Documenting Phone Calls - Physician Office Practice Toolkit Resources to Assist You

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One key area of record-keeping that is often overlooked is the documentation of patient phone calls, whether during or after office hours. When dealing with patient phone calls in the office, it is important to have the patient's chart available to review prior relevant clinical information and document current communication. When calls are received out of the office, especially at an inconvenient moment, such as during the movies, dinner at a restaurant, or in the middle of the night, it is also important to have a process in place to capture timely documentation of the communication. Adequate phone call documentation reflects clinical decision-making, supports actions taken, and provides for safe continuum of care.

The following claim analyses highlight the lack of documentation of patient phone calls, which played a significant role in the defense of the claim. In each of these cases, the claimant prevailed and significant indemnity payments were made on behalf of the defendant physicians.

Case 1
Claimant was a 77-year-old female who alleged negligent post-operative management of cataract surgery, resulting in permanent loss of vision in her left eye.

Case Summary
(Day 1, Monday) The patient had surgery by Dr. 1 to extract the cataract of her left eye.

(Day 5, Saturday) Patient experienced white spots in vision of left eye and called Dr. 1's office after hours. Dr. 2 was on call and responded to the patient. Dr. 2 testified that the patient only complained of cloudy and hazy vision (no complaint of white spots). Dr. 2 advised the patient that this was not an emergency and it could wait until her next scheduled appointment in two days. Dr. 2 did not examine the patient or contact Dr. 1 regarding the patient's complaint. Dr. 2 did not document any notes of the phone conversation with the patient.

(Day 7, Monday) Patient was seen at Dr. 1's office for next scheduled appointment and on physical exam was found to have reduced visual acuity. Patient informed Dr. 1 she had white spots in vision since Day 5. Dr. 1 diagnosed the patient with Endophthalmitis and immediately referred her to a retina/vitreous specialist, who saw her on the same day and agreed with Dr 1's diagnosis. The specialist performed a Pars Plana Vitrectomy to administer antibiotics.

(Day 19) Dr. 1 was continuing to follow the patient. Her left eye visual acuity was 20/400.

Outcome
(Three years later) Patient was seen by Dr. 3 and was found to have Ischemic optic atrophy of the left eye, resulting in significant and permanently reduced visual acuity of the left eye.

Risk Issues
There was a question of what exactly the symptoms were that the patient identified to Dr. 2. Documentation of the phone call and the specifics of the call, including the complaint and advice given, could have clarified this in the medical record and prevented a claim from being filed, by supporting Dr. 2's testimony.

Dr. 2 did not notify Dr. 1 of the patient's phone call. Covering or on-call physicians should advise the covered physician about any patient contacts...
or treatments rendered during the coverage period at the time of the handoff, and document the discussion.

Conclusion
Comprehensive and concise documentation serves first to promote a continuum of care; in addition it demonstrates the process of critical thinking upon which doctors base their actions. It is also important to communicate with the patient’s physician when covering for another physician to ensure everyone involved in the patient’s care is kept informed.

Case 2
Claimant was a 28-year-old female alleging negligent performance of answering service and office staff, resulting in delayed treatment.

Case Summary
(Day 1) 28-year-old female patient presented to Emergency Department with fractured ankle. Dr. 1 attempted a closed reduction of the fracture and was unsuccessful. Patient was admitted for surgery on the following day.

(Day 2) Patient had ORIF, with plates and screws, and a cast applied by Dr. 2. The patient was discharged to home the next day with instructions to follow up with Dr. 1 in one week.

(Day 6) Patient called Dr. 1’s office and spoke to answering service. She requested to speak with Dr. 1 secondary to a “pop” she felt, complaints of pain and that the cast was loose. She also needed a prescription for pain medication at a pharmacy close to her home. According to the claimant’s testimony, the answering service was rude and inappropriate with her and stated that the on-call doctor would call her. The on-call doctor never called the patient. The answering service records did not reflect patient’s need to speak with the on-call doctor, just that the patient wanted to pick up drug samples at the doctor’s office.

(Day 11) Patient called Dr. 1’s office four times requesting to speak with the doctor with complaint of pain and need for pain medication, as well as a new foul-smelling odor emanating from the cast. The office made an appointment for the patient to see the doctor in four days and told the patient that the doctor would not fill any prescriptions after hours and that the doctor would not be contacted. The office had no record of the phone call.

(Day 12) Patient called Dr. 1 again with complaint of severe pain and foul odor. The doctor’s office had no record of this call. The patient had phone bills proving all phone calls made to the doctor’s office.

(Day 15) The patient went to Dr. 1’s office for scheduled appointment where it was found that she had a significant infection of the ORIF site.

The patient informed Dr. 1 of the phone calls she made to the answering service and office. The patient was immediately admitted for surgical debridement and skin flap.

Outcome
The patient was discharged to home two weeks later with a PICC line and visiting nurse services. The wound healed with significant scarring, permanent numbness and weakness.

Risk Issues
There was inadequate policy and protocol for both the answering service and the office staff with regard to triaging patient phone calls to determine which ones require immediate attention; there was also no policy or protocol requiring documentation of calls. There was incomplete and inconsistent documentation of phone conversations between the patient and the answering service, as well as the office staff.

Conclusion
A clear policy and protocol for both the answering service and the office staff should be developed for conducting telephone assessments and triage, and to document and communicate patient questions and concerns. Both staff and the answering service compliance should be routinely monitored.

Summary
Documentation is a critical part of patient care as it serves to memorialize the doctor’s thought process, the patient’s state of health, and is the foundation for defense of a medical malpractice claim. In some cases, concise documentation will prevent a claim from being filed. Lack of and incomplete records can aid the plaintiff’s attorney in demonstrating negligent care, even when standards of care are met.

The Princeton Insurance Physician Office Practice Toolkit was developed for and provided to office-based physicians. It includes a convenient off-hours patient telephone call record pad, which is designed to improve documentation of out-of-office patient phone calls. The toolkit also contains a sample telephone call log for in-office use.

To request additional patient telephone call record pads, please call our Risk Resource Line at 1-866-Rx4-Risk.