Accident & Emergency Department's response to patients' inquiries by telephone

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Summary

A prospective survey of all telephone calls for medical advice to the Accident & Emergency Department of Leicester Royal Infirmary was undertaken. The objectives of the study were to quantitate the frequency and circumstances related to these inquiries. Over the study period of 10 days, details of 154 telephone calls were recorded. The results demonstrated the perception of the general public, that the A & E department was the most logical place to contact. Only 30% (46) attempted to seek advice from their general practitioner prior to calling the department.

Introduction

Patients will frequently telephone doctors for advice. It is common practice amongst paediatricians to liaise with parents in this manner in the United States. Up to 12% of a paediatrician's working day involves the management of patients by this method[1]. However guidelines are laid down by the American Paediatric Association on the telephone management of paediatric problems[2]. Individual centres have developed protocols tailored to their requirements[3]. The advantages of protocols are that they provide a checklist, guidelines on management and a record. In accident & emergency (A & E) medicine, the advice given may be substandard and jeopardize the patient[4]. The inability of doctors to obtain important historical information on the telephone is well documented[5]. In the UK, no such guidelines exist for A & E departments to give advice on the telephone. Junior doctors are not trained to deal with this aspect of assessment. The calls may be sporadic and impersonal. It is difficult to judge the capability of the caller to describe a condition or follow the advice given. The medico-legal position of this dispersal of information is also open to question.

Patients and methods

All telephone requests for medical advice over a period of 10 days were entered into the study. Details were recorded on proforma sheets completed by members of the medical staff. These included the nature of the request, the complaint group, duration of symptoms and reason for contacting the A & E department. The caller was specifically asked if attempts had been made to call their GP and if so what advice had been given.

Results

Information was collected on 155 calls for medical advice. Of these 35 (23%) had consulted their GP about the problem. However 15 (10%) had attempted to do so but engaged telephone lines and referral to a deputizing service deferred their efforts. Thus approximately two-thirds (67%) thought it was necessary to contact only the accident & emergency department. The nature of the inquiries were as follows; accidents and traumatic incidents 41 (26%), medical 33 (21%), parasuicide 21 (14%), surgical 14 (9%), dental 11 (7%), stings and bites 6 (4%), orthopaedic 5 (3%), obstetrics and gynaecology 5 (3%), psychiatric 3 (2%), assault 2 (2%), and miscellaneous 13 (9%). The duration of the problem was less than 24 h in 88 of the cases, whilst 63 callers described the complaint of 48 h to greater than one month. The reason for telephoning the accident & emergency department stemmed from the patient's or their relatives' initiative in 142 (92%) incidents (Table 1). General practitioners suggested three (2%) patients ring the department themselves. Further evaluation was deemed necessary by the senior house officers in 75 (49%) of the cases, in that the patient was told to attend the A & E department or their GP (Table 2).

Table 1. Source of telephone call

	No. of cases	*%*
Patient	99	64
Relatives or friends	43	28
Place of work	6	4
General practitioner	3	2
Others	3	2

Table 2. Advice given to patient

	No. of cases	*%*
Attend A & E department	48	33
Urgent GP consultation	27	18
Routine GP consultation	16	11
Referral to dentist	10	7
Referral to specialty	5	3
Reassurance	41	28

Discussion

The use of the telephone to give medical advice has become an established practice in medicine. The normal practice in this department is for the calls to be answered by the triage nurse, unless the person asks specifically to speak to a doctor. The call will be documented by the triage nurse and include both the time and date of the inquiry. If the request is, for example, information on poisonous substances, the

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triage nurse may consult with the Edinburgh Poisons Information Service via prestel link and advise accordingly. Should doubt exist on behalf of the nurse or junior doctor, a registrar is resident on-call 24 hours a day in the department to consult with.

In the USA, paediatricians can spend up to one-eighth of their working day on the phone[1]. Most of the reported studies in the literature relate to paediatric practice. However telephone calls for general medical advice to this hospital are transferred to the A & E department.

There are no established guidelines and nursing or medical staff may take the call depending on the patient request. If the inquiry is for advice the triage nurse will provide the same and liaise with the medical staff if deemed necessary. If the request is to speak to a doctor, then a member of the medical staff will take the call. For the purposes of this study all calls were transferred to the medical staff. The question arises as to who should take the call. In a recent survey of emergency rooms' responses to a set scenario, only 4% allowed the caller to speak to a doctor[4]. It is reported that the majority of calls will be for minor ailments with 1% being true emergencies[6]. The majority of patients in this study (66%) did not even consider contacting their GP. This may give some insight as to the expectations of the A & E department by the general public. The difficulty arises for the nurse or the doctor receiving the call. The calls are sporadic, impersonal and may occur when the department is very busy. Unfamiliarity with the patient or past medical records make it difficult to judge the callers capability of describing symptoms or signs, or their compliance with advice given.

This may be reflected by the number of callers in this study advised to consult with a doctor or the A & E department. There is also evidence to suggest that doctors may not obtain important historical information[3,5]. This may lead to inadequate advice being given to the patient. In this context GPs may be in a better position to give the advice. The use of protocols and training in telephone assessment attempts to address these problems, and has been shown to improve standards[3]. The protocols provide a checklist, guidelines on patient management and a record of the conversation. Their use by nurse practitioners identifies three groups of patients, those who need to be seen, those who require a consultation with a doctor, and those who can be managed at home[7]. Thus it does not have to be a member of the medical staff answering these calls. In fact trained health assistants using protocols perform better than medically qualified personnel[3]. Documentation of the conversation has important medico-legal implications because if it is inadequate the vulnerability to litigation is enhanced. It has been stated that once advice is offered, one has assumed a legal obligation and responsibility for advice given[8].

Some would suggest that the only advice that should be given is to attend the hospital[9]. Although these comments stem from the American literature a personal communication with a UK defence society suggests a similar situation in this country; this being that if medical advice is offered to a telephone caller a professional relationship arises. If the caller acts on this advice and detriment ensues then the question of negligent advice arises. This will be enhanced by lack of documentation. It is also suggested that this applies not only to A & E departments but to any member of the medical profession.

We plan to investigate further the compliance of patients with regard to the advice given and their expectations.

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