FROM THE EDITOR

There should be more GOLD in the EMR

The medical community approached the concept of the electronic medical record (EMR) with a mix of optimism and trepidation. Both have been realized to some extent. My workday has most certainly not been shortened, but much of my "after-hours" work can be done at home at my computer and not in the hospital reading through stacks (sometimes pounds) of paper charts containing uniquely personalized but often illegible handwritten notes. At least for patients who have received care within my own health system I can now readily access clinical notes, lab results, vital signs, and prescribed medications. This is obviously beneficial for patient care, and it facilitates efficient clinical decision-making.

Along with the mandates for utilization of electronic records and the expectation of accountability for responsible billing in clinical practice came new requirements to justify levels of billing. This quickly led to the morphing of the physician's clinical notes, initially meant for communication and archiving, into documents for billing. All-inclusive templates, drop-down menus with default responses, and parroted closing phrases stating the amount of time spent in the patient visit devoted to patient counseling and education have become the norm in both inpatient and outpatient notes. It's an amazing demonstration of physician discipline and training how that same percent of time can be provided in virtually every visit with every patient.

But the value of the clinical note as a form of communication between physicians and other caregivers has diminished significantly, with little recognition of the fact that the communication needs of different members of our "healthcare teams" are not the same.[1] In the days before cyber-medical record-keeping, I might not have been able to find or read all the physician notes, but at least I knew who wrote the note and when, and what was actually done and discussed during the patient visit. But from personal experience and what I have read in the limited literature,[2] that element of faith can no longer be taken for granted.

In addition to providing an eased shareability of information, the EMR at the least should shine in providing a platform for physicians to collect and track specific objective information necessary to implement guideline-suggested best practices. So it is disappointing to read in this issue the commentary by Ehteshami-Afshar and Merchant[3] on the lack of routine documentation in the EMR for patients with chronic obstructive pulmonary disease (COPD), especially as there is a well-accepted tool to do this that facilitates implementation of high-quality, guideline-based care, ie, the Global Initiative for Chronic Obstructive Lung Disease (GOLD).[4]

COPD is a major cause of mortality and morbidity and repeated hospital admissions. There are many incentives for primary care and subspecialty physicians to utilize the EMR to incorporate the GOLD guidelines into routine shared patient care. But apparently, objective and subjective information is not being regularly documented and shared. Pulling objective information automatically into our notes should be a relatively simple process that can be facilitated by our information technology colleagues. But the qualitative, subjective information that impacts the interpretation of the objective air-

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flow (and other) data must be ascertained by the clinician and then analyzed, hopefully generating a useful assessment and plan (not just an ICD code) that is transparent to the entire healthcare team.

Subjective information such as change in sputum color in the morning, vocational environmental exposures, or necessitated alteration in the path taken when walking the family's golden retriever is part of the patient's story that should overlay the interpretation of the objective information. Yet it is the patient's story, and often a detailed relevant physical examination, that is so often missing from many clinical notes. In an elegant opinion piece in *Annals of Internal Medicine*, Gantzer et al[5] presented reflections from the American College of Physicians "Restoring the Story to Health Records" task force. For those of you as frustrated as I am with the often bloated patient notes that leave me wondering how so much could be written with so little said, the Gantzer paper is a worthwhile read. I didn't get an answer to the problem by reading it, but I felt relieved that others are tackling the problem.

My clinical notes are not models for practice. But I hope that my notes are clear as to what I examined and what I asked (and forgot to ask) the patient.

Recently, I struggled with interpreting the significance of my exam finding of a left-sided systolic murmur and scant bibasilar end-inspiratory "Velcro crackles" with a single S2 and no gallop, and the patient's expressed symptom of feeling "a little" short of breath when walking up steps. This was a new patient (to me) with rheumatoid arthritis who had been treated with methotrexate and was transitioning care. A previous cardiac exam, accessible courtesy of the EMR, was described as "RRR" and the chest exam as "normal." That note included a structured list of patient responses to the review of systems, and I assume this was done to meet regulatory needs for billing, as well as to improve "personalized patient care." But none of that information was of any help to me or the patient.

As voiced by Gantzer et al,[5] practicing physicians need to retake control of the clinical note. We can do better at keeping it a useful tool for communication.

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