

**Get the Story, Get the Picture, and make Shared Decisions.**

Caller's have expectations

..... what they want .... generally:

- to know who they are speaking to
- to get a timely response
- empathy and recognition of their anxiety ..... recognition of their concerns
- empowerment to deal with .....to know what they can do about, their problem
- to know what to do if things change / get worse

Once you have the story .....

- obtain enough clinical information to make clinical decisions
- be prepared to negotiate your suggestions
- collaborate with the caller on the best course(s) of action

**Differences between telephone and face-to-face consultations**

- lack of visual clues / signs → need for clear verbal communication
- explicit communication rather than relying on implicit visual cues / clues
- specific difficulties with deafness, language problems
- confidentiality uncertainties at both ends
- communication often via third party
- improved access for those with mobility difficulties or those who are highly mobile!
- improved time efficiency for both parties

**Output of triage : “Disposal” or “Call Disposition”**

You need to be aware of your options and your resources.

- Ambulance (arranged by you for them)
  - A&E (own transport, if less urgent)
  - Home Visit (... and specify urgency)
  - OOH Treatment Centre (own or OOH patient transport if available?)
  - Various Community based service options (Int.Care, Mental Health Crisis Team etc)
  - “Referred” to pharmacist ... for OTC Rx
  - Advice (+/- prescription faxed to pharmacy)
- & consider your safety net  
& consider : should they see own GP ?

**Pitfalls in telephone consultation; where things go “wrong”**

- Not reading the Call Handler (CH) script and considering your options
- Bad openings, “yawn, hi it's the emergency doctor here”
- Interrupting the patients story / narrative
- Objecting to the patients statements
- Not finding out why they have called (their concerns and/or their beliefs)
- Committing too early to your one and only chosen option
- Showing clear lack of confidence
- Thinking aloud, giving too much away, and lacking focus

- Thinking too far ahead ... putting their own GP in an awkward situation. When recommending patient sees their own GP, generating specific expectations especially of investigation or referral can cause problems. Could you avoid a clash of expectations by leaving more room for their own GP to assess and manage? Use a generic follow up statement e.g. “I think your own GP would be happy enough to see you, assess you and help you out”.
- Commenting on other clinicians performance, “bad mouthing” fellow professionals generates complaints. Don't get caught up commenting to patients about other clinicians apparent negative behaviours; it generates and fuels complaints. If another clinician's behaviour gives serious cause for serious concern there are routes for referring that concern.
- Making them hang up on you out of frustration.
- Re-triaging – rarely, if time delay, can be appropriate, otherwise a recipe for confusion and complaint. Speak to the clinician who did the triage.

**Telephone Consultation Etiquette : what makes a useful consultation?****Beginning**

- Identify yourself CLEARLY by name and the organisation you work for.
- Identify who you are talking to: name and one identifier, use a valid excuse if you are not comfortable with this e.g “..... can I just check I have the correct record”, “and can I just confirm your date of birth.....?”
- Apologise if there is delay in response (diffuses the caller)
- Early decision dilemma – you may be able to infer from the CHs message that the case appears to be an ALTC. Act on this decisively and swiftly. Only if there is resistance to your recommendation would you need to assess further
- Open early with an empathic / empathetic tone “I'm led to believe that your are concerned about your child .....Jade/ Kylie etc
- Project your verbal image with a smile (empathetically tuned for the recently bereaved!)
- Start with an open question: How can we help you? What's been happening with ..... What's the situation with ..... What can we do for you..... (addresses the expectation issue without committing yourself)

**Middle**

- Use active listening. Make yourself interested. Concentrate on their words not your ideas.
- Use grunts, mmm's, ahaa's and empathetic ahhh's as appropriate
- Pick up on cues, the use of “strong” words; reflect these back with a question
- Use open questions : “How, What, Where, When, Which
- Use “Why” carefully or avoid it.
- Allow the caller to voice their concerns; & Acknowledge their concerns

- Enhance by clarifying and summarising
- Do clearly define the patients reason for calling. Why have they called at this time ? By asking “what’s changed”
- Assessing children : “please describe to me, what little ..... is doing now?”
- If it becomes clear that the call will not be ended with advice, and needs face to face assessment whether in hospital of the Primary Care OOH centre, then move on to “floating” (suggesting) appropriate action.
- What do they expect? - Be careful with the timing of this one. A good open empathetic telephone consultation may modify expectations. The inappropriate-home-visit-demander may be inspired by your concern and reassurance and be empowered in knowing what to do. Expectations will often be revealed in the narrative. Directly asking about expectations early could lead you off directly into an awkward negotiation before assessment has taken place.
- Introduce closed questions with statement of purpose. Focus on relevant clinical specifics, seeking +ve & -ve responses to system oriented clinical questions. Remember closed questions don’t always get accurate responses.
- Do enquire about recent contact with their (own) GP, ongoing medical conditions & current medication to get a fuller picture.

### Ending

- Once you have gathered enough information to act, suggest clinically appropriate management.
- Get agreement on your recommended outcome
- Instructions: K.I.S.S. .... Keep it short and simple
- Check caller knows what’s happening!  
- How are they going to get to A&E / PCC?  
Directions to PCC (bring their medications!)
- Chose a closing safety net statement : 2 messages maximum.  
- specific reasons to call back, based upon one or two specific additional symptoms, or symptoms changing in severity, or taking longer than an expected time-frame for recovery.
- Good safety nets are short and simple BUT specific, AND suggest action to take.
- Specific safety-netting gives the patient more control & empowerment to cope with their problem.
- Sound empathetic, not over-anxious ... “they” end the call.

### Use Persuasive style

Be aware : Only wanting a win .... fearing compromise, can trigger confrontational aggression. Collaboration ... use “We” to mean “you & I” .... & not “our organisation”

Put aside you personal feelings .... Concentrate on the issue to be resolved.

If the other party has a different point of view, do not view this as a challenge. “We have a problem that we need to talk about to find a solution that works for both of us”.

Recognise and work on the conflict of ideas .. not on the conflict between the two of you.

Be determined to reach an agreement not secure a personal victory.

Look at your objectives from their point of viewpoint. You require their involvement.

Sell your point “sunny side up” (i.e. the positive bits for them)

Listen .... Say the right things in the right way at the right time; know when not to speak ..... listen carefully.

Be wary of compulsive talking, a symptom of lack of confidence – especially interrupting the other person whenever they say something potentially “objectionable” (e.g. scientific fallacy).

Do not give your argument away too quickly – leaves you no space to change the way you put forward your case.

Do allow the other person to complete what they have to say .... You need to know what they are thinking.

“Float” suggestions rather than commit. “there are various things we could do, suppose I were to suggest ..., what do you think? Had you thought...? Recognising that “demand” usually comes from their anxiety arising out of uncertainty.

Be wary of offering face-to-face consultation before you “get the story & the picture” →

- may not be what is needed by either of you
- may not be what the caller / parent wants
- does not give them more control, it makes them more anxious.

You want to know what can be done to help them best.

### What to do about the parents that “inappropriately” demand a home visit?

Performance review of calls suggests that it is commonplace for doctors to “put their foot in it” by not assessing on the phone and then offering face to face consultation as an only-solution when one really isn’t needed.

What concerns would they have about travel? Dispel myths. The “unreasonable” demand rarely arises if you have been empathetic to their concerns, your advice has been confident, clear and simple to understand. They should now know what to do and how to cope. More access to the covert, more chance of shared outcome. Assess first ..... do not ask for expectations directly and engage in negotiation without “the facts”. Then you can influence and persuade.

Consider slightly manipulative escalations, e.g. “We both want the best for your child. We have better facilities and diagnostic equipment here at the PCC to assess your child”.

Consider a “Wince” e.g. “Oh. Oh really. Pause.

Most parents do bring their kids down to our PCC.

This allows us to prioritise home visits for the infirm elderly and terminally ill; you would be able to be seen more quickly at the PCC”.

If you are still stuck, shrug off your emotions, you have not failed, it does happen.

Bottom line - be wary of choosing your battles.