I am struck by how fabulous a doctor I have become—all because of e-mail. I woke up as is my habit and scanned my e-mails with my morning tea prior to starting to work on my task list. My patient who had enrolled in a bariatric study had undergone a pre-enrollment endoscopy for placement of a study device. She was found to have a concerning gastric lesion and contacted me via secure e-mail in a panic. As I walked into my office, I narrated her story to our gastroenterologist and her concern about cancer. She had her endoscopy and biopsy done that very day. Needless to say, we had a happy patient with a good outcome and a potentially precancerous lesion removed. Normally this process, had she contacted the office and received a referral to the specialist, would have taken about 30 days.

Serendipity or conscientious use of technology to improve the care of a patient? Probably a bit of both. My reach as a physician has truly increased.

Not only was the e-mail communication cost effective (she would have needed the procedure anyway as there was no surrogate), but we managed to bypass unnecessary appointments (one with me and another with the GI physician or his nurse practitioner) and went straight for the answer. She did not lose any time off work or any sleep due to anxiety that it might be cancer.

Another patient stubbed his toe. I was able to manage his care through e-mailed photographs to ensure that the cellulitis was indeed improving, thus enabling him to continue work and prevent a hospitalization—all due to the amazing camera on his iPhone. I could go on and on. I practice, like many of us, in a hospital-based clinic that sees patients with severe forms of chronic disease. Many of my patients have poor health literacy, low socio-economic status, and chronic disease—the deadly trifecta.

The real question and challenge is how to develop scalable programs that provide this instant action, particularly among the top 5% who spend 50% of resources. As of 2010, 77% of the population used the Internet, yet use of electronic health records (EHRs) and their associated patient portals is limited, with fewer patients using them in a meaningful way.

In order to use patient portals, e-medicine has to evolve. At this point, most institutions, physicians, and patient communities are not equipped to handle patient portals and connectivity as they exist on iPhones, iPads, or other “smart” devices. In addition, we must have insurance companies pay for this performance and not the endless lists of parameters that fail to make a measurable impact on public health.

I am also concerned, as we develop these systems, that we are creating a new class based on Internet and web-based connectivity. Will the top 5% of utilizers who are the sickest be the ones using the patient portals? Will health care systems, insurances, doctors, and patient communities come together in realizing the need for education? Are we looking at another metric of health care disparities?

Let it not be akin to the EHR development, where the users (physicians) have a love-hate relationship with the technology: We love to hate the EHR and what it represents because we were told that we had to use a product without providing input based on our clinical experience.

As we move toward reforming and reshaping our practice of medicine, we must include a vision and a strategy that includes not only offering web- and mobile-based technologies but educating patients on how to use them.

References