



## Dictation Review

### **I'm too busy to review all my dictation. Isn't my "Dictated But Not Read Stamp" enough?**

No. This message is unacceptable because it basically states that your work is incomplete with respect to that particular patient. What's to ensure that you will return to the document, read and sign it after it has been stamped and filed ?

Read everything you dictate, write and sign.

You will be held responsible for the contents of any patient letters, consultation letters, or dictation whether it is stamped "dictated but not read" or simply left unsigned. Many physicians have been embarrassed to later discover they sent consultation letters or signed progress notes that contained ridiculous - or dangerous - typographical errors. Consider the following entries from actual medical records:

- "The patient had a baloney amputation in 1989." ("a below-knee amputation");
- "Patient had a pabst beer today." ("a pap smear");
- "The patient was found in the bathroom without a purse." ("without a pulse").

These entries were merely embarrassing. However, the following entries resulted in problems defending claims:

- "Patient history: had no carcinoma, no family history." (This patient had a history of adenocarcinoma.)
- "CMS normal, swelling now present." (This patient had a fresh cast and swelling was not present. However, compartment syndrome developed two days later and the typographical error made it appear the physician missed the early signs.)

Signing off on all entries in the medical record is essential for many purposes. Most third-party payers require it; follow-up treatment questions cannot be addressed if the provider is not identified; internal quality improvement activities require clinician's identities; and, as the above examples demonstrate, it may be critical in defending a malpractice claim years later. It is not enough to assume that "everyone knows" your handwriting. Claims may be brought years later - maybe a decade in some states for minors - and the same personnel may not be around to identify who wrote a particular note.

Develop an office sign-off policy to include the following elements:

- If initials are used, keep a current master list of initials and full names so that years later you will be able to accurately identify the author of a chart entry.
- If any physicians or staff have the same initials, full last names should be used to avoid confusion.
- If signature stamps are used, policy should dictate that only the owner uses his or her stamp. Signature stamps create many potential problems and are not recommended.
- Do all of your entries clearly identify who participated in each patient visit and who was responsible for entering each piece of information? If not, you may have the perfect set-up for a malpractice claim.

Take the time to change your practice now to avoid a serious documentation issue later.



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