Risk Management: The Importance of Comprehensive Documentation in the Patient's Chart

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INTRODUCTION

Documentation errors or omissions oftentimes confound defense counsel during the trial of dental malpractice matters. Unfortunately, it is common for a practitioner's notes to be overly brief, incomplete, or have portions missing. Often, these simple and seemingly harmless errors can leave a negative impression with the jury during trial. Such errors suggest that the dentist's care was not well planned, or arguably negligent. The following case illustrates the importance of a well documented dental chart when a patient's claims for negligent care are brought to trial.

This particular matter included allegations of inadequate documentation with respect to the patient's dental history, care plan, consent for treatment, and dental visits. Ultimately, the defense was able to successfully explain to the jury the unique reasons for the sparse documentation in the plaintiff's chart, which were: (1) the plaintiff was, himself, a dentist, and familiar with the plan of care and proposed treatment, (2) the defendant's treatment was successful as the upper bridge he inserted lasted five years and did not require treatment during that time period, and (3) the treatment was rendered, and the chart was maintained at the plaintiff's own dental office. Despite the successful result, the lesson learned by the defendant at the conclusion of the trial was clear and simple: dentists can reduce their litigation exposure by conscientiously documenting their patients' chart. More importantly, a well documented chart establishes the foundation for a strong dentist-patient relationship, results in better communication, and dental care, and also guards against costly litigation.

DISCUSSION

During trial, plaintiff's counsel attempted to use the chart, with its sparse entries to suggest that the defendant had rendered inadequate and negligent care. The most glaring record-keeping omission was the defendant's alleged failure to document a care plan for the insertion of the patient's upper bridge. Notably, the plaintiff was a colleague and friend of the defendant, and this was offered as a reason for the sparse documentation in the chart. The plaintiff also claimed that the defendant failed to update his medical history on each office visit. The defense countered this argument by showing that the defendant inserted the upper bridge successfully, and that it lasted for five years. The defense contended that as a result of the successful treatment, no frequent office visits were necessary during this time period, and accordingly, there were no chart entries. During trial, the defense learned that even seemingly baseless allegations of malpractice become harder to defend without a properly documented chart which includes a complete, current, and comprehensive note for each office visit.

The claim of inadequate documentation associated with the plaintiff's informed consent was also an issue raised during trial. Ideally, dentists should never render care to their patients without documentation reflecting that the patient's informed consent was properly obtained. Indeed, patients should be made to understand and participate in the development of the care plan prior to treatment in order to make informed decisions about their care. With most practitioners, an informed consent typically includes a detailed explanation by the dentist about the proposed treatment, as well as the potential risks, benefits, and alternatives to the treatment. The patient then acknowledges, in writing, his affirmative choice to pursue one of the treatment options offered. In good practice, a patient's informed consent should be obtained prior to dental care, and ideally during a prior office visit when proposed treatment is being discussed and contemplated.

Unfortunately, in this case, there was no documentation of an informed consent discussion between the dentist and the plaintiff. Usually, such lack of documentation suggests that there was no valid exchange of information with the patient about the proposed treatment and options. Without this critical documentation, informed consent claims become tremendously difficult to defend at trial. In this case, the claim for lack of informed consent was eventually withdrawn by the plaintiff's counsel because the plaintiff was in fact an experienced dentist, and it would have been difficult to prove that he was uninformed about the proposed dental treatment (there was evidence that the plaintiff participated in the care planning and treatment), as well as the risks, benefits, and alternatives to the treatment. Indeed, he had in fact undertaken this very treatment with his own patients.

With regard to claims of incomplete or inadequate notes, the defendant acknowledged that his terse notes were most likely a function of the fact that plaintiff was a fellow practitioner and friend and he did not need to describe care as he normally would for another patient. Generally, in practice many dentists document the chronology of care, but often fail to document the specifics of each office visit. In this case, the defendant learned that the small amount of time necessary to record an accurate and detailed note is well worth the effort, and can help to defend against frivolous litigation.

LESSONS LEARNED

Proper documentation of the chart includes accurately recording all relevant patient information. This includes the plan of care, informed consent, and any other information deemed necessary to the patient's treatment. The following points may seem obvious, but are worth noting and would help defend and prevent against unnecessary litigation:

1. Document every office visit, no matter how minor. Document all of the events chronologically.
2. Chart entries should be comprehensive. They should detail specifically the nature of each office visit, the treatment rendered, the diagnostic tests performed (x-rays, study models), the materials used, and the laboratories involved.
3. Handwritten notes should be neat and legible. Often the dental chart can have handwritten notes which are sloppy or illegible, and this can work against the defense at trial. Illegible entries leave the dental care more open to attack and interpretation. Moreover, the dentist should not write in the margins of the chart, or write in different color inks, or add text to the original written entry. This gives the appearance of an altered chart. If necessary, the dentist should make any additional notes as a separate dated addendum.
4. Simply record the medical history or facts on each office visit. For example, do not speculate or guess as to a patient's state of mind, i.e., symptoms of mouth pain.

CONCLUSION

The defendant learned that his dental practice can certainly be enhanced with comprehensive documentation of the patient's chart. Further, comprehensive recordkeeping serves as the basis for the defense at a malpractice trial. Overall, a dental practitioner's risk management is enhanced by detailed records, and the dentist must keep complete records for both treatment and legal purposes, as well as to educate his/her patients so that they may understand and contribute to their care plan. In so doing, patients will be more likely to understand their dental needs, and participate in the development of their care plans, and less likely to litigate based on negative outcomes. Better and more intelligent recordkeeping also enhances a dentist's communication with his/her patients. This results in increased trust in the dentist, which further reduces the risk of potential litigation.

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