Patient Safety and Telephone Medicine

Some Lessons from Closed Claim Case Review

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OBJECTIVES: The telephone can facilitate medical care but also result in adverse outcomes leading to telephone-related malpractice suits. Analyzing claims might identify errors amenable to prevention. The objective of the study was to describe medical errors involving the telephone in patient-clinician encounters that significantly impacted medical care and medico-legal outcomes.

DESIGN: The design of the study was a descriptive, retrospective case review of telephone-related closed malpractice claims that included depositions, expert witness testimony, medical records, allegations, injuries, and outcomes.

PATIENTS/PARTICIPANTS: Forty defendants from 32 cases coded specifically as telephone related by a major provider of malpractice insurance. Leading specialists sued: Internists, pediatricians, and obstetricians.

MEASUREMENTS AND MAIN RESULTS: Cases were reviewed by a physician experienced in telephone medicine and independently checked by a risk management nurse specialist and discussed by 2 additional risk management analysts before arriving at full agreement. Twenty-four (60%) cases were settled or awarded to the plaintiff. The most common allegation was failed diagnosis (68%), most common injury was death (44%), and most common setting was general medicine ambulatory practice. Leading errors were documentation (88%) and faulty triage (84%). The average indemnity was \$518,932, with a total indemnity of \$12,454,375.

CONCLUSIONS: Telephone-related claims were costly; injuries were catastrophic. Poor documentation and faulty triage were major factors influencing care and legal outcome. Telephone errors may represent the tip of the iceberg in patient safety in ambulatory practice; however, these preliminary results need to be confirmed in a larger sample of cases.

KEY WORDS: telephone errors; patient safety; telephone medicine; malpractice; ambulatory practice.

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INTRODUCTION

Alexander Graham Bell's famous quote, "Watson, come here I need you" after accidentally spilling battery acid gave birth to the first telephone and simultaneously to the role of the telephone in seeking medical care.¹ Despite the well-documented benefits of telephone medicine in both triage²⁻⁴ and disease management,⁵⁻⁷ the complexity and sheer volume of medically related telephone communications leave patients vulnerable to errors in management and clinicians vulnerable to malpractice claims.^{8,9} Further, managing patients at a distance, synchronously by telephone or asynchronously by e-mail,¹⁰ can be more challenging than an office visit^{9,11,12} and adds a level of medico-legal risk that can be difficult to measure.⁸ Although there are methodologic limitations, the study of malpractice claims can improve our understanding and prevention of medical errors.¹²⁻¹⁵ The report¹⁶ by the Physician Insurers Association of America (PIAA) of an indemnity payout of \$71.8M for 786 telephone-related malpractice claims by specialty and case outcome (Table 1) highlights the need for greater insight into patient-clinician communication over the phone that contributes to adverse medical outcomes and litigation.

Miscommunication between patient and clinician is a significant patient safety issue in the ambulatory setting and a major determinant of the decision to sue.^{12,13,17,18} Understanding what really occurred or what went wrong in a telephone conversation, unless it is taped, is challenging at best. As a proxy, we performed an in-depth analysis of medical malpractice cases where the telephone played a significant role in the adverse medical outcome that motivated the malpractice suit. The objective of this report is to describe the specific types of errors in telephone communications that contributed to the medical malpractice allegations, the frequency of errors over the phone that occurred by specialty, and the medico-legal outcomes. Representative case reports with recommendations for improvement are included from the leading 3 specialties involved (Appendix). We hope these findings heighten the awareness of the inherent risks when patients present medical complaints by phone and provide a framework for prevention through improved quality of telephone care and service for practitioners and patients who rely on the telephone in their clinical practice.

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Table 1. PIAA* Telephone-related Malpractice Claims Data by Specialty, Case Outcome, and Indemnity

Defendant type	Total	CWIP number [†]	CWOP number [‡]	Mean indemnity	Total indemnity
Internists	195	61 (23%)	134 (26%)	\$234,242	4,288,786
Obstetricians	141	45 (17%)	96 (18%)	\$284,712	2,812,061
Pediatricians	97	40 (15%)	57 (11%)	\$281,258	1,250,312
Orthopedists	30	13 (5%)	17 (3%)	\$208,936	\$2,716,166
Emergency physician	1	1 (1%)	0	\$75,000	\$75,000
Surgeons	36	12 (5%)	24 (5%)	\$274,399	\$3,292,787
All other specialties [†]	286	91 (35%)	195 (37%)	\$301,350	\$27,422,861
Totals	786	263 (33%)	523 (67%)	\$273,224	\$71,857,973

*Source: Physicians Insurers Association of America

[†]Includes General and Family Practice, Ophthalmology, Neurology, Cardiovascular Disease, Plastic Surgery, Psychiatry, Gastroenterology, Urology, Neurosurgery, Radiology, Gynecology, Otorhinolaryngology, Cardiovascular and Thoracic Surgery, Dermatology, Radiation Therapy, Anesthesiology, Other Nonsurgical Specialties, Oral Surgery, and Pathology

[‡]CWIP—closed with indemnity payment (settled or plaintiff verdict at trial)

[§]CWOP—closed without indemnity payment (dismissed, frivolous, plaintiff cancelled)

DESIGN

All cases that were specifically coded as telephone related were identified in the database of the ProMutual Group, the leading provider of malpractice insurance for physicians in the Northeast. During the study period, ProMutual insured approximately 12,000 physicians per year. Claim frequency on average has been 4.2%. The actual claim frequency can be higher or lower depending on the physician's specialty.

Between 1995 and 2005, there were 32 cases involving 40 defendants from multiple specialties, with Internal Medicine comprising almost half of the sample, followed by obstetrics and pediatrics, comparable to the aggregated PIAA specialty distribution of the 781 telephone-related cases (Table 2). Case files were reviewed, which included plaintiff and defendant depositions, expert witness testimony, medical records, claim reports, offer of proof, and telephone logs when available.

Forty-two initial cases were reviewed by a primary care physician experienced in telephone medicine malpractice and checked independently by a ProMutual Group risk management nurse specialist. There was a high degree of agreement; 2 cases were removed because of disagreement between reviewers. Eight cases were eliminated because the telephone was considered a minor component of the lawsuit and patients' medical care. All 32 final cases were further discussed with a group that included 2 risk management analysts before arriving at full consensus about the definition of error types (Table 3), the significance of the role played by the telephone in patient management, and the frequency of error types (Table 4).

The ProMutual Group's database also provided detailed information about each patient claim, allegation, and injury, the number of phone calls made by the patient, details of the telephone call, physician specialty, case outcome, and indemnity payment. Details of the case outcome are described by specialty as claims closed with payment (CWIP), i.e., settled or plaintiff verdict at trial, and claims closed without payment (CWOP), i.e., dismissed, frivolous, or withdrawn by the plaintiff (Table 5).

RESULTS

Defendants

All 40 defendants in the 32 cases were physicians. Internists (18), obstetricians (6), and pediatricians (6) comprised 75% of

those sued in the telephone-related claims (Table 2). All were in group practice. There were 36 male and 4 female physicians.

Error Types

Based on the specific elements of the telephone-related complaints found within the medical records, 3 categories of telephone medicine errors were defined (Table 3) and then, if present, identified for each case (Table 4). The leading error type was poor documentation in 88% of the 32 cases, with faulty triage decisions a close second in 84%, usually because of incomplete history taking over the phone. Failing to recognize the potential seriousness of a frustrated patient's multiple calls for the same problem was identified in 44% of cases, primarily because the multiple providers taking the calls were unaware of prior calls. Lack of policies and protocols for managing telephone calls in the office, found in 38% of the cases, resulted in dropped messages and delayed response to patient calls. Problems encountered when a second physician

Table 2. Specialties at Highest Telephone Medico-legal Risk: ProMutual vs PIAA

Specialty data of total claims	Current study number (%) of total claims	PIAA* number (%)
Internal Medicine	18 (45)	195 (25)
General and family practice [†]		158 (20)
<Internal Medicine plus general and family practice>		353 (45)
Obstetrics	6 (15)	141 (18)
Pediatrics	6 (15)	97 (12)
Subtotal	30 (75)	591 (76)
Other [‡]	10 (25)*	190 (24) [§]
Total	40 (100)	781 (100)

*Physicians Insurers Association of America

[†]No general or family practitioners in the ProMutual series

[‡]Includes Orthopedics, Obstetrics, Surgery, and Corporation of Physicians (vs individuals)

[§]Includes Ophthalmology, Neurology, Cardiovascular Disease, Plastic Surgery, Psychiatry, Gastroenterology, Urology, Neurosurgery, Radiology, Gynecology, Otorhinolaryngology, Cardiovascular and Thoracic Surgery, Dermatology, Radiation Therapy, Anesthesiology, Other Nonsurgical Specialties, Oral Surgery, and Pathology

Table 3. Telephone Medicine Error Definitions

Error type	Definition
Documentation	None, inadequate, record correction postdated
Faulty triage	Patient should have been given an appointment, sent to an emergency department versus advised; management decision based on incomplete history
Dysfunctional office systems	
Mismanagement of multiple calls	Two or more calls for the same problem not appreciated as an alert or risk factor
Lack of policies	No policies or protocols for management of telephone calls
Covering MD impact	Handicapped by having no prior history and no access to medical record

was covering for the primary provider were found in 28% of the cases indicative of the stress experienced by several defendants providing on call coverage to multiple practices, having no prior knowledge of the patient, and not having access to patients' medical records and prior history.

Allegation and Injury

The leading allegation was failure to diagnose for 27 of the 40 defendants, followed by negligent treatment in 4 (Table 6). Fourteen of the 32 patients died. Causes of death included: 4 cases of myocardial infarction, 2 cases of pulmonary emboli, 2 patients with meningococemia, 2 cases of intestinal perforation, and 1 each of cardiac arrhythmia, cerebral hemorrhage, acute pancreatitis, and suicide from an overdose of antidepressant medication.

The diagnoses of the nonfatal alleged injuries included breast cancer, perforated bowel, cerebral palsy and spastic diplegia, brain damage, amputation, and visual disability with an allegation of failure of or delayed diagnosis in each instance. There were 2 negligent medication-related allegations, which included 1 overdose resulting in death mentioned above and 1 case of iatrogenic Cushing's syndrome from an excessive steroid dose prescribed, in error, over the phone.

Medico-legal Outcomes

Of the claims against the 40 defendants, 24 (60%) cases were settled or awarded to the plaintiff and closed with payment (CWIP, Table 5). Settlements were made because of clear liability or a judgment by the insurer that the defendants would not make a strong witness during trial. Sixteen (40%) were closed without payment (CWOP Table 5) namely, dismissed as frivolous or withdrawn by the plaintiff in the middle of the process. The average indemnity for the closed claims was \$518,932, with a total indemnity of \$12,454,375.

DISCUSSION

Whereas this case review on claims focuses upon the use of the telephone as an extension of the patient/clinician encounter involving access to clinical care, the increasing complexity of telephone medicine is reflected by its expanded scope over the

past decade. Far from the old call hour with one's own patients over coffee from home, telephone medicine now encompasses not only triaging and prescribing medical management for acute and chronic illness but also chronic disease case management,⁵⁻⁷ computerized protocols,^{19,20} patient education, counseling and communicating laboratory, and imaging results.²¹ Triage nurses may now seek certification in telephone triage as a subspecialty of nursing.²² After hours, call centers have received high marks for quality, safety, and patient satisfaction.²³⁻²⁷ The American Academy of Pediatrics (AAP) has established a Section on Telephone Care as a nationwide educational network of nurses and physicians actively involved in telephone care service and research. Whereas 30% of all pediatric encounters are by telephone,³ adult medicine generalists, who are the largest group and at highest risk of all the specialties for telephone-related medical malpractice suits, spend almost as much time on the telephone as reflected in this quote by an Internist^{4,28}:

Internal medicine is an endless series of telephone calls interrupted by occasional live patients who happen to wander into one's office

It is no surprise that, as the "front door" to most practices, the telephone has become a target for liability issues, highlighting a pressing need for increased risk management training as an important component of telephone care and medical education.²⁹ The AAP has recently published a comprehensive statement on compensation for telephone care,³⁰ collaborating closely with the American College of Physicians and the Academy of Family Practice as key allies in this effort. If compensation for telephone care does indeed become a reality, the telephone could become an even riskier business, as patient expectations may be higher once they are charged for a previously free service.

In this study, the availability of closed claim case files coded by the insurer as telephone related provided a unique opportunity to focus on identifying specific errors in telephone care in individual cases that led to the allegations of malpractice (Table 3).

We believe that these errors may be just the tip of the iceberg, as it is virtually impossible to determine the extent to which a telephone call contributes to any medical malpractice suit because of limited documentation in a huge volume of calls. In our series, 3 of the 5 error types identified poor documentation, faulty triage, and the covering physician factor significantly impacted the assessment of the medical complaint. Improved documentation clearly would have lessened the "he says, she says" debates left for the jury to decide and perhaps decreased the number of lawsuits, the emotional stress, and the overhead costs of malpractice litigation, which

Table 4. Frequency of Telephone Medicine Errors*

Error type	Number of cases† (n=32)
Documentation	28 (88)
Faulty triage	27 (84)
Dysfunctional office systems	
Mismanagement of multiple calls	14 (44)
Lack of policies and protocols	12 (38)
Covering MD impact	9 (28)

Table 5. Indemnity by Defendants by Specialty for ProMutual Telephone Medicine Cases*

Defendant type indemnity	Total	CWIP number [†]	CWOP number [‡]	Mean indemnity	Total
Internists	18	11 (46%)	7 (44%)	\$459,034	\$ 5,049,375
Obstetricians	6	1 (4%)	5 (31%)	\$75,000	\$ 75,000
Pediatricians	6	4 (17%)	2 (13%)	56,250	\$ 625,000
Corporation of physicians	4	4 (17%)	0	1,068,750	\$ 4,275,000
Orthopedists	4	3 (12%)	1 (6%)	\$791,667	\$ 2,375,000
Emergency physician	1	1 (4%)	0	\$0	\$0
Surgeons	1	0	1 (6%)	\$0	\$0
Totals	40	24 (60%)	16 (40%)	\$518,932	2,454,375

*Some cases had more than 1 type.

[†]CWIP—closed with indemnity payment (settled or plaintiff verdict at trial)

[‡]CWOP—closed without indemnity payment (dismissed, frivolous, plaintiff cancelled)

are exorbitant (Appendix, case 1), even when claims lack evidence and are dismissed.¹⁴ Regarding faulty triage decisions, a dynamic seems to emerge when medical complaints are presented over the phone compared to seeing patients in the office. Evaluation is more difficult on the phone because of time pressure, as well as not being able to see the patient during the dialogue. As a consequence, history taking is often rushed and incomplete, letting the patient, rather than the clinician, do the triage (Appendix, case 3). Two of the error types, multiple calls for the same problem and dropped messages, relate to the quality of responsiveness and access to the physician. Multiple calls, for example, should be viewed as red flag signaling that the patient needs to be seen (Appendix, case 2).

The 2 common themes in the majority of malpractice cases are failure to diagnose and a breakdown in patient-clinician communication. These issues often lead to delayed or missed diagnosis.¹² Failure to diagnose was the leading allegation in approximately two thirds of our cases. In an analysis of 1,162 malpractice cases by the ProMutual Group, failure to diagnose was the principal allegation in 39% of the cases, with Internal Medicine and family practice having over half of their malpractice cases based on this allegation.¹⁸

Whereas the defendants in all of our cases were physicians, office staff members at all levels were involved in the communication process, including medical assistants, certified nurse midwives, and nurses. The decision to sue is determined by both the severity of the medical injury as well as the sensitivity, responsiveness, and communications skills in meeting patients' needs.¹³ In our series, communication errors were present in 38% of cases.

LIMITATIONS OF THE STUDY

We acknowledge the limitations of this study, particularly the small sample size and the subjectivity and potential for bias in any retrospective review requiring judgment calls. Whereas the sample is 32 cases, it included all the cases coded as telephone related rather than a random sample. Our findings of the specialties at highest risk, the types of allegations, and injuries, when compared with the larger aggregated PIAA data (Table 2), suggest that the errors reported in this series may indirectly be representative of the larger physician population involved in telephone-related malpractice. To increase objectivity in this review, we required an independent reviewer and group consensus. Furthermore, we agreed that the errors were

not marginal even in hindsight and had the benefit of complete files needed to balance the differences in opinion expressed by plaintiff, defendant, and the expert witnesses.

CONCLUSIONS AND RECOMMENDATIONS

Telephone-related medical malpractice in the ambulatory setting is a significant and costly patient safety and malpractice issue relating to the quality of care. How common? We will probably never know because of the difficulty of distilling out the exact role of a phone call from a complex encounter and the frequent lack of documentation. We think it may be the tip of an iceberg; however, these results are preliminary and need to be confirmed using a larger sample. The highest risk specialties in our series were Internal Medicine, obstetrics, and pediatrics. Absent or poor documentation was present in almost all cases highlighting the need to document all medically relevant telephone calls. The urgency of multiple calls for the same problem often went unrecognized. Dysfunctional office systems and communication led to dropped messages.

We feel that the most effective risk management strategy is to improve the quality of telephone care and service to patients.³¹ The lessons learned from this series have identified several telephone errors that are amenable to risk prevention and improved quality of medical care. Based on our findings, prevention should include a more disciplined approach to documentation, improved office systems, and increased training in the skills of telephone medicine.^{31,32}

Table 6. Type of Allegation for ProMutual Telephone Medicine Cases

Allegation type	Number
Failure to diagnose	27 (67.5%)
Negligent treatment	4 (10%)
Medication related	2 (5%)
Procedure related	2 (5%)
Negligent prenatal	2 (5%)
Negligent labor and delivery	1 (2.5%)
Surgery related	1 (2.5%)
Failure to prevent suicide/homicide	1 (2.5%)
Totals	40

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Financial Disclosure: The only documentation in the medical record was a sketchy note prefaced with a question mark—"? did tell pt. to come to office. failed to follow up," which did not appear to be written in real time. The lack of clear documentation and the suspicious note strongly supported the plaintiff's allegation that the physician made the recommendation that no visit was needed for an examination based on the reported normal mammogram.

Conflict of Interest: Conflict of interest disclosure is indicated in the following:

Dr. Harvey Katz was a consultant to the ProMutual Group, and Dawn Kaltsounis, Liz Halloran, RN, and Maureen Mondor are employees of the ProMutual Group.

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APPENDIX: THREE CASE STUDIES

Case 1: Specialty, Internal Medicine

Allegation: Failure to diagnose breast cancer resulting in reduced chance of survival

Issue(s): Poor, possibly "touched up" documentation; faulty triage decision, patient never seen; call back problem

Outcome: Settled, closed with payment because of high degree of liability and weak case: \$1,045,000 indemnity

This 41-year-old woman discovered a lump during her self breast examination. Family history was positive for breast cancer. She telephoned her primary care physician to request a mammogram, which he ordered. The patient alleged she requested an appointment but was told an examination was not necessary because the mammogram was normal, an allegation that was denied by the physician. Six months later, the patient noted that the mass was larger and called her physician again, but the call was allegedly never returned. She consulted and was examined by another physician followed by an excisional biopsy. The diagnosis was extensive intraductal carcinoma. She underwent a radical mastectomy and currently remains cancer-free.

Comment: The only documentation in the medical record was a sketchy note prefaced with a question mark—"? did tell pt. to come to office. failed to follow up," which did not appear to be written in real time. The lack of clear documentation and the suspicious note strongly supported the plaintiff's allegation that the physician made the recommendation that no visit was needed for an examination based on the reported normal mammogram.

Recommendation. Never change or touch up a medical record entry. All parties agreed that a patient with this problem should have been examined, and the examination clearly documented in the medical record. A universal guideline is that if a patient asks to be seen, they should be seen. Further, an in-person examination should be required for any new, potentially high-risk problem. If a patient declines, this should be well documented in the medical record.

Case 2: Specialty, Obstetrics and Gynecology

Allegation: Delay in diagnosis of preterm labor because of failure to respond to complaint of decreased fetal movement reported by telephone

Injury: Neurologic damage to newborn infant born prematurely (29 weeks) with subsequent cerebral palsy and spastic diplegia

Issue(s): Failure to respond to multiple calls

Outcome: Closed with payment, Corporation of Physicians settled for \$575,000 indemnity

A 22-year-old woman was treated successfully for infertility by her obstetrician. In her 5th month of pregnancy, she noticed decreased fetal movement and reported this to the physician's receptionist whose note documented the patient's call. The message was referred to the nurse midwife in the practice. She attempted to return the call, but no one was home. The patient alleged that she had called several other times but her calls were not returned. She phoned the following day to report spots of blood and mucous after urinating and was scheduled for an immediate appointment. Examination revealed that her cervix was dilated 4 cm, and she was admitted to the hospital for tocolytic treatment. Contractions continued. A low transverse c-section was performed because of a double floating breech presentation. The infant was delivered at 29 weeks and subsequently diagnosed with cerebral palsy and spastic diplegia.

Comment. Multiple calls for the same problem are often not recognized as an alert to the urgency of a problem. Often, multiple staffs are receiving calls unaware of prior calls because they are not documented or communicated within the office. In this instance, the message was dropped.

Recommendation. Recognize multiple calls for the same problem as a risk factor and need for an office visit. When no one is home and the message may indicate a serious problem, close the loop by repeat calls and documenting the attempts.

Case 3: Specialty, Pediatrics

Allegation: Failure to diagnose meningitis resulting in death

Issue(s): Inadequate history taking; no documentation, unresponsive to multiple calls

Outcome: Closed with payment, \$225,000 indemnity

A mother phoned the pediatrician at 5:23 PM having tried several times unsuccessfully during the day. Dr. G. acknowledged problems with the answering service and testified that the mother told him that her son, a 6-year-old boy with Down syndrome, had fever, chills, vomiting, and a rash that looked to her like chickenpox. Dr. G. did not ask any questions about the rash or illness. Dr. G. prescribed symptomatic treatment and advised to bring her son to the emergency department if he became worse. His condition deteriorated. An ambulance was called when his mother found him "stone cold and rigid" at 2:30 AM. The child was noted to have an extensive petechial rash. He was pronounced dead upon arrival of fulminant meningococemia.

Comment. This tragic case begs the question, who is doing the triage? An experienced pediatrician was alleged to be negligent in taking a complete history and making the triage decision to treat over the phone rather than see the patient based on the mother's diagnosis. The pediatrician acknowledged that he should have asked more questions. Because there was no documentation of the phone call, there was no way to verify the physician's testimony or objectively contradict the patient's version of events. As in most undocumented calls, it comes down as a "he says, she says" situation for the jury to decide. This was compounded by an answering service problem.

Recommendation. An evaluation of telephone-reported symptoms requires the same focused and relevant history taking as in an office visit. Documentation, complete history taking, and monitoring the answering service closely are all needed for quality improvement. Patients should not be doing their own triage.