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Defensible documentation: An offensive strategy

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Here is a real scenario: You are a busy healthcare provider with a thriving outpatient practice and increasing revenue. As your caseload grows, you notice that you are falling behind on notes and not documenting as well as you did in the past. Today you receive a legal threat from a large law firm via certified mail that names you as the sole defendant in a medical malpractice suit alleging you were negligent and the direct cause of a patient needing a subsequent neck surgery after being under your care nine months prior. In between patients, you look up the patient case and see that most of the notes appear to be repetitive, contain no updated objective measures, and there are no statements in your assessments to justify continued treatment to the prescribed plan of care after you had seen this patient for four weeks. You also notice there isn't a discharge note, and there is no record that you followed up with the patient when they simply quit coming to their appointments. Frantically you call your malpractice insurer, send them all the patient case files, and the long arduous process of litigation begins. Damian Conway summed up the importance of effective, thorough, and defensible documentation in the following quote: "Documentation is a love letter that you write to your future self."

A good defense prepares a good offense

The best way to think about your medical documentation is that it should defend what you do medically, convey your thoughts based on all the medical information provided to you, and go on offense if you are ever audited or served with a legal threat. You should approach your documentation as if you will be audited and sued, not being nave in believing that it won't happen to you because you have five-star reviews on Google. In a review of 2021 medical malpractice lawsuits, 4% of the claims were related to "poor documentation of patient instruction and education."[1]To reiterate, this is just one element that should be addressed and included in your documentation. As you are likely aware, there are dozens of documentation elements that should be present alongside patient instruction/education, such as patient history, previous surgeries, history of condition management, sociodemographic information, familial history, etc. So, imagine that every four out of 100 evaluation and treatment notes you write are likely incomplete and potentially exposing you to medical liability.

You should approach every interaction, evaluation, and treatment with the goal of recording all relevant subjective and objective information related to your responsibility as a healthcare provider. While I attended physical therapy school at the University of St. Augustine in Florida, defensible documentation was the focal point of multiple class discussions and writing assignments. One of my favorite professors, Dr. Lisa Chase, recommended we treat every patient like they are our best friend, spouse, mother/father, another physical therapist, a medical doctor, attorney, and insurance auditor. This advice stuck with me, and it applies to pursuing and promoting integrity in both patient care episodes and the representative medical documentation.