Telephone care requires use of language that paints clear picture for parent, doctor

by Jeffrey L. Brown, M.D., FAAP

Confronted by families clamoring for more convenient access to care, rising office overhead and increasing productivity demands, it’s no wonder that pediatricians use telephone encounters to manage certain clinical problems with established patients.

It takes unique communication skills, however, to provide quality telephone care. Most pediatricians learn telephone care on the job, and not all are equally skilled at “seeing” the patient over the phone.

Malpractice risks

Poor telephone communication leads to poor patient care and significantly increases potential liability for the doctor. On average, malpractice claims for telephone care are more expensive than for face-to-face care.

The Physician Insurers Association of America reports that among closed malpractice claims from 1985-2006, the average indemnity payment among all physicians for telephone care was $272,327, about 36% higher than the average indemnity payment for all malpractice claims paid during that same time period ($199,902). The average pay-outs for pediatrician claims for telephone care during that same period were 3.7% higher ($282,630).

Malpractice payments against pediatricians for meningitis care given by telephone averaged $520,771, 19% higher than meningitis care provided face-to-face ($437,423).

Ask the right questions

During phone encounters, pediatricians need to develop a mental rather than a visual image of the patient’s general appearance. This is essential to putting the patient’s symptoms and complaints into proper context.

For example, two patients present with gross hematuria. One is seen at a preventive medicine exam and looks well. The other looks ill at the office visit, has a high fever or is in pain from trauma. The pediatrician would follow different diagnostic algorithms with different degrees of urgency for each patient. A greater level of concern would attend the patient complaining of a “terrible stomachache” who looks sick and is febrile than one walking through the door and looking well. Conversely, there will be less immediate concern for the child whose general appearance does not suggest either acute or chronic illness when the parent reports that “my child is sick all the time.”

Telephone care requires the use of language that creates an unambiguous picture for the parent and the doctor. The words: “Trouble breathing” might mean signs or symptoms...
ranging from a stuffy nose to retractions. “Straining or pulling to get air in or out” better describes dyspnea.

To substitute for an initial visual impression of general appearance, ask a series of questions to assess the degree or intensity of the child's symptoms. Initially, less specific questions are more useful than those that are highly detailed: A small child with diarrhea who looks happy and playful is very unlikely to have significant dehydration regardless of how often he wets his diapers or whether he cries with tears.

Examples are:
• “Does your child look sick the way he would with a cold or much worse than that?”
• “Do you feel frightened or worried about the way your child looks?”
• “Is he up and around, or is it difficult to get him out of bed?”
• “Has he been refusing to eat? For how long?”
• “Does he look pale and sweaty, or does his color look OK to you?”
Modify questions to take into account cultural and racial considerations and the parent's level of health literacy.

Once the general “first impression appearance” is in your mind, ask more specific evaluation questions. If you aren’t convinced that the child “looks” all right, it is prudent to bring the patient in to be evaluated quickly.

Misunderstandings can result in diagnostic errors or delays in treatment and may become sources of potential liability. Inexperienced practitioners often find it best to learn a questioning pattern from a formal telephone triage manual until they develop their own repertoire of questions. Experienced pediatricians should not forget common sense and intuition.

Whether you’re a novice or have many years of experience, self-evaluation at the end of every call can improve communication skills. Ask yourself:
• Did I have a clear mental image of how the child “looked” when I made my triage decision?
• Did I ask my questions in a concise and unambiguous way?
• Is it likely that the parent could have misunderstood me, or I misunderstood her?
• Do I feel comfortable with the overall way that the call went?
If the answer is “no” to any of these, call the parent back.

Document calls
Pediatricians often take after-hours calls “on the run.” Develop a system that gets call documentation to the patient’s chart in a timely fashion. Some pediatricians leave recorded messages on the office telephone, their cell phone or put notes on their PDAs. Keep “sticky” telephone encounter forms handy to jot down notes when you’re on the phone with a patient and affix them in the patient’s chart later.

Any form of delayed entry needs to include the time the note was entered into the chart as well as the time the call was received. If you plan to bill for telephone visits, the documentation will need to be more thorough.

Document the call-back instructions given to parents. You can use the acronym PCWAS. Tell parents: “Call me back if your child’s symptoms Persist, Change or are Worsening, or if they cause you Anxiety. I need to know if they include any of the following symptoms that are Specific to your child’s condition.” (For example, after head trauma: vomiting, sleepiness or severe headache.) Then write “PCWAS” in the chart.

How well do pediatricians document telephone care? AAP Periodic Survey of Fellows #69 showed a statistically significant increase from 1992 to 2007 (44% vs. 75%, p<.05) in the percentage of pediatricians who reported keeping records of all telephone contacts during office hours. The results are not so encouraging for after-hours telephone care. There was no significant change from 2001 to 2007 in the percentage of pediatricians keeping records of telephone contacts after office hours.

However, among those who did, more respondents said they documented “instructions given” (94% vs. 91%, p<.05) and when “physician returned the call” (76% vs. 67%, p<.05) in 2007 compared to 2001. (See table.)

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