Telephone consultations

Improving quality and safety of telephone based delivery of care: teaching telephone consultation skills

J Car, G K Freeman, M R Partridge, A Sheikh

High quality telephone based health care delivered by appropriately trained staff should be available to all

The opportunity to consult by telephone is now an integral part of any modern patient centred healthcare system.[1] The public values the option of consulting by telephone, citing advantages of quicker access to care, greater convenience, and more choice in the way health care is received.[2] In the United States up to a quarter of all primary care consultations are now conducted over the telephone, but there are also risks associated with this form of communication.[3] Key approaches and skills that clinicians need to acquire to minimise these risks include use of detailed protocols for the organisation of a telephone service, structured evaluation of the urgency of calls, and issues to do with confidentiality. None of these has so far been incorporated into doctors' formal training, and this needs to change.

Telephone contacts are increasingly used as an extension of, or substitute for, traditional face to face contacts with a range of primary and secondary healthcare professionals. Telephone services now include delivery of routine and emergency care, facilitating health promotional interventions, obtaining results of laboratory investigations, and repeat prescriptions.[2] Many doctors are, however, still reluctant to provide this form of service and this probably reflects lack of confidence, perceived vulnerability and, underpinning these, a lack of appropriate training.[4 5] This is unsurprising because, although there are a number of skills that are common to all forms of consultation, consulting by telephone does require an additional range of skills. These include a more refined appreciation of the importance of verbal cues and focused history taking to compensate for the inability to examine the patient.

The British Medical Association's guidance for general practitioners, *Consulting in the Modern World*, warns doctors on the one hand of the limitations of telephone consultations: ''During a telephone consultation the doctor cannot see, touch, examine, investigate, smell or, in the strictest terms, even hear the caller/patient'' and then advises that: ''telephone consultations when correctly conducted can be considered to be safe and acceptable practice''. Both the limitations and the advantages of telephone consultation are therefore apparent, but doctors and medical students are given little advice or training in how to conduct telephone consultations correctly or develop the requisite skills. Most other professional and commercial services, including health related nurse run telephone services, insist on training for those who develop telephone based services.

Training courses need to help clinicians build appropriate attitudes, skills, and knowledge and should include both generic and specialty specific modules. In addition to verbal cue sensitivity and more focused history taking, generic topics include training in the adequate documentation of telephone encounters and awareness of when telephone consultations are inappropriate (for example, where there are language difficulties or where there is a clear necessity for clinical examination or need for use of investigative facilities) and an appreciation of relevant medicolegal issues. Clear guidance is needed regarding the ''substitution'' of questions for examination such as asking the patient to measure her/his temperature, blood pressure, peak flow or blood glucose level; exploration of strategies for home management including self-monitoring; negotiation of a plan and assessment of its feasibility; follow up arrangements; and management of expectations for a home visit. In addition, medical managers need to be aware that planned telephone consultations must require availability of medical records, a confidential telephone line in a quiet area, and the resources to document the consultation and to communicate this to others such as the general practitioner and the patient. There must be opportunities for early face to face consultation if the need becomes apparent during the telephone consultation. Hospitals should also consider offering morning or evening ''commuter'' telephone clinics for patients in employment.

Each specialty must consider its specific telephone training needs. We anticipate that these may focus on issues such as ''warning signs and cues'' for various disorders, guiding patients in performing limited self-examination (for example, determining if a rash blanches or, for asthma, asking an adult patient to record his/her peak flow or the mother of a child with asthma to assess the pulse rate or respiratory rate) and prescription guidelines (for example, prescription of non-steroidal anti-inflammatory drugs in acute low back pain).[6] Professional bodies need to provide clinicians with evidence (or state the absence) of the effectiveness and safety of such interventions to allow clinicians to undertake an evidence linked assessment of the advantages and limitations of telephone consultations. Future versions of guidelines, such as the British Thoracic Society/Scottish Intercollegiate Guidelines Network (BTS/SIGN) asthma guidelines, might include key questions to be asked during a telephone consultation.[7 8]

There is evidence that clinicians' performance, confidence, and satisfaction with delivery of care by telephone can be improved by short educational programmes.[9–14] As for teaching traditional consultation skills, simulated patients are the cornerstone of teaching programmes aimed at improving telephone consulting skills.[15] Such training should become an integral part of the consultation skills programmes that now run throughout undergraduate, general practice, and specialist training. For established clinicians, training opportunities need to be offered as part of continuing professional development.

A number of studies have identified substantial variation in the quality of telephone consultations.[16 17] Monitoring and assessing the organisation and quality of telephone consultations is essential, and this appraisal should extend to receptionists and other essential team members. Many of the quality indicators for telephone consultations can be adapted relatively easily from other organisations such as The Telephone Helplines Association, UK.

With over 90% of the UK population now having ready access to a telephone, and with an increasing array of services now available on the telephone, it is essential that mechanisms are developed to ensure that high quality telephone based health care delivered by appropriately trained staff is available to all. *NHS Direct* (and similar developments in a range of commercial

services) have heralded a much needed shift in culture, and it is now time that mainstream primary and secondary healthcare services followed suit.

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Authors' affiliations
J Car, G K Freeman, Centre for Primary Care and Social Medicine, Imperial College, London, UK
M R Partridge, Department of Respiratory Medicine, National Heart and Lung Institute, Imperial College, London, UK
A Sheikh, Division of Community Health Sciences (GP Section), University of Edinburgh, Edinburgh, UK

Correspondence to: Dr J Car, Department of Primary Care and General Practice, Centre for Primary Care and Social Medicine, Imperial College, London W6 8RP, UK; josip.car@imperial.ac.uk

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Open disclosure of medical errors

Open disclosure: the only approach to medical error

R Lamb

Open, honest, and timely disclosure should be the only approach to medical error

The open, honest, and timely disclosure of medical error to patients should be, as Americans say, a ''no brainer''. It is ethically, morally, and professionally expected of clinicians.[1–3] It is clearly the right thing for patients who frequently say that, when things go wrong with their health care, what they need most is disclosure, an apology, and information about what happened and how it can be prevented from happening again.[4]

Clinical staff might feel that open disclosure is either too difficult to deliver or labour under the perception that, by doing this, they will increase the risk of litigation. But being honest with patients about errors and mistakes is the right thing for doctors, other clinical staff, and the hospital involved. Open and truthful discussion with the patient is the first stage in promoting and fostering an environment and culture that, through honest discussion, encourages the learning needed to improve systems and thus reduce medical error. Doctors and other clinical staff who are not used to such an approach to discussing errors will need support as such discussions are difficult. But once an error has been acknowledged, discussed, and acted upon, clinical teams can get on with their job of treating the sick.

This all sounds so obvious, particularly to a reporter like me who, during 25 years in journalism, has frequently interviewed patients who have suffered from the health care they have received. But, traditionally, the decision about whether or not to disclose information about an error when it has taken place has largely been left to individuals. Traditions die hard and, while many individual clinicians undoubtedly do deal with such matters openly and honestly, it is clear from public statements of many patients that, even in the 21st century, this does not happen often enough and it is not encouraged in a systematic, organisation-based way. Or, when it does happen, it may not be handled satisfactorily from the patient's point of view.[5]

Certainly, my experience has been that, when patients take their stories to the news media, most of their anger is about how they were treated after the adverse event rather than the event itself. Mostly (and there are exceptions), these people have already tried hard to resolve issues through local and official channels and feel that they are not getting anywhere. Going to the news media is an action of last resort, born of frustrated attempts to find out the truth.

In New Zealand in 1995 a patient referred to in a later inquiry as ''patient A'' was diagnosed and treated for cervical cancer. She discovered that four cervical smears before this had been reported as normal or inconclusive when, in fact, they showed evidence of cancer. Put simply, her cancer could have been diagnosed earlier and, if it had, her treatment may have been considerably less invasive and subsequent health problems avoided. Fearing that many other women may have been similarly affected, she wanted to find out why her cancer had been undiagnosed and tried to get official agencies to investigate. In 1999, believing that was getting nowhere, she felt that she had no option but to take to court the by then retired pathologist responsible for the diagnostic error and the unnecessarily late diagnosis of her cervical cancer. The matter then became public, finally hit the headlines, and set up a train of events that led to the 2001 Gisborne Cervical Screening Inquiry. The problems that were uncovered have led to wide ranging recommendations for improvements to the national cervical screening programme.