
EHR Workflow Friction: Why Trained Clinicians Still Get Stuck at the Point of Care

Key Highlights

- A clinician who knows the EHR can still lose half an hour on a task that should take a minute, when the local workflow isn't clear inside the system. Knowing the software and doing your job in it are different things.
- Vendor EHR training teaches the system well, but it's generic, usually delivered in English, and recorded in a reference environment that isn't your hospital. The gap to your actual workflow is where daily friction lives.
- Physicians already spend close to two hours in the EHR for every hour of direct patient care (Sinsky, Annals of Internal Medicine, 2016). Every search-and-ask detour adds to that load, and to the queue of patients behind it.
- In-app guidance and in-app search close the gap by putting the right step, and the right local work instruction, inside the live system at the moment of need, without the clinician leaving the screen.

A one-minute task that took half an hour

Picture a routine follow-up in an outpatient dermatology clinic. The clinician needs to raise a lab order and print a specimen label for a urine culture. It should take under a minute. Instead, the right path in the [EHR](#) isn't obvious. A colleague is asked, then a second, and the two of them look at the screen and suggest different routes. Two doctors are called during the busiest clinic hours; the patient sits on hold for the best part of ten minutes. Close to half an hour later a form and a label finally print, and the sample can go to the lab, where the actual collection takes a few minutes.

This isn't a story about people who didn't try. Everyone in it was competent and doing their best. The problem sat in the space between the system and the work: a common step that no one could reliably find, with no clear support at the moment it was needed. That pattern repeats across outpatient departments every day, and it's rarely counted as a cost because no single instance looks like one.

Knowing the system is not the same as doing the job

It's tempting to read a scene like that as a training failure. Usually it isn't, at least not in the way people assume.

EHR vendors provide capable training. It teaches the functionality of the system thoroughly, and it's organised by role: inpatient clinical users, outpatient clinic staff, scheduling, the emergency department, and so on. But that training is generic by design. It's typically recorded in a reference environment that isn't configured like your hospital, often in a single language, and it teaches the software rather than your local process. Hospitals know this, which is why they build their own work instructions and run their own classroom sessions on top.

The gap that remains is the important one. A clinician can finish vendor training able to explain the system and still not know the exact path your organisation uses to order a urine culture and print its label, because that path depends on local configuration, policy, and workflow. Knowing the EHR in general does not tell you how to do your specific job in this build of it. That gap is where friction like the half-hour lab order comes from, and no amount of generic content closes it.

What that half-hour costs

Clinical staff time is the most expensive resource a hospital has, and this kind of friction spends it in several directions at once. The clinic runs late. Interruptions pull two, three, four other people off their own tasks to help. A doctor is taken off patient care to answer a phone call about a menu path. The patient waits, uncertain, for something that should have been routine.

None of that shows up as a line item, which is exactly why it persists. But it compounds. Physicians already spend nearly two hours on the EHR and desk work for every hour of direct patient care, a figure established by Sinsky and colleagues in *Annals of Internal Medicine* (2016) and still borne out by the AMA's 2024 data, which puts EHR time at roughly six of every eight scheduled hours. Every search-and-ask detour is added on top of an already heavy load, and it lands during the exact hours the department can least absorb it.

There's a workforce cost too. The KLAS Arch Collaborative, drawing on more than 500,000 clinicians, found a 90-point gap in EHR experience between clinicians who feel well prepared and those who don't, and links that experience directly to burnout and to whether people stay. Friction that makes clinicians feel deskilled at their own workstation is not a minor irritation. It wears on the people you most need to keep. We put figures on that wider cost in our [companion post on the](#) real cost of poor EHR adoption.

See how healthcare organisations close the gap between EHR training and daily practice.

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Closing the gap at the point of care

The fix isn't more generic training. It's support that lives where the work happens, in the local workflow, at the moment a clinician is stuck.

In-app guidance is the first piece. [Assima Assist](#) sits inside the live EHR and walks a clinician through the specific local path, step by step and role by role, at the point of need. The half-hour

lab order becomes a short, guided sequence the clinician completes without leaving the screen, calling a colleague, or pulling a doctor off care.

In-app search is the second. [Assima In-App Search](#) surfaces your hospital's own work instruction for a task from directly within the application, so the answer to "how do we order this here" is one search away rather than four phone calls away. The knowledge already exists in most hospitals. The problem is that it's rarely reachable at the moment and place it's needed.

Behind both, simulation builds the competence that makes the guidance stick. Assima Train lets staff rehearse the real local workflow on a hyper-realistic, anonymised copy of the EHR before they ever do it with a patient in front of them, so the first live attempt isn't the first attempt at all. Guidance handles the moment; practice builds the confidence that reduces how often the moment arrives. It is the complement to strong preparation before go-live, which we cover in our post on the [biggest EHR adoption problems in hospitals](#): training builds the capability, and point-of-care support carries it into the daily work.

The target is straightforward: first-time-right for these everyday tasks, without the clinician leaving the system or interrupting anyone else.

Conclusion

The half-hour lab order wasn't caused by staff who couldn't be bothered, or by training that never happened. It came from the gap between knowing a system in general and performing a specific task in a specific build of it, with no support at the point of need. That gap is where a large share of everyday EHR cost hides, spread thinly across thousands of small moments that never get counted.

Close it in the flow of work, with guidance and searchable local instructions inside the live system and [realistic practice](#) beforehand, and the one-minute task takes one minute. That's not a small win when it happens dozens of times a day, in every clinic, on the most expensive time a hospital has.

See it on your own systems. Book a demo and we will show you how Assima turns your live EHR into hands-on practice and point-of-need guidance