

Things I Have Learned: Welcome to the Big Show

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It has been just over a year since my first submission to *Dynamic Chiropractic*,¹ and I recently noticed a response in *DC* about that article by a chiropractor in the Netherlands.² The chiropractor, Dr. Clifford Morris, seriously disputed the need for orthopedic testing in the assessment of the patient, suggesting these tests are performed only to satisfy the insurance companies. The article discussed the topic of short leg and some of the tests used to clinically evaluate that finding. My original idea for the article grew out of several comments made by some of the residents here in the hospital - they just automatically assumed it meant one leg was indeed shorter. I knew the short leg could signal different functional conditions, and I had to go back through several of my books to look up and relearn what they were.

At first, I was surprised at the response to my article; maybe even a little angry. Why would someone apparently get so mad at me for sharing what I had spent time researching? But the more I thought about it, the more I had to agree with Dr. Morris' comments. As he stated, it truly is a pity we have to go to such great lengths for documentation. Dr. Morris raised some valid points; most notably: "Why waste time with all these orthopedic tests, and then do all that paperwork?"

Before I go any further, I will state that my writing was not a mandate. I looked up those tests so I personally could remember them, and then compiled them in a format so I could share them with my colleagues. Orthopedic tests are tools used to evaluate a patient to help you reach a diagnosis. Depending on your specialty or style of practice, you may focus more on radiographic line analysis, orthopedic testing or palpation to reach your diagnosis. I like to share little clinical pearls or specialized testing tricks as I find them. I have learned more from my colleagues in this way than I ever have in a seminar or classroom.

I also can say it is a pain in the butt to do all that paperwork. It does often seem as if we are constantly required to do ever-more paperwork for less money. However, the standard of care for our profession is that all patient contact and care need to be documented. One of the reasons medical doctors can only see a limited number of patients in a day is because they have built time into their schedules to do the required paperwork. Paperwork is a part of every branch of health care today. Whenever you encounter a patient, there should be some level of documentation: Were their complaints better or worse after the adjustment? What spinal areas did you adjust? What therapy procedures did you provide? Good record-keeping is an integral part of good patient care.

So, why bother with all those notes?

1. It allows you to *track your patient's care and progress*. Most patients come in with pain and hopefully, under your care, they will get better. What did you do? Good notes let you look back and review what you did along the way to care for your patient. If an attorney or an insurance company ever asks for a narrative summary of your patient's care, all the data is ready for you to

put such a report together.

2. It allows you to *communicate* your findings, your treatments and the patient's response to other paraprofessionals in a way they recognize and understand. It also allows them to have a copy of your treatment notes in their file so their records on the patient are up to date. One of the most common tactics insurance companies will use to deny care is summed up by the phrase: "Treatment plan not supported by documentation." The only way you can fight such a comment is to have the notes already completed and in the file so you can address those denials immediately.
3. Thorough examinations and good records *raise your level of professional credibility*. In his recent article in *DC*,³ Dr. Steven Kraus discussed the "credibility gap" we face as chiropractors in the mainstream health care system. Although we know how effective conservative care is, there is a bias against chiropractic. One of the points he raised is that we cannot change the system when "our own insufficient documentation practices fail to show the effectiveness of our approach."
4. *It's good marketing*. What better way to get your name in front of the other doctors you work with than to send them a report on their patient with your name attached? They have to see it. The more patient notes you send them, the more they see your name.
5. If you ever have a case go to court or trial, your notes are your *strongest defense* for your treatment plan and care.⁴ The first time I went to court for a patient was for a young man I had treated for phantom pain. He had suffered a traumatic amputation of his foot in an industrial accident. I treated him twice and his symptoms resolved. My care was not questioned until two years later; by then, I had totally forgotten what I had done to treat him. My notes were the only evidence I had to justify my care. (And by the way, we did win that case.) NCMIC points out that the treating physician is automatically suspect when in court.⁵ Your records can be your biggest asset in defending your treatment.
6. *It reflects on your image as a professional*. In my work with legal nurses, I once heard the comment, "Two professions are known for under-documenting care - chiropractors and dentists, and two professions are known for overtreating - chiropractors and physical therapists." That is not a professional image with which any of us wants to be associated. Failure to meet the documentation standards of the profession reflects badly on the profession as a whole and helps reinforce a negative image that is already out there.⁶
7. *Because it's the standard of care*.⁷ Documentation is part of practice. It doesn't matter whether you are a straight or a mixer; if you use Gonstead, diversified, Nimmo or acupuncture; or if you are a cash-only practice - it is your professional responsibility to document what you find, what you plan to do and how you treated the patient. Whether you like it or not, your treatment notes will be looked at by a medical physician, insurance company or attorney at some point in time. The rule of thumb is: "If it isn't written down, it didn't happen." That is not the medical rule; it's the general rule for all of health care. It doesn't matter if you are an MD, *DC*, acupuncturist, massage therapist, or physical therapist - the medical-legal obligations apply.

I can appreciate that Dr. Morris does not see the need to spend a lot of time with specialized testing. He lives in a place with a controlled health care system that allows him to practice in that way. That is fantastic! I can only imagine not having that level of stress in my daily practice. But I don't live in Holland, I live in the U.S., and the fact is there is a standard of care in this country that is clearly defined. It is dangerous to think that because we are chiropractors, we do not need to keep records to the same degree as medical doctors. As they say on ESPN before a big game: "Welcome to the Big Show." We must learn to think outside the chiropractic bubble in terms of health care in general. Ultimately, it is the patient we take care of, not the insurance companies, attorneys or other doctors. Whether or not you feel obligated to document your case, responsible patient care mandates it.

Chiropractic deserves every bit of respect any other health profession does, but that respect comes with a level of responsibility. Yes, it is a pain. Yes, it takes more time, but like it or not, documentation paperwork is part of professional health care.

References

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