Family Practice Forum

The Telephone in Medical Practice

Peter Curtis, MD
Chapel Hill, North Carolina

The first telephone call ever made in Alexander Graham Bell's workshop was a call for medical assistance to deal with an acid spill from a battery. Since then this form of communication has become an integral and vital part of all medical care systems, except in primitive cultures and in societies with low technological skills. It is possible that in the future the role of the telephone in providing medical care could become much more important still.

At the present time great reliance is placed on transportation systems to move people from their work and homes to the place where they can receive treatment. But as energy sources dwindle and petrol-driven travel becomes even more costly, physicians may not be able to regularly depend on their patients' ability to get to the office or hospital. One may have to rely more and more on the ambulance services, the physician's readiness to make home visits and, dare I say it, people walking to get medical care. If such a situation should arise, the telephone would play a greater part in assessing medical need, in diagnosis, in reassurance of the worried well, and in psychotherapy.

From the Department of Family Medicine, School of Medicine, The University of North Carolina at Chapel Hill, Chapel Hill, North Carolina. Requests for reprints should be addressed to Dr. Peter Curtis, Department of Family Medicine, The University of North Carolina-CH, Room 711, Clinical Sciences Building 220 H, Chapel Hill, NC 27514.

This is already happening here in the United States where local telephone calls are often free. The American National Ambulatory Care Survey* has shown that 637 telephone calls per 1,000 population are made annually to physician's "offices," and one textbook even contains a chapter on the use of the telephone in pediatric practice. Many physicians have recognized the value of the early morning telephone hour in cutting down home visits and reducing patient numbers in the office.

In medical practice I have come to realize that the telephone is really an extension of myself, used in a multitude of ways to approach and serve patients, the medical establishment, employers, the legal profession, the police, the ambulance service, the local priest, and the alderman. In addition to the medical care practiced face-to-face with the patient, it occurs to me that there is a variant: a medical art form which is purely verbal and distant, and which can be labeled, "telephone care."

Telephone care can be divided into four areas of expertise. The first comes under the heading of accessibility, and really constitutes a part of practice management. It is incumbent on the provider of a medical service to offer an efficient and sensitive response to the patient. This means an ade-

*Division of Health Interview Statistics, National Center for Health Statistics: The 1973 Health Interview Survey. Rockville, Maryland, National Center for Health Statistics, unpublished data.

quate number of telephone lines, well-trained receptionists, and practical arrangements for emergency calls.

The second area lies in the diagnostic skill of the nurse or physician. Although trained to obtain accurate information when face-to-face with a patient, it is surprising how slapdash we are with our questions over the telephone. The actual reason for calling the physician may be hidden behind a more acceptable (to the physician) symptom or problem.[1,2] This "hidden" call is the patient's way of enlisting the physician's interest and getting into the medical care system or, alternatively, it may occur because the patient is afraid of expressing some anxiety that the physician will regard as irrelevant or unnecessary. There is a skill, which can be both taught and learned, in unraveling the behaviors and beliefs of people without the benefit of eye contact.

Treatment constitutes the third area of telephone care. Therapy for mild self-limiting illness, such as upper respiratory tract infections, is straightforward and the telephone is an ideal means of practicing the wait-and-see medicine which forms a significant part of primary care. This includes counseling and reassurance—two skills that patients often rank at the top of their assessment of the physician's response on the telephone.

The fourth area of telephone care concerns the ability to understand and be understood—in other words, communication skills. It is well established that the effectiveness of any interaction between physician and patient is highly dependent on both participants feeling at ease with each other. The high level of comfort, adequate collection of relevant information, and collaboration by both parties usually follow the beneficial effects of good verbal and visual communication. However, it is the physician who is responsible for setting the tone of the encounter, or at least for moderating and adjusting it, based on experience with the patient. A similar interaction on the telephone suffers from a reduction of sensory information to both parties. Not only is the visual communication lost, but the linguistics of the voice seem to alter. Encouraging "uh-uh's" may sound like indigestion, the therapeutic silence so beloved by psychiatrists becomes hostile, heavy breathing, and the physician may have problems in detecting anxiety, irritation, or anger in the patient.

Friends, patients, spouses, and a tape recorder are useful ways of finding out how one sounds over the telephone—and the reactions are often surprising. I have been astonished to find out that I have been regarded as blunt and rude by many people, in spite of having the best intentions.

However adept one may be in talking to patients on the telephone, it is important to realize that the same skills must be exhibited by the other representatives of medical care services—reception, paramedical, secretarial, and nursing staffs. They are often better at it than physicians are; but if not, their behavior may seriously jeopardize physician-patient relationships.

Perhaps one of the most fascinating aspects of telephone care rests with communication between physicians, both in content and in attitudes. The admitting resident who "talks down" to the primary care physician who is attempting to arrange an admission to a teaching hospital may be setting for himself a pattern of hierarchical attitudes which are ultimately a disservice to patient care. Because of the distance between them and the absence of visual cues, physicians may find it easier to be hostile, condescending, and unhelpful.

On the other hand, telephone communication can be a rapid way to get to the heart of a clinical problem. I have frequently detected a reluctance among some physicians to pick up the telephone and ask another doctor for advice and help. This reluctance can quickly become a habit. The telephone is a vital instrument to the physician's life, as vital as the stethoscope. We should have more instruction in using it.

References

1. Clyne MB: Night Calls: A Study in General Practice. London, Tavistock, 1961
2. Stewart MA, McWhinney IR, Buck CW: How illness presents: A study of patient behavior. J Fam Pract 2:411, 1975