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GUEST EDITORIAL

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Working with scribes—the good, the surprising

The clerical work involved in managing the electronic medical record (EMR) is clearly not at the top of the skill set for physicians, yet many office-based clinicians find themselves bogged down in this work with no easy way out.

However, practices that are adopting team-based care—where each team member works at the top of his or her skill set—are finding a solution in the form of scribing, or team documentation. This approach can ease that burden and perhaps even help to curb physician burnout in the process. But many questions still surround this approach, notably: What do we know about the quality of this documentation?

Research conducted by Misra-Hebert et al reported on in this issue provides some insight—and reason for optimism. (See article at right.) Their study found that scribes' outpatient notes stack up quite well when compared to those of physicians. And having worked with this approach to documentation, I can attest to its benefits, as well.

Misra-Hebert et al's study in this issue attests to the quality of scribes' notes. My personal experience is that charts are usually closed at the end of each half-day.

Two approaches, one goal. There are 2 different ways that physicians can get help with documentation. One involves the use of trained scribes, who come from a variety of backgrounds and are charged with writing down, or scribing, what the physician says. The other involves training staff, usually certified medical assistants (CMAs) or licensed practical nurses (LPNs), to take on a wide variety of additional duties including refill management, care gap closure, and most of the duties concerning the EMR—including documentation.

Misra-Hebert et al studied the second approach and found important evidence that using staff in this way does not adversely affect—and may even enhance—documentation previously done entirely by physicians.

This change in the way we approach EMRs involves commitment, as I've seen first hand. There needs to be significant training to make this work and there needs to be more staff, since physicians require 2 of these valuable team members to function effectively. (At least that's been our experience.)

We are in the process of implementing team-based care throughout our 32-location health care system and have found that using CMAs and LPNs to assist with documentation is a "win" for everyone.

1. A win for the patient. Patients immediately notice that their physicians are now able to focus on them during the office visit, since they no longer have to tend to the demands of the computer. In addition, since the CMAs/LPNs are with patients during the entire visit, the patients bond with them and feel the extra support from this relationship.

2. A win for the care team. Physician satisfaction has never been higher. Charts are usually closed at the end of each half-day. There is no need to take work home

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at night. CMAs/LPNs feel empowered and meaningfully involved in patient care. Their increase in satisfaction mirrors that of the physicians.

3. A win for the system. Not only are quality measures improving, but access improves since this team support increases efficiency. The biggest surprise of all for us was a financial one. We are able to see more patients per day and are billing at a higher level of service, since there is more time to attend to more of the patient's needs (thanks to the additional team support).

There is much talk about putting joy back into the practice of medicine. But the benchmark of any change needs to be whether it helps our patients. I believe that team documentation does. Happier, less burned-out physicians are able to better focus on patients during their visit. As one patient recently said to me at the end of a visit, "I feel like I've got my doctor back."

That's something that patients, and doctors alike, can feel good about. JFP