Meticulous documentation certainly serves to optimize patient care. If our records are thorough, they are more helpful to referring doctors and to other specialists involved in the care of our patients. Likewise, good records help to maintain continuity of care in a group practice setting. Furthermore, if we thoroughly document historical details and physical findings, we are better able to organize our thought process as we work to ultimately determine a diagnosis and to develop a treatment strategy. Our patients deserve the full benefit of our expertise, and part of that expertise is a well-organized approach to their care. Most of us are busy enough in practice that we cannot possibly recall in detail all of our patients. When we maintain a detailed record of each patient visit, we are then better able to review treatment, offer explanations, and answer questions over the entire duration of a patient’s treatment.

Careful documentation of patient care is an absolutely important part of risk management strategy for the OMS. Combined with good doctor-patient communication and informed consent, a good medical record will help OMSNIC to defend you against an allegation of malpractice or against a dental board complaint. The extra time spent in developing a thorough medical record is far less onerous than any time spent defending your care of a patient who has initiated a malpractice action against you.

**Elements of the Medical Record**

The elements of a good medical record include the legible documentation of the history, physical findings, assessment (differential diagnosis when indicated), discussion of informed consent, treatment (and the rationale for the treatment), patient instructions and follow up care. The “SOAP” format is an excellent way to provide thorough documentation of the history (subjective), physical findings (objective), diagnosis (assessment) and treatment (plan).

The medical record should provide an easily followed account of the patient’s entire course of treatment, including any worsening or improvement of the patient’s problem(s). Finally, as a rule, the medical progress notes should contain only clinical information. Financial information should be kept separate from the clinical information. A worst case scenario for an OMSNIC defense attorney is when the financial records contained in the chart are more extensive and legible than are the clinical records.

**Use of Medical Records in Litigation**

Defense counsels have often pointed out to us that plaintiffs’ attorneys will usually review the medical records before deciding to file a malpractice lawsuit. If your records clearly document your clinical findings, your diagnosis, your thought process, your treatment recommendations and your explanation to the patient, then such detailed records will often deter a plaintiff’s attorney from filing a lawsuit.

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Your Best Defense

ammunition to be used against us in litigation. It is impossible to predict which of our records will be subject to future scrutiny. Therefore, all of our documentation must be of sufficient quality so as to assist in our defense. Time and again, we have seen claims where good medical records have helped to successfully defend a poor outcome. The converse has been true as well, where we have seen the defense of a skilled and caring OMS compromised by poor medical records.

Anesthesia complications are particularly devastating to the OMS and patient alike. We must be aware that if malpractice litigation results from an untoward anesthesia outcome, OMS anesthesia record keeping will be held to the standard of an anesthesia record used in the hospital OR setting. Anesthesia record keeping by OMS must include contemporaneous time stamped documentation of the medications administered and of the vital signs. The same applies to recordkeeping during resuscitation of a patient. The OMSNIC website has anesthesia and resuscitation records that are available for download.

Medical Records and Reimbursement

Another aspect of medical recordkeeping that impacts the practice of OMS is the manner in which documentation of patient care affects reimbursement. We have all heard the adage, “If you didn’t document it, you didn’t do it”. If our treatment of a patient is poorly and incompletely documented, the result may be improper coding and billing and therefore inadequate reimbursement. Increasingly, third party payers are demanding that treatment records be submitted with claims. Too often the treatment records of an OMS patient are deemed unsupportive of the submitted procedure codes, and reimbursement is thus reduced or denied.

The practice of OMS is busy and demanding. The time constraints imposed by clinical practice unfortunately often detract from thorough recordkeeping. The above discussion serves to remind us that good documentation is an important part of the practice of OMS and of risk management that we cannot overlook.

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