Kansas Legislative Research Department

July 15, 1977

MINUTES

SPECIAL COMMITTEE ON PUBLIC HEALTH AND WELFARE

June 21-22, 1977

Wichita State University, Wichita, Kansas

Members Present

Representative Michael G. Johnson, Chairman
Senator Wesley H. Sowers, Vice-Chairman
Senator John E. Chandler
Senator Bert Chaney
Senator Mike Johnston
Representative Theo Cribbs
Representative Kenneth Francisco
Representative Sharon Hess
Representative Marvin L. Littlejohn
Representative Pascal A. Roniger
Representative Larry F. Turnquist

Staff Present

Emalene Correll, Kansas Legislative Research Department
William G. Wolff, Kansas Legislative Research Department
Sherman Parks, Revisor of Statutes Office

Other Present

Mary J. Wiersma, Kansas Farm Bureau, Manhattan, Kansas
V. J. Valgora, Wichita State Univeristy - Physician's Assistant Program, Wichita, Kansas
Stephen Gladheart, Wichita State University - Physician's Assistant Program, Wichita, Kansas
V. Gary Anderson, M.D., Wichita State University - Physician's Assistant Program, Wichita, Kansas
Carla A. Lee, R.N., Wichita State University-Nurse Clinician Program, Wichita, Kansas
Jack Milligan, Kansas Optometric Association, Topeka
Eric Schuman, P.A., Family Practice Group, Topeka, Kansas
Bill Kimble, Wesley Medical Center, Wichita, Kansas
R. H. Winters, Wichita State University - CHRP, Wichita, Kansas
Judith C. Runnels, Kansas State Nurses Association, Topeka, Kansas
Charles W. Wurth, Mid America Nursing Center, Wichita, Kansas
Kent A. Richardson, Kansas Pharmaceutical Association, Wichita, Kansas
Hugh Polson, State Board of Pharmacy, Wichita, Kansas
Larry K. Shaffer, Kansas Hospital Association, Topeka, Kansas
Sandy Pieschl, Family Practice Nurse Clinician/Practitioner, Eureka, Kansas
Evelyn Smith, Wichita State University, Nurse Clinician Program, Wichita, Kansas
Roberta D. Thiry, Kansas State Nurses Association, Lawrence, Kansas
Joyce M. Olson, Kansas State Nurses Association, Shawnee, Kansas
Carolyn K. Voth, Kansas State Nurses Association, Overland Park, Kansas
Ray E. Showalter, Kansas State Board of Nursing, Topeka, Kansas
S. D. Rodenberg, Wichita State University - CHRP, Wichita, Kansas
Grace Kassebaum, Kansas State Board, National Association of Social Workers, Wichita, Kansas
Jim Matney, Wichita State University - CHRP, Wichita, Kansas
Phillip W. Durand, Physician's Assistant, Wichita, Kansas
Elizabeth J. Sheldon, Physician's Assistant, Wichita, Kansas
William C. Swisher, State Board of Healing Arts, Wichita, Kansas
Elizabeth Carlson, State Board of Healing Arts, Topeka, Kansas
Mark Harms, Physician's Assistant, Chanute, Kansas
John L. Christensen, Physician's Assistant Student, Marion, Kansas
Vicki Anderson, Physician's Assistant Student, Wichita, Kansas
Patti Quick-Showalter, Physician's Assisant Student, Wichita, Kansas
Don Satterfield, Physician's Assistant Student, McPherson, Kansas
David W. Baldwin, Physician's Assistant Student, Baxter Springs, Kansas
Richard Allen, Physician's Assistant Student, Wichita
Sonya Porter, R.N., Nurse Clinician, Wichita State University Student Health, Wichita, Kansas
Janiece Moreland, R.N., Institute of Logopedics, Wichita, Kansas

Others Present (Continued)

Helen Holstead, R.N., Wichita State University, Wichita, Kansas
Jessica Brown, Physician's Assistant Student, Wichita, Kansas
Bob Brelland, Physician's Assistant Student, Wichita, Kansas
Meredith Crespo, Wichita State University - Physician's Assistant Program, Wichita, Kansas
John F. Meyers, Cedar Vale Regional Hospital, Cedar Vale, Kansas
Rojean DuBois, R.N., Nurse Clinician, Newton, Kansas
Jay S. Benton, M.D., Newton, Kansas
Wanda Maltley, R.N., Nurse Practitioner, Wichita, Kansas
Joe Harkins, Department of Health and Environment, Topeka, Kansas
Frank Jacobs, Department of Health and Environment, Topeka, Kansas
Dr. Cramer Reed, Wichita Branch, Kansas University School of Medicine, Wichita, Kansas
R. Rex Lee, M.D., Wichita, Kansas
Shirley Sayler, R.N. , Wichita, Kansas
Harriet I. Taylor, AVTS Nurse Assistant Program, Wichita, Kansas

The meeting was called to order at 10:00 a.m. by the Chairman, Representative Michael G. Johnson.

After discussion, the following schedule for Committee meetings was adopted:

July 19-20
August 23-24
September 20-21
October 18-19
November 2
November 20

Proposal No. 50 - Credentialing of Health Care Personnel:

Staff noted this proposal grew out of concern on the part of committees and individual legislators who are required to make decisions about licensing and scope of practice for various health care professions.

Because of the significant number of new types of health care personnel and the problems inherent in determining scope of practice and need of licensure for each of them, HEW in a 1971 report asked states to observe a two-year moratorium on licensure of new groups. The 1973 HEW report requested states to observe an additional two-year moratorium to allow time to study alternative credentialing mechanisms, licensing boards, and guidelines for determining whether a group should be licensed.

Staff stated the Kansas Supreme Court and the Court of Appeals have held it is within the power of the state to prescribe the duties and requirements of individuals within a profession and to restrict or revoke the licenses of such individuals.

Staff reviewed the preliminary draft of the 1976 HEW report. Copies of the final report will be sent to Committee members as soon as it is released. Staff also noted that several states have studied the licensing question and have established statutory guidelines to be followed in determing who should be licensed.

Proposal No. 60 - Physician Extenders

Staff noted this proposal grew out of questions raised relative to whether or not the training, credentials, and scope of practice of physician's extenders should be more specifically defined by statute. Following the recommendation of an interim committee, the present physician's assistance statutes allow the employing physician to determine the scope of practice of the physician's assistant for whom he is legally responsible. This approach was adopted to give greater flexibility to the program in its developmental stage.

Staff reviewed the provisions of present statutes relative to physician's assistants and nurse practitioners. It was noted that the State Board of Healing Arts cannot enforce the provisions of K.S.A. 1976 Supp. 65-2896b (b) because a PA is not required to report his employment status to the Board. Consensus was that consideration should be given to requiring such reporting at specified intervals.

Staff reviewed the provisions of the two physician's assistant bills held in Committee last session — H.B. 2417 and S.B. 256.

S.B. 256 and H.B. 2417 would regulate by statute what the physician's assistant may or may not do. Under the present law, the employing physician determines the scope of the physician's assistant's responsibility. Another approach would be to regulate the physician hiring the PA, i.e., requiring a contract between the physician and the PA approved by the Board of Healing Arts.

Staff stated another area of concern is what hospitals will allow the physician's assistant to do and the relationship of the physician's assistant to other hospital personnel. Some hospital boards have adopted rules governing the operation of the PA in the hospital.

Referring to a letter from Dr. James Hill, Secretary, State Board of Healing Arts, (Attachment A) which has caused concern among physicians, staff noted two things: (1) the law uses the term "direction and supervision" rather than "direct supervision" as stated on page 1; and (2) the reference probably refers to federal rather than state laws. However, the letter points up some areas for possible Committee consideration: (1) conformity of any legislation with other state statutes and rules and regulations and federal laws and rules and regulations; and (2) direct payment to physicians' extenders.

Noting the lack of an acceptable definition of nurse practitioner, staff stated previous interim committees had asked physicians and nurses to develop a satisfactory defintion but the joint committee appointed by these groups has not reached agreement. At issue in the definition are areas of diagnosis, prescription of drugs, and supervision.

Carla A. Lee, R.N., Chairperson, Nurse Clinician Department, Wichita State University, distributed a packet of materials covered in her presentation. (Attachments B through F) She stressed the philosophy that with additional training, the nurse practitioner can function in an expanded role based on an interdependent relationship with the physician.

In answer to questions, Ms. Lee made the following points: originally the Wichita University curriculum was based on a survey sent to all general and family physicians; the physician and the applicant he is sponsoring jointly write objectives which, if congruent with the program, become the shared objectives of the program; faculty make site visits and the physician serving as preceptor is given a packet of materials relative to his role and responsibilities. Since the nurse clinician program is a generalist program, students sponsored by a specialist must have an alternate preceptor in general or family practice. Priority is given applicants sponsored by a rural Kansas family or general practitioner. Nurse practitioners work under protocals i.e., a written agreement, equivalent to a standing order, that given a certain specified condition, assessments will be made and specified treatment started. The Nurse Clinician program endorses the concept of protocols although there are some problems since the physician is not always willing to put things on paper.

According to Ms. Lee, the nurse practitioner role centers around health maintenance, continuity of care, and long term care. Other areas of possible service are in industrial and school settings. She stated that who is responsible for what and who is accountable to whom needs to be studied.

Valjean Valgora, Director, Physician's Assistant Program, Wichita State University, discussed the background of the program, notable developments, and the accomplishments of the program in Kansas. (Attachment G). The program is a 24 month program — 11 months didactic training with subjects similar to the first two years of pre-med but taught on a modular system, and 13 months clinical experience on a rotation system.

In answer to questions, Mr. Valgora made the following points: in the selection process, consideration is given to a Kansas rural background but the candidate must be competitive; candidates are asked what they think they would like to do after graduation but are not specifically asked if they would serve in a rural Kansas community; they have not found that a person from a rural area will necessarily go back to a rural area; factors influencing their graduates to go to rural areas such as Sublette, Tribune, and Syracuse are that over one-half of the clinical rotation is spent in this type setting, students do not become used to what is available in larger communities, and salaries are higher in rural areas (average salary - $18,000, urban Kansas - $12,000, rural Kansas - $22,000); graduation is based on on-site evaluations by physicians serving as preceptors and program staff, and the successful completion of a comprehensive examination.

The curriculum for the Wichita program is based on recommendations of physicians who are modular advisors, questionnaires sent to Kansas physicians, and questionnaires asking students to discuss the strengths and weaknesses of the program from their point of view.

This program, which has grown from 12 to 30 students per class, costs approximately $2,200 per student per year. Plans are to maintain the present class size since the amount of individualized instruction would require doubling the faculty if the class size were increased.

The program will remain at the VA hospital since the VA has just remodeled facilities for the program, and provides staff, materials and, most importantly, patient proximity.

Differences between a nurse practitioner and physician's assistant are that the nurse practitioner expands the use of nursing skills and her first responsibility is to the client while the physician's assistant serves as a physician extender whose first responsibility is to the employing physician.

Following Mr. Valgora's presentation the Committee adjorned to the V.A. Hospital to meet with first year students in the physician's assistant program. After members and staff of the Committee introduced themselves, students introduced themselves and gave their backgrounds. Committee members noted the high credentials and varied backgrounds of the students. In answer to a question, Mr. Valgora stated admission requirements are four years of direct patient contact or a degree in biological science or some combination of these two, including successful completion of a certain number of specified courses.

In answer to questions, most students indicated they would like to stay in Kansas if positions are available. Mr. Valgora stated a follow-up study of graduates indicates females, whether single or married, tend to practice in larger communities.

Mr. Valgora noted that although all students have preceptorships and all graduates are employed, there is a noticeable decrease in the number of physicians in target areas willing to employ a physician's assistant. He attributed this primarily to the confusion about what a PA can or cannot do and the problems of third party payments.

Under present delegation of authority statutes, a physician can delegate anything to anyone he hires. If legislation like that proposed last session is passed, this could mean a PA would be limited in what he could do but if he called himself by some other title he would not be so limited.

In answer to a question, Mr. Valgora stated that under Medicare physicians can be reimbursed only for things traditionally performed by a physician. Therefore, if a PA performs any of these services, the physician cannot be reimbursed. This means the PA could be a financial liability to the physician. Emphasis was placed on the fact that physicians' assistants do not want to be reimbursed directly by third party payments but they feel it is important that the physician be reimbursed for services provided by the PA who is on a fixed salary. It was noted that Medicare is a federal problem but Medicaid is a state administered program.

Certification, granted by the National Commission on Certification of Physicians' Assistants, is based on graduation from an approved program, and performance on the National Board Exam developed and administered by the National Board of Medical Examiners. Recertification is based on meeting continuing education requirements and, every sixth year, by passing a recertification examination. The Kansas Academy of Physicians' Assistants is already providing many continuing education courses on a circuit basis.

Mr. Valgora stated that some doctors have said that if S.B. 256 passes, they cannot use a physician's assistant. The provisions of this bill would have cut the 300,000 patient visits made by physicians' assistants last year to less than 200. Students stated they are hopeful the Legislature will pass a law which will permit them to use their skills to relieve the pressure on doctors. They also expressed the hope that the law will use a positive approach stating the physician's assistant is part of a team under the supervision of a physician rather than stating what the physician's assistant can or cannot do.

In answer to a question, Mr. Valgora stated that sometimes there is a problem with acceptance of the physician's assistant in a hospital. The physician's assistant can be seen as a threat and until a June 1 Attorney General's opinion, there was a question about the legality of a nurse carrying out a physician's assistant's order.

Staff distributed copies of written statements submitted by the Kansas Medical Society, (Attachment H), the Kansas Pharmaceutical Association (Attachment I), the Kansas Farm Bureau (Attachment J), and the Cedar Vale Regional Hospital (Attachment K) noting that a representative of each of these groups will be present on the 22nd to answer questions.

The meeting was adjourned at 5:15 p.m.

June 22, 1977

The meeting was called to order at 9:05 a.m. by the Chairman, Representative Michael G. Johnson.

The following students in the physician's assistant program appeared before the Committee: John L. Christensen, Vicki Anderson, Patti Quick-Showalter, Don Satterfield, David W. Baldwin, and Richard Allen.

In answer to questions, the students made the following points: the physician's assistant's role is predicated on the fact the physician's assistant is under the supervision of the physician; the physician's assistant is somewhat autonomous and will have to make independent judgments whether the physician is in the next room or several miles away; the criteria should not be distance but how close is the contact between the physician and the PA; the PA is trained to know the difference between normal and abnormal and between what he can handle and what he cannot handle; the PA is further trained by the employing physician to know what that physician wants in a given situation; physicians' assistants are aiming for an interdependency with the physician. In response to a question it was noted that "supervision" as used by the students means responsible direction and control, with the licensed physician or physicians assuming legal liability for the services rendered by the physician's assistant. Such supervision shall not be construed to require the personal presence of the supervising physician, but be within a reasonable distance. A physician shall supervise no more than two physician's assistants.

It was pointed out by the students that as the Committee approached the problem of establishing limits on the scope of practice of the PA, care must be taken to avoid the pitfall of telling a doctor how to conduct his business. The students stated that another issue which needs to be addressed is that of a supervising physician when the employing physician is not available because of vacations or for other reasons.

Evelyn Smith, Outreach Supervisor in Dodge City and a practicing nurse practitioner, presented a written statement. (Attachment L) and letters from two physicians in the Dodge City Medical center (Attachment M). In answer to questions, she stated the Center has a satellite clinic in Cimarron staffed by a physician and a nurse practitioner. The physician's concern is that the nurse practitioner be responsible to a physician and not be allowed to have a private practice. Nurse practitioners concur with this view.

Sandy Pieschl, a nurse practitioner working for a physician in a two-physician practice serving three counties, outlined her responsibilities in the hospital and office which include doing patient histories and physicals, checking progress of hospitalized patients, reporting findings to the physician; assisting in labor, delivery and surgery; being on call when the physician is and covering emergencies she is qualified to handle; sending patients for tests if needed; seeing patients with long-term problems such as diabetes; suturing; putting on casts; taking X-Rays; doing simple lab procedures and EKG's. She stated that if a situation is not covered by a protocol or she feels she cannot handle it, she calls the physician before proceeding. She receives many phone calls at home which she feels reflect her acceptance by patients.

Ms. Pieschl noted the problem of writing prescriptions and referred to a letter from Dr. Hill, State Board of Healing Arts, which appeared in the March 7, 1977, issue of the Kansas Pharmaceutical Association Journal. She stated that she writes prescriptions if they are included in the protocol or after checking with the physician and signs the physician's name and her name. She feels this is equivalent to a phone call to the pharmacy which is considered acceptable.

In answer to questions, Ms. Pieschl stated she makes independent nursing judgments at times and emphasized the importance of protocols and close communication with the physician. She also noted that the physician's assistant and the nurse practitioner each have a distinct role to play in health care delivery. Although there is some overlapping, the nurse practitioner is primarily assisting the patient with a primary purpose of turning responsibility for health back to the patient while the physician's assistant follows the physician model.

Larry K. Shaffer, Director of Education, Kansas Hospital Association, presented a written statement. (Attachment N). Concern was expressed over the employment of physicians' assistants by hospitals. Mr. Shaffer stated presently seven physicians' assistants are paid by hospitals although he was not certain the title was used. He assumed the hospital and medical staff made the decision to hire a physician's assistant. On request, the Association mails hospitals a packet including the American Hospital Association guidelines and other pertinent literature.

The problem of liability was raised with reference to the Darling case. It was noted the increased liability is not because there is a physician's assistant with hospital privileges but because there is another person providing services in the hosptial.

The Committee asked the Kansas Hospital Association to arrange for the administrator of a hospital employing a physician's assistant to appear before the Committee.

Valjean Valgora, Director, Physician's Assistant Program, Wichita State University, stated the program appreciates the Legislature's support and is appreciative of the permissiveness of present legislation to allow the development of the program. He stated he did not believe legislative intent, as interpreted by the Board of Healing Arts, was that the physician always be physically present which would severely limit the value of the physician's assistant and preclude the use of physicians' assistants in satellite clinics. He recommended the Committee consider legislation to clarify that supervision and direction do not mean physical presence of the physician. He suggested that supervision be defined as taking responsibility for the practice of the physician's assistant and the direction of that practice and that geographic proximity be reasonable to the given area and situation.

He stated legislation is needed to clarify that the physician's assistant can prescribe drugs within reasonable limits, i.e., should not include Schedule II drugs. Without clarification, or with the passage of S.B. 256, we will continue to have a situation in which persons with training cannot do what people without training can do. Presently the usual and customary procedure which is allowed by the Board of Pharmacy rules and regulations, is for a pharmacist to fill a prescription or a refill order phoned in by a physician's receptionist or nurse.

Mr. Valgora referred to a meeting held with the Kansas Hospital Association and nurse supervisors to discuss problems which have arisen involving physicians' assistants and nurses in hospitals. Three directors of nursing stated the nuring staff benefited from having physicians assistants practicing in the hospital. Initially there was apprehension and misunderstanding and there still are some individual personality problems as there are in all areas of the hospital.

Referring to earlier testimony, he stated that a hospital cannot employ a physician's assistant as a physician's assistant. They may pay the salary and arrange for the PA to do things for the hospital but the PA must be hired by a physician to whom he is responsible.

Mr. Valgora noted that according to insurance actuarial figures there should have been over 1,000 suits filed against physicians' assistants or physicians hiring them but to date there have been none. The primary factor is that the PA is providing communication with the patient. They do advise the PA to carry his own insurance which is approximately $150.00 per year and advise the physician to name the PA on a rider on his own policy.

Mr. Valgora stated that nurse practitioners and physicians' assistants feel the nurse practitioner is a nursing extender and should be governed by the Nurse Practices Act; the physician's assistant is a physician extender and should be governed by the Board of Healing Arts. Physicians' assistants further feel that if they are to be governed by the Board of Healing Arts they should have a representative, not necessarily a voting member, on this board.

V. Gary Anderson, M.D., Assistant Director, Physician's Assistant Program, Wichita State University, stated that because of his experience, he firmly believes trained people can assume some duties usually assumed by physicians. Physicians' assistants have a legitimate role in health care. Legislation is needed to guarantee physicians' assistants are well trained, are credentialled, are certified, preferably by a national test, and are supervised by a responsible physician. Legislation should give the hiring physician the authority to determine what his physician's assistant does, should specifically state the responsibility and liability of the employing physician and should provide a procedure for handling complaints.

Noting that problems in legislation have arisen because people meant to do some one thing and did another, Dr. Anderson suggested that in writing recommendations it will be important to have people at various levels in the field read them and share their reactions.

In answer to a question, Dr. Anderson stated the Board of Healing Arts would be the logical board to govern physicians' assistants and to handle complaints. A separate board would create problems and is not favored by physicians' assistants.

In answer to other questions, Dr. Anderson stated a physician should not have more than two physicians' assistants; that he felt those who work with a physician's assistant a month or two have no negative comments and that the reluctance of the Board of Healing Arts in this area is based on a lack of contact or experience with physicians' assistants. He felt it was acceptable for a physician on vacation to leave his physician's assistant under the supervision of a physician in another community if he was comfortable with this, had worked it out with the pharmacy and the hospital and the legal questions are answered.

Carla Lee, Chairperson, Nurse Clinician Program, Wichita State University, presented a written statement with recommendations which she identified as hers and not necessarily those of Wichita State University. (Attachment O).

In answer to questions, Ms. Lee made the following points: how many nurse practitioners one physician can employ needs to be based on how adequately the medical part of the nurse practitioner's practice can be supervised; some perimeters relative to nurse practitioners prescribing drugs should be established by law; the latter should allow prescriptions based on a protocol or standing orders and be flexible enough to be responsive to specific situations.

J. S. Benton, M.D., Newton, who employs a nurse practitioner, presented a written statement. (Attachment P)

Dr. Swisher, representing the State Board of Healing Arts, stated the first step needed is to define "physician's assistant". There must be guarantees the physician is capable of supervising a physician's assistant, is using the physician's assistant properly, and there is supervision on a continuing basis. He noted two physician's assistants are the most a physician can supervise and direct. There needs to be a guarantee the physician's assistant has the proper education, has passed a specified exam and has the proper credentials. He noted one case where a student did not pass the national exam but had graduated from an approved school so he could be registered under

present law. There are problems in the area of prescribing drugs but many of these can be worked out. The duties of a physician's assistant must be worked out cooperatively by the employing physician and the physician's assistant with the approval of the regulating body because no law can be written that will cover every situation. He cautioned that although risks to the patient are more imaginary than real, it is important to protect the public from those who would find loopholes in the law.

Dr. Swisher called attention to physician's assistant regulations developed by Drs. Anderson, Reed, Jones and Shipp for the Board of Healing Arts which were turned down by the Attorney General on the basis the Board did not have statutory authority to develop such rules and regulations. He stated these are still valid and if they could be incorporated into legislation this would satisfy the Board of Healing Arts. These regulations are to be reviewed at the next meeting.

In answer to a question about how the Board of Healing Arts interpreted present law to require direct supervision and determined their definition of this term, Dr. Swisher stated it was based on Attorney General's Opinion 77-186. This Committee will review this opinion at the July meeting.

In answer to other questions, Dr. Swisher stated a physician's assistant could work for more than one physician if it was well thought out; the present Board of Healing Arts believes the physician should define what his physician's assistant can do and would not develop a laundry list through rules and regulations; the physician's assistant has the potential of reducing health care costs but because of increased availability of services may increase the number of visits possible in a given time.

The Committee recessed for lunch at 12:15 p.m. and reconvened at 1:45 p.m.

Roberta Thiry, Kansas State Nurses Association, presented a written statement. (Attachment Q). In answer to questions, Ms. Thiry stated that limiting the number of nurse practitioners a doctor can supervise to two would hurt nursing and health service. She noted in some public health departments one physician is responsible for a total health program and many nurses functioning in an expanded role. Although a nurse needs physician supervision when doing medical things, this supervision is not needed when nursing services are being provided. For example, nurses hired by an obstetrician to provide primarily educational services for patients would need physician supervision when doing medically related acts but not when performing educational services. She noted that nursing has six areas of practice in which they are not responsible to a physician.

In answer to a question Ms. Thiry stated there is no minimum number of hours or specific course content required for nurse practitioner training programs.

Ray E. Showalter, Secretary, State Board of Nursing, presented a written statement. (Attachment R) In answer to a question, Mr. Showalter stated the Board feels the nurse practitioner is primarily extending nursing services and therefore should be controlled by the Board of Nursing. Gray areas in which the nurse practitioner may be viewed as a physician should be covered by protocols.

He stated the "additional acts" clause in the proposed definition (page 3, Attachment R) gives authority for following through on special areas of nursing such as midwifery. The Board is not interested in developing a laundry list.

The Committee requested a copy of the proposed definition shown as an amendment to the present statutory definition of practice of nursing.

Dr. Cramer Reed, Vice Chancellor, Wichita Branch, University of Kansas Medical Center, presented a written statement. (Attachment S)

Concern was expressed by the Committee that the Board of Healing Arts apparently had taken the term "direction and supervision" in the present statute and using an Attorney General's opinion had said this meant the same as direct supervision. Dr. Reed stated this was in direct conflict with talks he had had with Dr. Swisher. If this is an Attorney General's opinion, it could be a serious difficulty in developing a viable program in Kansas.

Eric Schuman, physician's assistant in a group family practice, made a statement and answered questions. A transcript of his statement and the questions and answers is attached. (Attachment T)

Elizabeth Carlson, State Board of Healing Arts, stated the $25.00 fee for the physician's assistant examination needs to be raised since the cost to the Board can be as high as $160 if it is taken three times, the maximum allowed. In answer to a question, she noted that since 20% of the total registration fees was such a small amount of money, it was deposited in the healing arts fund rather than establishing a separate fee fund which would necessitate a separate set of books and a separate budget.

Elizabeth Sheldon, President, Kansas Academy of Physicians' Assistants, stated that although physicians' assistants have hospital privileges there are problems. Nurses are sometimes hesitant to carry out orders written by the physician's assistant if they feel they can wait for the doctor. Also, the physician's assistant cannot admit patients. She noted the guidelines developed by the St. Joseph Medical Center would give them admission privileges if necessary legislation were passed. Legislation in these areas is important. Legislation giving physicians' assistants prescription rights except for Schedule II drugs is also needed. She stated the physician for whom she works called all the pharmacies and most of them will now honor a prescription she signs but this may not be legal.

Ms. Sheldon stated she feels that Medicare regulations restricting payment for the services of physicians' assistants has adversely affected care for the elderly. Before this interpretation, patients could talk to her and she could take time with them. Now they wait for the physician who may see them for five minutes and give them a prescription.

Ms. Sheldon stated that PA's want to provide relief for the physician and help provide good medical care for Kansas. They do not want to hang out their own shingle. They want to be able to stay within the law while doing what they are qualified to do.

Joe Harkins, Department of Health and Environment, presented a written statement. (Attachment U) In answer to a question, he stated public health nurses trained for an expanded nurse role in a formal non-certified program provided by the Department are providing expanded role services without direct supervision. The physician is not there but he is legally responsible for what they do.

R. Rex Lee, M.D., introduced Shirley Saylor, his office nurse, and Harriet I. Taylor, a chief nurse at St. Joseph Medical Center. He stated he has had a physician's assistant in his family practice since the first class graduted from Wichita. He is amazed at their knowledge and their acceptance by patients and nurses.

In answer to a question, Dr. Lee stated in his office the fee is the same whether the pateint sees him or the physician's assistant. The PA spends more time with the patient, goes into a patient's problems more thoroughly and is better in some areas such as weight control and family problems.

Answering questions, Dr. Lee stated it is absolutely necessary for the physician's assistant to be able to write prescriptions if they are to be of value to the physician and to the patient. This would not need to include Schedule II drugs. Such prescriptions should not have to be countersigned or seen by the physician but the physician should be legally responsible for them as for all other acts performed by the physician's assistant. The PA should be able to practice while the physician is on vacation if arrangements have been made for another physician to serve as back up in situations requiring consultation.

Ms. Taylor, in answer to a question, stated she does not feel threatened by physicians' assistants in her work setting. She stated she goes to the PA in Dr. Lee's office with the same confidence as if seeing the physician. Other patients feel the same way.

Ms. Saylor, in answer to a question, stated her reaction to the PA in their office was positive. The PA is very capable and each of them have a distinct role to play.

Kent A. Richardson, Kansas Pharmaceutical Association, stated the problems referred to in their study had been worked out through interaction and discussion. However, there is still some question as to how legal it is for a nurse practitioner or a physician's assistant to sign a prescription.

Hugh Polson, State Board of Pharmacy, in answer to questions, stated the state has patterned its regulations after the federal regulations which say schedule II, III, IV, and V drugs cannot be prescribed by anyone but a doctor. A Committee member noted his impression of the federal law was that a state authorizes a class of persons to prescribe and these persons get a federal BND number entitling them to write prescription for all classes of drugs. Is the problem the fact the physician's assistant is writing prescriptions under the physician's BND number? Mr. Polson stated this question had not come up. Reacting to the suggestion that a physician's assistant be able to apply for a BND number, Mr. Polson said this would entitle him to write prescriptions for all drugs including those in Schedule II.

In answer to a question, Mr. Polson stated the Board could spell out what a physician's assistant could prescribe in rules and regulations but these would have to be approved by the Legislature. The Board would feel more confident if circumstances under which someone else can sign a prescription for the physician were set out statutorily, i.e., drugs on a list submitted to the pharmacist by the physician.

In answer to a question, Mr. Polson stated that if an inspector finds a different signature on a prescription, he makes a copy of the prescription and sends it to the Board of Pharmacy. The Board then sends a letter to the pharmacist asking him for clarification. If the signature was that of the physician's assistant, the Board would not censure him but would tell him not to fill such prescriptions in the future. The Board of Pharmacy received notification from the Board of Healing Arts that such prescriptions were like a scrap of paper and should not be filled. This is an area which needs to be clarified by statute.

Mr. Polson, in answer to a question, stated present rules and regulations are confusing because a physician's assistant who cannot write a prescription can call one in and have the doctor send a signed prescription later. Under present rules and regulations, any agent of the physician can phone in a prescription and it will be filled.

Mary Wiersma, Kansas Farm Bureau, in answer to a question about the statement which was distributed earlier stated they feel third party payments should be paid for services given by physician extenders but they have not taken a position on whether or not payment should be made directly to the physician extender.

John F. Meyers, Cedar Vale Regional Hospital, noted their position was stated in material distributed earlier. They strongly support the concept of physicians' assistants but feel completing a formalized training program should not be the only way to become certified. This means skilled people will be sent back to school unnecessarily, since they presently cannot take the National Board Examination unless they have graduated from an approved program.

Mr. Valgora clarified that the first time this exam was given it was not open to any but graduates of an approved program because this testing was used to establish norms. Since then the examination has been open to anyone who can demonstrate they have had at least four years experience compatible with the duties of a physician's assistant.

In answer to a question, Mr. Meyer stated he felt the number of physicians' assistants a physician could have should not be arbitrarily limited to two. It would be better to state the limit would be two unless certain conditions were met.

Next Meeting

The next meeting of the Committee will be July 19 and 20 in Topeka. The agenda will include staff discussion of the HEW Credentialing Report, testimony on nurse practitioner and physician's assistant issues by people who have requested to be heard, discussion and work on a balloon copy of H.B. 2417 showing the amendments proposed by Senator Sowers, Representative Walker and Dr. Reed and a staff review and interpretation of Attorney General's Opinion No. 77-186. If time permits, staff will also review bills held in Committee pertaining to audiologists, speech pathologists, alcoholism counselors and denturists. These areas will be given further attention at future Committee meetings as time permits.

The meeting was adjourned at 5:00 p.m.

Prepared by Emalene Correll

Approved by Committee on:

July 20, 1977
(Date)

Attachment A

STATE OF KANSAS

BOARD OF HEALING ARTS

OFFICE OF
JAMES E. HILL, M. D., SECRETARY
ELIZABETH W. CARLSON, EXECUTIVE SECRETARY
503 KANSAS AVENUE, SUITE 500
TOPEKA, KANSAS 66603
PHONE: (913) 296-7413

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WILLIAM C. SWISHER, M. D., WICHITA

TO: All Licensees of the Kansas Healing Arts Board

FROM: James E. Hill, M.D., Secretary

DATE: March 1, 1977

SUBJECT: Physician's Assistants Registered with the Kansas Healing Arts Board

Problems arising from interprofessional relationships between physicians and physician's assistants in the state of Kansas continue to surface. Because of this, the Healing Arts Board believes that it is expedient that the Board's position on this inter-relationship should be made known to every practitioner.

The use of physician's assistants in hospitals which are certified as Medicare-Medicaid providers raises questions of billing in complying with federal regulations. Problems arise because certain procedures are approvable only when authorized by state law. Pharmacies are concerned with the legality of prescriptions that are signed by physician's assistants. Nurse physician's-extenders are not being considered other than reminding you again of your responsibility. I will address each of these problems separately.

The 1976 Legislature addressed itself to physician's assistants in K.S.A. 65-2896 through K.S.A. 65-2897. Physician's assistant is defined as a skilled person qualified by academic training to provide patient service under the direct supervision of a physician licensed to practice medicine and surgery who is responsible for the performance of that assistant. In other words, the physician is professionally, morally, and legally responsible for the professional acts of the physician's assistant, regardless of where or how they occur. A physician's assistant is not certified or licensed; he is simply registered.

The Healing Arts Board is charged with determining that, in actuality, the physician's assistant so registered has completed the academic preparation that is required by law in K.S.A. 65-2896, paragraphs a, b, and c. In addition, under certain conditions that are listed under K.S.A. 65-2896 b, a physician's assistant's name may be removed from the register.

The Board deems it necessary that all orders shall be countersigned immediately after they are written (immediately being defined as not later than twenty-four (24) hours). All personnel caring for a patient shall be identified to that patient in an understandable manner and it is the sponsoring physician's responsibility that this is done. The Board is concerned with the loose interpretation of "supervision of physician's extenders"; any interpretation must be reasonable. Feedback tells us that interpretation varies, most frequently with geographical location and with the case load of the physician.

Atch. A

In a recent communication from the Department of Health and Environment, problems in this area of physician/physician's-extender relationship are brought up having to do largely with proper authorization, questionable areas where the granting of authority to physicians extenders is not clearly defined. I will enumerate:

1. Performing physical examinations and recording patient histories. (The Regional Office will approve this practice if authorized by state law.)

2. Ordering medications, including controlled drugs, and other treatments on his own authority. (The Regional Office will approve this practice if authorized by state law.)

3. Other laboratory and X-ray procedures. (The Regional Office will approve if authorized by state law.)

4. Perform minor surgical procedures. (The Regional Office will approve if the state law so states.)

5. Signing of the supervising physician's name by the physician's assistant. (Regional Office will approve if the state law specifically states this is an acceptable procedure.)

The Kansas statute is silent in these areas. It is possible that in the next legislative session more definitive legislation will be passed. It should be remembered that this truly is a new field; guidelines have been frequently non-existent. The cautious approach of past legislators is commendable and caution in the future encouraged. (Personal opinion)

The Kansas Pharmacy Board questions policy in areas where physician's extenders sign prescriptions using the physician's name, or use their own name. The Pharmacy Board extends this concern into hospitals where physician extenders order medication. The hospital problems are largely settled by hospital board decisions and rules, although it may surface in small hospitals, i.e. one or two-man hospitals.

Problems originating in this area do reach the Board but with Board encouragement these problems are usually worked out on a local level. The Board considers a prescription to be a legal document, subject to forgeries and evidence in court -- certainly a privilege that should be diligently guarded by every practicing physician. To protect both the physician and the physician's assistant certain flexibility is desirable. The physician may wish to write the prescription and sign, have the assistant write the Rx and the physician sign, or authorize the P. A. to write prescriptions or hospital orders and the physician countersign within 24 hours. Under present laws a prescription signed by a physician's assistant may be refused by the pharmacist or by the hospital.

I trust this will help clarify the duties a physician's assistant may assume, as well as remove any confusion that may exist as to the Board's position on the relationship between the physician and the physician's assistant.

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Honorable Johnson, Chairman of the Interim Public Health and Welfare Committee. other members of the committee, ____________________ attendees.

My name is Carla Lee. I am chairperson of the Nurse Clinician Department and Project Director of the Kansas Regional Medical Preceptorship Project, both housed in the College of Health Related Professions at Wichita State University.

I am most pleased to address you and welcome the opportunity to speak to Proposal "60", which directs the committee to study the role of physician extenders. I will speak on educational preparation of Nurse Practitioner/ Nurse Clinician's and their utilization.

Materials have been provided in a packet that describes the curriculum, gives definitions of Nurse Clinician/Nurse Practitioners, lists types of functions, and speaks to some aspects of economic impact.

Thus, I will speak on the following specifics regarding the program.

What it is.
Why it exists.
When it started.
How it is meeting its goal.
How it is different from Physician's Assistant, Nurse Practitioner, and Registered Nurse.
And Projections for the future.

The Nurse Clinician Program was initiated as a project through the Kansas Regional Medical Program in 1971, with the first class being admitted in 1972 at the University of Kansas, Kansas City, Kansas.

After the completion of the first didactic portion of the program, the entire Nurse Clinician Program was transferred to the College of Health Related Professions at Wichita State University; at that time under the administrative leadership of the Dean of the College of Health Related Professions, D. Cramer Reed. A Medical Director, Dr. Gayle Stephens, was employed in 1972, along with a Project Director, Alma Cochran; the first class on the WSU campus was admitted in January of 1973.

The Nurse Clinician Program was established in Kansas as one of the methods by which Health Care Delivery could be enhanced to citizens of Kansas, particularly in the rural areas, where at that time, it was documented and still is that there is a shortage of physicians in rural areas of the country as well as a medical maldistribution of physicians.

In addition, the provision of adequate primary care has been a documented shortage. It was believed and is evident that registered nurses with advanced preparation can provide primary care. Thus, the second purpose of the program was related to expanding primary care services that could be made available to consumers with the first contact of the agency being with nurses

Atch. B

who had advanced skills. This concept in and of itself was not brand new as the county health nurse has served in this role for several decades. The difference in this particular model was an educational model formally preparing nurses through an academic network of education, evaluation and certification.

The intention was the planned method of nurses serving with physicians particularly in medically underserved areas. The program has continued to meet this objective well as shown by data that will be presented later.

Academic Requirements. Academic requirements are written in the material provided.

Basically, students must be registered nurses, currently licensed and meet Wichita State University Admissions regulations and sponsored by a licensed physician. Students complete six courses (26 semester hours), approximately 832 contact hours of instruction in a 12-month, 3-semester program.

Curriculum is composed of two phases; didactic and preceptorship. Prior to beginning the didactic phase, students take a comprehensive pre-test to assess learning needs. Didactic courses center on core skills for especially primary care practices.

Clinical Assessment. A course in which the student enhances knowledge of health, distinction between normal and abnormal findings and learn steps of the clinical process: assessment, diagnosis of problem, implementation, plan and evaluation. All this is predicated on a collaborative model with other health professionals, especially the physician.

Clinical Pathophysiology. A course which is designed to understand the mechanisims of the disease process, especially conditions which the Nurse Clinician/Practitioner will be monitoring care of, such as patients with diabetes, chronic heart disease, respiratory conditions, gynecological conditions, arthritis, and others. In addition, essential aspects of acute conditions are stressed as part of primary care.

Ecology of Primary Care. This course presents information related to health care maintenance and management, such as nutrition, emotional care, growth and development of all age groups, to patient activation-teaching programs.

Health Care Systems Analysis. A course which centers upon understanding and applying principles of team management, interdependency roles, and collaborative techniques. Information is presented with relation to standards of practice, scope of practice, legal aspects, development of protocol.

The preceptorship phase of the program consists of the following courses which the registered nurse takes in the home setting under the supervision of a preceptor who serves as a faculty of the Nurse Clinician Department for the primary purpose of expanding and extending the skills in general and family practice areas.

The two practicum courses are taught by directed study technique by a faculty-designed modular approach and clinical supervision by physicians. Practicum number I emphasizes continuity of care of patients and Practicum number II focuses on family care. Both courses emphasize health care that can be

provided by Nurse Clinician/Nurse Practitioners through established protocols collaboratively developed with physicians.

Students are post-tested at the close of the program and are then eligible to take National Certification Exams, which at this point, are optional for nurse practitioners. We have had approximately 15 of our graduates report for testing. The tests were offered for nurse practitioners for the first time in November of 1976 with planned twice a year testing.

The legal definition for nurse practitioners/clinicians have not been totally specified. State-developed definitions are included in this packet.

The department is currently staffed by the following:

Carla Lee, Chairperson and Project Director
Myron Hultgren, M.D., Medical Advisor
Joy Parcel, Program Coordinator
Helen Halstead, Assistant Professor
Betty Stroot, Preceptorship Coordinator
Evelyn Smith, Assistant Instructor, Outreach Coordinator

Supportive staff assisting in the program include approximately 40-50 local physicians; 10-15 nurses in allied health personnel, who both teach selected classes in the didactic phase and supervise clinically. Approximately 15 physicians continue to serve in the role of clinical supervisor during the didactic phase.

For further expansion of role taken, please see the enclosures in packets, (entitled: Functions, and Socio-Economics).

It is our experience that registered nurses have significantly expanded their knowledge and skills while completing the program as evidenced by gain scores of 15-20% on pre and post-tests.

Graduates through follow-up studies have shared that they are performing in intended areas of service. Most have returned to serve in rural areas. Physicians and nurse clinicians report much satisfaction with the role, and patient acceptance with benefits reported as follows: increased services as well as volume of patients, reduction in waiting time, increased time spent with patients, patient education increased, cost containment, reduced incidence of hospitalization, increased availability of services, increased emotional support for patients, and improved communication. These results in five short years continue to show a reasonable investment for the benefit derived.

I will be glad to provide further information, if you desire. Thank you for this presentation opportunity. For further information, please contact:

Carla A. Lee, R.N., Ed.S., F.A.A.N.
Chairperson and Project Director
Box 43
Wichita State University
Wichita, KS 67208

(316) 689-3605

Attachment C

WICHITA STATE UNIVERSITY
COLLEGE OF HEALTH RELATED PROFESSIONS
NURSE CLINICIAN DEPARTMENT
DESCRIPTION OF NURSE CLINICIAN PROGRAM

The Nurse Clinician Program is designed to involve registered professional nurses in a formal learning experience, focused upon the biopsychosocial assessment of pediatric and adult clients/patients and families and upon the principles of clinical management of such clients/patients. The program is divided into two phases: 12 weeks of didactic study and selected clinical experiences and 9 months of clinical preceptorship with periodic seminars on the Wichita State University Campus. A certificate of completion is awarded upon satisfactory completion of all required courses during both phases of the program. Graduates of the program are eligible to take National Certification Exams for Nurse Practitioners given by the American Nurses Association.

MAJOR OBJECTIVES

The major objective of the program is to expand the role of the nurse and effect a new outline of relationships among physician, nurse and patient as central manpower elements of the health care team. The new relationships constitute a means of promoting the health care delivery network by (a) extending the geographic distribution of health care services, (b) expanding the scope of care (preventive maintenance and rehabilitative as well as episodic), (c) increasing the productivity of the health care team by shifting some responsibility for health care management to the patient as a consequence of patient education by the Nurse Clinician/Practitioner.

Wichita State University conceptualizes the Nurse Clinician/Practitioner as a primary care generalist (a) assuming those medical management responsibilities designated by the physician in relation to a given group of patients, and (b) providing access to health care services at the point of entry into the health care delivery system. It is expected that these responsibilities will be assumed in addition to those aspects of client/patient care that do involve generalized nursing skills in ambulatory care settings.

ACADEMIC REQUIREMENTS

Admission. In addition to fulfilling all requirements for admission to Wichita State University, and the College of Health Related Professions, students wishing to enroll in the Nurse Clinician Program must apply for, and obtain approval of, the Admissions Committee of the Nurse Clinician Department. Applicants to this program must be registered nurses, with an associate degree, diploma, or a bachelor's degree. Students must submit a photocopy of their current license to practice as a registered professional nurse with a minimum of one year professional nursing experience; official records from their school of Nursing and all colleges attended. Students must be sponsored by a licensed physician who serves as preceptor during the 9 month preceptorship by contract with listed specific objectives. Students must be enrolled or admitted at Wichita State University and apply for undergraduate or graduate credit as appropriate and must meet the requirements accordingly. Students desiring to apply this credit toward a degree in nursing are highly encouraged to discuss this with the specific school of nursing prior to completion of the Nurse Clinician Program. Spring admissions deadline is September 1, and the Fall admission deadline is March 1.

Selection of students for the Nurse Clinician Program will be based on collaboration between a registered nurse and a sponsoring physician, both of whom agree: (a) to participate in sequential problem-orientated learning experiences, based upon material objectives; (b) to specify in advance, the assignment of functions on the basis of perceived levels of understanding and responsibility in relation to the current health care content of a given practice; and (c) to establish and maintain a collaborative team relationship during the training program.

Atch. C

A Preceptorship Manual will be provided to physician sponsors. Physician sponsors will be informed of their responsibilities for learning during the preceptorship phase following the 12 week Core Course. Included in this will be a conceptual framework to be used as a basis for concensus and the engagement of participants in an exchange of ideas about reciprocal expectations.

During the 9 month preceptorship, the physician is expected to (a) provide supervised learning experiences, and (b) monitor and evaluate performance regularly. Both nurse trainee and physician sponsor will be directly and continuously involved in (1) generating standards of performance; (2) setting and determining the achievement levels of the goals during the learning experience, and (3) developing recordkeeping systems which can be used as instruments for continuous evaluation. The physician is expected to indicate willingness to cooperate in pre and post training evaluation of patterns of patient processing in the practice setting. Evaluation measures will hopefully include overall productivity costs per unit of service, and outcomes of care provided by the collaborative team pattern of practice, compared to pre-existing patterns. The total evaluation will focus on role evaluation of both the physician and the nurse, patient acceptance of the Nurse Clinician, and the impact of the introduction of an expanded role of the nurse on the capacity of the team for delivery of quality health services.

<u>Curriculum.</u> The Nurse Clinician curriculum consists of Didactic and Preceptorship phases distributed throughout the year, with participation in periodic seminars required. Students may enroll in HS 521, Independent Study, for 1 to 6 hours of credit, supervised by the Nurse Clinician Department, by arrangement during the preceptorship.

Once admitted, students must take the following courses to receive a certificate of satisfactory completion:

	NAME OF COURSE	HOURS	RECOMMENDED SEMESTER SEQUENCE
NC 505	Clinical Pathophysiology	3	1
NC 515	Ecology of Primary Care	3	1
NC 525	Health Care Systems Analysis	3	1
NC 535	Clinical Assessment	5	1
NC 545	Nurse Clinician Practicum I	6	2
NC 555	Nurse Clinician Practicum II	6	3
ELECTIVES			
NC 540	Directed Studies in Expanded Role	1-4	2 or 3
NC 550	Special Topics	1-4	2 or 3
NC 560	Health Assessment Methods	3	2 or 3
NC 565	Quality Assurance	3	2 or 3

CIAL REQUIREMENTS

Nurse Clinician students are required to show proof to professional liability and health insurance coverage in amounts of not less than $100,000/300,000. In addition, students are required to provide their own transportation to health care facilities affiliated with the program.

GRADUATION REQUIREMENTS

Students must obtain a minimum of 2.0 Grade Point Average (on a 4.5 Scale) in all required course in the Didactic and Preceptorship phases of the curriculum and show evidence of competence in expanded role functions.

PROGRESSION

To progress in the professional sequence, a GPA of 2.00 must be earned in all professional courses. If students receive a D or F in only one segment of a course that combines theory and clinical practice, they still fail the course. Students who receive a D or F in any professional course may not progress in the professional sequence. If their overall academic record remains at 2.0 or above and they desire to continue in the program, they may petition the Committee on Admissions and Progression in the Department.

Additional information may be obtained by writing: Chairperson, Nurse Clinician Program, Wichita State University, Wichita, Kansas 67208.

COURSES FOR GRADUATE/UNDERGRADUATE CREDIT

505. Clinical Pathophysiology. (3). 3R. A lecture and discussion presentation designed to prepare primary care nurse clinicians to enter the preceptorship by providing knowledge of biological concepts in terms of clinical pathophysiology and mechanisms of disease. Prerequisite: Departmental Consent. H 23 505 0 1201

[illegible]. Ecology of Primary Care. (3). 3R. A lecture series designed to discuss applied knowledge of principles of human behavior. Psychosocial components of client/patient management are introduced through the study of wellness-illness behaviors in relation to cultural forces and of emotional stresses as these effect the client/patient, family and health team members. Prerequisite: Departmental Consent. H 23 515 0 1201

545. Nurse Clinician Practicum I. (6). IR, 5L. A course designed for clinical application of theoretical content identified as related functions for expanded role nursing. The practicum is designed for primary-care settings to meet the requirements of expanded role program to receive a certificate of completion. Emphasis is placed on history-taking

525. Health Care Systems Analysis. (3). 3R. A seminar and discussion course designed to prepare primary-care nurse clinicians to enter the preceptorship by analyzing role identification and the relationship between the nurse clinician and members of the health team in the delivery of the health care. Focus is on continuity and comprehensiveness of health care as the goals of role modification. Prerequisite: Departmental Consent. II 23 525 0 1201

535. Clinical Assessment. (5). 3R, 2L. A course utilizing lecture, seminar, demonstration, clinical lab and clinical experience sessions that prepare the primary-care nurse clinician to enter the preceptorship by providing basic knowledge and skills in clinical assessment and management of clients/patients. Methods of history taking and interview techniques, physical assessment, multiphasic screening, sources of clinical data, special procedures, developmental assessment and aspects of well-child care are explored. The assumption of responsibility for the in-depth care of multiple-problem clients/patients is explained. Prerequisite: Departmental Consent. H 23 535 0 1201

545. Continued:
skills and physical and psychosocial assessment. Prerequisites: Departmental Consent, Physician Preceptor. NC 505, 515, 525, 535. H 23 545 2 1201.

555. Nurse Clinician Practicum II. (6). IR, 5L. A clinical application course designed to enhance problem solving skills of nurse clinician preceptees in client/patient management situations in their preceptorship setting. Emphasis is on case presentation and analysis of the assessment, planning, implementation and evaluation phases of health care delivery with modification of the plan of care. Prerequisites: Departmental Consent, Physician Preceptor. NC 505, 515, 525, 535. H 23 555 2 1201

ELECTIVES

540. Directed Study in Expanded Role Nursing. (1-4). A guided-design course contracted with student composed on objectives, description of study, method, anticipated results, and selected resources. Results include scholarly description of study with critique of relevancy to expanded role nursing. Prerequisites: NC 505, 515, 525, 535 or Departmental Consent. H 23 540 3 1201

550. Special Topics (1-4). Specialized individual or group study on specific topics relevant to the nurse practitioner role with adaptations made to relate to student's individual interests and practice areas, e.g., advanced clinical assessment, problems in pathophysiology. Prerequisites: NC 505, 515, 525, 535, or Departmental Consent. H 23 550 0 1201

560. Health Assessment Methods. (4). 3R, 2L. A classroom and practice lab course designed to increase the health care provider's ability to perform basic biopsychosocial assessments upon clients representing the full life span. Emphasis is placed upon normal aspects, but stress factors are also given consideration. Prerequisites: Departmental Consent. (Open to non-majors). H 23 560 2 1201.

565. Concepts of Quality Assurance in Health Care. (3) 3R, 2L. Course focuses upon current social concerns with assessing quality of health care and appropriate utilization of activities and resource. Prerequisites: NC 505, 515, 535, 545, or Departmental Consent. (Open to non-majors). H 23 565 0 1201.

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NURSE CLINICIAN PROGRAM
BOX 43
WICHITA STATE UNIVERSITY
WICHITA, KANSAS 67208

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DEFINITIONS

PROFESSIONAL REGISTERED NURSE

The practice of professional nursing means the performance for compensation or gratuitously, except as permitted by K.S.A. 65-1124 and amendments thereto, of any act in the observation, care, and counsel of the ill, injured, or infirm, or in the maintenance of health or prevention of illness of others, or in the supervision and teaching of other personnel, or the administration of medications and treatments as prescribed by a person licensed to practice medicine and surgery or a person licensed to practice dentistry; requiring substantial specialized judgment and skill based on knowledge and application of the principles of biological, physical, and soical science.(3). Thus, we would suggest that the definition of the Registered Nurse become the definition of nursing practice for the Registered Nurse.

EXPANDED NURSING ROLES

The goal to attain higher levels of wellness among persons in society and the problem of an increase of communities who do not have adequate numbers of health team members, have caused new demands on nursing to assume more responsibilities in the health delivery system. As a result, two types of expanded nursing roles have evolved; that of Nurse Practitioner/Clinician and Clinical Nurse Specialist.

NURSE PRACTITIONER/CLINICIAN

Nurse Practitioners/Clinicians are R.N.'s who have advanced skills in the assessment of the physical, biophysical and psychosocial health-illness status of individuals, families or groups in a variety of settings through health and development history taking and physical examination. They are prepared for these special skills by formal Continuing Education which adheres to ANA approved guidelines, or in a Baccalaureate Nursing Program which meets expanded role criteria. These programs will educate the Nurse Practitioner/Clinician in the physical and psychosocial assessment and the ordering of appropriate laboratory and diagnostic tests according to protocol collaboratively established between the physician and Nurse Practitioner/Clinician to determine the health-illness status of individuals, families, and groups in a variety of settings. Nurse Practitioner/Clinicians's institute and provide continuity of health care to clients (patients), work with the client to insure understanding of and compliance with the therapeutic regimen within established protocols, and recognize when to refer the client to a physician or other health care provider. The Nurse Practitioner/Clinician provides instruction and counseling to individuals, families, and groups in the areas of health promotion and maintenance, including and involving such persons in the planning for their health care. Nurse Practitioner/Clinician's work in collaboration with other health care providers and agencies to provide, and where appropriate, coordinate services to individuals and families.

Since the focus is clinical practice, he/she ceases to be recognized as a Nurse Practitioner/Clinician if he/she fails to maintain active clinical practice in direct patient care for 40-50% of the time.(2).

Atch. D

CLINICAL NURSE SPECIALIST

The Clinical Nurse Specialist is a practitioner holding a Master's degree with a concentration in specific areas of clinical nursing. The role of the Clinical Nurse Specialsist is defined by the needs of a select client population, the expectations of the larger society, and the clinical expertise of the nurse. By exercising judgment and demonstrating leadership ability, the Clinical Nurse Specialist functions within a field of practice that focuses on the needs of client system and encompasses interaction with others in the nursing and health care systems serving the client. The Clinical Nurse Specialist's role includes participation in activities designed to continue self-development, advance the goals of the nursing progression, and promote effective collaborative relationships with members of other health care disciplines.

The function of the Clinical Nurse Specialist is unique with respect to the particular use of clinical judgment and skills regarding client care, service as an advocate when the client is unable to cope with a particular situation, and influence for change as necessary in the nursing care and in the health care delivery system.

The Clinical Nurse Specialist is obligated to operate within and to affect nursing care delivery systems and the total health care delivery system. While roles may change by circumstances for a certain period of time,this practitioner ceases to be recognized as a Clinical Nurse Specialist when the patient-client-family ceases to be the basis of practice.

As a practitioner, the Clinical Nurse Specialist operates within three separate fields which remain in a state of dynamic change. These fields represent the health status of the client, the nursing care delivery system, and health care delivery system. Each of these fields is so interrelated as to continuously affect the other.

The nursing care delivery system is a distinct subtype within the health care delivery system. As a practitioner, the Clinical Nurse Specialist provides health teaching to select clients in the achievement or maintenance of health; facilitates the utilization of valid health care measures and of community resources; and assists in regulating or controlling external enviromental forces. The Clinical Nurse Specialist provides, identifies, and describes nursing practice situations according to the educational needs of colleagues, and based on these needs applies appropriate teaching-learning strategies. As a role model, the Clinical Nurse Specialist affects nursing practice and nursing intervention both in a select health care setting and in the community.

The Clinical Nurse Specialist identifies the need for and is involved in research which is directed toward clinical problems in nursing theory and nursing care delivery systems and in the interpretation, evaluation, and implementation of research theories and findings into nursing practice.

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As a consultant, the Clinical Nurse Specialist provides assistance within the area of specialization to colleagues and to consumers in planning and evaluating health and illness care.

The Clinical Nurse Specialist helps develop evaluative criteria and patient outcomes used in the measuring and monitoring of qualitative and quantitative aspects of nursing care. The Clinical Nurse Specialist participates in peer review to evaluate the practice of nursing delivered by other Clinical Nurse Specialists and by groups of nurses in a given setting. (1976)

10-1-76

Submitted by the adHoc Committee on Definitions of the Nurse Clinician/Nurse Practitioner Conference Group.

Attachment E

NU[illegible] CLINICIAN PROGRAM
BOX 43
WICHITA STATE UNIVERSITY
WICHITA, KANSAS 67208

FUNCTIONS:

(A) General-

One of the most important functions of the Nurse Practitioner is the delivery of primary care. This includes identifying the health status of an individual or family, screening for problems that need to be referred to a physician or other resource, managing acute or eposodic illnesses, managing stable chronic illnesses, teaching patients health maintenace, utilizing community resourses in meeting patient needs, counseling, and coordinating all phases of the patient's health care. Emphasis is placed on preventive care and health maintenance.

(B) SPECIFIC--

1. Case finding and medical referral. Identification of ills, actual and impending.
2. Case finding and social agency referral. Pshyco-social factors and complications.
3. Pre and Post Partum care
4. Well baby checks
5. Rest and Nursing home visits
6. Follow up of patients following discharge from therapeutic regimens.
7. Identification of deviation from 'normal"
8. Assessment of the responses of patients to illness and of their compliance with and response to prescribed treatment.
9. Determine the need for, performance of and interpretation of basic selected diagnostic and therapeutic procedures, tests.
10. Recommendation of modifications needed by patients coping with illness or maintaining health, such as in diet, exercise, relief from, and adaptation to handicaps or impairments.
11. Making referrals to appropriate agencies.
12. Routine assessment of the health status of individuals and families.
13. Provision of family planning services
14. Supervision of health care of normal children.
15. Eliciting and recording a health history
16. Assessing the environment
17. Providing emergency treatment

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ACUTE CARE-

1. Securing and recording a health and eevelopmental history and making a critical evaluation of such records as an adjunct to planning and carrying out a health care regimen in collaboration with medical and other health professionals.
2. Performing basic physical and psychosocial assessments and translating the faindings into appropriate nursing actions.
3. Discrimination between normal and abnormal findings on physical and psychosocial assessments and reporting findings when appropriate.
4. Making prospective decisions about treatment in collaboration with physicians
5. Initiation actions within a protocol developed by medical and nursing personnel such as making adjustments in medication, ordering and interpreting certain laboratory tests, and prescribing certain rehabilitative and restorative measures.

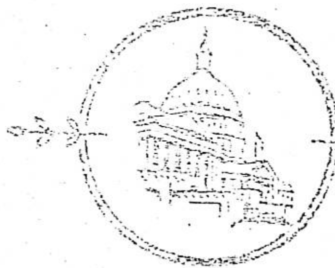
LONG TERM CARE-

1. Giving treatments, rehabilitative exercises, and meds as prescribed by the physician.
2. Teaching patients and family members to carry out the medical plan for special diet, taking into consideration cultural background, personal preferences, and financial status.
3. Teaching patients and family members to give these traatments or medications when indicated.
4. Observing and evaluating patients' physical and emotional condition and reaction to drugs or treatments.
5. Calling new signs or symptoms to the attention when the physician and arranging for medical attention when the patient's condition appears to warrant it.
6. Instituting immediate life-saving measures in the absence of a physician
7. Making necessary changes in a treatment plan in the light of changes in the patient's physical or emotional tolerance, and in accordance with an established treatment plan.
8. Making appropriate referral for continuity of care
9. Make judgments about the use of accepted pharmaceutical agents as standard treatments in diagnosed conditions.
10. Assume primary responsibility for determining possible alternative for care settings and for initiation referral.
11. Conducting nurse clinics for continuing care of selected patients.
12. Conducting community clinics for case finding and screening for health problems
13. Assessing community needs in long-term care and participating in the development of resources to meet them

In providing comprehensive care the nurse practitioner may function in a secondary care setting. This care will be determined by the nurse practitioner and the physician and the hospital rules

Collaboratively agreed upon, it's expected that the clinician will contribute markedly to continuity of health care as the patient moves from the ambulatory care setting through acute care facilities and progresses back to office or clinic supervision. Interaction with other personnel in the hospital setting, participation with the admitting physician and direct care to the patient and his family encompass the clinician role in secondary care settings. Ordinarily these activities are subordinate to those described in the earlier description of functions in primary care settings.

Attachment F



Socio-
ECONOMICS

Nurse Clinician

GERALDINE C. HOLMES, Ph.D. and
RITA E. BASSETT, Kansas City, Kansas

SHORTAGE of primary care physicians in rural Kansas and the uneven access to primary care services throughout the state was one of the problems identified by the Kansas Regional Medical Program during its early years of operation. This problem was studied, and several projects were initiated to remedy it. One of the most successful has been the use of physician extenders in private office practices which are located in medically underserved areas.

In 1971, primary care physicians in Kansas were asked if they would be willing to employ a physician extender in their practice, and if so, what type of training these individuals would need in order to work effectively in a new role.[1] On the basis of information received from this survey and consultation with many people in medicine and nursing, a program was developed for training experienced nurses to work as primary care nurse clinicians in ambulatory health care settings. The program was reviewed and approved by a committee of professional experts, by the Regional Advisory Council of the Kansas Regional Medical Program, and by the Division of Regional Medical Programs in Washington.

The Nurse Clinician Training Program was started in January 1972, in Kansas City, at the University of Kansas Medical Center. However, following core training for the first class the program was transferred to the Wichita State University Branch of KUMC, because an alternative training program for nurse clinicians was developed at KUMC.

The course includes a two-month didactic phase, during which time students reside in Wichita, followed by a ten-month preceptorship with a sponsoring physician. By November 1975, 72 nurse clinicians had completed the program and 34 others were in various stages of training. Of the total, 49 are employed in medically underserved areas of Kansas, 30 are employed in Wichita or other urban areas of the state, 27 are working in other states. Eighty per cent of those employed in Kansas serve in private group or solo practices.

Results of 1973 and 1975 interview studies of participants in the nurse clinician training program at the Wichita State University/KUMC Branch are reported. Findings from literature reviews and the first productivity case studies are summarized.

There has been a great deal of interest in the state and nationally in learning more about the participants in the program and the experiences of nurse clinicians in private practice settings. Therefore, the staff of the Kansas Regional Medical Program (KRMP) has conducted a series of studies to evaluate the effectiveness of the program. In spring 1973, a study of the working roles of the first 21 participants in this program was conducted. The motivation of nurses and physicians who had participated, the working roles of clinicians, and the perceived problems and benefits associated with their employment were studied. Concurrently, a systematic review of professional literature was initiated which has

From the Department of Planning and Evaluation, Kansas Regional Medical Program.

Atch. F

focused on the utilization and productivity of physician extenders, the nature of primary care practice, and the delivery of primary care services in the office practice setting. On the basis of these findings, a series of case studies to [illegible] the impact of nurse clinicians on the productivity of office practice was initiated during summer of 1974. These case studies have been conducted in Kansas in two rural solo practices, a rural two physician group practice, and a suburban solo practice.

Professional literature provides extensive evidence that patient acceptance of physician extenders has not been a significant problem. Ten studies conducted since 1967 demonstrate that physician extenders can manage selected types of patient problems equally well with physicians. Three studies indicate that the range of profit to physician employers of pediatric nurse practitioners is $2,500-$17,000 during the first year of employment.[3,4] A recent study of MEDEX shows a range of profit to physician employers of $12,840-$39,210 a year.[5] A 1972 study by Pondy[6] suggests that the role definition of a physician extender has substantial influence on productivity, and this study cites an actual increase of 9 per cent in the number of patient visits processed after the introduction of a physician assistant into a solo practice in North Carolina. The first productivity case study of a solo practice in Kansas indicates that 20 per cent of patient visits which would normally require the attention of a physician are being managed successfully by a nurse clinician, and she allows the physician to increase his productivity by approximately 12 per cent.

Nurse Clinicians in Kansas

Research evidence to date documents and describes some of the problems associated with being a nurse clinician and with employing one. It also provides a very strong argument that such individuals can and generally do make a very significant contribution to the practices and communities in which they are employed.

Interviews were conducted in April and May 1972, with the first 2[illegible] nurses who entered the program and their preceptors or employers. In fall 1973, interviews were conducted with 45 more recent graduates and preceptees and 30 of their employers.

The 65 nurse clinicians interviewed ranged in age from 2[illegible] to 57 years (median age, 34). Prior to entering the program, they worked in nursing 17 months to 3[illegible] years. The majority of the early graduates were employed as a nurse in private practice before entering the program, and were employed as nurse clinicians in the same practice following preceptorship. However, 20 of the more recent graduates were employed by hospitals before they entered the program. Most of the former hospital nurses are now employed in group or solo practices. At the time they were interviewed, 45 clinicians were employed in private medical practice, 10 in public health departments, 7 in hospital settings, and 2 in university health centers. One was not employed.

Two clinicians serve their communities from offices in which the physician is no longer present. One physician died, the other retired at the age of 70. Both of these clinicians work with sponsoring physicians located in towns about 20 miles distant. They work from standing orders, consult by telephone with the physicians, and refer patients whose problems are too complex for the clinician to handle alone.

The first 2[illegible] graduates of the program were employed in Kansas after their preceptorship, and 16 of them have been working in small towns and communities which can be described as medically underserved. Many of the more recent graduates are also employed in rural Kansas communities. However, a sizable number of the more recent graduates have come from and returned to Wichita for employment.

The increase in students from Wichita has a direct relationship to the announced termination of the Regional Medical Programs by the federal government on June 30, 1976. The RMP staff in Kansas was reduced by 38 per cent in 1973. Since that time, it has not been possible for the staff to help significantly with the time-consuming and important task of recruiting qualified nurses and preceptors from medically underserved areas in Kansas. KRMP has funded the Nurse Clinician Training Program since its inception in 1970. In 1975, the State of Kansas assumed fiscal responsibility for core training in Wichita, and KRMP provided funds for the preceptorship phase. The program, in its present form, will require additional state funding to continue beyond 1976.

Interviews have been conducted with 40 Kansas physicians who have served as preceptors, and several of these individuals have participated in the training of more than one nurse clinician. All but two are in family practice, internal medicine, pediatrics, or general practice. One is a nephrologist at KUMC, who served as preceptor for a nurse nephrologist. The second is director of the Institute of Logopedics in Wichita. Preceptors have ranged in age from 30 to 57 years. However, most are between 40 and 55 years of age, and have been practicing medicine 10-30 years.

Role of Nurse Clinician

The role of the nurse clinician is varied, and is unique in some respects. However, a number of common tasks are carried out by most clinicians who work in primary care settings. The definition of a particular nurse clini-

cian's role appears to depend upon four factors: (1) the type of practice in which she is employed; (2) the [illegible] and preferences of her employing physician; (3) her [illegible] abilities and [illegible]; and (4) the nature of [illegible] needs.

In the [illegible]-month [illegible] and clinical program at W[illegible] nurse clinicians have received training relevant to the performance of [illegible] health care tasks. Fifty-two nurse [illegible] have participated in the study of working [illegible] role change in relation to these tasks. This study revealed that all of the nurse clinicians working in a private practice perform physical assessments, determine the need for and order basic diagnostic tests on [illegible], make preliminary interpretation of basic diagnostic tests, and engage in patient education. About half are supervised to some extent when making preliminary interpretations of basic diagnostic tests. Otherwise, these tasks are performed independently by clinicians.

Most clinicians (75-98%) also perform the following tasks independently: (1) obtain and record patient histories; (2) conduct adult and child well-care physical examinations, including gynecological and breast examinations on women; (3) organize information for presentation to the physician; (4) make initial assessment of emergency cases; (5) educate patients in nutrition, special diets, and preventive and emergency measures for high-risk conditions; (6) determine the need for and order throat cultures as well as perform them; (7) perform visual screening procedures and immunizations; and (8) conduct pre and postnatal checkups, well baby physicals, and child care education.

No direct supervision is required for the 40 per cent of the clinicians who perform audiometries, tonometries, and EKGs; 36 per cent apply casts; and 31 per cent report assisting in the operating room. As in the case of those doing minor suturing, most of these clinicians were formerly hospital nurses.

The other tasks that most clinicians perform (but in which more than 25% have supervision) are determining the need for and ordering x-rays, blood tests, assessing [illegible] function and venereal diseases. Most clinicians [illegible] and manage chronic problems such as diabetes, hypertension, obstructive lung disease, and [illegible] approximately one [illegible] manage renal insufficiency [illegible] physician supervision.

[illegible] and [illegible] per cent of the clinicians take [illegible] and write progress reports on [illegible] two thirds of the clinicians performing [illegible] independently. Fifty-one per cent [illegible] minor suturing. Fewer than 15 per cent [illegible] administer anesthetics, manage uncomplicated [illegible], perform circumcisions, insert IUDs [illegible] routine laboratory procedures.

Seventy-two per cent of the clinicians make house calls; 68 per cent make nursing home visits; 59 per cent make hospital visits with the physician, and most of these nurses also make rounds unaccompanied.

There are some tasks that clinicians are capable of performing but do not perform. Half of the physicians report that clinicians do not perform male genital examinations, do no suturing, and do not remove growths because of a fear that patients may not accept this service from anyone but a physician.

When comparing the group of nurse clinicians interviewed in 1971 with those interviewed in 1973, a shift in the percentage of clinicians performing certain kinds of tasks was observed. The more recently trained clinicians are taking more responsibility for monitoring and managing chronic illnesses. They are doing fewer of the time-consuming diagnostic tests (i.e., x-rays, Denver Developmental Screening Tests, and EKGs) and less routine laboratory work. Pre and postnatal checkups are being done by 20 per cent fewer of the more recent graduates.

Most tasks presently performed by clinicians are tasks which they did not perform as registered nurses, and a majority perform at least 25 new health care duties. Most clinicians report that prior to training they did not take complete histories, perform physical examinations, make physical assessments, secure Pap smears, or order basic diagnostic tests. Such tasks now comprise a staple part of their responsibilities.

Some tasks nurse clinicians perform are not new; they are ordinarily assigned to registered nurses. For example, a majority of clinicians did and still do take x-rays, give immunizations, and provide education for patients in the use of prescribed medications. Only a few clinicians view patient education as a new function, but they have expanded the scope and depth of the education they provide.

Seventeen clinicians have reported a reduction in the kinds of routine nursing tasks they perform. Those most frequently deleted from the roles of nurse clinicians are taking routine temperatures and blood pressures, administering medications, and performing routine laboratory tests.

The nurse clinicians in this study provide many services to patients which previously required the attention of a physician. Some of these are provided independently, while others are provided with supervision and consultation of the physician. However, the amount of physician supervision required is reduced during the course of preceptorship and, therefore, the physician's time is freed for other patient care responsibilities. Frequently performed tasks tend to be those which require less physician supervision. This finding is consistent with re-

sults of a study of physician's assistants in other states.[7]

The 63 nurse clinicians and 49 physicians interviewed were asked to state their reasons for participating in the program. Nurse clinicians gave six basic responses: (1) to acquire a more interesting and satisfying professional role; (2) to learn more about patient care; (3) to enhance professional status; (4) to comply with the request of an employing physician; (5) to meet a need for health care in a particular community; and (6) to make more money. The reasons most frequently cited were to engage in more interesting work and to learn more about patient care. A desire to increase income was given as a primary or secondary reason for entering the program by only 12 per cent of the clinicians interviewed.

Physicians gave three primary reasons for agreeing to serve as preceptors: (1) to provide better care for patients already served, (2) to reduce working hours; and (3) to serve a larger number of patients. Most physicians who have trained or employed nurse clinicians have done so to provide a better quality of care to their patients, whether by increasing services, out-of-office visits, or concentration on serious problems. Some have felt a need to provide health care services to new patients who were without a physician.

Twenty-two physicians cited a need to reduce their own working hours as a central reason for training and employing a nurse clinician. Even when this reason was the sole one, the implication was clear that physicians felt unable to reduce time spent in patient care unless a satisfactory alternative existed for providing such care. Three physicians agreed to serve as preceptors primarily because they were asked to do so.

All of the clinicians interviewed felt an increased sense of professional competency, and 86 per cent reported a significant increase in their job satisfaction. Most enjoyed feelings of greater professional challenge and fulfillment in their new roles. They recognized that they were making a more significant contribution to patients now than they were able to in their previous role.

However, there are aspects of their new role that some clinicians do not enjoy. Ten experienced some insecurity in performing certain tasks, and six were uncomfortable with the vagueness of their role. Four clinicians have found that they miss another type of nursing in a hospital environment, and ten objected to increased paperwork at the expense of patient contact. A few have become concerned about the increasing length of their work [illegible]. Although a desire to make more money was not a primary reason given by most clinicians for seeking additional training, the issue of appropriate compensation became a concern for many as they have become experienced and established in a new role. In 1973, 13 of 15 clinicians employed in private practice felt that they were receiving an adequate salary for their services. However, the interviews conducted in 1975 revealed that half the nurse clinicians in this group felt that they were not receiving appropriate compensation for their added responsibilities. Eleven of these clinicians have received a salary increase since entering nurse clinician training, and eleven have not.

Although no information was sought on the salaries paid to clinicians, 63 clinicians provided information on the raises they have received since the completion of their preceptorship. *Table I* shows the distribution of salary change that accompanied the change in role from registered nurse to nurse clinician for this group of individuals.

The Physician's View

Kansas physicians who employ nurse clinicians report several types of benefits, including a significant reduction in work-related stress and fatigue. This benefit is cited as a crucial factor in the decision of a few physicians to continue practice in rural Kansas communities. Several physicians comment that the work day is less stressful when a clinician is present, because patients do not have to wait so long to receive attention. In some overburdened practices, long waiting periods for patients have caused a deterioration in doctor-patient relationships.

Twenty-three of 31 physicians who gave "a desire to reduce working hours" as one reason for employing a nurse clinician have attained that objective. The reduction has averaged 10-14 hours per week. However, five physicians report reductions of only 3-6 hours per week. Some of those who report a significant reduction in working hours are still investing 10-12 hours per day in patient care.

Between 1969 and 1971, surveys were conducted in four states to determine physician attitudes toward the use of physician extenders. In those states, the following percentage of physicians surveyed indicated that they would or could profitably employ a physician extender:

TABLE I

MONTHLY SALARY CHANGE FOR NURSE CLINICIANS AFTER TRAINING (N = 63)

Decrease*	2	$201-$300	7
No increase	16	$301-$400	0
Expecting increase	9	$401-$500	3
$100 or less	11	$501-$600	3
$101-$200	12		3

* Both clinicians experiencing salary decreases were previously in hospital settings and are now in group practice.

Kansas, 56 per cent; Pennsylvania, 70 per cent; Wisconsin, [illegible] per cent; and Kentucky, 79 per cent.[8] One barrier to the utilization of physician extenders uncovered by these surveys was a perception on the part of some physicians that the employment of such an individual would constitute a considerable financial risk. However, studies available on the financial benefits to physicians who employ a physician extender indicate that there is some degree of profit to most of these employers.

Interviews with physicians in Kansas who employ nurse clinicians reveal that the patient charge is generally the same whether the patient is seen by the physician or by the nurse clinician. This policy seems appropriate since nurse clinicians manage independently many patient visits which formerly required the attention of the physician. Patients with problems which are too complex for the clinician are seen by the physician alone or in collaboration with the clinician.

Case studies being conducted in Kansas regarding the impact of nurse clinicians on the productivity of an office practice indicate that clinicians can and sometimes do make a financial contribution to a practice through the patient visits they manage independently and by enabling the physician to make more productive use of his own time.

Physicians serving as preceptors or employers, when asked to identify problems relative to utilizing nurse clinicians, said the greatest difficulty is in defining the clinician's role in a way that maximizes benefits and prevents problems. In several practice settings, working out an operational role has required experience and adjustment. Judgments of physicians vary on what a nurse clinician should do; decisions are based on their perception of the abilities of the clinician, what patients will accept, the needs of their practice, and risks associated with medical-legal liability. Sixteen physicians indicated that the initial difficulties they experienced in creating an appropriate role for the clinician were due to other personnel in the office. Nine cited vague laws or fears of malpractice suits as a factor influencing the role of the clinician.

The cost of malpractice insurance has not increased in Kansas for physicians because they employ nurse clinicians. However, the legal status of clinicians is vague and, as a result, relatively conservative use is being made of their abilities in some situations. In many practices, patients have a choice of seeing the physician or the nurse clinician. In others the physician sees each patient who has already been seen by the clinician, even if only for a moment.

Difficulties experienced by most physicians have been minimal, but concern about potential problems persists in the minds of a few. Generally, acceptance of the nurse clinician by patients and by other professional persons has not been a problem. Most physicians report positive or enthusiastic acceptance of the nurse clinician. A few noted mixed responses initially, but patient resistance was overcome quickly. Irritants such as jealousy exhibited by other employees in the office have been limited.

Others in the health professions seem more reluctant to accept the nurse clinician role than the general patient population. Forty-five per cent of the clinicians reported positive reactions from other nurses, but 75 per cent reported neutral or negative responses from those in other health professions. Ten negative responses were from other physicians in the communities, and eight were from hospitals. In only a few instances, however, were responses serious enough to limit the clinician's function.

Acceptance of nurse clinicians did not come about automatically. Most physicians prepared their patients and office staff for the nurse clinician by personally explaining her role and expressing confidence in her competence. Another factor contributing to positive acceptance is that many clinicians have been well known to patients prior to training for the new role.

Benefits to Patients

Improved access to health care services has been identified by most physicians and nurse clinicians in this study as the most significant benefit to patients. In practices in which the clinician sees patients independently, most average nine or ten patient visits each day; some see fewer than five patients a day, and others average more than 20 patient visits per day. Ten physicians gave estimates of additional patient visits made possible by the assistance of the clinician, and these estimates ranged from 5 to 30 patient visits per day.

Most physicians and clinicians feel that patient waiting time for service has been reduced and that quality of care and patient education have improved. The frequency with which these and other patient benefits have been identified is summarized in *Table II*.

Although patient charges are not generally reduced when a patient sees a nurse clinician rather than a physician, patients often receive more professional attention and more comprehensive care without any additional charge. For this reason, some clinicians and physicians feel it appropriate to say that the cost of health care services to some patients is reduced when a nurse clinician is utilized. Some feel also that improved care can reduce the number of return visits and the cost of hospitalization, and this perception has received some support from other studies.[9]

TABLE II

BENEFITS TO PATIENTS RESULTING FROM NURSE CLINICIAN UTILIZATION

Patient Benefit	% Citing Benefit PHYSICIANS (N=49)	CLINICIANS (N=60)
1. Reduction in waiting time for care	100	89
2. Increase in time spent with patients	91	76
3. Increase in number of patients seen	83	100
4. Patient education has been improved	83	72
5. Saved time and travel expense for patients by home visits and new practice sites	51	69
6. Improved quality of care	40	23
7. Increased availability of care at night and on weekends	33	43
8. Reduction in incidence of hospitalization	4	0
9. Improved communications	2	3
10. Increased emotional support for patients	0	1

Two physicians in Kansas reported an increase in cost to the patient as a result of utilizing a nurse clinician. However, both indicated that the clinician obtained more information and provided more services. Therefore, this increase in cost is related to increased service. Most physicians and nurse clinicians in the study felt that the patient benefits cited could not have been realized without the nurse clinician training program or the recruitment of another physician to the practice or community.

Summary

The utilization of nurse clinicians in practices studied has produced advantages for patients, the clinicians, and their employing physicians. The type of benefit derived is closely related to the physician's reason for employing a clinician. For the most part, physicians who wished to provide more comprehensive care, to serve more patients, or to reduce their own workload have achieved the desired results. Nurse clinicians have contributed to the [illegible] of physicians and have provided expanded services to patients. They are generally well accepted.

Nurse clinicians in medically underserved communities in Kansas are improving access to needed health care [illegible], are helping retain some physicians in rural communities, and they are providing services which would not be available otherwise. Therefore, it seems important that the problems which do exist in regard to the training and employment of nurse clinicians in Kansas be resolved.

Adequate financial support for the nurse clinician training program after 1976 is needed. The legal status of nurse clinicians requires further clarification. Some problems related to third party payment for services provided by nurse clinicians need to be resolved. The issue of appropriate compensation for the services of a nurse clinician deserves attention; it could be addressed through a study of salary scales of physician extenders to supply an external perspective to those who are concerned about this matter.

At the time of this study, the 41 graduates of the Wichita based program who are employed in medically underserved areas of Kansas are managing, or enabling their employing physician to manage, an additional 1,078 patient visits a day. This figure is based on an average of ten patients/day seen independently by clinicians and 12 additional patients seen on the average by physicians. The projected annual figure of an increase in patient visits by 25,872 (5,280 per practice) is based on 240 eight-hour work days/year. These patient visits occur in communities which experience difficulty recruiting the additional physicians they need. This benefit alone seems worth the total investment required to maintain the program which has trained these individuals.

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Attachment G

I am Val Valgora. I am a graduate Physician's Assistant having received my education at Duke University, Durham, N.C. I am currently chairman and Director of the Physician's Assistant Program of W.S.U., a position which I have held since Oct. 1972. I am past president of the Kansas Academy of Physician's Assistants. The purpose of my appearance today is to speak for the P.A. in Kansas, to inform you of the accomplishments of those P.A.s and the W.S.U. Program.

Hx of PA's -

In the early 1960s the nation was faced with a severe health care problem. There were not enough physicians. Many of the physicians that were available were specialized in other than primary care and many more were located in major population centers. These three factors indeed presented a bleak outlook for health care in rural and other "medically underserved" areas. The idea of educating people other than physicians who were capable of performing some of the functions of physicians was thus born and has become the P.A. as we know him today.

In the relatively short history of the PAs there have been several notable developments.

1. The American Medical Association has devised an accreditation process for schools. The AMA developed essentials for approval of P.A. Program and has an on-going program to evaluate these progrsms which includes an on-site evaluation.
2. The National Board of Medical Examiners has developed an examination which is administered early to evaluate graduates' knowledge.
3. A National Commission has been formed to certify P.A. graduates based on their performance on the National Board Examination.
4. Most states have passed legislation which recognizes the P.A. and allows them to practice within that state. (In many of these states, registration is based on graduation from an AMA approved program and passing the National Board Exam).

Atch. G

5. A demanding continuing education process for recertification has been developed and is operational. This process may be the most stringent of any of the medical or allied health professions since it requires, in addition to continuing medical education, recertification by examination every 6 years.

In my opinion, Physicians' Assistants are a well credentialed group that have proven their capability of increasing both the quality and quantity of medical care in the United States.

P.A. Accomplishments in Kansas - Since the inception of the P.A. Program at Wichita State University in 1972, there have been many accomplishments which those associated with that Program can be justifiably proud.

1. The State of Kansas has, in steadily increasing increments, become fully responsible financially for the Program which was totally funded by Federal dollars at its inception in 1972.
2. By August 1976, the Program has produced 59 graduates. Of these graduates, 4 were located outside of Kansas and only 8 were in practice other than designated medically underserved areas.
3. The Program received full three year approval from the AMA. (This is the longest approval possible at this time.)
4. During the calendar year 1976, over 300,000 patient visits were accomplished by Physician's Assistants in Kansas. Of these visits more than 240,000 were in medically underserved areas. It is interesting that in no case was there a threat of a malpractice action being filed. In fact, there has never been a malpractice suit filed against a P.A. who has graduated from an approved program in the entire U.S.

Attachment H

J. [illegible] M.D., KANSAS CITY, PRESIDENT
W. [illegible]YER, M.D., WICHITA, PRESIDENT-ELECT
D. [illegible]ERING, M.D., SALINA, FIRST VICE PRESIDENT
P. [illegible]ODWIN, M.D., LAWRENCE, SECOND VICE PRESIDENT

J. R. COOPER, M.D., SHAWNEE MISSION, SECR[illegible]
W. K. WALKER, M.D., SEDAN, TREASURER
C. C. CONARD, M.D., DODGE CITY, AMA DELE[illegible]
ALEX SCOTT, M.D., JUNCTION CITY, AMA DELEGATE

THE KANSAS MEDICAL SOCIETY

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JERRY SLAUGHTER, EXECUTIVE DIRECTOR
GARY CARUTHERS, EXECUTIVE ASSISTANT
VAL BRAUN, EXECUTIVE ASSISTANT

June 15, 1977

The Honorable Michael G. Johnson, DDS
Chairman, Special Committee on Public Health and Welfare
State Capitol Building
Topeka, Kansas 66612

Dear Representative Johnson:

Thank you for the invitation to appear before your committee which is studying Interim Proposal No. 60, relating to the use and regulation of physician extenders. Unfortunately, I will be out of town and unable to attend your meeting, so I have taken this opportunity to set forth some of our thoughts on this matter.

In any discussion of the role of physician extenders, it must be kept clearly in mind that a physician extender is precisely that--someone who extends or supplements the services of a physician in order that more comprehensive care can be rendered to, in some cases, a greater number of people. A physician extender is not a substitute for a physician. By virtue of training and experience, a physician extender can fill a specialized role in the delivery of health care, although the limitations of such training and experience specifically preclude a physician extender from independently practicing medicine.

The key to the successful integration of physician extenders into the health care team lies with the employing physician. Physician extenders (P.E.'s) must be affiliated with a physician responsible for the care that is rendered by the P.E. Hospitals, nurses, or other health care personnel and facilities are not licensed to practice medicine, therefore they should not employ or be responsible for physician extenders. Only a licensed physician should employ and retain the legal responsibility for the acts of a physician extender.

Clearly, the state has a legtimate interest in requiring that P.E.'s be registered, or in some way identified, at the state level. The appropriate place to register P.E.'s is with the Kansas State Board of Healing Arts, which also licenses physicians. Similarly, a P.E. should be registered with the physician employing and responsible for his activities. Beyond that, the registration of P.E.'s need not be more complex than requiring the basic credentials information, etc.

Atch. H

Much has been said about developing a "laundry list" of tasks and procedures that P.E.'s can or cannot do in working with a physician. It would seem that this would be a monumental task because of its subjective nature, and also because of the many varied types of P.E.'s that are being trained today. A more appropriate definition of the scope of practice of a P.E. gives sufficient flexibility to the responsible (employing) physician to utilize the P.E. in the manner that best takes advantage of the training, experience, and special abilities of the P.E., as well as the particular practice characteristics of the physician. It is imperative that the law contains this flexibility to meet the needs of practice characteristics in both a rural and urban setting.

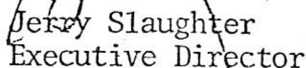
This flexibility extends also to the discussion of what adequate supervision is in the use of a P.E. Supervision can take many forms, and depends as much on the talents and capabilities of the physician as it does on the capabilities of the P.E. Some thought might be given to establishing a maximum number of P.E.'s that can be utilized by one physician, but that again should be sufficiently broad to encourage quality, efficient health care delivery, and discourage abuse.

We hear more and more about the conflicts that seem to arise when P.E.'s enter the hospital setting. Physician opinions differ on this subject, but generally it can be said that hospitals have a compelling interest in determining what role a P.E. may fill in the hospital environment. Absent an emergency situation, it would seem inappropriate that a P.E. be allowed to do procedures in the hospital that heretofore have been done exclusively by physicians.

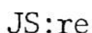
Because of the importance of a P.E. affiliating with a physician, so too should reimbursement for services rendered. It would seem inappropriate to consider a P.E. an independent contractor with third parties when the essence and intent of his training and experience prepares him for a cooperative, dependent working association with a physician.

I appreciate the opportunity to offer some of our thoughts on this proposal, and hope that this is a constructive addition to the discussion. If you have any questions, or if I can assist you in any way, please do not hesitate to contact me.

Very cordially yours,



Jerry Slaughter
Executive Director



JS:re

Attachment II

KANSAS PHARMACEUTICAL ASSOCIATION
P.O. Box 4218, Gage Center Station
1308 West 10th Street
Topeka, Kansas 66604

SUMMARY REPORT on PHYSICIANS' ASSISTANTS AND NURSE CLINICIANS

The Kansas Pharmaceutical Association's Professional Affairs Committee recently distributed a survey to Kansas Pharmacists regarding Physicians' Assistants and Nurse Clinicians. The purpose of the survey was to determine any problems our practitioners faced and to outline what help we could provide to solve these problems.

The overall results of the survey do indicate general acceptance of Physicians' Assistants (PA's) and Nurse Clinicians (NC's) by both the pharmacy profession and the general public. It appears from our survey that in most cases any local problems have been resolved by communication between the pharmacist-physician-P.A. and N.C.

In an attempt to be helpful to those involved and those having an interest in this area we have outlined below a summary of some problem areas identified. It is hoped that through such a summary we may all be able to improve upon the health care of Kansas citizens. Kansas pharmacists have no interest in assuming the roles of PA's or NC's, however we expect that our expertise in the area of drugs will be used.

1. Pharmacists' receipt of a prescription order

It appears from our survey that in the majority of those cases reported to us PA's and NC's are writing and signing prescription orders in the absence of a practitioner. In many of these cases the PA's and NC's are writing and signing the physicians' names plus their own and the legal status of such a practice is questionable. In some cases the physician's name is stamped on the prescription and then countersigned by the PA or NC.

This is a very confusing area for pharmacists and appears to be an area which should be reviewed.

2. Receive prescriptions with improper directions

In approximately half of the cases reported, pharmacists are routinely receiving prescription orders with improper directions. In most cases these problems have been solved by the pharmacist calling the physician. However, if point #1 were clarified, this problem could also be alleviated.

Atch. I

3. Refill Authorization

The survey did point out that refill authorization is given by the PA or NC without consultation with the physician as a matter of routine. Pharmacists question whether this practice is truly in the best interests of the patient.

Summary of 1, 2 and 3

In response to the problems pointed out in points 1, 2 and 3, pharmacists have indicated that they do call and discuss these problems with the PA, NC and physicians. In the majority of all cases problems have been resolved through this mechanism. In fact, we see the trend that PA's and NC's are now calling the pharmacist to request information on dosage regimens and quantities plus other areas. While communication does appear to be working in this area, there still appears to be a need for further delineation of responsibilities. We would also appreciate being consulted regarding any regulatory action.

Acceptability of PA's and NC's in the community

In over 90% of the cases reported by pharmacists, PA's and NC's are very well received in the community. The only area of possible confusion is the consumer assuming these individuals are physicians. It was suggested by several people that a name tag specifying Physician's Assistant or Nurse Clinician be used.

Overall Summary

We also asked for general comments on the PA & NC which indicate that they are a very vital part of health care in Kansas. We would, however, suggest that there be a review of the handling of prescriptions by PA's and NC's. The pharmacists are not only concerned about the legality of dispensing a prescription written by a PA or NC but also the improper directions in over half of the cases reported. It is the hope of our association that this information will be helpful in future educational programs and possibly outlining some areas which should be reviewed for possible regulation. Our association supports any effort to help solve these few problem areas.

DPJ/ss

THE KANSAS PHARMACEUTICAL ASSOCIATION
1308 WEST 10TH
P. O. BOX 4218, GAGE CENTER STATION
PHONE (913) 232-0439
TOPEKA, KANSAS 66604

DOUGLAS P. JOHNSON, R. PH.
EXECUTIVE DIRECTOR

6/16/77

TO: Special Committee on Public Health and Welfare

FROM: Douglas P. Johnson, R.Ph.

SUBJECT: Physician Assistants and Nurse Clinicians
(Hearing June 22, 1977 - Room 208, Life Sciences Bldg.
Wichita State.)

I appreciate the opportunity to comment on the study of Physician Assistants and Nurse Clinicians through this mechanism as I have another commitment that will not allow me to be in Wichita today.

The Kansas Pharmaceutical Association conducted a survey of its members last year to get a feeling on the actions of Physician Assistants and Nurse Clinicians in regard to drug prescribing. Attached is a "Summary Report" of that survey for your consideration.

It is important to understand, that while our Summary Report does not list any percentages, approximately 90% of those responding had nothing but praise for the manner in which they have had dealings with PA's and NC's. Therefore, the summary report deals with comments received from approximately 10% of those responding. The report is offered in a constructive manner to point out some potential problems and some areas which we believe could use clarification.

A member of our Governmental Affairs Committee, Kent Richardson is present today and would be glad to answer any questions you might have. A member of the Kansas Board of Pharmacy, Hugh Polson is also present today and available for questions.

At this time we are not prepared to offer any recommendations on either of the bills dealing with PA's or NC's. However, a committee of our association will be meeting June 29th, 1977 for this purpose.

CC: Kent Richardson
Hugh Polson
KPhA Board of Trustees
KPhA Governmental Affairs Committee

DPJ/ss

AFFILIATED WITH
THE AMERICAN PHARMACEUTICAL ASSOCIATION

Attachment #J

Statement to the
Special Committee on Public Health and Welfare

Proposal No. 60--Physician Extenders
Presented by

Paul E. Fleener, Director
Public Affairs Division--Kansas Farm Bureau
June 22, 1977

Mr. Chairman and members of the committee we appreciate the opportunity to file a statement with you relative to Proposal No. 60. You have been charged with the responsibility of studying the role of physician extenders, including regulation of such persons, the utilization of these persons and the relationship of "physician extenders to the supervising physicians."

The entirety of the policy position of Farm Bureau members in Kansas is set forth below for your consideration. Some of it may, in fact be irrelevant as regards Proposal No. 60, so I would invite your attention particularly to the fourth paragraph.

Medical Professionals in Kansas

We favor development of additional residency programs to provide in-state programs for those University of Kansas School of Medicine graduates interested in primary care medical practice.

In the development of additional primary care residency positions, we urge particular emphasis be given to on-site--community based--residency training. We urge the legislature to finance such residency programs. Such funding could come from the state share of General Revenue Sharing monies.

If additional state funds cannot be made available for new primary care positions, then we suggest reallocation of available funds to give priority to primary care residency training programs.

We continue to support the training programs for the physician's assistant and nurse clinician as now developed by KUMC. We encourage Kansas communities to utilize the services of these medical "extenders" whenever qualified personnel can be recruited. We will continue to work for established legal guidelines for the practice of paraprofessionals in our state.

Atch. J

As a practical inducement to qualified youth interested in a medical career, we will support reinstatement of a state loan forgiveness program. We suggest that such a loan program be based on need and require a year's service in a rural Kansas community or a Kansas inner-city area for each year of schooling funded by a state medical loan.

Mr. Chairman, we--an organization of laymen--may well be using the phrase "physician extenders" inappropriately. Be that as it may, I suspect we are not alone. We have company in this misusage. Too frequently many people lump together all non-physician--full members of the medical team--as "physician extenders." That is regrettable. To pick out one great profession as an example: Nursing is viewed by some as a profession, which we believe it to be. Others--frequently MD's and congressional committees--view nurses as "extenders," or something less than fully qualified professional persons, also regrettable.

In order to give your committee something of a deeper understanding of our long-term interest in and commitment to better health care in Kansas, we submit for your review a resolution which was in our policy booklet for the year 1975 and previously. It's no longer there because you (the Legislature) did act on the Board of Nursing. We insert it here, however, to indicate that we believe nursing to be a profession, that legislative and congressional committees (particularly those with appropriation functions) should recognize and fund accordingly--where funding is under consideration--governmentally-aided programs recognizing the professions within the medical community. If that sentence is cumbersome, I will simply say--third party pay should be considered an appropriate action.

Professional Nursing

In keeping with our belief that qualified medical professionals are required in all geographical parts of the state, we recommend that the State Board of Nursing continue to have the authority to develop curriculum for nursing programs in Kansas. We further believe the State Board of Nursing should be composed of a majority of registered professional nurses,

with representation from other health-related professions and the public at large. Such Board should be responsible for mandatory certification of both registered and licensed practical nurses.

We would refer you back to our 1977 Resolution to indicate our support for your efforts, or those of the medical community to establish appropriate legal guidelines and a framework for interdisciplinary endeavors in the medical community.

We appreciate the opportunity to file this statement with you and the members of the committee.

Attachment K

CEDAR VALE REGIONAL HOSPITAL P.O. Box 398 Cedar Vale, Kansas 67024 Phone (316) 758 2266

STATEMENT PREPARED FOR HEARING ON REGULATION
OF PHYSICIAN ASSISTANTS BEFORE A JOINT INTERIM
COMMITTEE OF THE KANSAS LEGISLATURE

Tuesday, June 21, 1977 and Wednesday, June 22, 1977

Wichita State University
Wichita, Kansas

Jointly Prepared by:
Rosellen E. Cohnberg; M.D. F.A.A.P., F.A.A.F.P., M.S.P.H.
Chief of Staff, Cedar Vale Regional Hospital; and John F.
Meyers, Administrator, Cedar Vale Regional Hospital, President
Cedar Vale Hospital, Inc.

When considering how physician assistants can most effectively contribute to the delivery of health care the most important concept is flexibility. In sofar as the availability of physician assistants goes (the "supply" of P.A.'s), the most important concept is mobility. We will deal with these ideas in turn.

In order for a physician to fully utilize the services of an assistant the supervising physician must be free to use his or her own judgment in determining the precise limits of responsibility and accountability in duties assigned. Each practice and each medical delivery setting is unique, just as each supervising physician is unique in utilizing available resources to solve the complex of problems that a given patient may present. Efforts to standardize the precise duties of a physician assistant would have the same effect of a standardization of medical practice. We feel strongly that the goal of any health care delivery team should be quality care, an idea incompatible with standardized (cookbook) care.

Standards tend to become rigidities written in stone. Thus, standards can have only a negative effect on how physicians may use assistants. To establish standards, norms, or anything of the sort needlessly limits the use of a P.A. In effect, it says that the collective judgment of a state legislature or bureaucracy is somehow superior to the individual judgment of a supervising physician on how that physician uses an assistant.

We see absolutely no need to destroy the flexibility in use of P.A.'s which is already controlled by the good common sense and judgment of the individual physician.

CEDAR VALE REGIONAL HOSPITAL P.O. Box 398 Cedar Vale, Kansas 67024 Phone (316) 758 2266

Standards already governing the physician also govern the physician assistant through the employing physician. P.A.'s now perform under the authority of the supervising physician's license. The supervising physician is ultimately responsible and could lose his or her license if the P.A. performs inadequately, improperly, or obviously beyond his or her capabilities. But only the attending physician can effectively judge how the assistant performs and what the limits of his capabilities are. The doctor should be free to exercise judgments in these matters, fully realizing that if the judgment is at fault then both the patient and the physician will suffer.

This implies a point not yet brought out: there must be a close interpersonal relationship between physician and assistant. This relationship must be built on trust, knowledge of individual capabilities, and commonalities in philosophies of patient care. In short, to be fully effective the physician assistant must be an extension of the physician. The establishment of norms, standards, performance criteria, or anything of the sort would inevitably result in two things. First, it would limit the physician in how the assistant could be used (without, incidentally reducing the physician's liability in the event of misuse; and second, it would destroy in part the interpersonal relationship and trust so essential to effective use of physician's assistants.

As to the second factor noted in the opening paragraph, one of the most rapidly emerging difficulties in use of physician's assistants is recruitment. The supply of competent P.A.'s is short, and we must avoid a further reduction in the supply which would come about through strict licensure requirements. Any licensure requirement represents a barrier to recruiting physician's assistants, particularly those from other states. The stricter the requirement, the more inpenetrable the barrier, and the more unlikely will be the prospect of obtaining qualified personnel. Why should an outstanding physician assistant go through the mechanics of licensure when he can work for the same amount of money in another state where no licensure is required. Thus, licensure beyond registration, which already is in existence, should be avoided.

We realize that some of the concerns facing the Kansas State Legislature revolve around potential or possible misuse of assistants by practicing physicians in the state. We recognize that the possibility for misuse does exist, but so does the possibility for malpractice, for gross negligence, or for a host of other misconducts. Even if possibility for misuse of physician's assistants is more real than imagined, we submit that corrective mechanisms already exist within the statutes. Physicians can be disciplined for malfeasance, and gross misuse of physician's assistants would unquestionably be malfeasance.

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Still another issure not yet discussed is that of "supervision". In this area perhaps an interpretation might be helpful. An assistant working in the same facility as, and in constant contact with, the physician could certainly be considered under that physician's supervision. At the other extreme is the hypothetical physician who takes a long vacation leaving the P. A. in charge but calls his office daily to tell the P.A. what to do. This, obviously, seems too lenient an interpretation.

However, in between these extremes are a host of situations that could and probably would occur. One example would be a satellite clinic staffed by a physician's assistant and located several miles from the supervising physician's office. The P.A. could be in constant daily radio and/or telephone contact and could even have closed circuit television linking him with the supervising physician. Although physically removed, there is definitely a functional and effective supervision involved. Another example would be a physician attending an afternoon medical seminar two or three hours distant from his office where the P.A. is holding down the fort. The supervising physician could leave standing orders for known problems and a telephone number for the P.A. to call and contact the physician should an emergency arise. This, tool seems to be a reasonable land functional interpretation of adequate supervision.

While we grant that some interpretation might be acceptable, we would argue against any strict, rigid rules which would interfere with the supervising physician's flexible use of his or her assistant. At most we would suggest a very loose, generalized guideline with clear a-lowances for unique and extraordinary circumstances which might be encountered by the attending physician.

In summary, please let us say that we are thoroughly and unequivocally in favor of the physician assistant concept. We believe that there is a great deal of potential good that can be realized through the effective and appropriate use of physician's assistants. This has been clearly demonstrated by us in Cedar Vale and elsewhere by others. We believe that physicians as a whole are capable of making sound judgements in using physician assistants as part of the health care delivery team which the supervising physician heads. We believe strongly that for the full potential of physician's assistants to be realized, the physician must be given great flexibility in using the P.A., and the mobility in the supply of P.A.'s must be maintained. Specific restriction of physician's assistants in any form would inevitably detract from the potential. Standardized limitations on what physician assistants can do, strict licensure of physician's assistants, and other such measures, would place them in the same straight-

CEDAR VALE REGIONAL HOSPITAL P.O. Box 398 Cedar Vale, Kansas 67024 Phone (316) 758 2266

jacket now being tightened around the supervising physician. Such actions would produce simply another level of professional, prescribed from fully utilizing his or her capabilities. Therefore: We urge that no new legislation be considered which would limit the flexibility or mobility of physician's assistants.

If the Kansas State Legislature feels compelled toward legislative action in relation to physician assistants, we would suggest only one thing. This relates to Senate Bill 14 which was passed during the 1975 session of the Kansas legislature. In that legislation, registration of physician's assistants was limited to skilled persons "qualified by academic training" to provide patients services under the direction and supervision of a physician. We submit that academic training is not the only way to become a physician assistant. Experience must be taken into consideration. We personally know of at least four persons who have not gone through a formal physician assistant training program but who have served for many years in what in effect is "appreticeship" to physicians. If we know of four such people, there must be many more. Together, they comprise an important pool of talent but a pool which can not be used in Kansas. Legislation correcting this inequity would be highly desirable. Therefore: We urge that serious consideration by given to modifying existing law to allow for persons to be registered as physician assistants in Kansas on the basis of academic training and/or experience.

Thank you for the opportunity to present our views on this important subject. We hope that they will be useful to you in your deliberations and, hopefully will persuade you to use extreme caution in proposing any legislative change which would limit the flexibility and mobility of physician's assistants.

Should you wish any additional information or wich to talk to us personally, please do not hesitate to contact us.

R. E. Cohnberg, M. D. F.A.A.P.,
F.A.A.F.P., M.S.P.H.
Chief of Staff, Cedar Vale
Regional Hospital

J. F. Meyers, President
Cedar Vale Hospital, Inc.;
Administrator, Cedar Vale Regional
Hospital

Attachment L

The present Nurse Clinician/Practitioner program provided for me the background I needed in the time I could give to that purpose. I had been working for a family practitioner or general practitioner for approximately three years when I entered the program. I had a good deal of experience touching on what I am doing now, but not in depth. Primary Care Nursing lends itself very well to the expanded role.

The physicians where I presently work are very supportive to the Nurse Clinician and I feel we have a good model for the interdependence of a physician/nurse clinician/practitioner team. When I do a complete workup for Dr. Williams, for example, we discuss the problem and reasons for the workup. I do the physical examination in the a.m. while he is in the operating room, ordering lab work, etc.

My findings are submitted to him via the patient's chart plus conversation. He sees that patient in the afternoon to discuss the results of lab work, the history and physical, and plan of action. We do collaborate on what the plan might be. The Nurse Clinician in our office takes emergencies that come to the clinic and takes appropriate action. She consults with the physician. He doesn't want to re-see these patients, but sees ones with abnormal findings at her request. This is in total sympathy with how the NC/P is trained at WSU.

I have examined many patients and found cancer of the breast,enlarged ovaries, enlarged thyroid, pheochromocytomas, hernias. In family practice I saw routine OB patients every other time attending without the physician. The quality of care was improved because I used my time with that patient to teach about diet, weight gain, parenting, breast feeding--nursing kinds of tasks. The patient acceptance has always been high when time for teaching has been included.

Atch. L

This is part of the philosophy of our program too - to turn the responsibility of patient care back to the patient. This seems to have become a lost art. Our society does not pass lay medical information on to our children. Until recently much of it was wrong or superstitions. This is how the elders lost their credibility. Physicians are not taught in Medical School a lot of patient teaching or find themselves pushed too fast to have time. This is the beauty of the team approach.

P. A. Bill Hearing

It is recognized that Nurse Practitioners assume legal responsibility for their own practice.

The Nurse Practitioner seeks medical collaboration through written statements of policy called protocol. This delineates the doctor's area of accountability and the Nurse Practitioner's area of accountability. At times there may be an overlapping of roles to provide comprehensive care to the patient or client. Expanded nursing prefers the interdependent planning and implementation of the patient's total care. The interdependent team approach to patient care does not require constant supervision of a physician as does the proposed law for the P. A.

Colorado proposed statute for rules and regulations for expanded role of nurses states the specifics to which I speak very well.

The Kansas Master Planning Committee position paper helps to clarify the differences especially in the dependent vs. interdependent roles of the PA and NP.

I do not support any effort to merge the two roles as one at this time for the purpose of rules and regulations to guide practice.

Attachment M

June [illegible]

[illegible] A. Lee, R.N.
Project Director
Nurse Clinician Program
[illegible] of [illegible] Professions
[illegible]
[illegible] State University
[illegible], Kansas [illegible]

Dear Carla:

[illegible] this letter so that you may use it in an advisory capacity [illegible] the Nurse Clinician program.

I feel that the Nurse Clinician program has been a forward step in the medical care of this community and in other communities in the state. This program has been well received by the patients, and I believe reasonably well received by the professional people involved in medical care. It is my opinion that the [illegible] given to this program has primarily been because of the willingness of both the Nurse Clinician and the physician to work closely with the Nurse Clinician under direct supervision.

[illegible] are [illegible] nurses performing similar functions without being named Nurse Clinicians. I feel, however, that the training and recognition of some formal [illegible] program has greatly increased the nurses' ability to extend their [illegible] proper guidance in the physician's practice. I further feel [illegible] the [illegible] of the nurses in this program in their capabilities and in [illegible] has been very satisfactory.

I [illegible] aware of [illegible] segments of people who desire to establish this as a separate [illegible] and I would be unalterably opposed to this because of the [illegible] could open. It would be placing the nurse in an untenable [illegible] the multitude of problems that [illegible] it would defeat the [illegible] of the expanded role as a team pro- [illegible] better patient care. The patient should expect to get [illegible] the [illegible] of oversight or [illegible]

Atch. M (not legible)

advice. I consider this to be an obligation of the physician and of the Nurse Clinician when dealing with the patient. This obligation can be fulfilled with the team approach, however, with the fragmentation, it could be a chaotic process.

Sincerely,

Morgan L. Stockwell, M.D.

MLS:jb

[illegible] 1977

To Whom It May Concern:

I have recently reviewed the proposed Senate Bill 255 and the concomitant House Bill [illegible] concerning the Physician's Assistant Registration. I have strong feelings that the Physician's Assistant and the Nurse Clinician should not be brought together in coverage under one act, but that the Nurse Clinician [illegible] should fall under the Nurse Practice Act.

The Physician Assistant and the Nurse Clinician have markedly different backgrounds and functions, and it would be my feeling that the Nurse Clinician's background would be somewhat negated [illegible] under a Physician's Assistant Act.

The Dodge City Medical Center in Dodge City, Kansas, has been a primary innovator in the use of the Nurse Clinician, and we have well documented proof of their value in the extension of the physician's services in the area.

I would be equally opposed to any change in the statutes that would permit the [illegible] of either of the above named parties without physician's supervision. I do, however, firmly contend that the Nurse Clinician in the rural [illegible] has provided an extension of physician's services and [illegible] for [illegible] that has [illegible] Kansas [illegible].

Sincerely,

[illegible] Williams, M.D.

Attachment N

TESTIMONY FOR CONSIDERATION

BY THE

SPECIAL COMMITTEE ON PUBLIC HEALTH AND WELFARE CONCERNING
PROPOSAL NO. 60 - PHYSICIAN EXTENDERS

PRESENTED BY: THE KANSAS HOSPITAL ASSOCIATION
LARRY K. SHAFFER, DIRECTOR OF EDUCATION

JUNE 22, 1977

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

THANK YOU FOR THE OPPORTUNITY TO PRESENT SOME OF OUR VIEWS AND CONCERNS PERTAINING TO THE PREPARATION, REGULATION AND UTILIZATION OF PHYSICIANS' ASSISTANTS.

I AM LARRY SHAFFER, DIRECTOR OF EDUCATION FOR THE KANSAS HOSPITAL ASSOCIATION. THE MEMBERSHIP OF THE KANSAS HOSPITAL ASSOCIATION CONSISTS OF 150 NOT-FOR-PROFIT GENERAL, ACUTE-CARE HOSPITALS, AS WELL AS SEVERAL HOSPITALS OWNED AND OPERATED BY THE STATE AND FEDERAL GOVERNMENTS.

I APPEAR BEFORE YOU TODAY WITHOUT AN OFFICIAL ASSOCIATION POSTURE, PERTAINING TO THE EVOLVING PROFESSION OF PHYSICIANS' ASSISTANTS. THIS IS NOT TO SAY, HOWEVER, THAT THE KANSAS HOSPITAL ASSOCIATION IS NOT AWARE OF THIS NEW EVOLVING PROFESSION OR OF THE MANY ISSUES AND CONTROVERSIES SURROUNDING ITS EVOLVEMENT.

Atch. N

THE PROLIFERATION OF NEW HEALTH CARE PERSONNEL DURING THE PAST DECADE AND THE EFFORTS TO INCORPORATE THESE NEW PERSONNEL INTO A SYSTEM BOUND BY TRADITIONAL MODES OF HEALTH CARE DELIVERY, AS WELL AS AN INCREASING NUMBER OF LAWS, POLICIES, STANDARDS AND REGULATIONS, HAS NATURALLY CREATED PROBLEMS AND CONCERNS FOR THOSE WHO ARE LEGALLY AND MORALLY RESPONSIBLE FOR THE DELIVERY OF HIGH QUALITY AND ECONOMICAL HEALTH CARE.

THE PROBLEMS AND CONCERNS OF HOSPITALS, THAT ARE CREATED BY THE ADVENT OF PHYSICIAN ASSISTANTS, ARE COMPOUNDED BY THE FACT THAT THIS PARTICULAR NEW PROFESSION HAS TRANSCENDED UPON AN ALREADY DELICATE SITUATION, THE RELATIONSHIP BETWEEN THE HEALTH CARE INSTITUTION AND THE PRACTICING PHYSICIAN.

THE RELATIONSHIP BETWEEN THE HOSPITAL AND THE PHYSICIAN IS OF A DIRECT NATURE. IT IS A RELATIONSHIP ESTABLISHED AND MAINTAINED BY BY-LAWS AND ACQUIRED PRIVILEGES. THE HOSPITAL ADMINISTRATION AND THE PHYSICIAN HAVE DIRECT AND IMMEDIATE ACCESS TO ONE ANOTHER.

A SIMILAR PROCESS IS BEING USED FOR PHYSICIAN ASSISTANTS; HOWEVER, THERE IS AN APPARENT DIFFERENCE IN THAT THE PRACTICING PHYSICIAN SERVES AS THE INTERMEDIARY BETWEEN THE PHYSICIAN ASSISTANT AND THE HOSPITAL. NEITHER THE HOSPITAL NOR THE PHYSICIAN ASSISTANT HAVE DIRECT AND IMMEDIATE ACCESS TO ONE ANOTHER. THE HOSPITAL MUST DEPEND EVEN MORE HEAVILY UPON THE PHYSICIAN FOR EMPLOYING QUALIFIED AND COMPETENT PHYSICIAN ASSISTANTS AND FOR PROVIDING ADEQUATE DIRECTION AND SUPERVISION TO THE PHYSICIAN ASSISTANT.

The precarious relationship between the hospital and the physician assistant is probably the greatest concern of hospitals. And, of course, this kind of relationship raises serious questions as to the hospital's liability for the function of physician assistants within the hospital.

Another concern of hospitals is the apparent demoralizing effect the advent of the physician assistant has had upon other health care personnel employed by the hospital who have had a traditionally close and direct relationship, with the physician.

With these concerns in mind, it seems that reasonable standards and regulations relating to the preparation and functions of the physician assistant are necessary, and further, that guidelines pertaining to the functions of the physician assistant, relating to the various levels of preparation, may need to be considered.

We would also hope that future developments in legislation, pertaining to the profession of physician assistants, will give serious consideration to the precarious relationship between private health care practitioners and health care institutions, as well as the need for cooperative working relationships between the private practitioners and the health care personnel employed by the health care institution.

The Kansas Hospital Association will continue to study the development of this new profession and the potential ramifications for hospitals.

WE ARE ENCOURAGED BY THE ADVENT OF PROPOSAL NO. 60, AND STAND READY TO BE OF ANY ASSISTANCE, THAT WE CAN, TOWARD THE STUDY.

MR. CHAIRMAN, I WOULD BE MOST HAPPY TO SHARE COPIES OF MY TESTIMONY WITH THE COMMITTEE, IF YOU WOULD LIKE.

I HAVE ATTACHED A COPY OF GUIDELINES BY THE AMERICAN HOSPITAL ASSOCIATION, PERTAINING TO THE PHYSICIANS' ASSISTANT IN THE HOSPITAL. I AM SURE THESE GUIDELINES WILL MORE ADEQUATELY DESCRIBE THE CONCERNS OF HOSPITALS THAN I HAVE.

I WILL BE HAPPY TO ATTEMPT TO ANSWER ANY QUESTIONS YOU MIGHT HAVE.

THANK YOU.

# # # # #

Attachment C

RECOMMENDATIONS REGARDING NURSE PRACTITIONERS

Studies conducted national (Solz) in the state (KRMP), and by the Wichita State University Nurse Clinician Department all show that nurse practitioners are professionally fulfilling the roles of providing health care maintenance and assistnace in delivering continuity of medical care. They are stable with regard to continuing their service as professional nurses, both by practice primarily in medically underserved areas geographically and by not gravitating to other allied health or medical professions. It is my belief that this will remain constant and thus support the economic investment of $2000/year/student for the services that nurse practitioners provide on a long term service basis.

The previously mentioned studies show that the selected health and medical functions for which nurse practitioners are educated are practiced interdependently with members of the health care team, particularly physicians. These functions include:

- health screening activities
- preventive care
- histores and physicals
- maintenance and follow up care for long term patients.

Lastly the studies report patient benefits as follows:

- increased quality of services, as well as volume
- reduction in working time
- increased time with patients
- patient and family education
- cost containment
- reduced incidence of hospitalization
- increased availability of health care services
- increased emotional support and communication

The WSU program has continued to have substantial support as evidenced by state funding and continued involvement of approximately 50 physician lecturers and 100 preceptors. I submit support letters received from Dr. Stockwell, and Williams of Dodge City Medical Center, witn regard to benefits derived by addition of nurse practitioners to practice and their recommendations regarding legal controls. In this, as innumerable other situations, physicians and nurse practitioners report much satisfaction with the role.

Considering the above statement I recommend:

1) That the R.N. not be incorporated in P.A. legislation new section 6 of S.B. 256, nor that N.P. be legislated under the title of physician extender.

2) That Rules and Regs be developed by the Board of Nursing to supplement the Nurse Practice Act for provision of Control measures for practice standards for nurse practitioners predicated on the firm belief in interdependence of medical and nurse practitioners.

3) That consideration be given to revising sections of the Nurse Practice Act that are limiting for Nurse Practitioners, i.e., the disclaimer in the definition of professional nursing.

As you all know, there is much left for all of us to do to meet the health care demands of the public. I believe that with legal expansion of services which can be delivered by registered nurses in the role of Nurse Practitioner, the health care delivery system will be eased of the majority of its pressure, and that citizens will receive increased quantity and quality of health care by this concerted team approach.

Thank you for this opportunity to share reasons and recommendations for the future of expanded roles.

Atch. O

Attachment ~~E~~ P

A STATEMENT FOR THE LEGISLATIVE INTERIM
COMMITTEE ON HEALTH LEGISLATION

Mr. Chairman and members of the Committee, thank you for permitting me, a small town obstetrician and gynecologist, to present to you my experience and thoughts regarding nurse clinician practitioners.

It has been my privilege to be involved in the training of a nurse clinician-practioner and then to have her associated with me in my practice the past 19 months.

One of the unique things that a nurse clinician-practitioner brings to the extender role is her, or his, nurses training. She, or he, has been educated in chemistry, anatomy, physiology and psychology of health and of illness. The nurse has had practical bedside experience in relating to patients and their needs. The nurse has seen far better than many of us physicians the fears, the anxieties, and the emotional trauma most often due to ignorance with regard to what is happening. This nurse sees the educational opportunities and the needs for psychological support from a perspective different than the physician and certainly different than do the ancillary medical personnel trained through some other route.

The only way a nurse clinician-practitioner can function satisfactorily in office practice is as a member of a team of which the physician is the captain. The physician, while in charge, can only benefit from this arrangement if he or she makes full use of the counsel of the nurse clinician-practitioner in the management of the patient's problem. When this is done the patient is the one who really benefits.

The nurse clinician-practitioner is taught to recognize deviations from the normal. She or he is not trained as a diagnostician. It is not their desire to be junior doctors. It is their desire to function in the capacity of a nurse using to the fullest their nursing skills.

Atch. P

One thing that any good nurse can do is follow directions. This is what the nurse does when he or she follows a protocol in the subjective and objective findings, their assessment and management. The protocol is established by the physician carefully working with the nurse clinician-practitioner, to make certain he or she understands the protocol and to incorporate into the protocol what the clinician-practitioner can contribute from his or her nursing knowledge.

Nurse clinician-practitioners, as I said before, do not wish to be junior doctors. Nurse-midwives are not trying to replace physicians. The nurse clinician-practitioner and the nurse-midwife are only wanting to extend their nursing skills to the fullest in meeting the needs of the patients. Since they are trained as nurses and want to function as nurses, I strongly feel the nurse clinician-practitioners and the nurse-midwives should be licensed and their special abilities recognized and certified by the Kansas State Board of Nursing and not by the Kansas State Board of the Healing Arts. To place them under the latter board might encourage some of them, over a period of time, to get more grandiose ideas regarding themselves.

As I stated earlier, I participated in the training of a nurse clinician-practitioner and she has been associated with me in my practice of obstetrics and gynecology for 19 months following the completion of her training. This has been a most beneficial experience both for me and for my patients. She has made available additional services to the patients that otherwise would not have been possible due to the limitations of time from a rather large patient load. She has served to educate the patients about their own bodies and physiology and also to help explain their pathology. She has counselled the patients regarding their feelings toward pregnancy, breast feeding, etc.

She is a tried and proven assistant in the operating room and in the delivery room. Many of my younger patients are much more willing to submit to an exam by her than by a man. I highly commend the nurse clinician-practitioner concept to you as a most worthwhile method of giving superior care in an economical fashion.

Thank you again for permitting me to make this presentation.

Respectfully submitted,

J. S. Benton, M. D.
Diplomate American Board of Obstetrics and Gynecology

Attachment Q

PRESENTATION BY THE KANSAS STATE NURSES' ASSOCIATION
BEFORE THE SPECIAL COMMITTEE ON PUBLIC HEALTH AND WELFARE
REGARDING PROPOSAL 60
June 22, 1977

Mr. Chairman and members of the Special Committee on Public Health and Welfare, my name is Roberta Thiry, President of the Kansas State Nurses' Association. I am here today representing their interests regarding Proposal 60. We believe that health care is more than medical care. Health care involves the utilization of many different providers. Among the many providers are physician assistants and nurses. The term, physician extender, is apparently being used to include both Physician's Assistants and registered nurses in expanded roles. It is KSNA's position that the two are sufficiently different in definition, preparation and legal status that they should not be defined by the same term. Nurses are functioning in a variety of expanded roles; however, this testimony is concerned with the Nurse Practitioner in primary care. For our purposes the terms Nurse Clinician and Nurse Practitioner may be used interchangeably.

The American Medical Association's 1970 definition is that the Physician's Assistant "is a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant." Each physician determines the scope of practice for Physician's Assistants in his employ and is accountable for their actions.

Programs to prepare the Physician's Assistant vary in length and content, but have been developed primarily to expand the volume of medical services offered by physicians. In Kansas, as in most states, the Physician's Assistant is not licensed and is directly responsible to the physician as specified in the Healing Arts Act.

The Nurse Practitioner, as defined by the American Nurses' Association Council of Family Nurse Practitioners and Clinicians, is a primary care provider prepared to give continuous personalized care to the patient/client at the point of entry into the health care system, and to continue as the individual's care provider. The

Atch. Q

rse Practitioner's scope of practice is determined by the nursing profession ar is implemented in accord with the state Nurse Practice Act. That portion of the Nurse Practitioner's practice which involves medical services is determined collaboratively with the physician.

A Nurse Practitioner's preparation consists of a specialized program of study beyond that required for registered nurse licensure. Programs range from 36 to 52 weeks in a continuing education program to educational programs granting baccalaureate and master's degrees. Such programs have developed in response to societal needs and in response to increased demands placed on nurses.

A Nurse Practitioner is a licensed health care professional responsible and legally accountable for his/her own actions as defined by the Nurse Practice Act and to the consumer. Current law does not place one profession under the supervision of any other profession. To do so with nursing could jeopardize all professions and would profoundly limit the delivery of comprehensive health care services.

In brief, Physician's Assistants are unlicensed and directly accountable to the physician who is liable for their actions. The Nurse Practitioner is licensed, liable and accountable for his/her own actions, a portion of which are carried out in collaboration with the physician.

Utilization of the Physician's Assistant or Nurse Practitioner will of necessity be influenced by their preparation, legal status and relationship with the physician. The demands for community based health services, the numbers of persons with chronic illnesses, and an increased emphasis on prevention and maintenance of health care have altered the traditional relationships of health care providers and methods of health care delivery.

Nurse Practitioners deliver care in a variety of settings including, but not limited to, homes, ambulatory care centers, health maintenance organizations, schools, industries, adult care homes, and physician's offices. The skills of the Nurse Practitioner are especially adapted to patient populations requiring health main-

nance and management of chronic disease. Examples include care of the well chi family planning, peri-natal care, supervision of chronic childhood and adult conditions such as diabetes, hypertension, arthritis, and physical handicaps. Traditionally physicians have been illness oriented. It follows, then, that Physician's Assistants will also be illness oriented due to their dependent role. To subsume both the Nurse Practitioner and the Physician's Assistant under the title of physician extender implies that both require the same level of physician supervision.

If a Nurse Practitioner is to provide quality care, it is imperative that a collegial relationship be developed with a physician. Where there is overlap in services between the physician and the Nurse Practitioner, a mutually agreed upon framework must be developed for the provision of joint care.

We not only support collaboration, consultation and referral between Nurse Practitioners and physicians, but recognize the absolute necessity of this relationship if comprehensive health care is to be provided. Nurse Practitioner's are ethically, legally and morally committed to the right of consumers to adequate services. The physician is the recognized expert in medical aspects of health care, the nurse in nursing aspects. The roles of each are complementary and not substitutive. Reinhardt, an economist at Princeton University states that:

> "If (Nurse Practitioners) must remain under visual supervision (or authorization) of a physician, their special and specialty distribution will necessarily parallel those of a physician, and thus permit continued existence of gaps in access to primary care."

In summary, both Physician's Assistants and Nurse Practitioners have contributions to make in the provision of health care to the citizens of Kansas. Since the Nurse Practitioner provides a broader range of services, the potential impact on the quality of health care is greater. Since the Physician's Assistants extend the provision of medical services by physicians, they logically function under the jurisdiction of the Healing Arts Act. It is KSNA's position that the functions

the Nurse Practitioner should be regulated through the Nurse Practice Act as only a small portion of their functions relate to medical care. It is, therefore, necessary that the Nurse Practice Act be revised to allow for current practice and future evolution of professional nursing practice. Regulation of expanded roles would then be implemented through rules and regulations formulated by the Kansas State Board of Nursing with input from appropriate groups.

We recognize the need for regulation of nurses expanded roles. We believe strongly that nurses should be regulated by other nurses through the Board of Nursing. We appreciate the opportunity you have provided us to state our concerns, and trust the committee will give them due consideration.

Attachment R

THE KANSAS
STATE BOARD OF NURSING

701 JACKSON, ROOM 314
TOPEKA, KANSAS 66612

Phone 246

TESTIMONY BEFORE THE SPECIAL COMMITTEE ON
PUBLIC HEALTH AND WELFARE
REGARDING PROPOSAL NO. 60

June 22, 1977

Ray E. Showalter, R.N., M.S.
Executive Administrator

Mr. Chairman and Members of the Committee:

Thank you for allowing me to make this presentation for the Board of Nursing. Your committee has undertaken the very difficult task of determing and formulating the legislation which is necessary to enlarge and control the expanded role of the nurse. The Board recognizes this step as a grave undertaking in which you will be obligated to sort out all aspects of the problem and arrive at those solutions which will improve the health care available to the Citizens of Kansas within the framework of qualified personnel and economic considerations.

The Board of Nursing has consulted with the Kansas State Nurses' Association and wishes to endorse the testimony of that group. In addition I wish to reiterate that the profession of nursing must be practiced in collaboration with all of the other health care providers under the authority of the Board of Nursing.

The Board directed that my remarks should reflect some of the arrangements developed in other jurisdictions and that I should suggest some specific changes in the nurse practice act which would adequately

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provide for the expanded role of the nurse in Kansas.

Some states have enacted legislation which provides for the registered nurse to perform "additional acts." This provision is implemented variously through administrative regulations developed jointly by the boards of nursing and medicine, through administrative regulations developed solely by the boards of nursing, or as acts which are properly recognized by the nursing profession.

Reports about the implementation of the legislation providing for the "additional acts" indicate some difficulties. The greatest difficulty seems to arise when joint promulgation by the boards of nursing and medicine is required.

The Kansas Board of Nursing believes that it is appropriate for the authority for medical practice to be assigned to the Board of Healing Arts and the authority for nursing practice to be assigned to the Board of Nursing. Because the Board of Nursing believes that this clear cut dichotomy is needed it follows that the Board of Nursing would support an "additional acts" amendment which gives the authority for its implementation to the Board of Nursing. The Board could then develop the appropriate administrative regulations, subject to legislative review, that provide for implementation. The regulations would need to speak to functions, educational requirements, and program approval. Legislative review insures proper administrative regulations within the intent of the statutory authority.

After a review of the nurse practice acts from a number of states, the Board of Nursing suggests that the generic term "Advanced Registered Nurse Practitioner" and the initials "A.R.N.P." be considered as an appropriate identification for nurses who are prepared to perform

expanded roles. The A.R.N.P. certificate could then indicate the specific area of practice for which the individual is qualified. These areas would include but not be limited to Nurse Midwife, Child Health Nursing, Psychiatric Mental-Health Nursing, Family Nurse Practitioner, Obstetric-Gynecological Nurse Practitioner, and Nurse Anesthetist.

The Board of Nursing proposes that K.S.A. 65-1113 (b) (1) be amended to read:

> The practice of nursing as performed by a registered nurse, except as permitted by K.S.A. 65-1124 and amendments thereto, is a process in which substantial specialized knowledge derived from the biological, physical, and behavioral sciences is applied to the care, treatment, counsel, and health teaching of persons who are experiencing changes in the normal health processes; or who require assistance in the maintenance of health or the management of illness, injury, or infirmity or in the achievement of a dignified death; and such additional acts as are recognized by the nursing profession as proper to be performed by a registered nurse, and such further functions as may be defined in the rules and regulations of the board not inconsistent with the provisions of this act.

Furthermore it is proposed that the following be added to the same section as item (e):

> An "Advanced Registered Nurse Practitioner" means a person who is certified by the board to function in an expanded role.

Some of the other amendments which such a change would require include wording which would make it an unlawful act in K.S.A. 65-1114 for anyone to practice or offer to practice as an advanced registered nurse practitioner or to use any title etc. to indicate that any person is an advanced registered nurse practitioner unless such an individual is certified by the board. Amendments would also need to be provided for K.S.A. 65-1115, K.S.A. 65-1117, K.S.A. 65-1118, K.S.A. 65-1119, and K.S.A. 65-1120.

Again, thank you for this opportunity.

Attachment 5
E.F.

Summary of Testimony by D. Cramer Reed

Before the Kansas Legislative Interim Study Committee

on the Role of the Physician Extender, Wichita, June 22, 1977

Mr. Chairman, my name is D. Cramer Reed, and I wish to testify regarding the role of the physician extender and especially concerning legislative proposals pertaining to the role of the physician assistant.

My comments are predicated on the assumption that the committee has previously heard testimony recommending that neither the House or Senate bills proposed during the 1977 session adequately addressed the issue, and that the committee is considering proposing entirely different legislation to be introduced in the 1978 session.

I wish to support such action because both of the previously referenced bills had several aspects that recommend them, however, neither is totally adequate to perform the functions that I believe the Legislature desires.

There are two specific areas that are of concern in both previously proposed bills. It is my understanding that Dr. Swisher has previously discussed these, thus, I will only mention them for the record. First, I believe there must be clarification regarding the matter of "physician supervision" of the PA. This is a difficult one to address, however, until it is thoroughly reviewed and clarified, the effectiveness of these particular health professionals will be severely limited. It is to be hoped that Kansas would not make the same error that certain other states have by placing stringent, unrealistic restrictions on the functions the PA can perform except under "direct supervision." The Kansas State Board of Healing Arts would appear to be the best agency to develop rules and regulations covering this matter, and it is my understanding that the present membership of that body is such that it can realistically establish such guidelines. The second concern I wish to express has to do with the specification that the physician's assistant not be permitted to prescribe medication under any circumstances. I can appreciate the concern that has been expressed regarding this issue by various individuals and certain professional groups. However, it is my belief that the well-trained, registered PA is quite capable of prescribing certain medications under specified conditions so long as the supervising physician concurs in this practice. It must be remembered that even the present permissive Kansas law provides that the employing physician is still the individual responsible for all acts of the PA. Clinical algorithms and protocols have been successfully used in a variety of clinical settings for some time now and appear to be a very effective mechanism of supervision of the clinical practice of such extenders and serious consideration should be given to incorporating such language in legislation relating to these health professionals.

I wish to express my personal appreciation to the committee for permitting me to testify out of sequence to enable me to fulfill my commitments with another Legislative Study Committee beginning sessions at another site.

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Attachment T
FF

Wichita State University

June 22, 1977

(Verbatim transcript)

Testimony Before The Special Committee On Public Health And Welfare Of The Kansas Legislature

By Eric Schuman,
Physician Assistant

Good afternoon ladies and gentlemen of the committee. I want to thank Mrs. Correll for permitting me to testify this afternoon, and I think it's commendable that you're here in Wichita looking first hand at the physician assistant program. I am a physician assistant working with the family practice group in Topeka. I did my undergraduate work at the University of Maryland in Broadcast Media. I spent three years working as the executive director of the Freeport Area Council of Churches in northwest Illinois where I was involved largely with a clinic for medically indigent patients. That's how I became interested in medicine. I later attended the Long Island University Physician Associate Program in New York City where I received my Bachelor of Science degree. I was board certified by the National Commission on Certification of Physician Assistants in 1976. I am a fellow of the American Academy of Physician Assistants and serve as the delegate from Kansas to the Council on Primary Care. Since March of 1976 I have been with the Family Practice Group in Topeka, a recent grantee of the Robert Wood Johnson Foundation. The purpose of that grant is to provide family medical care in a group setting to patients of all socioeconomic strata in a community which has an acute shortage of primary care physicians. This will be a four year grant. We have a group which will consist of six family physicians, several physician assistants and nurse practitioners, as well as RN's, health educators, and we will be developing satellite facilities in the underserved areas of the city - north and east Topeka.

My own work is in two areas. In the development of our practice I am concerned with health education. I am specifically interested in the development of media resources and have developed a television hookup from St. Francis Hospital, with which we are affiliated for a four year period, from their staff education office to our office. We have access to 1000 hours of television tapes on subjects such as hypertension, diabetes and well child care. We use these with our patients every day in conjunction with the services of our health educator who is an RN. I am also working in the development of our two satellite facilities and am presently involved in attempting to select a site in east Topeka which would be appropriate for a new office.

My other area of involvement, as you might imagine, is in the provision of primary care to our patients. I work in an office in the Continental Medical Building, next to St. Francis and Stormont-Vail Hospital, and I see approximately 15 patients each day. These patients have scheduled

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appointments with me. I am clearly identified to these patients as a physician assistant by appointment cards, and by our receptionists, nurses and in my own introduction to these patients. If you will see our family practice brochure, on page 2 there is an introduction to the concept of the physician assistant. All of our patients are given a copy of this brochure.

The types of patients I see cover the entire spectrum of medical problems in primary care. I call your attention to this Individual Physician Assistant Profile. It was compiled by the medical school at the University of Wisconsin, and it is a profile of my practice in the week from April 4 - April 8, 1977, and it details for you every patient contact that week by diagnosis, and problem in order of the frequency for each ailment. It also profiles these patients in terms of their ages, sex, whether I saw them in the office or the hospital and the degree of supervision under which I saw these patients - whether I saw through direct supervision with a physician physically present in the room; indirectly, with possible consultation with Dr. Robert Jacoby, my supervising physician; or independently, which is defined in this study without consultation.

Dr. Jacoby is usually physically present in the office where I work. I consult with him one to three times each day as needed. In addition, he reviews and countersigns all of my charts after I dictate them and they are typed, and we have weekly patient conferences about more difficult problems. In the hospital I see two to five patients daily. We have a fairly young practice, and we have been in Topeka for just under two years. I have privileges at all three of the general medical hospitals in Topeka. I make supplementary evening rounds on all of our patients, and I have appeared before the credentials committees of each of the hospitals, either in person or by resume. At the hospitals I perform the duties you might expect; histories and physicals on admission, the ordering of appropriate laboratory studies, the writing of progress notes and medication orders which I write are countersigned within 24 hours by Dr. Jacoby.

I am delighted with the acceptance in the medical community in Topeka, specifically with the other members of the medical staff as well as the nurses. Nurses are most supportive of my role, and I am still the only physician assistant in Topeka, so it is a unique position. I try to introduce myself at each unfamiliar nursing station I come to and tell them a little bit about who I am and what I do. I usually find them very friendly and helpful. I have felt very rewarded by this.

To get my two bits in as everyone else has today, I would like to share with you my opinion concerning legislation in the State of Kansas regulating physician assistants. First of all, I believe the law should state what qualifications a physician assistant should have to practice in the state. I think a PA ought to have board certification by the National Board of Medical Examiners, or I think he should have graduated from an AMA approved physician assistant program such as the one in Wichita. I think that physician assistants should work only for qualified, practicing

physicians in the state of Kansas, and one thing I haven't heard stated before about who those physicians might be is that the doctors should meet the AMA's Physicians Recognition Award which specifies 100 hours of continuing medical education every two years. The same is required of us by the American Academy of Physician Assistants in order to keep our certification. If we don't meet these requirements we need to be recertified by board examination every two years instead of every six years.

I think our privileges should be confined to the scope of our employer's practice and qualifications. For example, if a physician assistant is working with a physician who does not deliver babies and has no privileges to do so, the PA shouldn't either. I think also, in echoing what several others have said today, that physicians should not employ more than two PA's. I don't think that is in the best interests of our patients.

I think, as Senator Chandler said this morning, the law should make no attempt to delineate a laundry list of procedures a physician assistant may or may not perform. I think the delegation of responsibility should be solely in the hands of the supervising physician. In the few states where these laundry lists have been written into the law, I think the results have been disastrous. I think the function of the physician assistant as an extension of the primary care physician has been subverted, and I think there is no point in having physician assistants under those circumstances. I further believe this because of the fact that most physician assistants, including myself, do not wish autonomy from the physician for whom we are working. The PA concept is a creature of the AMA and an extension of the physician. I want to be working in an interdependent relationship with the physician. Therefore, since I am not autonomous of him or her I think he or she alone should have the responsibility of delegating authority and which particular functions or procedures I might perform in his office.

Finally, as far as supervision is concerned,a P.A. should have at least telephone access to the physician. I think that physician should be in the state of Kansas at the time and not vacationing in New Mexico. I would be happy to answer any questions at this time.

Questions Of A Special Committee On Public Health And Welfare

The Committee: Question - What you are saying is that your function as an extender should cease at times when a physician is not within at least telephone access?

Mr. Schuman: Reply - Yes. I think all of our training was directed in that particular vein.

The Committee: Question - How long have you been in practice?

Mr. Schuman: Reply - I have been out of school since 1975

The Committee: Question - Have you ever been asked to do anything you weren't qualified to do by your physician?

Mr. Schuman: Reply - Yes. He didn't ask me to do it. He just asked me if I would feel comfortable doing such and such and I said "No I have only watched that procedure before. Would you mind going with me this time. And he replied, "sure."

The Committee: Question - do you feel there are other members of your profession that would have taken it upon themselves to do it?

Mr. Schuman: Reply - I certainly hope not.

The Committee: Question - When you have a new patient that comes to your office does he or she see you first or the doctor first or is it customary to see both of you at the same time?

Mr. Schuman: Reply - No, patient's don't usually see us jointly. There are different categories of patients. For example, a patient who has been seeing me all along when he or she calls up for an appointment is probably going to ask to see me. He will probably see me alone unless I specifically ask Dr. Jacoby to accompany me.

The Committee: Question - Suppose I call up on the phone and say, " I have a problem and I would like to make an appointment."

Mr. Schuman: Reply - First you would be asked how soon you needed to be seen and how serious was your problem. If you replied, "right away, today, I am really sick, " then the receptionist might tell you that Dr. Jacoby's schedule was filled today but that we could schedule you with our physician assistant, Mr. Schuman. Patients are given an alternative and are never forced to see one particular practitioner or another.

The Committee: Question - Are the charges for the patients you see the same as those charged by Dr. Jacoby?

Mr. Schuman: Reply - Yes it is

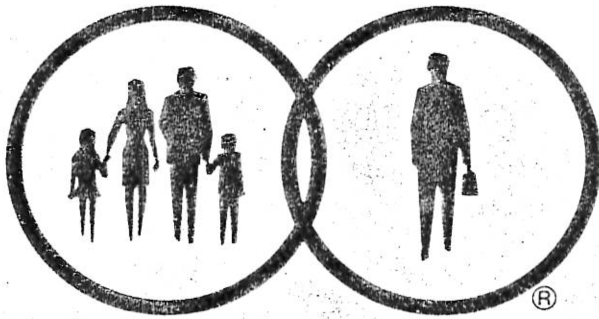
The Committee: Question - Even hospital visits?

Mr. Schuman: Reply - No, they are free.

The Committee: Question - So would you generally say then that your employment would have no effect on health care costs delivery?

Mr. Schuman: Reply - Sir, if I were an economist I could answer your question but I am afraid I am not. I would have to think about that.

The Committee: Question - Are there any further questions? If not, I thank you, Eric.



FAMILY PRACTICE

Robert E Jacoby II, MD

631 Horne, Suite 340
Topeka, Kansas 66606

232-9394

FAMILY PRACTICE

Robert E Jacoby II, MD

OFFICE HOURS

232-9394

9:00am-12:00 Noon, 1:30pm-5:00pm
Monday, Tuesday, Thursday, Friday

9:00am-12:00 Noon Wednesday only

10:00am-12:00 Noon Saturday only

Please limit routine calls to office hours. The answering service will reach the doctor after hours for emergency calls.

OTHER IMPORTANT NUMBERS

Hospitals:	Stormont-Vail	234-9961
	St Francis	354-8411
Ambulance:	Stormont-Vail Rescue	232-0434
	Hospital Ambulance Service	232-9111
Fire:	354-9511	
Police:	354-9551	

631 Horne, Suite 340
Topeka, Kansas 66606

We wish to welcome you and your family to our office and Dr Jacoby's practice. This pamphlet is an effort to give some general information and answers to common questions concerning our office.

OUR STAFF

Dr Jacoby is a graduate of the Topeka Public School system, the University of Kansas, Johns Hopkins University Medical School and the University of Kansas Family Practice Residency. Mildred ("Millie") Woolaway, RN, was raised in Nebraska and attended the Holton, Kansas, public schools; she is married, has four children and is a graduate of the Stormont-Vail School of Nursing. Physician's Assistant Eric Schuman, a native of Washington, DC, is a graduate of the Long Island University/ Brooklyn-Cumberland Medical Center Physician's Associate Program in New York City. Karen Christensen, medical assistant, is a native of McPherson, Kansas, and mother of two children. Sue Tucker, receptionist, was born in Mayetta, Kansas, and earned a BA in Recreational Therapy at Washburn University. Nell Jackson, medical secretary, was born in Wichita, Kansas, attended both the College of Emporia and Emporia State Teachers College, is married and has three children. Sheryl Woolaway (Millie's daughter), our records clerk, is a senior at Highland Park High School. Agnes Lundgren is a retired senior citizen who is back at work part time as assistant medical secretary. Linda Heim, RN, subs for Millie from time to time, is married and has two children. She is a native Topekan and a graduate of Sisters of Charity School of Nursing. Connie Menninger, group practice administrator with a Boston-East Texas background, has an BA in economics from Stanford University, is married and has six children.

PHILOSOPHY OF PRACTICE

Family Practice is American medicine's newest specialty, organized in 1969 as a response to the general need for a well-trained, modern equivalent of the traditional family doctor or general practitioner. Family Practice is a specialty in breadth rather than in depth. Your family doctor is trained in all the common areas of primary health care and is dedicated to doing comprehensive care with special emphasis on the family unit. Your family doctor has also had university residency experience in many secondary levels of medical care.

The "family" is defined loosely to include those related by circumstance or events as well as by marriage and blood; we care for single people, too.

EXPANDING OUR ROLE

January 1977 marks the beginning of an exciting growth period for this office. We are the recipients of a grant from the Robert Wood Johnson Foundation to organize a group practice in family medicine. We hope to expand our physical plant and personnel to at least twice the present size in the Continental Medical Building, with future plans to include other offices in outlying areas of the city.

PHYSICIAN'S ASSISTANTS

Physician's Assistants are specially educated medical personnel who extend the services of your family doctor. They are trained to take medical histories and perform physical examinations. Under physician supervision, they assist in diagnosis and treatment of a patient's illness. Having Physician Assistants on our staff means better ability to care promptly for our patients and in some cases more time and depth in analyzing your individual health needs. While they are not physicians (MD's), most PA's have a bachelor of science degree in health or medicine. A PA always has access to a physician for problems or consultation. Appointments with our P[illegible] [illegible]ll be routinely handled in the same manner as those w[illegible] Dr Jacoby.

WHAT WILL BE EXPECTED OF YOU

Our office hopes to provide you with the type of medical care that you want and need--in return, we have certain expectations. In order for us to keep good records and see that the basic medical needs are met, we will ask of each new patient that we have a complete evaluation or history and physical assessment of current problems at the first visit, or as soon as can be conveniently scheduled. If there are financial problems, suitable payment arrangements will be made. Once one member of a family has been seen in our office, it should be understood that we are prepared to take responsibility for caring for the entire family unit if you so wish. Dr Jacoby will take the responsibility to decide when referral to another physician is necessary and would in turn appreciate being a part of any decision by you to seek advice from another physician. We will also expect that you act responsibly in following medical instructions concerning appropriate testing and medical follow-ups, such as periodic checkups, Pap smears, immunizations, rechecks of blood pressure and chronic diseases such as diabetes.

WHAT TO EXPECT OF US

We provide primary care for any and all medical problems. This includes routine medical care, obstetrics, gynecology, newborns, pediatrics, adult care and geriatrics, as well as acute and chronic medical problems. We may also be able to help with appropriate counseling and referral. Laboratory testing requiring blood specimens will be initiated in our office, although the actual processing will usually be done in an outside lab. Routine throat and urine cultures will also be performed in our office.

PRESCRIPTIONS

Prescriptions are usually written generically rather than by trade names in the interest of economy to our patients. Unless circumstances dictate otherwise, prescriptions and refills will be given during office hours only; generally it is unwise medically to prescribe without access to the patient's medical records.

APPOINTMENTS

Making an Appointment: Please explain the nature of your visit when calling in for an appointment so that the necessary amount of time may be scheduled for your visit. Data Base appointments (complete history and physical) should be made three to four months ahead; routine items such as a school physical or a Pap smear should be made three to four weeks ahead.
Least busy time to call for an Appointment: 8:30-9:30am.
It is not necessary to make an appointment for a throat or urine culture, but it would be helpful for staff planning if you would call in ahead to let us know when you are coming in for such a purpose.
When arriving for an Appointment: Check in, giving the necessary information, including any new information such as change in name, address or phone number. Make yourself comfortable in the waiting room. We will do our best to minimize the wait, for we are just as concerned as you when you are required to wait an unusual length of time. (Your cooperation in being on time can mean less waiting time for you.)
Rescheduling an Appointment: When YOU must do so, it is helpful if you can let us know of the change as far in advance as possible. When WE must do so, we will call you if we know sufficiently ahead of your designated arrival time and reschedule you for a later time, very possibly that same day. When an emergency occurs that takes Dr Jacoby away while you are having an appointment or waiting for one, you have three options:

* Wait until he returns (staff will advise)
** See the Physician Assistant instead (it may be that the PA or nurse can complete your visit)
***Reschedule your appointment for a later time

WHEN PHONING IN

Phone calls to the office will be answered by office personnel when appropriate; when necessary Dr Jacoby will answer phone messages in order of priority and urgency as seems appropriate. There is no special ti[illegible] for "call backs". We would ask that some message be left with our receptionist so that we may judge the urgency of the problem. It might be helpful for you to have paper and pencil handy when you call in.

SPECIAL COVERAGE BY ANOTHER PHYSICIAN

From time to time Dr Jacoby will be unavailable for an extended period of time, such as when he is attending a medical meeting out of time. Our staff will handle calls during office hours as usual, utilizing the physician covering for Dr Jacoby when necessary. The answering service will respond during non-office hours at the 232-9394 number and will relay your message to the physician who is taking Dr Jacoby's calls.

ACUTE EMERGENCY PROCEDURE

In the event of an acute emergency, the patient may need to be transported to either hospital emergency department, where the personnel will assess the situation and notify Dr Jacoby as needed.

CONFIDENTIALITY OF MEDICAL RECORDS

No information will be released by our office to anyone, including insurance representatives and attorneys, without your written consent.

INSURANCE

We hope that all of our patients carry suitable health insurance. At the time of the first office visit, we hope to explore limits of coverage and make sure that both parties understand exactly what services are taken care of by insurance and what are not. We do accept assignment on Medicare claims, and our office will handle all billing for such patients. Our office will submit Blue Cross-Blue Shield claims for our patients; other insurance claims will be submitted by our patient with an insurance copy of our statement for services rendered at the time of the office call. If there are questions regarding insurance billing or other matters, please ask for help from Karen or Sue.

Dr Jacoby is a participating Blue Shield physician.

FEES

Initial, new patient, introductory office visit (The first visit, even though not a complete evaluation, costs more than later visits because of the expense involved in initiating medical records, office procedures and other business matters.)	$12.00
Standard Follow-up Office Visit	10.00
Comprehensive Data Base Exam, new patient (A complete history and physical exam, requiring two or three times the length of the usual office visit.)	35.00
Periodic Comprehensive Evaluation (This takes the place of the annual physical.)	25.00
School Physical	12.00
Pelvic Exam and Pap Smear	20.00
Throat or Urine Culture	5.00
Total Obstetric Care (lab work extra)	350.00

There may be several other categories of visits with different fees; generally, office visits requiring more than average time, more supplies or more of the staff's time will be charged a higher fee. Patients are encouraged to pay their medical bills at the time of the office visit because it will help us hold down costs which would otherwise eventually be passed along to patients. Otherwise, patients will receive monthly statements which will be copies of accounts kept in our office. We encourage any patient with a question about any of our fees or billing procedure to ask at the time of their visit or phone the office. We will be glad to make suitable adjustments in case of financial difficulties or other special problems.

House Calls

Dr Jacoby will make house calls when it is impossible or unwise for a patient to travel to the office or the hospital. If there is a serious medical problem, the laboratory, x-ray and other special aids available in the office and hospital may be important to your doctor in assessing and treating the problem.

FEEDBACK

You will be notified in writing of test results and/or basic findings. Usually this notification is sent within 10 days to 2 weeks. If the information is of an emergency nature, you will be phoned by Dr Jacoby.

SPACE FOR YOUR PERSONAL NOTES

98/7753/17

INDIVIDUAL PHYSICIAN'S ASSISTANT PROFILE

a program of the

epartment of CONTINUING MEDICAL EDUCATION

UNIVERSITY of WISCONSIN-EXTENSION

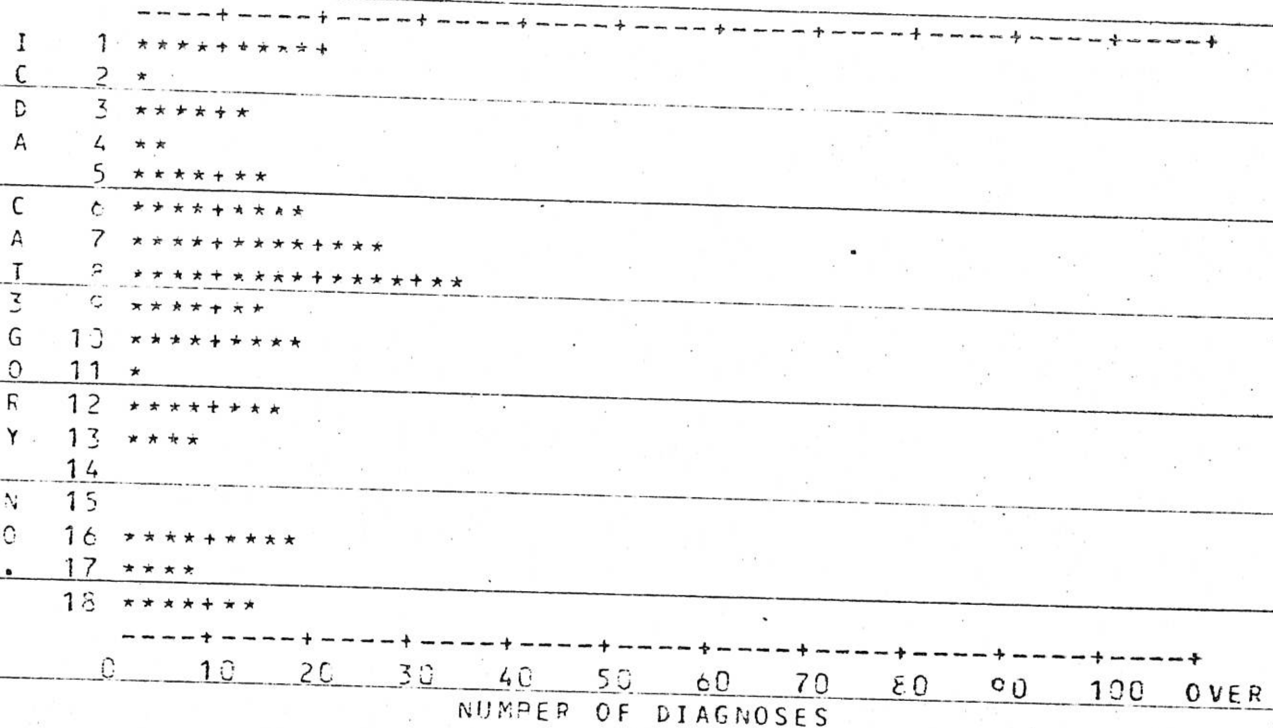
sponsored by the

MERICAN ACADEMY of PHYSICIAN'S ASSISTANTS

PROBLEM PROFILE

PHYSICIAN CODE NO. 98/7753/170000/0000/0000
DAYS OF DICTATION 04/04/77, 04/05/77, 04/06/77, 04/07/77, 04/11/77, 04/08/77
TOTAL NUMBER OF DIAGNOSES 218

BAR GRAPH OF TOTAL DIAGNOSES (PATIENT PROBLEMS) GROUPED INTO THE 18 CATEGORIES OF THE INTERNATIONAL CLASSSIFICATION OF DISEASES (ICDA)

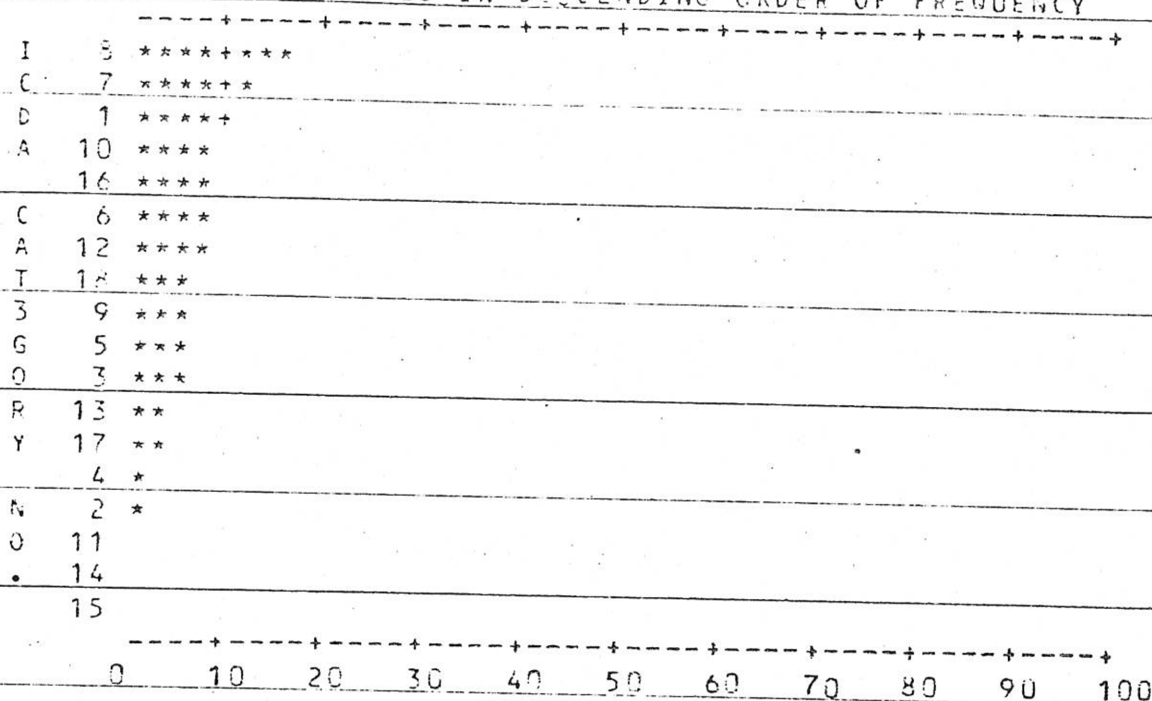


KEY TO ABOVE BAR GRAPH

	NO. OF DX
1. INFECTIVE AND PARASITIC DISEASES	20
2. NEOPLASMS	2
3. ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES	12
4. DISEASES OF BLOOD AND BLOOD FORMING ORGANS	3
5. MENTAL DISORDERS	13
6. DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS	17
7. DISEASES OF CIRCULATORY SYSTEM	25
8. DISEASES OF THE RESPIRATORY SYSTEM	34
9. DISEASES OF THE DIGESTIVE SYSTEM	13
10. DISEASES OF THE GENITOURINARY SYSTEM	18
11. COMPLICATIONS OF PREGNANCY, CHILDBIRTH AND THE PUERPERIUM	1
12. DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE	15
13. DISEASES OF MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE	7
14. CONGENITAL ANOMALIES	0
15. CERTAIN CAUSES OF PERINATAL MORBIDITY AND MORTALITY	0
16. SYMPTOMS AND ILL-DEFINED CONDITIONS	18
17. ACCIDENTS, POISONINGS AND VIOLENCE	7
18. SPECIAL CONDITIONS AND EXAMINATIONS WITHOUT SICKNESS	13

PHYSICIAN CODE NO. 78/7753/17J000/0000/0000

BAR GRAPH OF THE PERCENTAGE OF TOTAL DIAGNOSES GROUPED IN THE 18 CATEGORIES IN DESCENDING ORDER OF FREQUENCY



KEY TO ABOVE BAR GRAPH

		% OF TOTA
8.	DISEASES OF THE RESPIRATORY SYSTEM	15.6
7.	DISEASES OF CIRCULATORY SYSTEM	11.5
1.	INFECTIVE AND PARASITIC DISEASES	9.2
10.	DISEASES OF THE GENITOURINARY SYSTEM	8.3
16.	SYMPTOMS AND ILL-DEFINED CONDITIONS	8.3
6.	DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS	7.8
12.	DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE	6.9
18.	SPECIAL CONDITIONS AND EXAMINATIONS WITHOUT SICKNESS	6.0
9.	DISEASES OF THE DIGESTIVE SYSTEM	6.0
5.	MENTAL DISORDERS	6.0
3.	ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES	5.5
13.	DISEASES OF MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE	3.2
17.	ACCIDENTS, POISONINGS AND VIOLENCE	3.2
4.	DISEASES OF BLOOD AND BLOOD FORMING ORGANS	1.4
2.	NEOPLASMS	.9
11.	COMPLICATIONS OF PREGNANCY, CHILDBIRTH AND THE PUERPERIUM	.5
14.	CONGENITAL ANOMALIES	.0
15.	CERTAIN CAUSES OF PERINATAL MORBIDITY AND MORTALITY	.0

PHYSICIAN CODE NO. 98/7753/170000/0000/0000

LISTING OF THE MAJOR CATEGORY DIAGNOSES AS THEY OCCURRED IN DESCENDING ORDER OF FREQUENCY. UNDER EACH OF THE MAJOR CATEGORIES IS A LISTING OF SUB-SUB CATEGORIES IN ORDER OF DESCENDING FREQUENCY

TOTAL NUMBER OF DIAGNOSES 216

CATEGORY 8. DISEASES OF THE RESPIRATORY SYSTEM

Code	Diagnosis	# OF
8A462	ACUTE PHARYNGITIS	5
8D493	ASTHMA	5
8A460	ACUTE NASOPHARYNGITIS (COMMON COLD)	4
8A465	ACUTE UPPER RESPIRATORY INFECTION OF MULTIPLE OR UNSPECIFIED SITES	4
8A466	ACUTE BRONCHITIS, BRONCHIOLITIS	4
8D490	BRONCHITIS, UNQUALIFIED	3
8C486	PNEUMONIA, UNSPECIFIED	2
8E507	HAY FEVER	2
8A463	ACUTE TONSILLITIS	1
8E503	CHRONIC SINUSITIS	1
8E505	NASAL POLYP	1
8E508	OTHER DISEASES OF UPPER RESPIRATORY TRACT	1
8F511	PLEURISY	1

CATEGORY 7. DISEASES OF CIRCULATORY SYSTEM

Code	Diagnosis	# OF
7C401	ESSENTIAL BENIGN HYPERTENSION	7
7H451	PHLEBITIS, THROMBOPHLEBITIS	6
7D412	CHRONIC ISCHEMIC HEART DISEASE	5
7E424	CHRONIC DISEASE OF ENDOCARDIUM	3
7E427	SYMPTOMATIC HEART DISEASE	3
7G440	ARTERIOSCLEROSIS	1

CATEGORY 1. INFECTIVE AND PARASITIC DISEASES

Code	Diagnosis	# OF
1D034	STREPTOCOCCAL SORE THROAT, SCARLET FEVER	5
1A009	DIARRHEAL DISEASE	4
1J098	GONOCOCCAL INFECTIONS	3
1L110	DERMATOPHYTOSIS	3
1B011	PULMONARY TUBERCULOSIS	1
1F054	HERPES SIMPLEX	1
1J099	OTHER VENEREAL DISEASE	1
1N131	TRICHOMONIASIS UROGENITALIS	1
1N133	ACARIASIS	1

CATEGORY 10. DISEASES OF THE GENITOURINARY SYSTEM

Code	Diagnosis	# OF
10E622	INFECTIVE DISEASES OF UTERUS (EXCEPT CERVIX), VAGINA, AND VULVA	4
10E626	DISORDERS OF MENSTRUATION	4
10D616	DISEASES OF PARAMETRIUM, PELVIC PERITONEUM (FEMALE)	3
10D611	OTHER DISEASES OF BREAST	2

PHYSICIAN CODE NO. 9?/7753/17?000/0000/0000/ PAG

10A583 NEPHRITIS, UNQUALIFIED
10B599 OTHER DISEASES OF URINARY TRACT
10C607 OTHER DISEASES OF MALE GENITAL ORGANS
10E621 OTHER DISEASES OF CERVIX
10E627 MENOPAUSAL SYMPTOMS

CATEGORY 16. SYMPTOMS AND ILL-DEFINED CONDITIONS # C

16B790 NERVOUSNESS AND DEBILITY
16A783 SYMPTOMS REFERABLE TO RESPIRATORY SYSTEM
16A782 SYMPTOMS REFERABLE TO CARDIOVASCULAR, LYMPHATIC SYSTEM
16A780 CERTAIN SYMPTOMS REFERABLE TO NERVOUS SYSTEM, SPECIAL SENSES
16A781 OTHER SYMPTOMS REFERABLE TO NERVOUS SYSTEM, SPECIAL SENSES
16B791 HEADACHE

CATEGORY 6. DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS # O

6G381 OTITIS MEDIA WITHOUT MENTION OF MASTOIDITIS 1
6D355 OTHER, UNSPECIFIED FORMS OF NEURALGIA AND NEURITIS
6F378 OTHER DISEASES OF EYE
6G384 OTHER INFLAMMATORY DISEASES OF EAR 1
6G389 OTHER DEAFNESS 1

CATEGORY 12. DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE # OF

12B692 OTHER ECZEMA, DERMATITIS 5
12A682 OTHER CELLULITIS, ABSCESS 3
12C706 DISEASES OF SEBACEOUS GLANDS 3
12C709 OTHER DISEASES OF SKIN 3
12B696 PSORIASIS, SIMILAR DISORDERS 1

CATEGORY 18. SPECIAL CONDITIONS AND EXAMINATIONS WITHOUT SICKNESS # OF

18A005 WELL BABY AND CHILD CARE 7
18A000 GENERAL MEDICAL EXAMINATION 3
18H070 POSTPARTUM OBSERVATION 2
18G060 PRENATAL CARE 1

CATEGORY 9. DISEASES OF THE DIGESTIVE SYSTEM # OF

9E560 INTESTINAL OBSTRUCTION WITHOUT MENTION OF HERNIA 5
9E564 FUNCTIONAL DISORDERS OF INTESTINES 3
9F575 CHOLECYSTITIS, CHOLANGITIS, WITHOUT MENTION OF CALCULUS 2
9B532 ULCER OF DUODENUM 1
9D551 OTHER HERNIA OF ABDOMINAL CAVITY WITHOUT MENTION OF OBSTRUCTION 1
9F571 CIRRHOSIS OF LIVER 1

CATEGORY 5. MENTAL DISORDERS #
- 5A299 UNSPECIFIED PSYCHOSIS
- 5B300 NEUROSES
- 5B303 ALCOHOLISM
- 5B309 MENTAL DISORDERS NOT SPECIFIED AS PSYCHOTIC ASSOCIATED WITH PHYSICAL CONDITIONS
- 5C315 UNSPECIFIED MENTAL RETARDATION

CATEGORY 3. ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES #
- 3A244 MYXEDEMA
- 3D277 OBESITY NOT SPECIFIED AS OF ENDOCRINE ORIGIN
- 3B250 DIABETES MELLITUS
- 3C269 OTHER NUTRITIONAL DEFICIENCY
- 3B251 DISORDERS OF PANCREATIC INTERNAL SECRETION OTHER THAN DIABETES MELLITUS
- 3D274 GOUT

CATEGORY 13. DISEASES OF MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE
- 13A713 OSTEOARTHRITIS, ALLIED CONDITIONS
- 13A712 RHEUMATOID ARTHRITIS, ALLIED CONDITIONS
- 13B723 OTHER DISEASES OF BONE
- 13B728 VERTEBROGENIC PAIN SYNDROME

CATEGORY 17. ACCIDENTS, POISONINGS AND VIOLENCE # (
- 17Q977 ADVERSE EFFECT OF OTHER, UNSPECIFIED DRUGS
- 17R989 TOXIC EFFECT OF OTHER SUBSTANCES CHIEFLY NONMEDICINAL AS TO SOURCE
- 17E847 SPRAINS, STRAINS OF OTHER, UNSPECIFIED PARTS OF BACK
- 17M929 CONTUSION OF OTHER, MULTIPLE, UNSPECIFIED SITES
- 17S996 INJURY, OTHER UNSPECIFIED

CATEGORY 4. DISEASES OF BLOOD AND BLOOD FORMING ORGANS # (
- 4A285 OTHER, UNSPECIFIED ANEMIAS
- 4A289 OTHER DISEASES OF BLOOD, BLOOD-FORMING ORGANS

CATEGORY 2. NEOPLASMS # (
- 2B151 MALIGNANT NEOPLASM OF STOMACH
- 2E189 MALIGNANT NEOPLASM OF OTHER, UNSPECIFIED URINARY ORGANS

CATEGORY 11. COMPLICATIONS OF PREGNANCY, CHILDBIRTH AND THE PUERPERIUM (
- 11A634 OTHER COMPLICATIONS OF PREGNANCY

MADISON ACADEMIC COMPUTING CENTER PROGRAM CROSTAB2
INDIVIDUAL PHYSICIAN'S ASSISTANT PROFILE
DESCRIPTION OF PATIENT CONTACTS

TAB 1
TOTAL NUMBER OF PATIENT CONTACTS

CATEGORY VAR. 1	COUNT
P.A. TOTAL PATIENTS	108

TAB 2
AVERAGE NUMBER OF PATIENT CONTACTS PER DAY

CATEGORY VAR. 2	COUNT
AVER NO PATIENTS PER DAY	21.60

TAB 3
NUMBER OF PATIENTS BY SEX --- PCOL=PERCENT COUNT=NUMBER

CATEGORY SEX	COUNT	PCOL
FEMALE	62	57.41
MALE	46	42.59
TOTAL	108	100.00

TAB 4
NUMBER OF PATIENT CONTACTS BY TYPE/PLACE OF ENCOUNTER
PCOL= PERCENT COUNT=NUMBER

CATEGORY PLACE	COUNT	PCOL
OFFICE	73	67.59
PHONE	16	14.81
HOSPITAL	19	17.59
TOTAL	108	100.00

MADISON ACADEMIC COMPUTING CENTER PROGRAM CROSTAB2
INDIVIDUAL PHYSICIAN'S ASSISTANT PROFILE
DESCRIPTION OF PATIENT CONTACTS

TAB 5
DISTRIBUTION OF PATIENTS BY SEX AND AGE GROUPINGS
PROW=PERCENT OF THE ROW   PCOL=PERCENT OF THE COLUMN
ROWS........CATEGORIES OF AGE
COLUMNS....CATEGORIES OF SEX

	FEMALE	MALE	TOTAL	
NEWBORN	9	15	24	COUNT
TO 5	37.50	62.50	100.00	PROW
YEARS	14.52	33.33	22.43	PCOL
	11	7	18	COUNT
5 TO 20	61.11	38.89	100.00	PROW
YEARS	17.74	15.56	16.82	PCOL
	22	12	34	COUNT
21 TO 40	64.71	35.29	100.00	PROW
YEARS	35.48	26.67	31.78	PCOL
	13	5	18	COUNT
41 TO 65	72.22	27.78	100.00	PROW
YEARS	20.97	11.11	16.82	PCOL
	7	6	13	COUNT
65 YEARS	53.85	46.15	100.00	PROW
AND OVER	11.29	13.33	12.15	PCOL
	62	45	107	COUNT
TOTAL	57.94	42.06	100.00	PROW
	100.00	100.00	100.00	PCOL

MADISON ACADEMIC COMPUTING CENTER PROGRAM CROSTAB2
INDIVIDUAL PHYSICIAN'S ASSISTANT PROFILE
DESCRIPTION OF PATIENT CONTACTS

TAB 6
DISTRIBUTION OF PATIENTS BY SEX AND TYPE OF CONTACT
ROWS.......CATEGORIES OF PLACE
COLUMNS....CATEGORIES OF SEX

	FEMALE	MALE	TOTAL	
OFFICE	44	29	73	COUNT
	60.27	39.73	100.00	PROW
	70.97	63.04	67.59	PCOL
PHONE	12	4	16	COUNT
	75.00	25.00	100.00	PROW
	19.35	8.70	14.81	PCOL
HOSPITAL	6	13	19	COUNT
	31.58	68.42	100.00	PROW
	9.68	28.26	17.59	PCOL
TOTAL	62	46	108	COUNT
	57.41	42.59	100.00	PROW
	100.00	100.00	100.00	PCOL

TAB 7
DISTRIBUTION OF PATIENT CONTACTS BY TYPE OF CONTACT AND BY AGE
ROWS.......CATEGORIES OF AGE
COLUMNS....CATEGORIES OF PLACE

	OFFICE	PHONE	HOSPITAL	TOTAL	
NEWBORN	19	3	2	24	COUNT
TO 5	79.17	12.50	8.33	100.00	PROW
YEARS	26.39	18.75	10.53	22.43	PCOL
	15	3	0	18	COUNT
5 TO 20	83.33	16.67	.00	100.00	PROW
YEARS	20.83	18.75	.00	16.82	PCOL
	21	7	6	34	COUNT
21 TO 40	61.76	20.59	17.65	100.00	PROW
YEARS	29.17	43.75	31.58	31.78	PCOL
	10	2	6	18	COUNT
41 TO 65	55.56	11.11	33.33	100.00	PROW
YEARS	13.89	12.50	31.58	16.82	PCOL
	7	1	5	13	COUNT
65 YEARS	53.85	7.69	38.46	100.00	PROW
AND OVER	9.72	6.25	26.32	12.15	PCOL
	72	16	19	107	COUNT
TOTAL	67.29	14.95	17.76	100.00	PROW
	100.00	100.00	100.00	100.00	PCOL

TAB 8
DISTRIBUTION OF PATIENT CONTACTS BY DEGREE OF RESPONSIBILITY FOR DIAGNOSTIC DECISION

CATEGORY DIAGNOSE	COUNT	PCOL
INDEPEN- DENT DECISION	73	70.87
UNDER INDIRECT SUPERVIS	8	7.77
UNDER DIRECT SUPERV	22	21.36
TOTAL	103	100.00

TAB 9
DISTRIBUTION OF PATIENT CONTACTS BY DEGREE OF RESPONSIBILITY
FOR THERAPY / DISPOSITION DECISION

CATEGORY THERAPY	COUNT	PCOL
INDEPEN- DENT DECISION	66	67.35
UNDER INDIRECT SUPERVIS	10	10.20
UNDER DIRECT SUPERV	22	22.45
TOTAL	98	100.00

TAB 10
DISTRIBUTION OF PATIENT CONTACTS BY FIRST / FOLLOW-UP VISIT
FOR THIS PROBLEM

CATEGORY VISIT	COUNT	PCOL
FIRST VISIT	31	28.70
FOLLOW- UP VISIT	77	71.30
TOTAL	108	100.00

Attachment 6

Testimony of the Kansas Department of
Health and Environment

to

Special Committee on Public Health and Welfare

regarding

Role, Trends in Utilization, Regulation, and
Relationship to Physicians of New Health Professionals

June 22, 1977

Presentor: Joseph F. Harkins
Director of Planning and Public Education

Atch. U

Introduction

Thank you for the opportunity to offer the view of the Department of Health and Environment on the important subject of New Health Professionals. This is a complicated subject which has received considerable attention from state legislatures during the last several years. Evidence of this activity is reflected by the fact that thirty (30) states have revised their Nurse Practice Acts to expand the role of nursing since 1972.[1] By 1976, less than ten years after physician assistants first entered the marketplace, forty-three (43) states had passed laws governing their practices.[2] Kansas has dealt with the practice of physician assistants with legislation. While there may be a need for some additional role clarification and regulation of the physician assistant, this is not a major problem. The key issue yet to be addressed in our state is the expansion of traditional nursing practice.

Role and Trends

Since the late 1960's, approximately sixty (60) programs training physician assistants have been established. These programs have produced a total of approximately 3,000 graduates.[3] There are now an estimated 200 Nurse Practitioner programs which have produced approximately 7,000 graduates.[4] Annual production of Nurse Practitioners now routinely exceeds that of Physician Assistants by 500 per year.

This production of health providers is important. Present annual manpower production figures in the U.S. are as follows:

Nurse Practitioners	1,500
Physician Assistants	1,000
Physicians	13,000

In 1967, there were 247,000 MD's providing patient care in the United States. In the last ten years, we have added 122,000 professionals (including PA's and NP's) to the work force. This is an increase of 50% in absolute numbers and if the production is supplemented with additional increases in medical education already planned, there will be a ratio of one physician to every 250 people in the U.S. by the year 2000![5]

From these figures, one must ask - is there a significant role in the future for a large number of so-called "physician extenders"? This extender role, now carried out by both PA's and some NP's, may not achieve large scale penetration of the medical market place in light of the vastly increasing number of physicians due to enter during the next three decades. The extender role almost certainly will survive this dramatic change in market conditions, but large scale growth seems somewhat unlikely.

On the other hand, the large scale growth in NP programs is not based primarily on the concept of the physician extender role. To the contrary, this movement has never been hailed as an "answer" to the physician shortage problem in our traditional medical market place. Rather, the movement is considered an addition to or enhancement of services available in the health care market place. These services,

geared to health promotion and disease prevention, have been a scarce commodity in the United States for too many years.

I want to make this point as clearly as possible. There are two basic types of new health professionals 1) the physician extenders, a role that the PA is trained to carry out and which many NP's are also prepared for by training and/or experience and also perform; and 2) the nurse in an expanded role, struggling to establish a new set of health services essentially distinct from the traditional physician role, that emphasizes education and support rather than medical care treatment of specific diseases or trauma.

Making the distinction between the two basic role models is relatively easy in theory; but, in practice, things are not quite so neat and tidy. A large grey area exists between the traditional medical model and the expanded nursing role model. Where the line is drawn between the two is obscure to the point that I must say it cannot be done with precision. I would hasten to add that a sharp legal distinction is not even desirable at this time during which two dynamic professions (medicine and nursing) are going through rapid change and need flexibility for growth within limits adequate to protect the public safety.

The non-medical expanded nursing role has been evolving over many years. It is commonplace in the field of public health nursing where financial subsidies are generally available for programs such as maternal and child care. There presently is no satisfactory form of financial support

for the nurse in an expanded (non-medical) role other than through public health programs. Third party payors have consistently refused to reimburse nurses directly for such services. On the other hand, while I suggested the prospect of limited growth for the PA, financial support for them is generally more available since sponsoring physicians can frequently bill for the services of an assistant. Unless the financing can be found for the NP in a non-physician extender practice, both forms of these new health professionals may represent little more than a minor embellishment of the health care system as we know it today.

Concern about the lack of primary care in Kansas is widespread. If primary care is defined broadly, and we think it should be, to include health promotion, disease prevention, and medical care, the physician extender and the nurse in an expanded role can both play important roles in solving the problem. Kansas is appropriately supporting training programs for physician assistants and nurses in expanded roles. While I have suggested the possibility of modest growth of the physician extender role, it remains an important one. The expanded role of the nurse is also a vital addition and needs support in further development.

Regulation

PA professional regulation efforts began in the late 1960's when four organizations (the American College of Physicians, the American Academy of Pediatrics, the American Academy of Family Practice, and the American Society of Internal Medicine) jointly developed a program to accredit PA's. The Joint Committee on Accreditation reviews applications,

conducts site visits, and makes recommendations to the Joint Council on Medical Education of the AMA which is formally recognized by HEW as the accrediting body for PA programs.

As a result of early accreditation efforts, PA programs are very similar in terms of curriculum and clinical training. Further standardization was enhanced by the offering of a certification examination by the National Board of Medical Examiners. The Council on Medical Education has published a succinct standard definition and description of a PA.

A sharp contrast exists between the orderly professional regulation of PA training and that associated with NP training. There is a high degree of variability in format, curriculum, and clinical training requirements in these programs. These variations reflect, in part, different emphasis between preparing nurses for physician extender roles versus an expanded nursing role. Therefore, no broadly accepted description of the NP role exists since it is essentially a function of the type of practice chosen. The American Nurses Association has recently taken the leadership in developing mechanisms for program accreditation and certification of graduates of NP programs.

This contrast between the level of professional regulation is understandable and not a sign of neglect. Rather, it is a reflection on the complexity of developing a new concept of health services delivery within the confines of a highly regulated field with strong legislation protecting the field of medicine.

Legislated regulation for PA's has been a rather simple matter with most states providing for delegation of physician powers. These programs are usually administered by the Board of Healing Arts and are working satisfactorily.

Legislated regulation of nurses in expanded roles is not so simple. This is due to the multiple roles nurses have chosen. Actually, nurses who have chosen to function exclusively as physician extenders can do so under the delegated authority of physicians. These nurses would not be functioning as nurses under this medical role model.

Nurses opting for an expanded role that does not include medical acts can and should be able to do so under the Nurse Practice Act. This role, as I have mentioned, involves assessment, counselling, and education. Some would argue that these are synonymous to diagnosis and treatment - acts which are forbidden by the Nursing Practice Act and the Board of Healing Arts Act. Others would argue that these are "nursing diagnosis" and "nursing treatment", which are different from "medical diagnosis" and "medical treatment".[6] At first, this latter argument may sound like a semantic absurdity, but it has considerable merit. New York State passed a new definition of nursing including the following terms:

> "1. 'Diagnosing' in the context of nursing practice means that identification of and discrimination between physical and psychosocial signs and symptoms essential to effective execution and management of the nursing regimen. Such diagnostic privilege is distinct from a medical diagnosis.
>
> "2. 'Treating' means selection and performance of those therapeutic measures essential to the effective execution and management of the nursing regimen, and execution of any prescribed medical regimen."[7]

Thus, the traditional distinction between nursing and medicine is preserved but the definition of the nursing role is broadened. Several states, including Colorado, Indiana, Washington, and Pennsylvania, have since enacted similar changes.

There are two basic options for regulation of the nurse desiring to practice simultaneously as a PA and a NP.

1. Provide a broader regulation role for the Board of Nursing to include administration of guidelines that would be established by either the Board of Nursing; the Board of Healing Arts; or both. This option would include the expanded definition of nursing and guidelines for performing certain medical acts. Variations of this option have been implemented by several states.[8]

2. Allow the nurse to function simultaneously under both laws. Certain delegated acts would fall under the Board of Healing Arts and nursing acts (under an expanded definition) would fall under the Board of Nursing.

We would recommend the latter option. It would provide for maximum flexibility in further experimentation with role models while assuring adequate public safety. Another advantage would be the lack of additional bureaucratic activities necessary to achieve a joint regulatory function.

As I mentioned earlier, the nurse opting exclusively for the physician extender role should be regulated under present laws dealing

with delegation of medical acts.

Summary

The Nurse Practice Act should be changed to include an expanded definition of nursing. This new role will be an essential one for improving the health status of our society by placing greater emphasis on preventing or deferring illness and disability. An effective way of providing for this expanded role is the redefinition of nursing to include nursing diagnosis and treatment. This can, we feel, be done without encroaching on the field of medicine.

[1]Bonnie Bullough, R.N., "Nurse Practice Acts", Nursing 77, Feb, 1977, p. 73.

[2]Preliminary Information on Physician Assistants and Nurse Practitioners, National Center for Health Services Research, March, 1977 (unpublished).

[3]Charles Lewis; Raski Fein; David Mechanic, A Right to Health, 1977, (chapter 9).

[4]Ibid.

[5]Ann Bless and Eva Cohen, The New Health Professionals, Aspen Publications, 1977, p. 372.

[6]Virginia Hall, Statutory Regulation of the Scope of Nursing, National Joint Practice Commission, June, 1975.

[7]Ibid.

[8]Bullough, op cit.