CLINICAL COMMENTARY

Copy Forward

Peter C. Galier, M.D.

I was frustrated. Covering the senior resident on the Medicine service was not the problem. For years, I have covered my own patients on a daily basis, so seeing patients, writing notes, answering calls was not a problem. It was simplicity at its best. In the room, talk to the patient, examine them, collect the data, notes and consults, then write a note. Elegance and simplicity. However, the ominous words of the resident from the day before loomed in my head. "Be sure you *type* your notes tomorrow, Dr. Galier. I know you like to write them." Of course I did, 'Simplicity', 'Elegance', I thought. What's wrong with that? "No one really looks in the chart anymore for notes, only for orders, ECG's and the like. I guess it must be hard to change at your…"

The deer was in the headlights.

Diaphoresis notable on the brow, mild neck pulsations. Slight tremor. I was already writing the note in my head, but it was the poor resident I was observing. It was OK. I knew how to finish his sentence. "Old". "Dinosaur." "Older attending." "Technologically challenged." Never mind that my VCR (yes *VCR*) still flashes "12:00", or that I don't own a portable GPS to find the nearest Starbucks, or that I still buy tickets to events at the box office, or that a "wi-fi" hot spot is something I would think wise to avoid for health reasons.

"Copy forward." I wasn't sure exactly whom the resident in the room was speaking to, but since it was just the two of us, I took a stab at it. "What do you mean?" I asked. "Well, if you start a new note each day, it will take you forever, so you just need to 'copy forward' the resident's last note. See, here. Go to notes. Bring up the last note. Hit 'copy forward'. Then edit the new, copied note. Then sign it, and you're done."

I had nearly finished handwriting my note as the friendly young man gave me the step-by-step instructions. "So *that's* how they have time to write such long, complete, complex all-inclusive, detailed notes on all these patients every day!" I felt like I had figured out the rubix cube, only to discover the other five sides were all amuck.

"You know, Care Connect is coming. You'll be able to do everything online. I mean *everything*. You won't even have to be here to do it!" I tried to contain my glee.

I looked at the forwarded note. OK. Delete the previous subjective. Replace with current. Added the most recent vitals, but forgot to delete the previous ones. Typed half the exam in all CAPS before I realized it. (Did you know that typing *anything* in all caps means you're yelling? The resident asked if I was upset at the LOWER EXTREMITY EDEMA). Then spent time deleting 3 weeks of previous imaging, labs, cultures and consult rec's, and replacing it only with the day's most current. Then did an assessment and a plan.

"DONE!!!" Only 9 more to go, and at this pace, I would finish slightly before the resident returned the next day.

"Dictate them." Again, another mysterious voice from behind. This time, one of my "generational colleagues"."Just dictate it. It's in the system. Concise, fast, and it is electronic. Everyone is happy." Great, but then I remembered: Care Connect.

"But, Care Connect. It's coming, you know that right? We will be able to do *everything* on the computer, from *anywhere*. Will you still dictate?" "No need" he said. "You will have templates." Good God, what did I miss? "You mean like a 'copy forward'?" "No, no, templates. They will populate with information automatically. Meds, Vitals, data. No more looking around." "I have my own way of organizing my notes though, how will that work? What if I don't like the way the template is laid out?" "You can personalize the template to suit you. There will be phrases and texts and navigators and reconciliation hard stops and... blah blah blah blah…" I began to hum a tune in my head. "Many of the residents have already used it in their medical schools. Lots of the fellows did their residency with

Care Connect, and they will train us on how to use it. It will be fine. They all said so!"

The electronic medical record or "EMR" is something of an enigma to me. In theory, it sounds great. Integrated medical records, able to share information within the system, consolidation to a single site. How could it be bad? One of my colleagues answered succinctly, but spot on: "It's as good as the user. It's as useful as the accuracy of what gets put in, especially from the start." Correctly inputting allergies, correct medication lists, correct doses, correct health maintenance dates, correct vaccines and dates, correct and accurate description of symptoms and findings. My father-in-law used to own a Radio Shack store. Whenever a customer complained something did not work, he always said "double O, E"; "Owner-Operator error" was 99% of the problem. He was a visionary to the EMR.

Patients wonder, what will happen to the personal connection? The eye contact? The vocal inflections? The reading of body language? Most are excited about things being electronic, but fearful of the loss of personal interact.

Some are fearful that almost all of their care, and office interactions will be "web based", and not able to connect with a real person if they need to. Think about the last time you did a bank transaction from other than an ATM. "Having a problem with your (fill in the name of your favorite utility, credit card, or bank) statement? Visit our website at www….." Many places don't even give you the option of speaking to a person on the phone menu, but I find pressing "0" always seems to get me to a rather surprised representative.

Some doctors worry about how data will be used. Will it be used to help doctors and patients navigate better care? Will it be used by insurance companies to monitor data for benchmarks as a way to incentivize doctors, or use punitively? Will governmental agencies monitor what therapies we prescribe, and to whom they are given?

Most, I believe, worry about the patient. Will they still feel a connection to us (non web-based, that is)? Will we still remember that the actual complaint/symptom/finding that does not fit from a drop down menu is still best "free-texted" in? Will we use the ability to forward the information to other practitioners in real time to facilitate care, and keep the patient involved in their care? We have to make sure that the system works for "us" and the patient, and not the other way around.

Time will tell, and we will be measured more by our patients' reactions and quality of care, than by quarterly "performance" benchmarks.

Fast forward and Care Connect has arrived. Eight hours of training, two months before roll out, and three personalization labs later, I have learned a new vernacular of "submitting a ticket", "parking lot the question", "find a red vest", "visit the playground", and of course the phone call to the support line where I am reminded that "If you are having a problem with Care Connect, please visit our website at…"

The power of group angst has its benefits, however. Milling around the work rooms you hear the heartbeat of ingenuity. Doctors teaching each other what they learned from trial and error. Nurses gently guiding you through an easier way of ordering the drip because *they* learned it from their charge nurse. People sharing how to configure ipads and smart phones despite being told that they are not "supported" (by the way, "not supported" does NOT mean they won't work, just that they won't help you get that detached from a laptop). They customized templates to work for how *they* saw patients, rather than changing how they organize their thoughts to fit it. They shared how to get labs and vitals and imaging and nursing notes to "populate" their notes and how to put in prompts so that important items would not be overlooked. Some of the doctors wanted the exam portion left blank, so they had to manually type it in their own words, just like the "old days".

Two weeks into it, I ran into the same resident in the work room. "Hi Doctor Galier. How are you handling the new EMR? Need any help?" I finished my note, and said how it seemed easier than I thought. Auto populating nursing notes and imaging, only recent data seemed to make me more efficient. The prompts kept me from forgetting important things, and I still get to hand type a physical exam. He found my description interesting, and asked to see it. So, without missing a beat, I did my billing, checked the day's office schedule, glanced through my inbox and forwarded a radiology report to the specialist needing it, ordered the morning labs from my "favorites" list, and "copy forwarded" him my note, and shared the template.
Now, on to the VCR…..

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