With a Little Help From My Friends

My two-year tenure as Editor-in-Chief ends with this issue. I was struggling a bit with a topic for this month's letter, until I read an article by Dr Atul Gawande in the November 12 issue of the *New Yorker* called "Why Doctors Hate Their Computers." Bingo.

At my institution, we recently converted to a new electronic medical record system, whose acronym—EMR—may as well be a four-letter word. Making the change was moderately traumatic, with doctors, nurses, pharmacists, medical assistants, and schedulers all losing their mind at various times. Six months into the new system, folks seem to be getting the hang of it. The change was somewhat less stressful for me, as I had gone through EMR implementation a few years earlier at another institution. I knew what to expect. What has been most interesting for me is the difference in how each place has operationalized it. Let me clarify.

At my old institution, there was a huge effort made toward improving patient safety in the years prior to the EMR rollout. As EMR implementation neared, it became apparent to the doctors that we were about to become responsible for the physical act of ordering every laboratory test, every scan, every consultation, etc. We would need to click all the appropriate boxes in the EMR, for example, and type the reasons for the chest x-ray or the pulmonary consultation. This did not seem like the best use of the physicians' time, and some protesting occurred. We were told that physician order entry resulted in fewer errors, thus improving patient safety. The organization went so far as to ban verbal orders. If your patient over in the treatment room developed chest pain, not only did you need to run over from clinic to evaluate the patient, you then needed to find a computer, log in, find the patient's chart in the EMR, and then order the electrocardiogram with multiple clicks and some typing. Clinic productivity definitely took a hit. I needed 30 minutes to see a return patient and 60 minutes to see a new patient. I was the rate-limiting step in our operation.

At my new institution, the oncology division provides physicians with nurse coordinators and nurse practitioners. I was unsure how we would best utilize all of this support in an EMR world designed to have everything flow through the doctor. Fortunately, the oncology division has allowed us to fully utilize our available help, and my nurse is permitted to enter all of the orders. If I see a patient who is ready for chemotherapy treatment, I walk into the room and focus on addressing treatment-related issues and providing a pep talk. When I come out of the room, the chemotherapy orders have been loaded into the system and are ready for me to sign. I can quickly double-check and then sign with one click. If I am seeing a return patient, we typically know in advance what the plan will be—for example, "return in 3 months with our usual labs and scans." I can just verbalize it, and it gets entered. I can sign later with just one click. Sometimes the visit gets complicated. What if the patient unexpectedly needs transfusions? Putting in orders for blood products is a multistep process that would tie me up for several minutes. My nurse does it faster and probably better. Another advantage is that while she is doing that, I can write my clinic notes. This system is an efficient use of available manpower, and I do not become the rate-limiting step. We can see return patients every 15 minutes. Admittedly, the nurse practitioner is taking care of some of the return visits, but even without an NP, I can see a return patient every 20 minutes. And I am spending more time talking to the patients, able to look them in the eye rather than at the screen. Is patient safety being compromised by the fact that I am not personally entering all of the orders? I sincerely doubt it. Because we are equitably dividing the work, no one is rushed, hurried, harried, or frantic. So EMRs do not have to be an engine of physician burnout, provided that the institution is willing to provide some help.

Best wishes to the new Editors-in-Chief (there will be two) as they pick up the editorial baton. Editing *Clinical Advances in Hematology & Oncology* has been very enjoyable. A big thanks to Devon Schuyler, the Editorial Director. It is always fun to work with people who are good at what they do. We all need a little help from our friends.

Sincerely,

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