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Editorial

Addressing Deficiencies in Dental Documentation for Enhanced Patient Care

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The field of dentistry has been revolutionized by technological progress and innovative treatment methods, leading to enhanced quality and efficiency in dental care. A key element in delivering effective patient care is the precise and thorough documentation of dental records [1]. Properly prepared and maintained dental records provide benefits across various domains, including medical, surgical, legal, and ethical considerations [1-3]. These records serve as official documents that include diagnostic details, clinical notes, treatments administered, and communications with patients in the dental office, such as home care instructions and treatment consent (Charangowda, 2010) [4].

Comprehensive documentation is vital in healthcare, including dentistry, to ensure quality care, enhance patient safety, improve treatment outcomes, support continuous patient care, maintain data integrity, boost employee productivity, and aid research [1-7]. When dental records are accurate and complete, they transcend mere administrative functions, forming the basis for safe, ethical, and defensible care. Despite its critical importance, dental documentation often suffers from issues like inconsistencies, omissions, variability, and inaccuracies. The lack of a universally standardized format for dental records can lead to miscommunications and potential errors [1]. The situation has been exacerbated by the introduction of electronic health records (EHRs), as insufficient training on these systems has resulted in incomplete or incorrectly entered data [1,8]. In this context, the integrity of dental records is not just an administrative issue but a clinical and ethical necessity. To ensure documentation supports rather than hinders patient care, a comprehensive understanding of the challenges, gaps, and potential solutions is essential. This editorial contends that dental documentation should be regarded as a clinical skill, given the same priority as infection control or treatment planning. Neglecting this aspect puts patients at risk and places practitioners at a legal and ethical disadvantage.

Widespread and deeply rooted deficiencies

Despite clear professional guidelines and the increased digitization of health records, documentation in dental settings continues to be plagued by gaps. Studies consistently highlight missing treatment rationales, incomplete medical and dental histories, failure to document consent discussions, and a lack of continuity in follow-up notes. In a 2014 study, Devadiga found that documentation inconsistencies were prevalent in both private and public dental practices in India, leading to clinical miscommunication and potential harm. Similarly, Mortazavi., *et al.* (2015) [6] identified documentation as a weak point in the medico-legal preparedness of dental professionals in Iran [6]. Even in higher-resource settings audits have revealed that essential information is often missing from patient charts [9]. The problem is not merely one of individual oversight but systemic. Few institutions have enforceable documentation protocols. Undergraduate and postgraduate curricula often underemphasize record-keeping, prioritizing technical and clinical skills instead.

Digital does not equal accurate

The transition to Electronic Dental Records (EDRs) was expected to bring about better standardization, immediate access, and organized formats. However, in reality, digitization has brought

about new issues. Without proper training, clinicians might overly depend on copy-paste functions or default templates, which can weaken clinical judgment. Some may even forgot narrative notes entirely, simplifying complex patient care situations into mere checkboxes and dropdown menus. A study conducted by Sidek and Martins in 2017 revealed that the success of EHR systems relies not only on their technical quality but also on the users' capability and willingness to engage with them effectively [10]. This is sup m ported by more recent research indicating that inadequate training in digital record usage results in fragmented, incomplete, or inconsistent entries [11,12]. Merely implementing software does not address the issue but conceals it.

When documentation fails, patient safety suffers

The consequences of poor documentation extend beyond administrative concerns they pose clinical dangers. An overlooked allergy notes, an unrecorded chronic condition, or a missing follow-up plan can lead to significant patient harm [13,14]. For example, prescribing NSAIDs to a patient with uncontrolled hypertension or performing an extraction on a patient taking anticoagulants can have life-threatening outcomes if the medical history is poorly documented or miscommunicated.

In cases involving multiple disciplines, where orthodontists, periodontists, and prosthodontists jointly manage a patient, the absence of a clear, shared record can result in conflicting treatment plans and redundant procedures [10]. Beyond clinical risks, inadequate records pose a legal threat. In legal or regulatory proceedings, courts heavily rely on clinical notes. If something is not documented, it is assumed not to have occurred. Even when clinical care is appropriate, poor records can expose clinicians to accusations of negligence [15].

Rebuilding the culture: Documentation as a clinical competency

Enhancing documentation requires more than just electronic platforms and policies as it necessitates a cultural shift within dentistry. Documentation should be viewed not as clerical work but as an integral part of patient care. Just as dentists are trained to diagnose a carious lesion or manage an abscess, they should be explicitly taught to record patient history, risk factors, treatment rationale, informed consent, and outcomes with precision and clarity. This shift should begin in dental education. Record-keeping should be incorporated into preclinical training, reinforced during clinical placements, and evaluated in exams and OSCEs OSCEs (Objective Structured Clinical Examinations). Postgraduate programs and continuing education must treat documentation as a core competency, not as optional CPD (Continuing Professional Development). Institutions and regulators must also play their part. Dental councils, hospital boards, and private clinics should develop or adopt standardized templates for clinical notes; integrate regular documentation audits into quality assurance; reward high-quality documentation during performance appraisals; and provide training in EDR systems as part of onboarding and revalidation.

Conclusion

In an era where dentistry is increasingly integrated with general health systems, documentation is no longer a back-office function but it is front-line care and the precision with which we record patient encounters and critically reflects the quality of care we deliver. If we truly believe in patient-centered, evidence-informed dentistry, then we must treat and consider documentation as a clinical act as which protects our patients, our colleagues, and ourselves. The responsibility does not rest solely with individual clinicians but with the leaders and stewards of dental care systems. Clinical directors, department heads, and policymakers must acknowledge that documentation as a shared institutional responsibility. Investing in education, infrastructure, audit tools, and cultural reinforcement will yield benefits not only in legal protection and compliance but, more importantly, in patient safety, continuity of care, and professional excellence.

"It's time we stop treating documentation as an afterthought. It forms the foundation of patient care, and without a solid foundation, even the best-built crowns will fail"

Conflict of Interest

The author declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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