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Message Deleted? Resolving Physician-Patient E-mail through Contract Law

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PROFESSIONAL PAPER

**MESSAGE DELETED? RESOLVING
PHYSICIAN-PATIENT E-MAIL
THROUGH CONTRACT LAW**

MICHAEL A. McCANN*

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MESSAGE DELETED? RESOLVING PHYSICIAN-PATIENT E-MAIL THROUGH CONTRACT LAW

MICHAEL A. MCCANN

This article examines the impact of e-mail on the physician-patient relationship, and how contract law can resolve the uncertainties incumbent in this nascent form of communication. Indeed, courts have yet to indicate when the physician-patient relationship begins by e-mail, or to what extent e-mail affects the duties of the relationship. Instead of waiting for judicial guidance, physicians and patients can employ specialized contracts to clarify the role that e-mail plays in their relationship. As a result, more physicians and patients will regard e-mail correspondence as a valuable means of communication, and a tool for improving the quality of health care as well.

I. INTRODUCTION

The physician-patient relationship has remained largely intact over the past 2500 years. Recent advancements in technology, however, may test its rigidity. Indeed, the advent of e-mail communication between physicians and patients has raised new questions about traditional duties. Communication between physicians and patients has entered uncharted waters, and e-mail will surely challenge both the scope and predictability of the physician-patient relationship.

For some, physician-patient e-mail will mark a new and improved era of communication. The potential benefits are numerous, and studies consistently indicate that the vast majority of patients would like to e-mail their physicians. Moreover, physician-patient e-mail may enable physicians to receive critical information more readily, in addition to serving as a new tool for disseminating medical knowledge. For patients, e-mail may prove empowering, as it will allow direct and instantaneous communication with their physicians. Such a prospect seems particularly appealing when compared to present day inconveniences like sitting in uncomfortable waiting rooms or engaging in awkward phone conversations. Along these lines, e-mail may enhance patient convenience, as patients may directly obtain test results from any location and may schedule or cancel appointments with the click of a mouse.

On the other hand, both patients and physicians may encounter several drawbacks in this new communication arrangement. For one, a patient may misinterpret information provided in an e-mail, particularly since most medical text exceeds the comprehension of lay people. In addition, should physicians prefer to link their patients to commercialized health websites rather than expend energy typing detailed e-mails, patients may feel overwhelmed, if not ill-informed by what they read. Finally, employers may be able to read patient-physician e-mails, which, in some instances could adversely affect those patients' professional opportunities.

Physicians also encounter a mixed bag of benefits and detriments by e-mailing patients. At first blush, the advantages appear quite appealing. Most apparently, e-mail avoids the "telephone tag" and voice-mail messaging inherent in telephone communications. This benefit seems particularly helpful for administrative activities, such as rescheduling appointments and refilling prescriptions. Second, physician-patient e-mail enables physicians to clarify advice or to direct the patient to helpful resources on the Internet. Third, physicians may receive more information by e-mail than by in-person consultations, thus reducing the necessity of back-and-forth conversations. Fourth, physicians can respond to e-mail messages at their own convenience, and thus decrease the amount of time spent answering patients' questions by telephone. Fifth, e-mailed communications facilitate improved record keeping, particularly when compared with easily lost handwritten notes. Sixth, e-mail correspondence may help physicians identify troublesome symptoms from those patients who avoid seeing the doctor—the risk-prone patients. Lastly, physicians may have an economic incentive to employ e-mail, particularly since most patients express a willingness to pay for this capability.

Despite this seemingly extensive list of advantages, physicians may also confront a number of drawbacks when e-mailing patients. Less than one-third of physicians e-mail their patients, even though over 90% of physicians use the Internet. One may deduce that the detriments outweigh the benefits.

As a foremost drawback, the law has not yet indicated when the physician-patient relationship begins by e-mail, or to what extent e-mail affects the duties of the relationship. Although parallels to phone conversations can be drawn, this analogy may not be exact. This is particularly true in the context of e-mails to out-of-state patients, where the notion of "minimal contacts" proves relevant. Along these lines, physicians must be wary of interstate e-mails, since a number of states have already banned electronic consultations. This Article also

incorporates the experiences of “radio” and “television” physicians to help navigate through issues concerning the formation of the physician-patient relationship. Second, though e-mail may prove an efficient means of organizing medical records, physicians must be careful to preserve their confidentiality. Indeed, the burden is on the physician to ensure that e-mails are not intercepted or lost, and the recently enacted *Health Insurance Portability and Accountability Act*, which stiffens rules and penalties for breaking those rules, only heightens this burden. E-mails can also serve as medical records in medical malpractice suits, thus countering whatever organizational benefit they provide. Third, because the standard of practice for physician-patient e-mail does not yet exist, physicians lack guidance on how frequently they should check and reply to patient e-mails.

Although worrisome, the legal drawbacks to physician-patient e-mail may prove secondary to more everyday considerations. First, most healthcare companies do not reimburse physicians for e-mails to patients. Second, many physicians find human interaction vital to their occupation and prefer it to electronic interaction, particularly when e-mails can take much longer to draft than it would take to hold phone or personal conversations. Third, some posit cultural barriers to physician e-mails—namely, that physicians simply prefer to handwrite notes than to type e-mails. Therein lies the fourth and, perhaps, underlying barrier to physician-patient e-mail: many physicians do not type nearly as well as they speak.

In examining the impact of e-mail on the physician-patient relationship, this Article begins with a cultural and legal history of the relationship, followed by a discussion on the rising usage of Internet and e-mail facilities by patients and their physicians. This Article then surveys the advantages and disadvantages of physician-patient e-mail, first from the standpoint of patients, and then from the perspective of physicians. Finally, this Article suggests that specialized contracts may prove helpful when resolving uncertainties incumbent in this form of communication.

II. A LEGAL PRIMER FOR THE PHYSICIAN-PATIENT RELATIONSHIP

A. HISTORICAL EVOLUTION

Expectations surrounding physician-patient relationships date back over two millennia, when Hammurabi, leader of Babylon from 1792 to 1750 BC, developed what is often regarded as mankind's first legal system. The "Code of Hammurabi" consisted of 300 laws that were inscribed onto an eight-foot-high stone pillar. Most significantly, the Code marked the first time "stipulated law" governed instead of custom or tradition.¹ Central to the Code was the notion of just punishment, whereby the degree of punishment inflicted would attempt to equate the degree of harm caused. Laws pertaining to patient care vividly evidenced this principal. Specifically, if an unskilled physician harmed one of his patients, his hands were usually cut off, or, less often, he was executed.²

Over a thousand years later, Hippocrates, a Greek physician in fifth century BC, developed the "Hippocratic oath," which required each new physician to declare, "I will follow that system or regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous."³ As a result, physicians were called upon to show respect, integrity, and compassion when working with patients.⁴

In modern times, the principal rationales for the physician-patient relationship appear unchanged. For instance, in *Cobbs v. Grant*,⁵ the Supreme Court of California identified four reasons for imposing certain obligations on a physician who undertakes the care of a patient:

The first is that patients are generally persons unlearned in the medical sciences and therefore, except in rare cases, courts may safely assume the knowledge of patient and physician are not in parity;

1 William H. Rodgers, *Where Environmental Law And Biology Meet: Of Pandas' Thumbs, Statutory Sleepers, and Effective Law*, 65 U. COLO. L. REV. 25, 33 (1993).

2 Charles F. Horne, *The Code of Hammurabi: Introduction* (1915), available at <http://www.fordham.edu/halsall/ancient/hamcode.html#horne> (last visited Dec. 21, 2002); see also *Code of Hammurabi* (L. W. King trans. 1915), available at <http://www.lawresearch.com/v2/codeham.htm> (last visited Dec. 21, 2002).

3 *Hippocratic Oath*, at <http://scs.student.virginia.edu/~alphaed/hippo.htm> (last visited Dec. 21, 2002).

4 Jennifer Wang, *White Coats, New Obligations*, HOUS. CHRON., Aug. 17, 1996, at 37.

5 502 P.2d 1 (Cal. 1972).

The second is that a person of adult years and in sound mind has the right, in the exercise of control over his own body, to determine whether or not to submit to lawful medical treatment;

The third is that the patient's consent to treatment, to be effective, must be an informed consent;

[T]he fourth is that the patient, being unlearned in medical sciences, has an abject dependence upon and trust in his physician for the information upon which he relies during the decisional process, thus raising an obligation in the physician that transcends arms-length transactions.⁶

Although its rationales have remained largely constant, the physician-patient relationship has become manifest in more contemporary applications. Rather than standardizing the terms of the relationship with a national law, as found in ancient Greece or Babylon, individual states now govern the physician-patient relationship. This is not surprising, since medical practice is generally regulated by each state. The Tenth Amendment did not extend to Congress the power to regulate the health professions.⁷ Moreover, the physician-patient relationship was not recognized in common law, thus easing the way for states to determine their own set of physician-patient standards.⁸ The first state to do was New York, in 1828.⁹

The power of states to determine their own standards for medical practice has been challenged and consistently upheld. For instance, in *Dent v. West Virginia*,¹⁰ the Supreme Court upheld a state's right to establish standards for medical practice, including licensure restrictions.¹¹ Likewise, in *Hawker v. New York*,¹² where a state law regulating public health was contested, the Court held, "it is clear that legislation which simply defines the qualifications of one who attempts to practice medicine is a proper exercise of that power."¹³ Similarly,

6 *Id.* at 9.

7 U.S. CONST. amend. X; see also Ross D. Silverman, *The Changing Face of Law and Medicine in the New Millennium*, 26 AM. J.L. & MED. 255, 256 (2000) (describing the importance of the 10th Amendment in the context of medicine).

8 Erica Smith-Klocek, *A Halachic Perspective on the Parent-Child Privilege*, 39 CATH. LAW. 105, 112 (1999).

9 *Id.* (citing 2 N.Y. Rev. Stat. 1828, 406 (pt. 3, c. 7, art. 9, § 73)).

10 129 U.S. 114 (1889).

11 *Id.* at 123.

12 170 U.S. 189 (1898).

13 *Id.* at 193.

the U.S. Court of Appeals for the Fourth Circuit, in *Bryan v. Rectors & Visitors of the University of Virginia*,¹⁴ reaffirmed that state law regulates the standards for the physician-patient relationship.¹⁵

B. CONTRACT FOR CARE

For the most part, the physician-patient relationship is now viewed as a contractual agreement, created by either express or implied consent between the parties.¹⁶ The “contract” typically requires the physician to provide non-negligent care, both in diagnosis and treatment, and in accordance with the prevailing professional standard. To illustrate this point, the Supreme Court of Kansas held, “a physician is obligated to his patient under the law to use reasonable and ordinary care and diligence in the treatment of cases he undertakes, to use his best judgment, and to exercise that reasonable degree of learning, skill, and experience which is ordinarily possessed by other physicians....”¹⁷ At the same time, the physician-patient relationship does not guarantee the patient successful treatment; it guarantees only that the physician will use proper care.¹⁸

If a patient believes that her physician has violated this contract, she may bring a malpractice suit for damages resulting from the physician’s negligence. The patient has the burden to demonstrate the existence of a physician-patient relationship.¹⁹ Most medical malpractice claims sound in tort, rather than contract,²⁰ yet without a physician-patient relationship, a physician cannot be held liable for malpractice.²¹ Indeed, the existence of malpractice presumes the existence of a duty of care, which itself is dependent on the existence of a physician-patient relationship.²² The duty of care for a physician is

14 95 F.3d 349 (4th Cir. 1996).

15 *Id.* at 351.

16 Sharon M. Glenn, *Liability in the Absence of a Traditional Physician-Patient Relationship: What Every “On Call” Doctor Should Know*, 28 WAKE FOREST L. REV. 747, 753 (1993).

17 *Durflinger v. Artilles*, 673 P.2d 86, 92 (Kan. 1983).

18 *See, e.g., Galloway v. Lawrence*, 145 S.E.2d 861 (N.C. 1966) (holding that a physician cannot be held liable unless he was negligent or did not possess the degree of professional knowledge and skill had by others in his specialty); *Koury v. Follo*, 158 S.E.2d 548, 554 (N.C. 1968) (finding that not even a specialist in a particular field can guarantee the success of his treatment).

19 *See, e.g., Doherty v. Hellman*, 547 N.E.2d 931 (Mass. 1989).

20 *See Glenn, supra* note 16, at 752 (citing KEITH S. FINEBERG ET AL., *OBSTETRICS/GYNECOLOGY AND THE LAW* 77 (1984)).

21 *See e.g., St. John v. Pope*, 901 S.W.2d 420, 423 (Tex. 1995).

22 *See, e.g., Reynolds v. Decatur Mem’l Hosp.*, 660 N.E.2d 235, 238-39 (Ill. App. Ct. 1996) (limiting the duty of a physician to situations where there is a physician-patient relationship); *McKinney v. Schlatter*, 692 N.E.2d 1045, 1047-51 (Ohio Ct. App. 1997) (ruling that a court cannot find that a physician breached her

similar to that for a lawyer.²³ Specifically, the patient must demonstrate that the physician owed her a duty of care, the duty was not satisfied, and a breach of duty resulted, which itself generated an avoidable injury.²⁴

Therefore, determining the existence of a physician-patient relationship is the first step in analyzing physician liability arising from communication with patients. Although creation of the relationship is a question of fact for the jury,²⁵ it typically arises when a person seeks the medical services of a physician and the physician affirmatively agrees to provide care.²⁶ Importantly, courts usually require clear signals by the physician that she has assented to this arrangement.²⁷ For instance, the Court of Appeals of New York positions the moment of creation at the instant when “a physician, by taking charge of a case, represents that he will use reasonable care and his best judgment in exercising his skills.”²⁸

Although most courts recognize that a physician-patient relationship is established as soon as the physician commences treatment of the patient, a minority of courts has required additional steps. For instance, a Connecticut court recently stipulated that the patient must rely upon the advice before a relationship is triggered.²⁹

duty where no physician-patient relationship exists).

23 Matthew L. Howard, *Physician-Patient Relationship*, 25 ARCHIVES OF OTOLARYNGOLOGY – HEAD & NECK SURGERY 471 (1999).

24 Kirk v. Michael Reese Hosp. & Med. Cent., 513 N.E.2d 387, 395-96 (Ill. 1987).

25 See, e.g., Lyons v. Grether, 239 S.E.2d 103, 105 (Va. 1997) (holding that in Virginia, whether a physician-patient relationship is created is a question of fact, turning upon a determination whether the patient entrusted his treatment to the physician and the physician accepted the case); see also Dodd-Anderson v. Stevens, 905 F. Supp. 937, 944 (D. Kan. 1995), *aff'd* 107 F.3d 20 (10th Cir. 1997) (holding that in Kansas, the existence of a physician-patient relationship is a question of fact); Walker v. Jack Eckerd Corp., 434 S.E.2d 63, 69 (Ga. Ct. App. 1993) (holding that in Georgia, existence of physician-patient relationship is question of fact for jury); Gallion v. Woytassek, 504 N.W.2d 76, 80 (Neb. 1993) (holding that in Nebraska, it is within the purview of the jury to determine whether physician-patient relationship exists); Cogswell v. Chapman, 672 N.Y.S.2d 460 (N.Y. App. Div. 1998) (holding that in New York, it is generally a question of fact for the jury whether an implied physician-patient relationship exists); Tumblin v. Ball-Incon Glass Packaging, 478 S.E.2d 81, 85 (S.C. Ct. App. 1996) (holding that in South Carolina, existence of physician-patient relationship is question of fact for the jury).

26 Howard, *supra* note 23, at 236.

27 See, e.g., Adams v. Via Christi Reg'l Med. Cent., 19 P.3d 132, 140 (Kan. 2001) (holding that “the doctor must take some affirmative action with regard to treatment of a patient in order for the relationship to be established”).

28 Pike v. Honsinger, 49 N.E. 760, 762 (N.Y. 1898).

29 Dugan v. Mobile Med. Testing Servs., 2001 Conn. Super. LEXIS 2617, at *7-*8 (Conn. Super. Ct. Sep 12, 2001) (emphasis added); *but see* Wehrman v. United States, 648 F. Supp. 386, 396 (D. Minn 1986) (suggesting that reliance is a wholly separate analysis from formation of the physician-patient relationship,

For the most part, however, reliance by the patient is not required for formation of the relationship; instead, a simple affirmative act on the part of the physician to provide medical advice usually suffices.

Assessing whether a physician's particular action qualifies as "affirmative," however, can prove contentious. Generally, courts require some form of explicit communication between the physician and the patient for an act to be considered affirmative. The requisite communication traditionally arises when the physician personally examines the patient.³⁰

In recent years, however, courts have recognized a physician-patient relationship in the absence of any personal contact between the physician and patient. This "secondary contact" often evolves when one physician consults another physician about a patient. As soon as the "consulting physician" posits an opinion, he creates a physician-patient relationship.³¹ Some specialists, such as pathologists or radiologists, are particularly affected by secondary conduct, for they often serve as consulting physicians yet rarely speak with or even see the actual patients.³²

To justify extending the physician-patient relationship to consulting physicians, courts frequently emphasize contractual obligations. For instance, in *Corbet v. McKinney*,³³ a Missouri appellate court held, "where the consultant physician does not physically examine or bill the patient, a physician-patient relationship can still arise where the physician is contractually obligated to provide assistance in the patient's diagnosis or treatment and does so."³⁴ Even when a consulting physician appears several degrees removed from the patient, courts will often highlight contractual obligations in order to identify a physician-patient relationship. To illustrate this point, in *Hand v. Tavera*,³⁵ a physician's contract with a hospital triggered a physician-patient relationship simply because the hospital had a

"[a]bsent a ... physician-patient relationship, plaintiff's reliance on the continuing treatment doctrine is simply misplaced").

30 See *Irvin v. Smith*, 31 P.3d 934, 941 (Kan. 2001).

31 See, e.g., *Lee v. City of New York*, 560 N.Y.S.2d 700, 701 (N.Y. App. Div. 1990) (finding that a physician-patient relationship "is created when the professional services of a physician are rendered to and accepted by another person for the purposes of medical or surgical treatment").

32 See, e.g., *Schrader v. Kohout*, 522 S.E.2d 19, 23 (Ga. Ct. App. 1999); see also *Bovara v. St. Francis Hosp.*, 700 N.E.2d 143, 146-47 (Ill. App. Ct. 1998); *Dougherty v. Gifford*, 826 S.W.2d 668, 674-75 (Tex. App. 1992); *Peterson v. St. Cloud Hosp.*, 460 N.W.2d 635, 638 (Minn. Ct. App. 1990); *Phillips v. Good Samaritan Hosp.*, 416 N.E.2d 646 (Ohio Ct. App. 1979).

33 980 S.W.2d 166 (Mo. Ct. App. 1998).

34 *Id.* at 169.

35 864 S.W.2d 678 (Tex. App. 1993).

contract with the patient's healthcare plan. Furthermore, a simple contractual obligation to be on call may give rise to a physician-patient relationship.³⁶

Not all courts have freely inferred a relationship between a consulting physician and patient, however. For instance, a Michigan appellate court found that, "merely listening to another physician's description of a patient's problem and offering a professional opinion regarding the proper course of treatment is not enough. Under those circumstances, a doctor is not agreeing to enter into a contract with the patient. Instead, she is simply offering informal assistance to a colleague."³⁷ Along these lines, an Indiana court identified the patient, rather than the physicians' contractual obligations, as the determining factor: "The important fact in determining whether the relationship is a consensual one, however, is not who contracted for the service but whether it was contracted for with the express or implied consent of the patient or for his benefit."³⁸ On balance, however, courts evince a willingness to find a physician-patient relationship between a consulting physician and a patient even when the consulting physician's involvement appears minimal.

C. DUTIES OF CARE

Once formed, the physician-patient relationship imposes several fiduciary duties on the physician. Those duties include confidentiality, informed consent, and continued treatment even after the relationship ends.

A physician is ethically obligated under state law to refrain from disclosing information obtained through the physician-patient relationship,³⁹ but this rule is not absolute. In fact, the Supreme Court

36 See, e.g., *Lecton v. Dyll*, 65 S.W.3d 696 (Tex. App. 2001) (reasoning that an on-call physician has contractually agreed to a physician-patient relationship with those whom he involves himself with while on call, whether the involvement be substantial or not); see also *McKinney v. Schlatter*, 692 N.E.2d 1045, 1050-51 (Ohio Ct. App. 1997) (finding a physician-patient relationship between an emergency room patient and an on call physician who had been consulted by the emergency room physician over the phone and had participated in the diagnosis and treatment of the patient); but see *Lownsbury v. VanBuren*, 762 N.E.2d 354, 362 (Ohio 2002) (declaring, "even where an on-call physician is contractually obligated to perform the services at issue, the physician-patient relationship cannot be established unless it appears that the physician was actively involved in caring for the patient").

37 *Oja v. Kin*, 581 N.W.2d 739, 743 (Mich. Ct. App. 1995).

38 *Walters v. Rinker*, 520 N.E.2d 468, 472 (Ind. Ct. App. 1988).

39 See, e.g., *Saur v. Probes*, 476 N.W.2d 496, 498 (Mich. Ct. App. 1991) (citing a violation of the Michigan Public Health Code, MICH. COMP. LAWS § 333.16221 (2002)). See generally *Judy E. Zelin, Physician's Tort Liability for Unauthorized Disclosure of Confidential Information about Patient*, 48 A.L.R.4th 668

of Ohio declared, “in the absence of prior authorization, a physician or hospital is privileged to disclose otherwise confidential information . . . where disclosure is necessary to protect or further a countervailing interest which outweighs the patient’s interest in confidentiality.”⁴⁰ Along these lines, payers, consulting physicians, and other health care workers may review a patient’s record.⁴¹ Should those professionals obtain access, they too become bound by the duty of confidentiality. For instance, in *Wakeford v. Rodehouse Restaurants of Missouri, Inc.*,⁴² a rehabilitation counselor, who had access to the confidences of the patient and his treating physician, was bound by the duty of confidentiality.⁴³

The physician-patient relationship also imposes a duty on the physician to inform the patient of treatment options, thereby enabling the patient to make an informed choice. This duty is premised on the notion that, “each man is considered master of his own body . . . the law will not allow a physician to substitute his own judgment, now matter how well founded, for that of his patient.”⁴⁴ The duty to disclose has generally been limited to “material information,” which has been defined as, “that which the physician knows or should know would be regarded as significant by a reasonable person in the patient’s position when deciding to accept or reject the recommended medical procedure.”⁴⁵ As an example of materiality, the U.S. Court of Appeals for the Eighth Circuit considered the consequences of an ovary removal to be material, thereby obliging the physician to disclose that information.⁴⁶

A physician must also ensure that treatment continues until the relationship ends, and even at that time, certain obligations remain. Courts have broadly extended the duration of the physician-patient relationship.⁴⁷ Surgeons, for instance, are required to continue caring for their patients until the threat of post-operative complication is

(2002).

40 Biddle v. Warren Gen. Hosp., 715 N.E.2d 518, 524 (Ohio 1999).

41 See Alyssa R. Spielberg, *On Call and Online*, 280 JAMA 1353, 1355

(1998).

42 584 N.E.2d 963 (Ill. App. Ct. 1991).

43 *Id.* at 973.

44 Collins v. Itoh, 503 P.2d 36, 40 (Mont. 1972) (citing Natanson v. Kline, 350 P.2d 1093, 1104 (Kan. 1960)).

45 Sard v. Hardy, 379 A.2d 1014, 1022 (Md. 1977).

46 Roberts v. Francis, 128 F.3d 647 (8th Cir. 1997).

47 See, e.g., Dashiell v. Griffith, 35 A. 1094, 1096 (Md. 1896) (holding that “when a physician is employed to attend upon a sick person, his employment as well as the relation of physician and patient continues, in the absence of a stipulation to the contrary, as long as attention is required, and the physician or surgeon must exercise reasonable care in determining when the attendance may be properly and safely discontinued”).

past.⁴⁸ Even if a patient fires a physician, that physician can nevertheless be found liable for failing to safeguard the former patient's health. To illustrate this point, in *Turner v. Children's Hospital, Inc.*,⁴⁹ an Ohio appeals court imposed liability on a physician for neglecting to disclose a DPT contraindication to a patient who had already terminated the physician-patient relationship. Despite the fact that the relationship had ended, the court explicitly extended the physician's duty of care to provide "whatever services are accepted in the medical profession to safeguard the patient's health."⁵⁰

Although the physician-patient relationship arises contractually, public policy considerations typically preclude physicians and patients from negotiating over a physician's duties of care. For instance, in *Sanchez v. Sirmons*,⁵¹ a New York court voided a contract clause between a physician and patient that had eliminated the patient's right to a jury trial. Most reprehensible to the court, the physician had asked the patient to sign the waiver only a few hours prior to surgery.⁵²

On the other hand, a physician may restrict the scope and terms of her employment. For instance, a physician may contractually restrict her specialty, scope of practice, geographic area, and work hours.⁵³ To illustrate this point, in *Adams v. Commissioner*,⁵⁴ a group of private physicians were allowed to contractually limit their work hours to nighttime and early morning shifts. In an equally revealing case, the Texas Court of Appeals found that an on-call physician had created a physician-patient relationship by the terms of his employment, and the court emphasized that the physician's contract did not require him to treat all persons who were in need of medical attention.⁵⁵ As Part IV of this Article demonstrates, physicians can also use contracts to enhance

48 See, e.g., *Longman v. Jasiek*, 414 N.E.2d 520 (Ill. App. Ct. 1980), *appeal denied* 83 Ill. 2d 570 (Ill. 1981).

49 602 N.E.2d 423 (Ohio Ct. App. 1991).

50 *Id.* at 432.

51 467 N.Y.S.2d 757, 761 (1983).

52 *Id.* at 761.

53 Glenn, *supra* note 16 (citing BARRY R. FURROW ET AL., LIABILITY AND QUALITY ISSUES IN HEALTH CARE 284, 285 (1991); see also *Adams v. Comm'r*, 71 T.C. 477, 481 (1978) (finding that interns and residents who perform valuable services for hospitals may simultaneously receive training in a specialty).

54 71 T.C. 477, 481 (1978); see also *Overstreet v. Doctors Hosp.*, 237 S.E.2d 213, 214 (Ga. Ct. App. 1977) (noting that an emergency room physician had contracted to provide 24-hour staffing).

55 *Fought v. Solce*, 821 S.W.2d 218, 220 (noting that "the relationship of physician and patient is contractual and wholly voluntary... [therefore] a physician is not to be held liable for arbitrarily refusing to respond to a call of a person even urgently in need of medical or surgical assistance provided that the relation of physician and patient does not exist at the time the call is made or at the time the person presents himself for treatment").

the functionality—and appeal—of e-mail communications with patients.

III. EVALUATING THE SCOPE OF ONLINE USAGE BY PATIENTS & PHYSICIANS

A. INTERNET EXPLORATION

For an increasing portion of Americans, the Internet has become an important means of exchanging information. In fact, according to a recent report released by the U.S. Commerce Department, the number of Americans using the Internet reached 143 million in September, 2002, or 54% of the population.⁵⁶ Remarkably, this figure represents a 26% increase in usage over the past two years, exceeding several private-sector projections.⁵⁷ These figures largely mirror trends of Internet usage seen during the later portion of the 1990s: 43 million Americans were online in 1997, 65 million in 1998, and 100 million in 1999.⁵⁸

No doubt contributing to the increase in its usage, the Internet has become a convenient tool for conducting a variety of research pursuits, including health research. It is estimated that 75% of Americans between the ages of fifteen and twenty-four used the Internet for health research in 2001, surpassing the 72% who downloaded music and the 67% who participated in chat rooms.⁵⁹ This phenomenon appears in Internet users of all ages. In 2001, 98 million Americans used the Internet to find health information, up from 54 million in 1999.⁶⁰ According to several studies, health-oriented web surfers most frequently use the Internet to find preliminary information

⁵⁶ Marina Mello, *U.S. Web Usage Reaches 54 Percent*, BLOOMBERG NEWS SERVICE, Feb. 4, 2002, available at LEXIS, News Library.

⁵⁷ See Silverman, *supra* note 7, at 259 (mentioning that Nielsen/Net Ratings claimed that only 115.2 million Americans were using the Internet by October 2001).

⁵⁸ *Id.*

⁵⁹ See *Health-Internet: 75% of Young Web Users Seek Health Info Online*, AM. HEALTH LINE, Dec. 12, 2001, available at LEXIS, News Library (citing the Kaiser Family Foundation poll); see also *Generation Rx.com: How Young People Use the Internet for Health Information*, available at <http://www.kff.org/content/2001/20011211a/> (last visited Dec. 21, 2002).

⁶⁰ See Angela Allen, *On the Table: Navigate to Nutrition Nuggets on the Internet*, COLUMBIAN (Washington, VA), Feb. 13, 2001, § Food, at 1 (citing 1 HARRIS INTERACTIVE HEALTH CARE NEWS 5 (2001), available at <http://www.harrisinteractive.com/news/allnewsbydate.asp?NewsID=225>). But see Silverman, *supra* note 7, at 259 (claiming that as many as 70 million Americans used the Internet to search for health information in 1999).

prior to consulting a physician; to read more about their diagnoses;⁶¹ to examine reports on the course of diseases; to buy vitamins; and to download fat-free recipes.⁶² Noticeably, these studies do not indicate e-mailing physicians as a primary use.

As with the larger population, more physicians discover the Internet each day. One study estimates that over 90% of physicians were online by February 2001, and more than half used the Internet on a daily basis;⁶³ another study reveals a startling 875% increase in physician Internet usage from 1997 to 1998.⁶⁴ Similarly, more physicians are using the Internet while at work: it is estimated that usage in the area of clinical work rose from 34 to 40% between 1999 and 2000, and use in physicians' offices grew from 51 to 56%.⁶⁵ Likewise, 85% of physicians use at least one Internet application in their practice.⁶⁶

Online medical usage provides a number of benefits to physicians. Among them is the ease with which physicians can locate medical information. According to MD Consult,⁶⁷ an online clinical information service used by physicians and other health professionals, 90% of its users indicate that "it was frequently impractical to research

61 See Silverman, *supra* note 7, at 260.

62 See Leah Beth Ward, *Web Plays Huge Role As Health Adviser*, DALLAS MORNING NEWS, Nov. 27, 2000, at D1.

63 See *New Survey finds that Medical Information Service Significantly Improves Physicians' Ability to Resolve Patient Care Questions*, BUS. WIRE, Mar. 5, 2002, § Healthwire.

64 See Michael Stroh, *Online Medicine: The Doctor is In and The Jury is Out*, BALT. SUN, June 23, 1999, at C03 (citing study conducted by the Healthcon Corporation). Likewise, the American Medical Association found that 70% of physicians used the Internet during 2000, up from 20% in 1997. *AMA Survey: Physician Internet Use Jumps*, HEALTH DATA MANAGEMENT (May 9, 2001), available at <http://www.healthdatamanagement.com/html/ExpertStory.cfm?DID=5704> (last visited Dec. 21, 2002).

65 See *New Survey finds that Medical Information Service Significantly Improves Physicians' Ability to Resolve Patient Care Questions*, *supra* note 63.

66 See *Doctors Accepting Technology, with Reservation*, AM. HEALTH LINE, May 9, 2001, § Health-Internet, available at LEXIS, News Library (citing Health Technology Center study).

67 Formed in 1996, MD Consult (www.mdconsult.com) helps physicians answer clinical questions and stay abreast of recent developments online. MD Consult claims that it is accessed by more than 250,000 health professionals, and over 1,000 health care organizations, including more than 90% of the nation's medical schools, under paid subscription plans. Each month, subscribers conduct more than 1.5 million information searches using the service, primarily during daytime practice hours. MD Consult delivers 40 medical reference books, full-text articles from more than 50 influential medical journals, MEDLINE and other databases, more than 600 peer-reviewed clinical practice guidelines, a comprehensive drug database that provides prescribing information for over 30,000 medications, more than 3,500 customizable patient education handouts, and a suite of features which identify and report current developments in medicine. MD Consult is part of Elsevier Science.

clinical questions as they would have liked using traditional means” and 66% believe that non-Internet information sources (i.e. medical journal literature) are inferior to the Internet in providing current medical news.⁶⁸

A second advantage concerns the amount of research time saved by using the Internet. In the MD Consult survey, 70% of physicians surveyed reported that it takes them less than ten minutes on the Internet to find what takes up to 24 hours in medical journals; on a weekly basis, the Internet saves physicians an average of 1-3 hours.⁶⁹

Perhaps most importantly, physicians view the Internet as an *effective* method of finding information. A 2001 study conducted by the American Medical Association reaffirms this finding, revealing that 86% of physicians describe the Internet as useful in obtaining medical information.⁷⁰ Likewise, 55% of physicians in another study agreed that the Internet has “reduced medication errors.”⁷¹

B. E-MAIL USAGE

In addition to increasing web use, Americans are sending e-mails more frequently. Presently, nearly half of the adult population uses e-mail, and this percentage has steadily increased in recent years. According to the U.S. Commerce Department, 45% of the U.S. population uses e-mail regularly, up from 35% in 2000,⁷² and only 15% in 1996.⁷³ E-mail has become increasingly essential to professional occupations. For instance, one study suggests that e-mail became the primary method of business communication as early as 1998, with

⁶⁸ See *New Survey finds that Medical Information Service Significantly Improves Physicians' Ability to Resolve Patient Care Questions*, *supra* note 63. The online survey was conducted in January 2002, and was sent to a random sample of MD Consult users. Results were drawn from a total of 388 respondents, spread across hospital, private, and group practice settings, and more than 25 specialty areas.

⁶⁹ *Id.*

⁷⁰ See *E-Health: Few Physicians Use Internet in Their Practices*, AM. HEALTH LINE, May 11, 2001, § Provider News, *available at* LEXIS, News Library. In addition, of physicians responding to the MD Consult survey, 76% ranked MD Consult as effective or very effective in supporting daily patient care with information resources; 82% rated MD Consult as effective or very effective in answering those clinical questions that would otherwise go unanswered; 83% report using MD Consult weekly to learn current medical news. *Id.*

⁷¹ *Nation's Health Care is in 'Critical Condition'*, PR NEWSWIRE, Oct. 29, 2002, § Health News; *see also* MD Consult study, *supra* note 67 (finding that 20% of physicians identified the Internet as “essential to their medical practices”).

⁷² See Mello, *supra* note 56.

⁷³ Stephen M. Borowitz & Jeremy C. Wyatt, *The Origin, Content, and Workload of E-mail Consultations*, 280 JAMA 1321, 1321 (1998).

36% of business executives using e-mail more than any other communication tool, compared with 26% who used the telephone most, and 15% who preferred face-to-face meetings.⁷⁴

On the other hand, Americans see their e-mail usage as limited, primarily by security concerns. Simply put, many Americans do not trust e-mail as a safe mode of communication. These concerns are best illustrated by the reaction of Americans to the possibility of voting for political office by e-mail. According to one study, 66% of Americans believe that election fraud would occur if voters could e-mail their ballots, and 51% contend that e-mail voting should be outlawed.⁷⁵ Nevertheless, Americans see e-mail as an efficient tool for expressing public opinion. For instance, of the 45% of people polled who claimed to have contacted their congressperson to express a view, 73% said they had used e-mail.⁷⁶

Like most Americans, physicians routinely use e-mail to communicate. And like many Americans, physicians appear to have safety concerns. This is perhaps best evidenced by the scant number of physicians who e-mail their patients. While data have conflicted over the frequency at which physicians e-mail patients, every study has found that the vast majority of physicians do not e-mail their patients. For instance, the American Medical Association found that 25% of physicians used e-mail to communicate with their patients in 2001,⁷⁷ while the Harris Polling Group claimed that only 13% communicated by e-mail in 2001, the same percentage found by Harris in 1999.⁷⁸ Regardless of which study is accurate, however, the same conclusion is reached: most physicians do not e-mail their patients.

⁷⁴ See *E-mail leaving phone in dust, survey finds*, HOUS. CHRON., Apr. 14, 1998, § Bus., at 1 (citing Ernst & Young study).

⁷⁵ See *Majority of Americans Uncomfortable with Online Voting*, PR NEWSWIRE, Nov. 1, 2000, § Fin. News.

⁷⁶ *Id.*

⁷⁷ See *E-Health: Few Physicians Use Internet in Their Practices*, *supra* note 70. The data was derived from a survey of 1001 physicians, excluding those employed by the federal government, as well as those over age 70, or in residency training programs.

⁷⁸ See Victoria Colliver, *Digital Diagnosis*, S.F. CHRON., May 9, 2001, at B1. In slight contrast, Healtheon found that 33% of physicians used e-mail to communicate with patients in 1999, up from 11% in 1998, and 3% in 1997. See Silverman, *supra* note 7, at 261 (using data derived from a survey of 10,000 physicians nationwide).

IV. WEIGHING PHYSICIAN-PATIENT E-MAIL IN THE CONTEXT OF THE PHYSICIAN-PATIENT RELATIONSHIP

A. ADVANTAGES FOR PATIENTS

Patients perceive a number of advantages to communicating with their physicians by e-mail. First, patients can use e-mail to perform a number of administrative functions that would eliminate the need for a visit to the physician's office or even a phone call. According to a recent survey, 90% of adults would like to communicate with their physicians online; 77% would like to e-mail questions when no visit is necessary; 71% would like to make appointments by e-mail; 71% would like to request refills of prescriptions by e-mail; and 70% would like to receive medical tests results by e-mail.⁷⁹

Patient empowerment is a secondary benefit of physician-patient e-mailing. According to one observer of the online health industry, when patients can directly e-mail their physicians, "the role of the patient [shifts] from someone who just passively follows doctors' orders to people taking charge of their own health care."⁸⁰ Some commentators also attribute patient empowerment to the elimination of the "red tape" and bureaucracy often encountered during hospital visits.⁸¹ E-mailing may also embolden certain patient groups which would otherwise avoid seeking face-to-face medical attention, such as teenagers with sex-related questions about which they might be too embarrassed to ask their physician in person.⁸²

Aside from enhanced convenience and empowerment, physician-patient e-mailing may benefit patients simply by giving them more direct and frequent contact with their physicians. This benefit satisfies a demand from patients for more interaction with their physicians.⁸³ Additionally, if patients save the e-mails containing their

⁷⁹ See 2 HARRIS INTERACTIVE HEALTH CARE NEWS 8 (2002), available at <http://www.harrisinteractive.com/news/allnewsbydate.asp?NewsID=225> (describing the results of a nationwide survey conducted online from a cross section of 2,014 adults aged 18 and over, between Mar. 27 and Apr. 2, 2002, where figures for age, sex, race, education, income, and Internet usage were weighted when necessary to bring them into line with their actual proportions in the adult online population).

⁸⁰ See Stroh, *supra* note 64 (quoting Dr. Tom Ferguson, editor of the FERGUSON REPORT, an e-mail newsletter that monitors the online health industry).

⁸¹ See Virginia Postrel, *Sometimes the Patient Knows Best*, N.Y. TIMES, Jan. 3, 2000, at A19.

⁸² *Id.*

⁸³ See Stroh, *supra* note 64 ("[P]eople are saying, 'I want my doctor to spend more time with me.'") (quoting Dr. David Stern, assistant professor at the University of Michigan Medical School).

diagnoses or courses of treatment, they can refer to them later, rather than calling the physician back or only partially remembering the instructions.

B. DISADVANTAGES FOR PATIENTS

E-mailing physicians may not always be a panacea for patients. A patient may misinterpret information provided in an e-mail. Although this hazard is unlikely to occur in administrative or non-urgent e-mails, such as e-mails used for rescheduling appointments or refilling prescriptions, it may occur if a physician engages in lengthy discussion with the patient, involving interpretations of test results or qualifications of diagnoses. Indeed, while much has been written about the communication of non-urgent requests, it is estimated that 90% of patients who use e-mail do so to communicate important, sometimes even urgent matters to their physicians.⁸⁴

Not only do most physician-patient e-mails include complex information, but patients who receive disappointing news may react worse after reading it on a computer screen than they would after hearing it in person. In fact, a well-documented flaw of e-mail correspondence is that e-mail text may sometimes fail to evince emotion, tone, or emphasis, and can sometimes lead to distorted perceptions by the reader, particularly if the reader is not personally acquainted with the sender.⁸⁵ As a result, the use of affixed symbols such as “:-(” has added to the e-mail lexicon in an attempt to provide greater context. Given the sensitive nature of medical consultations, however, the use of such symbols seems inappropriate. Even advocates for physician-patient e-mail acknowledge that e-mail is best suited to cover “non-urgent medical problems,” or matters concerning those patients who suffer from “chronic but stable conditions”; likewise, advocates concede that e-mail is not appropriate for new patients or emergency situations.⁸⁶

A patient referred by his physician to health-related websites may also become confused by their content. According to a recent study conducted by the Rand Corporation, medical information on the Internet is often inadequate and difficult to understand.⁸⁷ Many sites

84 See Borowitz & Wyatt, *supra* note 73, at 1321.

85 See *Qualcom Takes E-mail Beyond the Smiley Face*, PR NEWSWIRE, Jan. 22, 1998, § Fin. News.

86 See *Online Doctor Visits: Study to Examine Feasibility*, AM. HEALTH LINE, May 10, 2001, § Health.

87 RAND, *Evaluation of English and Spanish Health Information in the Internet* (2001), available at <http://www.rand.org/publications/documents/interneteval/> (last visited Dec. 21, 2002).

are promotional or quasi-promotional in nature, yet their objective of selling products is indistinguishable from their legitimate health-related content.⁸⁸ Also casting doubt on the value of supplemental websites is that they typically offer incomplete information: less than minimal coverage for half of the topics they address, and virtually no coverage of several widespread ailments, such as childhood asthma and obesity.⁸⁹ Most troubling, a majority of patients do not understand the content of health-related websites. The average patient seeking health information online possesses a 9th-grade reading level, whereas health web sites typically necessitate at least a 10th-grade reading level for full understanding, with over half requiring college-level comprehension.⁹⁰

Perhaps allaying some of the concern that most patients do not understand electronically-communicated health information is the fact that only 17% of Americans between the ages of fifteen and twenty-four trust the health information they find on the Internet “a lot,” in comparison to the 85% who trust the information they receive from their physicians “a lot.”⁹¹ Of course, this begs the question of why physicians would even refer patients to health-related websites, if most of those patients do not trust the websites, and many of those that do trust the information do not understand what they are reading.⁹²

Aside from misinterpreting e-mails from physicians or health-related websites to which they are referred, patients must also guard against employer observation of sensitive employee e-mails. As a general matter, employers own their e-mail systems, as well as any messages that are sent or received over those systems.⁹³ Patients’

88 *Id.*

89 *Id.*

90 *Id.*

91 *See Health-Internet: 75% of Young Web Users Seek Health Info Online*, *supra* note 59.

92 Some health websites have been “accredited” by the Utilization Review Accreditation Commission (URAC), a Washington-based health accreditation firm. Using 53 “quality” criteria (e.g. comprehensiveness, accuracy, fairness), URAC accredited 13 health websites in December 2001. UTILIZATION REVIEW ACCREDITATION COMMISSION, DEC. 2001 STUDY. *See* <http://webapps.urac.org/websiteaccreditation/default.htm> (last visited Dec. 21, 2002). *See also Nation’s First Accredited Health Websites Announced*, PR NEWSWIRE, Dec. 12, 2001, § Fin. News. Similarly, Harris Interactive announced its “Best-in-class e-Health Websites” in January 2001, in which it used such criteria as “easy to understand material,” “ease of navigation,” and “up-to-date information” to evaluate 159 health websites. *See* 1 HARRIS INTERACTIVE HEALTH CARE NEWS 4, (2001), available at <http://www.harrisinteractive.com/news/allnewsbydate.asp?NewsID=225> (last visited Dec. 21, 2002). *See also Harris Interactive Announces Best-In-Class e-Health Websites*, BUS. WIRE, Jan. 29, 2001, § Healthwire. It is unclear, however, whether any of these new standards will impact patient confidence in health websites, or their understanding of the material contained therein.

93 *See* Spielberg, *supra* note 41, at 1356 (citing *Smyth v. Pillsbury Co.*, 914 F. Supp. 97 (E.D. Pa. 1996)).

concerns are amplified by the fact that e-mail may be stored indefinitely, even after the employee has deleted the message.⁹⁴

Courts have disagreed over the extent to which employers are entitled to read their employees' e-mails, although all courts facing the issue have sanctioned a great deal of access. In *Smyth v. Pillsbury*,⁹⁵ the District Court for the Eastern District of Pennsylvania found that employees have no reasonable expectation of privacy in e-mail communications, reasoning that employees assume the risk when voluntarily using an employer's e-mail system.⁹⁶ However, in *McLaren v. Microsoft Corp.*,⁹⁷ while the Texas Court of Appeals eventually ruled in favor of the employer, the court recognized that an employee might have a "reasonable expectation of privacy in the contents of his e-mail messages sent over the company e-mail system," provided those e-mails are in a personal e-mail folder, the folder can be accessed only by the employee, the company has recognized this arrangement, and the company does not suspect the employee of typing "illegal or unprofessional comments."⁹⁸

Although the *McLaren* exception for employee e-mail privacy appears remarkably narrow, the District Court for the Eastern District of Pennsylvania recently declined to hold as a matter of law that an employer has absolute power in viewing employee e-mails, noting, "it is still possible that Plaintiff could prove a set of facts that would demonstrate she had a reasonable expectation of privacy in the e-mail communications."⁹⁹ Likewise, in *Fischer v. Mt. Olive Lutheran Church, Inc.*,¹⁰⁰ the District Court for the Western District of Wisconsin denied an employer unlimited access into an employee's non-work e-mail accounts (e.g., those hosted by Microsoft Hotmail or Yahoo E-mail), although the court refused to affirmatively protect those e-mail accounts from employers.¹⁰¹ These rulings suggest that if an employee were to create a personal e-mail account or, alternatively, a private

94 Spielberg, *supra* note 41, at 1355.

95 *Smyth v. Pillsbury Co.*, 914 F. Supp. 97 (E.D. Pa. 1996).

96 *Id.* at 101 (noting, "unlike urinalysis and personal property searches, we do not find a reasonable expectation of privacy in e-mail communications voluntarily made by an employee to his supervisor over the company e-mail system notwithstanding any assurances that such communications would not be intercepted by management").

97 *McLaren v. Microsoft Corp.*, 1999 Tex. App. LEXIS 4103 (Tex. App. May 28, 1999).

98 *Id.* at *10-13.

99 *See Kelleher v. City of Reading*, 2001 U.S. Dist. LEXIS 14958, *17 (E.D. Pa. Sept. 24, 2001).

100 *Fischer v. Mt. Olive Lutheran Church, Inc.*, 207 F. Supp. 2d 914 (W.D. Wis. 2002); *see also Konop v. Hawaiian Airlines*, 302 F.3d 868 (9th Cir. 2002) (finding that an employee may have privacy right preventing an employer from viewing the employee's secured website without permission).

101 *Fischer*, 207 F. Supp. 2d at 928.

folder for health matters within the employer's e-mail system, and the employer recognized this arrangement and was without reasonable concern over the appropriateness of the employee's e-mails, the employer would not have access to those e-mails. Given the uncertain protection for non-work e-mail accounts and the seemingly tenuous string of conditions for protecting business e-mail accounts, however, most employees would probably just prefer to give their doctor a call instead.

C. ADVANTAGES FOR PHYSICIANS

Although few physicians e-mail their patients, there can be several advantages for physicians from using this method of communication. From a practical standpoint, e-mail avoids the "telephone tag" and strings of voice-mails inevitable in telephone communications. This benefit seems particularly helpful for administrative activities, such as rescheduling appointments and refilling prescriptions. E-mail may even prove more reliable than phone messages for conveying administrative information, especially when a physician (or a physician's assistant) requests a "read receipt" for outgoing e-mails, thereby providing documentation of when and if a particular e-mail was received by the patient; in contrast, a patient can always claim that he never received a phone message.

Physician-patient e-mail also enables physicians to clarify advice provided during a patient's in-person consultation or to direct a patient to resources on the Internet.¹⁰² With respect to e-mail as an edifying resource, a number of physicians believe that e-mail can enrich earlier comments, and once the patient has digested a diagnosis, e-mail can serve as an effective means for answering follow-up questions.¹⁰³ As for directing patients to supplemental Internet links, a market for such resources has arisen,¹⁰⁴ although as noted in the

102 See Borowitz & Wyatt, *supra* note 73, at 1321.

103 See Spielberg, *supra* note 41, at 1355.

104 For instance, Medscape.com (www.medscape.com) provides updated medical articles to both physicians and patients. The site purports "to strengthen the physician-patient relationship" by encouraging physicians to refer their patients to the website to supplement information provided during consultation. *GM and Medscape Expand Digital Health Care Alliance to Buffalo-Area Physicians*, BUS. WIRE, Nov. 27, 2001, § Healthwire. For those patients who find Medscape.com too technical, they can turn to its less sophisticated partner, WebMD.com (www.webmd.com). Other healthcare portal agencies emphasizing familiar names, such as Dr.Koop.com (www.drkoop.com), sponsored by former United States Surgeon General C. Everett Koop, and, similarly recognizable, the Mayo Clinic (www.mayohealth.org), offer a vast array of advice, from summaries of existing medicines to discussions about future medical breakthroughs. Other websites attempt to use innovative technologies to attract users. For instance, the Los Angeles-based EcureMe.com (www.ecureme.com) is the first to offer videoconferencing to link

preceding Section, a substantial portion of patients may not understand what they are reading.¹⁰⁵

Additionally, patients may e-mail their physicians pertinent information prior to a consultation, thus reducing the necessity for a prolonged back-and-forth conversation when the patient arrives.¹⁰⁶ Physicians who use e-mail report having more time to respond to questions at their own convenience. It is estimated that e-mail decreases the amount of time spent answering patients' questions by telephone, which in turn enables physicians to better manage their schedules.¹⁰⁷

E-mail communications are also helpful for record keeping. Since the e-mail message itself qualifies as a medical record, and since it likely provides more detail than handwritten notes from telephone conversations, it can likely serve as the most complete record available.¹⁰⁸ As a result, e-mail allows physicians to recall patient exchanges with greater certainty.

Perhaps most importantly, e-mail correspondence may help physicians identify troublesome symptoms of patients who dislike going to the doctor. These patients are commonly referred to as "risk prone" patients. To illustrate: one physician who regularly e-mailed a risk prone patient was able to detect a serious kidney problem months before the patient was scheduled to visit.¹⁰⁹

Finally, physicians may better market themselves by using e-mail to correspond with their patients. In fact, the ability to e-mail a physician may significantly affect whether a patient chooses one health plan, or one physician, over another. According to one recent study, 55% of adults claim the ability to e-mail influences their choice of

patients with physicians throughout California and Nevada. For a discussion of web healthcare sites, see Kim Komando, *Get a Second Opinion on Medical Advice on the Internet*, DAYTON DAILY NEWS, July 22, 2001, available at LEXIS, News Group. See also *VirtuCare to Give Patients Internet "Axes,"* BUS. WIRE, Aug. 20, 2001, § Healthwire.

105 See *infra* pp. 28-29.

106 See *Online Doctor Visits: Study to Examine Feasibility*, *supra* note 86 (citing Dr. Jeffrey Rideout, chief medical officer for Blue Shield of California).

107 See Spielberg, *supra* note 41, at 1355.

108 See Spielberg, *supra* note 41, at 1357.

109 This example cites the experience of Dr. David Voran, a family practitioner in Kansas City, Kansas who e-mails many of his patients daily. In the instant case, Dr. Voran was able to convince a hypertension patient to e-mail daily blood pressure readings. Through the e-mail correspondence with this patient, Dr. Voran was able to detect a rise in blood pressure readings, and after requesting that she come to the office, tests revealed that an artery to one her kidneys had clogged. Because the clogging was detected early, surgeons saved the kidney, and saved the patient from indefinite dialysis as well. See Stroh, *supra* note 64, at C03.

health plans, and 56% say it influences their choice of physicians.¹¹⁰

D. DISADVANTAGES FOR PHYSICIANS

Considering that only 13 to 33% of physicians e-mail their patients, even though over 90% of physicians use the Internet, it stands to reason that there are number of persuasive disincentives. In fact, the expansive range of disadvantages requires this Section to be subdivided into four parts, as an attempt to clarify four unresolved areas of primary concern: ambiguity regarding the creation of the physician-patient relationship by e-mail; confusion over a physician's ability to e-mail out-of-state patients; uncertainty regarding the effect of e-mail on a physician's duties of care; and trepidation of the financial and practical risk inherent in physician-patient e-mail.

1. RELATIONSHIP FORMATION

Simply put, physicians do not know if a physician-patient relationship spawns immediately from e-mailing, or whether patients and physicians must exchange a certain level of information by e-mail in order to trigger and sustain the relationship. In fact, case law on this topic does not exist. It may therefore be helpful for us to compare e-mail with telephone conversations as a means of creating a physician-patient relationship.

As a general matter, a physician engaging in a phone conversation with a person seeking medical advice can trigger a physician-patient relationship.¹¹¹ To illustrate this point, in *Bienz v. Central Suffolk Hospital*,¹¹² a New York court found that a telephone call to a physician's office for the purpose of initiating treatment can create a relationship, if it is incident to the physician offering advice during the conversation.¹¹³ Following this reasoning, in *Weaver v. University of Michigan Board of Regents*,¹¹⁴ the Michigan Court of Appeals held that a telephone call merely to schedule an appointment may not establish a physician-patient relationship, unless the caller received medical advice while on the phone.¹¹⁵ Therefore, a physician who avoids

110 See Allen, *supra* note 60.

111 See, e.g., Clanton v. Von Haam, 340 S.E.2d 627, 630 (Ga. Ct. App. 1986); see also Cogswell v. Chapman, 672 N.Y.S.2d 460 (N.Y. App. Div. 1998) (holding that a physician-patient relationship can be established by a telephone call to a physician).

112 557 N.Y.S.2d 139, 139-40 (N.Y. App. Div. 1990).

113 *Id.* at 140.

114 506 N.W.2d 264 (Mich. Ct. App. 1993).

115 *Id.* at 266.

discussion of medical advice during a phone conversation can avoid entering into a physician-patient relationship.

A telephone conversation between two physicians can also trigger a physician-patient relationship. For instance, in *Cogswell v. Chapman*,¹¹⁶ an emergency room physician called an ophthalmologist in order to obtain advice on the treatment of an eye injury. Although the ophthalmologist did not see or examine the patient, take a patient history, or receive financial compensation for his assistance, the mere fact that he suggested a particular form of treatment triggered a physician-patient relationship. The ophthalmologist insisted that his recommendation was not binding upon the emergency physician, and that his advice was merely “informal.”¹¹⁷ An unpersuaded New York court found that the defendant “had more than an informal interest and involvement in plaintiff’s condition . . . especially in light of defendant’s expertise in the field and [the emergency room physician’s] lack of expertise in this area.”¹¹⁸

Taken together, *Bienz*, *Weaver*, and *Cogswell* suggest that as soon as a physician provides medical advice—even when such advice appears more like casual opinion than critical reflection—a physician-patient relationship emerges. Indeed, these decisions broadly extend the scope of physicians’ “affirmative actions” sufficient to trigger a physician-patient relationship. In fact, under *Cogswell*, once a physician takes any action demonstrating “more than an informal interest and involvement” in a plaintiff’s condition, he initiates a relationship with a patient. As a result, when a physician replies by e-mail to a person seeking medical advice, or, in the context of *Cogswell*, when a physician consults with another physician by e-mail, a physician-patient relationship likely emerges, regardless of how cursory the response.

In addition to this examination of the existing case law, an analysis of the anticipatory steps taken by physicians to prevent initiating physician-patient relationships over telephone conversations can also shed light on relationship formation. These steps are most evident when observing how “radio” and “television” physicians answer questions from listeners. In a telephone interview conducted by the author, Martin Messenger, Senior Vice President and Deputy General Counsel of CBS, stated that radio physicians are expected to provide generalized advice when answering a caller’s question.¹¹⁹ At the same time, Mr. Messenger acknowledged that by providing

116 672 N.Y.S.2d 460 (N.Y. App. Div. 1998).

117 *Id.* at 461.

118 *Id.* at 462.

119 Telephone Interview with Martin Messenger, Senior Vice President and Deputy General Counsel, CBS (May 7, 2002, 9:24 EST). Infinity Radio, an affiliate company of CBS, owns 183 radio stations.

medical advice particular to a caller, a radio physician may affirm “the pretense” of a burgeoning physician-patient relationship, but since the physician is also speaking to an entire radio audience, “no reasonable caller would expect to initiate a relationship with a physician through a call-in show.”¹²⁰

Unlike radio physicians, television physicians typically answer telephone questions in taped segments.¹²¹ Moreover, callers usually leave messages on the studio’s answering machine, rather than engaging in actual conversation with the physician. As a result, television doctors’ comments are often scripted. To illustrate this point, Dr. Timothy Johnson, ABC News Medical Editor and well-known “TV doctor,” noted in an e-mail interview that his “responses are generalized and [do] not presume to tell the questioner what exactly to do.”¹²² As with Mr. Messinger’s radio experience, Dr. Johnson could not recall one instance where a television viewer claimed that a physician-patient relationship had been initiated by comments made on the air.¹²³

The experiences of Mr. Messinger and Dr. Johnson appear to limit the practical application of *Cogswell*. Although *Cogswell* articulated a physician-patient relationship that arises whenever a physician expresses “more than an informal interest and involvement” in a patient’s condition, television and radio doctors may answer specific medical questions without the apparent risk of cultivating a relationship. Granted, on-air physicians are instructed to provide generalized and conservative answers. In the radio setting, however, a physician is in direct communication with the caller, thereby spontaneously offering medical advice particular to the caller’s condition. It is even possible, if not likely, that the radio physician will answer follow-up questions from the caller. Yet even in this setting, Mr. Messinger, a prominent network attorney, could not recall one instance where a relationship was later alleged.

The experiences of Mr. Messinger and Dr. Johnson should provide encouragement to those physicians who invite e-mails through website advertising. In fact, many websites now offer on-line consultations, and they often take precautions that neither television

120 Perhaps most revealingly, in his 25 years at CBS, Mr. Messinger could not recall having seen a demand letter—let alone a claim—from a caller who claimed that he received harmful advice from the radio doctor, nor is he aware of any physician who was forced into a physician-patient relationship because of comments made over the air. *Id.*

121 *Id.*

122 E-mail from Dr. Timothy Johnson, ABC News Medical Editor, to Michael A. McCann (May 9, 2002, 12:08 EST) (on file with author).

123 *Id.*

nor radio physicians take. Asktheneurologist.com (www.asktheneurologist.com) is one such website. For \$12.00, an individual may e-mail a question to the website's owner and operator, Dr. Jeffrey Burns, a resident neurologist at the University of Virginia. In a telephone interview, Dr. Burns, like Dr. Johnson, expressed that his consultations provide generalized and informational advice, and he often encourages those with troublesome symptoms to see a physician.¹²⁴ In fact, the website requires the visitor to read a disclaimer which expressly notes, "AskTheNeurologist.com is an informational service only. It is not intended for diagnosis and treatment of any health condition. The information provided is not intended nor is it implied to be a substitute for professional medical advice."¹²⁵

Moreover, some consultation websites, such as America's Doctor (www.americasdoctor.com), take additional steps to distance themselves from prospective patients. Specifically, America's Doctor preserves anonymity by having the visitor provide only his zip code, rather than his name, and by assigning the physicians randomly, so that visitors cannot be sure they will consult with the same physician twice.¹²⁶ As a result, the ease of establishing or inferring a physician-patient relationship under *Cogswell* appears to be diminished by both the track record of radio and television physicians, and by the numerous safety measures employed by physician-sponsored websites.

2. OUT-OF-STATE MEDICAL COMMUNICATIONS

E-mail communication with patients in other states provides a second legal quandary for physicians. Generally, a physician cannot practice medicine in another state without a license from that state,¹²⁷ and individual states are empowered to regulate the practice of medicine within their borders.¹²⁸

A number of states require licensure before an out-of-state physician may provide care to patients electronically.¹²⁹ Although

124 Telephone Interview with Dr. Jeffrey Burns, owner and operator of Asktheneurologist.com (Apr. 15, 2002).

125 See *Asktheneurologist.com Disclaimer and Service Agreement*, available at http://www.asktheneurologist.com/disclaimer_and_service_agreement.htm (last visited Dec. 21, 2002).

126 See Stroh, *supra* note 64.

127 See, e.g., *Andrews v. Ballard*, 498 F. Supp. 1038, 1042 (S.D. Tex. 1980) (noting that a person cannot practice medicine in Texas without a medical license).

128 Jennifer M. Ranucci, *Medical Licensure Barriers Obstruct the Interstate Use of Telemedicine*, 163 N.J.L.J. 184.

129 See Spielberg, *supra* note 41, at 1357 (citing Alabama, Arkansas,

experts are unclear whether these laws cover e-mail,¹³⁰ and no court has yet to answer this question, the operational practice of those physicians who invite e-mails suggests that physicians should discover the location of the e-mail recipient prior to sending the e-mail. To illustrate this point, Cyberdocs.com (www.cyberdocs.com), which was based in Massachusetts but employed physicians from a number of states, answered e-mails only from visitors living in states where the company employed physicians.¹³¹

Unresolved questions of personal jurisdiction likely contribute to the absence of case law on out-of-state physician-patient e-mails. As with all persons, a court cannot exert jurisdiction over a physician unless that physician has “minimal contacts” with the state pursuing her.¹³² In the context of physicians seeking patients, “minimal contacts” can be established simply by mailings to attract out-of-state patients or to correspond with existing patients.¹³³ For instance, in *Bullion v. Gillespie*,¹³⁴ a patient from Texas traveled to California to see a urologist who had written a widely-circulated book on urology. After the urologist examined and diagnosed the patient, he agreed to mail pharmaceuticals to him. Periodically, the patient would correspond with a physician in Texas, who would in turn correspond with the urologist to keep him abreast of the patient’s progress. The U.S. Court of Appeals for the Fifth Circuit held that a Texas court could exercise personal jurisdiction over the urologist, in part because the Texas physician served as a suitable nexus between the patient and the urologist, thus preserving the original relationship.¹³⁵

Even when a physician is not well-known, nor solicits business or participates in an interstate marketing scheme, he can nevertheless create “minimum contacts” in a state in which he does not practice simply by receiving mail from a resident of that state. In *Kennedy v. Freeman*,¹³⁶ the U.S. Court of Appeals for the Tenth Circuit concluded

Arizona, Connecticut, Florida, Georgia, Iowa, Indiana, Kansas, Massachusetts, Maine, Mississippi, Nebraska, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, and Virginia); *see also* Dent v. West Virginia, 129 U.S. at 114 (1889) (upholding a state’s right to establish standards for medical practice).

130 *Id.*; *see also* Ranucci, *supra* note 128.

131 *See* Silverman, *supra* note 7, at 265.

132 *See* Howard, *supra* note 23, at 238 (citing *Int’l Shoe v. State of Wash.*, 325 U.S. 310 (1945); *see also* Mass. Sch. of Law at Andover, Inc. v. Am. Bar Ass’n, 142 F.3d 26, 35 (1st Cir. 1998) (noting that courts typically employ a three-part test for determining whether an exercise of specific jurisdiction is consistent with due process. The analysis consists of an inquiry into (1) relatedness, (2) purposeful availment (or “minimum contacts”), and (3) reasonableness).

133 *See, e.g.*, *Bullion v. Gillespie*, 895 F. 2d 213, 217 (5th Cir. 1990)

134 *Id.*

135 *Id.*

136 919 F.2d 126 (10th Cir. 1990).

that a Texas physician created a physician-patient relationship with an Oklahoma patient merely by analyzing a tissue sample that had been mailed to him by an Oklahoma physician.¹³⁷ Indeed, the U.S. Court of Appeals for the 10th Circuit found that the Texas physician had “purposefully directed his actions [toward Oklahoma],” by utilizing the U.S. Postal Service to receive the patient’s test.¹³⁸

Outside the context of medicine, case law on e-mail and personal jurisdiction does exist. In *Bellino v. Simon*,¹³⁹ the U.S. District Court for the Eastern District of Louisiana found that a defendant who actively solicited business through his web site and had many conversations by phone and e-mail with the witness had sufficient contacts with the state of Louisiana.¹⁴⁰ Although the *Bellino* court did not posit whether e-mail contacts alone could warrant personal jurisdiction, the U.S. Court of Appeals for the Sixth Circuit, in *CompuServe, Inc. v. Patterson*,¹⁴¹ exercised personal jurisdiction over a non-resident defendant who had regularly e-mailed file attachments through an Ohio Internet server.¹⁴²

Bullion, *Kennedy*, *Bellino*, and *CompuServe, Inc.* all shed light on how physician-patient e-mails can affect personal jurisdiction. *Bullion* and *Kennedy* suggest that minimal contacts can be achieved simply by e-mailing a patient medical advice. *Kennedy*, moreover, suggests that a physician who receives an e-mail from an out-of-state patient or physician has “purposefully directed his actions” toward that state. Interestingly, with many physicians now employing websites that provide their e-mail addresses, a patient can readily “mail” a medical question to a physician. Furthermore, by describing e-mail and telephone conversations as equivalent modes of communication, *Bellino* suggests a willingness to find the same personal contacts in e-mail “conversations” that are found in phone conversations. Finally, *CompuServe, Inc.* indicates that a defendant cannot escape a finding of minimal contacts even when his only nexus with the state was through the Internet and e-mail. As a result, it strongly appears that a physician can cultivate minimal contacts, and thus be held liable in an out-of-state court, if he e-mails or reads e-mail from an out-of-state patient.

3. DUTY ADHERENCE

137 *Id.* at 129.

138 *Id.*

139 1999 WL 1059753 (E.D. La. 1999).

140 *Id.* at *3.

141 89 F.3d 1257 (6th Cir. 1996).

142 *Id.* at 1263-65.

Assuming a physician-patient relationship is formed, either by e-mail or conventional means, physicians who e-mail patients must examine how their medium of communication affects their duties. As noted in Part I, physicians have a duty to maintain patient confidentiality.¹⁴³ In the context of electronic communication, physicians must protect e-mails from unauthorized observation, just as they must protect audio recordings or written memos. Bluntly, the Physician Insurers Association of America advises physicians to never e-mail patient confidential medical information, absent complete certainty that the e-mail address is correct and that only the patient has access to the account.¹⁴⁴ To illustrate how physicians have reacted to these concerns, the American Medical Association estimates that only 17% of physicians obtain or transfer medical records by e-mail or other Internet methods.¹⁴⁵

Recent federal legislation only reaffirms the need for physicians to engage in secure patient e-mailing. Specifically, the *Health Insurance Portability and Accountability Act* (HIPAA)¹⁴⁶ establishes new regulations for electronic messaging of patient information.¹⁴⁷ Effective April 14, 2003, HIPAA will prohibit the use or disclosure of all health information without the patient's authorization and will require that all medical records be stored securely until two years after the patient's death.¹⁴⁸ Moreover, HIPAA will demand more stringent identification of e-mail users, including the recommendation that signature e-mails be employed to ensure message integrity.¹⁴⁹ Therefore, a physician will have to save every e-mail sent to a patient until two years after that patient dies. Saving e-mails is also necessary because an e-mail serves as a medical record, and can thus be used in litigation.¹⁵⁰

The simplest means of overcoming e-mail security concerns is to communicate by encrypted e-mails, meaning e-mails that are scrambled during transmission and are inaccessible to Internet interlopers.¹⁵¹ Several health websites offer this service for free.¹⁵²

143 See *infra* pp. 15-16.

144 See Shelly Schwartz & Bob Keaveney, *Doctors: Employ Caution on Internet, Study Warns*, DAILY REC. (Balt. MD) Mar. 25, 1998, at 11.

145 See Ann Carrns, *Internet Use by Physicians is Increasing, but Numbers Continue to Come up Short*, WALL ST. J., May 10, 2001, at B9.

146 Pub. L. No. 104-191, 110 Stat. 1936 (1996).

147 *Id.*

148 See Beth D'Addono, *Savvy Patients Know What's in Their Medical Files*, NEWSHOUSE NEWS SERVICE, Jan. 27, 2000, § Lifestyle.

149 See HIPAA Advisory.com, *HIPPA Primer*, available at <http://www.hipaadvisory.com/regs/HIPAAprimer1.htm> (last visited Dec. 21, 2002).

150 See Spielberg, *supra* note 41, at 1357. At the same time, however, case law has not yet illustrated this form of liability.

151 See *Online Medical Liability Addressed by National Consortium*, PR NEWSWIRE, Jan. 29, 2002, § Fin. News (quoting Mark Gorney, M.D., medical

Despite the availability of free resources, however, physicians consistently select alternate means to communicate sensitive information, and HIPAA will probably further discourage them from employing e-mail.

The standard of care for physician-patient e-mail serves as another concern for physicians, particularly since this standard remains undefined. Characterizing the standard of care for physician-patient e-mail is challenging, but in some ways it can be compared to the standard of care for phone messages between physicians and patients (even though this standard also remains largely undeveloped). Two cases, however, prove helpful, each discussing one of these modes of communication.

In *St. Charles v. Kender*,¹⁵³ a pregnant patient experienced excessive pain and then called her primary care physician repeatedly over a period of two days. After failing to receive a return call from either her primary care physician or the covering physician, the patient traveled to the hospital where she learned that she had suffered a miscarriage. In addressing the physicians' conduct, the Appeals Court of Massachusetts noted,

literal application of the contractual standard requires knowing what the medical community accepted as a response standard in 1987, but we incline to the view that finding whether a two-day delay is an unreasonable time to get back to a patient is the sort of task that a jury may be expected to discharge without the help of an expert. *There is a common sense aspect to the question.*¹⁵⁴

Therefore, *St. Charles* suggests that a physician can be held liable for failing to respond to voice-mails, even if the standard of care is unknown, provided that "common sense" dictates liability.

Physicians have also been held accountable for their e-mail habits, albeit it in the limited context of transitioning from traditional forms of communication to e-mail messaging. In *Smith v. United States*,¹⁵⁵ a government hospital was in the process of converting from a

director for the Doctors Company, one of the largest national malpractice carriers: "Given these risks and the HIPAA guidelines, it makes good sense to use a network that includes both encryption and authentication for transmitting messages.")

¹⁵² See, e.g., Virtu-care.com (www.virtu-care.com); MDchoice.com (www.MDChoice.com); or PersonalMD.com (www.PersonalMD.com).

¹⁵³ 646 N.E.2d 411 (Mass. App. Ct. 1995), *review denied*, *St. Charles v. Kender*, 648 N.E.2d 1286 (Mass. 1995).

¹⁵⁴ *Kender*, 646 N.E.2d at 413 (emphasis added).

¹⁵⁵ 119 F. Supp. 2d 561 (D.S.C. 2000).

manual reporting system for radiology test results to a computerized system. During this transition phase, the mandatory method for communicating the results was direct telephone contact from the radiologist to the requesting physician. Additionally, for abnormal test results, two supplementary notifications were generated: one by way of e-mail, sent directly from the computer system to the requesting physician's e-mail account; the other by way of an automatic printout at the requesting physician's printer, which printed regardless of whether the requesting physician even used his computer.¹⁵⁶

The lawsuit in *Smith* arose because the plaintiff had a mammogram, which indicated an abnormality, but neither she nor the requesting physician was notified of the result for five months. In short, the radiologist called the requesting physician, but the requesting physician was not available. Feeling secure that the requesting physician would check his e-mail, the radiologist did not call again.¹⁵⁷ Unfortunately for the patient, the requesting physician never checked his e-mail. The requesting physician should have also received an automatic computer printout, but the printer malfunctioned, and the report was never generated. Therefore, all of the notification precautions failed.

Principally, the plaintiffs argued that had the radiologist known that not every physician checks her e-mail, he would have made a greater effort to reach the requesting physician by telephone. Not surprisingly, the radiologist testified to that effect.¹⁵⁸ The U.S. District Court for South Carolina, however, found that the hospital did not have a duty to inform the radiologist of other physicians' e-mail habits, for the automatic printout was a "reasonable procedure" to guarantee notification.¹⁵⁹ Instead, the court focused on the facts that the phone communication was the primary means of notification and that the radiologist did not make a reasonable effort to connect with the requesting physician by telephone, even though he left a message with the requesting physician.¹⁶⁰

Although the *Smith* court declined to impose liability on a physician who did not open his e-mail, it essentially based its decision on the existence of two alternate methods of notification. Had e-mail been the only, or the primary method of conveying information, it stands to reason that the court may have imposed liability for the hospital's failure to ensure that its physicians check e-mail. Indeed, the

156 *Id.* at 565.

157 *Id.* at 570.

158 *Id.* at 578.

159 *Id.*

160 *Id.* at 578-79.

court emphasized that the phone call was the primary means of notification, thereby placing the burden on the caller to make reasonable efforts to effectively communicate the test results by telephone. Had e-mail been the primary means of delivery, the holding suggests that the sender would have had to ensure that the recipient opened the e-mail message. Of course, this can generally be accomplished by requesting receipt of delivery, though the sensitive nature of patient e-mails may spur courts to require a greater obligation on the part of the sender to ensure delivery.

4. OPERATIONAL CONSIDERATIONS

Even assuming that physicians are able to overcome the legal uncertainties of physician-patient e-mail, several practical obstacles would remain. First, critical e-mails, unlike most critical phone messages, may become buried by a slew of unimportant messages (i.e. spam), making it difficult to discern the important messages. Attorneys, who have already incorporated e-mail as a mode of professional communication, receive an average of 48 e-mails a day.¹⁶¹ That amounts to a new message every 10 minutes during the workday. Such an information overload may prove particularly difficult for physicians to handle, since most physicians are already hard-pressed for time.¹⁶²

Second, many physicians do not e-mail patients simply because they are not reimbursed for doing so. In fact, it is estimated that of the physicians who do not e-mail their patients, 40% are most discouraged by not being paid.¹⁶³ On the other hand, physicians likewise go unreimbursed for telephone conversations with patients, yet most physicians nevertheless utilize phone communications to converse with patients.¹⁶⁴ Moreover, some health insurers have begun to reimburse physicians for e-mail. For instance, in May 2001, Blue Shield of California became the first U.S. insurer to reimburse physicians for e-mailing patients, paying them \$10 for each qualified message.¹⁶⁵ Consumer demand appears to endorse Blue Shield's decision: one study found that 37% of patients would pay to e-mail their physicians, with \$10 a month or \$7 per e-mail as the average amount they would be willing to pay. Still, most insurers have not followed Blue Shield of California.¹⁶⁶

161 See *E-Mail Overload: Lawyers Receive Nearly 50 E-Mail Messages Daily*, According to Survey, PR NEWSWIRE, Feb. 6, 2002, § Fin. News (noting survey where 200 attorneys in the nation's largest law firms were asked, "On average, how many e-mail messages, both business and personal, do you receive daily?").

162 See, e.g., Liz Kowalczyk, *Online Medical Records Seen Empowering Patients*, BOSTON GLOBE, July 31, 2000, at A1 (quoting Dr. Daniel Sands, clinical director of electronic patient records and communication at Beth Israel Deaconess Medical Center: "Doctors are already overwhelmed, and they want to know if [patient e-mails are] going to increase their workload."); see also Jim Ritter, *New Doctors Say They're Mistreated*, CHI. SUN-TIMES, Apr. 15, 1998, at 4 (noting that residents typically work over 80 hours a week).

163 See *Doctors Accepting Technology, with Reservation*, supra note 66. In fact, according to Paul Gertler, director of the graduate program in health management at UC Berkeley's Haas School of Business, physicians are worried that, "unreimbursed Web visits will replace office visits." Colliver, supra note 78.

164 See Colliver, supra note 78.

165 See *Doctors Accepting Technology, with Reservation*, supra note 66.

166 See Eric Sabo, *Will an Email a Day Keep the Doc at Bay?*, available at http://www.medscape.com/viewarticle/402820_print (last visited Dec. 21, 2002)

Third, personality traits endemic in physicians, such as aversion to change, may deter them from e-mailing patients. For example, in 2000, the Medical Center at Princeton, New Jersey implemented an automated system for physicians to use when ordering tests. Each order was immediately sent to the appropriate hospital department, which in turn instantaneously provided the requesting physician with the test results.¹⁶⁷ Every physician was given electronic access to the system. Although the system undoubtedly saved time for those who became accustomed to it, only 15% of the physicians participated, with the remaining 85% preferring to write handwritten notes instead.¹⁶⁸

Lastly, and perhaps most rationally, many physicians avoid e-mailing patients because they speak far faster than they type. Indeed, typing classes in American public schools were not instituted until the mid 1970s,¹⁶⁹ while the average-aged physician began high school in 1969.¹⁷⁰ Although a number of older physicians have undoubtedly learned how to type, many of them may not type very fast and, as a result, probably find e-mail quite frustrating.¹⁷¹ This is amplified by the fact that speaking on the phone appears far more efficient: people talk at an average speed of 185 words a minute, while the average person can type no more than 60 to 70 words a minute.¹⁷²

V. CREATING CERTAINTY IN PHYSICIAN-PATIENT E-MAIL THROUGH SPECIALIZED CONTRACTS

The guidelines for physician-patient e-mail use remain largely undefined. Optimistically, one commentator predicts that the evolving standard of practice for physician-patient e-mail will ultimately define itself after a period of trial and error, just like the nascent standard of

(noting few insurance companies reimburse for email "visits").

¹⁶⁷ See D'Addono, *supra* note 148.

¹⁶⁸ *Id.*

¹⁶⁹ Emily L. Bell, *On This Date*, PITTSBURGH POST-GAZETTE, Dec. 15, 2000, at A2 (noting that in Pittsburgh's public schools, typing classes were instituted in 1975). Secretarial schools existed to teach prospective secretaries how to type long before the mid-1970s, though it stands to reason that only a very small percentage of these students went on to become physicians.

¹⁷⁰ Lydia Garrico, *Doctor Search for Small Towns in Kentucky Can Be Difficult*, MESSENGER-INQUIRER (Knight-Ridder/Tribune Business News Service), May 12, 2001 (noting that the average-aged physician is 47).

¹⁷¹ Letter to the Editor, *Poor Typing Slows Online Classes*, CHRON. OF HIGHER EDUC., May 19, 2000, at B12 (letter from Linda Rubinstein, Chair, Department of Business at Oxnard College (Cal.) expressing frustration that people who cannot type do not benefit from online resources).

¹⁷² Lee Bergquist, *New Technology May Speed Calls for Disabled*, MILWAUKEE J. SENTINEL, Nov. 24, 2001, at 01D.

practice for physician-patient phone calls a century ago.¹⁷³ In fact, several non-governmental agencies have already created guidelines for usage. The American Medical Informatics Association, for instance, has made a series of recommendations for physicians. Among other things, they have encouraged physicians not to use e-mail for urgent matters, to inform patients of privacy issues, to generate paper records of patient e-mails, and to obtain informed consent from patients prior to e-mail use.¹⁷⁴

Physician-patient e-mail, however, may prove far more complicated than physician-patient telephone conversations. Although *Smith* provides some guidance on the standard of care for physician-patient e-mail, a number of legal questions remain unanswered. Would an automated “out of office” reply suffice when a physician is unavailable, or would e-mails need to go to some sort of “answering service”?¹⁷⁵ Would a physician be expected to check her e-mail remotely?¹⁷⁶ In *St. Charles*, where a physician was held liable for not checking his phone messages for two days, it is suggested that physicians must ensure that patient e-mails are checked regularly. Lastly, how would a court treat e-mails forwarded from other physicians? *Kennedy*, if we literally apply its holding to e-mail, suggests that a physician who merely *opens* such an e-mail can be bound by a physician-patient relationship, a finding even further supported if the physician is aware that the sender is another physician. Even if the *Kennedy* doctrine proves excessive in the context of e-mails, physicians who e-mail patients must nevertheless recognize the willingness of the *Cogswell* court to infer a physician-patient relationship despite a seemingly informal setting. At the same time, however, the experiences of Mr. Messinger and Dr. Johnson suggest that reasonable steps, such as limiting advice to generalized information, can slow the formation of a physician-patient relationship.

Instead of waiting for a standard to evolve, specialized contracts may be used to limit the uncertainty caused when physician-patient e-mail intersects with duties prescribed by the physician-patient relationship. Namely, a physician can use contract law to control the

173 See Spielberg, *supra* note 41, at 1357.

174 Beverley Kane & Daniel Z. Sands, *Guidelines for the Clinical Use of Electronic Mail with Patients*, 5 J. AM. MED. INFORMATICS ASS'N 104, 106-08 (1998).

175 One expert suggests that lawyers should schedule blocks of time for e-mail and, during other times, use “out-of-office replies” telling senders when to expect replies. *E-Mail Overload: Lawyers Receive Nearly 50 E-Mail Messages Daily, According to Survey*, *supra* note 161 (citing Kathleen Call, executive director of The Affiliates). For non-emergency matters, this advice seems sensible for physicians, as well.

176 Rachel Cantor, *Internet Service of Process: A Constitutionally Adequate Alternative?*, 66 U. CHI. L. REV. 943, 964 (1999) (noting that many individuals check their e-mail through remote servers).

formation of the relationship, and, if the physician elects to form a relationship, she can then employ contract law to define its parameters. As a result, more physicians may regard physician-patient e-mail as an acceptable means of communication. Indeed, as observed in *Adams*,¹⁷⁷ a physician may contractually limit his scope of practice, provided such limits do not exceed the boundaries established by public policy. The character of these contracts will undoubtedly vary depending on the expectations of both the physician and patient, as well as the nature of the physician's practice and the patient's degree of medical sophistication. Thus, the contracts need to be "specialized" rather than "standardized," but this Article offers a series of sensible provisions.

As a starting point, a physician can employ the generalization techniques prescribed by radio and television doctors when trying to avoid the creation of a physician-patient relationship through e-mail. Instead of answering a potential patient's e-mail inquiry with a message containing medical information—which would risk the formation of a physician-patient relationship under the reasoning of *Bienz* and *Weaver*—a physician could respond with standardized contractual language stating that no medical advice would be given without an in-person visit. This response could be delivered either as an automatic reply to sender, or as an individual e-mail employing standardized text. Through either mechanism, the physician satisfies his Hippocratic Oath, since he has responded to an individual in need of care, yet his response remains under the *Cogswell* threshold, in that it does *not* express "more than an informal interest and involvement." Moreover, in contract law terms, the automated response effects a "counter-offer" rather than an "acceptance." The physician has not accepted the potential patient's request for medical advice; rather, the physician has rejected the offer and informed the potential patient that medical advice may be dispensed only through alternative forms of communication.

Physicians can also contractually limit their capacity to be held liable in certain out-of-state courts by purposefully directing their electronic actions *away* from those states. Although *Kennedy* suggests that a physician who simply opens an e-mail from a patient or a physician in another state has purposefully directed her actions at that state, no court has expressly made such a conclusion. A physician should generate automated responses to all e-mails, stipulating that the physician may legally dispense advice only to patients who reside or seek treatment in the states where the physician has been licensed to

177 71 T.C. 477, 481 (1978); *see also* *Overstreet v. Doctors Hospital*, 237 S.E.2d 213, 214 (Ga. Ct. App. 1977) (noting that an emergency room physician had contracted to provide 24 hour staffing). For an extended discussion, *see infra* p. 18.

practice. Moreover, by using an automated response instead of reading an e-mail, the physician acts in conformity with *Bellino* and *CompuServe*. A “conversation” has not taken place: an automated response is equivalent to a detailed answering machine message consisting of instructions on how to reach the physician through a different method.

After a physician and patient have entered into a physician-patient relationship, they can then agree as to how frequently e-mail should be checked and what parameters should govern the information conveyed by e-mail. Such limits may not exceed the boundaries set by public policy, but the frequency at which one checks e-mail should not worry policy makers. This is particularly true when alternative forms of communication exist, such as telephone calls or hospital visits. As evidenced in *Smith*, a physician may not be held liable for failing to check e-mail when e-mail serves as merely one of several secondary forms of communication. Given that principle, physicians should instruct patients to call, in addition to e-mail, if an important question or emergency matter presents itself. Furthermore, physicians have an incentive to limit the scope of matters conveyed through e-mail messages since they serve as medical records and can thus be used against a physician in court.

Along these lines, patients would also benefit from a contractual arrangement specifying the scope of information to be conveyed by e-mail. Given the complexity of many medical matters, a patient would often be better served by speaking with a physician. For example, in light of the communicative disadvantages of e-mail text, speaking with a physician may be more appropriate when a patient is to receive a negative prognosis. Moreover, such a communicative arrangement would add predictability to the relationship.

Lastly, physicians should contractually limit patient e-mails to those without attachments. As explored in Part III, HIPAA requires severe penalties for breaking patient confidentiality. Because attachments run a higher risk of online interception, avoiding their use appears sensible. Similarly, patients should contractually specify that physician-patient e-mail be directed to non-work e-mail accounts. Although courts have carved out a very limited confidentiality exception for employee e-mails transmitted over an employer’s e-mail network, patients would undoubtedly feel more secure if their employers could never read their physician-patient e-mails.

VI. CONCLUSION

Even with specialized contractual arrangements, many physicians will nevertheless refuse to e-mail patients. This is due in part to the fact that few health maintenance organizations reimburse physicians for e-mails to patients. Moreover, many physicians find sending e-mail to be time consuming, if not altogether frustrating, because they speak much faster than they type. Additionally, spam may interfere with a physician's ability to identify critical messages.

For the time being, therefore, physician-patient e-mail will likely remain limited to administrative matters, such as rescheduling appointments or refilling prescriptions. In the future, however, as more computer-savvy physicians enter the field and as e-mail becomes more secure, physician-patient e-mail will undoubtedly become more prevalent. Specialized contractual arrangements will enhance legal predictability and delineate expectations, and they will only accelerate the rate at which e-mail becomes a part of the physician-patient relationship. Perhaps more importantly, specialized contracts will enable the law to catch up with the market, which has already evidenced a demand for physician-patient e-mail. When that time arrives, the Hippocratic Oath will unquestionably take on new meaning as young physicians declare, "I will follow that system or regimen which, according to my ability and judgment, I consider for the benefit of my patients."