The Difference Between Documentation and Communication **April 27, 2025**

Dear Residents,

During my recent rotation on the rheumatology consult service, I encountered several complex cases, including a particularly challenging patient whose clinical course evolved from a positive ANA and elevated liver enzymes to a diagnosis of MDA-5 positive dermatomyositis. I carefully composed a note detailing this progression, attempting to reconcile her varied diagnoses over time with her current presentation. To organize my thoughts, I initially drafted the note in Word after reviewing multiple prior notes, imaging studies, laboratory results, and biopsy findings, and later entered the finalized version into Epic.

The following day, I received an email from the Health Information Management Service warning me that my "note had been 100% copied from outside of Epic." They strongly advised me to use templates and even provided a sample for future reference.

This experience highlighted an ongoing tension I have often felt when working with the electronic health record (EHR): balancing the use of structured data (critical for registries and reporting) with more nuanced, narrative documentation that fully captures the complexity of a patient's story but may not align neatly with EHR structures. Additionally, there is the persistent pressure to meet documentation standards that satisfy coding and billing requirements—sometimes at the expense of clarity and true clinical communication.

Effective consultation, especially for complex patients, requires the ability to carefully distill evolving clinical information into an assessment that either confirms, excludes, or redefines a diagnosis. This process relies on precise language to express varying degrees of certainty—using phrases like "most consistent with," "unlikely to be," or "more likely to be." Clear justification must accompany these judgments to guide the care team.

Unfortunately, the art of note writing is increasingly being lost in the electronic age. Notes are often bloated by information carried forward with little new insight, sometimes perpetuating inaccuracies. In one case during the rotation, a patient's daily hospital summary continued to state that a rheumatology consultation was "pending" even after our evaluation had been completed.

New tools like "diagnosis-aware notes," recently introduced at CUH, are a welcome innovation to support more effective communication. It is important to remember that different types of notes serve different purposes: the history and physical (H&P) primarily helps you synthesize and understand the patient's problems; the daily progress note communicates an updated, actionable plan of care to the team; and

the discharge summary serves as a permanent record of the most significant and actionable aspects of the hospital stay.

In the end, note writing remains a critical clinical skill—one that demands not just compliance with systems, but clarity, thoughtfulness, and craftsmanship in communicating patient care. As residents, I understand the pressure you feel to "get your notes done" and to meticulously capture every lab value, imaging finding, and biopsy result. I applaud your diligence, but I encourage you to focus on crafting notes that not only document thoroughly but also communicate clearly and effectively.

This April has had consistently pleasant weather. Let’s hope we get a few more weeks of this in May as well before summer starts. I hope you’ve had some free time to relish the outdoors. Miriam and I enjoyed a Rufus Du Sol concert at the Dos Equis Pavilion.

Wishing you a great week,

Dino Kazi