between verbal and nonverbal communication are essential to effectively conduct such psychotherapy.[26] These elements cannot be gleaned from e-mail. Nonetheless, because of strong transference feelings and/or lack of clarity in the immediate moment, some patients, particularly those with various anxiety disorders, adolescents, and patients with borderline personality disorder and eating disorders, may experience difficulty expressing certain issues when face-to-face with their clinician in the office, but they may communicate these sentiments and reflections more easily via e-mail.[24]

Some patients may wish to convey post-session feelings and reflections to their clinician via e-mail. If clinician and patient agree on the utility of the patient writing reactions to sessions via e-mail, the patient should understand that the clinician will do no more than acknowledge receipt of the message and perhaps add a brief, encouraging remark but will not engage in an e-mail dialogue. A review of e-mail messages should be conducted in the next session.

If e-mails begin to contain suicidal threats or imply increasing preoccupation with suicidal thoughts, the clinician probably should choose some method other than e-mail to discuss the suicidality. E-mail is not, for many reasons, a good medium through which to discuss various aspects and types of suicidality. The clinician may need to phone the patient immediately to assess the seriousness of the threat; at the very least, e-mail messages that raise concern in the psychiatrist need to be discussed in the next office visit if the e-mail communication is to continue as an adjunct to therapy. Beyond brief cautionary notes, it is preferable that clinicians not attempt to clarify the limits of e-mail communication in e-mails themselves, since the very process of discussing appropriate limits for e-mail communication may expand the nature of these e-mail communications.

Some types of routine "reporting in" via e-mail by patients in psychotherapy may be appropriate and helpful. In cognitive-behavioral therapy, e-mail can help track specific monitored behaviors and cognitions. Such techniques have recently been applied as an advantageous adjunctive tool in treating ambulatory patients with eating disorders who may be asked to report their daily nutritional intake and patterns of exercise and purging via e-mail.[24,25]

Parts of an E-Mail

Subject line. The AMIA suggests that patients be asked to state explicitly the subject of their message in the e-mail subject line to aid in triage. PP: In psychiatric practice this is usually not necessary since most e-mails will not go through triage. The patient's name and subject matter can be viewed on the "opening screen" of the e-mail program.

Identification. If not clear from their e-mail addresses, patients should be reminded to include their name and other identifying information in the body of the e-mail. When requesting prescription renewals, pharmacy name, phone number, patient birth date, dosage, and frequency of taking the medication should be included in the e-mail. To save time, clinicians could create an automatic reply to prompt for this information.

E-Mail Replies

Automatic reply. Physicians are advised to develop an automatic reply to acknowledge receipt of e-mail messages, but patients need to know that an automatic reply is not an indication that the e-mail has been either read or acted upon. PP**:** This latter point is particularly important in psychiatric practice. Some clinicians may wish to add information in their automatic reply messages regarding (1) how frequently they read e-mail and (2) when they are away from the office, with information about who is covering and how to reach the person(s) providing coverage.

Reply when e-mail messages are read and acted upon. Clinicians should always reply with a brief response and comment indicating that the message has been read and acted upon. For the purpose of printing copies for saving in the patient's medical record, replying to messages by including the patient's original message as part of the document allows clinicians to keep a record of the entire exchange in a single document. This record is useful in the event that the patient makes negative claims about the clinician's conduct or attitude. However, if other family members or friends can access the patient's e-mail account, the patient's original messages should not be included in the clinician's reply to preserve confidentiality at the patient's end.

Record of e-mail. Patients should be informed that all e-mails, including the clinician's responses, will be printed and filed in their medical records. PP**:** In large health care institutions, considerable thought must be given to record privacy in psychotherapy notes.

Patient automatic reply. Some patients may wish to confirm receipt when they receive an e-mail from their clinicians. PP**:** This practice may sometimes trail into an ongoing give-and-take dialogue, which many clinicians may prefer to avoid.

Tone of E-Mail

The tone of an e-mail message should always be professional. Anger, annoyance, flirtations, or other unprofessional tones must be avoided. Clinicians who feel particularly irritated with certain patients should refrain from sending e-mails until they can communicate without leaking irritation into the messages. Replies should be short, focused, and neutral or mildly positive, but never more informal than the clinician's usual office style.

PP**:** It is evident that patients may misinterpret the meaning of communications even in office settings where nonverbal cues are present. Since e-mail lacks nonverbal cues from clinicians, patients may be even more likely to misinterpret e-mail communication and develop untoward transferential reactions. One patient became sexually excited when her psychiatrist replied to her e-mail late at night. The patient experienced his e-mail as a form of secret communication with her when most of the world was asleep. Another patient became extremely embarrassed after signing off a late night e-mail with "Love,…" an endearment she generally reserved for close friends and relatives. Replies to highly affect-laden e-mails from patients, whether positive or hostile, should be short and neutral or mildly positive in tone and should avoid encouraging an extended dialogue via the e-mail.

Address Books

It is helpful for clinicians to keep an address book of all of their patients who use e-mail, but one should never send mailings to the group as a whole. Any mailing must avoid listing other individuals receiving the e-mail. PP**:** Each e-mail should be sent only to individuals. When an e-mail is received from a patient, clinicians should be certain not

to "copy" anyone else (unless there is explicit written consent from the patient that a specific other provider may be informed).

AMIA MEDICOLEGAL AND ADMINISTRATIVE GUIDELINES

Informed Consent

Before e-mail communication begins, good practice suggests that clinicians provide informed consent forms and obtain signatures on appropriate forms (Appendix 1). The consent form can list communication guidelines, describe what is and is not appropriate e-mail content, explicate limitations on the privacy of the communication, and state when phone calls or visits to the emergency room should take precedence over e-mail.

PP**:** Explicit statements regarding what is and is not an emergency are needed. Suicidal and homicidal intent should specifically be mentioned in this regard. Consent forms should also include statements exonerating all parties in the case of technical failure. For example, when a Michigan broadband provider was sold to another company recently, many clinician users found themselves without e-mail access for a week or more during the changeover.

Privacy in the Office and Home

It is important to insure that professionally used e-mail accounts are password protected and that unauthorized individuals cannot and will not access them. E-mail accounts that communicate with patients should never be shared with family or friends.

Third party communication. E-mail should not be forwarded to third parties without explicit (and in psychiatric practice, signed) permission from the patient.

Marketing. Marketing to patients should never take place via e-mail. PP**:** In psychiatric practice, marketing should never take place via any other mode as well.

Encryption. Patients need to know whether or not encryption technology is being used and what steps they might need to take in this regard.

Replies. As stated above, clinicians need to be certain that replies are going back only to the patient and that no one on the patient's end can inadvertently read the patient's original message to the clinician.

Record keeping. E-mails should be regularly backed up to disk or CD-ROM to prevent the permanent loss of patient information. As previously mentioned, paper copies should be filed in the record.

Policies. The physician should have copies of policies regarding e-mail saved in both electronic and written form.

THE QUESTION OF FEES

One cannot address aspects of e-mail communication without some discussion of whether one should bill for the time spent reading and replying to patient e-mails. Obviously, as with many issues in this rapidly emerging area of medicine, there are no set rules. While it does take time to read the e-mail, and time spent with patients is fundamental to billing for psychiatric services, we nonetheless believe that at this point there should not be a fee for reading, responding to, or generating electronic communication. There are a number of reasons why we take this position. The first is that e-mail work is still a very small part of psychiatric practice. The second is that if the e-mails are kept short and succinct by both parties involved, following the principle that e-mail is to be used primarily to provide factual communication and not psychotherapeutic dialogue, then the time spent, in actuality, will be quite small. The third is that there currently is not, to the best of our knowledge, reimbursement forthcoming from third party payers for the time physicians spend with e-mail, though that might change in the future.

If e-mails begin to take up more and more time, then perhaps the best way to bill for that time would be to bundle the fee into the regular office fee. The regular fee would be raised slightly as a way to pay for the opportunity that each patient has to communicate with the psychiatrist via e-mail, even if any particular patient chooses not to utilize the opportunity.

There are other ways besides bundling to set a specific fee for the e-mail communication, but how to implement these remains uncertain at present and will probably vary with individual clinicians. A similar situation is how clinicians handle phone calls. Some charge for them and some do not. Some charge only if the call extends beyond a certain time limit. For example, one would not bill for a phone call that lasted a minute or 2 to work out a change in appointment schedule, but if that call extended to 5 or 10 minutes as the patient described all the crises that led to the need to change the appointment, then charging for the phone call becomes more understandable and applicable.

One additional caveat about billing needs to be put forth. Both authors of this paper are full-time academicians. While we both do clinical work, our entire income is not based on that clinical work. Psychiatrists and physicians who spend the overwhelming majority of their time in clinical practice (and generate the bulk or all of their income from that clinical practice) may feel more ready to bill for e-mail time and effort. That position appears to be both understandable and acceptable. But before the bill is generated, the patient should, of course, be made aware of the policy.

ILLUSTRATIVE CASE VIGNETTES

Case 1

Ms. A, a 34-year-old woman with panic attacks according to DSM-III-R criteria, was referred for medica-

tion management. Her attacks were associated with fear that she might encounter her former lover, even though he had moved out of state. Shortly before referral, she started cognitive-behavioral therapy with a social worker. Ms. A worked out of town. After seeing Ms. A for initial consultation, consulting with her psychotherapist, and assessing her as possessing good object relations,[27] the psychiatrist determined that most aspects of the psychopharmacologic treatment could be managed via e-mail. In a second meeting, the psychiatrist and Ms. A discussed this possibility. Ms. A's e-mail account was private. The psychiatrist explained how he used e-mail, and both agreed that they would try to manage the medications primarily via e-mail.

Treatment with venlafaxine, up to 225 mg/day, initially diminished her panic attacks, but after 6 months the attacks reappeared. The bulk of discussions concerning prescribing had occurred via e-mail, with some of the e-mails copied to her therapist after prior agreement. When the panic attacks began to recur, the psychiatrist spoke with both Ms. A and her therapist by phone, and after these conversations, he increased the venlafaxine dose to 300 mg/day. When the increase failed to ameliorate the panic, an office appointment was scheduled. During that appointment, the decision was made to discontinue venlafaxine and begin citalopram. Side effects of citalopram were subsequently monitored via e-mail, and Ms. A improved as the citalopram was increased to 60 mg/day. Another office appointment was scheduled after Ms. A began to complain of sexual side effects.

This case demonstrates how adjunctive e-mail management can be used in an administratively split psychotherapy/medication-management treatment to help monitor ongoing psychopharmacologic treatment. By using the "copy" function of e-mail, the psychopharmacologist easily kept the psychotherapist informed of his treatment. When the case became more complicated and required changes in medication or discussions concerning sexual side effects, the psychiatrist reverted to phone or face-to-face contact.

Case 2

Ms. B, a 28-year-old woman with DSM-III-R borderline personality disorder, was being treated by her psychiatrist with both psychotherapy and medication. Over 6 years of intermittent treatment, Ms. B had shown considerable progress, particularly in the last 3 to 4 years. Treatment initially started with twice-per-week sessions, but over the years, office visits gradually decreased to 1 every 2 to 3 weeks. In the past, Ms. B was prone to phone the psychiatrist and threaten or hint at suicide, but through treatment and abstinence from alcohol, this behavior eventually ceased. As she improved, Ms. B gradually became less angry and sadistic in her threats and comments to her psychiatrist and stopped making suicide threats. Though she had been treated with multiple medications in the past, for the past 18 months, she had been taking only lorazepam, 1 mg t.i.d.

Ms. B continued to have difficulty coping with work stress. The psychiatrist suggested she join a Dialectical Behavior Therapy (DBT) group. He also proposed that their individual appointments be further reduced in frequency and suggested that he and Ms. B keep in contact by telephone at least monthly and meet every 2 to 3 months in person, primarily to discuss medication. The psychiatrist thought that Ms. B concurred with this plan.

Prior to this appointment, Ms. B had never communicated with the psychiatrist by e-mail, even though the psychiatrist's e-mail address was clearly printed on his business card and was also available through the university's online directory. Two days after the session in which the decrease in individual appointments was suggested, the psychiatrist received an e-mail from Ms. B:

> I am writing letters to my family and to my various attorneys requesting that they sue you for malpractice. You simply criticize my lack of progress and give me useless advice. You can go to hell. You are not available to me—not that this is a surprise, since you are a phoney.

The psychiatrist called the patient but there was no answer; he left her a message for her to call him. Three days later, the patient sent another e-mail: "Please call into my pharmacy 6 monthly refills for my lorazepam 1 mg. Controlled substances can be renewed for 6 months. I am not interested in calling you every month to beg for refills." The psychiatrist replied by e-mail: "We would need to talk about this face to face. I can be reached this evening at home or you can call my secretary to set up an appointment." Ms. B replied 3 days later: "I would ask if I could call you tomorrow, but I am unable to talk to you in a concise meaningful way. I should be able to talk to you and know when to shut up but I can't."

They eventually did speak by telephone, at which point the psychiatrist told Ms. B that he was sure that she understood that he could not write prescriptions for her to have 6 months of medication under any circumstances and certainly not after her previous e-mail but that he would be happy to meet with her in person to see if some of the misunderstandings could be clarified and ironed out. In the subsequent face-to-face meeting, use of e-mail was clarified, and the patient and psychiatrist were able to move toward the reduced frequency of appointments and securing Ms. B's involvement in the DBT group, as previously discussed. Ms. B joined the group and used e-mail to inform the psychiatrist about her impressions of the group. The psychiatrist simply acknowledged receiving each of Ms. B's e-mails by reply but did not comment on, support, or refute her feelings and impressions of the DBT group.

This example reveals how patients may sometimes use e-mail to express feelings or threats that have to be dealt

with face to face. While the psychiatrist acknowledged receipt of Ms. B's 2 angry and upset e-mail messages, his goal was to meet with her in the office to clarify how e-mail should and should not be used in treatment. Eventually, Ms. B found ways to use e-mail to stay in touch without expecting or demanding that the psychiatrist substantially respond or engage via e-mail. This agreement allowed Ms. B to express her feelings to the psychiatrist without having the "ongoing" treatment transferred into a give-and-take e-mail exchange.

CONCLUSION

The full impact of e-mail technology on psychiatry remains to be seen.[28–30] Because of the importance of nonverbal signals in psychiatric practice, e-mail communication should never take the place of face-to-face contact. Nevertheless, e-mail may add efficiencies to psychiatric practice, and, with proper guidance, it may augment current modes of treatment. Studies are warranted to delineate systematically the clinical problems and situations in which e-mail communication might further enhance clinician-patient relationships and foster better care. At the same time, appropriate cautions must be exercised to safeguard patients' privacy and maintain clinical practice standards as we gradually incorporate these new technologies into our daily activities.

Drug names: citalopram (Celexa), lorazepam (Ativan and others), venlafaxine (Effexor).

REFERENCES

1. Pew Research Center. The Pew Internet & American Life Project. Daily and overall internet activities chart. Available at: http://www.pewinternet.org/reports/chart.asp?img=6_internet_activities.jpg. Accessed January 20, 2002
2. Wolinsky H, Wolinsky J. Healthcare Online for Dummies. New York, NY: Hungry Minds; 2001
3. Smith IK. Dr. Ian Smith's Guide to Medical Websites. New York, NY: Random House; 2001
4. Sittig D, King S, Hazelhurst BL. A survey of patient-provider e-mail communication: what do patients think? Int J Med Inf 2001;61:71–80
5. Couchman GR, Forjouh SN, Rascoe TG. E-mail communication in family practice: what do patients expect? J Fam Prac 2001;50:414–418
6. Fein EB. For many physicians, e-mail is the high tech house call. New York Times. Nov. 20, 1997:A1
7. Take two aspirins and e-mail me in the morning. Consum Rep 2002;67:60–61
8. Kane B, Sands DZ. Guidelines for the clinical use of electronic mail with patients. J Am Med Inf Assoc 1998;5:104–111
9. Mandl KD, Kohane IS, Brandt AM. Electronic patient-physician communication: problems and promise. Ann Int Med 1998;129:495–500
10. Beredjiklian PK, Bozentka DJ, Bernstein J. E-mail in clinical orthopaedic practice. J Bone Joint Surg 2001;83-A:615–618
11. DeVille K, Fitzpatrick J. Ready or not, here it comes: the legal, ethical, and clinical implications of e-mail communications. Sem Ped Surg 2000;9:24–34
12. Moyer CA, Stern DT, Katz SJ, et al. "We got mail": electronic communication between physicians and patients. Am J Managed Care 1999;5:1513–1522
13. Hensinger RN. E-mail medicine. J Ped Ortho 2001;21:275–276
14. American Medical Association. Guidelines for physician-patient communications. AMA Web site. Available at: http://www.ama-assn.org/ama/pub/category/2386.html. Accessed July 10, 2002
15. Rothchild E. E-mail therapy. Am J Psychiatry 1997;154:1476–1477
16. Manhal-Baugus M. E-therapy: practical, ethical, and legal issues. Cyberpsychol Behav 2001;4:551–563
17. American Psychiatric Association's Office of Healthcare Systems and Financing. The clinical use of e-mail by physicians. Psychiatr Pract Managed Care 2000;6:3–4
18. American Psychiatric Association's Office of Healthcare Systems and Financing. AMA guidelines for doctor-patient e-mail. Psychiatr Pract Managed Care 2000;6:6–7
19. Spielberg A. On call and online: sociohistorical, legal, and ethical implications of e-mail for the patient-physician relationship. JAMA 1998;280:1353–1359
20. Schwaber EA. Countertransference: the analyst's retreat from the patient's vantage point. Int J Psychoanal 1992;73(pt 2):349–361
21. Neill RA, Mainous AG III, Clark JR, et al. The utility of electronic mail as a medium for physician-patient communication. Arch Fam Med 1994; 3:268–271
22. Kuppersmith RB. Is e-mail an effective medium for physician-patient interaction? Arch Otolaryngol Head Neck Surg 1999;125:468–470
23. Huntley AC. The need to know: patients, e-mail, and the Internet. Arch Dermatol 1999;135:151–156
24. Yager J. E-mail as a therapeutic adjunct in the outpatient treatment of anorexia nervosa: illustrative case material and a discussion of the issues. Int J Eat Disord 2001;29:125–138
25. Bailey R, Yager J, Jenson J. The psychiatrist as clinical computerologist in the treatment of adolescents: old barks in new bytes. Am J Psychiatry 2002;159:1298–1304
26. Tasman A, Riba MB, Silk KR. The Doctor-Patient Relationship in Pharmacotherapy: Improving Treatment Effectiveness. New York, NY: Guilford Press; 2000
27. Kernberg OF. Object-relations theory and clinical psychoanalysis. New York, NY: J Aronson; 1976
28. Huang MP, Alessi NE. The Internet and the future of psychiatry. Am J Psychiatry 1996;153:861–869
29. Pew Research Center. The Pew Internet & American Life Project. The online health care revolution: how the Web helps Americans take better care of themselves. Available at: http://www.pewinternet.org/reports/toc.asp?Report=26. Accessed Jan 20, 2002
30. Pew Research Center. The Pew Internet & American Life Project. Daily Internet activities chart. Available at: http://www.pewinternet.org/reports/chart.asp?img=6_daily_activities.jpg. Accessed Jan 20, 2002

Appendix 1 appears on page 806.

Appendix I. Illustrative Information and Consent Form for E-Mail Communication in Psychiatry[a]

E-mail: Think Before You Send
[physician name], M.D. [e-mail address] ([area code]) [phone number]

Risks, Benefits, and Alternatives
Before you use e-mail to communicate with a physician, you should understand the potential benefits, the potential risks, and the alternatives.

The *benefits* of e-mail include being able to send and receive e-mail at any time day or night; never having to leave messages with intermediaries; avoiding voice mail and telephone tag; being able to take as long as you want to compose messages; and automatically having a record of communications to refer to later. Your e-mail messages also become part of your clinician's confidential medical record.

The *risks* of e-mail are that messages may not be received and confidentiality could be breached. An e-mail could fail to be received if it is sent to the wrong e-mail address or if it just is not noticed by the recipient. Confidentiality could be breached in transit by hackers or Internet service providers, or at either end by others who have access to either the account or the computer.

The *alternatives* to e-mail are, of course, writing a letter or a note, making a phone call, and meeting in person.

Uses
Certain issues lend themselves more easily to e-mail; others may be more appropriately dealt with on the phone or in person. We suggest the following:

Possibly appropriate for e-mail:
- scheduling appointments
- giving "status reports"
- reporting mild–moderate medication side effects

Probably inappropriate for e-mail:
- reporting moderate–severe medication side effects
- discussing issues
- dealing with urgent or severe problems (especially suicidality)

Please discuss this with your psychiatrist or other clinician if you have any questions.

Turnaround Time
How soon an e-mail you send will be read may be an issue. Different clinicians check their e-mail with different frequencies.

Dr. [name] usually checks e-mail:

At the office	e.g. Every few hours
At night	e.g. Usually doesn't
On weekends	e.g. Once or twice a day
Out of town	e.g. Sometimes

If you don't get a timely response to an e-mail, please call:
Dr. [name] ([area code]) [phone number]
Hospital/department
during the day ([area code]) [phone number]
after hours ([area code]) [phone number]

Confidentiality
Confidentiality is an important aspect of mental health services. These are measures Dr. [name] takes to safeguard the security of e-mail:

Safeguard	Yes	No
Keeps his/her [e-mail address] password to him/herself (ie, doesn't share that account or e-mail address)	❑	❑
Limits access to printed e-mail messages to a single assistant (name: [assistant name]; e-mail address: [assistant email address])	❑	❑
Prints out and deletes confidential e-mail	❑	❑
Saves confidential e-mail on his computer in encrypted form	❑	❑
Requires a password to use his computer	❑	❑
Requires a password to unlock his screen saver	❑	❑
Is able to encrypt and decrypt e-mail using Pretty Good Privacy, http://www.pgp.com	❑	❑
Uses other encryption systems, specifically [system name]	❑	❑
Other specific issues: [list other issues]	❑	❑

CONSENT:
I have read the information provided above, and I will use the guidelines for my e-mail communications with Dr. [name]

Name: _____
Signed: _____
Date: _____

Name: _____
Signed: _____
Date: _____

Name: _____
Signed: _____
Date: _____

[a]Adapted with permission from Robert Hsiung, M.D., "Dr. Bob," University of Chicago, Chicago, Ill. Available at: http://counseling.uchicago.edu/info-hsiung.html.