Can we return to the ABCs of crafting a medical record note?

Medical record "note bloat" is adversely impacting communication among clinicians. It is time to refocus on the ABCs of note writing including accuracy, brevity, and clarity.

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Prior to 1980, medical record notes were generally hand-written, short, and to the point. Senior physicians often wrote their 3-line notes using a fountain pen in an elegant cursive. With the transition to electronic medical records, notes have become bloated with irrelevant information and frequently lack a focus on the critical clinical insights that optimize patient care. The use of smart phrases to pull vast amounts of raw data into the note is a major contributor to note bloat. The unrestrained use of the copy and paste functionality generates a sequence of cloned notes that grow in length as new information is added and little information from prior notes removed. With each subsequent clone the note often becomes less accurate, lengthier, and more difficult for a reader to understand. In one survey of 253 physicians who wrote electronic notes, 90% reported that they used the copy and paste function, with 71% reporting that use of this function caused inconsistencies within and among notes and increased the repetitive presentation of outdated

information in the note.[1] Although the surveyed clinicians recognized that the copy and paste function caused problems, 80% reported that they planned to continue to use the copy and paste function.[1]

The SOAP note

The problem-oriented SOAP note is written in the classic structure of **subjective and objective information**, followed by an **assessment and plan**.[2] The structure of the SOAP note emphasizes the logical and sequential collection of data followed by data analysis, resulting in a focused assessment and plan. When notes were hand-written and short, the entire SOAP note could be viewed on one page. Like a dashboard, the eye could quickly scan each key component of the note, facilitating the simultaneous integration of all 4 components of the note, facilitating understanding of the patient's clinical situation. When the SOAP note structure is used to create a multipage electronic note, the result is a note that often confuses rather than enlightens the reader. A 5- to 10-page SOAP note is often useless for patient care but demonstrates the ability of computer-savvy clinicians to quickly generate a note thousands of words in length.

The APSO note, a response to note bloat

When a medical record note becomes a multipage document, clinicians should consider switching from the SOAP note structure to the APSO note, where the **assessment and plan** are at the top of the note, and the **subjective and objective** information is below the assessment and plan. The APSO format permits the reader to more quickly grasp the critical thinking of the author and facilitates a focus on key points relevant to the patient's condition. The note can be written in the SOAP format, but then the assessment and plan are brought to the top of the note. In my clinical experience fewer than 10% of clinicians are using an APSO note structure. I believe that, with a multipage note, the APSO structure improves the experience of the reader and should be more widely utilized, especially by clinicians who are prone to crafting a bloated note. In a survey of more than 3,000 clinicians, approximately two-thirds of the respondents reported that, compared with SOAP notes, APSO notes were easier and faster to read, and APSO notes made it easier to follow the clinical reasoning of the author.[3]

New evaluation and management billing guidelines—An opportunity to reduce note bloat

Previous evaluation and management federal billing guidelines emphasized documentation of a myriad of clinically irrelevant details contributing to note bloat. The new federal evaluation and management billing guidelines pivot the focus of the note to the quality and complexity of medical decision making as demonstrated in the **assessment and plan**.[4] Prioritizing the assessment and plan as the key feature of the medical record note should help reduce the length of notes. The American College of Physicians recently recommended deleting the complete review of systems and prior histories from most notes unless relevant to medical decision making and the assessment and plan.[5]

The open note

The open note mandate was contained in federal regulations developed to implement the 21st Century Cures Act, which required patients to have access to the information in their medical record. In order to comply with the regulation, health systems are sending most notes and test results to the patient through the health system's patient gateway. The open note process entered my practice through a stealthy progression, from an initial step of permitting a clinician to easily share their note with a patient to a top-down edict that all notes, except some notes that have a high risk of causing patient harm, must be sent immediately to the patient. Obviously, an open note supports "transparency," but I am unaware of high quality evidence that open notes improve the health of a population or reduce morbidity or mortality from health problems.

The federal mandate that clinicians share their notes or risk fiscal penalties is coercive and undermines the independence of health professionals. Open notes may have many benefits, including:
- improving a patient's comprehension and sense of control over their health issues
- increasing patient trust in their health system
- increasing the number of questions patients ask their clinician.[6]

Open notes may also cause unintended adverse emotional trauma to patients, especially when the note communicates "bad news." In one study of 100 oncology patients, approximately 25% of respondents reported that reading clinical notes was emotionally difficult, and they sometimes regretted having read the note.[6] One patient reported, "I think MyChart is great but in this whole cancer thing MyChart has not been a good thing." Another patient reported, "Reading serious stuff like that is just too taxing for me to be honest with you."[6] An additional finding of the study was that patients reported their notes were written with too much medical jargon and repetition of information.

Open laboratory, pathology, and imaging data—Helpful or harmful?

A component of the open note mandate is that laboratory, pathology, and imaging data must be shared timely with patients. Some health systems incorporate a 3-day pause prior to sharing such data, in order to provide the clinical team with time to communicate with the patient before the test results are shared. Some health systems, including my health system, have engineered the open note data-sharing system to immediately share the results of most completed laboratory, pathology, and imaging studies with the patient. Immediate sharing of data may result in the patient first learning that they have a serious, life-threatening health problem, such as cancer, from their patient portal rather than from a clinician. As an example, a patient may first learn that they have metastatic cancer from a CT scan that was ordered for a benign indication.

Another example is that a patient may first learn that they have an HIV infection from their patient portal. This can be a shocking and emotionally damaging experience for the patient. For many test results, it would be best if a clinician were able to communicate the result to the patient, providing support and context to the meaning of the result, rather than sending sensitive, life-altering information directly from the laboratory or imaging department to the patient. Leaders in medical education have spent decades teaching clinicians how to communicate "bad news" in a sensitive, supportive, and effective manner. The open sharing of laboratory, pathology, and imaging data short-circuits the superior process of relying on a highly capable clinician to communicate bad news.

Crafting the open medical record note

Building on the advice that "when life gives you lemons, make lemonade," I have begun to pivot the purpose of my medical notes from a product useful to myself and other clinicians to a product whose primary purpose is to be helpful for the patient. The open note can facilitate building a trusting relationship with the patient. My notes are becoming a series of written conversations with the patient, emphasizing compassion and empathy. I am increasing significantly the amount of educational information in the note to help the patient understand their situation. In addition, I am replacing traditional medical terms

with verbiage more appropriate in the context of a conversation with the patient, reducing the use of medical jargon. For example, I have stopped using "chief complaint" and replaced it with "health issues." I am diligently avoiding the use of medical terms that have negative connotations, including "obese," "psychosomatic," "alcoholic," and "drug addiction." I include encouragement and positive comments in many of my notes. For example, "Ms. X is successfully managing her health issues and experiencing improved health. It is a pleasure collaborating with her on achieving optimal health."

Can we bring sanity back to medical note writing?

The primary role of a clinician is to spend as much time as possible listening to patients, understanding their needs, and helping them achieve optimal health. There are many benefits to an electronic medical record, including legibility, accessibility, interoperability, and efficiency. However, in current practice "note bloat" undermines the potential of the electronic medical record and makes many notes ineffective to the process of advancing the patient's health. We are competent and highly trained clinicians. We can craft notes that are simple, specific, story-driven, compassionate, and empathetic. If we return to the ABCs of note writing, focusing on accuracy, brevity, and clarity, we will make note writing and reading more rewarding and improve patient care. ●

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