Table 1: Consolidated affinity diagram

Main category	2nd level category	3rd level category	Affinity notes
I. Technology	a. The microscope is a valuable tool in making diagnoses	i. I like the freedom and flexibility to choose the order of slides I review during case examination	1. I "jump" to the next level if I see something just starting to appear in the slides.
			2. I do not always follow the slide order; sometimes I "jump" to a particular stain.
			3. Some pathologists review slides in a sequential order.
		ii. The optical microscope can accommodate different types of slides and stains	1. Pathologist turned up light to see nucleoli better.
			2. Pathologist navigates more slowly on live frozen sections.
			3. *Breakdown: fresh slides are wet and may stick to the microscope.*
		iii. The microscope is a manual and an adjustable tool: either hand can be used to manipulate each function	1. One pathologist used the left hand to navigate and switch magnifications and the right hand to focus.
			2. Another pathologist used the right hand to navigate.
		iv. I look at a field of view, get relevant information, and move on	1. Jerky movements of slide provide overlapping still frames.
		v. I am aware that the slice of tissue placed on a slide represents a two-dimensional sample of a three dimensional structure	1. I can order deeper levels to get a better overview of the whole specimen.
		vi. Confirming the microscope is set up for maximum efficiency can save me time throughout the day	1. I start my day by par-focaling the microscope to ensure that switching magnifications will require less time for focusing the microscope throughout the day.
	b. The APLIS affects my workflow	i. The APLIS is a source of many breakdowns	1. *Breakdown: APLIS crashes and everything must be hand-written.*
			2. If the APLIS crashes I write all my notes on the working draft/ requisition, and type them into the APLIS later.
			3. *Breakdown: I wasn't able to enter a desired tissue code after I signed out a case.*
			4. *Breakdown: "Final complete" status was neither final nor complete.*
			5. *Breakdown: APLIS can't access a case if someone else has it open.*
			6. *Breakdown: APLIS crashed the night before so the fellow wasn't able to finish typing up the case.*

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Table 1: (*Contd...*)

Main category	2nd level category	3rd level category	Affinity notes
			7. *Breakdown: APLIS update breaks image support so I can't view gross images taken by the pathology assistant.*
II. Communication	a. The final report reflects my professional skills	i. My reports should have a professional look and feel	1. Formatting on the final report is important for reliability and professionalism.
			2. *Breakdown: Text decoration sometimes needs to be done by the pathologist.*
			3. I follow an existing protocol for dictation.
			4. *Breakdown: Formatting issue- white space and tab conversions are not consistent.*
		ii. I often need to correct errors and provide final edits to the report prior to sign-out	1. Spell check is used frequently.
			2. Sometimes transcriptionists catch my mistakes.
			3. One user did n't like report formatting done by a transcriptionist so he changed it.
			4. When double-checking my case before sign-out, I pay particular attention to voice recognition errors.
	b. I am aware that the words that I use in my final report will affect others	i. I am aware that the content of my final report significantly impacts patient treatment	1. Key words in the "comment" field trigger predictable actions by clinicians.
			2. Patient's age is an important factor while considering treatment options.
			3. Sometimes I want to ensure a specific treatment by using certain language in my report.
		ii. For cases that may be potential legal cases it is helpful to use proven "veteran" wording	1. Pathologist used an expert pathologist's template to report potentially tricky legal cases. [x2]
	c. Creating a final report is a complex process	i. Input of data into the APLIS can be tricky	1. *Breakdown: Weak typing skills can slow down the pathologist.*
			2. *Breakdown: Sometimes when dictating, the barcode reader doesn't work and I have to type it in.*
			3. *Breakdown: Tabs- they do not work between systems*
			4. *Breakdown: It is difficult to include images in reports; I'd do it if it was easier. [x3]*
		ii. I have flexible options in reporting	1. If pending stains exist, the decision to either sign out the case or create an addendum depends on patient treatment options.

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Table 1: (*Contd...*)

Main category	2nd level category	3rd level category	Affinity notes
			2. Addendums are also issued to address specific questions from clinicians. 3. Wrote unsure provisional diagnosis in a different part of working draft. 4. On some cases a provisional report is issued as a best guess. 5. If I include images in my final report, the images are not included in faxed reports. However, these reports are also printed and sent via regular mail with the images included. 6. Design idea: Future reporting modalities could include text pagers, text messages, or email.
		iii. Quantitative data provides additional data to case interpretation	1. I often need to measure and document objects for the final report. 2. I can estimate the size of Structures by knowing the microscope field of view size at different magnifications.
		iv. Complex diagnoses are complex to report- it is difficult to remember all items that should be included in a report	1. *Breakdown: Forgot to do Fuhrman nuclear grade.* 2. *Breakdown: While dictating, the pathologist couldn't remember part of a case; had to reexamine slide.*
	d. Until a case is signed-out it is a work in progress	i. Upon sign-out the case becomes an official part of the medical record	1. Once a case is electronically signed out, it is immediately added (automatically) to the EMR and is faxed to the clinician. 2. One user dictates in batches, then he signs out all his cases at night or the following morning. 3. Sign-out can be conducted in batches or "on the fly." 4. One user would conduct batch sign-out if he had resident help. 5. One user dictates one case at a time and signs out in batches.
		ii. I have to ensure that the document contains certain features/information	1. All intradepartmental consults are memorialized in two places. 2. Input of tissue code helps provide the pathologist with legal protection. 3. Accuracy in coding is important because it affects billing.

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Table 1: (*Contd...*)

Main category	2nd level category	3rd level category	Affinity notes
			4. All stains must be mentioned in the comment for billing purposes 5. A comment is added to document - additional tissue was submitted. 6. If I speak with a clinician about a case I document this action in the comment. 7. If I show the case to another pathologist for QA purposes, I document it in both the comment and the APLIS QA tab.
		iii. The working draft helps me organize my thoughts about a case	1. Pathologist manually writes rough outline of report on working draft; the pathologist uses the draft later to double check against his final diagnosis during sign-out. [x4] 2. The working draft had a checklist, but it was not used. 3. Writes pending stains on working draft with an open checkbox checked when received. 4. *Breakdown: Forgot to write the ordered stain on working draft.* 5. *Breakdown: Ran out of writing space on working draft; had to use back of paper.* 6. Wrote a question mark on front of notes (instead of behind) on working draft. 7. I like to write very detailed notes on my marking draft to help with dictation.
	e. To reach a conclusion about the case as a whole, findings on the slides need to be aggregated	i. I like to annotate slides to help remind me of important findings to include in my final report	1. *Breakdown: Changes in annotation are messy and hard to read.* 2. One user wrote "PIN" (prostatic intraepithelial neoplasia) on a slide and circled the gland. 3. I double-underline especially important findings. 4. Annotates margins of cancer to help calculate tumor volume. 5. Annotates presence of carcinoma, demarcates margins, grades, and # of positive lymph. 6. User transcribed from slide annotation to working draft.
		ii. I also annotate slides for other reasons	1. Annotations save time for future reviewers of the case.

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Main category	2nd level category	3rd level category	Affinity notes
			2. I use a sharpie to orient myself on 2 slides that originated from the same tissue but were stained with different stains. 3. I annotate my slides by dotting important findings so that I can easily return to the key features on a slide. 4. Sometimes he also puts an "X" annotation on label instead of glass to mark presence of cancer. 5. *Breakdown: Annotation circle gets in the way of examining a slide.*
		iii. I need to quickly re-familiarize myself with a case when I reexamine it	1. I visually recognize a case without a microscope by the shape of the tissue. [x2] 2. If interrupted, I use a flipped or out of place slide to mark progress. 3. I flip the last slide on a tray to indicate that I have completed reviewing all slides in the tray. 4. A quick glance at the case package provides a quick recall of previously examined cases. 5. *Breakdown: Pathologist couldn't remember if a stain had been ordered.* 6. I type in personal memos to help me remember a case when I revisit it.
	f. A quick turnaround time (TAT) is key to maintaining good relationship with clinicians	i. We try to ensure we provide a rapid TAT	1. "I am not as concerned about TAT as other pathologists." 2. Kidney biopsies require a phone call to clinician for preliminary results because the IF component takes much longer than the H&E component. 3. I generally look at older cases first, before new cases. 4. "Difficult biopsies kill TAT". 5. TAT is an important measure of service quality. 6. I try to do quick biopsy cases first to shorten my overall TAT.
		ii. Workflows in the histology lab and grossing station may affect my workflow	1. I am more willing to order additional stains if a case is already delayed due to other reasons. 2. On this particular service, the first slides come out at around 1. am.

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Table 1: (*Contd...*)

Main category	2nd level category	3rd level category	Affinity notes
			3. I need to be mindful of the cutoff time for ordering certain stains. 4. Cutoff time (for the PA's) to submit additional tissue is 4 pm. 5. IHCs usually arrive a day later, depending on the time of order. 6. If I am waiting for a non-essential stain, I can sign out the case first, then issue an addendum to the case in order to provide a shorter TAT.
	g. We try to confirm that we provide accurate and complete diagnoses	i. In contrast to other fields in medicine we have the ability to conduct quick consults	1. We show all 1st time cancer diagnoses or cases that will require another procedure to another pathologist. 2. QA is mandated on a certain percentage of cases. 3. It is common to "curbside consult" another pathologist for unusual or tricky cases. 4. I can ask another pathologist to take over a case if it's more appropriate.
		ii. Sometimes I use references to help me analyze a case	1. *Breakdown: Pathologist couldn't remember the abbreviation for a stain.* 2. I use Immunoquery, an online database, to help identify patterns in IHC staining.
		iii. I am wary that mental fatigue can affect my performance	1. Pathologist is wary of mental fatigue and how it limits diagnostic capability. 2. Some cases have greater than 60 slides. 3. On some cases I alternate between stains to break up the monotony. 4. On multi-part cases I review the "easy" parts first to get them out of the way before I tackle the more complex parts. 5. Sometimes I hold pending cases for the next day because I'm too tired. 6. On cervical biopsies I have to be careful not to focus on epithelium (I might miss the glands).
		iv. Pathologists need to have self-confidence in their professional abilities	1. If you are a good pathologist you should not second guess yourself too much.
		v. I am aware that misdiagnoses can result not only in patient harm but also in lawsuits	1. Melanocytic lesions are a litigious area in medicine.

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Main category	2nd level category	3rd level category	Affinity notes
			2. Although sometimes additional sections and slides may not offer additional information they do offer peace of mind that the pathologist did not miss something. 3. If any changes to the final diagnosis are required, I need to create an amendment. 4. We try to avoid amendments but sometimes they occur. 5. Amendments trigger a long chain of events that need to be documented.
III. Synthesis/ preparation	a. I need to have reliable support staff	i. I depend on the histology lab for timely delivery of slides	1. The histo lab pages me with "555" if new slides are delivered to a resident. 2. The histo lab pages me with "333" if new slides are available to be viewed.
		ii. I expect the histology lab to provide high quality slides	1. *Breakdown: Poor histology work could cause delays if additional recuts or levels are needed.* 2. I only look at negative controls when the possibility of over-staining exists. 3. A stain failed and I had to wait another day to repeat it. 4. *Breakdown: I had to remove a big blob of paraffin present on a slide.*
		iii. The histology lab follows standard protocols that increase my ability to trust their workflow	1. Pathologists must be able to adapt to various qualities of specimen preparations at the histology. 2. IHC stains are performed at another hospital. 3. Generally, simultaneous orders for additional stains that include related stain types will be distributed together. 4. *Breakdown: Sometimes labs don't follow protocols.* 5. Each slide usually carries two tissue sections per block; the section closer to the label is always the first level.
		iv. I depend on pathology assistants in the gross room to properly submit the specimen to histology	1. The lab follows a standard inking protocol for cervical cone biopsies. 2. The gross room follows a protocol that allows a maximum of three sections per block [x2].

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Table 1: (*Contd...*)

Main category	2nd level category	3rd level category	Affinity notes
			3. Cervical cone specimens are usually oriented in a clockwise fashion.
		v. I depend on pathology assistants in the gross room to properly sample the specimen to ensure that I receive a good representation of the tissue in the slides	1. I use a gross request form to order additional tissue to be cut and stained.
			2. *Breakdown: The pathologist expected to see a slide based on the type of specimen, but the pathology assistant didn't prepare as many sections as the pathologist was accustomed to.*
			3. When in doubt, I have the pathology assistant submit the entire specimen
			4. Sometimes submitting the remainder of the specimen can create a lot more work for the pathology assistant, histotech, and the pathologist.
		vi. I depend on the pathology assistant in the gross room to properly document and dictate the grossing process	1. *Breakdown: I wanted to be more specific about orientation in my dictation, but I was limited by the gross description and specimen.*
			2. *Breakdown: If there is a discrepancy between what I see on a slide and what I read in the gross description, I might need to look at the actual specimen.*
			3. When additional tissue is submitted, the pathology assistant appends this information to the original gross dictation for documentation.
		vii. Having a trainee on service changes my workflow	1. *Breakdown: Pathologist interrupted by phone call because resident didn't preemptively call on an important case.*
			2. The fellow tracks the stains-stains that already arrived and stains that are pending.
	b. Tissue is stained with different stains to highlight different morphologies	i. H and E stains are the gold standard	1. Pathologists often returned to H & E-stained slides to revisit ROI seen on IHC-stained slides.
		ii. IHC stains are specific stains based on an antigen–antibody–chromogen reaction	1. IHC stains include red or brown chromogens. However, in dermpath the red chromogen is used more frequently to prevent confusion with pigments in the skin that are naturally brown.

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Main category	2nd level category	3rd level category	Affinity notes
			2. For melanocytes, IHCs are used to help visualize the distribution of melanocytes in the dermis. 3. Hundreds to thousands of IHC and special stains are available to the pathologist. 4. Occasionally a standard panel of stains is ordered to rule out a specific type of tumor (lymphoma). 5. Often IHC stains provide indications of normal morphologies as well as abnormal morphologies.
	c. I perform many routine double checking	i. I am responsible for errors conducted by my histotechnologists	1. I had to fix an item in the report mislabeled at the time of accession. 2. I count slides at the end of a case and cross check this number with the gross description to see if any slides are missing. [x2] 3. Before I sign-out a case I always double check the clinician and patient names 4. I check the backside of the first slide and also random slides for labeling errors. [x2]
		ii. I consistently verify information to prevent errors	1. Double-checked patient name in email with the patient name in APLIS to confirm it is the right patient. 2. *Breakdown: Label tissue mismatch causes uncertainty.*
iv. Organization	a. Efficient management of ongoing case workload is a critical part of my workflow	i. I need to have a system to help track and organize my cases	1. I match accession numbers on the slide label to paperwork and the APLIS. 2. I retrieve a list of my cases by clicking on a work list. 3. *Breakdown: Pathologist ordered additional levels; upon arrival slides from an old case were mixed with the new slides.* 4. *Breakdown: Biopsy slides were mixed with surgical slides.* 5. One pathologist relied on the overdue list to inform him about cases that were not completed. 6. *Breakdown: Paperwork and slides were not delivered at the same order.*
	b. I like to sort and organize my cases by the function I need to perform	i. It is easy to lose track of slides, trays, and cases	1. *Breakdown: Sometimes I intend to revisit interesting case but slides were already filed.*

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Main category	2nd level category	3rd level category	Affinity notes
			2. *Breakdown: Forgot the reason slides were displaced from a tray.* 3. *Breakdown: Sometimes cases are lost underneath a stack of papers.* 4. "I had several IF cases on my desk in the morning, I wasn't sure if they were signed out yet or not so I had to check". 5. *Breakdown: Many miscellaneous "orphan" slides are available.*
		ii. It is difficult to track case status	1. *Breakdown: Pathologist had difficulty determining the status of a STAT case.* 2. Once I sign out a case, it's gone from my queue (no easy way to see cases I signed out). 3. Requests for additional stains are typically delivered as several cases per tray. However, when matched up they become 1 case per tray, not really put in order. 4. *Breakdown: When multiple different additional stains are ordered on a case, the additional slides may arrive at different times of day and on different days; this can become confusing.* 5. *Breakdown: If additional stains do not arrive cases may be left unnoticed in the pending pile until they show up in the overdue list.*
		iii. It is difficult to track stain status	1. Status of pending stains is important to case management. 2. *Breakdown: There is no quick way to check stain status, but it is a necessary and common task.* 3. *Breakdown: There are always lots of orphans slides without a case, lying around.* 4. *Breakdown: I thought I ordered stains; when they didn't come I checked and realized I never ordered them.*
		iv. I often organize cases in trays and piles in an order that is practical to me	1. I have different piles of case trays for different statuses (pending sign-out, stains, etc.) 2. I set aside cases for intradepartmental consultation into a pile. 3. If I check the "hold" box it puts the case at the end of my queue. 4. I like to group trays into the following piles- pending stains and tests, consults, and "show other people".

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Table 1: (*Contd...*)

Main category	2nd level category	3rd level category	Affinity notes
			5. I keep my pending cases under the table.
	c. I like to estimate my daily workload	i. I like to know my day's workload	1. I want to finish certain things before lunch. 2. At 11:00 AM the "lunch train" arrives.
	d. I like to prioritize my cases	i. Some cases are more important than others	1. An orange post-it wrote on slide tray indicates STAT case (greater importance).[x2] 2. Categorize cases by clinician, complexity and difficulty, and type of specimen. 3. STAT cases usually result in an immediate phone call to clinician after examination of case. 4. I might have to quickly look at a few slides to decide importance of a case. 5. I prioritize cases by biopsy / surgical and also by cases I might get called about.
	e. My day's workload may be determined by the service or surgical pathology "bench" I am assigned for that day	i. Different benches have different responsibilities	1. When I am on GYN bigs (15-30 cases) I rotate between frozen sections and sign-out. 2. When I am assigned to GYN quicks I have more cases but each case has less tissue and fewer slides. These (GYN quicks) are usually biopsies as opposed to resections.
	f. like to "get a feel" for the day's workload so I can plan effectively	i. The accession list is a useful summary of my day's cases	1. The accession list is a useful resource for estimating the total number of cases and for segmenting/sorting the cases. 2. First thing in the morning I check the accession list and the overdue list. 3. Sometimes I need to match cytologies with corresponding surgical. 4. *Breakdown: Cytologies don't always match with surgical.* 5. *Breakdown: Sometimes a long accession list can be too cumbersome to use.* 6. On a busy day on the dermatopathology bench I may have 90+ cases.
V. Workflow	a. I like to understand the context of a case when I start to review it	i. I rely on the clinician to provide clinical history	1. One pathologist contacts a clinician via e-mail to request additional clinical history. 2. In bladder biopsies it is useful to see the urologist's cystoscopy report.

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Main category	2nd level category	3rd level category	Affinity notes
			3. *Breakdown: I Might have to call clinician if I can't read their hand writing on the requisition sheet.*
			4. I web-page residents when I need to talk to them about a case.
			5. *Breakdown: Sometimes the surgeon doesn't orient the specimen well.*
			6. *Breakdown: "This surgeon is driving me crazy; he mislabeled this part as ovary."*
		ii. The APLIS is an important source of information	1. Sometimes I read the gross description for context. [x3]
			2. Paper working drafts printed from CoPath are associated with the slides.
			3. *Breakdown: I have to go to too many different tabs in CoPath to get the information that I want.*
			4. Pathologists frequently revisit case information during slide examination.
		iii. Clinical information is key to case interpretation; however, depending on the information source, the clinical information may need to be filtered	1. Resident/fellow delivers shortcut case information (from working draft) just prior to slide examination. [x2]
			2. The pathologist has a different comfort level for each clinicians and their provided clinical histories.
			3. Sometimes we rely on the hand-written requisition sheet rather than on the transcribed clinical history.
		iv. I aggregate data to make expectations of what to see on a slide	1. I like to create a hypothesis based on case specifics before I look at the slide. [x2]
	b. I am very skilled in quickly gleaning relevant information from glass slides	i. We obtain a lot of useful information at low magnification	1. Lower magnification identifies targets for examination on higher magnifications. [x2]
			2. Lower magnification used to put findings in context. [x2]
			3. Residents (less experienced) use higher magnifications and screen slides more slowly.
		ii. Looking for specific features on high magnification is sometimes like looking for a needle in a haystack	1. I spend lots of time at high magnifications (40×) looking for mitoses. [x2]
			2. I spend lots of time at high magnifications looking for invasion in melanomas.

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Table 1: (*Contd...*)

Main category	2nd level category	3rd level category	Affinity notes
			3. I spend lots of time at high magnifications searching for eosinophils.
			4. I go to 40× to see nucleoli and basal cells better.
		iii. I have a different approach for different specimen types	1. I go to 20× to get a better look at dysplasia on LEEP specimens.
			2. When I look for melanoma in a lymph node, I look for pigment using low magnification.
			3. Some cases provide more obvious data from the gross examination than from the microscopic examination. Magnification and navigation behavior depends on specimen type.
		iv. I use different approaches for different stains	1. Mindset during examination of IHC-stained slide is different from H & E-stained slides. In IHC, we are typically more concerned about a binary result (presence or absence of an antigen).
			2. Sometimes additional stains can be misleading.
			3. Sometimes even a large panel of stains does not provide the ability to determine the origin of a tumor.
			4. We keep a mental tally of the markers (i.e., IHC stains) expressed by the cell population of interest.
		v. Some sections of a slide provide more information	1. Pathologist spent significant amount of time with the dermoepidermal junction in the field of view.
			2. Pathologists seem to scan the edges of the tissue frequently. [x2]
		vi. Glancing at a slide without using a microscope also provides important information	1. *Breakdown: Only some slide labels have bar codes.*
			2. Amount of red vs blue stains in low magnification scans is important to me.
			3. Slides with IHC stains are labeled with a different barcode type (1D) applied on top of the original label.
	c. Looking at the slides in the slide tray helps me mentally organize a case	i. Organization of slides in a slide tray provides key information about the group of cases I am about to examine	1. *Breakdown: Occasionally, two slides are located in one slot, causing sorting confusion.*

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Main category	2nd level category	3rd level category	Affinity notes
			2. I like to separate between different parts placed in the tray; if there are more than ten slides per part, they might be doubled up. 3. I like to re-organize my slides by part at least. 4. In many practices cases are separated by a blank space on the tray. [x3]. 5. I typically get one slide per block, depending on the protocol. 6. On some cases the pathologist examined stains in groups, while in other cases she alternated IHC with H & E stains. 7. *Breakdown: "When I looked at the tray I got confused because the slides in the tray didn't seem to belong together."*
		ii. I get additional clinical history from the electronic medical record	1. For more complex resections, I review the surgeon's operation notes. 2. I like to know the last menstrual period for every endometrial biopsy. 3. *Breakdown: I have to retrieve data from the EMR when the provided clinical history is insufficient.* 4. Pathologist used PowerChart to obtain additional clinical history in more complicated resections (OP note, letter of correspondence, radiology consults). 5. Used PowerChart for 15% of large breast cases, 10% of large GYN cases.
		iii. Frequently reviewing slides of previous biopsies obtained from the patient is helpful	1. Sometimes I need to review slides from a previous related biopsy. [x2]
		iv. I like to organize my work in a certain order	1. I split work by patients (only 1 patient per tray). 2. Numerically and alphabetically orders trays and slides within trays.
		v. I presume that if no frozen section is available the surgeon is less concerned about this case	1. If there is no frozen section, the case is more likely to be benign.
	d. I treat incoming consults differently from my routine sign-out workflow	i. There are additional sources of information in a consult package	1. When reviewing a consult case I read the pathology report provided by the originating pathologist. [x2]

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			2. I like to check the originating clinician in a consult to see if I've had experience with him or her.
			3. I tend to make judgments about outside pathologists based on wording they use in a report.
		ii. There are different questions to answer when reporting on a consult	1. *Breakdown: Pathologist was confused about why a consult was being sent.*
		iii. Consults = examination of slides from outside histology labs	1. *Breakdown: Slides from different labs have subtle differences in staining and appearance.*
		iv. Final reports for consults have their own protocols for appearance	1. *Breakdown: Consults have non-standard part names.*
	e. I have additional professional responsibilities	i. Teaching is an important duty of pathologists	1. I got paged to help a pathology assistant with gross examination in the gross room.
			2. I am conscious of resident and fellows' time, so I review with them, for teaching purposes, key slides. However, I revisit the entire case on my own later.
		ii. Pathologists have laboratory administration duties	1. Examination and sign off on controls for IHC and other special stains is part of the pathologist's daily responsibilities.
	f. I like to save time while typing reports	i. Some reporting systems provide a voice recognition (VR) option	1. VR only works 60% of the time.
			2. Loading the VR profile takes a long time before I can actually start dictating
		ii. There are many things to remember to include in a final report	1. Synoptics are helpful in recognition vs. recall.
			2. Synoptics are used in some cancer diagnoses.
			3. Synoptics help standardize the reporting of some cancer diagnoses.
		iii. Macros can be helpful in automating repetitive tasks	1. Macros decrease mouse clicks, movements, typing, etc. for repetitive tasks.
			2. One macro takes the user from report editing to the ordering stains screen.
			3. One macro takes the user from accession number entry to report editing.
			4. *Breakdown: Quick texts are only helpful if I can remember the abbreviation.*
		iv. The report doesn't need to be completed all at once	1. I put placeholders in my dictation notes for things that need to be filled in later.