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Use of e-mail for consulting with patients in general practice

I was surprised to read in the editorial 'Use of e-mail for consulting with patients in general practice'¹ that the author dismissed the issue of security of clinical information, stating that 'other industries routinely conduct transactions of a confidential nature via email, for example banking and insurance'. This is incorrect. Institutions such as banks do not use e-mail for confidential transactions because it is not secure. Their use of e-mail is limited to defined conditions and for strictly limited purposes. Secure email is possible (for example, using public key infrastructure [PKI] or other forms of encryption) but this has had only limited use.

Although the UK Department of Health advocates the use of electronic communication between clinician and patient, there are issues of privacy, confidentiality, security, and data storage to be resolved in addition to the need, as outlined in the editorial, for health professionals to adapt to the use of this form of clinical communication.

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1. Atherton, H. Use of e-mail for consulting with patients in general practice. *Br J Gen Pract* 2013; **63(608)**: 118–119.

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Author's response

Thank you for your response concerning the crucial issue of security when using e-mail for the transfer of clinical information. Rather than dismissing the issue of security I recognise that this is something that needs to be explored. Your point raises questions about what people view as 'confidential' information and this view will differ, regardless of the view of the sender. This is especially likely to be the case in a healthcare setting.

While contact between banks and insurance companies and their customers is largely routine, there are occasions where e-mail exchanges do contain information that an individual is likely to consider personal; for instance details about insurance claims or insurance policies attached to e-mails. Therefore use of e-mail by these sectors even when restricted to 'defined conditions and for strictly limited purposes' does not necessarily exclude confidential information.

If we then think about the healthcare setting, an individual GP has responsibility for the information they send in an e-mail, but must also respect patient autonomy with regard to their views on what is appropriate content for an e-mail. Where e-mail consultations are initiated by the patient, the patient freely makes the decision to send clinical information via e-mail. The notion of confidentiality in this scenario becomes more complex; is it as defined by the GP, or does the patient's decision override any professional judgement?

Given that GPs are already using e-mail with their patients we should be focused on finding a solution to the issue of security and confidentiality that will work in a healthcare setting, drawing on experiences with existing methods of communication and reflecting on how other sectors have managed such contact. We need formal guidance that facilitates and protects rather than restricts GPs and patients.

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The challenge of communication in interpreted consultations in diabetes care

Seale is right to observe that this is the first published empirical study of interpreter-mediated consultations in UK primary care; in the past 10 years, with several colleagues I was unsuccessful in getting funding for such a study.¹ The paper is shocking to the extent that it shows in one UK setting — but there is no reason to suppose this was atypical — a flagrant disregard for well-evidenced guidelines^{2–4} on the need for proper interpreters in consultations between health professionals and people with limited English proficiency.

One of their most glaring findings is that in interpreted consultations professionals used mostly third-person pronouns (she, his) while in non-interpreted ones almost entirely second-person forms (you, your); in other words the health professionals were saying to the interpreters 'does he take sugar?' They note '*Thus a concordance analysis showed that "does he" is the most common two-word phrase associated with providers' usage of "he" in these consultations (33 times), and the most common verbs occurring before "him" in provider talk in these consultations are "see", "ask", "give", "tell", and "help".*'

All guidance points to the importance of addressing the patient directly, 'do you take sugar?', allowing the interpreter simply to relay the same words.

The various qualitative findings point to serious shortcomings in consultations interpreted by 'informal' (usually family members) interpreters, and highlight the need for proper provision.

The implication of this study, as noted by Joe Kai in his editorial, is surely that the cost of paid interpreters (whether face-to-face or a telephone service) is likely to outweigh the loss of effectiveness in diagnosis and