Below is a letter concerning contact with patients. I have found this practice useful. It decreases anxiety on the part of the patient and the doctor. I write to recommend it to emergency physicians everywhere.

I give my cell phone number to patients all the time. By that I mean 2-3 times a shift. I have been doing it for years, almost since I first got a cell phone. I have given it out hundreds of times. I recommend that we encourage our emergency medicine (EM) residents to do so also. It is an easy option, and it can help avoid all sorts of problems. Discretion is in order, but there are not a lot of exceptions. There are some types of patients that I do not give it to.

I give it to patients for several different reasons. Often I want to know what happened to the patient. Did they get better? Did my recommended treatment work? For instance, they had abdominal pain, and I want to know if they got over it. I say, “Call me in 48 hours and let me know what happened.” Out of 100 of these types of requests I may get one call back. I assume that they get better and that they forget about it. Our medical system is good, and we generally get it right.

I give it to the unsatisfied patient very often. I think you know the interaction. You have finished your workup, and you are discharging the patient. You are giving your summary, and the patient or family member obviously thinks that you have either not done enough, ought to admit the patient, or that you are wrong. They will not state this, but it is obvious that they are not entirely happy. At that point, I say my standard discharge spiel. “With this treatment you should get better and better. If you get worse, notify your doctor immediately. If unable to reach him/her, return immediately to the emergency department (ED). By the way, here is my phone number. Call me if you have a problem or are getting worse. I don’t sleep with the phone, so I may not answer in the middle of the night. Sometimes I cannot be reached, so if you are worsening and cannot reach me right away, go to the ED immediately. But call me if you have a problem.”

At that point everything changes. The patients usually are very pleased. You have told them two things very clearly. First, you think that your diagnosis and treatment are correct. Second, that you care about them. You are not going to hide behind a wall of secretaries who will not connect you. You believe in your care.

I also give my number to patients that I am a little worried about. I think that I am right. However, I want to make sure that they get timely care if things turn worse. A patient has a tender area that I think is cellulitis, and I treat with an antibiotic. If they get worse, call me.

And what if they do call? It is a 30-second conversation. “Go to the ED. I will call them and tell them to be looking for you.”

During the eight or so years that I have been doing this, I have been called back perhaps six times. It has never been “abused.” Only once did I have to have the patient return to the ED, and it was not a major issue. My patient satisfaction scores are the best in the department.

Physicians in other specialties who see patients repeatedly might have difficulty with this. Because we in the ED do not have ongoing relationships with our patients, this practice should not create a problem. Residents might want to use their beeper numbers instead, until they are comfortable with the process.
Experience of an ED physician providing patients with personal contact information

To the Editor,

Emergency physicians traditionally have not given personal contact information to their patients. The emergency physician does not have an office, and historically, the lack of cell phones, e-mail, and electronic health records (EHRs) made it impractical for a patient to contact an emergency physician.

Elnicki et al [1] documented provision of personal contact information in Telephone Medicine for Internists in 2000. Researchers have attempted to identify factors relevant to providing personal

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contact information for non–emergency department (ED) physicians, including preferred contact method, frequency, obstacles, and impact on care. Wallwiener et al [2] reported that patients liked to use e-mail, and there were no adverse outcomes. Ye et al [3] reported that e-mail improves physician-patient communication. Peleg et al [4,5] reported that patients prefer phone contact, and physicians had a slight preference to provide a phone number over e-mail. The authors also described benefits including reducing outpatient visits, ED visits, and an increased sense of security [5]. Teutsch [6] advocates increased patient-doctor communication and shared decision making. Chin et al [7] report that surgical patients used the opportunity appropriately.

Wong et al [8] pointed out that physicians may not want to be called citing disruptions to work, providing advice without the medical records, and lack of payment. Peleg and Nazarenko [4] discuss the inability to do an examination, risk of errors, and concern about litigation. Confidentiality was noted to be a concern by Gaster et al [9].

Fears from emergency providers include lack of an ongoing patient relationship and episodic care. There is no literature specific to the provision of personal contact information in the ED. The author of this study wondered: “What would happen if an emergency physician provided a cell number and e-mail address to discharged patients?” This project was conducted to determine how often patients in a community ED would contact the ED physician. Secondary goals included comparing phone and e-mail contact rates, assessing changes in management, and identifying benefits and burdens to the physician.

This project was conducted at a community hospital ED with annual volume of 61,400 patients. Data were collected from February 1, 2012 to May 31, 2013. All patients discharged by a single emergency physician were provided with the following printed information:

“I (Dr. Mark Baker) would be very happy to answer any questions that you might have after you leave the ED. You can leave a message for me at 123-4567 or you can e-mail me at docmarkbaker@isp.com. The ED phone number is 234-5678. If you feel like you are getting worse, please do not wait for me to call or e-mail you back. Go directly to the ED.”

Contact date, time, medium, reason for contact, physician response, and notes were recorded. Documentation was added to the EHR when appropriate.

During the study period, the physician discharged 3283 patients. Ninety-seven patients (2.96%) contacted the physician after discharge. Contact was by phone for 83 patients (2.53%) and by e-mail for 17 (0.52%) patients. Three patients used both phone and e-mail for initial contact. Typical questions related to changes in symptoms or instructions. Some patients reported that they were still having pain. Five patients were given new prescriptions, and 5 were advised to return. Four patients were given work notes. Four calls were after 10 pm, all occurred shortly after the ED visit.

Almost 3% of discharged patients contacted this emergency physician. Comprehension of instructions could limit this frequency. Studies of follow-up instructions indicate that patients do not always read or understand their instructions [10–12]. Socioeconomic status, acuity, curiosity, and comfort with contacting the physician could influence this percent. Questions asked by patients who contacted the emergency physician for this project were not trivial. There was a 4:9:1 preference of telephone contact over e-mail. This preference could vary with geographic location, socioeconomic status, internet utilization, and changing technology. Ten patients (10.3% of those who made contact) had a change in management. Five were advised to return, and 5 were given prescriptions.

Reasons why an emergency physician would choose not to provide contact information include inability to access records, concern about providing incorrect information, lifestyle, being called at night, and unreasonable patient expectations. During the project, the emergency physician transitioned from accessing all patients’ records to rarely accessing records before calling patients. Being interrupted was not an issue; the phone number was for messages only.

Personal satisfaction will direct the decision by the provider to provide contact information. Anecdotally, this emergency physician felt that 100% of the patients appreciated the opportunity to discuss their care. The author recommends that ED providers consider providing patients with contact information. The provider may enjoy the continuity, and the patients may benefit from improved care and satisfaction. The author has continued the practice; it is enjoyable and professionally rewarding. A larger study with multiple providers would be informative.

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