

# Patient Telephone Call Documentation

## Quality Implications and an Attempted Intervention

Allen J. Daugird, MD, and Donald C. Spencer, MD  
*Columbia, Missouri*

The telephone is an important mode of communication in American medicine, accounting for up to one quarter of patient-physician encounters.<sup>1-4</sup> Although documentation of face-to-face patient-physician encounters in a patient's medical record is considered axiomatic, there is little in the literature concerning documentation of telephone encounters. Lack of such documentation could lead to an unnecessarily incomplete patient database with potential adverse consequences. An academic family practice satellite clinic that did not have a telephone call documentation policy was used as a site for investigating the consequences of instituting such a policy. It was hypothesized that physicians would have better recall of details of after-hours patient telephone calls after the policy intervention and that documentation of office and after-hours calls in office medical records would more likely occur.

### METHODS

The study practice is located in a rural central Missouri town of 11,000 people approximately 25 miles from a university medical center. The majority of patient care for the practice both during and after hours is provided by second- and third-year family practice residents. After-hours telephone calls are handled off-site by a resident physician at the local hospital. Before the intervention there was no policy in force regarding documentation of either office or after-hours telephone calls, and usually no documentation was done.

The intervention, which began in August 1986, consisted of the institution of a uniform telephone policy that made use of 4 × 6-in preprinted telephone message forms

similar to those described by Curtis and Talbot<sup>5</sup> and Spencer and Daugird.<sup>6</sup> The forms provided for the recording of date, time, name, age, problem, history, impression, plan, and follow-up. In the office all clinical telephone calls were handled initially by a clerk, who filled out the portion of the form dealing with demographic data and the problem. The form was then clipped to the patient's chart and given to a physician for action, usually a call back to the patient. The physician was to then complete the telephone form. Calls put directly through to the physician were also to be recorded on these forms by the physician. The forms were then permanently placed in the chart. All after-hours clinical calls from practice patients were also to be recorded, and the forms were then taken to the office for filing in patient charts. This new policy was widely communicated to residents and office staff.

For the office hours portion of the study, all patient telephone calls during weekday regular office hours were recorded on paper by a secretary as they were received for a two-week period both before (July 2 to 17, 1986) and after (September 2 to 15, 1986) the intervention. The office charts of these patients were subsequently studied to ascertain whether there was documentation of the telephone call, either handwritten in the chart or on a telephone encounter form. For the after-hours calls portion of this study, one of the authors asked each on-call resident about specific details of telephone calls from the previous night. Any notes or completed telephone call forms could be used by the resident in answering the questions. The resident physicians were generally interviewed on weekdays only. After-hours calls were thus sampled for a one-month period before (July 1986) and after (September 1986) the intervention. Data concerning whether the resident could remember the patient's name and age were tabulated. If the name could be remembered, the office chart was later checked to see whether documentation of the call was present.

Categorical data were subjected to chi-square analysis. Mean number of after-hours calls per day before and after the intervention were compared by the Student's *t* test.

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*From the Department of Family and Community Medicine, University of Missouri-Columbia, Columbia, Missouri. Requests for reprints should be addressed to Dr. Allen Daugird, M228 Health Sciences, Department of Family and Community Medicine, University of Missouri-Columbia, Columbia, MO 65212.*

TABLE 1. AFTER-HOURS TELEPHONE CALLS

	Before Intervention	After Intervention	P Value
Sample days*	21	19	
Calls per day (mean)	2.4 (SD 1.69)	1.5 (SD 1.54)	.09
Patient name recalled	46%	79%	.004
Patient age recalled	80%	85%	.87
Documented in chart	0%	78%	.0000

\* Physicians were usually queried on weekdays only for calls the night before  
SD—standard deviation

## RESULTS

During office hours 67 telephone calls were tabulated before and 20 after the intervention. The mean number of telephone calls per day was 6.1 before the intervention and 2.0 after ( $P = .001$ ). Before the intervention 43 percent of the calls were documented in the chart, and 75 percent were documented after the intervention ( $\chi^2 = 6.20$ ,  $P = .013$ ).

The results for after-hours calls are summarized in Table 1. There was no significant difference in the mean number of calls per day or in how well a physician could identify patient's age. There was quite an improvement, however, in the recall of the patient's name after the intervention. The most striking, but not surprising, finding was that no after-hours telephone calls were documented in the office chart before the intervention, whereas 78 percent were documented after the intervention.

## DISCUSSION

This study demonstrates that a relatively simple, inexpensive instrument, a pocket-sized pad of preprinted forms to record patient telephone calls, can markedly improve documentation of such data in the office chart. The study also demonstrates why such documentation is needed: without using the forms, resident physicians were unable to recall the name of more than one half of the patients involved in after-hours calls the previous day or night.

That the number of office telephone calls markedly decreased after the intervention was surprising. Unknown confounding factors inherent in the before and after sampling periods may have been present. At face value there may have been fewer telephone calls in September compared with July. Another possible explanation would be

that the secretaries recorded fewer telephone calls on their call list after the intervention because it involved recording the call twice: once on the form going to the physician and once on the call list.

It is interesting that in a survey of academic pediatric residency programs, Fosarelli<sup>7</sup> found that only a little over one half kept records of telephone encounters. Of those programs that did keep records, only 52 percent put them in charts. Arguments against putting them in the chart included the need for extra clerical help and the potential for charts becoming "unwieldy." In the present study having a separate page for telephone encounter forms that are then taped to the page "shingle-style," as laboratory reports often are, is an efficient, space-saving method to store these records in temporal order. Although the need for extra clerical time is undeniable, the important information gained for the next care provider is well worth the effort. Fosarelli also mentions the medicolegal risks of not keeping records of telephone encounters. Malpractice suits can sometimes hinge on what was said by a patient and to a patient over the telephone.<sup>4</sup> Without chart documentation a physician will be unlikely to remember or prove in court the details of such telephone conversations.

Last, it is important to emphasize that a telephone policy is equally as important as the telephone encounter forms. The form can help prompt the physician for information he or she might otherwise neglect but is useless if not used. Recording telephone calls must become a standard of care for a medical practice. In this study intervention, having faculty physicians ask resident physicians each morning about the previous night's telephone calls was undoubtedly a powerful reinforcement to record calls. A private medical practice might need peer pressure and review to help reinforce this practice. The authors submit that such an effort is worth the investment.

## References

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