personal
view

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Re: Discharge summaries

The editorial titled "Discharge Summaries" (*BCMJ* 2017;59:293) suggests that frustrations of dictation have changed little in the past 40 years, since I graduated from medical school. Thank you, to the practitioners who perform the onerous task. Anesthesiologists are primary consumers and appreciate finding a typed, concise oasis of information in the illegible chaos of a hospital chart. Ironically, the technology has long existed for simple and inexpensive one-time systematic adaptation, but for some reason administrative will has been lacking.

At the pre-admission clinic at Vancouver General Hospital in the 1990s, dictation frustrations were dealt with by creating a template and dictating only critical information: demographic (which invariably the admission, discharge, and transfer hospital software put in automatically), diagnostic (presentation, symptom, physical, lab), progress, outcome, recommendations, etc., which were then slotted into blank spaces in the preformatted document, producing consistent, concise, grammatically correct, and legible documents quickly and with minimal effort. This system would be equally efficient with keyboard entry instead of dictation.

Modern e-records can do the same thing. Historical information, which never changes, could be archived on an ongoing basis, and slotted into the appropriate preformatted documents, be they admission notes, progress notes, consultations, or discharge summaries, with minimal effort and without the need to repeat data entry. The history of past health would be repeated automatically on the admitting record and the discharge summary, and a precis of present admission data would be added the next time in the history of past health section. A discharge summary could be primarily generated automatically using the keywords of progress notes, with only the disposition and the dates added, a huge saving in time and energy.

A medical record should be conceived as a block of patient information that is historically fixed but temporally in evolution, rather than the storybook narrative of current hospital charts. This concept could be extended to storing patient information on their MSP card and updating both the consumer and the provider at every health care encounter, completely eliminating the need to send for old records every time. But I am getting ahead of myself. Vancouver Coastal Health transcription bought into such a conceptual change a quarter of a century ago, but further evolution has not occurred. The inertial monster that is the health records establishment in Canada does not seem interested, and it is difficult to identify who to try to influence. A decade ago, when they eliminated paper records older than 40 years, it occurred to me that pediatric operative reports from the 1950s and '60s would no longer exist because the surgeons and GPs would also have long retired. Meanwhile, that cohort of individuals was entering the age at which they were going to require more health care. I could not identify any route to voice my concerns.

I count the biggest failure in my career as being unable to bring user-friendly medical documentation into the 20th (let alone 21st) century before I retired. I pass on my thoughts to clinicians who have greater administrative skills than I. Good luck moving forward; take heart knowing that technologically and conceptually, at least, there are better ways.

—Laurence W. Lee, MD, FRCPC
Clinical Assistant Professor, Anesthesiology, Pharmacology, and Therapeutics
UBC Faculty of Medicine

Re: Who is checking the quality of referrals? College replies

I applaud the College's efforts to improve asynchronous communication between physicians for consultations [*BCMJ* 2017;59:256]. I find inordinate delays in health authority transcription to be the major factor in critical delays for emergency patients. I sent a letter regarding a man with suspected aortic dissection to our tertiary hospital on 9 August with a full consult letter the same day after full workup. The receiving physician dictated a comprehensive, appropriate reply, which I received by fax on 16 August (likewise added to the EHR).

The letter indicates a 7-day delay between dictation and transcription. I have no doubt that the Interior Health Authority (IHA) is working hard to improve this turnaround time, which I consider to be a dangerous practice for patient safety. The patients present back to my practice during the week, and I have no idea what the findings or treatment plans were because transcription takes a week. These timelines are typical in my experience.

I wondered if any standards were set for transcription times, and whether emergency physicians or IHA in-house consultants are obliged to use third-party dictation services when transcription times are dangerously long. Perhaps there is a role for physicians to develop communication channels outside of the health authority. Physicians are considered independent contractors and must meet professional and College standards. I would welcome any suggestions on how to do so within the current framework.

—Mike Figurski, MD, CPHIMS-CA
Big White, BC

The Interior Health Authority declined to provide a response, but has indicated that they will contact Dr Figurski directly regarding the incident he describes in his letter.—Ed

Canada's largest clinical trial: Marijuana legalization 2018

In the past year, many news stories, peer-reviewed articles, and opinion pieces[1] have debated how eased restrictions on marijuana possession and use stand to affect the lives of Canadians. This topic is of keen interest to the public and it would seem that everyone has an opinion on how accessible marijuana will reshape the economy and health outcomes, particularly among underserved and vulnerable populations. Members on either side of the debate have substantiated their arguments with those of politicians, doctors, and other leaders who regularly weigh in on marijuana legalization. At first, it may seem prudent to base our own arguments on those of leaders in the field; however, we do not recognize that many of the opinions of such experts are precisely that—views and opinions—which themselves have yet to be systematically validated at a national level.

Historically, federal restrictions on studies evaluating the economics and health effects of controlled substances, such as marijuana, have hampered our understanding of such substances.[2] Extrapolating risks and benefits of marijuana legalization within discrete populations where marijuana is already legal (e.g., Colorado) is fraught with bias, and much of the data for measuring long-term consequences of marijuana legalization remain immature.[3] As such, we are all blind when it comes to accurately predicting how the new laws will shape our country (if at all).

Regardless of whether marijuana legalization will increase the incidence of psychosis among teenagers while simultaneously undermining the marijuana black market, with certainty, we must be prepared to study

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these consequences. This means that *before* royal assent of Bill C-45 we have comprehensively outlined ways to evaluate how marijuana will affect Canada and its people. This means ensuring we have detailed baseline characteristics on marijuana usage associated with mental health, fatalities, and organized crime, among other measures. This means mobilizing funds and researchers who will be unhindered in studying the immediate and long-term effects of marijuana legalization. Given the widespread use of nonmedicinal marijuana in Canada, in effect, we must be ready to capitalize on studying the largest clinical trial of the century in this country.[4]

Recently, the timeline of marijuana legalization has come into question.[5] I have faith that we will be prepared if the Canadian Centre on Substance Abuse[6] maintains its commitment to objectively and transparently monitoring, the effects of marijuana legalization and further, if legislators are willing to act on findings from this and other research groups.

—David D.W. Twa, BSc
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Class of 2021

This letter first appeared as a post on the BCMJ blog.

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