From the Desk of the Medical Director

David Farris, MD | Medical Director, Oregon Medical Board

A big part of my new career is reviewing medical records. My PR – Personal Record – the biggest single chart to come across my desk so far – has been 51,000 PDF pages. This more than confirms what I began saying when the EMR showed up: Mountains of data; mole hills of information.

In commiserating with consultants about, "If it can be recorded, it must be recorded," and the ten-page daily progress note with no note of progress, I've found two who are willing to share their thoughts. Ron Turker, MD, a pediatric orthopedist, told me he had a prepared lecture for students and residents. Ee Lin Wan, MD, a hospitalist, has anecdotes on the next page showing how failed charting has delayed urgent diagnoses and created downstream liability issues. ✚

Short Notes Save Lives

Ron Turker, MD | Pediatric Orthopedist, Clackamas, OR

If you like a good story, medicine is the never-ending anthology. It's two parts storytelling, one part science. Hippocrates encouraged written narratives as a way to discern and then cure "natural illness." For two millennia, we literally charted our patients' courses from malady to recovery, learning from the journey. Until we got smarter and developed the electronic medical record (EMR). In two short decades, our notes have grown from condensed patient chronicles to mindless data-dumps. Bloated and unrecognizable, our modern charts no longer plumb the Hippocratic mystery of illness. Instead, they search for something more tangible: money.

When I was a medical student in the 1980's, my notes were limited by pens that ran dry, empty spaces on a page, and occasional hand cramps. With brevity in mind, one of my classmates — I'll call him Larry Okenklaus — had a peculiar note-writing strategy. Each morning, he sat at the nurses' station and wrote every chart note before he saw a single patient. His terse generic "templates" were designed to be "edited later." But time has limits, so it was no surprise that Larry's notes often went unrevised.

Ever the optimist, Larry typically started his accounts with reassuring affirmations like, "Patient without complaints." Often times, scribbled below Larry's entry, in someone else's handwriting, there were addenda, like, "…without complaints, except for — crushing sub-sternal chest pain."

Once, next to Larry's bland assurance that the "Electrolytes were benign," I saw an all-caps add-on, "EXCEPT for — potassium of 2.1!"

Although Larry's "Okenklaus note" was met with some skepticism, he was always the first guy to finish his work, and that attracted some early adopters.

Years later, as the nascent EMR began to take shape, I saw the potential to either fix or simply propagate Larry's time-saving strategy. One path would be to design a record that draws pertinent and well-formatted data into a chart note. To this we add a brief narrative, and voila, a concise informative note. The second option would be to cut and paste our way forward, amplifying inaccurate noise, and letting loose Okenklaus's monster. We providers chose the latter.

My current residents and students have grown up in this Okenklaustic system. Write first, edit later. I ask them all the same question: "What is the purpose of a chart note?" The typical mumbled response is: "To document." "Billing?" Or simply, "To cover your ass in case you get sued." All true, but off the mark.

"It's communication!" I explain. "Essential information for our colleagues, our teammates, and our future selves, when we see this patient again. We should write it as such."

"Short notes save lives!" I tell them. "If you bury the lede, no one will see it."

That critical potassium level hidden under irrelevant garbage can kill the patient. Picture the kids' game of telephone but with grown up stakes. That brilliant insight or fantastic diagnosis helps no one if it isn't passed on before the genius went home.

I explain to my students the basics of a good note: What you heard, saw, felt, thought, and plan to do next. Simple.

Then I share the bad news: Succinct, well-written notes are not rewarded. Money flows to those who document work rather than do work. Words matter when it comes to billing, and sometimes we're asked to change our words for "billing purposes" – to doctor not just our patients but their charts as well.

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Short Notes Save Lives, continued

Pasting words is easy; reading bloated notes is not. How much computerized chaff can our brains filter? One clinic day I kept track. I saw 25 patients, yet I'd reviewed 110 notes. By 10 a.m. I needed another cup of coffee. By 3:30 my brain filter was as clogged as a laundromat dryer. Details were missed.

To share an anecdote (which is anything but anecdotal), I relate an eight-page chart note from the Emergency Department. This detailed epic of a child with a non-displaced wrist fracture included a checklist of the six-year-old's smoking, drinking, and sexual history, which was capped by a series of vital signs laid out in unreadable prose. On page three, I finally discovered the boy had fallen while running.

By page five, I was relieved to know that the boy had stellar extra-ocular motion, perfect nares, and delightfully moist mucous membranes. Still, no mention of his wrist. Reading past his pristine lung exam, imperceptible liver margin, and normal inguinal nodes, I came to a point that stopped me cold. The ED doctor's note described the boy's cremasteric reflexes as being intact, both left and right.

One of two things happened in the ED that day. A doctor saw a little boy with a broken wrist and falsely documented that he'd examined the boy's testicles, thereby committing fraud. Or worse, in order to up-code the bill, a doctor pulled down the boy's pants and touched him inappropriately. Either way, it highlights the insidious nature of fraud. If you were the boy's doctor, which label would you prefer?

I cite this extreme example of the Okenklaus phenomena with reason. Not to shock, but to give pause. We have all signed notes containing items which are simply not true. We can fall back on well-worn excuses: "It's in the template." "I don't have time to edit." "That's what I'm being told to document." But in reality, we providers have been complicit in a near universal form of fraud. A lie is a lie whether scribbled by hand or summoned forth with a couple of keystrokes.

There is an opportunity on the horizon. As of January 1, 2021, CMS billing and coding guidelines have changed. We are now told to code clinic visits based on time spent gathering information, plus time spent with our patients, and the complexity of their care. Our narratives, though never perfect, can and should be short, clear notes that share our thoughts, concerns, and plans. And we'll still get paid.

The government and insurance companies have been forever chucking the financial ball in different directions and we've always chased it, most recently with bloated and factitious notes. Our notes belong to us. We sign them. They must not reflect the artifice of others. We should claw back ownership and be proud of what we write as truthful and uninfluenced by those who lack standing in our patients' health.

Our collective goal has been, and should always be, the delivery of health care, not the sale of medical care.

For thirty years I've played this game in one form or another, and now like a stubborn old Labrador who watches the throw, I think, "Get your own damned ball."

Short, thoughtful notes save lives. ✚

Author's acknowledgment: I realize these words come easily to a physician at the end of his career. I spent my second act in a salaried position to avoid as much of this inherent conflict as possible. And I slept a bit better. A bit.

Reminder: Required PDMP Registration

All physicians and physician assistants who hold an Oregon medical license and have a DEA number are required to register for the Prescription Drug Monitoring Program (PDMP).

To register, visit oregon.pmpaware.net and select "**Create an Account**."

For more information, please review OAR 847-010-0120 and OAR 333-023-0825, or contact the PDMP by phone at **866-205-1222** or via email at pdmp.health@state.or.us. You can also find information on the OMB's Prescription Drug Monitoring Program Topics of Interest webpage. ✚