



Falls in the Acute Care Setting

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Falls are one of the most common adverse events leading to injury in hospitals (Krauss et al., 2007). Fall rates in acute care hospitals range from 2.3 to 13 falls per 1000 patient days. Falls are more common on geriatric units, followed by medical units and surgical units. Predictably, specialized units such as stroke rehabilitation units or geriatric psychiatric units have the highest rates of falls. The majority of these falls occur in patients aged 65 years and older (Mertens, Halfens, & Dasen, 2007). According to Lyons (2005), hospital units staffed with less experienced nurses have higher rates of falls than units staffed by more experienced nurses.

Reasons for falls include such factors as gait instability, altered mental state, urgency, incontinence, a history of falling, use of medications such as sedatives and hypnotics, use of restraints, slippery high-gloss floors with excessive glare, and an environment unfamiliar to an acutely ill person (Milisen et al., 2007). In the pediatric patient population, the reasons for falls differ (Razmus, Wilson, Smith, & Newman, 2006). Contributing factors include medication use, a new environment, and underlying medical conditions that can hinder orientation and understanding of children (Cooper & Nolt, 2007). Injuries from falls commonly occur because of developmental risks (Razmus et al., 2006), but as with adults, the pediatric patient also may attempt to get out of bed without help.

Certain activities are associated with falls. Krauss et al. (2007) report that 82% of hospital falls occur in the patient's room, 85% are unassisted, and 47% are associated with toileting-related

activities. Data from the Pennsylvania Patient Safety Reporting System (PA-PSRS) shows that 6.6% of falls occurred while the patient was ambulating, 5.7% while lying in bed, and 5.6% while toileting.

Approximately 30% to 40% of hospital falls result in injury. Estimates of the number of falls that result in minor injuries vary from 30% (Milisen et al., 2007) to 42% (Krauss et al., 2007). Milisen et al. (2007) estimate that 15% result in serious injury or death and Krauss et al. (2007) estimate this number



to be 8%. The types of injuries that result include scrapes, bruises, skin tears, and lacerations. More serious injuries such as concussion, subdural hematoma, and fractures such as hip and femur, also occur. Fractures, especially in the elderly population, can have a devastating effect

on the individual's health. Holloway (2006) reports that more than 24% die within a year of the fall and 50% never return to their prior level of functioning. The toll of falls includes more than physical injuries. Some consequences include fear of falling, social isolation, anxiety and depression, and loss of confidence (Milisen et al., 2007).

The cost to hospitals and patients is significant. The cost of treating serious fall-related injuries is between \$15,000 and \$30,000 per fall. This totals \$1.08 billion to hospitals annually to treat injuries sustained in falls. One estimate is that in the United States, the total number of falls resulting in injury will be over 17 million by the year 2020 at a projected cost of \$85.4 billion per year (Koh, Manias, Hutchinson, & Johnson, 2007). The costs do not include the recent revisions to the Diagnosis-Related Groups (DRGs) by the Centers for Medicare and Medicaid Services (CMS). Effective October, 2008, hospitals will not be reimbursed for some hospital acquired co-morbidities not present on admission, which includes fall-related injuries.

Clinical Implications

It is evident from the literature, that a clear definition of a fall is the first step in a fall prevention program. Lyons (2005) defines a fall as unintentionally coming to rest on the ground, floor, or other lower level from a standing, sitting, or horizontal position. Another definition distinguishes between assisted and unassisted falls. A patient fall is a "sudden unexpected descent from a standing, sitting or horizontal position, including slipping from a chair to the floor and an assisted fall (where an individual guides the falling individual to the floor), with or without injury to the patient (Cooper & Nolt, 2007).

The National Guideline Clearinghouse™ (NGC) is a public resource for evidence-based clinical practice guidelines. It is an initiative of the Agency for Healthcare Research and Quality (AHRQ), US Department of Health and Human Services (HHS). One guideline available is "Prevention of Falls and Fall Injuries in the Older Adult." This guideline was originally developed by a panel of nurses with expertise in falls prevention, education, and research, representing institutional, long-term care, and academic settings under the auspices of the Registered Nurses Association of Ontario (RNAO) and published in January 2002. An update published in March 2005 was developed by a panel of nurses and other healthcare professionals, from a range of practice settings and academic sectors, with expertise and interest in falls and fall injuries in the older populations convened by the RNAO.

The nurse practice recommendations supported by the strongest evidence include:

- ◆ Assessment of fall risk on admission.

- ◆ Assessment of fall risk after a fall.
- ◆ Strength training as a component of multi-factorial fall interventions; however, there is insufficient evidence to recommend it as a stand alone intervention.
- ◆ Multidisciplinary team, implementation of multi-factorial fall prevention interventions to prevent future falls.
- ◆ Periodic medication reviews throughout the institutional stay to prevent falls among the elderly in health care settings. Patients taking benzodiazepines, tricyclic antidepressants, selective serotonin-reuptake inhibitors, trazodone, or more than five medications should be identified as high risk.
- ◆ Consideration of the use of hip protectors to reduce hip fractures among those clients considered at high risk of fractures associated with falls; however, there is no evidence to support universal use of hip protectors among the elderly in health care settings.
- ◆ Inclusion environmental modifications as a component of fall prevention strategies.

These practice recommendations do not include the methodology for assessing fall risk. The evidence in the literature shows that the Morse Fall Scale (MFS) and Hendrich II Fall Risk Model (Hendrich II) are not effective in predicting falls in children (Rasmus et al., 2006). However, elements of the MFS were found to be predictive of falls and were used as part of a proposed new tool called the CHAMPS Pediatric Fall Risk Assessment Tool. The effectiveness of this tool has not been tested. The

Hendrich II was shown to predict falls effectively in adults (Hendrich, Bender, & Nyhuis, 2003). Many studies describe fall prevention strategies for all age groups. It is important for hospital staff to select effective strategies for preventing falls that consider both extrinsic and intrinsic factors. Nursing staff are key to a successful fall prevention program and all should be knowledgeable about fall prevention strategies and actively participate in the development, implementation and evaluation of a facility's fall assessment and prevention program.

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ARNP and PA Scope of Practice

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Frequently there are issues that arise concerning the scope of services that can be performed by a Physician Assistant ("PA") and Advanced Registered Nurse Practitioner ("ARNP"). While there is a wealth of existing laws governing PAs and ARNPs there is still some confusion and uncertainty as to what each provider is permitted to do. This article will be limited to a cursory overview of significant provisions as they relate to the supervision requirements of each practice but will suggest some resources that may be helpful should the reader want more information.

As a preliminary matter, the Boards of Medicine and Osteopathic Medicine have the authority to implement rules and discipline as they relate to PAs as they fall under the Medical Practice Act (458.347, Fla. Stat.) and the Osteopathic Medical Practice Act (459.022, Fla. Stat.), ARNPs are governed by the Board of Nursing (464.001, Fla. Stat.), though some provisions concerning the use of ARNPs do exist under the rules promulgated by the Board of Medicine. Additional regulations are set forth for PAs and ARNPs in chapter 64B8-30,

and chapter 64B9-4 of the Florida Administrative Code.

ARNPs

In June 2006, Governor Bush signed House Bill 699, which modified aspects of physician supervision of advanced registered nurse practitioners in the office setting. The law essentially limits the numbers of office sites where a physician may supervise ARNPs or PAs. However, there are several exceptions to this law, which do not apply to physicians supervising ARNPs employed in a licensed hospital or ambulatory surgical facility or working in conjunction with a college of medicine or nursing, an accredited graduate medical program or a nursing education program. The level of general physician supervision of ARNPs remains unchanged. The supervising physician must be available either in person or by communication devices, unless the protocol between the ARNP and the physician states otherwise. Under the "Standards for Protocols" in F.A.C. 64B9-4.010, the supervision must be appropriate for prudent health care providers under similar circumstances. ARNPs should remain mindful that the supervising physician is established through the written protocol **filed** with the Department of Health, which identifies the physician and the delegated medical acts which the ARNP may perform and is signed by both the ARNP and the supervising physician. Additionally, the new law now requires that the protocols must be reviewed by the Board of Nursing, with non-compliant individuals to be referred to the Department of Health.

Under Florida law, an ARNP shall only perform medical acts of diagnosis, treatment and operation pursuant to a protocol between the ARNP and a Florida-licensed medical doctor, os-

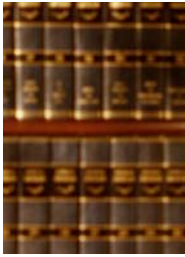
teopathic physician or dentist. The degree and method of supervision is to be determined by both parties and must be specifically identified in the written protocol. More specifically, the protocol should be appropriate for prudent health care providers under similar circumstances and general supervision by the physician or dentist is required, unless otherwise specified. As a rule, ARNPs do not have the authority in Florida to prescribe controlled substances.

In considering an appropriate protocol, Florida law requires a consideration of the following factors: risk to the patient, education, specialty and experience of the parties to the protocol, complexity and risk of the procedures, practice setting and availability of the physician or dentist. Parties to the protocol should consider the specific minimum terms which must be included in each protocol. These terms are fully discussed under 64B8-35.002, F.A.C. Once completed, the original of the protocol and notice must be filed with the Department on an annual basis, with a copy of the notice to be kept at the site of the practice of each party to the protocol. Any changes or amendments to the document must be filed with the Department within thirty (30) days of the alteration. Finally, even after the relationship is terminated, the protocol must be maintained for future purposes for a period of four (4) years.

PAs:

Physician assistants on the other hand, do not require any written protocols unless they are practicing in a health department setting. See 154.04(1)(c), Fla. Stat. On occasion, some insurance companies, hospitals, physicians or other entities may require protocols at their discretion. However, a PA must ensure that a Supervision Data Form is submitted to the Department of Health.

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Florida law requires that all records generated by a PA be countersigned by the physician within seven (7) days for the first six (6) months of employment and thereafter no less than every thirty (30) days. Practitioners working in hospitals are urged to ensure that the

hospital bylaws do not require countersignature in less time. Keep in mind that PAs cannot make a final diagnosis or interpret x-rays, lab studies or EKGs. The final diagnosis is made when a physician countersigns the medical record.

Under Florida law, a supervising physician shall delegate only tasks and procedures which are within the supervising physician's scope of practice, or those tasks and procedures which the supervising physician is qualified by training or experience to perform. See 64B8-30.012 F.A.C. Essentially, the decision as to whether a PA may perform a task or procedure under direct or indirect supervision is made by the supervising physician based on reasonable medical judgment regarding the probability of morbidity or mortality to the patient. **The supervising physician must be certain that the PA is knowledgeable and skilled in performing the tasks and procedures assigned. However, Florida law does identify the following duties as those which are not permitted to be delegated at all, except where otherwise expressly authorized by statute: prescribing, dispensing or compounding medicinal drugs (See 458.347(4)(e) for the exception) and making a final diagnosis.**

Additionally, the law identifies the following duties as those which are not to be performed under indirect supervision:

1. Routine insertion of chest tubes and removal of

- pacer wires or left atrial monitoring lines.
2. Performance of cardiac stress testing.
3. Routine insertion of central venous catheters.
4. Injection of intrathecal medication without prior approval of the supervising physician.
5. Interpretation of laboratory tests, x-ray studies and EKGs without the supervising physician interpretation and final review.
6. Administration of general, spinal, and epidural anesthetics; this may be performed under direct supervision only by PAs who graduated from Board-approved programs for the education of anesthesiology assistants.

All tasks and procedures performed by the PA must be appropriately documented in the medical record. During the initial six (6) months of supervision of each PA all documentation by the PA in a medical chart must be reviewed, signed and dated by a supervising physician within seven days. Subsequent thereto, a supervising physician must review, sign and date all documentation by a PA in medical charts within thirty (30) days. In a medical emergency the PA will act in accordance with his or her training and knowledge to maintain life support until a licensed physician assumes responsibility for the patient. Each supervising physician using a PA must remain mindful that he or she is liable for any acts or omissions of the PA acting under the physician's supervision and control. See 458.347(15), Fla. Stat.

Under 458.347(3), Fla. Stat., a physician may not supervise more than four (4) currently licensed PAs at any one time.

Important requirement shared by both? Be sure to submit your protocols to the respective Board on an annual basis. Be sure to update these protocols, as needed, and ensure that your professional practice is in compliance with all requirements.

Lastly, it is important not to be lulled into a sense of compliance with the law by simply believing that any person can perform medical services if under direct the supervision of a physician. While there are provisions for medical assistants under the Medical Practice Act, a practitioner must look to his or her own practice to determine if providing such medical services is within the scope of his or her license. An example of this would be a registered nurse providing laser therapy under the supervision of a physician. Would the Board of Medicine permit its delegation or does the Board of Nursing believe that it is inside the scope of a registered nurse's practice? The answer to both questions is **no**. As such, we encourage providers to always check with their health care legal counsel prior to providing new services where there may a question as to whether it is appropriate.

The authors encourage readers to read the appropriate rules governing both PAs and ARNPs as well as review profession updates by the respective Boards at their websites. There is helpful information on the websites for the Florida Academy of Physician Assistants and the Florida Nursing Association websites. Additionally, the Florida Board of Medicine website has helpful and useful information.

<http://www.fapaonline.org/>
<http://www.floridanurse.org/>
http://www.doh.state.fl.us/MQA/medical/me_home.html



Legal Case Review: The Disruptive Physician

Cristina Palacio, Esq.

"[T]he disruptive practitioner is by definition contentious, threatening, unreachable, insulting and frequently litigious. He will not, or cannot, play by the rules, nor is he able to relate to or work well with others" So stated Dr. Fishter, a staff psychiatrist at Lewistown Hospital in Mifflin County Pennsylvania, during a trial regarding a 28 day suspension imposed by Lewistown on Dr. Alan Gordon for verbally abusing a nurse. As it turned out, it was quite a good description of Dr. Gordon, for whom the suspension was only the beginning of a multi-year effort to encourage him to modify his behavior. The litigation between Dr. Gordon and Lewistown Hospital began in 1993 and concluded in 2006, involved both state and federal courts and generated five published court opinions. The series of cases strongly supports the principal that a medical staff has the responsibility of addressing disruptive physician behavior as part of its duty to promote quality patient care; and action taken in that regard is appropriate professional review action that is subject to the protection of the Health Care Quality Improvement Act (42 U.S.C. §11101 *et. seq.*).

Case Summary.

The (first) precipitating event occurred on July 14, 1992, when Dr. Gordon, an ophthalmologist, told an ED nurse (by his own admission) that she "should get off her ass and that she was a wrench in the works, she was obstructing patient care." (The nurse alleged that Gordon used more profane language, but Gordon's version of the event was accepted by the court.) Dr. Gordon had

been on the medical staff of Lewiston since 1980, and there was no question regarding his competency. Prior to this incident, however, Gordon had already been reviewed by the Credentials Committee for his behavior in a series of incidents involving verbal attacks on fellow physicians and nurses, resulting in a written warning that any additional episode would result in a recommendation to the Board that he be suspended. After investigating the July 14th incident, the Credentials Committee recommended a 28 day suspension (long enough to make its point, but short enough to avoid a report to the National Practitioner Data Bank). Following a hearing and an appeal, both of which he lost, the suspension was implemented in September 1993, and Gordon sued the hospital in state court based on various claims, including violation of his constitutional due process rights, breach of contract, defamation and tortious interference with business relations. The trial court held against Gordon on all counts, granting summary judgment to the hospital. Gordon appealed and, of particular significance for the purposes of this review, he argued (amongst other things) that the hospital was not entitled to the immunity protection of the HCQIA (*Gordon v Lewiston*, 714 A.2d 539 Pa. Commw. Ct. 1998) In rejecting Gordon's argument, the court quoted Dr. Fishter's testimony that "[a]lthough Dr. Gordon himself [had not] ever demonstrated anything but competency as a practitioner in his specialty, there is [repetitive evidence of] supporting staff being intimidated, being distracted, fearful, which, if your supporting staff is not able to attend clearly only to the business at hand, namely, the management of the patient ... [places] patient care at risk." (*Id.* at 544) The court also quoted Hugh Greeley, chairman of the hospital/medical staff consulting firm The Greeley Company, who testified as an expert for Lewistown that where "a physician's behavior is disruptive to the activities of the hospital, affects the quality of ser-

vices provided and/or creates a condition in which employees must act in an environment of fear and trepidation, a hospital is *required* to take action." Consistent with those two opinions, the court found that "[b]ecause disruptive behavior by a physician at work relates to his or her professional conduct, we reject any notion that the Board did not take its professional review action in the reasonable belief that it was furthering quality health care merely because Dr. Gordon's suspension was not based on incompetence." (*Id.* at 545) Thus, after also finding that the hearing and appeals process offered to Gordon was consistent with HCQIA requirements, the court found that Lewistown's suspension of Gordon's privileges was subject to the immunity protections of HCQIA. (While the courts in this case continually refer to the 'hospital's action' it is important to remember that in these matters, the Board acts pursuant to recommendations from the Medical Staff, not pursuant to hospital administrative proposals.)

In 1994, while the state lawsuit was still pending, Lewistown began to receive complaints from patients and their families, claiming that they had received harassing, inappropriate and intimidating phone calls from Dr. Gordon regarding his perception of the inferior competency of their ophthalmologist, Dr. Nancollas – the only other ophthalmologist on Lewistown's medical staff. Gordon went as far as calling a former patient on the night before her scheduled surgery with Nancollas to complain to her about her decision to use his competitor. After contacting another former patient to inquire about her status, he called her a liar when she explained why she had switched to Nancollas. After receiving about 4 such complaints, Gordon received a letter from the hospital stating that if any more were received, the matter would be referred to the medical staff for investigation. Thereafter, additional complaints were received by hos-

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pital administration. Furthermore, during the same time period Gordon had another incident with a nurse. When a day stay surgery nurse would not permit a patient to proceed to the OR after Gordon thrice refused a request to document an H&P, Gordon stated loudly in front of several patients that the nurse “didn’t give a damn about the patients” and screamed at the nursing staff “you are all assholes.” In late 1995, after an investigation of these complaints and the nursing incident, the Credentials Committee recommended a 45 day suspension this time around. Gordon appealed the suspension recommendation to an independent arbitrator. While his appeal was pending, Lewiston administration received several additional complaints from patients, physicians and nurses regarding Gordon’s conduct, leading to a summary suspension, which he also appealed to the arbitrator. The arbitrator supported both the summary suspension, and the 45 day suspension.

Meanwhile, in the midst of the suspension appeals process, Gordon submitted his reappointment application. The Credentials Committee, in a final effort to effect an improvement in Gordon’s professional conduct, reappointed him after his written assurance that he would strictly adhere to specific behavioral standards outlined by the Committee. These standards included (1) directions that any complaints or concerns he had about other practitioners or nursing be addressed in writing to appropriate designated administrative or medical staff leadership and (2) a prohibition against attempting to communicate with patients of any other physician for the purposes of commenting on that physician’s competency. Within 7 months of his reappointment, Gordon violated both of these conditions within the same month by (1) composing a letter critiquing his competitor’s surgical methods, including the choice of procedure and anesthesia, the duration of his procedures, and the

length of his incisions and distributing the letter to more than 30 people, well beyond the persons designated in the reappointment conditions and (2) by calling a patient of Nancollas the night before her cataract surgery and making disparaging remarks about him. Shortly thereafter, the Credentials Committee recommended termination of Gordon’s membership and privileges. After (again) losing a hearing and an appeal, Gordon’s privileges were terminated. (It should also be noted that while Gordon inappropriately distributed his complaint, an investigation was conducted on Nancollas, with a finding that his practice met the standard of care.)

Gordon again sued Lewiston, this time in federal court based on antitrust claims (rather than due process and defamation as he had done in state court a few years before), arguing that the two conditions placed on his reappointment were unreasonable restraints on trade. He was unsuccessful in both the trial court (*Gordon v Lewistown*, 272 F. Supp. 2d 393 (M.D. Pa. 2003); *Gordon v. Lewistow*, 2001 U.S. Dist. LEXIS 25644 (M.D. Pa. May 21, 2001)) and the appellate court (*Gordon v. Lewistown*, 423 F.3d 184 (3d Cir. Pa. 2005).

Analysis:

Both the trial and appellate court provided detailed analyses of each of the antitrust claims raised by Gordon. Gordon claimed that the hospital’s actions against his privileges illegally affected competition in physician services for various ophthalmology surgery services. Several of his claims required proof of concerted activity or a conspiracy between the hospital and Gordon’s competitors, for which the courts found no proof. Additionally, except for the emergency eye surgery market, the courts found that the hospital did not have the requisite market share to support an antitrust action.

In the emergency eye surgery market, despite finding a controlling market share, the court found it was not the hospital's actions that had a negative impact on the market (leaving only 1 physician to provide all emergency care), but that it was Gordon's own conduct that resulted in the reduction of competition. Consequently, both the trial court and the appellate court ruled against Gordon on all his antitrust claims.

Furthermore, in upholding the hospital's termination of Gordon's privileges, the federal appellate court, similar to the state court in the 1993 action, found that the hospital's action against the physician for his unprofessional conduct was a 'professional review action' protected by HCQIA. HCQIA defines a 'professional review action' as an action affecting the clinical privileges of a physician "which is based on the competence *or professional conduct* of an individual physician (*which conduct affects or could affect adversely the health or welfare of a patient or patients*)." (42 U.S.C. § 11151(9)) Finding that the "record contain[ed] a plethora of evidence that Gordon's conduct in violating the [reappointment conditions] could affect adversely the health or welfare of patients," the court held that HCQIA "affords protection to actions taken against physician conduct that either impacts or potentially impacts patient 'welfare' adversely, meaning patient 'well being in any respect....'" (*Gordon*, 423 F.3d at 203)

The Florida federal court of appeals has taken a similar position in *Bryan v James E. Holmes Regional Center*, 33 F.3d 1318 (11th Cir 1994). While not quite as litigious as Gordon (there are not as many opinions generated by Dr. Bryan's actions), Dr. Bryan, known as an excellent general and vascular surgeon, was certainly as contentious,

threatening, unreachable, and insulting as Dr. Gordon. The court describes Bryan as "a volcanic-tempered perfectionist, a difficult man with whom to work, and a person who regularly viewed it as his obligation to criticize staff members at Holmes for perceived incompetence or inefficiency. Hospital employees, however, often viewed Bryan's 'constructive criticism' as verbal--or even physical--abuse." (*Id.* at 1324) Between 1976, when he joined the Holmes Regional medical staff and November 1990 when his privileges were terminated for his disruptive behavior, Bryan was the subject of more than 50 written incident reports based on his unprofessional conduct toward hospital staff and physicians alike. In one incident, Bryan told two anesthesiologists who caused a 3 minute delay in surgery when they took time to reexamine the patient record prior to beginning anesthesia administration that he "didn't give a damn about incompetent people's excuses." The anesthesiologists alleged that this was followed by a tirade of insults in front of the still-conscious patient. In another incident, allegedly as a prank to teach the nurse "responsibility," Bryan falsely told her that one of her patients had just hanged himself in his room.

Like Gordon, Bryan did not deny descriptions of his behavior. Like Lewistown, the Holmes medical staff tried gradual increases in disciplinary responses, beginning with informal discussions and warnings, moving to formal investigations, short suspension, and eventual termination, due to continued incidents of disruptive behavior. And like the federal appellate court in Pennsylvania, the federal appellate court in Florida found that the hospital's termination of Bryan's privileges were, consistent with the requirements of HCQIA, taken in a reasonable belief that such was necessary for the furtherance of quality patient care.

Risk Rx

Risk Reduction Strategies:

The two physicians discussed in the above cases clearly exhibited extreme disruptive and unprofessional behavior. Unfortunately, the medical staff's reluctance to address the issues early on no doubt contributed to the repetitiveness and escalating nature of the behavior. In recent years, it has become increasingly recognized that even moderately disruptive behavior can have a significant negative impact on the delivery of quality patient care. Consequently, Medical Staffs have become less tolerant of repetitive incidents, and increasingly willing to address disruptive behavior early on. Medical staff consultants, such as The Greeley Company and the Horty Springer law firm provide regular seminars on how to address disruptive physician issues. Strategies are usually aimed at assisting the involved physician to improve his or her conduct so that s/he can become a collaborative member of the health care team. But ultimately, non-improvement can, as these cases indicate, result in lost privileges. To avoid such an adverse action, physicians who recognize that they have behavioral issues would be well-advised to pro-actively seek the confidential assistance of the Medical Staff leadership in identifying areas that need improvement, and resources for attaining such improvement. The Shands HealthCare Medical Staff policies on appointments have specific provisions to assist physicians in such matters. In the event that self awareness is not forthcoming, a physician who is brought to the attention of the Medical Staff leadership and who is then subject to preliminary disciplinary action, still has an opportunity to obtain guidance for improvement. It is important to remember that the courts clearly recognize a Medical Staff's responsibility to promote appropriate functioning of the hospital by regulating inappropriate behavior that impacts, or could impact, efficient, effective patient care delivery.

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