4 Things Not to Do When Documenting

Good recordkeeping is critical in these litigious times. Consequently, many Doctors of Chiropractic have come to believe that “more is better” when it comes to documentation. However, there are a few "don'ts" in a clinical record that are important to keep in mind.

1. Don’t Be Subjective

Record entries should always be factual and objective. For example, documenting that the “patient is obviously a malingerer” is purely subjective and can be viewed as derogatory by the patient. In addition, it’s doubtful that someone reading these remarks would perceive the Doctor of Chiropractic as caring or compassionate.

The doctor could instead document: “No clinical findings or objective evidence account for the patient’s related symptoms.” That’s an accurate, objective record entry that’s in no way belittling.

2. Don’t Include Inappropriate Humor

Humor has absolutely no place in a record. Unfortunately, a review of actual records involved in medical malpractice litigation has uncovered entries like:

- “Measure for coffin” on the chart of a terminally ill patient.
- “Rx high-speed lead therapy,” implying the patient should be shot.
- “Circling the drain,” implying imminent death.

3. Don’t Joust or Bad Mouth Others

The record is not the place to bad-mouth other providers. One example of “jousting” is the D.C. who saw a patient referred from another D.C. and noted on the initial record entry, “Dr. Ronald obviously had no idea what he was treating or how to treat it. Luckily, the patient got to me in time.”

4. Don’t Include Payment/Collection Issues

Today, most D.C. practices do not mix a patient’s clinical and billing information in the same record, and that’s appropriate. If litigation ensues and subpoenaed records are interspersed with staff’s documented efforts to get the patient to pay outstanding bills, it can be very damaging for the D.C. That’s because a jury may think, “All he cared about was getting paid.”

There are some exceptions to this rule, however. If a patient refuses a recommended treatment because it’s not a covered service by his or her insurer, that should be documented. However, along with that statement should be notes about:

- Efforts by D.C. or staff to advocate on the patient’s behalf to the third-party payer for coverage of clinically necessary treatment
- Efforts by D.C. or staff to work out an acceptable payment plan for the patient to pay for the treatment personally.
- Offers to the patient of other acceptable treatment alternatives that are covered or are less expensive.

Recordkeeping that Passes the Test

Unprofessional recordkeeping can be damaging to a D.C., even if a lawsuit is never filed or if a case is otherwise found defensible. That's why doctors should strive for professional and objective documentation.