Clinician's Commentary

Client documentation is central to client care; it is also a challenging part of practice. This tension is well described by Harman et al. in their qualitative study, and I expect it is one that many, if not most, of the readers of this article have experienced. To me, this study describes why charting ought to be done, how charting is done, and possibilities for how charting could be done.

While the study design included both retrospective chart audits and participant focus groups, the results centre on the themes identified from the focus groups. The participants were physiotherapists working in New Brunswick Workplace Health, Safety and Compensation Commission-approved private fee-for-service clinics. Nonetheless, the issues raised by the study are experienced in other fee-for-service settings, such as home care and long-term care, and likely also in publicly funded settings such as hospitals.

The literature, as summarized by Harman et al., provides many important reasons why clinicians ought to be comprehensive in their client documentation, and their results show that clinicians recognize its clinical importance. Because we are self-regulated primary health care providers, these reasons extend well beyond the mere legal requirements; they encompass our ethical obligations “to act with integrity, to honour the rights and dignity of all individuals, to recognize [our] responsibility to society and to pursue a quest for excellence in professional activities.”¹ The Rules of Conduct of the Canadian Physiotherapy Association describe our responsibilities to the client, to the profession, and to society.² Effective charting fulfils our responsibility to our clients by describing our clinical decision making, by documenting each stage of our client interactions, and by putting the client at the centre of care. It also fulfils our responsibilities as professionals to present evidence of and rationales for the care provided, to demonstrate our compliance with the client's right to consent and participate throughout the treatment process, and to communicate effectively with members of the health care team. Furthermore, the quality of our charting may influence other professionals' view of our profession. Finally, effective charting relates to our responsibilities to society to improve the standards of health care and to comply with all applicable laws and regulations. But are these goals attainable?

Despite the many benefits and perceived values of charting, client documentation in practice is incomplete and can be viewed as tedious, time consuming, and a waste of valuable direct client-care time. The barriers identified by Harman et al. present several

dichotomies: thinking but not writing it down; defining impairment-based physiotherapy goals versus functional client goals; time spent with the client instead of charting; clients who progress quickly compared to those who progress more slowly. On top of these tensions, respondents also described a fear of failure that affects both physiotherapist and client. These barriers lead to the incongruence between what ought to be and what can be or is. But are these dichotomies irresolvable?

The health care sector today is characterized by increased demands and expectations from payers and clients, downloading to front-line providers, and scarce resources. The participants in this study articulated these pressures. Such stressors may lead to feelings of disempowerment and inability to enact change. It would have been interesting to know whether the participants in this study were experiencing reduced job and professional satisfaction to some extent because of the incongruence.

In the drive to meet day-by-day clinical challenges, there is little, if any, time to step back, to reflect, and to consider changes to one's practice style or approach. While participants in the study identified strategies for how charting could be done better, it was not clear whether they felt empowered to implement them. Time was described as the most profound barrier. Of the strategies listed, several—such as checklists, tear-off sheets, and standardized forms—would likely be simple to implement if there were time to develop them. The use of new technologies such as smart forms, personal digital assistants, voice-recognition software, and touch-screen or tablet PCs holds substantial possibilities to streamline the charting process. Once again, however, there needs to be up-front time to choose the right tool, develop the software, and/or train clinicians in its use. In addition, there would be associated costs for the individual and/or the clinic. Participants also recommended seminars or workshops, particularly in relation to idiosyncrasies of various third-party payers' expectations. Although these could be helpful, they may not be seen as the most important use of clinicians' time and money amid the available choices for lifelong learning opportunities. The paradox is that time, which is so precious, is needed in the short and medium term, to develop and initially become comfortable with these strategies, in order to reduce time demands and pressures in the longer term.

I would put forward a few other strategies that come to mind. In my experience, one of our best resources is our colleagues, through informal sharing of simple strategies each may have discovered. We may minimize the value of some simple steps we have taken to

streamline our charting processes, and thus feel that others would not find them of interest, rather than sharing them at a team meeting. Another strategy that participants did not mention is chart audits, whether done by peers or as part of an annual review process. Chart audits need not be seen in a punitive light; they can also be a collaborative learning experience. In some situations, however, performance monitoring may be necessary.

Developing the process for doing chart audits can be daunting. Harman et al. included a chart-audit process in their study; however, the present article does not indicate whether the audit encompassed compliance with institutional and legal requirements as well as review of the content and clinical reasoning. It would be interesting to know whether the charts originated as primarily handwritten documents and whether they were audited for both compliance and content.

I propose that the responsibility for charting falls to the individual physiotherapist but that implementing strategies to improve its quality and the time required is a responsibility shared by the individual physiotherapist, the facility or institution, the regulatory college, and the profession, through CPA. As individuals in a self-regulated profession, we have an obligation to uphold the standards of practice, our code of ethics, and our legal obligations. As facilities or institutions, we have an obligation to support physiotherapists to be successful in their clinical practice, to gain satisfaction in their job, and to achieve their potential. As regulatory colleges, we have an obligation not only to demarcate the standards of practice but also to provide practical tools for registrants

to meet those standards. As the Canadian Physiotherapy Association, we have an obligation to advocate for members (e.g., with third-party payers, fee schedules, standardized forms) and to facilitate their professional development.

Harman et al. and the study participants are to be commended for tackling this topic, for expressing the challenges, and for offering strategies. Thank you for providing the impetus for dialogue, among individual physiotherapists and within the profession, on this noteworthy topic.

*E. Lynne Geddes, PT, MRE
Clinical Professor and Assistant Dean,
MSc(PT) Program
McMaster University
Hamilton, Ontario
Senior Manager, Therapy Health Care Inc.,
Burlington, Ontario*

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