

PRACTICE PERFECT

COMPLIANCE & RISK MANAGEMENT

6 Tips for the After-Hours Telephone Consult

BY JEAN SHAW, CONTRIBUTING WRITER

INTERVIEWING ANDREW DOAN, MD, PHD, ANNE M. MENKE, RN, PHD,
AND RONALD W. PELTON, MD, PHD

One of the most commonplace items in your practice—the telephone—is also one of the riskiest. Perhaps because of the telephone’s ubiquitous presence in our lives, people don’t always take it as seriously as they should. As a result, there have been occasions when physicians did not give telephone consultations their full attention, and that’s a problem, said Anne M. Menke, RN, PhD, risk manager at the Ophthalmic Mutual Insurance Company (OMIC) in San Francisco.

“I have seen the telephone be a factor in malpractice cases time and again,” said Ms. Menke. Indeed, when OMIC reviewed its top-paying malpractice claims from 2011 and 2012, it found that several of them involved problematic telephone conversations. For instance, in one of the cases, “The physician didn’t even talk to the patient; he was talking to the patient’s spouse, who was refusing to bring the patient in,” noted Ms. Menke.

6 Tips for Avoiding Trouble

OMIC experts offer several tips for minimizing telephone-related problems and keeping your practice out of hot water.

1. Be truly accessible. Ronald W. Pelton, MD, PhD, and Andrew Doan, MD, PhD, both members of OMIC’s Risk Management Committee, give patients their cell phone numbers. “I make sure that patients know how to get in touch with me,” said Dr. Pelton, who practices oculofacial plastic and reconstructive surgery in Colorado Springs, Colo. “I don’t have a telephone answering service; I have an after-hours answering machine that gives my home and cell numbers.” These numbers are on all postoperative instruction sheets and medication labels as well, and Dr. Pelton points them out to his patients when he’s going over postop instructions. “I tell people, ‘If you can’t reach me, you aren’t trying hard enough.’”

Dr. Doan, a comprehensive ophthalmologist who practices in Temecula, Calif., said, “I welcome patient calls. That’s what our job is, right? There shouldn’t be any hesitation about having patients call.” Ms. Menke agreed, noting that even if you provide contact information on a routine basis, that doesn’t necessarily mean patients perceive you as being genuinely accessible. “You can’t say ‘Call me’ and then seem grumpy about it when a patient

Download This Form

After-Hours/On-call Telephone Contact Form

The image shows a thumbnail of a form titled "After-Hours/On-call Telephone Contact Form". The form has several sections with headings: "Patient Name", "Date of Birth", "Address", "Phone Number", "Insurance Carrier", "Insurance Policy Number", "Referring Physician Name", "Referring Physician Address", "Referring Physician Phone Number", "Referring Physician Fax Number", "Referring Physician Email Address", "Referring Physician Specialty", "Referring Physician License Number", "Referring Physician State", "Referring Physician Board", "Referring Physician Board Number", "Referring Physician Board State", "Referring Physician Board Country", "Referring Physician Board City", "Referring Physician Board State", "Referring Physician Board Country", "Referring Physician Board City", "Referring Physician Board State", "Referring Physician Board Country".

Go to www.omic.com and search for “Telephone Screening of Ophthalmic Problems” for an article by Ms. Menke on screening calls from patients. It includes a sample after-hours form (above) that prompts you to ask about recent procedures or surgeries, and whether the patient has contacted other health care providers about the same or related problems. The article also includes a form that staff can use to screen calls during office hours. You are encouraged to customize these forms to meet the needs of your particular practice and subspecialty.

does call. You want to make it clear: ‘If you’re in doubt, call me; it really matters to me,’” she said.

2. Take charge of the conversation. Once you’re on the phone, “You have to treat it as an office visit, bring your full attention to bear on it, and have a structured way of dealing with it,” said Ms. Menke. “I tell physicians, you have to drive the conversation.” Do-



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ing so requires asking the appropriate clarifying questions and employing a methodical approach. “You need to determine, ‘Do I have all the information I need in order to decide how to manage this patient? If not, what questions do I need to ask? Do I trust the information this patient is telling me, or do I need to see him to evaluate the complaints?’” Moreover, she said, “What instructions will you need to give to the patient at the end? When would it be necessary for the patient to call you back?”

3. Document the conversation comprehensively. “It is not possible to overdocument when it comes to a conversation on the phone,” said Dr. Pelton. “I document the date and the time of day, and I summarize what was said—then all of that always needs to go into the patient’s chart.”

OMIC has developed an after-hours form to help you document telephone conversations (see “Download This Form”). The form offers prompts that are designed to help the physician ask the appropriate questions and cover all the necessary bases. “The prompts can get you to focus on what’s going on with the patient,” said Ms. Menke, and can be used for all after-hours calls, including those with other caregivers, such as ER physicians, call partners, and members of your staff.

Depending on the situation, the form can be filed in the patient’s record or faxed to the office or call partner, said Ms. Menke. And if it pertains to a person who is not one of your patients, the original form “should go into an alphabetical file kept only for those types of calls and kept for 10 years,” she said.

4. Beware flawed information. The goal is not to avoid telephone conversations. Instead, it’s to remember that—whether you’re talking with a patient, a resident in the ER, or one of your partners—you’re trying to diagnose and manage based on limited information, said Ms. Menke. “You’re relying on information given by the person with whom you are speaking, and you can’t get any nonverbal clues” that might prompt you to follow a particular line

Other Phone Problems

Are your clinical and nonclinical staff trained to handle telephone calls during office hours? Your staff needs clear-cut protocols, said Dr. Pelton. “I make sure that nonclinical staff members don’t try to answer clinical questions. Patients often will call and say, ‘Let me ask you this ...’ Naturally, the staff wants to be helpful, but I’ve trained them to respond to all clinical questions with, ‘Let me have the nurse get back to you on this.’” He added, “You can avoid some serious problems this way.”

of inquiry, as you would if you saw them face to face.

In addition, she said, “Why is the patient calling? If he has bothered to call after hours, he’s worried.” And whenever you are having a conversation with a worried patient, your task is to determine whether that worry is warranted, she noted.

5. You may need to suggest an office visit. “I think you always have to be skeptical about the information you’re getting over the phone. You want to have a low threshold for getting off the couch and going in to the office,” Dr. Pelton said. Dr. Doan agreed. “By taking information over the phone, you’re accepting someone else’s clinical judgment,” he said. “I want to see for myself.”

Dr. Pelton added, “I have a very low threshold for telling a patient to come in and see me. I really try to give them that opportunity. If a patient says, ‘I just want to ask you a question about x or y,’ I’ll tell them something along the lines of, ‘Obviously, diagnosing you over the phone is nothing like diagnosing you in person, so I’m going by experience here, but it sounds like you’ve got y or z going on. But I’m actually in the office now, so why don’t you drop by and let me take a quick look at it.’” That way, he said, “I’ve given the patient the opportunity to come in, and I’m less likely to miss something.” Patients are “very responsive” to this approach, he said. “Often,

they want to come see you, but they’re afraid to ask.”

6. Follow up with the office. “The next piece of this is communicating with the office,” Ms. Menke noted. Following up with your practice or call partner is essential to make sure no problems slip through the cracks.

For instance, if you’re in a call group and get a late-night call from a patient who is unknown to you, make sure you follow up with the patient’s regular physician, she said. “Let’s say that that doctor’s office gets another call from the patient the next morning. If the patient’s physician sees that the on-call physician took two calls after hours, she will know that there’s an escalating problem.”

Use Electronic Media Carefully

The pervasiveness of electronic media—from e-mail to Facebook and Twitter—means that physicians need to increase their suspicion index, said Dr. Doan. “You have to be particularly careful about making a diagnosis through these avenues.”

In a few select cases, Dr. Pelton has been able to have patients send him images by cell phone or to talk to them via Skype, he said. “But nothing beats looking with your own two eyes. Again, just have a low threshold” for seeing the patient.

Bottom Line

“If you have a friendly attitude, you drive the conversation, you document it, you give the patient guidelines on when it’s necessary to call you back, and your care is appropriate,” said Ms. Menke, then your decisions will be supported. When these conditions are met, “The telephone consultation is not hard to defend.”

Drs. Doan and Pelton report no related financial interests. Ms. Menke is employed by OMIC.

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