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Hospital Medical Staffs Being Asked to Comply with Recognized Standards
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Your Life Your Health
The Examiner
November 19, 2015

From the level of activity and angst in the medical community today, you might think that some new and novel crisis has arisen, requiring hospital medical staffs 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 hospital rule is required to administer that realty.
5. Registered Nurses are not credentialed or privileged to practice medicine, or to prescribe medicines. For hospitals to pass a medical staff regulation stating this is redundant and unnecessary.

For Hospital Medical Executive Committees (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.

It is generally recognized that 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 – Computer Physician Order Entry
2. Core Measures – a set of practice standards by which hospital care quality is judged.
3. HCAPHS – Hospital Consumer Assessment of Physician and Hospital Systems.
4. Quality Metrics – Standards of care for healthcare providers
5. Meaningful Use – Federal standards of care which physicians must meet in using electronic medical records.
6. Pay for Performance – a major change from healthcare providers being paid for how much care they provide, to being paid by how well the patient does.

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.

Hospitals and the Medical Executive Committees which monitor care in those hospitals should not feel compelled to answer questions no one is asking, such as, "Nurses cannot practice medicine," and they should not fall into the trap of limiting creativity and innovation, thus stifling healthcare transformation, by inadvertently dismantling high functioning and highly effective healthcare teams.

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

A beginning is to define what "prescribing medication" means. The following is one definition. 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.

Summary

Advances in healthcare are taking place every day. Sometimes those advances are achieved simply by affirming what has been being done, or at least what should have been being done for the past fifty years.