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Capturing the Specifics of Telephonic Medical Advice

Have you ever given medical advice by phone to a patient, only to learn later that the patient was admitted to the emergency room shortly thereafter? Your telephonic advice may be legally questioned if the patient is hospitalized days after calling you to report new symptoms.

Today it is common for patients to **produce their cell phone records** to prove a conversation took place with their physician on a specific date and time. The burden then shifts to the physician to establish how, when, and how fully he or she responded.

CAP's Risk Management & Patient Safety Department recommends the following for documenting incoming calls from patients who report new symptoms:

1. Develop a structured telephonic message intake form for your office. Allow enough room to write down the caller's symptoms.
2. Train your staff to assess "call urgency" (i.e., how quickly a physician response is needed).
3. When returning a call, the physician, if possible, should speak directly to the patient.
4. Document specific medical advice, such as "Patient instructed to ____." Include measurable follow-up parameters such as "If still experiencing these symptoms within ____ hours (or days) go to nearest ED (or call for an appointment)."
5. If the patient resists the physician's medical recommendation (e.g., you request that he or she come in that day), then the physician - not a medical assistant - must use clear, direct language and counsel the patient of the risks of not following advice and possible ramifications. Document that you warned of these risks.

Appropriate instruction and documentation will protect both your patient and your practice.

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