



Writing Clinical Notes: Have We Made Progress?

Our clinical notes take a lot of time to write. Is it time well spent?

Clinical office notes communicate what happens within the examination room. The progress note is a tool for clinicians to convey information to each other to optimize the care of our patients. I read notes from specialists to help my patients navigate their care. These notes explain to me why a certain medication was prescribed or a specific test was ordered during the visit. I can also determine whether the patient understood what the consultant or one of my partners told them in another office visit. I rely on my own notes to remind myself what I was thinking during the patient's previous visit, especially if it was a long time ago. Why did I order that test? What was I thinking when I made that diagnosis? A well-written note is essential to patient-centered care.

It is no surprise to any clinician that these notes take a lot of time to write. A recent study showed that the average physician spends a mean of 1.77 hours daily on documentation outside of normal office hours.¹ EHRs have not improved the efficiency of writing notes; they have actually made completing documentation more cumbersome. In their classic 2017 paper, Arndt and colleagues described the burden of EHR documentation

on primary care clinicians.² In this study, for each hour of direct patient care, clinicians spent two hours interacting with the EHR. Excess documentation for billing purposes only increases the administrative burden.

Many of us worked during a time when handwritten notes were the norm. They were shorter and did not include problem lists, medication lists, or extensive reviews

save clinicians time and improve the usability of the EHR.⁴ Preliminary data demonstrates clinician satisfaction with the APISO note format in both outpatient and inpatient arenas.^{5,6}

OpenNotes is an initiative in the recently implemented 21st Century Cures Act. It provides patients with access to all notes written by their physicians, other medical providers, and care teams. The ability for

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of systems. The documentation was limited to the story (history or subjective), exam (objective), assessment, and plan. Note templates in the EHR, on the other hand, often include extensive supplemental data, much of which exists elsewhere in the record.

Recent studies have evaluated how notes are read. A 2015 cognitive task analysis of 16 primary care physicians found that the assessment and plan sections of office progress notes were reviewed first and were rated as the most important components of the note.³ Some organizations have recommended a change from the traditional SOAP notes (subjective, objective, assessment, and plan) to APISO notes (assessment, plan, subjective, and objective), which may

patients to access notes may be beneficial. With more complete information, patients can engage more fully in their care. Initial data suggests that most patients find it helpful to read their notes.^{7,8} On the other hand, a small study documented that more than 10% of patients were offended or felt judged by something the clinician wrote.⁹ The use of stigmatizing and judgmental language in notes is not unusual¹⁰ and may be more common in notes written about people of color.¹¹ One study looking at history and physical notes from an emergency department found that negative language was included in charts of Black patients 2.55 times as much as White patients.¹¹

As note writing in medicine evolves, we must continue to focus

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on tools that enhance its efficiency in primary care. The 2021 Medicare guidelines relieved clinicians of some of the burden of note writing by decreasing billing requirements. We need to continue looking for ways to reduce the amount of time clinicians spend writing notes, while at the same time paying attention to implicit bias in our notes. **FPM**



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