In this case, the jury believed the patient and found against Dr. A.

Dr. C did sign off on the student’s note, indicating her approval of the entry.

**Signing Off On Medical Record Entries: Will it prevent a claim?**

Two physicians were named in a malpractice claim, but not because they had both treated the patient. The lack of sign-off on the progress note made it impossible to confirm which physician treated her. The patient recalled that Dr. A had treated her; the physicians believed Dr. A’s partner, Dr. B, had treated her. The case went to trial with a jury ultimately deciding which physician had treated the patient.

Although the care was defensible, the physicians’ disagreement over who actually rendered it overshadowed any defense. Because there was no sign-off, both physicians suffered through a malpractice trial.

In a hospital setting, attending physician Dr. C was sued when the treatment recommendations in the chart were not followed and the patient had an adverse outcome. The attending physician had signed off on the medical student’s note - which called for an extensive battery of diagnostic testing – and recalled later that she had disagreed with the student’s recommendations and had not ordered all of the listed tests. However, she did not document her reasoning. The patient subsequently died. The chart reflected that the medical student recommended certain testing, the attending physician had signed off on the note, and that testing was never done. The family’s claim was settled.

A note describing her own recommended diagnostic pursuit would have likely changed the claim’s outcome. As plaintiff’s attorneys often say, “If it’s not in the medical record, as far as the jury is concerned it didn’t happen.” Dr. C’s testimony that she recalled disagreeing with the medical student’s entry sounded self-serving after the patient had died. While the course of diagnostic investigation pursued by the attending may have been perfectly reasonable and within the standard of care, the chart made it easy for the plaintiff’s lawyer to argue instead that she had “negligently failed” to follow her own approved recommendations, leading to the patient’s death.
Two very different situations

In one clinic

This obviously raised similar issues to the case of Dr. A and Dr. B

If you are a physician who always signs off on everything, do you always read what you are signing?

These entries were merely embarrassing

One where there was no physician sign off, one with sign off on a note the physician did not fully endorse -- but both doctors were successfully sued. Is it better to sign off on a note or not? Clearly signing off on a note you haven’t read -- or disagree with, without clarifying your position -- can create liability risks. But leaving a note unsigned does not in any way protect you from liability.

Other situations that may result in problems defending claims occur when original notes are recopied into the patient chart, or when dictation is not checked for errors.

Physicians were routinely faxing progress notes from satellite offices to the main clinic, where they were being recopied into the patient’s chart and signed off by the person doing the copying. There was no indication of which doctor saw the patient. It was impossible to later tell which physician(s) had cared for a patient.

There was no way to tell from the medical record who had treated any of the patients, creating an impediment to defending claims. An even greater risk arises if the person copying the note makes an error for which the physician will be held accountable.

If not, you are placing yourself at risk. 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”)

However, these 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 payors 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 – almost a decade for minors – and the same personnel may not be around to identify who wrote a particular note.

When developing a sign-off policy, consider:

- 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.

Review your own medical records and sign-off policies.

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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