were pleased that Haslam and Prasad did not contest the importance of vaccines, testing, treatment, local COVID-19–cautious resources, and problem-solving support.

We had a difference of opinion on several conceptual points. In our opinion, Haslem and Prasad cited low-rigor studies that were not focused on high-quality masks. Efficacy data come from the methodologies noted above, not later-stage T3 comparative effectiveness trials, which have limitations related to low adherence, low fidelity, and low monitoring. Second, SARS-CoV-2 poses cumulative harm from reinfections.[1,6] An infection or a reinfection remains a notable concern in a population that may have a limited treatment window[2] and limited life span. Third, reasonable mitigation can enhance rather than detract from social well-being by allowing friends and family to visit more safely with less concern toward disrupting a loved one's oncology care. Several types of mitigation require little to no cost.

In sum, people with cancer are among the most vulnerable to severe outcomes associated with COVID-19. Health care systems are encouraged to develop comprehensive supports to reduce the risks of COVID-19 among this vulnerable population.

Michael Hoerger, PhD, MSCR, MBA
James Gerhart, PhD
Maria C. Swartz, PhD, MPH, RD, LD

Author Affiliations: Tulane Cancer Center, Tulane University, New Orleans, Louisiana (Hoerger); Departments of Psychology and Medicine (Hematology and Oncology), Tulane University, New Orleans, Louisiana (Hoerger); A.B. Freeman School of Business, Tulane University, New Orleans, Louisiana (Hoerger); Department of Palliative and Supportive Medicine, University Medical Center, New Orleans, Louisiana (Hoerger); Department of Psychology, Central Michigan University, Mount Pleasant (Gerhart); Department of Pediatrics–Research, University of Texas MD Anderson Cancer Center, Houston (Swartz).

Corresponding Author: Michael Hoerger, PhD, MSCR, MBA, Tulane University, 6400 Freret St, 2007 Stern Hall, New Orleans, LA 70118 (mhoerger@tulane.edu).

Published Online: June 1, 2023. doi:10.1001/jamaoncol.2023.1520

Conflict of Interest Disclosures: Dr Gerhart reported grants from Michigan Health Endowment Fund. No other disclosures were reported.

Funding/Support: This work was supported in part by the American Cancer Society (134579-RSG-20-058-01-PCSM).

Role of the Funder/Sponsor: The American Cancer Society had no role in the preparation, review, or approval of the manuscript and decision to submit the manuscript for publication.

1. Hoerger M, Gerhart J, Swartz MC. Variability in COVID-19 vaccine response among people with cancer: what health care strategy best protects the vulnerable? *JAMA Oncol*. 2023;9(2):177-179. doi:10.1001/jamaoncol.2022.5874

2. Llanos AAM, Ashrafi A, Ghosh N, et al. Evaluation of inequities in cancer treatment delay or discontinuation following SARS-CoV-2 infection. *JAMA Netw Open*. 2023;6(1):e2251165. doi:10.1001/jamanetworkopen.2022.51165

3. Robineau O, Zins M, Touvier M, et al; Santé, Pratiques, Relations et Inégalités Sociales en Population Générale Pendant la Crise COVID-19–Sérologie (SAPRIS-SERO) Study Group. Long-lasting symptoms after an acute COVID-19 infection and factors associated with their resolution. *JAMA Netw Open*. 2022;5(11):e2240985. doi:10.1001/jamanetworkopen.2022.40985

4. Novack DH, Plumer R, Smith RL, Ochitill H, Morrow GR, Bennett JM. Changes in physicians' attitudes toward telling the cancer patient. *JAMA*. 1979;241(9):897-900. doi:10.1001/jama.1979.03290350017012

5. Moran JB, Dunn A, Kim S, Zapolin D, Rivera D, Hoerger M. Community-based N95 distribution during the COVID-19 Omicron BA.1 surge: feasibility, 1-month utilization, and price implications. *Transl Behav Med*. Published online April 3, 2023. doi:10.1093/tbm/ibad019

6. Hadley E, Yoo YJ, Patel S, et al. SARS-CoV-2 reinfection is preceded by unique biomarkers and related to initial infection timing and severity: an N3C RECOVER EHR-based cohort study. *medRxiv*. Preprint posted online January 5, 2023. doi:10.1101/2023.01.03.22284042

Standardized Documentation Is Not the Solution to Reduce Physician Time in the Electronic Health Record

To the Editor In their Viewpoint published recently in *JAMA Oncology*, Gabriel et al[1] expressed the view that oncologists spend too much time in the electronic health record (EHR). Although nurses also spend too much time in their EHR,[2] the authors state that this excess time is due to the documentation required to upcode visits. Given that EHRs are "not designed primarily to capture and present a patient's record as efficiently and effectively as practical,"[3(p523)] the literature points to other reasons why physicians spend too much time in their EHR, including the difficulty in finding and combining diverse sources of information to create a cohesive and comprehensive view of the patient; dealing with information that is incorrect, out of date, and duplicative; clicking a myriad of tabs, boxes, and pull-down menus; and responding to demands for information that are not directly relevant to the patient encounter.[4]

The authors[1] propose the creation of a set of structured elements in a standardized format for all of oncology. They point to mCODE (Minimal Common Oncology Data Elements) as evidence that a standardized description of oncology actually works.[5] Unfortunately, mCODE is not about clinicians using an EHR; rather, it is about the FHIR (Fast Healthcare Interoperability Resource) transfer of named objects across databases in the HL7 (Health Level Seven International) format. To accomplish what the authors propose, namely, to replace clinical narratives, including the chief complaint, the history of present illness, and the assessment and plan, we would have to implement a vast number of checkboxes and drop-down menus of structured text. Even so, it would be difficult for this approach to represent the patient. For example, every clinician knows that pain is not just its physical manifestations; it also has emotional and cognitive components, and the patient's feelings and thoughts must be considered in their diagnosis and treatment. Clinical narratives are central to medicine because they tell the patient's story, they help us understand the patient, they allow us to organize our thinking, and they guide our treatment plan. In the approach proposed by Gabriel et al,[1] physicians would have to search and select from hundreds, if not thousands, of boxes and menus (the exact number is unknown), and they would have to try to understand the patient based on the display of a conglomeration of boilerplate text.

The answer to the complaint raised by Gabriel et al[1] is not to play with their EHR; rather, it is to wait for natural language processing programs, such as ChatGPT, that can read open-vocabulary free-text narrative notes. They are coming; please be patient.

Harry B. Burke, MD, PhD

Author Affiliation: Uniformed Services University of the Health Sciences, Bethesda, Maryland.

Corresponding Author: Harry B. Burke, MD, PhD, Uniformed Services University of the Health Sciences, 4301 Jones Bridge Rd, Bethesda, MD 20814 (harry.burke@usuhs.edu).

Published Online: June 8, 2023. doi:10.1001/jamaoncol.2023.1523

Conflict of Interest Disclosures: None reported.

1. Gabriel PE, Singh AP, Shulman LN. Re-envisioning the paradigm for oncology electronic health record documentation by paying for what matters for patients, quality, and research. *JAMA Oncol*. 2023;9(3):299-300. doi:10.1001/jamaoncol.2022.6842

2. Pinevich Y, Clark KJ, Harrison AM, Pickering BW, Herasevich V. Interaction time with electronic health records: a systematic review. *Appl Clin Inform*. 2021;12(4):788-799. doi:10.1055/s-0041-1733909

3. Johnson KB, Stead WW. Making electronic health records both SAFER and SMARTER. *JAMA*. 2022;328(6):523-524. doi:10.1001/jama.2022.12243

4. Melton GB, Cimino JJ, Lehmann CU, et al. Do electronic health record systems "dumb down" clinicians? *J Am Med Inform Assoc*. 2022;30(1):172-177. doi:10.1093/jamia/ocac163

5. Osterman TJ, Terry M, Miller RS. Improving cancer data interoperability: the promise of the Minimal Common Oncology Data Elements (mCODE) initiative. *JCO Clin Cancer Inform*. 2020;4:993-1001. doi:10.1200/CCI.20.00059

In Reply We appreciate Dr Burke's thoughtful comments on our Viewpoint.[1] We agree that there are many drivers of excessive time spent in the electronic health record (EHR). The available literature does suggest, however, that documentation is an important factor, accounting for 25% to 45% of overall time spent.[2-4]

Most importantly, however, we believe that the time invested in clinical documentation is not producing value for patients, clinicians, or the health care system in general.[1] Notes are bloated by objective standards, and their information content, interpretability, and overall quality are poor by widely agreed-upon subjective standards. Of note, this poor quality is actually a contributor to excessive time spent on other activities, such as medical record review.

To be sure, regulatory and billing requirements are not the only factors influencing note content and quality, but they are the most powerful policy levers that exist, and they incentivize precisely the type of documentation that is not useful for patient care, quality monitoring, or research. We believe that this lever can be used more thoughtfully, both to improve clinical care directly and to accelerate progress toward secondary use of EHR data to power a "learning health system."

We also wish to address a misunderstanding regarding our recommendations[1] for structured data capture. We agree with Dr Burke that structuring all aspects of oncology documentation would be both impossible and highly undesirable. However, we believe that capturing a modest number of critical data elements can be feasible and highly valuable. At our own institution, we have implemented a template with only 8 core data fields. It takes seconds to complete but captures such essential information as therapeutic intent (curative, palliative), current disease status (responding, stable, progressing), patient performance status, whether treatment is being changed, and if so, the reason for change (eg, progression, toxic effects). Imagine the value for clinical care if these essential details were always communicated clearly to our colleagues; imagine the value for research and quality improvement if they could be easily extracted from the EHR in a computable format.

While natural language processing no doubt has a role to play in making EHR documentation more useful, accuracy has long struggled to reach acceptable standards, and technical processing pipelines are complicated and expensive. Additionally, natural language processing can only abstract what the clinician has documented, whereas structured templates help to ensure that critical data elements are captured. We doubt it will prove to be a better solution than clinicians simply recording their most essential observations directly in a useful format.

Peter E. Gabriel, MD
Aditi P. Singh, MD
Lawrence N. Shulman, MD

Author Affiliations: Abramson Cancer Center, University of Pennsylvania, Philadelphia (Gabriel, Shulman); Hematology-Oncology Division, University of Pennsylvania, Philadelphia (Singh).

Corresponding Author: Lawrence N. Shulman, MD, Abramson Cancer Center, University of Pennsylvania, 3400 Civic Center Blvd, South Pavilion 12-105, Philadelphia, PA 19104 (lawrence.shulman@pennmedicine.upenn.edu).

Published Online: June 8, 2023. doi:10.1001/jamaoncol.2023.1526

Conflict of Interest Disclosures: None reported.

1. Gabriel PE, Singh AP, Shulman LN. Re-envisioning the paradigm for oncology electronic health record documentation by paying for what matters for patients, quality, and research. *JAMA Oncol*. 2023;9(3):299-300. doi:10.1001/jamaoncol.2022.6842

2. Overhage JM, McCallie D Jr. Physician time spent using the electronic health record during outpatient encounters: a descriptive study. *Ann Intern Med*. 2020;172(3):169-174. doi:10.7326/M18-3684

3. Overhage JM, Johnson KB. Pediatrician electronic health record time use for outpatient encounters. *Pediatrics*. 2020;146(6):e20194017. doi:10.1542/peds.2019-4017

4. Holmgren AJ, Downing NL, Bates DW, et al. Assessment of electronic health record use between US and non-US health systems. *JAMA Intern Med*. 2021;181(2):251-259. doi:10.1001/jamainternmed.2020.7071

Assessment and Prognostic Value of Inflammatory Biomarkers in Patients With Colon Cancer

To the Editor We read the cohort study assessing the association of inflammatory biomarkers with survival among patients with stage III colon cancer by Cheng et al[1] with some interest. This post hoc analysis of 1494 patients who underwent potentially curative surgical resection and adjuvant chemotherapy for TNM stage III colon cancer showed an association between inflammatory status, recurrence, and mortality. In the context of a multicenter, double-blind, phase 3, adjuvant chemotherapy trial of anti-inflammatory agents, inflammatory status was measured using interleukin 6 (IL-6), tumor necrosis factor (TNF) α receptor 2 (sTNF-αR2), and high-sensitivity C-reactive protein (CRP) levels. The values of the objective biomarkers reported in this large, well-designed cohort study allow comparison with previous studies.

The median (IQR) plasma concentration of IL-6 reported by Cheng et al[1] (3.8 [2.3-6.2] pg/mL) is dissimilar to the median/