

FEATURE

# The burden of paperwork

Is this the match that is slowly burning up the joy and curiosity that should be part of practising medicine?

BY COLIN LESLIE



**W**e'll call it "paperwork," though for most doctors it's done on computer: a tsunami of documents, forms and letters both coming in to and going out of clinics daily, all requiring review, input and decisions by the nation's clinicians.

The weight of all this administrative work on Canadian doctors is crazy heavy—and is driving burnout. We

know this because when the *Medical Post* surveyed doctors about paperwork and asked for input, we received, well, a tsunami of responses.

Paperwork, of course, is patient care. It isn't going to go away but that doesn't mean we can't take a skeptical eye to what can be done about controlling it.

There have been successes in recent years. Remember how often doctors used to be asked to serve as guarantors for passports?

Another? The workplace reform law, which took effect in Ontario earlier in 2018, bans employers from asking for a sick note from doctors if the worker's illness lasts 10 or fewer days a year. This policy takes precedence over collective agreements with employers.

But for many doctors paperwork is a growing and soul-destroying burden.

"My paperwork in endoscopy has quadrupled over the last five years," said Toronto's Dr. Hemant Shah in a tweet. "Nothing about the procedure has actually changed—other than the patient getting far less attention from the care team (because of time spent on paperwork). At what point does paperwork become a threat to patient safety?"

Dr. Tandi Wilkinson, an ER physician at a rural B.C. hospital without an EMR, said it seems like paperwork is mandated by administration with no thought to physician workflow. Dr. Wilkinson is required to admit all the patients who will be under the care of the hospitalist. "To admit a patient to the hospital I hand-write a one-page summary, as my full dictation takes days to hit the chart. I also have to fill out a mandatory code status sheet, one for DVT prophylaxis and a preset admission order sheet. Each of those requires my name, and a date and time. And the allergy information needs to be completed on three separate sheets. And a medication requisition sheet. Also hand-write any radiology requisition forms. (The department won't do the test without my signature on the form; a nurse's signature is not adequate.) And then my actual orders. All that for one patient."

#### DR. REIDY'S 'DAY OFF'

It's an overcast Wednesday afternoon at her clinic just outside of Victoria and the office is closed to patients but Dr. Bridget Reidy is there, a bright yellow rain slicker hung behind her. She is going through a pile of paperwork consisting of tons of little things: an audiologist report on one of her patients that she has to read to make sure they don't need an ENT referral; an ultrasound she ordered that shows gallstones; a request

to re-refer a depressed patient; oddly low potassium on a patient's labs that she has to think about; a reminder to herself that she has to write a referral for plastic surgery . . . it goes on through the afternoon.

"It wouldn't be so bad if patients didn't think I had the day off," she said. When she calls a patient at 7 p.m. to give them a result and they say, "You're still at work, doctor?" well, it grinds a bit each time.

Every bit of paperwork requires a decision from her, and hours of this are draining; she tends to write complex referral letters in the mornings, when she's "fresh."

Dr. Reidy is from Michigan originally, and though she locumed around B.C. a bit a year ago she took over this solo practice from a retiring physician. About 80% of her visits are with patients ages 55 and older. She's heard some doctors say, "Do your paperwork in front of the patient" but she doesn't see how she can effectively do that. "Most patients can't keep quiet for long while I read or think," she said. "I pretty much have to talk about what I'm looking for while looking up things in their chart, even if it's needed for me to continue the visit. Even writing their scripts at the end of the visit, it's amazing how easy it is to make a mistake when your brain has just been pulled in a bunch of different directions for the past 20 or 30 minutes."

## "At what point does paperwork become a threat to patient safety?"

So into the evenings and sometimes on weekends, she's at it.

Physician paperwork falls into five broad categories:

- **Documenting:** The days when doctors could jot a few notes or none at all and move on are gone. "If you didn't document it, you didn't do it," is the medical-legal perspective, so the pressure to document has increased.
- **Reviewing test results.**
- **Filling out patient forms:** insurance, legal, workplace forms. Doctors get paid for some of this.
- **Making referrals and requisitions.**
- **Other,** such as completing hospital intake and admitting forms, and nursing-home paperwork.

But dividing paperwork into piles doesn't reduce its weight. So let us look at solutions.

#### SIMPLER, FEWER FORMS

"The CMA has ongoing efforts to help reduce the paperwork burden for Canada's physicians," Canadian Medical Association president Dr. Laurent Marcoux said. "We understand that this affects physicians at the clinical level—having to deal with lengthy paperwork ultimately means less time spent caring for patients."

Indeed, the CMA and Ontario Medical Association both pushed for the legal change ending sick notes for



short-term illness in Ontario. The CMA is hoping other provinces will follow suit, as it doesn't make sense to send a patient with a short-term common illness to a busy doctor's office, potentially infecting everyone there.

As well, the CMA worked with the Canadian Life and Health Insurance Association on standardizing forms for such things as short- and long-term disability. "The forms are definitely shorter now. More physician-friendly," said Dr. Jeff Blackmer, vice-president of professionalism for the CMA.

Joan Weir, director of health and disability policy at the insurance association, said the joint work with the CMA in recent years has gone well. "Insurers have recognized that physician referrals for the services of other healthcare professionals, such as massage therapists, no longer serve a useful purpose. Most standard plans offered today do not require a referral," she said. As well as massage therapists, that applies to physiotherapists, chiropractors and osteopaths. "Where referral still remains is more generally for a 'product,' such as orthotics."

While making forms simpler is

## Canada's worst forms – anecdotally

What 'worst' is will always be a judgment call, but a few doctors tell us about the forms that give them the most headaches **BY COLIN LESLIE**

### Insurance company forms

"The worst forms I've had to fill out are ones from insurance companies," said Dr. Mike Simon, a family physician in Saint John, N.B. "First of all, they're rarely one simple page, and they never ask for just a diagnosis. How easy it would be to jot down the sentence,

'The patient has had a total hip replacement and cannot return to his job as a policeman for at least eight weeks?' Instead, the forms ask for all current medications (with dose and schedule), details of the patient's past medical history, any consultations to specialists, how often the patient has seen

you for the problem, if the patient is compliant with his treatment and competent to endorse cheques."

### Hospital intake forms

"Our regional health authority (in Winnipeg) created a new centralized intake form for endoscopy referrals," said Dr. Candace Bradshaw, co-owner of a family medicine clinic in Winnipeg where she practices full-time with five physicians. "The form was four pages and very onerous. It also required a lot of unnecessary blood work to be ordered with each referral. Our members spoke up and after a series of meetings, and support from (our association) Doctors Manitoba, the form was simplified. Somewhat. This is just one of several central

intake forms required in our regional health authority. They are all unique. They are rejected if one small checkbox is missed. Before centralized intake, specialists used to screen the consults. Now they are screened by other healthcare providers or admin. If the triaging person decides your consult does not meet criteria for referral, it is rejected. And that decision seems to vary depending on who is doing the triaging. I have often had to bounce rejected referrals back, which requires extra calls, extra documentation and in the end . . . delays in patient care."

### Service Canada

"Medical report for Service Canada. It asks the patient's diagnoses and some other

always a good thing, calling for forms to be “standard” may not always be the best approach, some doctors say. “I’d like to say standardization is the way to go to simplify the process but I’ve seen the forms that come out of such a process—our old one-page prenatal form is now four pages long with much smaller print!” said Dr. Mike Simon, a family physician in Saint John, N.B.

## TECH SOLUTIONS

There are, to be sure, physician critics of EMRs who say they effectively encourage doctors to look at their computer instead of the patient, and that this practice is undermining the doctor-patient relationship. But for most doctors, the advantages of EMRs outweigh the disadvantages.

“One thing I’ve learned about the EMR is if there is something that I’m doing that seems to be really tedious or really repetitive, and I’m thinking, ‘Oh my gosh, there must be a better way!’ there probably is and I just don’t know about it,” said Dr. Loredana Di Santo, a family doctor in Maple, Ont., who is also a physician peer leader for OntarioMD, an agency tasked with expanding EMR

use in the province. In such a case, she’ll check if there’s a pre-existing solution with her vendor, or go to her community portal or user group, or even create a solution herself in her EMR.

Dr. Di Santo said she couldn’t imagine working without “encounter assists” (name may vary in other EMRs), where all the steps in a common type of patient visit—say, a urinary tract infection—are set out so she can speed through her encounter quickly.

Sarah Hutchison, CEO of OntarioMD, said doctors are increasingly going to see two big growing advantages as we move into the “mature use” phase with EMRs.

The first is “the integration aspect: How EMRs are increasingly enabled for the receipt of information. For us that is Hospital Report Manager, (so) information reports about a patient are directly integrated into the EMR, which makes that workflow so much more efficient for the physician and their office staff.”

The second, Hutchison said, is that EMRs are being used for quality improvement and looking at a doctor’s population of patients in a different way. “We’re meaningfully starting to really

help physicians move beyond the patient that is in front of them to think about their population health at the practice level.” For example, a doctor can look at screening rates, smoking status, all kinds of indicators across the population by using tools attached to their EMRs, she said.

We are also seeing tech innovations come up from the grassroots. Family doctors in B.C. have community-based groups called “divisions” that work together to achieve common health-care goals. PathwaysBC.ca, a website that family doctors use to get a range of information about specialists, including their specific areas of interest, wait lists, details on what is expected in a referral and other info, was originally developed by Fraser Northwest Division of Family Practice (which covers GPs in Vancouver’s suburbs). It was such a success that it was expanded to the Lower Mainland and eventually to the whole province, and is now jointly funded by B.C.’s divisions and the General Practice Services Committee. “The docs love it,” said Dr. Wendy Amirault, president of the Society of General Practice in B.C.

information but not a lot about severity and function. They use that scant information to decide whether to grant CPP (Canada Pension Plan) disability status long term. Nowhere on the form does it even ask if the patient can work! How can they make an appropriate decision for that?” asked Dr. Steve Blitzer of Thornhill, Ont. He used to have a large general practice but about 15 years ago switched to chronic pain management. Many of his patients are in a “paper chase,” he said, with Ontario’s Workplace Safety and Insurance Board, the motor vehicle accident insurer, long-term disability insurer, CPP and the Ontario Disability Support Program. Dr. Blitzer also does a lot of consulting for insurers and legal firms doing independent

assessments, so he sees both sides of the disability issue. He reviews many other doctors’ charts during these assessments, so he sees how others handle the forms.

“The Ontario Ministry of Community and Social Services form for disability support is a similar, short, fill-in-the-blank form. Nowhere on the form does it ask if the patient can work. Then they use that to decide whether the patient is disabled and cannot work.

“What people designed these forms? This has always perplexed me. Putting someone on CPP disability can give them \$16,000 a year till age 65, so 20 years would be over \$300,000. How that decision can be made from such a vague form is beyond me.

Sure, people can provide additional information, but they should ask for that from the start. With \$85 for the physician’s fee to complete this, doctors usually just fill in the blanks with short answers.”

## Ont.’s Workplace Safety and Insurance Board

“It is not just the nature of the form here but the fact that it is very, very clear that WSIB has little intention of being impartial or fair to anyone,” said Dr. Julie Connolly, a family physician in Sudbury, Ont. “WSIB would do well to bolster their forms to allow for doctors to indicate their impression of the legitimacy of the claim. Unfortunately, WSIB ... employs third-party doctors, physiotherapists, etc.,

who invariably state that the patient is well enough to return at least to modified duties (often in employment scenarios where there are no legitimate modifications possible) when they are not well enough. The massive stress WSIB’s investigations and treatments (sometimes requiring patients to forcibly go out of town to get, especially our northern folk) adds another very real dimension of distress and hence ‘dis-ease’ on top of the original injury. WSIB refuses to consider this. So, yes, while the forms are annoying, with rigid questioning, forcing doctors, on behalf of their patients, to attempt to fit circle pegs into square holes so to speak, WSIB’s greater crime is the clear impression it delivers

Some physicians have found one of their best tech solutions is with dictation software. "I have used Dragon Systems for almost 25 years and it is a lifesaver. The modern Dragon Professional Individual (not the 'medical' edition) is incredibly good, easy to use and inexpensive. I dictate just about everything," said Dr. Sandy Murray, a family doctor in Red Deer, Alta. "Scan a 'non-fillable' form into Adobe Acrobat or similar program and dictate text directly into the form. Presto! One can even insert an electronic version of your actual signature into it. There are all sorts of macro commands and auto-text options to speed entry." (That said, some doctors noted in online comments on our website that they tried dictation systems but found they weren't right for how they practise. A few Canadian doctors have gone further and use medical scribes but some physicians reject this option, as it is an added cost to their overhead. The counter-argument, of course, is these doctors are delaying their departure from the workplace for an hour or two after the last patient leaves, and that time is at the expense of their families.)

## PERSONAL SOLUTIONS

Alberta's Dr. Murray said he believes one of the keys to paperwork is to do as much as possible as you go through the day, "or at the latest at the end of every day or, less satisfactorily, at the beginning of the following day. Leaving paperwork even until the following day always introduces the problem of forgetting details, as is so easy to do when we see so many patients with similar complaints. And forgetting details is deadly."

Dr. Murray also said he's found some insurance companies will pay a premium fee if paperwork is completed accurately and promptly. The Workers Compensation Board of Alberta does pay doctors more for quick form completion.

Dr. Simon of Saint John said he has a system for patient forms. "If the patient has one of those onerous forms, I ask them to make an appointment with me to fill them out. Going over each question with the patient saves time and ensures we're on the same page (pun not intended). I'm not sitting in my office on Sunday night anymore, trying to guess if the patient can lift five pounds at work or seven."

Some doctors argue they find

paperwork less annoying if they know they are earning money for doing it—where that is permissible. "Charge for your paperwork," said Dr. Murray.

Still, charging patients can be challenging. "Insurance forms, return-to-work notes, travel insurance forms—patients get incredibly hostile when asked to pay for these services," one doctor wrote as a comment on our survey. "They take up a lot of time but the verbal abuse received from patients is not worth pursuing payment."

Another view is that paperwork doctors don't think is going to do anything to help their patient is inherently draining.

"When we rush to labs and imaging, we generate paperwork for ourselves both in the completing of the reqs in the first place and in the signoff and sorting out of test results after the fact," said Dr. Sarah Newbery, a rural family doctor in Marathon, Ont. "If those tests were necessary in the first place, then the time doing that paperwork is meaningful and contributes to care, but if they weren't necessary, then it can feel like drudgery to go through those results as they are neither helpful nor meaningful." **MP**

that no matter the expert opinion of the worker's family physician (doctor most expert in knowing the person injured), WSIB will do as it wills so as to minimize payouts."

## Disability Tax Credit

The Disability Tax Credit (DTC) form got mixed marks. One physician said, "It is concise, simple, unambiguous and properly sized to allow adequate answers in the space provided. Whoever designed this form definitely knows how a GP thinks, and I thank them for it."

But Ontario GP Dr. H. Jaye Goldstein recounts the story of a patient of his with secondary progressive MS: "On Jan. 12, 2018, I received a request from my patient to complete

a DTC Certificate. A thorough medical history clearly detailing the progression of her MS, and including the current status that she has a severely spastic gait, with drop-foot deformity requiring bracing, and that she is only able to ambulate with rollator walker and alternatively a wheelchair for all other mobility, has been forced to retire, has had her licence suspended because of neurological complications of her disease and has global ADL limitations, was documented." Copies of 18 pages of supportive data were submitted, including those from a neurologist, neurorehab and psychiatrists.

"This week I received a followup request from the DTC program," said Dr. Goldstein.

"They wanted additional information to determine eligibility and asked, I quote, 'Is your patient able to walk a distance of 100 meters using, as needed, any therapy, devices, or medication, yes, no or sometimes. If No or sometimes, it is mandatory to provide specific examples. When your patient is able to walk, does she require three times longer than the average person of the same age who does not have the impairment, at least 90% of the time. Has your patient's impairment lasted, or is expected to last for a continuous period of at least 12 months?'"

"There is more but you get the message. The Canada Revenue Agency clearly either doesn't read the reports or

is incapable of interpreting the information sufficient to formalize an opinion. This brings into serious question who is in charge of reviewing these applications and what their credentials are. They appear to be deficient in the necessary medical knowledge that would be an asset for the job description. This certificate's design leaves far too much potential for the adjudicators to decline applicants."

Dr. Goldstein said on this form, "While there are specific checks to indicate applicability based on disability, the final paragraph for description of impact, although objective for the physician, is far too subjective for the decision-makers."