



Editorial Comment

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Editor

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Many problems that we face as physicians are created by our tendency to provide poor documentation. Because of time pressure and lack of interest, more than frequent the documentation does not reflect the good care that is provided. When something goes wrong with a patient, the documentation in the medical record will be used to evaluate the quality of the care. Illegible notes, lack of clearly documented informed consent and lack of documentation about patient education are frequently used to question our practice.

It is very difficult to explain what happened in an adverse situation when the medical records are illegible. Practices today commonly employ electronic medical records. Many of these electronic systems not only facilitate communication by producing legible documents but they have integrated features designed to eliminate common errors. If you write all your notes, make an effort so they are legible to yourself and others.

It is important to note that patients are not really consented; they give the provider their informed consent. This consent notes for treatment should be clearly documented in the patient's record. A good idea is to note if the patient is accompanied by relatives during the consent process. The informed consent notes should never be documented after the treatment, i.e. in an operative report.

Physicians spend a significant amount of time educating patients. Nevertheless, because of lack of documentation, these efforts are not noted. If you spend time educating patients and especially if you provide them with readable material, you should document this in your notes. Notes that include the education provided to patients are useful in cases where a claim is made regarding lack of information.

Proper documentation and attention to detail may take a little time but at the end results in less chances of being served with a malpractice claim. Even with quality care, there is always the possibility that something will go wrong. In these instances, clear and substantive medical record documentation will be your best ally.

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