



Meaningful Scut Work

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As the week came to a close Friday evening, I was leaving the office a little later than usual. I passed by the preceptor office and observed several of our residents still at work intently engaged with their computers. In years past when I was program director, I took some personal pride in passing the same room after hours and finding it full of our doctors in training chatting back and forth about unusual patient encounters, the stresses of residency, or the latest events of their lives. They stayed late because they were enjoying the opportunity to spend the extra time together. By contrast, the present group held expressions that clearly indicated they would prefer to be any place but where they were.

I looked around the room and realized that no one was talking, and no one was smiling. There was no sense of the camaraderie that filled this room in past years. The only relationship that mattered was the one between doctor and monitor. My disappointment must have been evident as the chief resident spontaneously explained, "It's all of these electronic record requirements."

This was the moment I first made the connection between the tedium of computerized health records and what I remembered from my own residency days as "scut work."

Thinking back to my quest to enter a family medicine residency that offered the optimal learning

environment back in the 1980s, I recalled that somewhere among the list of issues that made up my search priorities was the question of scut work. To what degree were interns and residents called upon to run through the hospital placing intravenous lines, drawing blood gases, completing difficult venipunctures, and providing other technical services as needed? My concern was based on the presumption that these tasks offered low educational value and were a potential distraction from the more important efforts related to actually managing patients and their illnesses. I remember at least a few programs that were ranked lower on my Match list simply because I judged that the scut work burden was too high.

Years later, as director of a family medicine residency, I noticed that questions related to scut work burden seemed to disappear from the interview process. With time, the issue of that classical scut work had faded as hospitals developed teams of highly skilled technicians to deftly handle everything from simple venipunctures to specialized testing. Applicants simply assumed that these services were provided by any quality hospital and indeed, they were.

I attempted to discuss these thoughts with the group of residents before me. The only response was a sarcastic quip from the chief resident: "Nature abhors a vacuum."

Of course, she was right. As the traditional scut work subsided, a new group of more ominous distractions was growing, hidden in the complex circuit boards that are at the heart of modern computers as well as in the minds of health care administrators. With the expansion of the scope of the electronic health record in both ambulatory and inpatient settings, residents are increasingly called upon to manage those systems at the expense of more scholarly activities. Instead of delicately searching for subtle veins of the forearm as a source of blood, residents now search a cornucopia of tabs on a computer screen hoping to identify the proper heading to draw upon needed information. Instead of inserting intravenous catheters into severely dehydrated patients, residents now insert lists of data points that support billing levels and required quality metrics. Instead of studying algorithms that guide the approach to complex clinical presentations, residents now must memorize specific electronic work flow patterns to navigate the correct path toward a completed encounter. Maintaining currency in medical knowledge now competes with maintaining currency with the regular updates of computer platforms used to maintain

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the electronic record, updates that occur at a dizzying frequency.

As I shared these ideas, the group seemed to get more animated and turned away from their keyboards. We accepted that these newer tasks have their place in the future health care landscape as potentially beneficial activities. Indeed, I pointed out that traditional scut work like drawing blood gases on patients was certainly important for the seriously ill individuals affected. But there was also agreement that such busy work remains a major distraction in the educational environment. Hours of precious and increasingly limited training time are now devoted to developing expertise with electronic health record systems, and then more hours are spent in applying that expertise in the care of patients on a daily basis. Further, the problem with much of this scut work is that what is learned is not generally applicable to a resident's future practice. No universal system presently exists and whatever efficiencies are developed during the residency will very likely need to be learned anew when graduates invariably move on to a different electronic platform.

I was gaining momentum. "Nothing about managing the electronic health record even feels like what a doctor should be doing," I said. It struck me that placing an intravenous line in a patient with difficult circulatory access at least included a sense of achieving something medical. Such activities also had the added benefit of bringing the resident into close contact with the patient. The electronic health system does precisely the opposite, sending them off to distant isolated cubicles to complete their required tasks.

The conversation quieted, and the residents turned back to their keyboards. I walked away, but my thoughts remained focused on clinical education. As we all scramble to meet a checklist of standards for meaningful use of the electronic health record, motivated by very modest incentives, we are challenged to achieve fluency in a completely new language. Familiarity with terms such as measure code lists, quality data set elements, core CQMs, menu objectives, and EPs has become an obligatory addition to the family medicine training experience.

Resisting the growing feelings of discouragement prompted by that late Friday encounter, I try to anticipate a time when meaningful use will go the way of traditional scut work and be lifted from the service responsibilities of physicians in training. We all look forward to the day when those complex circuits and programs advance to the point that they truly simplify a doctor's work and let him or her focus primarily on the task of actually managing patients and their illnesses. This is the hope I hold onto when I consider the intrusion of scut work into the ever-expanding educational needs of family medicine residents that must be satisfied in an already overfilled 3-year training period.

But then I remember the words of my chief resident. Nature abhors a vacuum.

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