ONLINE PATIENT-CLINICIAN MESSAGING: FUNDAMENTALS OF ETHICAL PRACTICE

A Report by the National Ethics Committee of the Veterans Health Administration

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Founded in 1986, the National Ethics Committee (NEC) of the Veterans Health Administration (VHA) is an interdisciplinary group authorized by the Under Secretary for Health through the National Center for Ethics in Health Care. The NEC produces reports on timely topics that are of significant concern to practicing health care professionals. Each report describes an ethical issue, summarizes its historical context, discusses its relevance to VHA, reviews current controversies, and outlines practical recommendations. Previous reports have been useful to VHA professionals as resources for educational programs, guides for patient care practices, and catalysts for health policy reform. Scholarly yet practical, these reports are intended to heighten awareness of ethical issues and to improve the quality of health care, both within and beyond VHA.

Executive Summary

Surveys repeatedly show that patients want to be able to communicate with their clinicians online. And online patient-clinician communication is widely held to have significant potential to enhance patient-clinician relationships, promote greater involvement by patients in their own care (including self-monitoring), and ultimately improve the outcomes of care. Concerns have been raised, however, about patient privacy, the effects of online communication on patient-clinician relationships, and the potential impact on clinicians' workload and reimbursement.

This report by VHA's National Ethics Committee (NEC) examines the nature of online communication and explores the ethical challenges of online communication between patients and clinicians. It offers the following recommendations to assure the ethical practice of online patient-clinician messaging within VHA:

(1) Clinicians and health care organizations should ensure that online communication takes place only when the confidentiality and security of personal health information can be reasonably assured.

(2) Clinicians should ensure that patients who do not interact electronically receive the same quality of care as their online peers.

(3) Clinicians should be aware of the potential effects of online messaging on the patient-clinician relationship and take steps to avoid "depersonalization."

(4) Participation in online messaging should be voluntary for both patients and clinicians.

(5) Clinicians should assure that patient participation in online communication is well informed.

(6) Clinicians should limit their online communication with patients to appropriate uses.

(7) Health care organizations should recognize online interactions with patients as part of clinicians' professional activities in institutionally appropriate ways.

Introduction

Widespread adoption of computer-supported communication between patients and clinicians, i.e., "online" health communication, seems all but inevitable. Surveys repeatedly show that patients want to be able to email their clinicians to make appointments, refill prescriptions, get the results of clinical tests, even ask health-related questions that don't require an office visit.[1–4] And at least some of them are willing to pay out of pocket for the opportunity.[2] In particular, patient-clinician email or messaging is widely held to have significant potential to enhance patient-clinician relationships, promote greater involvement by patients in their own care (including self-monitoring), and ultimately improve the outcomes of care.[3,5–11]

For patients in the Veterans Health Administration, the option of communicating online with their clinicians is about to become a reality. VHA, a recognized leader in integrating information technologies into the delivery of health care, will soon make patient-clinician messaging available nationwide through its My HealtheVet initiative.[121]

Communicating online can offer efficiency and convenience for both parties, by overcoming the problems of "telephone tag" or geographic distance.[3,10,13–14] And many believe that it can promote more effective communication, at least insofar as it enables clinicians to convey complex information more clearly than is usually possible in telephone (or even face-to-face) conversations, and readily allows both parties to create a written record of their communication.[5,8,10,13,15] Moreover, recent evidence suggests that online communication can promote more efficient utilization of health care resources and thus help reduce costs.[16–17] A study sponsored by Blue Shield of California, for example, reported reductions of $1.92/patient/month for physician office claims and $3.69/patient/month for overall health care claims after the introduction of web messaging software.[17] And third-party payers are increasingly willing to reimburse for time spent communicating with patients online.[17–18]

Clinicians have been reluctant to adopt the practice, however, citing concerns about patient privacy, the possible impact on their workload, the lack of reimbursement for time spent online, and licensure and liability issues.[15,19–22] Studies confirm the importance of these considerations even among clinicians who *do* communicate online.[23–24] Despite such reservations, as a practical matter the question is rapidly becoming not *whether* online communication between patient and clinician will be accepted, but *how* to assure that good communication practices are adopted so that patients' interests are protected and online communication takes place in a way that enhances, rather than imperils, patient-clinician relationships. This report by VHA's National Ethics Committee (NEC) examines the nature of online communication, explores the ethical challenges of online communication between patients and clinicians, and offers recommendations for the ethical practice of online patient-clinician messaging within VHA.

Online Health Communication in Context

It is important at the outset to understand the nature of online exchange as a mode of communication. It is also important to recognize that online health communication between patients and clinicians can use different channels (encrypted or unencrypted email or web-based messaging), serve a variety of different purposes, and take place in the context of different patient-provider relationships.

[1] Current VA policy explicitly prohibits sending confidential information to patients via email, even at the patient's request. See *VHA Directive 2003-025: Confidential Communications,* May 23, 2003. Available at http://vaww.va.gov/publ/direc/health/direct/12003025.pdf; last accessed June 14, 2004.

Understanding the Medium. Many of the features that make online communication attractive also raise concerns, even among staunch proponents.[5] For example, that online communication is asynchronous—i.e., need not take place in real time—offers certain efficiencies, but can also create ethically troubling situations. What if the message conveyed is urgent and it isn't received right away? Similarly, online communication affords a measure of anonymity that may enable patients to communicate more candidly than they would in person or on the phone about topics they find embarrassing or sensitive, but also makes it possible for patients (or clinicians) to disguise their identities.

Further, most people treat electronic messages as an informal mode of communication, more like a telephone conversation than a written document. In doing so they neglect the fact that such messages are self-documenting and, unlike notes from telephone conversations, constitute a *verbatim* record of communication. If electronic messages are incorporated into the medical record as current professional guidelines recommend,[5,8,25–26] they represent the *only* occasion on which the patient's own words are entered directly into his or her record.[13]

Coupled with this relative informality, many users expect online communication to give them immediate access to those with whom they share messages.[9] In the context of patient-clinician communication, this can translate into a patient's expectation that his or her clinician will always be accessible. For their part, clinicians are no less socialized to feel that online messages demand immediate, or at least prompt, responses. Thus they may feel pressured to meet what they perceive to be patients' electronic "demands" for their time and attention. Whether clinicians' assumptions about patient expectations are accurate is open to question, however.[27] There is evidence in other contexts to suggest that clinicians attribute expectations to patients in general that patients themselves don't hold.[28]

Finally, electronic messaging is an inherently "thin" communications medium.[5,29] Electronic messages are extremely poor channels for conveying emotion or psychological state or for using language figuratively; puns or other figures of speech, and attempts at irony or sarcasm often fail to come across as the sender intended, sometimes with disastrous results. Electronic messages carry none of the "nonverbal" cues—tone of voice, "body language," breathing pattern, rate of speech, facial expression and posture, etc.—that people rely on to understand one another in face-to-face interactions.

Email vs. Web Messaging. To date, most online communication between patients and clinicians has taken place via Internet email using commercial services.[3,30] Email has the virtue of being widely available and easy to use. But without additional, often cumbersome software to encrypt messages and authenticate users, parties to email communication cannot be assured either of the confidentiality or integrity of message content or the identity of sender and recipient.

"Web messaging" (or "secure messaging"), in contrast, allows users to exchange information on a single, protected computer. Secure messaging requires users to take an additional step of logging on to a password-protected website before posting or receiving messages, but is otherwise easy to use and provides greater protection than conventional email. Moreover, secure messaging supports the use of message templates to organize the content of exchanges.[3,30]

Purposes. Online health communication between patients and clinicians can address administrative or "housekeeping" matters, such as scheduling appointments, updating patient demographic information, or addressing billing questions.[15] Or it can support specific clinical discussions—for example, when clinicians respond to patients' questions about a current health

condition or self-management.[15] Some exchanges can serve both ends, as when patients complete medical history questionnaires or clinical intake forms electronically prior to a health care visit.

Relationships. Finally, online health communication can take place in the context of different kinds of relationship between patient and clinician. Online communication is often thought of in the context of an existing patient-clinician relationship, and indeed several professional guidelines recommend that its use be restricted to this context.[5,8,15] Increasingly, however, patients and clinicians unknown to one another are communicating about health matters online—for example, when a patient posts a question to an online health consultation service or interacts in an online discussion group that is moderated by a clinician whom he or she has never met face to face.[30–35]

Ethical Challenges of Patient-Clinician Messaging

Despite considerable enthusiasm in some quarters[6] and expectations of real benefits for patients and clinicians who communicate online, such communication does pose ethical challenges that need to be addressed before clinicians fully embrace this new method of communicating with their patients. The most salient concerns about online messaging involve privacy and confidentiality, access, effects on patient-clinician relationships, voluntariness of participation, informed participation, boundaries of online professional practice, and fairness with respect to workload and compensation.

Privacy & Confidentiality. Privacy and confidentiality are central values in health care. As moral agents, patients have the right to determine who has access to their persons and personal information. They also have the right to expect that clinicians will not share their personal health information inappropriately outside the patient-clinician relationship. Privacy and confidentiality further have instrumental value in the health care setting in creating the conditions for trust between patients and clinicians that are essential to therapeutic relationships. The material and psychosocial harms that can result from breaches of confidentiality, such as stigmatization or discrimination, can be significant, and patients must be able to trust that information they share with clinicians will be kept in confidence. Clinicians thus have a well-recognized ethical obligation to respect patients' privacy and to assure that patients' personal health information is kept confidential and is not inappropriately disclosed to third parties.[36]

Online messaging in the health care setting thus requires good privacy practices specific to this environment. The ease with which information can be shared electronically, intentionally or inadvertently, requires that clinicians be vigilant in protecting patient messages. Just as patients' computerized medical records should never be left open to casual view on a computer monitor, neither should patient-clinician messages. Professionals also have a responsibility to establish understandings with patients about who will have access to messages, and under what conditions messages will be forwarded to third parties.[5,8] In the context of online patient-clinician messaging, privacy concerns extend to technical matters of electronic security and authentication. Mechanisms are evolving rapidly to prevent unauthorized electronic access to personal health information in transmission, to protect the integrity of information that is stored and transmitted electronically, and to assure that sender and recipient of an electronic message are each who they represent themselves to be. My HealthęVet is being designed to address these and other privacy concerns, including compliance with the Health Insurance Portability and Accountability Act.

Access to Online Health Communication. There is also concern that online communication between patients and clinicians will exacerbate existing inequalities in health care by discriminating

against those who have no or limited access to online communication. Many of those who are most in need of health care services are also among the most disadvantaged segments of the American population, who are less likely to be online and/or less able to take advantage of online health communication when they do have access.[37]

Meaningful access to online communication encompasses a number of factors. One, obviously, is access to the required technology itself. The "digital divide" between those who do and do not have access to the Internet and World Wide Web *is* closing—overall, 58 percent of American adults reported using the Internet in a 2002 survey.[38] But the same study found that there are still significant differences associated with ethnicity, income, education level, and age.[38–39] Cost of access is also a barrier for nearly a third of those who are not now online, particularly among older persons. Establishing free or low-cost points of access—in libraries, schools, community centers, or other public venues—goes only part way to addressing the problem, however. Health-related communications are "too personal to be made in a public arena" for one thing,[37] and restricting access to the normal operating hours of public facilities diminishes much of the value of online communication for users.

Just as important is patients' ability to use technology to which they have access. Patients who have poor skills in reading and writing, for example—nearly a quarter of American adults have difficulties with literacy that impair their daily functioning[38]—will require help if they are to communicate effectively with clinicians online. Similarly, patients who do not speak the same language as the clinicians with whom they interact, or who do not read or write in the providers' language, can face similar barriers to effective communication online as they do offline.[34] Other prospective users may require support and encouragement to become comfortable with the technology.[38]

Finally, some patients will not wish to participate in online communication. Great care must be taken to assure that patients who choose not to interact with clinicians electronically, or who are unable to do so, receive clinically appropriate care of the same quality as their online peers.

Effects on Patient-Clinician Relationships. Communicating online, some worry, puts patients and clinicians at yet a further remove from one another. For example, one physician told a 2001 Harris Interactive study,

> I think it would be a shame to manage patients' health care on the Internet and to lose the human interaction and contact. How can you build trust in your physician over a computer? I think one of the basic things we learned was human touch and caring. I find it difficult to believe that that, or some of that, won't be lost over the Internet.[1]

In a similar vein, other scholars contend that "[t]he absence of personal communication and connection that occurs in a face-to-face meeting is also a major, unquantifiable loss"[31] in online communication. Moreover, they note,

> nonverbal communication . . . plays a central role in communicating empathy, concern, and expressiveness. Physicians' skills in using and interpreting nonverbal communication also have been closely linked to patients' satisfaction.[31, cf. 40]

Not all clinicians share this view, however, and many would argue that online communication makes it possible to recapture professionally satisfying relationships with patients.[41–42] For example, one physician has remarked,

> Rather than episodic interaction during hurried office visits, I now have continuous communication. I feel like Marcus Welby again.[42]

Those patients who have communicated online with clinicians have described generally positive experiences, as we have seen. Patients have noted that online communication allows them to open up and speak frankly in ways they cannot in person, for example, enhancing rather than diminishing their relationships with their physicians:

> "Using Email with Dr. Moore is more convenient. It's often difficult for me to explain things to him in person. This way, I can write out my thoughts and concerns more clearly. The ability to be more direct with my physician is important to me." Another of his patients concurred. "I'm not as cautious as I am when I'm with him face-to-face," she said. "(Sending an email) is actually more personable for me."[30]

Online communication undoubtedly has the potential to change the dynamics of patient-clinician interactions, and individual patients and clinicians will doubtless respond differently to changes they experience.[23–24,27] But just how online interaction affects patient-clinician relationships is an empirical question that is still unsettled. Much surely depends on the specific circumstances of individual clinicians and the patient populations they serve.

Voluntariness of Participation. Patients should always have the right to refuse to communicate online with clinicians, just as they can refuse to interact with clinicians in other ways. For the present, those clinicians who are concerned that communicating online will diminish the quality of their interactions with patients should be permitted not to engage in this mode of communication. It would not be inappropriate, however, for health care organizations to offer incentives to clinicians to participate. And, if and when benefit is clearly established, it would be reasonable for health care organizations to require them to do so in the interests of providing more efficient care overall.

As with any new technology, experience may show that some concerns do not materialize, or are not as acute as initially expected. Within VHA, for example, as clinicians have used CPRS (the computerized patient record system) and become more experienced in working with electronic medical records, their initially negative expectations have gradually been overcome.

At the same time, allowing patients and clinicians to choose individually whether they will communicate online runs the risk of creating two classes of patients. Thus care must be taken to assure that opting out of online communication does not diminish access to and/or quality of care.[23]

Informed Participation. Patients should be able to make well-considered decisions whether to communicate online with clinicians about health care concerns. Clinicians thus have an obligation to explain their online communication practices. This should include discussing the limitations of web messaging—for example, that messages will not be exchanged in real time (i.e., patients should *not* treat communication with clinicians as "instant messaging"), or that messaging cannot convey some potentially important kinds of information (such as tone of voice). Clinicians should also explain their offices' or their organizations' practices for handling messages, just as they would alert patients to telephone protocols. Current professional guidelines recommend that clinicians enter into an explicit agreement with patients, either orally or in writing, regarding the terms and conditions that will govern their online communication.[5,8,25] Guidelines differ somewhat in their details, but all stress the need for agreements that disclose privacy risks and describe security practices; explain how

messages will be handled, including whether and in what form messages will be incorporated into the medical record and/or archived, and any provisions for terminating the option of online communication.[8,5]

With respect to defining terms and conditions for online communication, the eRisk Working Group has gone so far as to recommend that clinicians "consider developing patient selection criteria to identify those patients suitable for e-mail correspondence, thus eliminating persons who would not be compliant."[25] However, without clear evidence about how many patients "abuse" online health communication, or whether the class of potential "abusers" can be rigorously characterized, such recommendations are at best premature. By proposing to disenfranchise some patients, rather than limit some kinds of interaction, this response to concerns about potentially inappropriate use of online communication seems ethically unwarranted.

Whether patients should be required to give signed informed consent to participate in online communication is a less settled matter, however. The AMA recommends that patients sign agreements regarding the terms of online communication, and that those agreements be documented in the medical record.[8,13] But while "it is imperative that patients be clearly informed about the range and limits of electronic communication tools," some commentators disagree that the formal (legal) doctrine of informed consent should be applied in this context:

> Certainly we do not require that a patient sign a consent form before engaging in a telephone conversation or a face-to-face office visit. Likewise, the creation of additional paperwork for already overburdened patients and physicians in the way of an "Internet or e-mail consent form" is not necessary.[40]

Boundaries of Online Professional Practice. The disembodied nature of online communication also poses challenges with regard to professional competence and quality of care. Broad standards are emerging with respect to what kinds of health concerns can be appropriately addressed via online communication and which clearly should only be handled by telephone or face to face.

First, it is generally agreed that the constraints of the online medium make it poorly suited to initiating a patient-clinician relationship. The initial encounter between a patient and a clinician, in which that relationship is established, differs in important ways from subsequent interactions. By the conventions of professional practice, for example, the first encounter involves a physical examination—the relationship begins with direct observation and touching of the patient's body that cannot be accomplished online.[31] Professional practice also relies on an interpersonal relationship, which is most effectively established through an initial face-to-face interaction.

Second, there is strong consensus that online communication is not a suitable channel when the subject is of an urgent nature.[8,25–26, 29] Online communications are also inappropriate for exchanging highly sensitive information.[8,5, 25,26] Even when electronic communication technologies provide secure environments that support synchronous exchanges,[41] there are still circumstances that demand real-time, face-to-face interactions, as when the clinician must deliver "bad news" to a patient whom he or she reasonably expects to need the support that an in-person encounter provides.

Third, clinicians (as well as patients) should use care in composing exchanges that are clear, coherent, and succinct to assure that parties understand one another. Rambling messages with poorly organized content, or that touch on many different topics; messages that are carelessly worded or contain many grammatically incorrect or incomplete sentences or typographical errors; or messages that omit important pieces of information (e.g., sender's name and contact information)

are particularly problematic in the clinical context.[5,8,25] Using templates to guide patients in composing messages can help to assure clinicians receive the information they need to respond appropriately.[43]

Fourth, clinicians and health care organizations should establish and follow written policies and procedures regarding patient-clinician messaging. These should specify, at a minimum, standards for access to messages, timeliness in responding to messages, acknowledging incoming messages, archiving and backing up messages, forwarding messages to third parties, and circumstances under which the option to use online communication may be withdrawn.

Fairness with Respect to Workload & Compensation. In addition to concerns about the impact on the intangible dimensions of patient-clinician relationships, surveys have indicated widespread concern that online communication will be burdensome, adding to the clinician's workload.[2] Importantly, this is linked to concerns that exchanging electronic communication will simply be one more activity for which clinicians will not be compensated by insurers and health plans.[2,17,24] The little evidence available suggests that the impact of online communication may not be as negative as clinicians fear—those who most actively communicate with patients online report that it has not proven burdensome and indicate overall satisfaction with the experience.[23] But there can be economies of scale at stake: in some situations, unless the majority of patients in a practice communicate online, reading and responding to patient email *can* add to the clinician's or practice's workload without significantly enhancing efficiency.[13] As we have noted, however, the empirical question of impact on practice is complex, involving not only whether patients and clinicians have effective access to online communication, but also the mix of patients in a given clinician's panel, individual patients' expectations and communication habits, etc. How deep an impact online communication will have on clinicians' workload remains uncertain at this time, and is likely to be quite variable.

To date, most clinicians have not been reimbursed for time spent handling patient email. Third-party payers are exploring different mechanisms, however, including direct reimbursement for online services and patient copays.[44,16–18] There is a growing body of evidence showing potential cost savings—Blue Shield of California, for example, has projected savings of $3 million per month once e-consultation becomes available to all of its members[22]—suggesting that third-party payers are increasingly likely to implement mechanisms to reimburse clinicians for their online interactions with patients.

When a health care organization permits or, especially, when it encourages online communication between patients and clinicians, fairness requires that the organization acknowledge the workload involved in the activity. Organizations should adopt performance measures or other mechanisms that credit online interactions in a manner that is reasonably comparable to recognition given face-to-face interactions, and should take care to apply those measures evenhandedly. For example, if communicating online with some patients increases a clinician's efficiency and effectiveness overall, he or she should be recognized and rewarded appropriately.

Many of these concerns are touched on in professional guidelines for online communication that have been adopted in recent years by a variety of organizations, including the American Medical Association[8] and the eRisk Working Group for Healthcare, a consortium of medical societies, professional liability insurance carriers, and state medical board representatives,[25] among others.[44–46]

Patient-Clinician Messaging in VA

VA has been at the forefront in adopting information technologies to transform how health care is delivered and to improve the quality of care. Its computerized patient record system, for

example, makes patients' medical records available to clinicians throughout the largest health care delivery system in the country.[7] In November 2003 VHA launched My HealtheVet, a multi-phase project to develop "a web-based application that creates a new, online environment where veterans, family, and clinicians may come together to optimize veterans health care."[12] By March 31, 2004 more than 18,000 veterans (including patients), VA employees, and care providers had registered for the service.[12]

When fully implemented, My HealtheVet will enable veterans to manage a variety of administrative functions (such as prescription refills or appointments), access their personal health records, self-enter data, and grant family members or others access to all or to specified portions of the veteran's health information. Access to the various functionalities of the My HealtheVet portal is conditioned on three levels of increasingly stringent registration: veteran self-registration (for access to general benefits information or educational resources), validation through a VA database (for prescription refills, etc.), and face-to-face validation at a VA facility (for access to the personal health record). In its final stages, My HealtheVet proposes to launch a secure web-messaging application to support online communication between patients and their VA clinicians.[2]

Within VA, My HealtheVet will provide the secure environment required for responsible online communication between patients and clinicians dealing with matters of diagnosis, prognosis, and treatment plan. By having both patient and clinician log on to a password-protected website to retrieve messages, secure web messaging overcomes the need for complex encryption protocols. My HealtheVet registration procedures will serve to authenticate the identity of patient-participants while clinicians are authenticated through VA's normal mechanisms for granting clinical privileges and access to computerized patient records. Moreover, the proposed requirement that participants register in person for access to My HealtheVet's messaging function will offer opportunities to educate patients about how to use online communication wisely, and to identify those individuals who may need assistance to do so effectively or for whom online communication may not be appropriate or prudent.

Historically, VA patients have often been disadvantaged. Veterans who seek care in VA are "older, sicker, [and] have less income and less insurance than the general population."[47-48] The average age of VA enrollees is sixty-three, and 48 percent of VA patients are over the age of sixty-five (compared to 12 percent of the general population).[47] Some 28 percent of VA patients have annual incomes below $26,000; 15 percent have no health insurance.[47] The demographic profile of VA patients is changing as the overall veteran population changes, with rising numbers of younger, better educated, socioeconomically better off veterans,[49] but there is still a significant segment of VA's patient population who may not embrace or be well positioned to participate in online communication with clinicians. In addition, online communication is likely to be inappropriate for some defined patient populations whose numbers are projected to increase substantially over the next fifteen to twenty years, such as individuals with dementia.[50] This again argues for attention to assuring that efforts to encourage online communication do not disadvantage these patients.

Recommendations for the Ethical Practice of Online Patient-Clinician Messaging

Online communication is becoming a significant channel for interaction between patients and clinicians. If online patient-clinician communication is to serve patients' interests well, health care organizations and individual clinicians must be sensitive potential ethical pitfalls of online communication. VHA's National Ethics Committee makes the following recommendations to assure ethically sound online communication between patients and clinicians:

(1) **Clinicians and health care organizations should ensure that online communication takes place only when the confidentiality and security of personal health information can be reasonably assured**. Once implemented nationally, My HealtheVet will provide the foundation for a secure environment required for responsible online communication between patients and clinicians.

(2) **Clinicians should ensure that patients who do not interact electronically receive the same quality of care as their online peers.** Online communication should not be allowed to exacerbate existing inequalities in health care by discriminating against those who have no or limited access to online communication.

(3) **Clinicians should be aware of the potential effects of online messaging on the patient-clinician relationship and take steps to avoid "depersonalization."** Just how online interaction affects patient-clinician relationships is an empirical question that is still unsettled.

(4) **Participation in online messaging should be voluntary for both patients and clinicians.** As VHA gains more experience with this medium, requiring clinician participation may some day be justified. However, patient participation should remain voluntary.

(5) **Clinicians should assure that patient participation in online communication is well informed.** Clinicians should enter into an explicit agreement with patients, either orally or in writing, regarding the terms and conditions that will govern their online communication. However, there is no need to require patients to sign an informed consent form.

(6) **Clinicians should limit their online communication with patients to appropriate uses.** Online communication should not be used to initiate a patient-clinician relationship, to handle situations of an urgent nature, or to convey information that is highly sensitive. Messages should be carefully worded and organized to ensure effective communication, and should conform to organizational standards with regard to message handling.

(7) **Health care organizations should recognize online interactions with patients as part of clinicians' professional activities in institutionally appropriate ways.** This may be accomplished, for example, by formally scheduling time for messaging, or by adopting the recently proposed AMA CPT code for online evaluation and management of patients[54] to capture data regarding online patient communication, evaluation, and management as a professional clinical activity.

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Committee Members: Arthur Derse, MD, JD (Chair); Linda Belton, RN, CNAA, CHE; Michael D. Cantor, MD, JD; Jeannette Chirico-Post, MD; Jeni Cook, DMin; Sharon P. Douglas, MD; Ginny Miller Hamm, JD; Kathleen A. Heaphy, JD; Judy Ozuna, ARNP, MN, CNRN; Peter Nim Kwok Poon, JD, MA; Cathy Rick, RN, CNAA, CHE; Randy Taylor, PhD; Ladislav Volicer, MD, PhD

Ex Officio: Ellen Fox, MD

Consultant to the Committee: Michael J. O'Rourke

Staff to the Committee: Bette-Jane Crigger, PhD; Leland Saunders, MA

Director, National Center for Ethics in Health Care: Ellen Fox, MD

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Beth Acker, OIFO, Bay Pines VAMC
Gary Christopherson, Senior Advisor to the Under Secretary for Health
Curtis Clayton, Clinical Informatics Manager, VISN 1
Charlotte Depew, Nurse Practitioner, Minneapolis VAMC
Elizabeth Franchi, IA DQ Coordinator (VHA), Milwaukee VAMC
Gail Graham, Director, Health Information Management (VACO)
Nancy L. Howard, Deputy Director, Office of Compliance & Business Integrity (VACO)
Odette Levesque, Clinical/QA Liaison (VACO)
Linda Nugent, Director, Health Information Management, Bay Pines VAMC
Jeff Oak, Director, Office of Compliance & Business Integrity (VACO)
Robert Petzel, Director, VISN 23
Ginger Price, Deputy ACIO, Enterprise Strategy (VACO)
Stephania Putt, VHA Privacy Officer
Daniel Z. Sands, Center for Clinical Computing, Beth Israel Deaconess Medical Center, Boston; Harvard Medical School, Cambridge