Digital Documentation: More or Less?

By Barry P. Chaiken, MD, MPH

Remember the blue book? Starting as early as junior high school, teachers would hand out that pale blue 8" x 8" booklet, giving each student 50 minutes to handwrite everything they knew about a particular subject. Urban legend suggested teachers issued grades based on the number of pages filled rather than the contents of the illegible scribble. Because handwriting did not allow for cutting and pasting, there was no verbatim insertion of multiple Wikipedia pages to "enhance" a test-taker's spontaneous brilliance. The essay length was determined by the knowledge of the student and the quickness of the pen.

Before healthcare information technology (HIT) and electronic medical records (EMR), clinicians wrote their notes similarly. Limited by the strength and stamina of their dominant hand, and their knowledge of the patient's condition, medical documentation represented a singular clinician's assessment of a patient. When written well, these notes followed the format designed by Larry Weed, MD, more than 50 years ago: the problem-oriented medical record that, for each problem, included subjective and objective descriptors coupled with an assessment and plan (i.e., SOAP notes).

The introduction of EMRs over the past decade completely changed the way we write clinical notes. No longer limited by our handwriting speed, our notes reflect our typing speed instead—and, more importantly, they reflect the functionality of the EMR used for documenting care. Templates help structure clinical notes with prepopulated descriptors that are easily modified through pull-down lists.

Laboratory and other electronically exchanged data points can automatically fill these templates, causing the note to further expand. In addition, cut-and-paste functionality allows for parts of the medical record to be duplicated wholesale in a separate author's clinical note.

Although a more detailed note provides better clarity of a patient's medical condition, patients do not have just one clinical note in their medical record. All clinicians—physicians, specialists, nurses, therapists, residents—write notes. Inevitably, note writers will record similar patient findings and lab values, copy text from documentation already contained in the medical record, and detail assessments and plans already stated.

No byte-size clue

While a paper medical record provides the reader with clues to its complexity by the thickness of its binder, digital medical records offer no such visual aid. Indeed, considering the ease with which caregivers can generate pages and pages of digital documentation, it is unclear whether including the byte size of the clinical notes would effectively indicate the complexity of a patient's illness. Although EMRs offer access to clinical notes, they offer no sense of the number of notes or the volume of pages contained within. Skimming through the record to access important clinical content is more difficult due to caregivers' frequent repetition of findings, assessments, and plans.

Blaise Pascal, a French mathematician, logician, physicist, and theologian, wrote in 1656: *"Je n'ai fait celle-ci plus longue que parce que je n'ai pas eu le loisir de la faire plus courte."* Roughly translated, this reads, "I have done it longer because I did not have the leisure to make it shorter" ("Blaise Pascal," 2016).

This phrase, also attributed to Mark Twain and T.S. Eliot, clearly summarizes the documentation dilemma that faces clinicians using EMRs. As all of them are pressed for time, they use the fastest means of recording the most information. Like Pascal, they do not have the time to succinctly formulate the note and remove less important or distracting patient data documented elsewhere; instead, they must make it "plus longue" rather than "plus courte."

For researchers, the problem of bloated records presents a real challenge. In 2014 at the Digital Healthcare Conference in Madison, Wisconsin, researchers and informaticists sounded the alarm that the digital data stored in medical records may not be valid. The frequency with which information is copied from one note to the next makes it simple for inaccurate information to permeate a record. Similar to how an unsubstantiated rumor morphs into mainstream news, false information entered into a medical record, then copied over and over by other documenters, can become treated as truth.

One note

When Dr. Weed proposed the problem-oriented medical record, typical notes consisted of only a few sentences with little structure that meant nothing to anyone other than the note's author. At that time, more documentation meant better-informed caregivers across the clinical spectrum. With the advent of EMRs, the explosion of notes creates an environment where there is too much

documentation rather than too little. As the time available to focus on each patient diminishes, clinicians similarly have less and less time to review all the notes about a patient's current condition. Therefore, they choose some information to review and dismiss the rest, potentially overlooking critical patient information.

To effectively use EMRs to manage patient care, organizations must decrease the volume of documentation by embracing processes and policies that reduce redundant information. Unlike a final philosophy exam in college, shorter prose jam packed with critical facts delivers more value than drawn out descriptors that offer limited value in patient care.

Informaticists do not currently know what works best to decrease the size of notes. However, they do know that excessive documentation leads to bloated records and obscuration of important patient information. Potential solutions to reducing the bloat require close evaluation.

Removal of the cut-and-paste function within EMRs offers one option. Streamlined structured templates in lieu of free text notes offers another.

A third solution, the unified clinical note, is more radical but deserves serious consideration. The unified note requires all clinicians to write their notes in the same place within an EMR. This format creates a narrative that becomes an ongoing, longitudinal description of the patient's condition, the clinicians' assessment of the patient, and the current care plan.

The unified note ensures all caregivers see the same information, reduces duplicative data entry, and lessens everyone's documentation burden.

The positive impact of patient-centered medical homes and specialized, procedure-focused surgical teams illustrates that modern medicine requires a diverse clinical team approach to deliver care that is both high-quality and efficient. Perhaps we need a similar approach to apply those adjectives to the documentation process.

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