Telephone Consultations From the Urgent Care Center: *An Educational Model*

Urgent message: Communication between UC providers and consultant physicians can facilitate timely, efficacious patient management OR it can damage trust between the treating physician and the consultant.

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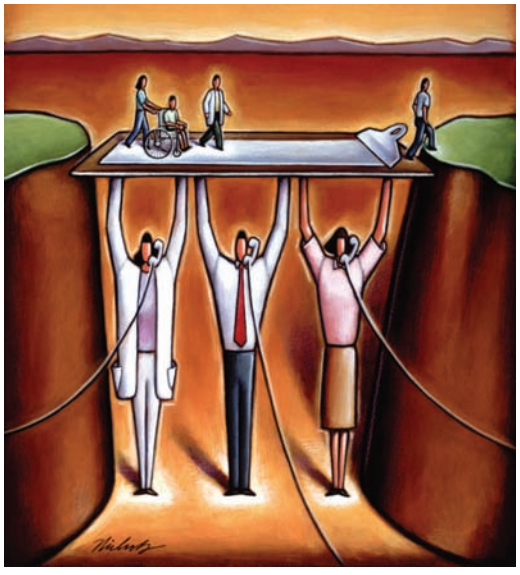
Introduction

Urgent care providers, as much as or more than any other specialist, must call consultants to admit, refer, appropriately treat, or obtain follow-up for their patients. At many urgent care centers, physicians are also often on the receiving end of calls from providers.



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Such physician-to-physician communication, usually by phone, can enhance patient care but often takes an inordinate amount of time and, if done poorly, can undermine collegial relationships.[1-3] Advances in communication technologies have allowed some medical centers to show some improvement in time management for non-urgent consultations.[4,5]

Despite increased use of e-mail, instant messaging, fax, web-based video conferencing, and radio systems for communication in daily life, the telephone remains the primary medium. Effective telephone consultations with other physicians reflect on the urgent care providers, their group, and their center's professionalism. More importantly, they can facilitate timely and efficacious patient management. Poor physician-to-physician telephone communications, on the other hand, may lead to inappropriate responses from consultants, as well as the urgent care provider garnering the consultant's distrust, a poor professional reputation, and difficulty obtaining such consultations in the future.

At a time when many specialty consultants and other primary care providers are often unwilling to see urgent care patients, unprofessional telephone communication may damage the image physicians want to project. On the other hand, good interactions often lead to professional collegiality, the ability to shorten such interactions based on mutual confidence and respect, and a more efficient working environment—all of which benefit the patient.

With "interpersonal communications" being a core competency of graduate medical education, a simple

method to help teach this important skill would be beneficial.

This paper describes such a model, specifying what to do before the call is made, what to say during the call to conserve time and to get the desired response, and the four possible actions the caller could want from the consultant: to see the patient, to admit the patient, to discuss aspects of the case and to provide insight, and to see the patient in follow-up. Two cases are used to illustrate suboptimal and elegant physician-physician telephone consultations.

Educational Mandate

The Association of American Medical Colleges maintains that a basic goal of medical education is to "develop a base of skills and strategies for working with physician colleagues and other members of the healthcare team."[6]

Similarly, the Accreditation Council for Graduate Medical Education (ACGME) recognizes the importance of interprofessional communication, making it one of their General Requirements applicable to residency programs in all specialties. The requirement states: "The residency program must ensure that its residents by the time they graduate can develop appropriate interpersonal relationships and communicate effectively with patients, their patients' families and professional colleagues."[7]

This is similar to the ACGMR core competency task, "interpersonal and communication skills," to be adapted to all residency programs.[8] Emergency medicine academics have recognized that "communicating with members of the healthcare team is crucial for the emergency physician" and intersects at many points with the "Model of Clinical Practice of Emergency Medicine."[9,10]

Studies have demonstrated that the great potential for communication breakdown between practitioners can have deleterious effects on patient care. Poor communication may be due to lack of formal training, poor communication skills, and time constraints.[11-15]

While some educational models have been used for physician-patient telephone interactions, no formal model has been adopted for consultations between urgent care providers and consultants—a critical and common part of our professional lives.[16] Medical students and residents learn telephone techniques from observation; this, unfortunately, leaves a lot to be desired. The following real-life cases illustrate, first, a typical negative encounter and, second, the most elegant of telephone encounters.

Case 1

The senior medical student calls the pediatric surgeon at 6 p.m. regarding a 9-year-old girl who probably has appendicitis.

Med student: "I have a 9-year-old girl with abdominal pain. She's not pregnant, has a normal urinalysis, and is on no meds…."

Surgeon: "Who is this???"

Med student: "I am Max Tern, a fourth-year student on rotation at Sunrise Urgent Care. My patient lives with her parents, has no allergies…."

Surgeon: "What do you want???"

Med student: "My patient has abdominal pain and we'd like you to see her."

Surgeon: "Does she have an acute abdomen? Has she had any imaging? What are her labs?"

Med student: "Um, I'll have to check."

Surgeon: [Click.]

The surgeon then angrily calls the attending physician.

Case 2

The urgent care physician calls the cardiologist at 10 p.m. regarding a 70-year-old man with aortic stenosis and true syncope.

Urgent care physician: "Bob, this is Jim at Sunrise Urgent Care. I have a 70-year-old man with severe aortic stenosis and true syncope. He's stable now, normal ECG, and has an IV and is on a monitor. The ambulance should be here shortly."

Cardiologist: "OK, can you fax the information to admissions? I'll arrange a CCU bed and, if nothing unusual turns up, I'll probably cath him in the morning."

An Educational Model

The following method is similar to one that most experienced physicians use naturally. In the format below, it can be easily taught and learned by telephone-consultation novices working in urgent care centers. It could also be used to teach physicians whose practice will involve calling into urgent care centers or to other consultants with referrals or for advice.

To derive the most educational value from this method, implement it just before a trainee makes such a call or just after the preceptor listens to a telephone consultation from a resident, student, or new primary provider that fails in one or more of the key elements. Using the model within moments of the less-than-optimal phone interaction reinforces the learning process.

Before the Call

A. Know *what you want* from the consultant; i.e., why are you calling? There are only four varieties of this request (**Table 1**).

B. Know *what you are going to say*. If necessary, write down the key points.
C. *Have the chart*, vital signs, and completed diagnostic results available, since you may not remember all the details.

During the Call

A. Be *direct and concise*. Writing down the points helps beginners do this.
B. *Speak clearly*. Consciously slow your speech if you are anxious or have an unfamiliar accent. (Do not get annoyed if you have to repeat yourself.)
C. Start by saying the *3 "W"s*:
   1. *Who* you are.
   2. *Where* you are calling from.
   3. *What* you want (in a simple declarative statement). This is the *most important part of the call* and, especially when the consultant is involved in other activities or is asleep, indicates the level of alertness they need to handle your call. The options are described below.
D. *Answer any questions*—if you actually know the answer. Don't guess if you don't know, even if you're asked for information that you should have obtained, but didn't.
E. Be certain, in the end, to *get an answer from the consultant* that addresses the reason you called. Responses from the consultants might include:
   1. They will admit the patient. Be certain to ask who will contact the admitting office and whether the consultant, a resident, a hospitalist, or someone else will write the admitting orders. If the patient may need surgery, ask if they should be kept "NPO."
   2. They will see the patient, either immediately or at a specified time. If the time course seems too long for the patient's condition, explain that and try to negotiate a more timely appointment.
   3. The case you are describing is outside their area of expertise. If they don't make it clear, you should ask who they think you should contact.
   4. They are not on call. Hopefully, they can direct you to the person who is on call for their group or that specialty. (Of course, sometimes they actually are on call, but misread the schedule. In those cases, you will simply must call them again.)
   5. They will not see the patient for any of a number of reasons—insurance, too busy, etc. Often, these patients must be referred to an emergency department that has these specialists on call and available.

After the Call

A. *Record* whom you talked with, as well as the time

Table 1. *What You Want* Can Only Take Four Forms

1. *I would like you (the consultant) to come see someone (NOW, or at some point)...*
   a. *...with <presumptive diagnosis or physical findings>, and the patient's condition is <stable, unstable, critical>*. Be specific about any STAT interventions you think are indicated, such as going to the operating room, cath lab, etc.
   OR
   b. *Since your patient is requesting that you see her, can you fit her into your schedule or meet her at the hospital?*
2. *I have a patient to admit to you with <presumptive diagnosis or physical finding>.* Before calling, know whether the patient is "theirs" because of a prior relationship, because they are covering for the patient's physician, or because they are on call for that specialty through the hospital or provider group for "unassigned admissions." Also check to see whether that physician is able to admit the patient to an appropriate hospital, given the patient's medical or psychiatric condition or insurance plan. (Unstable patients can always be admitted by the on call physician through an emergency departments unless that hospital has no ability to care for them. In that case, they must be transferred after stabilization.)
3. *I need to discuss a puzzling* (or not-so-puzzling; if it is their long-term patient, they may have more information than you can get) *case with you.* This verbal cue tells the consultant to pay attention and redirect their attention to you. At night, they will often ask for a moment to fully awaken so that they can process the information. If it is their patient, tell them the patient's name, age, and long-standing main complaint so they have a chance of recalling the person. If it is truly a puzzling case—infectious disease, endocrinology and toxicology consultants frequently get called with these types of cases—have the pertinent information available before calling.
4. *I need to refer a patient to your clinic.* If this call is made after office hours or on weekends, the consultant may not remember the call until the office staff asks about it. If they get a copy of the urgent care chart and it says that you spoke to them and they agreed to see the patient, it also helps jog their memories. Asking about these follow-ups in dicey cases helps patients get to the correct clinics. (What happens when they get there, due to lack of insurance, is variable.) Also, you can e-mail or fax the referral to the consultant's office; have them give you the address/number while you are on the phone with them. Physicians have found (and many patients know) that making such calls often bypasses lengthy waiting lists.[17]

and date. If you must call a number of consultants, which is common when referring to some specialties, list them all.

B. *List the consultant's recommendations*: appointment place and time or place and mode of transfer, as well as anything the consultant suggested be done, such as imaging, laboratory testing, or clinical interventions.

Given a succinct and meaningful interaction, the consultant may simply (1) say that they will see the patient in their office immediately, (2) accept the patient as an admission or say that they will evaluate the patient in the local hospital ED, (3) suggest the best course of action or further specific evaluation so they can recommend the next step, or (4) either accept the patient as a referral to their clinic or tell you why they cannot accept the patient and suggest a more appropriate referral.

Make a list of what the consultant wants done to prepare the patient for a procedure, admission, or further evaluation. Especially if you are requesting a STAT intervention, try to expedite the requested diagnostic tests, medication administrations, or procedures by calling ahead or by sending along the appropriate lab work.

One caveat when calling a teaching institution: If the consultant asks for every lab test to be back and every piece of unnecessary historical information to be gathered, e.g., "standing stool velocity," before he or she will see the patient, you know that you are probably dealing with a junior resident who lacks knowledge and confidence. If the situation is urgent, simply call their attending. If not, live with it. Even in private practice, you occasionally run into this sort of physician.

Discussion

It takes time to develop the rapport necessary for the shorthand conversation portrayed in Case 2. However, using the basic telephone etiquette for urgent care provider-consultant interactions (including consulting with emergency physicians) would have avoided the disastrous results described in Case 1. Consultants say that their trust in a specific caller helps them determine the validity of the information being given and that "junior practitioners may benefit from training in telephone consultations or from guidelines to make the process less haphazard."[17]

The method for telephone interactions with consultants as described above parallels in many respects "contextual" clinical case presentations, i.e., "a flexible means of communication and a method for constructing the details of a case into a diagnostic or therapeutic plan."[18]

This educational model, whether posted as a reminder near the telephones, put on pocket cards or into an electronic file for reference, or taught didactically, is simple to incorporate and leads to our ultimate goal: elegant medical practice and excellent patient care. ■

KEY CLINICAL POINTS

- Physician-to-physician communication, usually by phone, enhances patient care when done properly; handled poorly, however, it can undermine collegial relationships.
- Poor communication may be due to lack of formal training, poor communication skills, and time constraints.
- Calls to consultants may be more effective using the following approach:
  - Before the call, know why you are calling the consultant, what you are going to say, and have the patient's information at hand.
  - During the call, be direct and concise, speak clearly. Start by saying who you are, where you are calling from and what you want. Then answer any questions from the consultant and get an answer for your initial question.
  - After the call, record who you called and what was said, including any consultant recommendation.

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