



Letters to the Editor

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A MIDDLE GROUND BETWEEN PAPER AND ELECTRONIC ENVIRONMENTS

This letter is in response to your fine articles about computerized information systems in the September/October 1997 *Oncology Issues*. There is a widespread belief throughout the radiation and medical oncology communities that because they plan eventually to implement an electronic medical record, there is no need to upgrade the effectiveness of their current paper record, nor is there anything new available with which to upgrade it. Interestingly enough, our work with cancer centers throughout the country during recent years has resulted in the realization that there is a middle ground between all-paper and all-electronic. A quantum leap under time pressure is really not demanded. This middle-ground approach focuses on restructuring the hard copy record in such a way that the department can enhance its daily operations and create a bridge to the future for implementing computerization in phases according to allowable budgets and projections.

These middle-ground concepts of record folder construction and paper flow facilitate staff interaction and contribute to quality assurance, charge capture, and improved audit results. This approach buys time for thoroughly evaluating computerization options. Those departments that have chosen a new or an expanded oncology management system state that the well-organized hard copy record ultimately acts in synergy with the electronic record and is

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not simply a back-up to the system.

Radiation oncology administrators have stressed that by developing an optimum hard-copy record system they made it easier to convert the top priority areas to an electronic system when the time arrived. By taking the middle-ground approach, their conversion was less difficult, less costly, and they avoided the continued aggravations of an older paper record system.

Related to these individual modality circumstances is another general, and sometimes problematic, belief: Many administrators believe that one common paper record folder can be created to serve all modalities or at least radiation and medical oncology together. Our experience around the country has been that a combined record is almost impossible to design in a cost-effective manner or that the affordable design does not meet the needs of either individual modality. There are a few exceptions to this, but I believe our pointing out the obstacles could save your readership some time and provide an awareness of important items to address right up front.

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PROMOTERS OF HEALING

Halperin and colleagues (*Oncology Issues*, July/August 1997) discuss the stress that oncologists and all cancer care professionals undergo in caring for patients with life-threatening illness. My personal experience as a physician for forty-seven years and an Episcopal priest for twenty-five years may be of help to others, as it has enabled me to see and treat cancer patients daily in a realistic, forward-looking, and healthy way.

One day in my fifteenth year of medical practice it came to me that we in the "healing" professions do not really heal anyone. The healing is built into the body in creation.

All we and all our wonderful colleagues on the health care team have been taught are methods designed to get rid of whatever (i.e., cancer, infection, foreign body) is in the way of that built-in healing process. If we can get rid of the problem, the healing takes place.

If we identify ourselves as healers and then our patient becomes well, we must take the credit. If the patient does not become well, we must take the blame. This philosophy places an unrealistic burden on health care providers. By doing our job, which includes minimizing the harm that is part of any treatment, we have done all we can do, and we do not have the unrealistic burden of either praise or blame.

One of our essential functions is to tell each patient all we know about the kind of cancer he or she has, describe possible treatments—characterizing each as potentially curative or palliative—and their side effects, and allow the patient to make the decision. If we provide patients with good information, they can make good decisions. This, as I understand it, is the basis for informed consent. If we insist on making the treatment decisions for the patient, then we are responsible for the consequences and can be held responsible.

In our cancer center, anxiety, despair, and depression are minimized by the mutual explicit recognition by patients, family, and staff that we are doing the best that we know how to do, day by day, and trusting God for the future. I believe this to be an honest, realistic, and healthy view of what all members of the team are trying to do together. I recommend its consideration and adoption by all members of the health care team as therapeutic for the patients, the families, and those who care for them.

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