BY WILLIAM G. WILKOFF, M.D.

LETTERS FROM MAINE

Con-Templating

Do you use templates? If you haven't stepped over the threshold into the costly world of electronic health records, you may not understand the question.

In the old days, a template was a pattern or gauge for accurately creating a product. A stencil is a template. In addition to ensuring accuracy, a template allows its user to replicate the original product more efficiently.

Even if you haven't begun using electronic templates but practice in a group, you probably have adopted standard forms for a variety of patient interactions—for example, ones for sick visits, which may be disease specific, or for well visits, which may be age specific. Obviously, standardization can make it easier for practicing physicians and their staffs to find information through documentation guided by templates. These forms can be bought off the shelf or developed internally by members of the group after what can be contentious negotiations between providers. Those of us who practiced by ourselves quickly became wedded to the formats we developed ourselves. When one joins a group, it can be difficult to leave our old favorite forms. And, when new editions are proposed, tugs-of-war can erupt over where to position, and how big to make, the boxes.

Some physicians prefer detailed and exhaustive checklists; others like myself prefer broad categories with plenty of elbow room to scribble and create anatomically incorrect drawings. We don't like being fenced in by a myriad of little boxes. Instead we crave the wide-open spaces to create and express our individuality.

Should a template dictate practice? Is it the purpose of the form to remind, coach, or arm twist the practitioner into asking certain questions or performing certain tests? There is certainly mounting evidence that checklists for procedures can improve outcomes. But when we are talking about an office visit encounter, one could ask, "Is the form the boss of me? Or is it merely a tool to guide my documentation so that my coworkers can find and understand what I have done?"

When templates become electronic, they can become tools for replicating documents of dubious quality. For example, when one clicks on a box that says "normal pharynx," the computer may spit out a stored bit of dialogue that includes "uvula midline, tonsils not enlarged." In reality the child may have a bifid uvula and his tonsils may have been surgically removed. Although these inaccuracies may be trivial, one can easily imagine others that are not so innocuous.

How many of us really carefully read the final documents generated by our clicks or wand taps? How many of us remember what the computer is going to say when we click "normal"? This kind of error by click is most obvious in emergency department records, which read like textbooks. Having spent more time in emergency departments than I care to remember, I know that the computer-generated record often bears little resemblance to what was actually examined.

Few of us intend to deceive when we document our findings, but a computerized template can make it easy to do so inadvertently.

Even more troubling is the phenomenon in which templates become too narrow and disease specific. All children with earaches are not made equal.

The diagnosis may not be otitis media but school avoidance or anxiety. If the office staff has already loaded in a template specific for otitis, the practitioner may be influenced away from other diagnoses.

A template that functions too much like a cookie cutter can discourage a broader assessment of the patient as a unique individual. ■

DR. WILKOFF *practices general pediatrics in a multispecialty group practice in Brunswick, Maine. E-mail him at pdnews@elsevier.com.*