General comments on Accreditation and the use of electronic records

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As I understand it, the purpose of Medical Practice Accreditation process is to improve the quality of patient care. The process of accreditation ensures medical practices throughout the country maintain similar quality standards which minimise ambiguity & confusion while enhancing clarity, openness and accountability in office and medical procedures.

I am fully in favour of this process and had voluntarily begun such a process of self assessment before accreditation actually became official. When accreditation began, there was widespread reluctance to accept the concept. Many doctors and practice managers claimed that the standards prejudiced against small practices in favour of corporate practices because the standards were too onerous and required too much adjustment.

I demonstrated my enthusiasm and proved the doubters wrong by becoming the first medical practice in Canberra to be accredited.

It had been said that "All roads lead to Rome", but, metaphorically, I feel that some standard setters are sometimes saying : "You, the medical practitioner, can only get to where I say you should go, on the route I have laid down, and using the vehicle I have specified."
That is, they have become so focused and fixated on the "means" that they have lost sight of the "end".

The case of written record Vs electronic records is just one example of many such scenarios.

Let me explain:

Firstly, I am the first to acknowledge that the scanty notes and atrocious handwriting of doctors have been the target of satirists since time immortal. I remember the AMA once put up a competition showing the script written by a doctor and invited other doctors to decipher it. One respondent claimed that the document wasn't a script at all, but, rather, an ECG tracing!

When computer came along, there is little doubt that printed records and prescriptions had added great clarity to the transcription of records and prescription.

The significance of electronic records would be like the invention of Penicillin. It's a no-brainer!
It fixes everything and should be embraced wholeheartedly. How can anyone who has a computer go back to hand written records? Even blind Freddy can see that clearly printed medical records will lead to better patient care, just as the introduction of cane toads will solve the problem of insect infestations and foxes will eliminate the rabbit plague. What can possibly be wrong?

Well, I say computerised notes have their drawbacks:

<u>Typing while the patient is speaking is rude and Impersonal</u>

Many patients have commented that when they visit other medical practices in which the doctors type notes during the consultation, they find it off-putting. Writing on notes do not make noise. Tapping on the computer does.

<u>Electronic records are actually time consuming.</u>

Unless the doctor has done a speed typing course and can speed type confidently and correctly without looking, typing notes is a lot slower than writing. Most practitioners will have to stop, look and retract within 20 keystrokes.

<u>Printed media, Electronic media & Redundancy</u>

Reading printed material is, to me, inherently easier and more pleasant than reading from a screen. I believe this is why newspaper, magazines and books still exist. The day may be coming when iPad and eReaders will replace all books and printed media, but I don't think that day is here yet.

Doing crosswords and Sodokus on computer just doesn't give the same pleasure as pencilling them on paper. If one wishes to mark one's favourite TV programs for viewing later, would one prefer to circle or highlight them in the TV guide or would one look up the electronic guide, print it out, and then set multiple reminders on the iPhone or computer? Every day, we do things which affirm that putting pen to paper is not yet an obsolete practice. Why, then, are we in such haste to do away with paper records?

Aeroplanes have dual controls and all systems are duplicated intentionally. This is a form of built-in safety to protect that which is precious. Likewise, I am using a hybrid system to guarantee integrity of patient records. Is patient welfare precious?
Accreditation audit has found that the detailed smoking history and alcohol history are sometimes not recorded in the computer. However, they are recorded in the paper system. The doctor will still be able to see this information at a glance as he/she picks up the paper notes. As a result of the hybrid system, patient care has not been compromised.

I am not burying my head in the sand. I do use computer records to supplement my written notes. At the end of each consultation, I enter a one-word or one-phrase description of the consultation in the summary. This serves as a summary of running records on the computer. Both systems are up to date. I enter all pertinent history into the history section as they come in. These can be included in patient summaries if a patient ends up in hospital or needs to see another doctor (example attached). It doesn't take any more time because writing notes is a lot faster than keying them. I invest a bit extra time to enter details of pathology results (instead of just marking them) so that a locum doctor can scan them easily and pick up the trail of care (screen shot example attached). All these measures are proof that we ARE using electronic records effectively.

<u>Details are present but lost in transcription</u>

If a patient presents with an odd shaped rash on the inner aspect of the left wrist, as well as eczema on the tip of the inner surface of the right thumb and index finger, it will take me 10 seconds to make a sketch and indicate the precise position of the rash, it will take at least a minute to type up an entry, especially if one needs to call up diagram templates and tries to draw something with a mouse.

I use my pen to circle, and highlighter to highlight, pertinent details. It takes a few seconds. This is not easy to do in computerised notes, if one can even do it at all. Notes with highlighted, encircled details draw attention to critical data and alert the next doctor to the pertinent details. Making pertinent details stand out surely facilitates patient care. On the other hand, without the annotations and highlights, pertinent details can just be camouflaged in the pages of print outs. This effectively hampers patient care.

In one of my favourite TV programs, "Yes, Prime Minister", whenever Sir Humphrey wants to pull the wool over the PM's eyes, he'll put the details on a page of print and bury it three quarters of the way down the ministerial briefings. It's a plot to ensure the PM overlooks the essentials hidden in the document. Likewise, with computerised records, sure, everything is there legally and, in theory, retrievable. However, like the PM's briefings, the pertinent details are lost in the sea of words. Scanned documents are not searchable, nor are entered notes. How is that good for patient care?

I have requested notes from patients who transfer from computerised super clinics. The notes arrive in a two inch pile of clearly printed papers. Sure its all there, but in the real world, does the doctor who receives this pile of notes really sift through them to find the one line which documented an elevated blood sugar?

With my hand written notes, 3 years of consultations can be seen on two pages, with pertinent details circled or highlighted, it is much easier for the second doctor to pick up the trail of care.

<u>What happens during computer failure?</u>

I wonder how many practices have a fully up to date operational server on standby. If the server crashes, the surgery will be paralysed for a day while the service is being restored. No such problem with a hybrid system.

<u>Special features of my written notes</u>

I have designed a system of written notes with the enhancement of patient care in mind.

The data sheet picks up important medical, social, and family histories. Many years ago, the RACGP proposed the S.O.A.P. system of hand written notes claiming it will improve clarity in patient notes. I found the notes cumbersome as details of the consultation are buried in the notes, so I changed the format of the notes and have the S.O.A.P. in columns
This means a locum doctor only needs to scan down the "symptom" column to know for what conditions the patient has been coming to the doctor, similarly, scanning down the treatment column will give him an idea what treatment has been prescribed. I specifically use different colour pen for different care episodes so that each care episode is distinct and not merged with each other into a sea of words.
I use diagrams, highlighters and encircle pertinent details to help the next doctor to pick up the trail of care. There are many more innovative features in our paper system. I am happy to share them if any one is interested but I guess it is futile if the system is to be scrapped.

<u>There is more than one way to skin a cat, and other roads also lead to Rome</u>

I am not suggesting everyone should use a hybrid system but what I am suggesting is that accrediting bodies should focus on the end goal, (e.g. comprehensive patient record, easiness of access, easiness of picking up the treatment trail by the next doctor etc), accept, and acknowledge, the fact that there are other ways to achieve the same goal. Rather than recommending the wholesale abolishment of paper records, perhaps one can recommend features which will enhance paper records (like using highlighter to highlight initiation, cessation, and alteration of medications, pertinent test results etc, I can name a lot more). There is, perhaps, a possibility that the other ways (a hybrid system) may even be better than a totally electronic system. It's the best of both worlds.

I'd like to conclude with the words of wisdom from Sir Robert Hutchison:

From inability to leave well enough alone,

From too much zeal for what is new and

Contempt for what is old,

From putting knowledge before wisdom,

Science before art,

Cleverness before common sense,

From treating patients as cases and,

From making the cure of a disease

more grievous than its endurance

Good Lord, deliver us.

Sir Robert Hutchison

1871-1960

Dr C D Lee

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