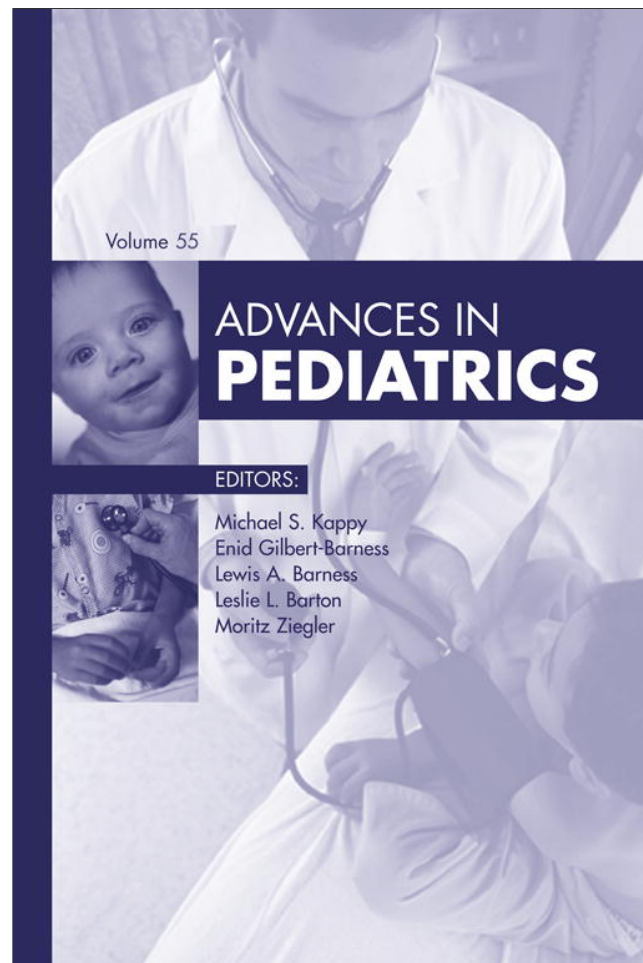


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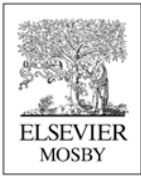


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Telephone Triage Liability: Protecting Your Patients and Your Practice from Harm

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Pediatricians receive more telephone calls than any other medical specialty. The American Academy of Pediatrics reports that 30% of office-hours pediatric care is provided over the telephone, as well as 80% of after-hours care [1]. Sometimes physicians are sued for the telephone advice they give. Pediatricians rank fourth in frequency of lawsuits after internal medicine, family medicine, and obstetricians. The purpose of this article is to help pediatricians prevent errors in telephone triage that could cause harmful outcomes for their patients, not to mention medical liability for their practice. After-hours calls (when the office is closed) account for most of the adverse outcomes. Therefore, preventive measures for these calls will be covered in more depth than office-hours calls.

Lawsuits against pediatricians have a better outcome than most specialties [2]. In 68% of cases, the claim was dropped, withdrawn, or dismissed. In 27%, a settlement was reached without going to court. Only 5% of cases go to trial, and of those, in 80% the verdict goes in favor of the physician. These data come from all pediatric lawsuits, not those just involving telephone care.

MALPRACTICE DEFINITION

To sustain a malpractice lawsuit, a plaintiff's attorney must prove the following: damage to the patient, duty to treat, direct cause (damage caused by our care), and deviation (departure) from standard of care. We will examine each of the 4 Ds in some depth.

Damage usually means permanent harm or injury to the patient. This can include death (eg, from shock), disability (eg, from kernicterus), disfigurement (eg, from necrotizing fasciitis), or unnecessary loss of all or part of an organ (eg, torsion of the testicle). In fact, the severity of the damage often determines the size of the malpractice award.

Of the total paid claims in pediatrics from 1985 to 2005, death accounted for 30%, major permanent injury for 29%, significant permanent injury for 12%,

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and minor permanent injury for 7% [2]. Damage is the essential element in the 4 Ds. If there is no injury, there should be no grounds for a successful lawsuit. However, of the total paid claims in pediatrics, major temporary injury accounted for 9%, minor temporary injury for 8%, and insignificant injury for 2%. Pain and suffering alone are not grounds for a lawsuit.

Duty to treat means the legal contract between the patient and health care provider has been established. The duty to treat begins when we start our telephone assessment or give any medical advice. It ends when the caller's medical problem is resolved, or at the time the duty is transferred to another health care provider. For our own patients, we are expected to be available or have a substitute health care provider available within a reasonable period of time. For patients who call us but are not in our practice, while we can decline to give advice, we accept the duty to treat as soon as we begin to help them. As for who is accountable and liable in these cases, it is the physician and the triage nurse. In an after-hours call center, the responsible people are the triage nurse and the call center supervising physician. The primary care physician (PCP) is not accountable unless he or she is consulted.

Direct cause means there is a causal link between the damage or harm to the patient and our performance. Usually, a life-threatening or serious medical condition is present that was not recognized or acted on by the triager. A delayed referral to medical care is a common denominator. Delayed referral leads to delayed diagnosis and delayed treatment. A direct or proximate cause means the damage occurs or progresses after the call is made. Over 95% of direct causes are from errors of omission or underreferral. Errors of commission are uncommon. An example would be recommending the application of a hot water bottle to the abdomen of a 1-month-old child with colic and causing a third-degree burn that leads to permanent scarring.

Deviation from standard of care means the urgency of the child's symptoms could have been recognized by a reasonable triage person at the time of the call. The standard of care is what a reasonable physician or nurse with similar training and experience would have done. Standard of care is defined by peers, experts, and guidelines. The standard of care is a range of reasonable responses, not optimal care [3]. Negligent care must fall below the lower limit of acceptable care.

TYPES OF LAWSUITS

In my view, there are three types of lawsuits brought against telephone triagers: true accusations (malpractice), false accusations, and imperfect call accusations. True accusations meet all the grounds for malpractice or negligent care. False accusations are ones in which the telephone care was reasonable, but the caller lies or distorts the facts and blames the triager for recommendations he or she did not make. The third type of accusation could be called the imperfect call accusation. It falls into the gray zone where the seriousness of the child's condition could not have been recognized at the time of the call and the damages or complications started after the call was finished.

TRUE ACCUSATIONS

True accusations mean the bad outcome and damage were directly caused by delayed referral to medical care. These are true malpractice errors. They are the worst-case scenarios that can teach all of us how to practice better telephone management. The delayed referral to medical care usually includes the following:

- Life-threatening emergency call can't get through
- Emergent call not returned promptly
- Triage doesn't refer a child with an emergent condition in immediately
- Triage sends child in by car rather than emergency medical services (EMS) or an ambulance [4]
- Triage sends child to office/clinic rather than emergency department (ED)

After-hours malpractice errors

Medical errors can occur at any step in the after-hours call process. The answering service's role is to receive calls, collect basic information, and then transfer this information to the nurse or physician on call [5]. The information is transmitted by fax, voice message, or pager to the call center or physician. During this process, the answering service can make an error (Box 1).

The charge nurse at the call center prioritizes the call. The telephone triage nurses then return the call. Most malpractice errors occur at this point in the call process because the decision making is by the triage nurse (Box 2). The physician, physician assistant, or nurse practitioner who provides backup to the call center nurse can also make an error (Box 3). Box 4 lists risk management rules that can prevent most of these medical errors if they are adhered to [6].

Office-hours malpractice errors

Generally office hours calls are very safe. The main reason for this is that there is no attempt to reduce access. If the caller wants his or her child seen, he or she is

Box 1: Answering service risk management

1. **Error:** Life-threatening emergency present and caller gets voice message machine or busy signal at answering service. They call again.

Example: 6-year-old with abrupt onset hives and stridor. Result: dies.

Risk Management Rule: Include EMS (911) on all intake messages. "If this is an emergency, hang up and dial 911 NOW."

2. **Error:** Answering service doesn't recognize life-threatening emergency and transfers call to call center by fax.

Example: 4-month-old with weak, slow breathing. Result: apnea and dies.

Risk Management Rule: Make sure your answering service has a brief list of life-threatening emergencies AND redirects these calls to 911 OR puts them through to the call center on a direct line.

Box 2: Telephone triage nurse risk management

1. **Error:** Delay in returning call regarding seriously ill child.

Example: 4-week-old with 102°F fever. Result: goes into septic shock.

Risk Management Rule: Have incoming faxes screened and prioritized into emergent, urgent and nonurgent categories. Attempt to return emergent calls within 5 minutes and urgent calls within 15 minutes.

2. **Error:** Child sent to ED by car rather than EMS.

Risk Management Rule: Use protocols with a 911 disposition and triage questions that recognize life-threatening symptoms.

3. **Error:** Transfer call to 911 without giving first-aid advice (eg, Heimlich maneuver).

Example: 2-year-old choking on foreign body. Result: arrests before reaching EMS.

Risk Management Rule: Before transferring a life-threatening call to 911, give 10 seconds of first-aid advice if advice could be life-saving.

4. **Error:** Nurse doesn't ask about complications of main symptom (eg, dehydration in child with diarrhea)

Risk Management Rule: Use triage protocols and ask all the questions.

5. **Error:** Nurse doesn't follow protocol.

Example: Dog bite to face and not referred to ED. Result: severe cellulitis, needs incision and drainage, leads to disfigurement.

Risk Management Rule: Follow and adhere to the protocol. Don't downgrade a disposition. If unsure, transfer call to PCP.

6. **Error:** Language barrier and child has serious condition

Example: Infant with severe diarrhea missed. Result: progresses to dehydration and hypovolemic shock.

Risk Management Rule: For language problems, transfer to a nurse who speaks that language OR to translation service.

7. **Error:** Triage nurse doesn't ask about chronic disease and caller doesn't mention.

Example: Child with Sickle Cell Disease and fever. Result: dies of pneumococcal sepsis.

Risk Management Rule: Always ask about chronic disease (eg, immunocompromised) to identify patients at special risk.

8. **Error:** Triage nurse assumes call doesn't need triage (advice only call).

Example: Breastfeeding question re: milk supply. Result: dehydration progresses to stroke.

Risk Management Rule: Require triaging of all newborn and sick child calls.

9. **Error:** Triage nurse allows parent to make diagnosis.

Example: Chickenpox. Result: actually meningococcal septic shock and DOA.

Risk Management Rule: Mainly triage by symptoms. Don't accept a caller's diagnosis unless it meets the protocol's diagnostic criteria.

10. **Error:** Nurse uses wrong triage protocol.

Example: Hives protocol instead of Rash, Widespread and Cause Unknown Protocol. Result: misses serious rash.

Risk Management Rule: All triage nurses are carefully trained and monitored to select the best protocol.

11. **Error:** Triage nurse accepts caller's story for injuries and doesn't consider child abuse.

Example: Infant with bruises from falling off sofa. Result: next injury is subdural hematomas from shaking injury. State Child Protective Services sues triage nurse and physician.

Risk Management Rule: Use protocols that include inflicted injuries (child abuse) in the differential diagnoses.

12. **Error:** Inexperienced nurse handles sick child call that doesn't have protocol.

Example: Buccal cellulitis not seen. Result: progresses to meningitis.

Risk Management Rule: When no protocol applies and child is sick, ask for consult from charge nurse or PCP.

13. **Error:** Protocols are inaccurate or incomplete.

Example: Herpes simplex of newborn not mentioned in newborn rashes. Result: progresses to herpes encephalitis.

Risk Management Rule: Use protocols that are tested, reviewed, and updated yearly.

14. **Error:** Nurse refers to ED now but caller doesn't have immediate access to transportation.

Risk Management Rule: Verify caller has available transportation to designated ED. If not, advise to call 911.

15. **Error:** Nurse tells caller to go to ED, but doesn't tell when to go.

Example: 3 year-old with testicular torsion. Nurse tells caller to go to ED, family goes 8 hours later. Result: testicle not viable.

Risk Management Rule: Nurse clarifies disposition site and timeline. Nurse checks caller's understanding and acceptance of disposition.

16. **Error:** Multiple calls regarding same child in one night.

Example: Child again triaged as mildly ill. Result: hidden agenda missed and social crisis escalates (eg, spouse abuse or child abuse).

Risk Management Rule: Have a policy that two calls about the same child in one night triggers a visit. (Exception: checking a drug dosage or care advice.) Repeated calls means the child needs an in-person evaluation.

17. **Error:** Nurse tells parents their child doesn't need to be seen in ED, but caller wants to be seen anyway. Nurse then implies that they can't be seen.

Example: Caller has fever phobia and nurse brings up ED co-payment issues.

Risk Management Rule: If the caller is still uncomfortable and can't be reassured *after* triage and advice, allow the caller to override the protocol. Have the child examined tonight or transfer the call to PCP.

18. **Error:** Nurse doesn't give call-back instructions.

Example: Newborn bleeding from circumcision. Result: hemorrhages and dies.

Risk Management Rule: Always give the caller indications for calling back (the contingency plan). If middle of night, ask parent to recheck child in reasonable time.

Box 3: Physician risk management

1. **Error:** Physician on call fails to answer page for over 1 hour or asks answering service to hold all calls for 1 hour.

Risk Management Rule: On-call physician also must be accessible and prioritize incoming calls.

2. **Error:** Physician switches antibiotics by telephone without examining child.

Example: Acute otitis media unresponsive to amoxicillin and high fever. Result: progresses to mastoiditis or meningitis.

Risk Management Rule: Don't switch antibiotics without examining the patient.

3. **Error:** Physician (doing second-level triage) downgrades triage nurse's disposition without talking directly to parent.

Example: Infant with fever and sounds listless to triage nurse. Physician not impressed. Result: misses septic child.

Risk Management Rule: Don't allow primary care physician (PCP) to overrule a triage nurse's referral to an ED without talking to the parent. The nurse should refuse to transfer the PCP's disposition to the caller if he or she disagrees with it and the result could be harmful to the child.

given an appointment. There are some exceptions, however, where delays lead to complications. The appointment scheduler may give a late-day appointment to a seriously ill child who then deteriorates. The scheduler may also give a next day appointment to a very sick child when it's a near closing time (late afternoon) call. The appointment scheduler may answer a simple question about a sick child instead of transferring the call to a nurse (eg, offering a Tylenol dosage for a 6-week-old with a fever). The physician who returns calls in bunches twice a day also runs the risk of delaying access. In addition, many of the preceding errors that occur with after-hours calls can happen during office hours.

The office-based physician may want to review the risk management rules for after-hours calls and reflect on whether they should be operational in their office. In addition, the following rules that are specific to office hours should be reviewed:

Box 4: Defense for false accusation calls

- Documentation of the call is key
- Disposition given is documented
- Protocol or resource used is documented
- Dosage of any recommended medication is documented
- Call-back instructions are documented
- Share this documentation with the accuser

- Never put a caller on hold until it's been confirmed that the call is not urgent.
- Have talking with a real person as one of the options on the automated attendant system.
- Require all sick child calls to go through nurse triage unless they can be worked into the appointment schedule within 2 hours. Also have the scheduler ask if there are any serious symptoms before giving an appointment.
- Don't allow nonclinical staff to give any medical advice over the telephone.
- Don't put emergent or urgent calls in the PCP's callback list. Either interrupt the PCP or have the triage nurse manage these calls.

FALSE ACCUSATIONS

A false accusation is one in which the triager arrives at and conveys an appropriate disposition, but later the caller claims that the triage nurse gave a different disposition and advice. An actual case example is a call about a 3-year-old who had chickenpox and bleeding into some of the lesions. The triage nurse sent the child to the emergency department immediately. The parent brought the child to another hospital several hours later. A diagnosis of chickenpox with aplastic anemia was made, and the child was admitted to the ward for a lengthy stay. The parent told a nurse on the ward that she had called a call center 3 consecutive days and each time was told that her child had chickenpox and didn't need to be seen. She said she was going to sue the hospital. This story eventually reached the private pediatrician who contacted our call center. There was no record in the answering service or in the call center of any preceding calls about this patient except for the call on the date the child was hospitalized. The private physician confronted the mother with this information and the mother backed down and stated she probably called some other nurse line but didn't remember which one it was.

What are the reasons a caller would lie or distort the interaction with a triage nurse? In our experience, false accusations usually involve a case where the parents delayed seeking care. They feel guilty about their actions, and shift their guilt to the nurse or physician who takes their call. If the physician who sees the child in the emergency department says something like, "you should have come in sooner," the parents may feel on the defensive and in turn blame somebody else for their delay in seeking medical care. In general, these parents seem to remember many more details about the call than we do and their selective memory usually favors them. Many times the parents have another family member who claims to have witnessed the call. In the final analysis, it's the parent's word against ours.

False accusations are usually one of four types:

- The caller claims we didn't refer the child in immediately.
- The caller claims we didn't tell them to call 911 or an ambulance.
- The caller claims we sent the child to the office instead of the emergency department.
- The caller claims we gave harmful advice or a wrong drug dosage.

The following is an example of a false accusation about a drug dosage. The triage nurse gives the caller the correct dosage of acetaminophen based on the

child's weight. She asks the caller to write it down and repeat it. The caller then proceeds to use a teaspoon to give acetaminophen from a bottle that has a dropper. The concentration per volume in the dropper solution is 3 times more than in the acetaminophen syrup. This dosage given over 2 days leads to acetaminophen poisoning and liver damage. While hospitalized, the parent blames the overdosage on the triage nurse. Fortunately the nurse has complete documentation of the dosage she recommended.

Adequate documentation is the only way to protect one's practice against false accusations. Documentation is our witness. In fact, it's important that physicians who don't document all their calls, do document any call that has an unexpected outcome such as hospitalization. It is acceptable medical practice to document that call in the patient's chart, even after the fact, as long as we record the correct date of entry. The nurse working in a call center has a lower risk than the primary physician taking calls at home for the following reasons: The nurse always documents the call. In fact, many call centers record all calls. This is the ultimate way to counteract false accusations and prevent them from moving on to a lawsuit. The nurse also has more time to address the call than the physician who may have other demands on his or her time, such as rounding on inpatients. In addition, the physician may have a conflict of interest, from the standpoint that if he or she is taking the call at night and is practicing in an area where an ED is not readily available, then he or she needs to get up and drive to the office and see the patient.

The amount of documentation necessary to defend against a false accusation is not extensive (see Box 4). The most important fact to document is the disposition that was given. The disposition is the decision reached following telephone triage as to where and when the caller was instructed to seek medical care. Was the caller told to call 911? Was the caller sent to the emergency department by car? Was the caller told to proceed immediately? The time frame for seeing the patient needs to be clearly documented, as does the fact that the caller agreed to it.

The minimal documentation needed for risk management also includes the following: If a nurse is taking the call, he or she must be using a protocol system and should document the specific protocol used for this call. Callback instructions, in case the child's condition deteriorates, should be given and documented. Any drug that is recommended should have the dosage documented. If one is using protocols, it is within the standard of care to write "advice given per protocol" or "triage per protocol." Then one only needs to document pertinent positives.

The documentation of the call must also be retrievable. Written records of telephone interactions can be kept in a file system or in a chart. In a call center, often the documentation is kept within a computer file on the hard drive. The ultimate defense is to have a recording of the call. This may be maintained on audiotape, CD, or the hard drive. It is difficult to answer the question as to how long to keep the documentation. Most lawyers would tell us to keep it until the statute of limitations runs out, which is until the patient reaches of 18 years of

age plus 2. Now that recordings can be compressed, keeping it this long may be achievable. From a more practical standpoint, if we haven't heard about a patient having an adverse outcome within 3 months after the call was made, it's highly unlikely that a lawsuit is forthcoming.

THE IMPERFECT CALL ACCUSATION

The chain of events in the accusation of an imperfect call goes as follows: The patient does not have a serious symptom or complication at the time of the first call. The patient then develops a serious disease or complication hours or days later. An example would be that the first pneumococcal bacteria crosses the blood-brain barrier after the end of the first call. Following the natural evolution of the patient's disease, a second call is made and the patient is referred for additional medical care or the family brings the child directly to an ED. The plaintiff's lawyer claims that we failed to diagnose the child's meningitis early enough. But we would ask, was the delay reasonable?

My view of imperfect call accusations is that they reflect unrealistic expectations of callers and lawyers. Perhaps the touting of medical technology in the media contributes to this expectation of perfection. In any event, hindsight is always 20/20. In my mind, the charge here is that the nurse had imperfect powers of prediction. He or she didn't have clairvoyance like the Monday morning quarterback always has. But the real question is, was his or her performance substandard?

How do we defend a good call? We need a "good-call checklist." We then can compare the call under question to the standards of care for a good call. Even an adequate, but not optimal, call can be defended in this way (Box 5). The recording, if there is one, and call documentation report are compared with the specific protocol that was used to triage the call. If the triage nurse is not using protocols, he or she is practicing medicine without a license. The benefit of protocols is that they've been preapproved by a medical advisory group, and they allow the reviewer to reconstruct the triage and advice that was provided. The triage nurse must meet the following criteria: use the appropriate protocol, adhere to the protocol, reach an appropriate disposition based on evidence, and gave callback instructions [7]. It can then be claimed that providing the callback instructions prompted the parents to call later, when the child's condition had changed, and for the triage nurse appropriately to make a timely referral following the second call.

The triage nurse needs to have followed any relevant policies or procedures that pertained to the call. For example, he or she may need to refer to the policy on child abuse and neglect legal requirements. The triage nurse needs to have completed a basic training program. It should be kept in mind that while registered nurses (RNs) have been accepted nationwide as qualified to do this type of work, it is difficult to defend a licensed practical nurse (LPN) who has provided telephone triage. The triage nurse's performance needs to be periodically reviewed. In addition, the completion of basic training and review needs to be documented. Since the PCP receives call reports on all of his or her patients, it

Box 5: Good-call checklist

- All calls are documented
 - A written report for this specific call is available for review. Ideally, a recording of the call is available.
- All calls are managed by triage protocols
 - Triage nurse used an appropriate protocol topic for this call
 - Triage nurse adhered to the protocol
 - Triage nurse reached an appropriate disposition based on history provided by the caller
 - Triage nurse gave call-back instructions to the caller
- Triage nurse followed any relevant policy or procedure
- Triage nurse completed basic training program
 - Triage nurse's performance is periodically reviewed
- Call system is monitored by a physician

can be pointed out that the PCP has been an ongoing reviewer of the triage nurse's work. Finally, the call system must be one that is monitored by a physician. In addition, call centers that are located within hospitals usually have met Joint Commission Accreditation of Hospitals standards.

Box 6: Protocols to reduce liability

- Don't delegate triaging task without protocols
- Use nationally recognized protocols
- Use protocols written and reviewed by physicians
- Use protocols that contain all common pediatric symptoms
- Chronic diseases are included as risk factors
- Child abuse is included
- Newborn topics are complete
- The disposition categories are realistic
- The decision-making process is easy to follow
- Life-threatening 911 emergencies are included
- Psychosocial emergencies are included (eg, suicide caller)
- Call-back instructions are present and specific
- The content has undergone a review process
- The content is referenced to the current pediatric literature
- The content has been widely used or tested in pediatric settings
- The content is updated on a regular basis

OTHER STRATEGIES FOR REDUCING MEDICAL LIABILITY

Defensible telephone triage is closely linked to protocols, documentation, policies, and procedures and training. Telephone triage should never be delegated to nurses without decision support tools. The protocols should be comprehensive, reviewed, compatible with American Academy of Pediatric policies, tested, and updated on a regular basis (Box 6) [8]. Adverse outcomes have occurred when calls are managed without protocols [9,10].

The calls must be documented. The minimal documentation for risk management was discussed earlier and is found in Box 4.

Policies and procedures that describe the roles of the triage nurse and the on-call health care provider should be written and in use (Box 7). Special policies to help the nurse access emergency referrals (eg, police, child protective

Box 7: Policies and procedures to reduce liability

- Have a system for prioritizing incoming calls.
- For 911 dispositions, verify compliance by calling the parent back in 3 to 5 minutes. If the caller is reluctant to call 911, clarify the reason for your concern about the child ("duty to terrify"). If the parent refuses to bring the child in, ask the primary care physician or the emergency room physician to talk with the family. Physicians have the authority to request a court order to treat if needed.
- Allow the nurse to override the protocol to a higher acuity and refer the child in for evaluation.
- Allow the nurse to transfer the call to the on-call PCP.
- Don't allow the nurse to downgrade the disposition to a lower acuity.
- Adhere to protocols. If not, justify any deviation in documentation.
- After reviewing home care advice, ask the caller, "Do you feel comfortable with the plan?" If not, either call back in 1 hour or have the caller come in without this step (ie, allow the caller to override the protocol to a higher acuity).
- If the caller calls again about the same problem within 12 hours, usually see the patient. (Reason: caller not reassured, child sicker than described, or hidden social agenda.) (Exception: checking a drug dosage or care advice.)
- All physician clients are required to have an on-call physician available to the triage nurse for consultation.
- If the patient needs to be seen and the on-call physician can't be reached or can't see the patient, always have someone else see the patient (eg, an emergency department physician).
- Chronic disease calls AND patients seen recently with complex acute illnesses (eg, infectious mono) are referred to the PCP.
- If after the call it is discovered that the wrong disposition or advice was given, call the family back.
- Exclude nonclinical staff from giving medical advice.
- Policies are available for emergency referrals (eg, to police, CPS, 911, ambulance service, crisis centers).

services, ambulance service, crisis center) should also be operational [11]. Clear guidelines on how to deal with calls about patients with chronic or complex diseases should also be available.

The emergence of national telehealth standards (eg, American Academy of Ambulatory Care and Utilization Review Accreditation Commission) has helped to emphasize the importance of ensuring competency of all telephone triage providers. As a result, training and quality improvement programs have become more comprehensive. Training and education must emphasize how to recognize and manage life-threatening and emergent conditions (Box 8). Selecting the most appropriate protocol for the caller's complaint is probably the most difficult step in triage. It is extremely important for optimal patient outcome. Special emphasis should be given to this aspect of nurse training (Box 9).

Box 8: Triage nurse training to reduce liability

- Emphasize that the child's safety and well-being are always the highest priority.
- Study all the triage and advice protocols.
- Study the anatomic version of the table of contents to appreciate the topics available within each body part (eg, respiratory or gastrointestinal).
- To improve the ability to recognize life-threatening or serious diseases, read the 911 section of each guideline.
- Study the diseases that have the highest rates of delayed diagnosis and malpractice claims. These are meningitis, appendicitis, and pneumonia.
- If the child sounds very sick to the triager, refer the patient in immediately even if no indicator is met on the protocol. Use the "child sounds very sick or weak to the triager" indicator.
- To recognize lethargic or toxic children, always ask about the child's current activity level. A helpful question is, "What is she doing right now?" If not active now, ask, "How does she look?"
- If the caller calls about a diagnosis (eg, chickenpox) rather than a symptom (eg, headache), don't accept their diagnosis unless it meets the diagnostic criteria listed in that protocol.
- Observe experienced nurses and physicians triage and document calls.
- Learn how to select the most appropriate protocol (see that checklist).
- Study all telephone care policies and procedures.
- Document completion of basic training.
- Provide ongoing reviews of nurse performance with sick child calls. Critique for selection of appropriate protocol, correct disposition, and accurate documentation. Document these reviews.
- Provide ongoing continuing nurse education (eg, monthly in-service topics). Document attendance.

Box 9: Selecting the best protocol

- Selecting the best protocol for the call is the most difficult step in using a set of protocols. It's very important for optimal patient outcome.
- For one predominant symptom, use the protocol for that symptom.
- For multiple symptoms, select the most serious symptom or the one that appears to be the most emergent. If none of the symptoms are serious, select the one with the highest likelihood of needing to be seen (eg, ear ache instead of cough, cold, or fever).
- For fever, use the protocol for the most serious associated symptom, unless fever is the only symptom.
- If uncertain where to start, ask the caller "Which symptom are you most concerned about?" (Exception: If the caller's answer is "fever," go to their second concern.)
- For a chronic disease and unrelated symptom, use the symptom protocol.
- For a chronic disease and related symptom, use the disease protocol if one is available (eg, asthma or seizures). If no disease protocol exists, put the call back to the PCP.
- Many protocols start with a section called "See More Appropriate Protocol." Use these prompts to re-think your needs. These are usually more specific topics and provide more specific triage than the topic you are currently in.
- For symptoms that are from unrelated systems, you will need to use 2 protocols (eg, HIVES and DIARRHEA). This rule applies to 5% of calls.
- For an acute symptom not covered by a protocol, ask a more experienced triage nurse for a consult, use an appropriate book or other resource, or refer the call to the PCP.

SUMMARY

By assigning accusations of malpractice to one of three categories, reasonable responses can be initiated. For true accusations regarding medical errors, the case should usually be settled out of court. For false accusations, the written and recorded documentation should be shared with the patient's primary care provider as soon as possible. The physician in turn should share his or her interpretation of the call with the family. This proactive approach usually results in the caller withdrawing the complaint. If a lawyer is already involved, often the claim will be dropped. For accusations of an imperfect call, these usually account for the 5% of cases that go to trial. Once a plaintiff's lawyer is involved, it is unusual for this type of case to be dropped. The defendant's lawyer will need an expert witness to compare the nurse's actual performance to the "good call checklist." In over 80% of these cases, the case will be settled in favor of the physician and nurse by proving their performance met a reasonable standard of care.

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