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OPTIMIZING PHYSICIAN TIME

The Executive Medical Committee of a hospital I am familiar with was meeting last year and, in preparation for a Joint Commission survey, wanted to formalize who can make entries into a patient's chart. After the usual recommendations of physician assistants (PA) and nurse practitioners (NPs) it was thought that the discussion was over until someone at the table mentioned "scribes." Scribes?! No one at the meeting had ever heard of such a thing.

Turns out the emergency physicians were using scribes to facilitate their charting and had been doing so for a number of years -- but it was news to the members of the Executive Medical Committee. After some explanation, and given the fact that it was a long established practice that apparently was being used by emergency physicians at other facilities, it was agreed that scribes could make entries into a patients chart as long as the doctor took full responsibility.

Just what were these folks doing? They were assisting the physicians in charting and, in addition, were helping them with some of their other tasks. What was the justification for this practice? The justification was very simple. Charting is extraordinarily expensive and EDs are generally very busy. The more time that doctors spend charting at computers and pulling up x-rays on a computerized image archiving system and doing computer order entry and the like, the less time they can spend with patients. Seems pretty straightforward.

Is charting expensive? As long as there are patients waiting to be seen, you bet it is. Here is a real life example. An emergency department with which I am familiar sees 2.7 patients per hour. The revenue generated per patient (both physician and hospital components) is conservatively $400 a patient (please, this essay is not about defending ED charges). If it takes 15 minutes out of every hour to do Medicare mandated charting on these patients (you know, the 10 item review of systems and the family and social history and the like), then the math says that each minute of time spent in an hour is worth $18. So, for every minute that you chart and don't see the next patient, it costs $18 in lost opportunity costs.

So charting is expensive primarily because it precludes physicians from seeing additional patients (or even spending more time with the patients they already have). Some hospital administrators flagellate themselves over the vast amount of money being laid out for transcription of dictated medical records and are driven to decrease these costs. At $0.13 a line, a 30 line ED record would cost a whopping $3.90. Even if it cost $5 it is trivial given that every minute spent on charting that could be used to see another patient costs $18. If dictation allows a physician to chart in half the time that is required by writing or, worse, using a computer, to document a history, physical, medical decision making and treatment, then transcription is a bargain by any measure. In addition, transcription allows for the breath of expression to more adequately describe the patient's condition and response to treatment – try that on a computerized system using pull down menus ad nauseum.

But I digress. Back to scribes.

In settings where dictation is not available, scribes can buy time for providers. They can go ahead of the doctor and get from the patient the essential elements of the history. They can get the past medical history, the medications, the allergies, the prior operations. They can summarize the patient's explanation of the history of present illness. Upon arrival of the physician, the scribe's legible notes can facilitate a more focused approach by the physician with expansion of selected parts of the documentation. The scribe signs the chart as does the physician. The physician takes responsibility for the record. He/she has reviewed it, augmented it and clarified it.

Another way in which scribes facilitate charting is to accompany a physician when they see a patient. The physician can generate the questions addressed to the patient and the scribe can document. One tactic that is often used is for the scribe to hold off on charting until the physician begins a summarization of the history of present illness. This allows the physician to separate the wheat from the chaff in the history and focus upon, and emphasize, the elements he/she thinks are the most important. Typically the physician would say something like, "OK Mrs. Jones, let me get this straight now." "You've had four days of moderate abdominal pain in your right upper abdomen accompanied by some nausea but no vomiting…." This allows a focused summarization and the scribe takes down this version of the history rather than an unfocused history that a patient may give spontaneously.

Regarding the physical, the physician may say aloud his/her findings for the scribe to note (and it makes it clear to the patient that the doctor is doing a very thorough job) and more sensitive findings (enlarged liver, appears older than stated age, etc) can be given outside the room. The scribe can also check off any test orders when the doctor tells the patient, "Well Mrs. Jones, I think we'll need to get some tests." "We're going to order a gallbladder ultrasound to see if you have any stones, a blood count and a lipase test." So now the patient knows what's in store and the scribe has checked off the tests the doctor has indicated. Any medications are written by the doctor and the doctor signs the chart.

There is no sitting down in front of a computer outside the presence of the patient where a doctor has to enter his/her user name and password, find the patient from a pick list and then go onto the page for ordering blood tests and click off the lipase and CBC and then go to the page for the imaging tests and click off the GB ultrasound and then go to the drug page and order some IV ketorolac (after acknowledging no allergies to this medication, no history of renal failure and no history or GI bleeding).

Others do it for him/her because it is understood that the doctor/nurse team is generating $18 a minute in revenue and the hospital cannot afford to have a doctor waste his/her time doing order entry – no less generating a computerized history and physical with documentation of response to treatment, medical decision making and that a call to the PMD was made who agreed to see the patient for follow-up care at 10am the next day – try that on a computerized system.

In addition scribes facilitate physician work in other ways. They check on the status of lab work that seems to be taking too long, they pull up the patient's x-rays on the imaging computer system saving the necessity for the doctor to enter his/her user name and password, find the patient on the list and click open the x-rays. Instead he/she walks over to the screen, checks to see the patient name and reviews the films – simple.

Bottom line – scribes are great. But it is truly surprising how few clinicians use scribes in their practice. Given that most physicians are being pressed to see more and more patients, you would think that anything that provides a cost-effective option to achieve greater efficiency would be readily embraced by the medical community. But this is just not the case when it

comes to the use of scribes. Most physicians have never heard of them and, even in the world of emergency medicine which is the area where scribes are most frequently used (given the large volume of histories and physicals that are generated) most practitioners are unaware.

Who makes a good scribe? College students who want to go to medical school are ideal. They are smart, fast, eager to learn and they love being in the environment in which medical care is being provided – and they love having it on their resume when they apply for medical school. So towns that have colleges are a good place to start. And EMTs who work for ambulance companies or in other settings are also an option. And in the setting of emergency medicine there are at least eight companies that will hire and train scribes for physicians (*ER scribe* and *ED scribe* will get you plenty of hits on the internet and *ER scribe* is even found on Wikipedia where there is a nice write up).

Who pays for the scribes? Well, in a private practice setting it is clear that the doctor does. What can you expect to pay -- anywhere from $10 - $20 an hour depending on the circumstances. Scribes who work in emergency departments present a unique challenge. If the physicians in the ED are employees of the hospital, it is clear that the hospital will need to pay. The more interesting question centers on who pays when the ED physician is an independent contractor. In this situation, it would seem fair that the hospital pay 80% (they collect $400 a patient) and the physician pays 20% (given that a physician may collect $100 a patient). But splitting of the costs rarely occurs.

Typically the contracting physicians bear the full cost. When this unfair arrangement occurs it is still easily feasible to justify the cost of a scribe being paid solely by the physicians. Assuming each patient generates $100 in physician income, and assuming physicians are seeing 2.5 patients per hour, then to pay for a scribe for one hour at a cost of $20 requires that 0.2 additional patient be seen -- not hard to defend at all. This is especially true when physician satisfaction and joy in practicing are taken into consideration and they are relieved from unnecessary hassles and their work is facilitated. Informal surveys of those using scribes are uniformly very positive.

Given that scribes make clear-cut economic sense for both physicians and hospitals, why are scribes so infrequently employed, especially in the hospital setting? Fundamentally, physicians are very conservative by nature. They are reluctant to break from tradition and using a scribe is certainly not traditional. Most have no experience with their use and are not familiar with other physicians who have used them. In democratic physician groups where a majority vote is needed to approve group actions, it would be expected that only the most entrepeneurial groups would agree to try using scribes. This is despite the fact that scribes can be taught relatively quickly and, in the unlikely event the experiment fails, there is little lost regarding time or cost.

There are options when a group is unwilling to use scribes and an individual physician wants to use a scribe. When this occurs, physicians should have the option of hiring their own personal scribes. When the physician shows up for work so does his/her scribe. The physician pays the scribe directly. Care should be taken when this occurs to follow all regulations regarding employees. In an era where physician payment is more and more based on productivity (RVUs) it is not hard at all to prove the value of a scribe.

One final point about scribes in the hospital setting. It is ideal to have hospital-based scribes as hospital employees for a number of reasons (rather than employees of independent contractor physicians). As hospital employees, scribes can be taught and authorized to enter test requests into hospital computer systems. Hospitals may be reluctant to allow this of scribes who are physician employees. In addition, hospital employed scribes can provide other services to physicians – they can assist at patient examinations, they can chaperone exams and assist with procedures. As employees of physicians, all of these extended tasks should be avoided and left

to hospital employees to perform and scribes should be not be allowed to touch patients for any reason to limit medicolegal risks.

And finally, the ultimate irony. Scribes being hired by hospitals and doctors solely to reduce the excess burden on doctors being expected to use computer systems. There are multiple stories of scribes being hired to do computerized physician order entry and to generate computer based charting of histories and physicals. Hospitals spend bigillion of dollars on a computer system and then, on top of it, hire a raft of new people to interface with the system so that doctors are not encumbered by these systems. It has happened in numerous hospitals once it has become clear how detrimental these systems are to physician efficiency.

So, what is the goal? Why are we drawn like moths to the flame of computerization in healthcare? Medicine seems to be dragging its feet when it comes to computerization on the clinical side. Proponents continue to make analogies regarding the airline and banking industries and how computerization has revolutionized them. But the analogy doesn't hold. Healthcare is not the airline or banking industry. It is one physician interacting with one patient extracting the nuances of a history and physical and, based on training and experience, coming up with a differential diagnosis – processes that are much more complex than commonly believed. And, in the process, we are dealing with a human interaction in which caring, trust and confidence need to be conveyed. It is about two humans, face to face. And how do computers fit into this transaction? They really don't.

Faster / better. Faster / better. That's it. Computerized physician order entry is probably tolerable – at best. Those who are particularly fond of the concept note the ease of doing "order sets" -- packages of tests and therapy that are done routinely on all patients with a specific problem. So you push one button and you blow out 15 orders on a suspected acute coronary syndrome patient. Easy. But how good is this? Aren't physicians paid to make the key decisions about what testing and therapy is needed. Does every chest pain patient need the 15 tests at a cost of X hundred dollars. So yes, it is easy. Is it good? Not necessarily.

Bottom line – the goal should be to have physicians unencumbered, their work facilitated. Ideally the physician would be free floating intellect interacting with patients and staff. Not required to write, not required to sit in front of a computer, not required to do anything but interact with patients and staff. This would be ideal, but it is not particularly practical. But it should be the direction in which we should strive to move. Instead we are moving in just the opposite direction. We want to encumber physicians by being data entry staff – entering into computers histories and physical and tests and drug orders and the like. On the premise that this system is better and safer we are being drawn to a system that is neither.

Sure we want rapid access to patient records and old EKGs and operative reports and medication lists and the like, but there are other ways to get this essential information from computers without burdening physicians to be data entry staff at the expense of patient care. Many systems exist to scan records and summarize lab and imaging reports and the like that use medical record and other staff to generate this information via a computer data base. The key is to have the right people do the data entry work --- it should not be by physicians. So, I would encourage all physicians who are having a computerized system forced upon them by administrators who seem to know something we don't to resist. We cannot afford to decrease physician efficiency in an era in which physicians are in short supply and there are others who can do data entry on our behalves.

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