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In Reply to Khoo and Teo: We thank Drs. Khoo and Teo for amplifying our call for management skills in medical education and for recognizing that more than a single "Management 101" course is necessary to change the practice of medicine. We agree completely that an introductory management course cannot, and should not, constitute the totality of training in these critical skills but, rather, that exposure to these concepts should be ongoing, "beginning in medical school and continuing throughout physicians' careers."[1] We further agree that education in management skills will require more than formal, rote learning; helping physicians become better leaders is a truly transformational learning endeavor. The question is, as Drs. Khoo and Teo ask, *How?*

Failures of leadership or management, as with those of clinical competency, can have significant consequences for patient care. Thus, waiting for physicians-in-training to experience a "disorienting dilemma" firsthand is likely both insufficient and undesirable for prompting this kind of learning (and also risks significant delays and variation in learning). Two strategies that we have explored in our own work for surfacing dilemmas and promoting reflection on critical management skills are (1) the review and discussion of leadership scenarios (as described by Drs. Khoo and Teo) and (2) the implementation of high-fidelity interpersonal simulations as part of ongoing physician training.

Developing context-specific leadership scenarios[2] and engaging senior, junior, and future physicians in robust discussions about what could be done to address them provides a forum not only for exchanging ideas about how to apply management concepts but also for reinforcing the importance of these skills as an accepted responsibility of medical practice. Moreover, in-depth simulations involving the application of management skills (e.g., deploying effective interpersonal skills with colleagues) present a relatively consequence-free environment in which to experiment with different leadership strategies, whether among junior residents or even department chairs,[3,4] and can provide physicians with the types of disorienting dilemmas Drs. Khoo and Teo highlight as the impetus for transformational learning.

Disclosures: C.G. Myers served as a visiting Education Overseas Expert for the National Healthcare Group in Singapore in July 2017.

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The Daunting Career of the Physician–Investigator: Don't Blame It on the EMR

To the Editor: In "The Daunting Career of the Physician–Investigator,"[1] Dr. McKinney provides an excellent overview of factors threatening research careers among physicians. Nevertheless, in discussing specific burdens of clinical practice, he places an inordinate and misdirected emphasis on the electronic medical record (EMR). As groups such as the American College of Physicians[2,3] and the American Medical Informatics Association[4,5] have described, many burdens commonly attributed to EMRs are actually due to other administrative demands in the EMR era. These include, but are not limited to, meaningful use requirements, quality reporting, and utilization review requests. The documentation required for Evaluation and Management (E&M) codes has always been problematic; however, this requirement has had an increasingly negative impact on charting time and note clarity as academic medical centers have increasingly focused on productivity metrics. Like all academic clinicians, physician–investigators are affected by this excessive emphasis on relative value units (i.e., RVUs), the onerous nature of E&M coding, and the burgeoning number of uncompensated administrative demands. Addressing these negative influences on clinical practice would allow EMRs to enhance physician–investigator careers by focusing on improving care, streamlining clinician workflow, and fostering research.

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