Medical Malpractice Suits are Up - How to Communicate to Avoid Being Sued

According to a recent American Medical Association report, on average, 95 medical liability claims are filed for every 100 physicians. This increase was found to affect some areas of practice more than others. While physicians likely will not want to switch their areas of practice, other means are available to help reduce exposure to medical malpractice causes of action.

Medical errors occur when something that was planned as part of a patient’s medical care does not work out, or when the wrong plan was used in the first place. Medical errors can occur in any setting of a health care system. Not all medical errors result in injury and not all medical errors are the fault of health care providers. Most medical malpractice claims are based on medical errors that have resulted in patient injury or death. Reducing medical errors lessens the risk of medical malpractice litigation.

The single most important way to help prevent medical errors is to be an active member of the health care team. The better a physician is at helping patients, the less likely they will face a medical malpractice lawsuit.

Clear and timely communication is key in avoiding medical malpractice suits. Open and honest communications with patients, lets them know how you will provide care for them and facilitates patients by providing needed information regarding their health conditions. Timely and thorough communications with ancillary health care providers assist with coordination of care and provision of comprehensive care. When all members of the health care team are communicating well, the risk of medical errors diminishes and patient outcomes improve.

The need for effective communication is not limited to verbal communications. A physician’s written documentation serves as evidence of the physician’s involvement and thought process regarding the patient’s care. Written documentation also supports the physician’s findings, recommendations, orders and plans concerning patient care. This is the physician’s chance to get what is in his head down on paper. Often other members of a health care team rely on documented physician consultations, progress notes and orders in determining the care and treatment a patient is to receive. It is important that a physician’s written documentation is legible so that it can be understood by all members of the health care team. According to a recent survey, the incidence of legible physician handwriting in patient’s charts varies from as low as 13% to as high as 80%. Illegible orders are routinely noted to be a source of medication errors. Improving legibility of orders and other medical documentation can reduce medication errors and medical errors, which reduces the risk of being sued.

Written documentation is not limited to time spent with a patient during examinations. Quite often, a patient will call in with a concern or question. Any such communications with patients over the phone, should be documented in the patient’s chart. The fact that a return call was made, as well as the nature of the conversation should be noted. Providing dates, and preferably times, for all written medical documentation is vitally important. If it cannot be
determined when a medical note was written, it is all but useless.

An often heard phrase in medical malpractice litigation is, “If it wasn’t charted, it wasn’t done.” Thorough documentation of a physician’s thoughts, actions, findings, orders and plans regarding a patient provides strong evidence of the physician’s assessment, diagnosis, care and treatment. Definitive documentation provides a much stronger evidentiary support of a physician’s care, than mere reliance on what the physician customarily does in like situations. While all normal patient findings may not need to be documented, relevant abnormal findings should be commented upon.

By providing timely, clear and thorough oral and written communications regarding patients the risk for medical errors decreases, patient care improves and conversely the risk of medical malpractice suits is reduced. Better patient-physician relationships reduce the filing of medical malpractice actions, while comprehensive documentation of patient care is crucial to defending medical malpractice actions. Good oral and written communications by physicians are important methods for reducing medical malpractice claims. If in spite of efforts to have open communication with patients, you anticipate potential litigation it may be helpful to call your medical malpractice carrier to get assistance regarding further communications with the patient.

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