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When the EMR Stole My Pen

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"Lost something, Doctor?"

"I think my nice pen slipped under your sheets," I explain.

Groaning at the thought of moving his diabetic legs, the patient says, "Maybe you should keep your nice pens at home."

People have been telling me that for years.

My first nice pen was a Sheaffer, a medical school graduation present from a friend. Silver trimmed in gold, it was the first item engraved with my new title of doctor. After everything it took me to get there, I couldn't leave the pen at home. From my first day of internship, it became my companion and cheerleader. On dull night duty, as I filled out warfarin orders or wrote blood slips, a glance at the gold lettering would remind me that my role mattered. If a patient needed a pen, I'd exhaust all options before reluctantly handing over mine. Australian doctors don't wear white coats, and my clothes seldom had functional pockets, but protected in my palm, my dutiful Sheaffer lasted 2 years before I lost it during a code. I felt simultaneously annoyed, guilty, and bereft. A voice in my head said it was only a matter of time before a nice pen went missing, but I loved to write, and in those days — with paper records, paper scripts, paper everything — there was a lot to write. So after some searching, I bought myself an elegant Waterman.

If an engraved pen could be lost, an unengraved one stood no chance, but I managed to hold on to my Waterman for a few years, until a friend upgraded it to a sleek Cross. By then, I was a fellow whose credibility rested on writing meaningful notes on the 30 or 40 patients I saw each day. With a nice pen, work never felt like a chore. I loved the swish of pen on paper, the gel technology that felt like ink without the mess. The act of writing parsed my thinking and made me more deliberate. Why would anyone leave a nice pen at home with all this writing to be done at work?

When I passed my fellowship exam, my husband surprised me with a black and gold Montblanc — and unexpected responsibility. Should I leave it in its silk cocoon, designated as a "milestone" pen? If I lost it, would my husband be more annoyed than I'd be devastated? But mere admiration couldn't do it justice, so I began taking it on rounds — and writing effusively.

When I became an attending, my brother bought me a congratulatory Montblanc, crimson with gold accents. I assumed that an attending wouldn't need to write much, but in the era of subspecialization, I'd routinely arrive to find my residents involved in testy exchanges with other units over a hapless patient who'd been subdivided into organ systems — situations demanding thoughtfully composed notes from me.

An elderly smoker with a large lung mass was bedbound and cachectic. The home team wanted a biopsy to exclude "something else." Emergency had already called cardiology about his bradycardia. Endocrinology wanted to chart his labile sugars. The man just wanted to be left alone.

A woman with newly diagnosed breast cancer had fractured her hip and was confused. Two teams argued over pain management. Orthopedics was questioning her prognosis before taking her for surgery. Nephrology was annoyed that she was dry. Neurology wouldn't see her without an MRI.

Such fragmented care was damaging to patients. I saw my job as cutting through the confusion, setting a direction, and taking responsibility for the whole person. And often, the best way to do so was by writing an opinion labeled "Consultant Note." I'd gather some files, find a quiet corner, and write a considered argument as to why instituting end-of-life care for one patient was the best way forward but

hastening surgery in another was paramount. Occasionally, other attendings thanked me for crystallizing matters. I never told them my pen made me think better.

Miguel de Cervantes said that "the pen is the tongue of the soul; as are the thoughts engendered there, so will be the things written." When I handwrote opinions that helped patients avoid futile interventions, receive urgent chemotherapy, or expedite an operation, I felt bound in a sacrosanct relationship with them. My aspirations for my patients were laid bare as I wrote. There was no backspace or delete button, no drop-down menu, no cut and paste — my notes were the best of me wanting the best for my patients.

I'd heard about the electronic medical record (EMR) years before it arrived at my hospital. My American colleagues had painted a bleak picture of burnout, early retirement, click fatigue, and merciless bureaucratization. On an American sabbatical, I saw that attendings spent no longer than I did seeing patients but twice as long on documentation.

But the EMR was coming, and we had to conform: anyone who didn't embrace it would be considered a troglodyte or — worse for doctors, who love to please — not a team player. Many of us therefore acceded to calls to become EMR "champions" and "superusers."

I saw the benefit of having radiology and pathology at my fingertips — but at the cost of a widened gap between me and patients. Now, physicians go on rounds with our computers, and some eyes never look up; others dart to the patient quickly before an alert demands a response. Can I justify the lack of thromboembolism prophylaxis for my dying patient? I can, but I'd rather spend the time talking to his grieving wife. Why do I want to reduce the insulin dose for a hypoglycemic patient? Clinical judgment isn't among the top choices.

If I spend a few extra minutes at the bedside, the EMR punishes me by logging me out. But if I

spend extra minutes on the EMR, the patient just waits. Insidiously, the EMR directs our attention and shapes our conduct. I've done entire ward rounds in which an intern hasn't looked up from the screen. How do I teach her? How will she recognize the look of pain, concern, anxiety, or relief on a patient's face that no data can capture?

But perhaps the EMR's most unanticipated disappointment for me has been the overnight irrelevance of my pen. Now notes are typed, discharge medications and request slips for interventions are computer-generated, and electronic signatures rule.

One day, after a tense family meeting, I tell my intern I'll write a note. Wheeling the computer toward me, she asks what kind of note. Where previously there was a crisp sheet of paper, now there's a sea of options. The prepopulated fields are distracting, the inaccuracies irritating. The keyboard sticks. And my typed contribution feels nowhere near as personal or valuable as a handwritten note. So I end up dictating a note for the intern — forgoing a connection that tells the patient, "I'm here, personally looking after you and here's my own writing to prove it."

The mobile workstation has no place for my pen, which keeps sliding off or getting lost in the bedclothes. Exasperated, I leave my pen behind one day. I arrive on rounds feeling exposed, but I see 30 patients without once needing a pen. Hoping it's an anomaly, I nevertheless repeat the act the next day. My dismay is complete. Just as the stethoscope, tendon hammer, and torch have grown redundant, so has my pen, not even midway through my career.

I still clutch my pen hopefully in the outpatient clinic, but as the EMR spreads there, I use it rarely, to sign scripts and medical certificates. I console myself that the refill lasts much longer, and a nice pen is less likely to get lost.

For my birthday, I received a stylish, artistic fountain pen in its own carrying case. It's imploring me to use it, and I'm finally confident about taking nice pens to work. But the opportunity to put it through its paces has disappeared. So it rests in a drawer with the others, relics of a bygone era.

I've instructed my friends and relatives: no more nice pens. They nod knowingly, thinking they've finally convinced me that nice pens deserve to stay at home.

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