



Sample Job Description

(Please Note: This is an example only and many of the do's and dont's written below can be modified to fit your desired protocols)

The following is intended to be as a general overview of the job description for scribes provided by ScribeAmerica to assist the doctors of *Sample Medical Center, Sample, WA and Sample Medical Associates (SMA)*. In essence, the scribes will provide assistance with all the clerical activities inherent to doctors practicing emergency medicine in the emergency department setting. This assistance will be under the direct oversight and control of the emergency physician, where the emergency physician will review and approve actions to be taken at key junctures during patient care. As there is variation within each emergency department, the final job description and roles to be assumed by the scribe will be tailored respectively. The intention is to minimize the emergency physician's clerical functions while maximizing his/her clinical role, thus improving patient flow and satisfaction, under the physician's direct oversight and control.

- **Completion of the Medical Record by Scribes**

- HPI/Past Medical History/ROS/Medications/Social History/Family History/Allergies**

- SMA doctors should take the history as usual and Scribes may record only what is elicited by the doctor.

- Laboratory Results**

- SMA doctors should review lab results on printout sheets that come directly from the lab or within the ELECTRONIC MEDICAL RECORD system.

- Radiology Results**

- SMA doctors should review this data as usual, (either on the PACS system or directly from the radiologist depending on the study). SMA doctors, not Scribes, should enter preliminary radiology interpretations in the Radiology Discrepancy log.

- **Gathering Data**

Scribes may gather laboratory results, faxed radiology reports, medical records and other data for review by the EMA doctors. Data should not be entered into the ELECTRONIC MEDICAL RECORD chart or otherwise in the medical record until it has been reviewed by SMA doctors.

- **Communication**

RN-MD

Scribes may not give verbal orders or other patient care orders.

(“The doctor wants the patient to have 5 mg of morphine.”)

Scribes may communicate that orders have been written. (“The doctor wrote orders for the patient.” or, “the discharge paperwork is on the chart.”)

Telephone

Scribes can make and answer calls for the MD. Scribes may not take medical data, (radiology reports, lab values, etc.) over the phone.

Directly with the patient

Scribes may not give medical advice, communicate medical information or care plans of any kind directly with the patient or patient’s family/friends. Scribes can communicate waits and delays as directed by the RN or MD.

- **Direct Patient Care**

Scribes may not engage in any direct patient care such as direct patient contact, (e.g. lifting patients from backboard, transporting, or assisting in security issues.)

Scribes may not assist ED techs in their roles of cleaning wounds, applying splints, CPR, setting up suture trays or drawing blood.

Scribes may not bring patients food or water.

Scribes may bring patients blankets after asking an RN or MD.

- **Prescriptions**

Scribes may not have access the narcotic prescription blanks or lock box.

- **Disposition**

Scribes may print the depart process at the MD’s direction.

Scribes may not put depart paperwork on the chart without SMA Physicians review.

Scribes may not disposition patients.