Phone calls: Protect yourself when you can't see the patient

Jon E. Grant, JD, MD, MPH
Associate professor of psychiatry
University of Minnesota Medical Center, Minneapolis

Man attempts suicide after telephone consultations

Kitsap County (WA) Superior Court

A 38-year-old man was hospitalized after a suicide attempt. He was diagnosed as having bipolar affective disorder and treated with lithium and olanzapine. Over the next 3 months a psychiatrist treated him, discontinued olanzapine and lithium, and started valproic acid.

Four months after the suicide attempt, the patient's wife called the psychiatrist. The patient claims his wife told the psychiatrist he was having paranoid delusions similar to those he had experienced before the suicide attempt. The psychiatrist says the wife reported only that the patient was confused. The psychiatrist told her that her husband should resume taking olanzapine and report the results in 1 to 2 days.

Two days later, the psychiatrist received a voice mail from the patient's wife, who reported that her husband had improved. The psychiatrist testified that he returned the call and was told that the patient was doing well. The patient denied that this call was made.

The next day, the patient concealed a knife in his briefcase, drove to a wooded area, and stabbed himself three times, lacerating his heart, lung, and diaphragm. He underwent surgery and survived.

In court, the patient argued that if the psychiatrist had evaluated him in person instead of over the telephone, the psychiatrist would have recommended hospitalization. He also alleged that the psychiatrist did not obtain informed consent before stopping olanzapine.

The psychiatrist argued that the patient gave informed consent to withdraw olanzapine and that the second suicide attempt was sudden, unpredictable, and impulsive.

• **The jury decided for the defense.**

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Called-in prescription fails to prevent suicide

Unknown Massachusetts venue

A woman with a history of depression, anxiety, and difficulty following prescriptions attempted suicide and was hospitalized after she and her husband separated.

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After discharge and under the care of a psychiatrist, the patient became dependent on lorazepam. When she tried to renew her lorazepam prescription but could not reach the psychiatrist, she called the pharmacy and attempted to impersonate the psychiatrist. The pharmacy did not fill the prescription and notified the psychiatrist.

The psychiatrist called the patient that evening and spoke with the patient and her minister, who was with her. The psychiatrist informed the minister that the medication would be delivered to the house if the minister paid for it, administered it to the patient, and saw her to bed. The minister agreed and followed the psychiatrist's instructions when the medication arrived.

Later that night, the woman broke into the minister's church and was apprehended by police. She was released after the minister assured police that the break-in was not a criminal matter.

At home, the patient called the psychiatrist again and left a voice mail. Phone records indicate that she stayed on the line for 5 minutes. The psychiatrist reported that he did not receive the message until the next day. By that time, the patient had hanged herself with a leather strap.

The patient's family claimed that the church break-in was a new, risky behavior that warranted an in-person evaluation. The psychiatrist argued that the patient often called his office, that the tone of her message did not suggest an imminent suicide attempt, and that neither the minister nor police feared she would harm herself. The psychiatrist's records showed numerous office visits and telephone calls regarding the patient's medication.

The family also claimed that the patient was extremely frustrated by her lack of progress. The psychiatrist countered that the patient refused his recommendations for further treatment.

• The case was settled for $600,000.

Most telephone calls will not result in legal trouble, but beware of miscommunication

Dr. Grant's observations

There are obvious benefits to dealing with patients over the telephone. First, phone consultations can prevent unnecessary office visits or a trip to the emergency room,[1] especially when a patient needs reassurance rather than an assessment.

Second, telephone contact can help you cost-effectively track an acute or chronic illness.[2] A short telephone conversation can spare some patients the expense of an office visit.

Recent data[3] suggest that care management and psychotherapy via telephone may improve clinical outcomes for patients taking antidepressants for depression. Physician-patient telephone calls average 4.3 minutes and very few are considered urgent, so most calls will not result in a legal problem.[4]

The above cases reflect what many psychiatrists do routinely: assess a patient and change medication without seeing the patient. Roughly 25% of physician-patient interactions occur over the telephone.[4] In one-third of these interactions, however, the physician and patient disagree on the reason for the call.[5] Given this rate of miscommunication, beware of potential legal trouble when communicating with patients by telephone.

PHONE MANAGEMENT PITFALLS

Improper diagnosis and treatment. The American Psychiatric Association (APA) considers starting a patient relationship without a face-to-face evaluation unethical, but office evaluations are not required when changing an established treatment plan.[6] APA's ethics committee suggests that face-to-face evaluations of established patients are required only if "clinically necessary," so use your knowledge of the patient and the call to determine clinical necessity.

The above cases appear to stem from the psychiatrists' failure to detect the severity of the

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patients' problems and to offer more intensive interventions. Two limitations of telephone conversation can increase the risk of missed diagnosis and delayed or inappropriate treatment:

- Telephone assessments tend to be rushed and not as systematic as an office evaluation.
- Making a thorough assessment is difficult without seeing the patient's nonverbal cues.

For example, an otherwise well-kempt person's disheveled appearance or a previously nonpsychotic person's apparent responses to internal stimuli would raise a red flag during an in-person visit.[7]

Breach of confidentiality occurs when a physician provides confidential medical information to someone other than the patient without the patient's consent.[7] In one study assessing physician telephone calls, the physician spoke to the patient in only 79% of cases.[8]

Disclosing information without consent could violate the patient's privacy. When a caller identifies himself as your patient, make sure you know who's on the phone. If the caller requests confidential information (such as HIV test results) and you're not sure that the caller is your patient, tell him you'll call back or ask the patient to come to your office for the test results. If the caller is giving but not requesting information, you are not violating the patient's confidentiality.

In the above cases, the psychiatrists discussed symptoms and treatment with someone other than the patient. In the first case, the psychiatrist violated the patient's confidentiality by discussing the patient's medication needs not with him but with his wife. In the bargain, the doctor did not get informed consent. The psychiatrist should have spoken directly to the patient or asked him for permission to discuss care with his wife. The patient might have been too confused to talk with the psychiatrist, leading the psychiatrist to offer different treatment recommendations.

Changing medication or dosages requires a thorough discussion of the drug's side effects, benefits, and alternatives with the patient.

TELEPHONE PROTOCOL FOR YOUR PRACTICE

Talk to the patient directly. As stated, discussing the patient's treatment with a spouse or someone else without the patient's permission violates the patient's privacy. Also, be cautious when interpreting information provided by someone else.

Speaking with the patient directly is crucial to accurate assessment. Without visual cues, the patient's words become crucial.

During the phone call, have the patient repeat any instructions you give.[9] This will minimize the risk for error.[5]

Document the call. In one study of psychiatrists receiving or making calls, only 45% documented the calls in the patient's chart.[2]

Your defense against a malpractice suit could hinge on the thoroughness of documentation. Make sure you record:

- the date and time of the call
- the patient's name
- the chief complaint and his or her disposition
- your assessment and any advice given
- necessary follow-up action
- requests for prescription refills
- and any symptoms that indicate that the patient should call back.[7]

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For example, document that you told the patient to call back if certain serious symptoms result from a medication change, such as a rash after starting lamotrigine or signs of toxicity after increasing lithium. Otherwise, tell the patient you will call back.

How long you wait to call the patient depends on his or her condition. If he or she is fairly stable, you might call after 1 week; if the condition is more serious, you might call the next day.

Avoid managing high-risk patients over the phone. In the above cases, an urgent office visit or a recommendation to report to the nearest emergency room might have been prudent.

Discuss your phone policy during the initial visit. Ask the patient if you can leave a personal message and if his or her message service is private.

Also discuss whether you will charge for phone consultation. Insurance companies often consider telephone conversations "incidental" and usually do not reimburse them separately. From an ethical standpoint, you can charge the patient for such calls if you discuss payment during the initial treatment contact.[6]

Telephone calls to patients can be time-consuming. Although 86% of psychiatrists feel they should receive compensation for these calls, less than 1% do.[2]

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