

Stop Writing Session Notes

A first-principles case for structured, longitudinal documentation in pediatric SLP, OT, and PT

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THE ARGUMENT IN BRIEF

Routine documentation in pediatric therapy is still treated as a writing task. After each session the clinician produces a note, often in an inherited SOAP format, as though the session were a self-contained unit of clinical meaning.

The principal value of routine documentation is longitudinal: preserving the information that lets treatment efficacy and skill development be evaluated over time. For that purpose, the durable record is better treated as structured, goal-referential data. Narrative remains available for exceptional context, and readable prose can be generated from the data. The prose need not carry the data.

01 What needs to survive the session

The most dependable future reader of a daily note is the clinician who will later write the progress report. That suggests a test:

FUNCTIONAL SUFFICIENCY TEST

Could future-you reliably ascertain the efficacy of the treatment and the client's progress of skill development with this information?

For routine pediatric SLP, OT, and PT treatment, the information that passes that test is remarkably small:

1	2	3	4
Target skill	Performance	Cueing	Supports

Cueing and supports are not ornamental. They are a second dimension of progress:

SAME SKILL, TWO SESSIONS		
SESSION	PERFORMANCE	CUEING AND SUPPORTS
1	65% 	maximal verbal & visual cues extended processing time reduced task complexity simplified language
9	70% 	moderate verbal cues reduced task complexity
The numerical gain is modest. The reduction in support dependence is not.		

Progress is a longitudinal property, not a daily adjective.

02 The model

A well-designed routine pediatric therapy record should be:

Goal-referential	Every recorded treatment target should directly reflect or clearly contribute to an active goal.
Structured	The data-bearing variables should use stable representations.
Longitudinally comparable	Repeated observations should be interpretable together.
Efficient	Completion should be fast enough that prompt documentation is realistic.
Legible	A parent, auditor, unfamiliar clinician, or other authorized reader should not need to decode private shorthand.
Narratively extensible	The clinician should remain free to add context whenever context genuinely contributes value.

The note can be generated from the data without making the prose the data.

03 Why SOAP is the wrong unit

S

RARELY ALTERS TREATMENT

Performance fluctuations already appear in the data. A change big enough to matter belongs in an updated plan.

O

CLOSEST TO THE DURABLE CORE

Useful observations are buried in inconsistent prose, hard to aggregate and compare.

A

PREMATURE INTERPRETATION

Daily assessment becomes noise because progress is not a daily property.

P

FREQUENTLY REDUNDANT

The treatment plan already exists. If it changes materially, change it formally.

SOAP treats the session as the unit of meaning. Pediatric therapy progress is usually meaningful across sessions.

04 Why the prose persists

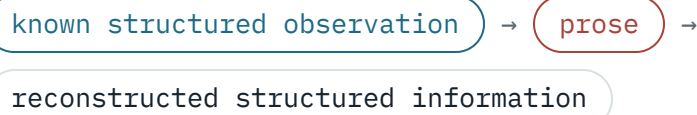
JUSTIFICATION	THE BELIEF	THE ANSWER
Habit	A paragraph feels safer.	Invisible defaults are powerful.
Compliance	Extensive documentation is required.	Compliance concerns information. Convention often concerns appearance.
Protection	More detail makes a stronger defense.	More words are not automatically more evidence.

ASHA does not prescribe a single documentation format ([ASHA, n.d.-a](#)), AOTA allows documentation types to be combined or reorganized ([AOTA, 2018](#)), and Medicare characterizes its documentation rules as minimum expectations ([CMS, n.d.](#)). Local payers can require more, but their requirements concern elements the record must contain, not the narrative form that carries them.

05 What it costs, and what AI does not fix

Documentation burden is widely recognized as a component of administrative workload and burnout ([Murad et al., 2024](#)), and rehabilitation clinicians report effects on clinical care and work-life balance ([Schwartz-Dillard et al., 2024](#)).

AI scribes can reduce documentation time ([Lukac et al., 2025](#)), but they answer the wrong question. Much of what matters in a pediatric session is not acoustic. And even perfect transcription still turns observations the clinician already knows into prose that must later be mined back into structure:



The more structure preserved at the point of observation, the less inference required downstream.

06 Objections, briefly

"Structured data create false precision."

They can. But prose does not resolve those weaknesses. It often hides them.

"You may not know which context will matter later."

Narrative documentation is itself selective and lossy. Free text remains available.

"Some outcomes resist quantification."

Then the goal should define what observable change counts.

"Two clinicians may mean different things by 'moderate cues.'"

Internal consistency matters far more than perfect translation between clinicians.

"Other readers may need more information."

Readable narrative can be generated from the record for any reader who needs it.

"Writing forces clinicians to reflect."

Reflection is not guaranteed by narrative volume.

"Measurement may distort treatment."

Goals are already expected to be measurable. Structure replaces retrospective estimation with contemporaneous observation.

The clinical record is the information. The note is merely one way of rendering it.

Documentation then becomes infrastructure for improving the work that comes next.

This summary condenses the full paper, *Stop Writing Session Notes*, which gives the complete argument, its treatment of objections, and full references.

Disclosure. The author is co-founder of Parlance Therapy, which develops documentation software for pediatric therapists. This paper does not describe or evaluate that software.

R References

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