Half of words in clinical notes copied, pasted from prior visits

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Previous studies have shown that duplicated text in EMRs results in physicians and other clinicians having their time wasted, making medical errors likelier and even making doctors more prone to burnout.

Now a study in *JAMA Network Open* quantifies just how prevalent the worrisome practice is.

After analyzing more than 104 million notes written for nearly 2 million unique patients in a six-year period, researchers found that 50.1% of the total text in the record was duplicated from text previously written about the same patient, according to the study “Prevalence and Sources of Duplicate Information in the Electronic Medical Record.”

And the problem only got worse from year to year.

In 2015, just 33% of the text in the notes were duplicated. By 2020, 54.2% of note text was duplicated from previous text, according to the study, for which researchers examined notes across numerous specialties in the Penn Medicine Health System from 2015 to 2020.

The practice was common no matter the level of training a physician had and it was common among nurses and therapists. It also was done equally by those who were authors of previous notes and those who had not written the earlier text.

These duplicated words mean a physician seeing 10 patients a day would need to review at least 85 pages of single-spaced text across 691 notes, the study found.

“The duplicated half of the content not only provides no new information, but also increases the time required for the reading clinician attempting to discern which information is accurate and timely vs false or irrelevant. Overworked clinicians may be disincentivized from reading such a bloated record, missing valuable clinical context not easily found elsewhere,” wrote study authors Jackson Steinkamp, MD, Jacob J. Kantrowitz, MD, and Subha Airan-Javia, MD.
The findings are related to a topic studied by AMA Vice President of Professional Satisfaction Christine Sinsky, MD, and colleagues and published in *JAMA Internal Medicine* last year.

“Both studies suggest that there is a significant amount of sludge in the system—overdocumentation, too much note bloat to read through, and overscreening for the sake of performance measurement,” Dr. Sinsky said.

Reducing physician burnout is a critical component of the AMA Recovery Plan for America’s Physicians. Far too many American physicians experience burnout. That’s why the AMA develops resources that prioritize well-being and highlight workflow changes so physicians can focus on what matters—patient care.

One such resource is the “AMA STEPS Forward® Taming the EHR Playbook.”

**System changes a must**

The duplications shouldn’t be attributed to individual physicians or other clinician authors behaving badly, wrote the authors of the new *JAMA Network Open* study. Instead, it’s a “rational response” by clinicians who are attempting to manage information in a documentation system that is “ill-suited to the task.”

However, the solution isn’t as easy as just banning clinicians from copying and pasting, the authors warned. Instead, study authors suggested that new systems to document visits should be examined and should take into account that:

- There is a subset of clinical information that remains true and relevant overtime that should remain visible in the EHR.
- Documentation systems be redesigned to take advantage of the stability of shared information over time.
- In the current documentation system, there is a trade-off between duplication and information scatter—having relevant information scattered across numerous documents rather than in one comprehensive document—and clinicians often duplicate in order to minimize scatter. Better systems could fix this trade-off.
- Using collaborative documentation systems that don’t require each individual or team to use a completely separate document could reduce duplication.
- Updates should be allowed to be made to a document, while maintaining old documents for medicolegal reasons.
The AMA STEPS Forward de-implementation checklist (PDF) offers eight changes to make to the EHR—including minimizing alerts and reducing note bloat—to save hours every day. The checklist outlines processes or requirements that add little or no value to patients and their care teams, but place unintended burdens on clinicians.

An episode of the “AMA STEPS ForwardPodcast” on EHR optimization discusses how to lobby leadership to eliminate extra EHR clicks and regain time in the day.

And learn about four quick-win changes—including eliminating unnecessary inbox messages and rethinking prescription refills—that can help physicians regain hours weekly.