“Clinical Documentation In The 21st Century”. An Executive Summary of a Position Paper From The American College of Physicians: Annals of Internal Medicine, Kuhn, et.al., Volume 162, No. 4, Date: 2-17-15.

An articulate commentary:

“Courts have long considered clinical documentation to be discoverable, and the existence of an unaltered contemporaneous medical record is considered to be a more trusted source of truth than the memory of a physician or patient. This has served as a driver for legible and more extensive documentation, with a particular focus on the inclusion of pertinent positive and negative history and physical findings, as well as clear statements of what the physician was thinking and why a particular course of action or treatment was or was not done. Electronic health records have made defensive documentation easier, which some would interpret as better documentation, and others would interpret as a source of “note bloat”, in which key findings and actions are obscured by superfluous negative findings, irrelevant documentation, and differential diagnoses, all of which make the record difficult and time-consuming to read. Entries are easily carried forward to current notes, these distended records can be a source of excess downstream documentation, which perpetuates the difficulty many physicians perceive when trying to quickly find a useful signal in a field of noise.” P. 12.

“Copy/paste features and templates in EHR make it easy to create long, verbose, repetitive, and difficult-to-read notes that may satisfy coding and audit requirements but do not adequately meet the need for clinical care and communication with other healthcare professionals involved in caring for the same patient. P. 13.