Make the call

"Hello Mr Smith, I'm Dr Richardson and I have been assigned as your physician during your hospital stay," I stated as I approached a frail, cognitively and hearing impaired elderly gentleman on the ward. "You have pneumonia, and we are going to try and make you better," I explained.

"What? You have to take my leg off?" he asked, somewhat surprised.

"No, Mr Smith, you have pneumonia, and we are going to make you better," I restated in a louder voice.

"Well, you gotta do what you gotta do," he said somewhat resigned to his fate.

Fortunately, Mr Smith improved with IV antibiotics and was discharged with both legs intact, much to his relief. My point is that good communication is a big part of being an effective physician. Not only are informed patients more accepting of necessary treatments, but I would argue that their clinical outcomes also improve.* Good communication takes time, and before granting my halo please realize I often fail miserably in this department.

My aging mother has spent most of the last few months accessing and consuming the health care dollars she contributed through her lifetime of MSP premiums. She is currently in the midst of her third protracted hospital stay involving numerous tests and procedures. This has highlighted another area of communication for me—the often forgotten job of keeping families informed. My mother doesn't have any cognitive issues so her care team is able to communicate with her directly. However, when I ask about her treatment plan she often shrugs her arthritic shoulders claiming it isn't clear to her. The cleaning staff who are in the area, while very good at their job, fall a little short when asked about the next step in treating heart failure. In addition, attempting to get further information from the various nurses who come on and off shift is very difficult. I so appreciate when one of her physicians takes a moment to call me and update me on her condition and next steps. Sadly, telephone contact like this is quite rare. My recent experience has encouraged me to keep the families of my patients, particularly those in hospital, more informed. I have always found family members incredibly thankful for a brief update about further investigations, treatment plans, and potential length of stay. This information prepares them for the worst or allows them to make plans for potential discharge or a change in level of care. I find these phone calls take only a few minutes, but they are appreciated by all and well worth the effort.

Good communication is a big part of being an effective physician.

So, one of my resolutions for 2019 is to call relatives less sporadically and more regularly. I encourage you to do the same. Happy New Year to you all.

—DRR

*I have no proof of this and I am certainly not going to perform a low-response survey study as evidence (see my September 2018 editorial concerning such studies).

Email jail

I feel like I am not unusual in sometimes planning to just shoot off an important or timely email when I have the required 2 minutes, especially when I know I might forget about it or just not get to it later. Just 2 minutes.

Perhaps you've shared this scenario: You have written your quick but eloquent missive and are standing up while pressing *send* on your way to your next consult, when you see that big beige box appear across your screen: "You have exceeded the storage limit for your mailbox. You may not send or receive emails."

In the privacy of my office, seeing that message will almost always be accompanied by a loud expletive-laden frustrated groaning blustering, "AAAARGGGHH, email jail!" emanating from what feels like the depths of my own motherboard. A task that should have taken 2 minutes either has to be aborted or put on hold, or I have to sit down and spend time deleting larger emails, then emptying the trash, then finding my draft, and then attempting a resend. If the mailbox cleanup did not suffice, then I have to go back and pick what must be dumped forever.

My emails live in an institutional account in an academic practice. I really, truly understand and respect limitations of shared storage space. I was fortunately once granted a glorious increase in allowable space, and I delete and archive regularly, although I am suspicious of archiving because I was burned once when *all* of my archived files disappeared with my trusty old computer (or became inaccessible) when the hardware was being updated. My archived emails had apparently been set up to be saved separately using older software or something-something-acronym-laden-IT-words something. But the cold hard result was that I didn't have them anymore.

If I am answering emails on my phone, the notification that alerts me that my emails haven't been sent due to my exceeding my mailbox limit is much less prominent, and the emails may nest in my outbox while I, blissfully unaware of their purgatorial fate, wait patiently for answers to emails my recipients haven't received.

It is often important to be able to store and search emails. I cannot print and file all of the emails that may be important in the future. In a world where physicians like me work with or within a hospital administrative structure for years or generations longer than the administrators on the current letterhead, we may have the most or even only institutional memory. Many of those memories are embedded in my email threads, and they will often be the source of information closest to the truth of decisions, plans, mistakes, and promises made.

I also run a practice where photographs are important. Patients living in the far reaches of the province understand the nonconfidential nature of email but consent to sending pictures of wounds and tissue expander progress because, on balance, that is how they can most effectively and safely communicate important questions or concerns. This practice is imperfect and reprimandable, but the proper route, which involves secondary websites and complex workarounds, involves levels of encryption and registration that are, in practice, not achievable by most of my patient families. We don't have a PACS system in our health region that allows patient photos to be sent, archived, and confidentially accessed like radiological images, so when a family sends them to my email, I save them as soon as I can to my individual institutional photo archive behind our firewall or print them for the patient chart, and then, in both cases, immediately delete the images from my inbox. This disposition requires me to be at my hospital office desktop. But there are days when I may receive 15 to 20 MB of photos, and I am not able to be at my desk, and I have to choose to delete them, save them to my laptop, or remain in email jail. Because of the firewall, I can't save them separately in a fashion that provides sufficient confidentiality. I need to find a better way.

So, I am now on the reduce-the-size-of-emails bandwagon. There are days when I get over 100 emails. Every time someone sends an email that is more than 500 KB, that adds to the total. I get notices of rounds, administrative news, and meetings every single day, including on weekends, many in which there are legitimately a few sentences of important information, but they are delivered via a PDF attachment with decorations, photos, and large announcement fonts that turn it into a 2 MB email. Announcements from the Department of Surgery are usually forwarded again at the divisional level, so the duplication doubles the megabytes. I recently printed a letter announcing a lovely award nomination that had four lines of content in it, but was a 5 MB attachment.

I encourage everyone to start applying the environmental movement's "reduce" portion of the three Rs to emails.

First, do I really need to receive the email in the first place? Large group emails often don't need to come to me the first time, let alone be answered with reply all. And honestly, if you need to really emphasize something within email text, instead of attaching a word file, I'm okay if you use a few ALL CAPS; I won't accuse you of yelling. Say what you need to in the body of the email, and make the subject line logically searchable. If I don't need to see details smaller than

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the pixilation of a small image, use the option that allows you to reduce image size. All of us with limited storage would be very appreciative if you could keep attachments and photos small, and use them only when necessary. Please don't embed photos or fancy logo attachments in ways that I can't un-embed or that aren't really necessary. Don't forward attachments I don't need, and take every opportunity to reduce the size of attachments when you do forward.

I will continue to do my best to archive and delete, keep printing to a minimum to save trees, and avoid jail.

Emptying the trash, thanks.

—CV

letters to the editor

When MDs treat other MDs: Sometimes less is more

In medicine, the opportunity to care for a colleague is a unique and rewarding one. However, it can be difficult to balance the desire to provide prompt care with the risks of overinvestigation and treatment. Here we present the case of a retired surgeon turned patient that exemplified some of these challenges and provided us with a learning opportunity that we'd like to share with readers.

An 81-year-old male surgeon was evaluated for chest pain, palpitations, and a troponin elevation. Acute coronary syndrome (ACS) was promptly diagnosed and standard therapies, including a coronary angiogram, were requested. Subsequently, laboratory tests revealed an acute kidney injury (serum creatine 404 umol/L), supported by the presence of hyperkalemia (K^+ 5.8 mmol/L). The on-call nephrologist was consulted; the patient's K^+ was pharmacologically treated, a Foley catheter was placed, a renal ultrasound was requested, and the angiogram was canceled. Several hours later, follow-up laboratory investigations were entirely normal. It was then determined that the original tests were reported in error, and likely no acute kidney injury was ever present. Unfortunately, our patient sustained trauma from the Foley, and the angiogram needed to be delayed owing to bleeding concerns on his ACS medications.

Medical errors are not uncommon occurrences,[1] and most relate to human factors.[2] A variety of decision support systems and quality improvement protocols exist to reduce mistakes.[3] Errors made by analytical equipment are less common and are on the decline.[4] In this case, the error related here not only resulted in patient harm but also led to needless investigations, prolonged hospitalization, and specialist referral. (In 2005, the average cost of hospitalization for ACS in Canada was $80 000.[5]) Thankfully, our patient recovered quickly and experienced no long-term morbidity. He graciously accepted our apology. As a retired surgeon, he wisely reminded the cardiology trainees to interpret laboratory results in the appropriate clinical context! It was a teachable moment in many respects.

—Thomas M. Roston, MD, FRCPC
—Pol Darras, MD, MSc, FRCPC
—Morris Pudek, PhD
—David A. Wood, MD, FRCPC

References

1. Van Den Bos J, Rustagi K, Gray T, et al. The $17.1 billion problem: The annual cost of measurable medical errors. Health Aff (Millwood) 2011;30:596-603.
2. Janatpour KA, Kalmin ND, Jensen HM, Holland PV. Clinical outcomes of ABO-incompatible RBC transfusions. Am J Clin Pathol 2008;129:276-281.
3. Kawamoto K, Houlihan CA, Balas EA, Lobach DF. Improving clinical practice using clinical decision support systems: A systematic review of trials to identify features critical to success. BMJ 2005; 330:765.
4. Carraro P, Plebani M. Errors in a stat laboratory: Types and frequencies 10 years later. Clin Chem 2007;53:1338-1342.
5. Canadian Institute for Health Information, The cost of acute care hospital stays by medical condition in Canada, 2004-2005. Ottawa: CIHI, 2008.

Re: Residential care disparities

I recently came across a report while on a public health elective in my fourth year of medical school. Admittedly, I am new to medicine, but I was truly shocked by the data presented by the Office of the Seniors Advocate BC. These provincial data were powerful, concluding, "if you are a resident living in a licensed care facility operated by a *contracted* provider versus one operated by a health authority, you are 32% more likely to be sent to the emergency department, 34% more likely to be hospitalized, have a 32% longer length of stay, have a 47% greater likelihood that you will become an 'Alternate Level