CLINICAL CASE
Copying and Pasting Patient Treatment Notes
Commentary by Deborah D. Nelson, MD

Dr. McGill was the first physician in his family. Success was never easy for him, but his perseverance was legendary in his undergraduate and graduate days; he was known for studying more, arriving earlier, and staying later than anyone. Early in the course of his pediatric residency, however, he began to experience problems with efficiency. As the patient population he was responsible for each day began to grow, he became more and more overwhelmed with his duties. On more than one occasion, he arrived at rounds not having seen all of his patients, written orders, or checked the daily labs.

The breaking point occurred when he arrived for rounds looking disheveled and unkempt and informed his attending that he simply did not go home after his call day, in order to have sufficient time to round on his patients and write their notes. When asked why he was unable to keep up with the demands of his patients and the daily tasks, he explained that the daily progress notes took up the majority of his time, many hours a day.

Only then was he informed that it is common practice for residents to simply copy and paste the previous examination, assessment, and plan to the following day's notes, only editing if any changes need be made. Because his home institution did not use electronic medical records, he had been unaware that "selective editing" was possible, appropriate, allowed, or even ethical. Now he agreed to selectively edit his daily notes and immediately saw his efficiency of long ago returning.

Unfortunately, a short time later, he transcribed some recommendations on the wrong note. He copied recommendations for one of his pediatric patients with staphylococcal cellulitis to a similarly afflicted patient—who also had renal disease. When the patient with renal failure was written for scheduled vancomycin therapy rather than pulse dose, it caused a rise in creatinine and the patient required a prolonged hospitalization.

Commentary
The modern medical record is quite different from that first one recorded by Hippocrates. The medical record of today is not only a clinical record to inform other physicians and health care workers of our finding, thoughts, and plans; it is also used as a legal document in the event of a malpractice claim or occupational injury, as support for billing payers for reimbursement, by hospital review committees for quality assurance and improvement, and for data collection in support of research.

The electronic medical record (EMR) has many benefits over the handwritten entries in a paper chart. EMR entries are always legible, they are dated and timed, and patient information can be available both at the point of care and remotely. Some EMR systems include computerized physician order entry and decision-support tools designed to improve patient care and safety.

While these features can save physician time by providing easy access to masses of information, they do not necessarily save time in the day-to-day entry of patient encounter notes. More than two-thirds of internal medicine residents who completed a survey reported that they spent in excess of 4 hours daily performing documentation tasks, while only one-third spent that amount of time with patients [1]. Adding this to the ACGME restriction on work hours, it is understandable why a busy resident would try to find ways to enter information into the EMR more efficiently. Efficiency, though, must not compromise patient care or the educational experience.

Copying and pasting of information within the EMR is one of the time-saving tactics seen in many medical centers. An electronic search of medical records found that the practice was common, though it varied with level of training. Copying of one's own notes was most common at the level of intern, and copying others' notes peaked among residents [2].

The practice takes many forms. Large sections of a note can be copied without change from one day to the next during a hospital stay; notes can be copied forward adding any new information from day to day, creating running notes, one provider can copy part of the note of another provider; and notes can be copied from one patient to the next. It is known by several terms: "copy and paste," "copy forward," and "cloning," among others.

Despite its widespread use, copying and pasting of notes raises a number of ethical issues. It has been shown to produce notes that are confusing, increasingly lengthy, uninformative, disorganized, internally inconsistent, misleading, or lacking in credibility and may introduce and propagate errors that can place patients at risk [2-6].

As a clinician educator, I am concerned about the loss of a major educational opportunity. Writing notes is a means of documenting history-taking and exam skills and the thought process that culminates in an assessment, differential diagnosis, and a plan of evaluation and treatment. Writing the daily progress note is an important training tool by which residents experience and internalize the cognitive processes that constitute medical reasoning and analysis, and it is a means for a learner to demonstrate the development of these skills.

Who is responsible for this error? Patient safety is a concern that we in health care must address. The focus of the current patient safety movement is on teamwork and

systems, as opposed to the historical risk-management model, which focused on individual human error. This case involves both human error and systems failure.

Dr. McGill certainly bears responsibility for his actions, including the presumed carelessness that resulted in harm to his patient. He had been told of the "copy forward" practice as a time-saving strategy. He took that practice another step, copying notes from one patient to another. This even more risky practice introduced the original error that resulted in harm to his patient.

Dr. McGill should be learning and practicing the critical thought processes that will enable him to write concise, focused, informative notes—which will save him time for years to come. His professional responsibility is to strive for the highest standard and not allow himself to fall to the lowest common denominator. His goal is not just to get a note on the chart; it is quality patient care.

The attending physician who encouraged this risky strategy also bears significant responsibility. It is of great concern when an attending physician or senior resident instructs a junior trainee to take shortcuts, particularly one that has been shown to confer significant risk to the patient. Was the attending physician clear about the need to carefully edit notes that had been copied forward? Did the attending properly oversee Dr. McGill, who had already demonstrated difficulty coping with the stress and demands of his patient care responsibilities? Is the attending teaching and modeling proper note skills?

What responsibility does the hospital bear in this situation? The hospital certainly shares responsibility for any system failures that resulted in harm to a patient in its facility. A fully functional computerized physician order entry (CPOE) system should have prevented this medication error from reaching the patient. In the absence of CPOE, was there a policy for a pharmacist to double-check orders for possible medication errors? Are there other systems in place to prevent them?

The hospital and the medical staff are jointly responsible for the trustworthiness of their medical records. Together they have an obligation to foster a culture that upholds the highest standards of patient care and quality. In systems that allow notes to be copied and pasted, there is a responsibility to audit the medical records to ensure their integrity. That said, I disagree with those who have advocated for removing the copy and paste functions from medical record systems. The ability to easily copy information is one of the major benefits of an EMR and can save much time and typing. The problem is not with the technology, but with how it is used and what information is copied. Copying usually static information such as demographic information, drug lists, and previous medical history is OK if the information is independently verified.

Somewhere in the process of checking template boxes, typing, clicking dropdown windows, cutting, counting, copying, and pasting, we have lost sight of the original purpose of the daily progress note—to succinctly communicate our findings,

thoughts, and plans. This is even more vital as house staff work hours are further reduced and patient handoffs increase. To this end, it is crucial that note quality in EMRs be high.

References

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