James L. Holly, M.D.

Comments to Christus St. Elizabeth Medical Executive Committee
October 29, 2015
Five Minutes Allowed
By James L. Holly, MD

Thank you for allowing me to speak to you this morning. I have been given five minutes and will take no more.

From the level of activity and angst in the medical community today, you might think that some new and novel crisis has arisen, requiring the Medical Executive Committee (MEC) to pass new and dramatic rules and regulations.

The reality is that medical staffs are now only being asked to comply with long-standing, existing regulations and standards of care, such as:

1. Registered Nurses cannot practice medicine.
2. Licensed Vocational Nurses, while being valuable members of the healthcare team in the ambulatory setting; have no role in the inpatient environment.
3. The judgment of quality and safety of healthcare interventions are often measured by the documentation of the time, the date and the person providing that care.
   Requiring physicians to time, date and sign their inpatient work is not new and novel, but has been the standard of excellence since the 19th Century.
4. More than any other time in healthcare, team work is critical. As more and more demands are made on physicians, it will take a team to meet those demands.
   The limitation on team work is that each team member has responsibilities based on their training, knowledge, skill set, licensure, credentialing and privileges.
   While my medical license says that I can practice Medicine and Surgery, I am neither credentialed nor privileged to post a surgical case for an operation. No new rule is required by the MEC to administer that realty.
5. Registered Nurses are not credentialed or privileged to practice medicine, or to prescribe medicines. For the MEC to pass a medical staff regulation stating this is redundant and unnecessary.

For the MEC to define what "practicing medicine" means would be helpful. For instance, it is helpful for the MEC to clarify the governance of the collaboration of RNs as members of an inpatient healthcare team.

RNs can:

a. Independently, **complete** a Review of System, a Family, Social, Surgical and Medical History, Past Medical History, Immunizations, Screening and Preventive health history.
b. **Compile** from an electronic medical record, the patient's chronic problem list, immunizations, and laboratory results from the ambulatory setting.
c. Serve as a **liaison and facilitator** between the attending physician and the hospital staff to communicate physician orders to staff nurses, making certain that these orders are communicated by the RN but with the overt declaration that they originated with the physician who is named with the order.
d. Serve as a **scribe** to complete electronically, in an EMR, or to dictate for transcription, a H&P, plan of care, orders and/or a treatment plan established by the physician verbally, in writing or electronically prior to the scribing being done.
e. Serve as a **scribe** to complete the Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan (formerly called a Discharge Summary) once the physician has seen the patient.

There are strange and new things which physicians face; things such as:

1. CPOE
2. Core Measures
3. HCAPHS
4. Quality Metrics
5. Meaningful Use
6. Pay for Performance

These are the new realities of healthcare and each imposes upon physicians new responsibilities. If physicians demand and continue to receive the right to lead healthcare, they must recognize these realties and accept the responsibilities which those realities impose upon us. We can complain; we can refuse, but ultimately, we will change, or we will be passed by. And, rude, hostile, profane and unprofessional conduct toward any member of the healthcare team must not be tolerated.

What is needed from the MEC is not a new rule saying that RNs cannot practice medicine but what is needed is for the MEC **not** to pass new regulations which effectively remove RNs from the inpatient healthcare team.

What we need are:

1. Specific definitions which accurately reflect the Texas Nursing Board's and the Texas Nursing Association's definition and description of the RNs Scope of Practice, which is very broad. (see the Appendix A)

2. Specific descriptions of CMS requirements – and this will change – which infer that RNs cannot independently complete the patient's Chief Compliant and the History of Present Illness, as these are currently defined by CMS as acts of "practicing medicine."
   And, let us say repeatedly, hospitals and physician do not need to live in fear of CMS. Just as SETMA confronted and helped change the Joint Commission's attitude and culture, together we can confront and change CMS, even the enforcement division.

3. The resolve by the MEC to require the medical staff to follow these simple rules, which are not new, but which have previously been ignored by the MEC and by hospital administrations.

4. The resolve on the part of the MEC and the hospital administrations to discipline physician who refuse to cooperate or who behave unprofessionally.

As you deliberate today, don't feel compelled to answer questions no one is asking , such as, "Nurses cannot practice medicine," and don't fall into the trap of limiting creativity and innovation, thus stifling healthcare transformation, by inadvertently dismantling high functioning and highly effective healthcare teams.

I am happy to answer any questions you may have for me.

Thank you

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Appendix A
Nursing Scope of Practice

Link to **Open Letter to the MEC at Baptist and Christus**: http://www.jameslhollymd.com/Letters/an-open- letter-to-the-medical-executive-committees-of-baptist-southeast-texas-hospital-and-christus-st-elizabeth- hospital#9. The below is taken directly from the above link. The below also includes the link to the letter from the Attorney of the Texas Board of Nursing in the first paragraph below which is quoted verbatim. And, the below includes information from other official documents of the Board.

Letter from General Counsel of the Texas Board of Nursing - May 6, 2013

The Texas Board of Nursing and the Texas Nursing Association do not and will not provide an advisory directory as to whether or not a certain practice is within the Scope of Practice of RNs in Texas. (reference http://www.jameslhollymd.com/Letters/pdfs/Texas-Board-of-Nursing.pdf)
From this letter the following is taken directly:

> "The Nurses Practice Act's description of an RN's scope of practice, and the **Six-Step Decision-Making Model for Determining Nursing Scope** of practice should provide…a good understanding of the Board of Nursing's position on an RN's scope of practice….The NPA and The Board of ***Nursing Rules and Regulations are written broadly so that every nurse may be able to apply tem to his or her own practice setting. The Board of Nursing does not have a list of tasks that a nurse can or cannot perform, because each nurse has a different practice setting, background, knowledge base, and level of competence. Nurses must use his or her best judgment when deciding how to verify physician orders; whether they should administer a medication or perform other tasks.***" (Emphasis added)

The following is the Texas NPA's description of the RN's Scope of Practice:

The **Texas Nursing Practice Act** (TNPA) and the official, board-endorsed **Position Statements** which expand the description of the RN Scope of Practice, leaves many questions not addressed clearly. The position statements on RNs carrying out order from CFNPs and PAs are helpful. It would be very helpful if the Board spoke officially on hospital staff nurses ability to receive orders from a hospital-credentialed RN who is employed by a physician when that order originates with a physician who is on the staff of the hospital. No one is asking for RNs to diagnose medical problems or to prescribe therapeutic or corrective measures. Nothing being done by the RNs employed by SETMA violates these rules.

> "The professional registered nurse is an advocate for the patient and the patient's family, and promotes safety by practicing within the NPA and the BON Rules and Regulations. The RN provides nursing services that require substantial specialized judgment and skill. The planning and delivery of professional nursing care is based on knowledge and

application of the principles of biological, physical and social science as acquired by a completed course of study in an approved school of professional nursing. Unless licensed as an advanced practice registered nurse, **the RN scope of practice does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures**. RNs utilize the nursing process to establish the plan of care in which nursing services are delivered to patients. The level and impact of the nursing process differs between the RN and LVN as well as between the different levels of RN education." (Emphasis added)

The *Six-Step Decision-Making Model for Determining Nursing Scope of Practice* does not indicate that SETMA's deployment of RNs on our hospital team violates any element of the TNA.

- The verbal transition of an order from a physician via an RN to a hospital-staff RN does not represent an "act of medical diagnosis or a prescription of therapeutic or corrective measure" by an RN.
- Because we are now working in an environment at SETMA where the continuum of care patient record is available at ALL points of care, the RN's placement of the diagnoses and plan of care and orders into a formal electronic document based on documentation by a SETMA or an ER physician's assessment and instructions, does not represent the "medical diagnosis or prescription of therapeutic or corrective measures."
- And, because the Hospital Care Summary and the Post Hospital Plan of Care and Treatment Plan (previously called the "Discharge Summary") is a product of the hospital record and of verbal and electronic huddles between the RN and the treating physician, this does not represent "medical diagnosis or prescription of therapeutic or correction measures" by the RN.

Appendix B

What does "to prescribe," or "prescribing," or a "prescription" mean?

To prescribe a medication or a treatment means to **initiate** (to start de novo), to **establish** (declare that a medication must be continued for a designated period of time), to **continue** (in a new care setting at a point of care transition) including the **name** of the medication (preferably generic name), the **dosage** of medicine, the **frequency** of dosage and the **route** of administration. Any change in any one of these elements represents prescribing of medication and can only be done by healthcare providers whose license allows such generally meaning a physician, a dentist, a podiatrist, a nurse practitioner and in some settings a pharmacist.

At each transition of care a reconciliation of medication must be completed – which includes from ambulatory setting to inpatient, from inpatient to ambulatory, from ambulatory care to the community, from NH to ambulatory setting, from NH to inpatient, from one inpatient unit to another inpatient unit, from inpatient facility to another inpatient facility, from inpatient to SNF, from inpatient to hospice, etc.