# 173: Stop Taking Your Charting Home with Dr. Sarah Smith


## Full Episode Transcript

**With Your Host**

**Bonnie Koo, MD**

# 173: Stop Taking Your Charting Home with Dr. Sarah Smith

Welcome to *The Wealthy Mom MD Podcast*, a podcast for women physicians who want to learn how to live a wealthy life. In this podcast you will learn how to make money work for you, how you can have more of it, and learn the tools to empower you to live a life on purpose. Get ready to up-level your money and your life. I'm your host, Dr. Bonnie Koo.

Hey everyone. So today's special guest is a friend of mine, Dr. Sarah Smith. And I know that one of the biggest complaints I hear from all physicians is charting. Charting at night, charting on weekends, charting for hours and not getting paid for it. It is the bane of so many of our existences. And did you know that it's possible to get your charts done before you get home?

When I say this to a lot of people, they say, "I wish." And they don't quite believe it's possible. I'm here to tell you that it is because I've talked to so many physicians who have worked with Sarah or another charting coach, yes charting coaches exist, who have literally revolutionized their time. Meaning they've freed up so much time because they're not charting.

And so I've had Dr. Sarah Smith inside my paid program, Live Wealthy. She's probably the most popular guest coach because who doesn't want to stop charting at night? And I don't think I need to say this, it's obvious, but this is definitely one of the things that makes physicians really unhappy and contributes to burnout because when you're working all the time, not being able to give yourself to the people that you love, to things that you love, your life suffers.

And so I'm excited that she's here because I know you're going to get so much value out of it. And if you are a physician who is struggling big time with charts, I just want you to be open that it is possible to stop charting at night without diminishing the quality of your notes or diminishing the quality of your patient visits.

All right, here's my conversation with Sarah.

Bonnie: Well, hi, Sarah. Thank you so much for being here.

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Sarah: Thank you for having me.

Bonnie: All right, so why don't you introduce yourself.

Sarah: So I am Sarah Smith. I'm a family physician in Edson, Alberta, which is a rural town. I'm also a charting coach, so I help physicians and clinicians get home with today's work done. And that can include any aspect of the clinical day, not just the charting.

It can look at the interruptions that are happening, our workflow, the work of the day, anything about the day that is stopping them getting home with the work of the day completed. So that is the work that I do in the world in regards to physicians.

Bonnie: Awesome. Well, obviously, this is so needed. And I have so many questions to ask because I know most of the people listening who are physicians or anyone who charts, right, it's not just limited to doctors, they're like, is it really possible to chart less? Because when I tell people that you exist, some people are like, "Oh my God, I need her." But then I do have skeptical doctors who don't even consider that this is a possibility. So I'm sure you've seen the whole range.

Okay, so I wanted to get a bit more background on you. How did you decide to do this?

Sarah: So I was a family physician working in Australia and within those first few years of doing family medicine I realized that we have a paperwork problem. I was often the bottleneck when it came to getting forms completed.

I may have had staff that could put the required pieces together to go with the document, but getting the actual work of it done, staying late at the end of clinic. I knew the security code on every clinic that I worked in because I was often the last to leave because I was sitting there doing my notes from the day.

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And then on weekends I would come in and do my work because at that point we couldn't access EMRs from home. That was kind of a little bit later on. So this was 15 years as a family physician. Still not sure what time I would be home, knowing that if I was home I wasn't done, that I was collecting this backlog of work that would then have to be done at some point.

Going away on holidays was a particular nightmare because we would have to kind of have everything up-to-date and emptied in order to be able to go away. But I've even heard the horror stories of people taking charts with them on holidays or during work while they're on holidays.

So I understood that it was a big problem. And I had asked my mentors along the way, how do we do this paperwork bit? Like how do we get the charts done? And the answer was always to come in on Sunday. Come in on Sunday and get it done.

That was it. That was the answer. So we moved then. So we traveled around Australia for a couple of years, which was really great. Made some memories, traveled as a family, semi-retired, super great. And then I went to Canada doing full-scope family medicine, plus emergency, plus inpatient work. And this problem followed me.

So the minute I started seeing patients in the clinic, my own patients, I would have this same dilemma. When am I going to be home? I would get a text, when are you home? Knowing that I wasn't done, that I was late again. Feeling completely useless that I still had work left to do at the end of the day, trying to figure out how do we do this? How do we actually figure it out?

And then my eldest child was in grade 10 and I remember them sitting in the lounge room chatting about university. And I was on my way to my study to do my charts and I thought, I'm going to miss out on his last two years at home if I don't figure this out. So that is how I ended up in this work, I had to figure it out for me first.

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Bonnie: That's such a compelling story. But also I just wanted to acknowledge that you decided to problem solve for this, right? Because I know so many, you know, we have this culture in medicine of, I'm sure you've heard, learned helplessness and that we can't do anything about it because everyone else is struggling. Your mentor said this is just how it is, come on a weekend.

Sarah: That's right, this is normal.

Bonnie: Yeah. And so just kudos to you, like there must be a solution I'm going to figure it out. I mean, that was the driving force, right, to make this happen.

Sarah: Well, no, actually, just like you said earlier, this is impossible, right? It's an unsolvable puzzle. That is exactly how I thought at the beginning. So skeptical, I get it because there was no way I thought there was any way of doing it differently. Clearly, after 20 years of doing this if I didn't know how to do it, I was never going to know how to do it, right?

Bonnie: Totally.

Sarah: Completely unsolvable puzzle. And I had read any article that had come out about efficiency, about the paperwork problem, about the administrative era and the administrative load on family doctors. Specifically at that point I was looking at family doctors. And even trying to do some of the things that were said in there, like see less patients. I mean, come on, I'm a single income earner for a family. I can't just drop the patient load. I have no other way of making income.

So I had to stay where I was because there wasn't anywhere else to work in town. Stay where I was, keep doing medicine, keep seeing the same number of patients that I was seeing in a day and get home after the last patient with everything done. That was my impossible mission. Mission Impossible. And I was not going to let it go this time. I am going to figure this out.

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Bonnie: Well, speaking of Mission Impossible, you know the new one just came out, right?

Sarah: Haven't seen it yet.

Bonnie: Yeah, I saw it. I'm a big fan of Mission Impossible and funny movies and actions. Yeah, so I saw it last week. I mean, it's fantastic. It's even better than the old ones. I also don't understand how Tom Cruise doesn't seem to age. But that's a whole nother discussion.

Sarah: He has a lot of money.

Bonnie: Yes, but his work is very natural. Anyway, that's a whole nother discussion.

Sarah: That is right.

Bonnie: I think it's pretty obvious to anyone listening that all of this charting after hours, weekends, nights, is definitely contributing to physicians being really unhappy and to burnout. So I think it's obvious, but I'm wondering if you just have anything else to say about that?

Sarah: Yeah. So the cost is huge. So when we think about what is it costing us, so I've heard this said before as well and it was true for me. I didn't think it was hurting anyone to chart in the evening and to chart on Saturday morning and to spend all weekend with paperwork, right? But it was unpaid work. You've earned the money in the room with the patient and so now you're adding hours without adding income for most of the work.

Now, some doctors are getting paid for some of that work or all of that work. But still, it's costing you life. It's costing you time with your family. It's costing you time with your kids. It's costing you exercise, ability to sit and watch a movie guilt free, have hobbies, other interests outside of medicine. And it's stopping the ability to rest well.

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I mean I was up till midnight or I was getting up at four to get the work done. It's costing me sleeping time, so then I'm not even as present the next day. I'm not coming in as my best self.

Bonnie: Yeah, well for yourself, your family and for your patients, right?

Sarah: Yeah. If we look at some of the income earned across the different models of payment for physicians, they're not getting paid any more if they spend 10 minutes or 30 minutes in a room with a patient. And if they then go and spend another 30 minutes doing the paperwork involved in that encounter, they're really under earning. You don't want to know what your hourly rate is at that point.

Bonnie: Yeah, I can just imagine. I mean, have you calculated it for yourself?

Sarah: It depends on what your pay model is, right? So it really depends on your pay model. So if you are doing the work, if you've doubled the work, then you're earning – I could have earned if I was in the pain of where I was before, so that was 120-ish an hour earned in the clinic. So then I go spend another hour in the evening doing that work, 60 bucks an hour. Plus, then you've got to pay overhead and taxes.

Bonnie: Yeah, you're making less than my assistant. Like literally. Who is amazing and I try to pay my contractors well. But it's a little insane, right?

I just had Jack's pediatrician, the podcast came out, I think, a week or two ago at the time of this recording. So he's a DPC, which I'm sure you know is the cash only model. And one of the things that pushed him towards creating this as he realized that his – Who was it? Oh, his wife who works in finance, his wife's assistant was making more than him based on the hourly rate and everything. And he was like, what is going on?

Sarah: That's right.

Bonnie: Yeah.

Sarah: Yeah.

Bonnie: So before we go into, obviously, this one podcast is not going to radically change – Well, I don't know because I've had you guest coach in my program and just one hour with my group has really helped them, like because they tell me. You're like one of the favorite guest coaches, I'm sure, because everyone hates charting. No one is like, oh, it's not so bad and I don't want to fix this problem. Like said no doctor ever, right?

Sarah: But what I find interesting, the feedback I got this week was I was in a guest coaching program with somebody else and one of the participants said, "Oh, I thought she was going to be telling me how to chart." And really that was nothing much to do with it at all. It was more about what are we saying yes to in the room and the cost of time for that yes? So what are we saying yes to later?

So when the patient says, "Oh, by the way, can you refer me to a dermatologist?" I'm picking on that because you are one. And we say yes and then we don't do it right now, I'll do that later. As in, oh yeah, that's a super easy, simple drive-thru question, right? Go to the drive thru, get your quick fix. Patient says I would like a referral to X and you're like, sure, and you move on.

Then at some point you've written down that you were going to refer them to the dermatologist. And then at some point you're like, oh, I better do that referral. And then you're like, what was I referring them for? Even which part were they interested in having looked at by the dermatologist? I don't even remember, now I've got to get them on the phone, I've got to get them back in.

There's a cost to doing work later. And since we said yes in the room, now we've got to figure out where we're going to do that work.

Bonnie: Yeah.

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Sarah: So when I'm working with physicians or clinicians it's about what is happening within that encounter? What is the language that we're using that's costing us time in the room? Like, how are you today? That's a three minute question out of your possible eight and a half minutes with the patient. Just noticing how we are paid, therefore and how much time have we got? Because most of the time we don't have a lot of control over that.

Some of us have all the control, but most of us have zero control over the number of minutes we're given with a patient. What are we going to do within that encounter? What are we saying yes to? And how are we going to get out of this encounter on time with the work of this encounter today done?

Bonnie: Okay, people listening are probably like, what the hell?

Sarah: That's right. So this is not how do I get my charts done? This is how do I structure my consultations or my time in the room with a patient or my patient protected time, so that it's not just the patient is seen and on time, and the documentation of that encounter is completely done. All of it. All of the documentation required to complete that encounter plus the billing, done, then you can move on.

Bonnie: All right.

Sarah: But that's a skill set. That is a skill set. That is not just a see patient, do note, which is what I teach. See patient, do the chart then move on to the next thing, right? It's also, well, I don't have time to do the note. Well, that's because you said yes to all the things in the room. Now we have to create this whole language and skill set of what do we do about that list that comes in?

Bonnie: Yes. Before we move on, because I know everyone's like, tell me all the things, Dr. Sarah. I think I know some of the barriers, but what are sort of the top barriers you see to implementing or to actually doing this? I have a few things in my mind, but I'm curious what you say.

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Sarah: It's hard to do new things, right? I'm already running an hour behind, how could I possibly add in the notes as well? My notes take too long. I see patients with really in-depth encounters, like psychiatrists, endocrinologists I hear you. I hear you say that in your head. That my charting is very long for the type of encounters that I have.

Bonnie: Can I pause you for a second?

Sarah: Yeah.

Bonnie: One of my new local friends, I don't know if she listens to the podcast, but she's an endocrinologist and she said the same thing. She charts like till 2am she told me.

Sarah: Yeah.

Bonnie: She's like, well, I have to really think about it. This is not something I can just flippantly decide. That's what she told me, literally verbatim.

Sarah: That's right. And so we're helping the physician who is in their workplace right now and with the struggles that they currently have. So your friend who's working till two in the morning to do her charts. Now we're going backwards and saying, okay, why? What is it about that encounter? What is it about this note? What's happening right now? And how can we start to make the changes that she is comfortable making?

So this is not my way for all. This is what is your most simple solution? How do we help you figure out your clinical day in the environment you're in with the concrete pieces of your day that you can't change? Like how with the staff you have, the patient load that you have, the type of encounters you have, even then how can we start to do things differently so that you can have life outside of medicine? Creating time for you or improving your income, whatever it is your goal that you're going for.

Because they come in with all the goals. I love it. They come in saying I want to be home at five with everything done. You're like, great, let's do it.

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What is your current experience? Well, it's leaving at nine. Okay, we've got to find you four hours, let's go.

Bonnie: Yeah. I also think, I'm sure you see, because you also have men that you coach, right? Yeah, I'm wondering, especially since I talk a lot about how women are socialized, I'm guessing that women might have a harder time with this because we want to say yes to everything.

Sarah: So the men also have very similar issues who are coming inside the program. They are coming in to learn the same skill set. They come in with a list, now what? They're working in the evenings and weekends, too. I mean, my mentors were men who were telling me to come in on Sunday.

Bonnie: I think I told you that I didn't quite have to chart because I basically finished the chart, and I had a scribe which helped, but still they don't do everything correctly. And I think once or twice I brought the charts home and to me, this was a while ago so I'm probably remembering it a little bit wrong. But I think I just got a little lazy that day, in terms of charting and finishing every room. And then I brought them home and I was like, never again. Because I would forget details.

Sarah: Yeah, you forget details. Exactly. And that's why it takes so much longer when you're doing it that evening, this weekend, in three weeks time, in three months time. Like this is part of the difficulty of having this leftover work. Like that referral that I said yes to and I can't even remember which knee it was that I was referring them for. Or was it the knee or were they actually wanting the shoulder?

That is an additional piece of guilt and shame that you put on yourself. Having to call the mother and say, what did I see your kid for last week? I wrote nothing down. I don't know what happened but the whole thing, you know, that is an extra heavy mental burden for the person seeing the patients, right?

Bonnie: Yeah, and probably, I'm just guessing, I think damage is a strong word, but probably the patient is like, what?

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Sarah: I like to say it like this, if you went to the lawyer or the accountant and you spent an hour with them and they wrote nothing down while you were in the room. Let's say it's the accountant, they wrote nothing down while you were there. How much do you trust them?

Bonnie: Such a good question, I never thought about that. I have a CPA, but I don't think that's the problem. But yeah.

Sarah: If they wrote nothing down, your goals, your wishes, your dreams, your current financial position. None of it they wrote down.

Bonnie: Yeah, it's like how can they do great service for you if they don't keep track of that? I mean, I think this is kind of going on the side but it's like I personally have an issue with remembering things. So I really have to write things down or I just literally forget. There's a running joke in my family about how bad I am around this. But yeah, if I don't write down a few notes, I literally don't remember how that meeting went.

And if I don't take the action based on the meeting, like, okay, I need to do XYZ, because I'm like, oh, I can do it later. So it's similar, but I'm not charting.

Sarah: Yeah.

Bonnie: Yeah.

Sarah: So the working memory for physicians they've studied, and they've studied the working memory of people in healthcare, but physicians particularly. We have very amazing brains. We can remember a lot, a lot, a lot in a working day. Incredible. Like clinical decision making, medical decision making is really high-level work. But we can also keep, Mary wants this and Jack from patient number two wants that, and you're going to remember to do the note for that, but it's taking away our focus.

So we can do it. We're very well practiced, those of us who are putting things off to later. We're very well practiced at keeping a lot of information in

there. Incredible. And how much easier is it as we walk into patient eight of the day and all of the work behind us is done? It just frees up so much more of that problem solving brain.

Bonnie: Okay, let's talk about, you kind of said something earlier about – First of all, I'm just so impressed that you were like, the how are you is a three minute conversation and getting the charts done before the next patient.

And so we talked a little bit about how people might react to that, because some doctors are like but I want to ask how are you. I want to have that chit chat. And how can I finish the chart in the room because I'm going to be running late? So you want to break that down a little bit?

Sarah: Yeah. So our relationship with our patients is not necessarily that social interaction every time, right? We are there to be able to help them with their clinical questions for today. When we derail them with the how are you, they also start using a different part of their brain to answer that question.

So they were all ready for you, ready to tell you about their knee and their shoulder and whatever else they brought in for you today. And we say how are you? And they're like pause, that leaves, find that question, find that answer, give you the answer, chit chat, now what are we here for today?

Whereas if we move straight into the, hey, what are we here for today, we get to the nuts and bolts of the problem. If you're running well on time and you want to have a chit chat or you finish your note, by all means. You get to do medicine your way, but it can sound different to how it is right now.

Bonnie: So it sounds like if you want to have that sort of few minutes of social interaction, do it at the end. That's what I'm hearing.

Sarah: Or don't do it with every patient every time.

Bonnie: Yes. Okay. And I can see people just having thoughts about that, right?

Sarah: Of course. Of course, if a part of the change is, ooh, no, that's not something I want to do, then don't. This is your consultation. You're the boss in the room. You're the one who gets to decide how you're going to run this space. But some of us have done it the way we've done it because that's what we were taught. We never step back and say, hang on a minute, where did all my minutes go?

Bonnie: No, totally.

Sarah: Some of you will have a knock on the door every encounter. Knock, knock. Hey, Mr. Jones is here, will you still see him? Poof, there goes all your decision making. All the information you were starting to process for that patient in the room and you have to now kind of re-orientate.

Okay, well, Mr. Jones is late. He usually comes in for X, Y, or Zed problem. I need to be at that meeting for five o'clock today. So if I say yes to him, but I'm already running 20 minutes behind, that's going to put me another half an hour behind. You're doing all of this stuff in your head before you say yes or no.

Bonnie: Yeah. Well, what I'm hearing is two things, it is basically task switching, which really slows down our brain.

Sarah: Costly.

Bonnie: I've read articles about how much extra time that adds, just how many extra minutes, right? Because our brain literally is like, yeah, shifting gears and there's a cost to that. And the second thing I'm also hearing is the skill of boundaries, right?

And that's something that, because I do teach that and that is something really hard, I think for everyone, because we're worried people are going to

be pissed. But then if we don't have boundaries, it's like you have to have them and then you have to enforce them. We fear that.

Sarah: Yeah, so for that particular instance it's just simply noticing what they knock on the door for. What are the questions they're asking? Just start being curious about your day. Just start noticing it from that step back perspective of your day. Say who interrupts me and what do they ask me?

And then when we know the answers to those questions, then we can say who did I need to tell this morning that this afternoon I need to be in a meeting at five. If I've got any late patients you have permission to just re-book them so that there's no knock on the door this afternoon. You have my blessing. Go ahead, go re-book them. When they turn up, you're like, let's re-book you.

Bonnie: Yeah, I gave a talk on boundaries at the White Coat Investor Conference and this was one of the things we talked about, how you have to think about what are the boundaries? What you just said is basically like, what are the things I'm getting interrupted for? Create the boundary, and when I say create the boundary, it's like don't knock on the door for this, you do this.

And I think part of it is when you haven't set them and enforced them, it is going to be a little jarring to patients who are used to you doing things. And so there's going to be some training involved. I have a friend who kind of I really thought about her from the get go. This is like her whole jam, she gives talks on this and the importance of really following through with this, no exceptions.

Sarah: And I'm a little lenient. I say if you have that one patient who caught the bus for two hours to get to you and they see you twice a year. And they brought their son and they need an interpreter and you want to spend an hour in the room with that patient, do so. You are still the decision maker in the room. You might get 15 minutes for that patient and you spend an hour.

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But don't be mad at yourself that you're now an hour behind. Just know I chose to spend that time with Mary today because I know the circumstances behind her travel to see me. And she's complex and I wanted to do the five things in the room for her.

But then Jack, who's next, and he has a 15 minute appointment, maybe today you give him what he needs today and it takes eight and a half minutes and you're out of the room. Right? So we don't have to be held by the clock every single time. Your value is not your time.

Bonnie: That is such an important concept because we do feel like we have to spend a certain amount of time because there's also patient reviews. I don't know if that's a thing in Canada, but I'm sure you know in the US patients will ding you for, really for anything.

What's your answer to patients who feel like they're not getting enough time?

Sarah: Patients will use up all your time and then still think they don't have any time with you. You can spend three hours in the room with some patients and they will have all the complaints about how you didn't spend enough time with them, right? So that is not how we actually please patients. A lot of patients will have no idea how long their appointment was set for or how long it takes to do any of the questions in the room.

I have a quick one for you, they say. I want to talk to you about my headaches. That's not quick. You know how long it takes you to do a headache inquiry, exam, assessment and plan. That's not a quick question, just so you know. So that is our job to help them understand I want to do a good job for your headaches, let's re-book you so I have the time to do quality work for you.

It's not about me. The patient doesn't care that I'm an hour behind. The patient doesn't care that I have a meeting. The patient doesn't care that I have kid pickup. They have zero interest in me, right? This is about a value proposition for them, okay?

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When you go to the hairdresser and you say, hey, I know I booked in for a haircut, but can you color me at the same time? And the hairdresser is like you don't want a five minute color. We'll get you back for that, we'll do a good job.

Bonnie: Yeah, basically the answer is no.

Sarah: But it's not saying no. It's saying you do not want a five minute color. And it's true, you don't want a five minute color. The hairdresser knows what a five minute color is like, right? You know how long a headache takes. And then the way, the language that we're using with our patients to help them understand. Yes, we need to talk about your headaches. I need a deep dive into that for you. Let's re-book you.

So it's not about just one problem in the room. You are the boss, you get to decide what you're going to say yes to in the room, but understanding within the context of what I'm given, what am I able to say yes to and what am I deciding is a priority today? Because they might want this form completed, but you really want to dive into that chest pain that they just said something about. And then that discussion that happens that says, hey, we need to really sort that out for you.

Bonnie: Yeah, in my brain I'm like, but patients get pissed if you tell them they have to come back or that you only can solve – Again, they don't understand how this works. So how do you deal with – I'm thinking about worst-case scenarios if you can't tell.

Sarah: Well you're not really because access is a problem, right? So they're thinking about, well, if I want them back, that's in a month. But if we really step back and say okay, why is it in a month? Okay, why are we so full that we can't get them back in for a month? And if we have zero control over how full we are, then what else is available? And how do we help our patients understand what to do if we're not available?

So sometimes waiting for your doctor in four weeks time is not the right answer and it's not what I want for you, my patient. I want you to go and get

available healthcare. And so me saying, hey, my colleagues are available at the walk-in clinic four days a week. I like all of them. I can read their notes and we can catch up with what happened when I see you next. That is a better message than I am not available for four weeks, so I'll see you in four weeks.

You might say, you know what? I'd love to dive into that juicy problem you just brought me, but we're going to do this today because that's something I can do for you very well. And I know that I can get you back in to have that other thing dealt with. And if we don't get resolution, then I'll see you next time.

Bonnie: Yeah. So it sounds like there's a few skill sets we're learning. How to literally talk to patients and set up expectations. Okay, let's talk a bit more about charting because basically what you said about seeing a patient and getting the charting done, do you mean actually getting the charting done so that you don't actually have to look at it later?

Sarah: It's completed, yes.

Bonnie: Okay. Let's talk more about that.

Sarah: Now, it does not have to be a skill that you say I'm going to do tomorrow and you're a whiz bang at it tomorrow.

Bonnie: Yeah.

Sarah: Because we do things in the way we do them because we've done them in the same way for years, right? So we have this method of doing our work and it's the way we've always done it for whatever reason. We don't need to say it's good or bad, it's just not working for us if it's not done in a timely manner immediately after this encounter.

Do you have to do every patient every day? Not when you're starting this new skill, right? You might decide I want to give this a whirl, but if the wheels fall off the wagon somewhere, that's okay, you're learning a new

skill. Give yourself the ability to say, hey, I'm going to fail a bunch of times on the journey towards this goal that I have for myself. I'll see the patient, and do the note.

Bonnie: Yeah, and as doctors we hate not getting it right away, right?

Sarah: Failing, right. We want to think about it until we know the answer and how to get it perfect, and then we'll do something. It's like no, no, no, no.

Bonnie: Yes.

Sarah: So my questions are just about pausing and deciding what's happening right now. When I'm in the encounter, how much of the work is getting done? Immediately after the encounter what's already in the file? How long is it going to take me to finish it in the way I do it right now? What is in my note and why?

You know what needs to go in your note, I don't need to tell you that. You need to give us the important what happened today, the positives and negatives of the assessment that helped you towards the diagnosis or the working diagnosis, your assessment and plan, right?

So what do we need for billing? What do we need for insurance? That's what needs to go into a chart note. And what else is in there, right? Are we writing a huge document? And why? Like what about that document could be different if you wanted it to be on? How and where could you get that note done if you wanted to?

So if you go back to a pod with eight other people and they're all going to be talking to you, that is not good thinking time. And some doctors say I need to think about this in order to figure out what's going on. I need quiet to think. And then I want to tell you, do you? Well how can you create something closer to that in the moment? Where else could you work that could be a little bit more conducive to you being able to pull your thoughts together for that patient?

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Bonnie: Right, because if you're interrupted, it's clearly going to just take longer.

Sarah: That's right. The work of charting is not just a you problem, okay? So this is informational continuity to your team, to the people who help you, right? So you might be putting in orders and if they don't get them right away and they're waiting on you, maybe you want to get done in a timely manner for your patient, for your staff, whatever.

And, for instance, in the emergency department, if you are leaving all your notes to the end or to tonight, so you've just put in a 12 hour shift, you are done. You're a wreck, your brain is fried. You go home, but think about your colleague going home after a 12 hour shift and charting for four hours. How likely are they to keep coming back every day? And what is that going to cost our department when we're down another doctor? Dang, that's expensive.

Bonnie: Yeah.

Sarah: This is not just a you problem. This is an us problem. How do we look after us to get our work done so we keep coming back? This is a sustainability question. If you're asking a doctor to see 30, 40 patients through a busy clinic like urology or ophthalmology, they see huge volumes. And you expect them to go home and then work? You're not going to keep them very long. They're going to be worn out.

So how do we notice our colleagues putting off work and say, hey, I just want to check in, how's it going? As we see our residents coming through and they're not getting their work done until midnight, you're seeing their pajama time charting. You're like that's not good for you. I want you sleeping. I want your best brain here tomorrow. This can be an us problem.

So when I've talked to teams, like the emergency department as a team, I'm like, hey, listen, guys, charting and documentation is not going to be complete after every encounter because you kind of do it bits and pieces encounter. You see them for a bit, go do some investigations, come back.

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It's kind of like three visits. There's three episodes of charting. You want everything up to where you're at right now.

Obviously, we can pause because you're the boss, if you've got something bleeding or coding or seizing or crowning, of course.

Bonnie: Yeah.

Sarah: But where can we put you so you can get that chart note done? It's a you problem, where can I do my work? And it's a them problem, us problem. If they're working, I know not to talk to her because she's in the purple chair, right? How are we looking after each other as well?

Bonnie: I mean, everything you said sounds great. And then, obviously, as you said, we have doctors who probably can't affect that kind of change in the type of environment that they are. That's a whole nother discussion.

Sarah: If they want it, they can. That's the beautiful thing about this. If you want something bad enough, we can make it happen. But it's that noticing what do I actually want about this? Some people are delighted by charting all weekend. They love it, they don't want to change. It's totally fine. I have no problem with you doing you, of course.

Bonnie: Are people really delighted by charting all weekend?

Sarah: They've got nothing else because they've been doing it so long, they wouldn't know what to do with themselves on a weekend.

Bonnie: That's fascinating to me.

Sarah: They choose it. They're choosing it because it's what they keep wanting to do. That's the way they're working through the week, creating the same result day after day, week after week, year after year. Does it get better? Not unless you actually decide you want something different, then it can change. Otherwise, our brain will do everything on rinse and repeat because that's what we do. Whatever we do, we do it efficiently because it's less energy, honestly.

Bonnie: Yeah.

Sarah: Even if it's not efficient, it's less energy than change. Change, deciding you want something different and doing it is very energy taxing.

Bonnie: Yeah, yeah, no, totally. It's like we can apply this to all different things. Obviously, this is a concept that I do with my coaching. So, it sounds like people need to, the doctor needs to want to change this, otherwise they wouldn't pursue you, I guess.

Sarah: That's right, absolutely. Well, they don't even need to pursue me. Even the pursuit of something different about their clinical day, just noticing I want different. Like I didn't even know I wanted different, I just didn't like what I had, right? I didn't think it was possible to have something different.

So if nothing else, if we can just start noticing our clinical day, decide do we like the way it's working for us and the result that it's creating what it's costing us? What is it costing us? If I was to do it this way and it was still this way in 10 years, am I delighted with my medicine? And if I'm not delighted, what would make it delightful? What would make it sustainable?

Bonnie: I mean, I have so many wheels turning. I'm also, you know, between you and I and all physicians, we know what physicians aren't happy with. And the first step is, are they willing to do something different? Do they even think something else is possible, right? And I think as we help more people, and people see that actually it is possible, then it's like this ripple effect, right?

Sarah: Yeah.

Bonnie: But if you don't know any better and everyone is just doing it, and even though they might be complaining, it's very easy to be like, oh, this is just the way it is.

Sarah: This is just the way it is. Now, are we saying that the system is perfect and we should just live within the system that we're in? No, of

course not. Of course not. But system change and changing the medical system, maybe there's people working on it and it will eventually change. But what you exist in right now, what is it about that that we can start to help you figure out so that it's more survivable, sustainable, easier, gives you back some evening or weekend time, right?

So this is about creating time so that you can rest well and have a life outside of medicine.

Bonnie: Yeah. Change is hard and it's worth it.

Sarah: Change is hard and it can be worth it if you want it. Even just a little bit better than what you have now can give you bucket loads of time back.

Bonnie: Yeah. Sometimes I think what's helpful when I talk to clients is, because I think also it can be a little overwhelming to be like, I want this and XYZ. And so sometimes I will say, how can we just make it 10% better? Or even like 10% less crappy? Because I think when I say that, it seems doable, and also like not underestimating the power of just making it a little bit better.

Sarah: That's right. Exactly.

Bonnie: Is there anything that you haven't said that you think is important or you want to say?

Sarah: So I think that there are many physicians out there that are really struggling in the area of feeling stuck or trapped about their clinical day. Whether that be I would prefer to be making more money, but I don't think I can move or I can't affect change in my workplace. I feel trapped by patients asking me multiple questions in the room. I think that the untrapping is important.

So a lot of the time we feel trapped, stuck, miserable, and we still have choice. There's still somewhere that you are able to make a different choice. You have choice. So we're not saying you need to make huge

change, but when you notice that I'm feeling stuck or trapped, I want you to pause and say, oh, what else here isn't the experience of being trapped? Where am I making decisions? Where's my choice?

So you're noticing that I do have some choice here, right? Even, I arrive at quarter to nine and my first patient is at nine, I chose this by what time I got up, how long it takes to commute, all those types of things. You get to see, oh, I see. I determined that I arrive at quarter to nine and I'd rather be here at 20 to nine because then I could get a little bit more done. You've got choice.

Bonnie: Yes.

Sarah: There are things about your day that you have got some choice around when you're feeling that trapped and stuck.

Bonnie: Yeah, I mean, I feel like that's what we do, and when I say we, those of us that coach anybody, is helping our clients see that they have a lot more agency than they think they do right now.

Sarah: Yeah, even if you can't get the MA that you really want, there could be something else about your day that we can start to improve. So I think that that's a big one, is that they could just be feeling really, really hard done by, very, very tired and under load right now as they say. Let's see if we can get some pressure off you and find your people.

Honestly, when you feel alone is when it's so much more dangerous to you and your mental health. Find your people, find your mentor, find the person who can help you make a little bit of change in your day. That's all.

Bonnie: Okay, where can people find you? Because I'm sure they want to learn more.

Sarah: Yeah, so they can find me on *The Sustainable Clinical Medicine Podcast* or chartingcoach.ca.

Bonnie: Yes. And how do people work with you?

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Sarah: Yeah, so we have the Charting Champions Program, which is the lifetime access for physicians program where we do the foundational steps of how do we do this getting home with everything done and the ongoing coaching calls and guest coaches that come into the program to give you all the ideas on how do we manage our clinical days differently, better. Any type of expert I can find for you guys, I bring into the program. And if you're a clinician, the Smarter Charting Program is the one I own.

Bonnie: Awesome. Well, thank you so much for being here. I mean, I feel like we could just talk for hours about all of this. And you're amazing, anyone who's listening who wants to stop charting at night, you need to check her out.

Sarah: Thank you so much, Bonnie. Thanks for having me.

Hey there, thanks so much for tuning in. If you loved what you heard, be sure to subscribe so you don't miss an episode. And if you're listening to this on Apple Podcasts, I'd love for you to leave a review. Reviews tell Apple that this podcast is, well, awesome. And it will help women find this podcast so that they too can live a wealthy life. And finally, you can learn more about me and what I do at wealthymommd.com. See you next week.