M I N U T E S

SPECIAL COMMITTEE ON PUBLIC HEALTH AND WELFARE

October 18-19, 1977
Room 527, State House

Members Present

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

Staff Present

Emalene Correll, Kansas Legislative Research Department
Bill Wolff, Kansas Legislative Research Department
Sherman Parks, Jr., Revisor of Statutes Office

Others Present

Doug Johnson, Kansas Pharmaceutical Association, Topeka, Kansas
Carl Schmitthenner, Kansas State Dental Association, Topeka, Kansas
Jerry Slaughter, Kansas Medical Society, Topeka, Kansas
Elizabeth W. Carlson, State Board of Healing Arts, Topeka, Kansas
Mau Dicker, Wichita State University, Wichita, Kansas
Elizabeth Sheldon, Kansas Academy of Physicians' Assistants, Wichita, Kansas
Judy Runnels, Kansas State Nurses Association, Topeka, Kansas
Jeff Wampler, Kansas Farm Bureau, Manhattan, Kansas
Ruth C. Dickinson, State Planning and Research, Topeka, Kansas
Roberta Thiry, Kansas State Nurses Association, Lawrence, Kansas
Joyce Olson, Kansas State Nurses Association, Shawnee, Kansas
Gloria Kilian, Kansas State Board of Nursing, Wichita, Kansas
Elizabeth C. Dayani, Kansas State Nurses Association, Kansas City, Kansas
Jo Boyer, Kansas State Nurses Association, Mission, Kansas
Bonnie L. Ransom, Health Planning, Topeka, Kansas
Virginia C. Will, Kansas Hospital Association, Topeka, Kansas
Elaine Dohmeier, Kansas Association of Hospital Schools of Nursing, Wichita, Kansas
Marguirite Coleman, Newman Hospital School of Nursing, Emporia, Kansas
Janet Macy, Kansas Association of Hospital Education Coordinators, Topeka, Kansas
Marylyn Hecke, Kansas State Department of Education, Topeka, Kansas
Barbara Elliott, Kansas Society Nursing Service Directors, El Dorado, Kansas
Alexine Larson, St. Francis Hospital, Wichita, Kansas
Carolyn K. Both, Kansas State Nurses Association, Overland Park, Kansas
Mary L. Kline, R.N., Wichita State University, Wichita, Kansas
Mary Ann Lillich, R.N., Maternal Child Clinical Specialist, Topeka, Kansas
Florence Nelson, R.N., Kansas State Nurses Association, Topeka, Kansas
Hester Thurston, University of Kansas, Kansas City, Kansas
Eva D. Smith, University of Kansas, Kansas City, Kansas
Carla A. Lee, Wichita State University, Wichita, Kansas
Terry Whelan, Kansas Association of Osteopathic Medicine, Topeka, Kansas
Student Nurses

October 18

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

Staff called attention to material which had been distributed:

Attachment A - Material from the Kansas Hospital Association as requested by the Committee.

Attachment B - Letter to Roberta Thiry from Elaine M. Dohmeier, R.N., Kansas Association of Hospital Schools of Nursing.

Attachment C - Memo to Committee members from the Kansas Pharmaceutical Association relative to retail dealers permits as requested by the Committee.

Attachment D - H.R. 422, a bill relating to rural health clinics. Staff called attention to page 7 subsection (3) and noted the bill also speaks to physicians' assistants and nurse practitioners who carry out medical procedures.

Proposal No. 60 - Physician Extenders

Doug Johnson, Kansas Pharmaceutical Association, stated he had answered questions during previous meetings of the Committee but had tried not to express support or non-support of issues being discussed because at that time the Association had not adopted a policy statement. He then presented the policy statement recently adopted by the Association (Attachment E). He stated surveys of pharmacists have indicated there are problems when a physician's assistant acts independently in the prescribing of drugs. He also noted that many pharmacists feel they could pass the physician's assistant exam and a physician in one community has stated he would sponsor the pharmacist. The Association does not feel this is the intent of the Committee.

Responding to questions and comments, Mr. Johnson stated the occurrence of problems related to physicians' assistants prescribing seems to be related more to the degree of independence of the physician assistant, including geographic independence, although there are slightly more problems with those who have been practicing quite a while. The receptionist or nurse in the doctor's office calls in prescriptions, as provided in the Healing Arts Act, based on the physician's diagnosis and orders not based on seeing the patient and making a diagnosis. If this is not true, then there are abuses which need to be looked at. The Association does not object to the physician's assistant writing prescriptions if he is not operating independently and if all prescriptions are co-signed by the physician. There needs to be a check and balance system in the law. Mr. Johnson stated that in previous years, the Board of Pharmacy has investigated cases of alleged violations of the Pharmacy Act by physicians and, if findings warranted, turned such cases over to the Board of Healing Arts as required by statute. However, since the Board of Healing Arts took no action on these cases, allegedly because all they could do was revoke a license or slap the physician's hands, the Board of Pharmacy tends not to follow up on complaints now.

In answer to questions about legend and controlled drugs, Mr. Johnson stated controlled drugs account for only about 40 percent of the prescriptions written. Both legend drugs and controlled drugs carry a statement on the bottle that a prescription is required. In addition a number appears on the bottles of controlled drugs indicating restrictions on the dispensing of the drug because of the potential for abuse and addiction. Legend drugs, however, can cause serious problems if not properly prescribed.

Responding to questions about physicians dispensing drugs, Mr. Johnson stated there are cases of physicians dispensing drugs in violation of the Pharmacy Act. The Association feels that the room where drugs are kept should be considered a pharmacy and the physician should be required to have a pharmacy license. Currently physicians have to have a DEA number to buy or prescribe drugs but they are exempt from registration with the Board of Pharmacy.

In discussion it was noted that if a physician's assistant is operating independently, he is doing so with the sanction of the supervising physician. Therefore, the problem is with the physician rather than with the physician's assistant and the recommendations of the Kansas Pharmaceutical Association do not get at the problem. Mr. Johnson stated he did not know how the Association can get at this part of the problem.

Mr. Johnson agreed to furnish Committee members with documentation of incidents involving problems noted in his presentation.

Staff distributed copies of the proposed physicians' assistants bill draft with the amendments requested by the Committee (Attachment F). Staff noted that in the previous bill draft the provision limiting a physician to two physician's assistants was in the section relating to registration. Since the intent of the Committee seemed to be that not more than two physician's assistants be employed by one physician rather

than that no more than two be registered to one physician, this provision has been put in a separate section, New Section 8. By consensus "for" is to be changed to "by" in the second line of New Section 8 on page 5. After noting concern with the word "employed" in this section and clarifying that employment is not a requisite for an agent relationship, a motion was made and seconded to strike New Section 8 and insert in lieu thereof "No responsible physician shall have under his or her supervision more than two physician's assistants at any one time." It was noted this could mean a physician could employ more than two physician's assistants but could supervise only two at any one time. To clarify the intent, the members making and seconding the motion deleted the words, "at any one time" from the motion. A question was raised as to whether the objection to the word "employ" related only to New Section 8 or included its use in other places in the bill, i.e., Section 3(b). It was noted that Section 3(b) deals with notification of a physician's assistant's employment and in this context the word has to do with such things as compensation and working hours. New Section 8 has to do with the practice of the physician's assistant. For example, if the responsible employing physician is out of town he may arrange for another physician to be responsible for his physician's assistant but the physician's assistant would not be employed by the latter physician. It was also noted that "employ" implies the employer is the billing and receiving agent for third party payments. Dropping the reference to employment might open the door for direct payment to a physician's assistant. The motion carried.

It was pointed out that Section 3(b) does not make any provision for hospitals such as the one in Chanute to report the employment of a physician's assistant since a hospital cannot be a responsible physician. Writing the bill so only a physician could employ a physician's assistant was suggested because of liability and the problem of determining responsibility. It was noted that although there might be some problems, if a hospital is willing to employ physician's assistants within the intent of the law and willing to assume the liability, the decision to do so should be up to the hospital.

A motion was made and seconded to amend Section 3(b) line 3 and 4 by deleting "cease to be employed by" and inserting in lieu thereof "change employment." This would make it broad enough to encompass employment by a physician or a hospital. It was noted that in earlier action the Committee had amended this section to place the responsibility for notification on the responsible physician specifying whether the previous or the present responsible physician is to do the notifying. Since the sentence being amended referred only to cessation of employment, the proposed amendment would necessitate amending the total section to make the previous intent of the Committee clear. Staff quoted the following section of the New York law which speaks directly to this situation: "Nothing in this article shall prohibit a hospital from employing physician's associates or specialist's assistants provided they work under the supervision of a physician designated by the hospital and not beyond the scope of practice of such physician." The motion and second were withdrawn. A motion was made and seconded to insert a new section incorporating the concept of the section of the New York law quoted, stipulating that hospitals are not limited to two physician's assistants. Motion carried.

A question was raised as to whether a physician in another state could hire a physician's assistant to practice in Kansas Staff stated a few doctors located in communities bordering Kansas could be practicing in Kansas under a license from another state. A motion was made and seconded to amend New Section 1(c) by inserting "and whose name is on the registry maintained by the Board of Healing Arts" before the period. A question was raised as to whether a physician maintaining a license in Kansas but not practicing in Kansas could have a physician's assistant practicing in Kansas. It was clarified that the motion referred to the physician's assistant's name and staff is to make this intent clear in the amendment. Motion carried.

In answer to a question, staff stated that if physician B were covering for physician A who had a physician's assistant, whether or not physician B accepts responsibility for the physician's assistant is up to the agreement between the two physicians. However, physician A would be ultimately responsible for the actions of his physician's assistant.

Staff reported on penalty provisions in other states. In states certifying or licensing physician's assistants, i.e., Colorado, if it is determined some action is needed, the responsible board can revoke or restrict the license. Some states, i.e., California, put all professional practitioners into one category for penalty purposes. Most states do not have a penalty provision.

It was noted that since the physician's assistant can function only in a relationship with a practicing physician, it would be difficult for the Board of Healing Arts to intervene in this relationship. If the physician's assistant violates the

terms of this relationship, the physician should terminate the relationship so the physician's assistant could not practice. If the physician does not terminate the relationship, the Board of Healing Arts could take action against the physician. A physician terminating a physician's assistant has the right to present the case to the Board of Healing Arts if he feels the physician's assistant should not be allowed to practice with another physician. This can be provided for specifically in the rules and regulations.

A motion was made and seconded to recommend the physician's assistant bill as amended by Committee action for introduction. Motion carried. A motion was made and seconded to recommend that the bill be prefiled. Motion carried.

The Committee recessed for lunch at 12:00 noon and was reconvened by the Vice-Chairman, Senator Wesley H. Sowers at 1:30 p.m.

Judy Runnels, Kansas State Nurses Association, introduced Joyce Olson, R.N., President of the Association, who presented a written statement (Attachment G).

Mrs. Runnels distributed a revision of the proposed changes to the definition of the practice of nursing (Attachment H). She then introduced Gloria Killian, President of the Kansas State Board of Nursing, who presented sample rules and regulations relative to the revised definition of the practice of nursing (Attachment I). Mrs. Runnels stated the sample rules and regulations were presented for information only in the hope they would speak to questions and concerns raised by Committee members at an earlier meeting. She then introduced Elizabeth Dayani, R.N., Maternal/Child Care Nurse Specialist, who presented a written statement (Attachment J).

Mrs. Runnels then introduced Mary Ann Lillich, R.N., and family nurse practitioner. Mrs. Lillich stated she worked for the Board of Health in Chicago after completing her bachelor's degree. She was interested in the expanded role in nursing and came to the University of Kansas for her master's degree. Her functions in a family practice group in Topeka include prenatal and natal care, counseling after delivery, well baby care, home visits on problem cases, birth control and family planning, and education programs. The latter includes developing booklets to provide information and answers to questions for pregnant women and about post natal care, and an audio-visual tape on natural childbirth. She stated she has met with good patient acceptance and feels comfortable seeing patients alone. There is referral between her and the doctors with whom she works.

Mrs. Runnels stated their purpose was to present the concept of what they feel is necessary -- a definition of nursing which reflects common practice, and provision for and regulation of the expanded role -- leaving the wording up to the Committee and staff. She distributed a copy of K.S.A. 65-1427, a section of the Dental Practice Act, noting the second paragraph had been discussed by the Core Committee and at the State Convention as an alternate approach. Reference was also made to the New York law, especially the definition of diagnosis and treatment.

In answer to questions the following points were made: The first step that needs to be taken is to get the basic generic definition of the practice of nursing in tune with present common practice. To function in an expanded role would require completion of the training for a license to practice as an R.N., completion of an advanced specialty program and additional certification by the Board of Nursing. Any R.N. can do anything within the scope of the practice of nursing but an expanded role nurse can function at a different level and more independently. The Association prefers the Board of Nursing be given the authority to develop rules and regulations pertaining to the expanded roles in nursing. States which have had two boards promulgate rules and regulations have found this approach was not as effective as they had thought it would be.

Elaine M. Dohmeier, Kansas Association of Hospital Schools of Nursing, presented a written statement (Attachment K). In answer to a question, Ms. Dohmeier stated the Association includes representatives of the seven three-year hospital based diploma programs leading to licensure as an R.N.

Dwight Metzler, Department of Health and Environment, noted the current dissatisfaction with primary health care, the need for physicians in some areas and the fact that, in some areas and in some types of service, physicians will not be available. He noted steps being taken to meet the health needs of Kansans, including training of emergency medical technicians, funding of home chore services and home health agencies which include the types of services nurses have mentioned, the increasing number of county commissions providing funding for local health officers and public health nurses so that now there are only seven counties which do not have at least one full-time public health nurse. He stated that concern with health care costs has placed emphasis on prevention and education which are functions of nursing. He urged the Committee to authorize the drafting of a bill based on the concepts presented by the conferees who appeared earlier.

Staff noted the problem of trying to put substantive law and authority for the Board of Nursing to certify nursing specialties or expanded roles in the definition section of the Nurse Practice Act. An alternative would be to use the present definition of the practice of nursing with removal of some of the restrictions and to insert a new section authorizing the Board of Nursing to set out specialties. Staff suggested the Committee might want to provide some guidelines to be used, such as training and education.

It was pointed out that the Board of Nursing has broad authority to develop rules and regulations to carry out the sections of the Nurse Practice Act relating to schools of nursing and to Licensed Practical Nurses but this authority is limited in relation to the R.N.

After Committee discussion, a motion was made and seconded to instruct staff to draft a bill along the following lines: establish the power of the Board of Nursing to develop rules and regulations, not inconsistent with the act, such power to apply to all sections of the act; delete the disclaimer clause and insert "in the context of the practice of nursing as defined in the act diagnosis means...and treatment means..." inserting the definitions used in New York law; authorize the Board of Nursing to establish specialties and the qualifications for certification in each, using K.S.A. 65-1427 as a guide rather than including a specific list of specialties; provide that no one can hold himself or herself out as practicing a nurse specialty unless authorized by the Board of Nursing to do so; and providing for sanctions for violations, using the wording of Section 5 of the physician's assistants bill as a guide. Motion carried.

The meeting was adjourned at 4:45 p.m.

October 19, 1977

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

Minutes

A motion was made and seconded to approve the minutes of the September 20-21, 1977 meeting as distributed. Motion carried.

Proposal No. 60 - Physician Extenders

A motion was made and seconded to amend the Nurse Practice Act to provide that the last three lines of 65-1113(b) also apply to both subsection (1) and (2), specifically the words "and such further functions that may be defined in the rules and regulations of the board not inconsistent with this act." Motion carried.

Instructions to staff for the Committee report on Proposal No. 60 included the following: a strong emphasis on the fact the physician's assistant is at all times under the direction and supervision of a physician; note the rules and regulations submitted by the Board of Healing Arts and the Attorney General's opinion on them; an explanation of the physician's assistant bill and the reasons for the decisions made by the Committee; note that the Committee does not consider physician's assistants a panacea for rural health care problems but it does feel the bill as recommended will encourage physician's assistants and physicians to practice in rural areas.

The feeling was expressed that the bill clarifies the intent of the Committee sufficiently to avoid the promulgation of restrictive rules by the Board of Healing Arts and therefore no action should be taken to give further recommendations or guidelines to the Board relative to rules and regulations.

Proposal No. 59 - Credentialing of Health Care Personnel

Staff reviewed the Health, Education and Welfare Report, "Credentialing Health Manpower", noting that Recommendation III relates specifically to Proposal No. 59. In reviewing Recommendation II, staff noted licensure boards in Kansas are moving toward the use of national exams. The Board of Healing Arts, the Board of Pharmacy and the Podiatry Board use national exams. The Dental Board and the Optometry Board use regional exams. Under Recommendation IV, staff noted Kansas is doing No. 3 and 4. Under Recommendation IV, staff noted that continuing education is included in all health care licensure laws in Kansas. In answer to a question, staff stated that HEW hopes the private sector will initiate the formation of a national commission. However, if steps have not been taken by the end of the year, HEW will convene a group to initiate action.

Three possible alternatives for Committee action were outlined: recommend adopting the credentialing guidelines listed in Recommendation III of the HEW report and other guidelines discussed by the Committee; develop criteria for credentialing and set up a procedure for the Statewide Health Coordinating Council to determine if a group should be licensed and make a recommendation to the Legislature; mandate the Statewide Health Coordinating Council to do a further study of the criteria to be used for credentialing and recommend to the Legislature the criteria that should be adopted in Kansas. During discussion the fact that there might be a distinction between licensure considerations for public employees and for private employees was suggested since classified employees have to meet specified qualifications before they are hired. Reference was made to the statement of the Connecticut Commission which was endorsed by the Connecticut Medical Society and Nurses Association (Attachment L). Attention was called to the criteria to be used in determining whether a group should be licensed and the statement on a moratorium until the Legislature developed a valid mechanism for licensure. It was noted that if an agency outside of the Legislature is to be involved in credentialing, the Statewide Health Coordinating Council would seem to be the appropriate one. The Council is already in existence, it has statewide representation which includes consumers, health care professionals and legislators.

After further discussion, there appeared to be a consensus that the Committee endorsed the adoption and use of criteria for credentialing but would not at this time recommend specific criteria to be adopted. A motion was made and seconded to have staff draft a bill mandating the Statewide Health Coordinating Council to do a study of criteria for credentialing of health care personnel and to make recommendations to the Legislature no later than December, 1978. It was clarified that the Statewide Health Coordinating Council is to recommend general criteria which could be applied to groups already licensed as well as groups asking to be credentialed for the first time. The importance of having a group to gather information and make a recommendation to the Legislature regarding credentialing, even though the burden of proof may be on the group requesting credentialing, was noted. The proposed bill will not prevent the introduction of licensure bills by individual legislators or indirectly by groups wanting licensure. It will provide the Public Health and Welfare Committees of the House and Senate with recommendations from a representative semi-professional group on which to base their decisions. Motion carried.

By consensus staff was instructed to include in the Committee report the concept of a moratorium on licensure until the Statewide Health Coordinating Council has submitted its recommendations and the Legislature has taken action on them. The last paragraph of the Connecticut statement (Attachment L) is to be reworded and included in the report. The Committee report is to note that the Committee looked at the HEW reports on credentialing and the approaches used by Connecticut, Minnesota and Virginia. Specific criteria are not to be included. The report is to note the findings of HEW relative to the problems with the present licensure system, especially as it relates to deciding who should be licensed. It is also to include the reasons why the Committee took the above position on this proposal.

In reference to the bills considered by the Committee, the report is to indicate the Committee held extensive hearings on all the bills. The position of the Kansas Association of Chiropractic and Senator Pomeroy on Judge McFarland's findings is to be noted. Staff noted that the Attorney General's Office is considering filing a motion to correct the findings in this decision. The report is to note that the Committee is not recommending action on any of the bills considered. It is to include the highlights of testimony relative to bills and the pros and cons considered by the Committee.

The above recommendation relative to the Committee report are to be considered further at the next Committee meeting.

It was noted the denturist situation is different from that of the other groups which appeared before the Committee because they cannot legally practice in Kansas at the present time. If denturists develop a certification program which would include an educational program encompassing the pathology and physiology of the mouth and a training program other than just an apprenticeship in a dental lab, there may be a place in the future for denturism. Establishing a relationship between the denturist and dentist similar to that established between the physician's assistant and the physician by the physician's assistant bill was suggested if the denturists can develop an educational program.

In answer to questions, Carl Schmitthenner, Kansas Dental Association, stated they have just implemented a project that will help locate and place dentists in the state. Indications are that there is surplus of dentists. For example, four states are estimating they will be unable to place 800 graduating dentists next year.

Next Committee Meeting

The next meeting of the Committee will be November 2, 1977. The agenda is to include Committee consideration of the nurse practice bill, the bill relative to a credentialing study by the Statewide Health Coordinating Council, and further consideration of instructions to staff for the Committee reports.

The meeting was adjourned.

Prepared by Emalene Correll

Approved by Committee on:

11/2/77
(date)

KANSAS HOSPITAL ASSOCIATION

MEMORANDUM

Frank L. Gentry
President

October 6, 1977

TO: Emalene Correll

FROM: Virginia C. Will, Assoc. Director of Education
Kansas Hospital Association

SUBJECT: Material that Elaine Dohmeier and I indicated that we would send related to discussion of Nurse Practice Act and the Special Committee on Public Health & Welfare — "Characteristics of Diploma Education in Nursing," and "Characteristics of Associate Degree Education in Nursing" following our conversation on September 21, 1977.

VCW:lms

Attachment

1263 Topeka Ave. • Box 417 • Topeka, Ks. 66601 • 913/233-7436

Atch. A

Manufactured in the United States of America

CHARACTERISTICS OF DIPLOMA EDUCATION IN NURSING

The diploma program in nursing serves the interests and goals of qualified students who desire an education that is centered in a community health institution dedicated to the care of patients. The characteristics of the diploma program in nursing are:

- The school is in the unique position of offering a readily accessible clinical laboratory that promotes the students' understanding of the hospital climate and resources and the interrelation of other health disciplines.

- The primary purpose of the school is to focus its attention and activities on developing the potentials of students as individuals and as competent beginning practitioners of nursing.

- The school may enter into cooperative relations with colleges or universities for educational courses and/or services. The school may also enter into cooperative relationships with health care institutions and agencies in order to provide learning experiences for students.

- The school provides the necessary educational resources, facilities, and services to students and faculty.

- The philosophy and objectives of the school give consideration to the personal and professional development of the students and serve as the basis for the development of the curriculum.

- The faculty, including nurse and nonnurse members, are cognizant of concepts and trends in nursing, nursing education, and general education. They have academic preparation and experience in nursing, nursing education, or other special fields of interest that ensures a quality educational program.

- The faculty are committed to the improvement of nursing education as it relates to nursing practice and the delivery of he

care and have a unique opportunity to promote changes in nursing practice in hospitals and other health care agencies.

- Admission requirements include graduation from high school or its equivalent with successful completion of certain prerequisite courses, satisfactory achievement on pre-entrance examinations, and satisfactory assessment of personal qualities and health status.

- Students are selected by the faculty and admitted directly to the program in nursing.

- Students are given the opportunity to demonstrate the knowledge and skills acquired in previous educational experiences for course exemption on advanced placement in the educational program.

- The faculty, utilizing trends and changes in education and health care, plan, organize, implement, and evaluate the curriculum within the framework of the philosophy, objectives, and policies of the school of nursing.

- The curriculum is designed to develop the knowledge and skill essential for beginning practice as a registered nurse.

- The curriculum includes courses in the theory and practice of nursing and courses in the biological, physical, and behavioral sciences. Learning is reinforced through the application of scientific and nursing principles in the care of individuals and groups with nursing and health needs.

- Early and substantial patient care experiences are provided in the hospital and in a variety of community agencies which serve to foster within the student a strong identification with nursing.

The graduates of diploma programs (1) are eligible to take the examination leading to licensure as a registered nurse; (2) plan, organize, implement, and evaluate plans of nursing care for individuals and groups of patients; (3) have an understanding of the hospital climate and the community health resources necessary for extended care of patients; (4) understand the role of other health disciplines and are contributing members of the health team; and (5) adjust readily to the role of beginning registered nurse practitioners in hospitals and similar community institutions.

ROLE, KNOWLEDGE, AND ABILITIES OF THE GRADUATE OF THE DIPLOMA PROGRAM IN NURSING

This description of the graduate's role, knowledge, and abilities, developed by an ad hoc committee and accepted by the National League for Nursing Council of Diploma Programs in May 1971, is based on seven assumptions in relation to the diploma program in nursing:

1. Preparation gives primacy to functioning in hospitals and similar community institutions
2. Understanding of the hospital climate and the interrelation of other health disciplines is fostered
3. The faculty has full authority and responsibility in the admission of students
4. The faculty has a singular opportunity to promote changes in nursing practice in hospitals
5. The graduate is capable of directing nursing care for a group of patients as well as being competent in the application of principles to the care of individual patients
6. Because of the understandings and abilities developed, the new graduate adjusts readily to the appropriate employee role in hospitals and similar community institutions
7. Graduation from the program permits initially freedom of choice in the provision of nursing service to people and subsequently academic and experiential alternatives

Role

The diploma program in nursing prepares an individual, eligible for licensure as a registered nurse, who functions as a generalist in hospitals and similar community institutions. The nurse in these settings provides nursing care to and engages in therapeutic, rehabilitative, and preventive activities in behalf of individual patients and groups of patients.

"Role, Knowledge, and Abilities of the Graduate of the Diploma Program in Nursing." *Nursing Outlook*, 7:19:463, July 1971.

Knowledge

In order to fulfill the role, the graduate of the diploma program has knowledge of nursing as an art and a science which encompasses:

1. Physical, biological, and behavioral science principles
2. Current concepts of health maintenance and therapeutic intervention
3. Prevalent illnesses of the individual
4. Community health problems
5. Common therapeutic and diagnostic equipment
6. Roles and responsibilities of other health disciplines and other nursing personnel.
7. Principles of management for planning nursing care
8. Legal and ethical aspects of nursing practice
9. Problem-solving technics
10. Theories of learning and teaching
11. Effective ways of communicating
12. Dynamics of interpersonal relationships

Abilities

In order to fulfill the role, the graduate of the diploma program as a person:

1. Accepts self and the continuing need for personal growth
2. Accepts other persons, recognizes and believes in the essential worth of each individual
3. Establishes positive relationships by recognizing the differences in self and others
4. Respects the spiritual, cultural, and moral values of others
5. Supports in an appropriate manner the emotional needs of others
6. Inspires the confidence of patients and others
7. Expresses ideas clearly when speaking or writing
8. Recognizes the significance of nonverbal communication
9. Uses listening as a tool for communication
10. Assumes responsibility for own behavior and competence

In order to fulfill the role, the graduate of the diploma program as a nurse:

1. Ascertains the physical and psychological needs, habits, and resources of patients

2. Establishes priorities of nursing care for individual or groups of patients based on needs
3. Implements plans of care that are modified as necessary
4. Applies scientific principles and concepts involved in the pr(tion and restoration of health
5. Recognizes situations or patient responses that have significance for other members of the health team
6. Detects symptomatic changes in patients (either spontaneous or in response to diagnostic and therapeutic measures) that requires independent action and/or the need to seek more expert assistance.
7. Performs procedures (including manual skills) and activities involved in nursing care with disciplined attention
8. Responds appropriately to environmental and safety hazards whether related to physical setting, equipment, and/or actions of others
9. Participates in the total care of the patient by coordinating the skills and abilities of other nursing personnel in administering nursing care
10. Ascertains the effect of family, personnel, and personal experiences on the patient
11. Incorporates the services of appropriate community agencies in the plan for continuity of care
12. Utilizes established channels for exchange of information related to the patient's welfare
13. Helps the patient and family understand the plan of nursing care and the role each plays to effect the fullest possible success of therapy during hospitalization and thereafter
14. Assesses the effectiveness of nursing care

CHARACTERISTICS OF ASSOCIATE DEGREE EDUCATION IN NURSING

Associate degree education in nursing is a well-established part of the system of higher education in the United States. Three-fourths of the programs are located in community or junior colleges and one-fourth are in senior colleges or universities. Associate degree nursing education provides both liberal and technical education for an individual who will contribute to the provision of nursing services needed by society.

An associate degree program in nursing is flexible and progressive, meets the changing needs of society, and is based on sound educational methods and a humanistic approach.

CHARACTERISTICS OF ASSOCIATE DEGREE PROGRAMS IN NURSING

1. The unit in nursing is an integral part of the parent institution and is structured, controlled, and financed as is any other unit of the institution.

2. Faculty members in the unit in nursing have the same privileges and responsibilities as other faculty of the institution. They are responsible for development, implementation, and evaluation of the program of learning.

3. The program of learning is usually organized for completion within a two-year period. It is based on a clearly stated rationale and a conceptual framework which are derived from its philosophy and objectives. The program of learning meets the requirements of the parent institution for granting an associate degree and of the state licensing agency for eligibility to write the State Board Test Pool Examination.

4. Students meet the requirements of the institution and its nursing program for admission, continuation of study, and graduation. They share in the responsibilities and the privileges of total student body.

The graduates of associate degree programs, given the opportunity to develop their potential, are prepared to:

1. participate with other members of the health team in rendering care to individuals.

2. use principles from an ever-expanding body of knowledge.

3. assess the individual's nursing needs.

4. plan day-to-day care of individuals.

5. select appropriate nursing measures with knowledge and precision.

6. implement measures to alleviate distress.

7. perform nursing and other therapeutic measures with a high degree of skill.

8. evaluate the individual's reaction to therapy.

9. supervise other workers in the technical aspects of care.[1]

Because career goals may change or often a student is unable to attain his ultimate goal without interruption, associate degree programs accept applicants with varying educational backgrounds and experiences by giving recognition to proficiencies already acquired. Also, if an associate degree graduate wishes to pursue his education further, he is provided an opportunity to validate his education and experience.

[1] *Criteria for the Evaluation of Educational Programs in Nursing Leading to an Associate Degree*, 3rd ed. New York: National League for Nursing, 1973. p. 11.

B

THE WESLEY MEDICAL CENTER
550 NORTH HILLSIDE
WICHITA, KANSAS 67214

October 6, 1977

Mrs. Roberta Thiry, Ph.D.
President, Kansas State Nurses' Association
820 Quincy
Topeka, Kansas 66612

Dear Bobby:

The Kansas Association of Hospital Schools of Nursing met today and I am writing to you as the spokesman for the group. Those of us who attended the hearing on the Nurse Practice Act on September 21, reported to the group and we also reviewed the revised copy of the Proposed Changes in the Nurse Practice Act at this meeting.

It is our belief that the definition as now written encompasses activities of any registered nurse and does not address the expanded role which we understood was the expressed purpose for opening the act. We are equally unsure as to the meaning of "certification by the Board" since we are unaware that the Board has such a mechansim currently.

The legislative committee seemed to feel that levels of practice needed to be addressed to ensure that all nurses would not be legally permitted to practice in an expanded role. We do not quarrel with that logic. We would like to recommend defining levels of practice to include 1) those eligible by additional education and experience to practice in an expanded role utilizing the intent formulated by the Master Planning Committee in its recent definition and 2) those having completed basic preparation to practice nursing from an AD, Diploma or BSN program.

We are somewhat disappointed to see nursing diagnosis eliminated from the proposal as this is an issue that needs to be dealt with to insure nurses legal protection for the duties they are required to perform.

It is our sincere hope that levels of entry for licensure will not be addressed at this time. Our feelings on this issue are not unknown to you, I'm sure. It would appear that we have enough of a challenge requesting our Nurse Practice Act to encompass and protect nurses functioning in an expanded role, that it would behoove us not to fragment nursing further by introducing areas of diversified interest.

We hope that you will consider the suggestions we have made, and we eagerly anticipate seeing some of our suggestions materialize in your next draft.

Sincerely,

Elaine

(Mrs.) Elaine M. Dohmeier, R.N.
Secretary, Kansas Association of Hospital Schools of Nursing

Atch. B

cc: Miss Florence Nelson

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

C

DATE: October 10, 1977

TO: Interim Study Committee on Public Health & Welfare

FROM: Douglas P. Johnson, R.Ph.

SUBJECT: Retail Dealers Permits

At a recent meeting of Interim Committee, I was requested to outline for the committee the use of retail dealers permits by chiropractors. I was also asked to list any recommendations in this area.

Attached is a document which outlines the problem and lists policy decisions we believe should be considered.

I hope this material is helpful to the committee, and I would be glad to answer any questions you might have.

DPJ:mj
Enclosure

Att. C

RETAIL DEALERS PERMITS

ANALYSIS & RECOMMENDATIONS

Problem:

Several chiropractors have been issued Retail Dealers permits, under the Pharmacy Act, because they are selling at retail, "Non-prescription drugs." The question is whether it was the intent of the Pharmacy Act that this take place, is it proper, and should it be continued?

Background:

The retail dealers permit was placed in pharmacy law several years ago to provide a mechanism for recall of products which were defective or abused. The mechanism currently in existence provides for issuance of a permit to a person selling at retail non-prescription drugs which are prepackaged, fully prepared by the manufacturer or distributor for use by the consumer and labeled in accordance with the requirements of the state and federal food drug and cosmetic acts.

The intent of the law was to have a handle on persons selling these drugs to the general public. The intent is further that the consumer is the one to make a decision to purchase these products by browsing a display of products, and self prescribing.

The permit is not a license to diagnose, prescribe and dispense these non-prescription drugs. It appears from a few calls that we have received, that in fact some persons believe the permit is a license to do these things.

The terms patent or proprietary medicines are commonly used when discussing this class of drugs. Patent and proprietary medicines are outdated terms that have been replaced with the term "non-prescription drugs."

According to Kansas law, it appears quite clear that "non-prescription drugs" are a part of the dictionary definition of materia medica.

Recommendation:

I. The Kansas Healing Arts act (65-2871) states "... chiropractors are expressly prohibited from prescribing or administering to any person medicine or drugs in materia medica..."

The language above appears to be outdated as we have no legal definition of "medicine" or "materia medica."

The legislature should consider a redefining of these terms.

Recommendation, cont.:

II. It is clear from the pharmacy act that if a chiropractor is selling non-prescription drugs at retail that they must have retail dealers' permits.

There appears to be several policy decisions to be made by the legislature; i.e.,

1) Should chiropractors sell non-prescription drugs at retail as part of their practice?

2) Should pharmacy laws be changed to provide an exemption for this current practice or to permit it to occur?

Conclusion:

As the interim committee considers policy decisions in this area, we offer the following comments for your review.

The law is currently clear to us that, "any individual" who wishes to sell non-prescription drugs may do so after obtaining a retail dealers permit. However, it does not seem in the public's best interest to permit a group of "Health Care Providers," who are licensed to perform one function, to expand this function in an area they have no expertise.

Our society has accepted the public's right to self-diagnose and purchase non-prescription drugs. However, we question the public benefit of allowing chiropractors to basically prescribe and dispense non-prescription drugs. They have no education or training in the action of these drugs and how they may effect other prescription drugs prescribed by a physician. The Board of Pharmacy has received a couple of examples from physicians in this area, and I am sure would be glad to share them with the Committee.

We believe it is misleading to the public to allow chiropractors to prescribe and dispense non-prescription drugs as a course of their practice. Consumers place faith in anyone they have chosen to see for a health problem without any knowledge of the individual's education and training. We believe for chiropractors to be involved in this area is to purport to be an authority in an area they have no education or training.

mj
10/10/77

Calendar No. 385

95TH CONGRESS
1ST SESSION

H. R. 422

[Report No. 95–425]

IN THE SENATE OF THE UNITED STATES

MARCH 22 (legislative day, FEBRUARY 21), 1977
Read twice and referred to the Committee on Finance

SEPTEMBER 9 (legislative day, SEPTEMBER 8), 1977
Reported by Mr. LONG, with an amendment and an amendment to the title

[Insert the part printed in italic]

AN ACT

To amend the Tariff Schedules of the United States to provide duty-free treatment of any aircraft engine used as a temporary replacement for an aircraft engine being overhauled within the United States if duty was paid on such replacement engine during a previous importation.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That subpart A of part 1 of schedule 8 of the Tariff Schedules of the United States (19 U.S.C. 1202) is amended by inserting immediately after item 801.10 the following new item:

Attch. D

"	801.20	Any aircraft engine or propeller, or any part or accessory of either, previously imported with respect to which the duty was paid upon such previous importation, if (1) reimported without having been advanced in value or improved in condition by any process of manufacture or other means while abroad, after having been exported under loan, lease, or rent to an aircraft owner or operator as a temporary replacement for an aircraft engine being overhauled, repaired, rebuilt, or reconditioned in the United States, and (2) reimported by or for the account of the person who exported it from the United States..	Free	Free ".

SEC. 2. The amendment made by the first section of this Act shall apply with respect to articles entered, or withdrawn from warehouse, for consumption on or after the date of the enactment of this Act.

TITLE II—RURAL HEALTH CLINIC SERVICES

MEDICARE AMENDMENTS

SEC. 201. (a) Section 1832(a) of the Social Security Act is amended—

(1) by striking out "paragraph (2)(B)" in paragraph (1) and inserting in lieu thereof "subparagraphs (B) and (D) of paragraph (2)"; and

(2) by striking out the period at the end of paragraph (2)(C) and inserting in lieu thereof "; and" and by adding the following new subparagraph at the end of paragraph (2):

"(D) rural health clinic services."

(b) Section 1833(a) of such Act is amended—

(1) by striking out "and" at the end of paragraph (1);

(2) by inserting "(except those services described in subparagraph (D) of section 1832(a)(2))" in paragraph (2) after "1832(a)(2)";

(3) by striking out the period at the end of paragraph (2) and inserting in lieu thereof ", and"; and

(4) by inserting the following new paragraph after paragraph (2):

"(3) in the case of services described in section 1832(a)(2)(D), 80 percent of costs which are reasonable and related to the cost of furnishing such services or on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A)."

(c) Section 1833 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(i) The Secretary is authorized to waive the provisions of subsection (b) of this section with respect to rural health clinic services and require in lieu thereof copayments by an individual receiving such services in cases in which he determines that such an alternative system is less costly. Such copayments shall not exceed $3 per visit to a rural health clinic, shall not exceed $60 per calendar year.".

(d) Section 1861 of such Act is amended by adding at the end thereof the following new subsection:

"Rural Health Clinic Services

"(aa)(1) The term 'rural health clinic services' means—

"(A) physicians' services and such services and supplies as are covered under subsection (s)(2)(A) if furnished as an incident to a physician's professional service,

"(B) such services furnished by a physician assistant or nurse practitioner as he is legally authorized to provide in the jurisdiction in which he performs such services, and such services and supplies furnished as an incident to his service, as would otherwise be covered if furnished by a physician or as an incident to a physician's service, and

"(C) in the case of a rural health clinic located in an area in which there exists a shortage of home health services (as defined in subsection (m)) due to a shortage of home health agencies (as defined in (o)), as determined by the Secretary, such services as would constitute home health services if furnished by a home health agency (without regard to the number of such services furnished by such rural health clinic), if such clinic meets such other conditions as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished such services by such clinic,

when furnished by a rural health clinic to an individual as a primary care patient.

"(2) The term 'rural health clinic' means a facility which—

"(A) is primarily engaged in providing rural health clinic services;

"(B) has an arrangement (consistent with the provisions of State and local law relative to the practice, performance, and delivery of health services) with one or more physicians (as defined in subsection (r)(1)) under which provision is made for the periodic review by such physicians of rural health clinic services for which payment may be made under this title furnished by physician assistants and nurse practitioners, and for the supervision and guidance by such physicians of physician assistants and nurse practitioners;

"(C) provides for the preparation by the supervising physicians, physician assistants, and nurse practitioners of medical orders for care and treatment of clinic patients, and the availability of such physicians for such referral and consultation for patients as is necessary, and for advice and assistance in the management of medical emergencies;

"(D) maintains clinical records on all patients;

"(E) has arrangements with one or more hospitals (as defined in subsection (e)) for the referral or admission of patients requiring inpatient services or such diag-

nostic or other specialized services as are not available at the clinic;

"(F) has written policies to govern the management of the clinic and all the services it provides;

"(G) has appropriate procedures or arrangements, in compliance with applicable State and Federal law, for storing, administering, and dispensing drugs and biologicals;

"(H) has appropriate procedures for utilization review;

"(I) directly provides routine diagnostic services (as prescribed by the Secretary) consistent with the provisions of State and local law relative to the practice, performance, and delivery of health services, and has prompt access to additional diagnostic services from facilities meeting requirements under this title; and

"(J) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are furnished services by the clinic.

For purposes of this title, such term includes only a facility which (i) is located in (I) a rural area which is designated by the Secretary under section 1302(7) of the Public Health Service Act as having a medically underserved population, (II) an area (other than an urbanized area, as defined by

the Bureau of the Census) in which the supply of medical services is not sufficient to meet the needs of individuals residing therein, or (III) an urbanized area (as so defined) if the majority of the patients served by such facility reside in an area described in clause (I) or (II), (ii) has filed an agreement with the Secretary by which it agrees not to charge any individual or other person for items or services for which such individual is entitled to have payment made under this title, except for the amount of any deductible or coinsurance amount imposed with respect to such items or services (not in excess of the amount customarily charged for such items and services by such clinic), pursuant to subsections (a), (b), and (i) of section 1833, (iii) employs a physician assistant or nurse practitioner, and (iv) is not a rehabilitation agency or a facility which is primarily for the care and treatment of mental diseases.

"(3) The term 'physician assistant' or the term 'nurse practitioner' means, for the purposes of this subsection, a physician assistant or nurse practitioner who performs, under the supervision of a physician (as defined in subsection (r)(1)), such services, as he is legally authorized to perform (in the State in which he performs such services) in accordance with State law (or the State regulatory mechanism provided by State law) and who meets such training, educa-

tion, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.".

(c) Section 1862(a)(3) of such Act is amended by striking out "in such cases" and inserting in lieu thereof "in the case of rural health clinic services, as defined in section 1861(aa)(1), and in other cases".

(d) Section 1861(s)(2) of such Act is amended—

(1) by striking out "and" at the end of subparagraph (C)(ii);

(2) by inserting "and" at the end of subparagraph (D); and

(3) by adding the following new subparagraph at the end thereof:

"(E) rural health clinic services;".

(e) Section 1864(a) of such Act is amended—

(1) by inserting "or whether a facility therein is a rural health clinic as defined in section 1861(aa)(2)," in the first sentence after "home health agency,";

(2) by inserting "rural health clinic," in the second sentence after "nursing facility,"; and

(3) by inserting "rural health clinic," in the last sentence after "facility," each time it appears therein.

(f) Section 1122(b)(1) of the Social Security Act is amended by inserting after the term "health care facility" the

following: "(including a rural health clinic as defined in section 1861(aa)(2) of this Act)".

MEDICAID AMENDMENTS

SEC. 202. (a) Paragraph (2) of section 1905(a) of the Social Security Act is amended to read as follows:

"(2)(A) outpatient hospital services and (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (l)) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (l)) and which are otherwise included in the plan;".

(b) Section 1905 of such Act is amended by adding after subsection (k) the following new subsection:

"(l) The terms 'rural health clinic services' and 'rural health clinic' have the meanings given such terms in section 1861(aa) of this Act.".

(c) Section 1902(a) of such Act is amended—

(1) by striking out the semicolon at the end of paragraph (13) and inserting in lieu thereof ", and", and by adding at the end of such paragraph the following new subparagraph:

"(F) for payment for services described in section 1905(a)(2)(B) provided by a rural health clinic under the plan of 100 percent of costs which

are reasonable and related to the cost of furnishing such services, on such other tests of reasonableness as the Secretary may prescribe in regulations under section 1833(a)(3) or, in the case of services to which those regulations do not apply, on such tests of reasonableness as the Secretary may prescribe in regulations under this subparagraph"; and

(2) by inserting ", or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic" before the semicolon at the end of paragraph (23).

(d) Section 1910 of such Act is amended—

(1) by amending the heading to read as follows: "CERTIFICATION AND APPROVAL OF SKILLED NURSING FACILITIES AND RURAL HEALTH CLINICS";

(2) by striking out "(a)" and inserting in lieu thereof "(a)(1)";

(3) by striking out "(b)" and inserting in lieu thereof "(2)"; and

(4) by adding at the end thereof the following new subsection:

"(b)(1) Whenever the Secretary certifies a facility in a State to be qualified as a rural health clinic under title XVIII, such facility shall be deemed to meet the standards

for certification as a rural health clinic for purposes of providing rural health clinic services under this title.

"(2) The Secretary shall notify the State agency administering the medical assistance plan of his approval or disapproval of any facility which has applied for certification by him as a qualified rural health clinic.".

(e) Section 1866(c)(2) of such Act is amended by striking out "section 1910" and inserting in lieu thereof "section 1910(a)".

DEMONSTRATION PROJECTS

SEC. 203. (a) The Secretary of Health, Education, and Welfare shall provide, through demonstration projects, reimbursement on a cost basis for services provided by physician-directed clinics in urban medically underserved areas for which payment may be made under title XVIII of the Social Security Act and, notwithstanding any other provision of title XVIII, for services provided by physician assistants and nurse practitioners employed by such clinics which would otherwise be covered under such title if provided by a physician.

(b) The demonstration projects developed under subsection (a) shall be of sufficient scope and carried out on a broad enough scale to allow the Secretary to evaluate fully—

(1) the relative advantages and disadvantages of re-

imbursement on the basis of costs and fee-for-service for physician-directed clinics employing physician assistants and nurse practitioners;

(2) the appropriate method of determining the compensation for physician services on a cost basis for the purposes of reimbursement of services provided in such clinics;

(3) the appropriate definition for such clinics;

(4) the appropriate criteria to use for the purposes of designating urban medically underserved areas; and

(5) such other possible changes in the present provisions of title XVIII of the Social Security Act as might be appropriate for the efficient and cost-effective reimbursement of services provided in such clinics.

(c) Grants, payments under contracts, and other expenditures made for demonstration projects under this section shall be made in appropriate part from the Federal Hospital Insurance Trust Fund (established by section 1817 of the Social Security Act) and the Federal Supplementary Medical Insurance Trust Fund (estabilshed by section 1841 of the Social Security Act). Grants and payments under contracts may be made either in advance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this

section. With respect to any such grant, payment, or other expenditure, the amount to be paid from each trust fund shall be determined by the Secretary, giving due regard to the purposes of the demonstration projects.

(d) The Secretary shall submit to the Congress, no later than January 1, 1981, a complete, detailed report on the demonstration projects conducted under subsection (b). Such report shall include any recommendations for legislative changes which the Secretary finds necessary or desirable as a result of carrying out such demonstration projects.

REPORT BY THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE ON MENTAL HEALTH CENTERS

SEC. 204. (a) The Secretary of Health, Education, and Welfare shall submit to the Congress, no later than April 1, 1978, a report on the advantages and disadvantages of extending coverage under title XVIII of the Social Security Act to urban or rural mental health centers.

(b) The report submitted under subsection (a) shall include evaluations of—

(1) the need for title XVIII coverage of services provided by mental health centers;

(2) the extent of present utilization of such centers by individuals eligible for benefits under title XVIII;

(3) alternatives to services provided by such centers

presently available to individuals eligible for benefits under title XVIII;

(4) the appropriate definition for such centers;

(5) the types of treatment provided by such centers;

(6) present Federal and State funding for such centers;

(7) the extent of coverage by private insurance plans for services provided by such centers;

(8) present and projected costs of services provided by such centers;

(9) available methods for assuring proper utilization of such centers;

(10) the effect of allowing coverage for services provided by such centers on other providers and practitioners; and

(11) the need for any demonstration projects for further evaluation of the need for coverage for services provided by such centers.

EFFECTIVE DATES

SEC. 205. (a) The amendments made by section 201 of this Act shall apply to services rendered on or after the first day of the third calendar month which begins after the date of enactment of this Act.

(b)(1) The amendments made by section 202 of this Act shall (except as otherwise provided in paragraph (2)) apply

to medical assistance provided under a State plan approved under title XIX of the Social Security Act on and after the first day of the first calendar quarter that begins more than six months after the date of enactment of this Act.

(2) Notwithstanding the provisions of paragraph (1), in any case in which legislation is required in order to conform a State plan for medical assistance with the requirements imposed by reason of the amendments made by section 202 of this Act (as determined by the Secretary), such State plan shall not be regarded as failing to comply with the requirements of title XIX of the Social Security Act solely on the basis of such failure to meet the requirements imposed by such amendments at any time prior to the first day of the first calendar quarter that begins after the close of the first regular session of the State legislature which begins after the date of enactment of this Act.

Amend the title so as to read: "An Act to amend the Tariff Schedules of the United States to provide duty-free treatment of any aircraft engine used as a temporary replacement for an aircraft engine being overhauled within the United States if duty was paid on such replacement engine during a previous importation, to provide reimbursement under titles XVIII and XIX of the Social Security Act for rural health clinic services, and for other purposes.".

Passed the House of Representatives March 21, 1977.

Attest: EDMUND L. HENSHAW, JR.,

Clerk.

Calendar No. 385

95TH CONGRESS
1ST SESSION

H. R. 422

[Report No. 95-425]

AN ACT

To amend the Tariff Schedules of the United States to provide duty-free treatment of any aircraft engine used as a temporary replacement for an aircraft engine being overhauled within the United States if duty was paid on such replacement engine during a previous importation.

MARCH 22 (legislative day, FEBRUARY 21), 1977
Read twice and referred to the Committee on Finance

SEPTEMBER 9 (legislative day, SEPTEMBER 8), 1977
Reported with an amendment and an amendment to the title

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

DOUGLAS P. JOHNSON, JR., PH.
EXECUTIVE DIRECTOR

E

PHYSICIAN ASSISTANTS

Policy Statement
Adopted
September 29, 1977

The Kansas Pharmaceutical Association has prepared this policy statement to aid those persons responsible for making decisions on the activities of physician assistants.

Two specific recommendations of the Policy Statement are as follows:

1) Legend Drugs - The Kansas Pharmaceutical Association cannot support allowing Physician Assistants to prescribe any legend (prescription) drug, and we recommend deletion of this section of the proposed bill.

2) Controlled Substances - The Kansas Pharmaceutical Association cannot support allowing Physician Assistants to prescribe any controlled substance.

After a careful review of the proposed Kansas physician assistant bill, the Kansas Pharmaceutical Association has adopted this policy statement. It is to be stressed that our comments are limited to the use of drugs by physician assistants.

The Physician Assistants movement has blossomed because of a perceived need and initial enthusiasm for a less expensive health care provider, but in the process, role definition has been vague. In our review of 37 states, we find that most states do not have any formal functional description of the P.A.; i.e., only a few have written statutes which enumerate the exact tasks of the P.A. Almost none of the statutes make any statement regarding the prescribing of medication.

In the face of facts and admissions by physicians that pharmacists know more about drugs than physicians, we have to wonder whether states that allow PA's to prescribe are following a logical course. The circumstances simply do not seem reasonable, wise, or scientific. The best that can be said is that the results are politically expedient. But what will be the long-term effect on the health of Kansans? We all seem concerned about increasing efforts to stop drug abuse, yet here we have a situation in which the effect of some legislation encourages those that have very little education in the use and action of drugs to prescribe prescription drugs.

We believe there is a danger that the already general problem of excess prescribing and drug use would be compounded by the intro-

duction of newer personnel with even less training having the opportunity to prescribe and treat. This would add particularly to the problems of drug abuse and the incidence of drug-drug interactions. Pharmacists have dealt for years with the problems of validating and verifying prescriptions telephoned in by office personnel, many of whom have had little in the way of formal medical training.

We have enough problems today with physicians that allow office personnel to dispense drugs in defiance of law. We cannot help but feel that placing a P.A. in the drug area is going to make this situation worse.

If so many rigorous years of training are required before a physician is allowed to prescribe drugs for his/her patients, why is so little training now acceptable to authorize lesser qualified individuals to execute the same function?

If pharmacists in Kansas looked at this issue from strictly a self-interest standpoint, we would probably say the bill is fine, because it will in our opinion increase the number of prescriptions written and dispensed. However, we do not believe this is in the public's best interest.

There is a strong feeling among our members that if this bill passes, they will take the P.A. exam. We estimate that over 90% of Kansas registered pharmacists could take and pass the exam today. We further believe that a large number of these individuals would have no difficulty finding a physician to sponsor them.

We live today in a drug-oriented society that believes that for every ailment, there is a drug to cure that ailment. Kansas law, as well as federal law, recognize 2 levels of prescription drugs. (1) Legend drugs. These drugs carry a federal warning "Caution - Federal law prohibits dispensing without prescription." These drugs are not mild home remedies but are rather potent substances that can kill as well as cure if not handled properly. (2) Controlled Substances. These drugs are divided into five (5) schedules. These products also carry the federal warning; however, because of their potential for abuse and addicting properties, they are under tighter prescribing and dispensing laws and regulations.

Prescription drugs (controlled substances and other legend drugs) are not simple preparations that are harmless. These products are habit forming, they kill, they cure, they relieve pain, etc. We believe it is a very dangerous move to allow other than physicians to prescribe these preparations. We understand the bill states that the Physician Assistant is under the direction of a responsible physician; however, without the actual presence of a physician, we do not believe adequate controls can be established.

In summary, we again urge your adoption of our recommendations to delete from the bill the PA's right to prescribe controlled substances and other legend drugs.

mj
10/14/77

PROPOSED DRAFT

_____ BILL NO. _____

By Special Committee on Public Health and Welfare

AN ACT concerning physicians' assistants; providing for the registration thereof; granting certain powers, duties and functions to the state board of healing arts; amending K.S.A. 1977 Supp. 65-2896, 65-2896a, 65-2896b and 65-2896c and repealing the existing sections; and also repealing K.S.A. 1977 Supp. 65-2897.

Be it enacted by the Legislature of the State of Kansas:

New Section 1. The following words and phrases when used in this act shall for the purpose of this act, have the meanings respectively ascribed to them in this section.

(a) "Direction and supervision" means the guidance, direction and coordination of activities of a physicians' assistant by his or her responsible physician, whether written or verbal, whether immediate or by prior arrangement, but does not necessarily mean that the continuous, immediate, or physical presence of the responsible physician is required during the performance of the assistant.

(b) "Physician" means any person licensed by the state board of healing arts to practice medicine and surgery.

(c) "Physicians' assistant" means a skilled person qualified by academic training to provide patient services under the direction and supervision of a physician licensed to practice medicine and surgery who is responsible for the performance of that assistant.

(d) "Responsible physician" means a physician who has accepted the ultimate responsibility for the actions of the

Atch. F

physicians' assistant under his or her direction and supervision.

Sec. 2. K.S.A. 1977 Supp. 65-2896 is hereby amended to read as follows: 65-2896. The state board of healing arts shall maintain a register of the names of physicians' assistants ~~who request to have their names placed on the register showing the record of training held by each person so registered and such person's current address~~ registered in accordance with the provisions of K.S.A. 1977 Supp. 65-2896a, as amended. A fee of fifteen dollars ($15) shall be charged for the initial registration. All registrations shall be renewed annually and any renewal thereof shall not be more than ten dollars ($10). The executive secretary of the state board of healing arts shall remit all moneys received by or for him or her from the provisions of this act in accordance with K.S.A. 1977 Supp. 65-2855. The state board of healing arts may adopt rules and regulations necessary to carry out the provisions of this act and the act of which this section is amendatory. ~~As used in this act the term "physicians' assistant" shall mean a skilled person qualified by academic training to provide patient services under the direction and supervision of a physician licensed to practice medicine and surgery who is responsible for the performance of that assistant.~~

Sec. 3. K.S.A. 1977 Supp. 65-2896a is hereby amended to read as follows: 65-2896a. ~~From and after the effective date of this act,~~ (a) No person's name shall be entered on the register of physicians' assistants by the state board of healing arts unless such person shall have:

~~(a)~~ (1) Presented to the state board of healing arts proof of graduation from an accredited high school or the equivalent thereof; and

~~(b)~~ (2) presented to the state board of healing arts proof that the applicant has successfully completed a course of education and training approved by the state board of healing arts for the education and training of physicians' assistants. Such course of education and training shall be substantially in

conformity with educational and training programs for physicians' assistants approved by the state board of regents; or

~~(c)~~ (3) passed an examination ~~prescribed~~ approved by the state board of healing arts covering subjects incident to the education and training of physicians' assistants.

(b) A physician's assistant shall at the time of initial registration and any renewal thereof present to the state board of healing arts the name and address of his or her responsible physician. Whenever a physician's assistant shall cease to be employed by his or her responsible physician, such responsible physician shall notify the state board of healing arts, the state board of pharmacy and the federal drug enforcement administration or its successor agency of such termination. Whenever a physician's assistant shall be employed by a responsible physician prior to the renewal of the physician's assistant's annual registration, such responsible physician shall notify the state board of healing arts, the state board of pharmacy and the federal drug enforcement administration or its successor agency of such employment. All such notifications shall be given to the state board of healing arts, the state board of pharmacy and the federal drug enforcement administration or its successor agency as soon as practicable but not to exceed a period of ten (10) days after employment or termination.

(c) On and after July 1, 1979, the state board of healing arts shall require every physician's assistant to submit with the renewal application evidence of satisfactory completion of a program of continuing education required by the state board of healing arts. The state board of healing arts by duly adopted rules and regulations shall establish the requirements for such program of continuing education as soon as possible after the effective date of this act. In establishing such requirements the state board of healing arts shall consider any existing programs of continuing education currently being offered to physician's assistants.

(d) A person whose name has been entered on the register of

physicians' assistants prior to the effective date of this act shall not be subject to the provisions of subsection (a) of this section, unless such person's name has been removed from the register of physicians' assistants pursuant to the provisions of K.S.A. ~~1975~~ 1977 Supp. 65-2896b, as amended.

Sec. 4. K.S.A. 1977 Supp. 65-2896b is hereby amended to read as follows: 65-2896b. The board of healing arts may remove a person's name from the register of physicians' assistants for any of the following reasons:

(a) The person whose name is entered on the register of physicians' assistants requests or consents to the removal thereof; or

(b) the board of healing arts determines that the person whose name is entered on the register of physicians' assistants has not been employed as a physicians' assistant or as a teacher or instructor of persons being educated and trained ~~as~~ to become a physicians' assistant in a course of education and training approved by the state board of healing arts under K.S.A. ~~1975~~ 1977 Supp. 65-2896a, as amended, at some time during the five years immediately preceding the date of such determination.

Sec. 5. K.S.A. 1977 Supp. 65-2896c is hereby amended to read as follows: 65-2896c. (a) ~~From--and--after--the--effective date--of--this--act,~~ No person shall use the title physician's assistant or words of like effect or the abbreviation "P.A." nor shall any person represent himself or herself to be a physician's assistant unless such person's name is entered on the register of the names of physician's assistants in accordance with the provisions of this act.

(b) Any person violating the provisions of this section shall be guilty of a class C misdemeanor.

New Sec. 6. A person whose name has been entered on the register of physicians' assistants may perform, only under the direction and supervision of a physician, acts which constitute the practice of medicine and surgery to the extent and in the manner authorized by the physician responsible for the

physicians' assistant. Before a physicians' assistant shall perform under the direction and supervision of a physician, such physicians' assistant shall be identified to the patient and others involved in providing the patient services as being a physicians' assistant to the responsible physician.

New Sec. 7. Prescriptions may be written by physicians' assistants as provided in this section when authorized by the responsible physician except for those controlled substances that are listed on schedule II under federal and Kansas uniform controlled substances acts. The prescription shall include the name, address and telephone number of the responsible physician. The prescription shall also bear the name and the address of the patient and the date on which the prescription was written. The physicians' assistant shall sign his or her name to such prescription followed by the letters "P.A." and his or her federal drug enforcement administration registration number.

New Sec. 8. No more than two (2) physicians' assistants shall be currently employed for any physician at any one time.

Sec. 9. K.S.A. 1977 Supp. 65-2896, 65-2896a, 65-2896b, 65-2896c and 65-2897 are hereby repealed.

Sec. 10. This act shall take effect and be in force from and after its publication in the statute book.

KANSAS STATE NURSES' ASSOCIATION
Presentation to
Special Committee on Public Health and Welfare
October 18, 1977

Mr. Chairman and Members of the Committee. My name is Joyce Olson, I am representing the Kansas State Nurses' Association.

I will be presenting rationale for the proposed changes in the definition of Nursing as found in the Nurse Practice Act. Since our presentation on September 20, 1977, we have made some changes. We have not, however, changed the intent of what we wish the proposed changes to accomplish. It is our understanding that exact wording can be developed in conjunction with the Reviser of Statues Office in drafting the bill.

There are two concepts upon which the proposed changes in definition are based. First, the definition must provide a generic scope of practice statement which facilitates the current practice and allows for the future development of professional nursing practice. Secondly, the changes must allow for the advanced practice of nurses functioning in expanded roles and provide for the regulation of that practice through the State Board of Nursing.

I would first speak to the generic scope of practice for the registered nurse. The proposed definition, while retaining some of the present wording, more specifically identifies the practice of nursing as "a process which 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 maintainence of health or the prevention or management of illness, injury or infirmity."

The typical registered nurse is no longer the one who only assigns patients to rooms and collects the urine sample in the doctor's office or clinic setting. The registered nurse in the hospital setting no longer only admits the patient to his room, puts him to bed, and thereafter proceeds to see that he/she has a daily bath, medications on time, and a bedpan when needed. In the community setting, the registered nurse is doing more than home visits to give medications or assist the mother and new baby. She/he no longer only provides routine immunizations and reports cases of communicable disease. The registered nurse in a particular practice setting may carry out these activities, but is also doing much more. Recognition of and sanction for the activities of the basically prepared registered nurse are provided for in the proposed definition. These are not advanced practice roles - they are roles that have developed as nursing, medicine, technology, and other facets of health care have changed.

The word process implies a systematic approach to planning and providing care; a series of actions conducing to an end - whether that end be totally achievable with nursing care, or requires referral to or consultation with the physician or other appropriate health care provider. The registered nurse in all settings is assessing the individuals health status, identifying nursing problems, planning and implementing care, evaluating that care, and referring when indicated.

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The addition of treatment (the techniques or actions customarily applied in a specified situation to the effective execution of a health regimen) allows the nurse to implement those actions which are accepted nursing practice.

For example: A person is admitted to the hospital following a cerebral vascular accident or stroke. There will be medical treatments related to medications IV's, laboratory tests and the like. There will also be a nursing regimen of treatments prescribed which would include: proper positioning to maintain body alignment, range of motion exercises to extremities affected to maintain function and prevent contractures, skin care to alleviate or prevent skin breakdown, a plan to assist the person in coping with altered body image and altered body function, a plan to assist the person in managing problems of eating, dressing, communicating and other activities depending upon the degree and type of bodily involvement. These activites do not require physician orders, they are part of good nursing care, cure, and prevention.

As the patient returns home referral to the Public Health or Visiting Nurse will provide continuity of care. It seems somewhat incongruent that some agencies accept only referral from the physician when the major portion of care and follow-up is nursing. This is in part related to the third party payment issue.

In coronary care units and intensive care units, nurses are monitoring patients diagnosing arrhythmias, giving medications, and defibrillating patients. This is done according to the protocol or policy of a particular institution, but judgement and decision-making are a part of the nurse's role when such situations occur. Similar decision-making is required when a patient is hemorrhaging, seizuring, or having an insulin reaction. Treatment begins before the doctor arrives. Nurses are also titrating and administering chemotherapy drugs to oncology patients based on protocol and monitoring patients for side-effects of drugs and complications of the disease process. This is accepted practice for nurses educated to function in intensive care units and with oncology patients.

Health teaching has become a primary function of the registered nurse. It is not mentioned in the present Act. Nurses are doing a major portion of teaching with persons having diabetes, hypertension, arthritis and a variety of other chronic illnesses and handicapping conditions. Teaching related to well baby and child care, parenting skills, behavior problems and adolescent concerns are other examples of health teaching.

Changes in the normal health processes speaks to not only physical illness but also to problems that occur in coping and adapting and to problems of individual and family interaction patterns. Assisting the person in adaptation and coping have long been a part of nursing.

Management of illness, injury, or infirmity implies not only the conducting or supervising of something but the skillful treatment to accomplish an end. This give sanction to an active role for the nurse in the process of care and cure for the patient, and recognizes a collaborative relationship. For example: A 20 month old male was admitted for a routine surgical procedure due to chronic ear problems. The medical focus was as it should probably be, on the surgical procedure. The nursing focus in addition to pre-and post operative care was on the life style of the child. Records revealed two past hospitalizations and 14 emergency room visits for a variety of problems including two fractures, three incidents of

foreign bodies in nose or ears, and other injuries and illnesses significant enough to bring the child to the Emergency Room. The nursing process included obtaining additional information about the family situation and parenting abilities, discussion of the plan with the physician and appropriate referral for follow-up. Without communication and collaboration between the two professions- each with contributions to management - would the child survive another 20 months?

The phrase regarding "execution of the medical regimen as prescribed by a person licensed to practice medicine and surgery or a person licensed to practice dentistry" as mentioned in an earlier hearing, was chosen to replace "the administration of medicines and treatment." This statement would permit nurses to function using protocals as well as specific physician or dentist's orders.

The provision for administration, supervision, and teaching adds only administration. This allows for the administrative and supervisory aspects of registered nurses with ancillary personnel; and for the teaching of other personnel and students. It also assigns responsibility and accountability to the registered nurse in carrying out these functions.

Graduates of basic nursing programs practice within the generic definition of nursing - some with greater or lesser expertise in specific areas dependent upon educational background, practice setting and population served.

The second concept to be addressed is that of advanced nursing practice (expanded roles) and the regulation of this practice.

The restrictive language of the present definition, specifically the disclaimer, prohibits nurse midwives from practicing in the State of Kansas and seriously limits the practice of other nurses already functioning in expanded roles.

A nurse-midwife as defined by the American College of Nurse-Midwives (ACNM) is a "Registered Nurse, who by virtue of added knowledge and skills has extended the limits of her practice to the area of management of care of mothers and babies throughout the maternity cycle as long as progress meets criteria accepted as normal." The nurse-midwife's care of mothers and babies can have a significant impact on the deficiencies in availability and quality of Maternal and Newborn care. The Forward Plan for Health, (U.S. Dept. of HEW, Public Health Service, June 1975) for years 1977-81, sees a "positive correlation between the receipt of Maternal Health care services and the reduction of infant mortality" and suggests that family planning contributes to improving the health of children. The nurse-midwife is able to give personal, total maternal and child care as well as family planning advice, thus potentially contributing to the greater well-being of Kansas families. The nurse-midwife, by virtue of her involvement with the family prenatally, could play a vital role in the prevention of child abuse, a current topic of concern.

The disclaimer inhibits the practice of nurse-midwives who need to treat and prescribe if they are to assume complete care for the normal pregnant woman and her newborn. The family planning component of nurse-midwifery and the practice of other family planning practitioners may also be inhibited if they are not allowed to prescribe and administer medications. The nurse-midwife would need to be certified to practice and would realistically maintain a collaborative relationship with a qualified medical practitioner.

Nurses practicing in other expanded roles are limited as well in the full utilization of their skills because of the disclaimer. In addition to the skills previously mentioned, nurses in primary care settings are also performing complete physical assessments, interpreting selected laboratory findings, making diagnoses in selected situations, and initiating and modifying selected therapies. A study done by Hearn (Nursing 77, October) looked at fifteen tasks, all judged appropriate by the U.S. Department of Health, Education and Welfare. She surveyed physicians and nurses to determine their acceptance or non-acceptance of the tasks. In twelve of the fifteen tasks, more than seventy per cent of both physicians and nurses concurred that they were appropriate tasks for nurses. Only three of the tasks approached fifty per cent disagreement on the part of physicians.

If expanded roles are to be sanctioned, then a mechanism to provide for regulation needs to be addressed. Competency of the practitioner and protection of the public need to be assured.

It is still our firm belief that "additional acts" as recognized by the profession and further functions as defined by the Board of Nursing in rules and regulations address these two issues. Professional opinion constitutes probably the best possible overall criterion of the legality of a nurse's acts.

An alternative that has been suggested is the following: "and upon certification by the Board, the performance of advanced nursing practice which shall be defined in the rules and regulations of the Board not inconsistent with the provisions of this act." This would allow the Board to develop rules and regulations which could address the issue of education required to practice, determine categories of practitioners and provide for certification and recertification of such individuals. I believe it is the intent of the Board of Nursing to speak to rules and regulations in their presentation.

To provide further illustrations of how proposed changes would influence the actual practice of nurses functioning in expanded roles, presentations will be given by two Family Nurse Practitioners.

As you may know, federal legislation currently under consideration would allow for reimbursement through Medicare and Medicaid of services provided by Nurse Practitioners in rural health clinics. Eligibility for federal funds may become an issue in Kansas if expanded roles for nurses are not permitted and defined.

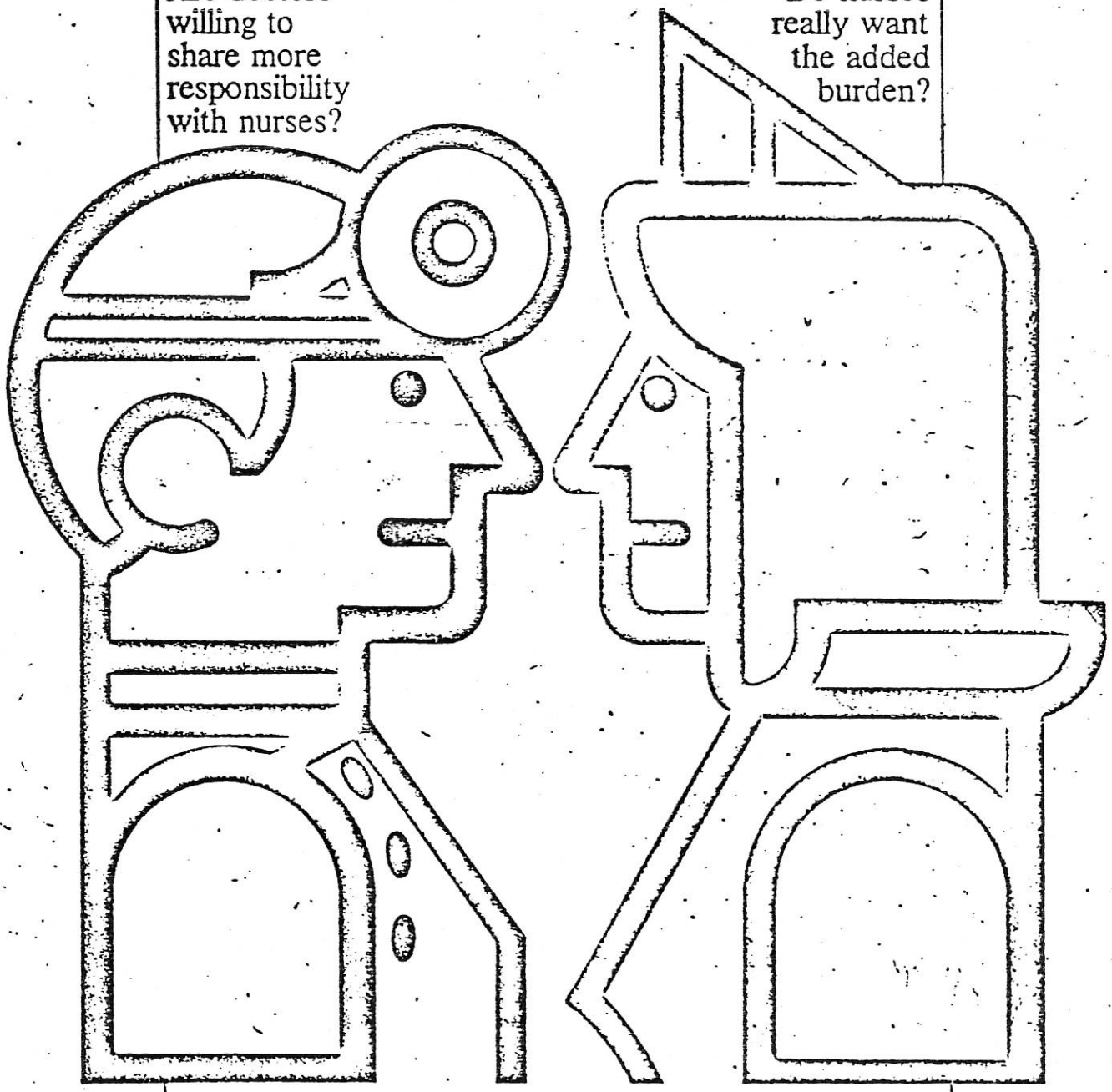
In summary, it is not nursing's intent to practice without physicians, but to work collaboratively with them in the provision of health care to Kansans. The concepts put forth in this presentation have been endorsed by nurses attending forums in 15 Districts to date, and by the convention body at our annual convention this past week. Nurses are ready to work for a change in the Nurse Practice Act.

Thank you for the opportunity to present the views of our organization. I will be happy to answer any questions you may have or refer them to other nurses in the audience.

Nursing77 CareerGuide

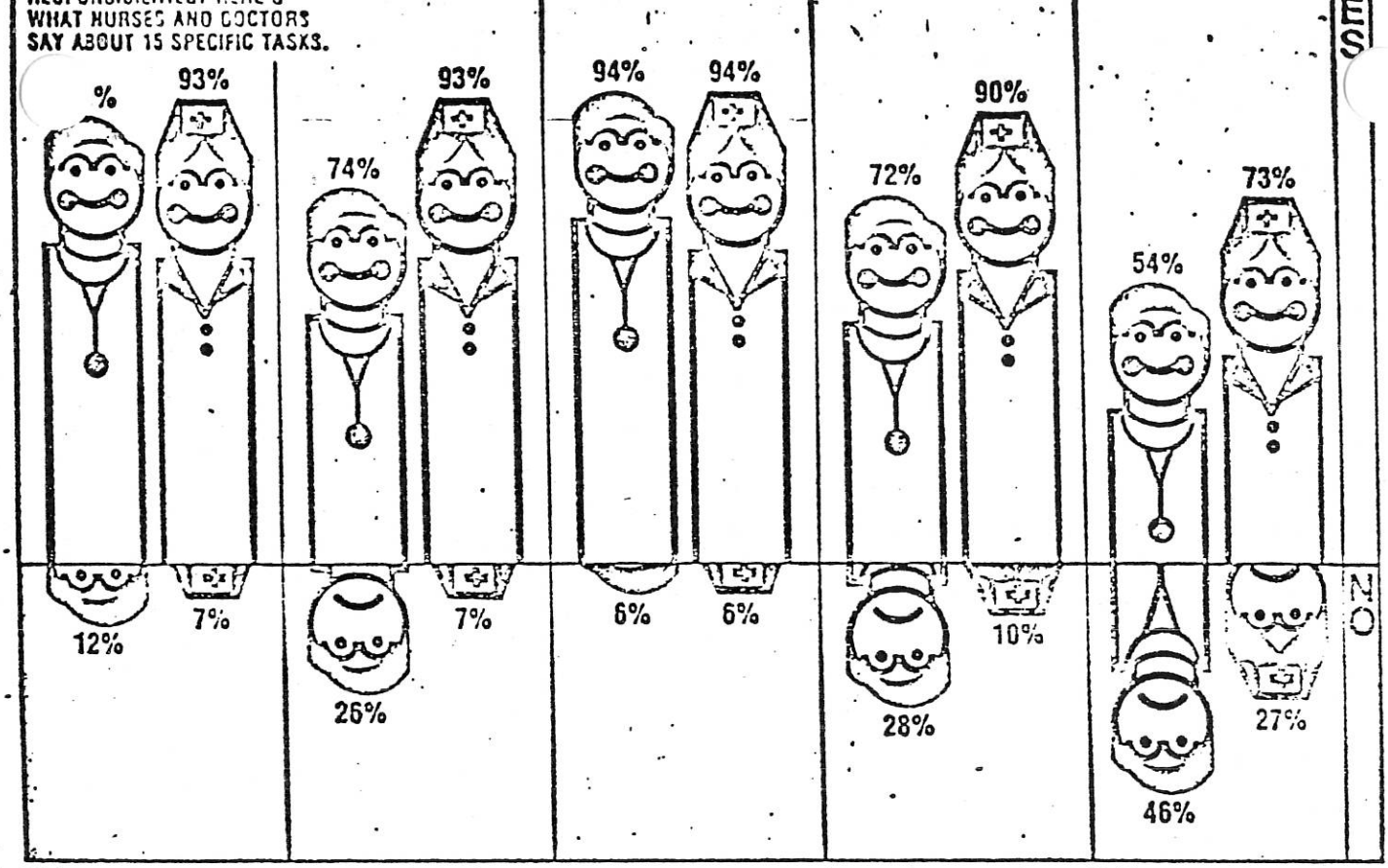
Are doctors willing to share more responsibility with nurses?

Do nurses really want the added burden?



A survey tried to answer these questions and found some startling opinions....

WHAT NURSES AND DOCTORS SAY ABOUT 15 SPECIFIC TASKS.



Eliciting and recording a health history.

Making physical and psychosocial assessments, recognizing the range of normal and the manifestations of common abnormalities.

Assessing family relationships and home, school, and work environments.

Interpreting selected laboratory findings.

Making diagnoses in selected situations.

THE EXPANDED ROLE FOR NURSES

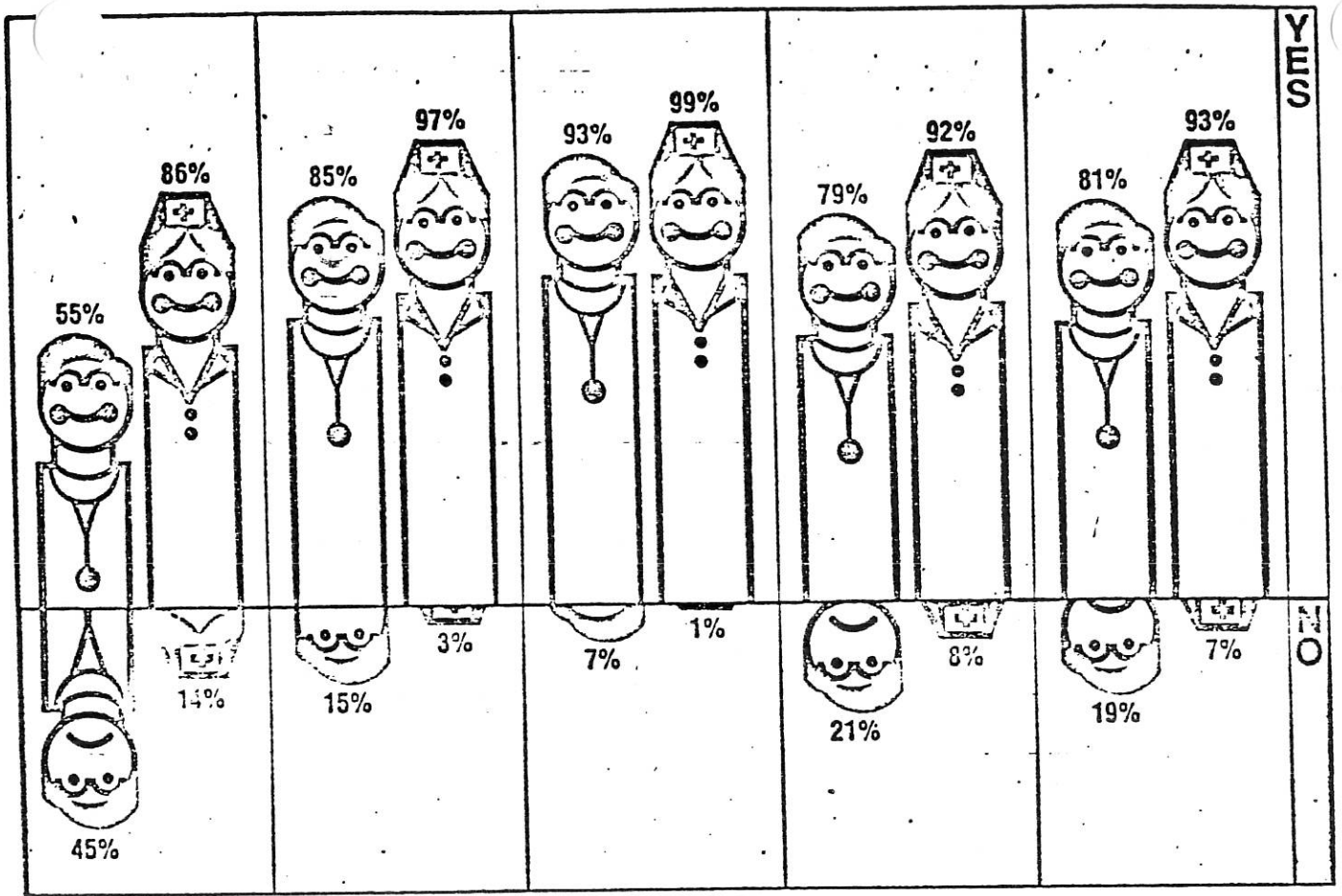
BY SUSAN WHITE, BA
Associate Editor, *Nursing77*
ILLUSTRATIONS BY JIM STOREY

If a patient on your ward appears to be going into shock, do you start an I.V. immediately? Or do you sit tight and wait for a doctor's order – no matter what?

If a patient with all the symptoms of TB comes into a clinic, do you order the appropriate X-rays and lab tests? Or do you feel obligated to wait for a doctor's initial diagnosis?

IF, IN BOTH INSTANCES, you'd sit and wait for the doctor, maybe you'd better start rethinking your role as a nurse. Could be you're still living in the past, waiting for a doctor's approval before you do anything more challenging than give a sponge bath. Or perhaps the doctors you work with are the source of your trouble — maybe they simply refuse to let you use all your nursing skills.

The subject of how much responsibility nurses are willing to accept — and how much doctors are willing to give — piqued the curiosity of Martha Hearn, RN, when she was a doctoral candidate at the University of Alabama. Mrs. Hearn — now Dr. Hearn and acting dean at Samford University School of Nursing in Birmingham, Ala. — solicited the opinions of 132



Choosing, initiating, and modifying selected therapies in selected situations.

Assessing community resources and needs for health care in the community.

Providing emergency treatment as appropriate, such as in cardiac arrest, shock, or hemorrhage.

Providing appropriate information to the patient and his family about a diagnosis or plan of therapy.

Making prospective decisions about treatment in collaboration with doctors, such as prescribing symptomatic treatment for coryza, pain, headache, nausea, etc.

Alabama doctors, 555 RNs, and 17 senior nursing students, through a lengthy questionnaire.

Each participant was asked whether she or he agreed that nurses should perform 15 tasks, all judged appropriate for nurses by the U.S. Department of Health, Education and Welfare (see accompanying chart). The jobs ranged from the commonly accepted practice of taking a health history to the more controversial task of making diagnoses in certain situations.

If all 15 tasks were commonly accepted nursing procedures where you work, you could, for example, find yourself:

- Determining that a diabetic patient's blood sugar is slightly elevated, and then altering either his diet or his medication — *without* a doctor's order.
- Explaining, in detail, postoperative care for a colostomy patient — *without* a doctor's order.
- Giving immunizations *without* a doctor's order, relying instead on a protocol formulated by staff nurses and doctors.

Encouraging results

Frankly, these are controversial ideas in many health-care facilities. Yet when the results of Dr. Hearn's survey came in, she found that the vast majority of the doctors and nurses agreed with the expanded role for nurses. Both groups particularly approved of such duties as "providing emergency treatment," "conducting nurse clinics for continuing care of selected patients," and "assuming responsibility for acquainting selected patients and families with the implications of health status, treatment, and prognosis."

Yet strong pockets of resistance existed. Predictably, disagreement was higher among the doctors — almost 20% of them expressed overall disagreement, some mildly, but some very strongly.

Doctors with 10 to 19 years' experience voiced the strongest disapproval of nurses performing the 15 tasks. Over 23% of them objected.

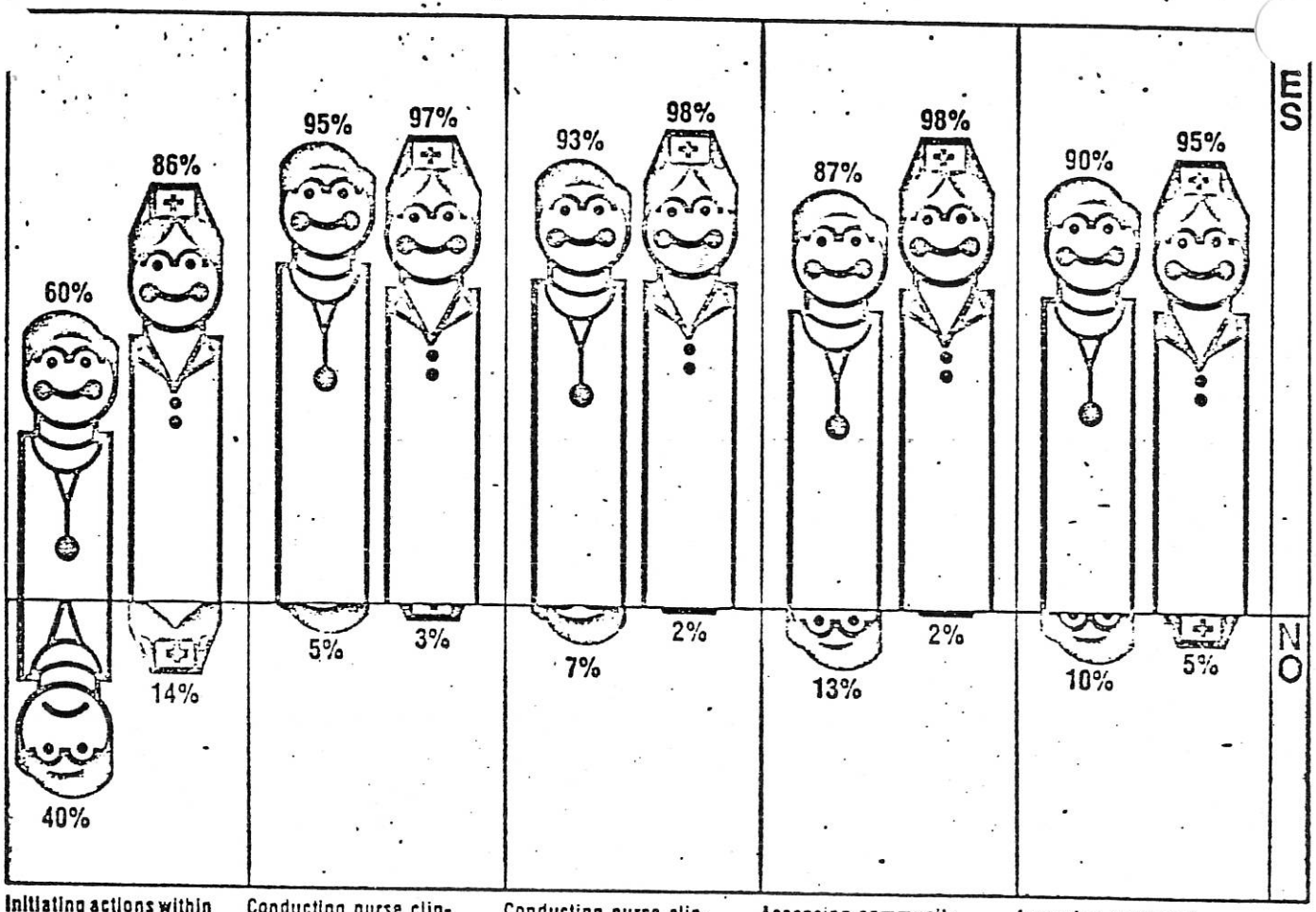
No one can say for certain just why doctors in this category reacted as they did. But Dr. Hearn did offer some thoughts.

"These doctors are just reaching the peak of their careers," she said. "Their practices are growing...they're making money...they feel they can handle things on their own. They don't think they need *any* help."

After a doctor has been in practice 20 years or more, the picture changes. Only 18.4% of this group objected to the nurses' expanded role. Again, Dr. Hearn speculates: "These doctors probably have as many patients as they can handle — maybe even too many. Suddenly they begin to think 'Am I *ever* going to be able to slow down?' And they gradually realize that well-trained nurses can provide the help they need."

The doctors' objections

One of the older doctors in Dr. Hearn's survey disagreed strongly with *every* statement.



"Nurses have no business whatsoever trying to perform tasks doctors have been trained to do," he scrawled angrily on the back of his questionnaire. "Nurses aren't capable of performing such tasks and should never be allowed to do so."

On the other hand, doctors who had recently graduated were quite confident of the nurses' capabilities. In fact, those with no more than 4 years' experience agreed 100% with the expanded role. "Nurses fulfilling this role can only enhance health care," wrote one.

Unfortunately, some doctors who wanted nurses to perform the tasks listed couldn't always find nurses with the necessary skills.

"I've been practicing in a small town for 15 years," wrote one doctor in his early forties. "During that time, I've actively searched for a nurse who was trained to perform the tasks listed on the questionnaire. So far, though, I haven't found one qualified for the job."

Clinging to the old role

You'd certainly expect to find doctors who are hesitant, if not downright unwilling, to delegate some of their authority to nurses. Surely some — perhaps many — of the doctors you work with fall into this category.

But Dr. Hearn's survey also showed that a small group of *nurses*, totaling about 8%, was unwilling to *accept* the added responsibilities. If you're one of those still hanging back, Dr. Hearn suggests you may be "hindered in the development of the nursing role as much by timidity from *within* as by pressures from *without*."

One 45-year-old nurse, who'd spent her 20-year career in a small-town hospital, was incensed enough to print her objections firmly on the back of her questionnaire: "Nurses who perform these tasks are overstepping their limits. Nurses should *never* attempt to do what doctors are supposed to do."

Not surprisingly, the strongest disagreement among nurses came from those who began their careers at a time when a nurse was usually considered only the doctor's handmaiden. About 9% of those with 20 years' or more experience remain to be convinced that nursing is expanding.

As the nurses' working experience decreased, so did their objections to the revised roles. Only 7% of those with 10 to 19 years' experience expressed general disagreement, and only 5% with 5 to 9 years' experience disagreed.

The exception proved to be a group consisting of nursing candidates and recent graduates with less than 4 years' experience. Their rate of disagreement rose to 8%.

Undoubtedly, some of those newly employed nurses were still adjusting to the realities of their new jobs and couldn't even co[illegible]ate handling more responsibilities.

Coping with the problems

When Dr. Hearn began her study, she wanted to identify the kind of education needed to help nurses comfortably assume their expanded role. Now she has some specific ideas, but she must rely on other nurses to help put them into action. Here's what she believes you can do, if you're among the majority of nurses:

- If you're a nursing student or teacher, make sure your school offers enough formal training — perhaps even some refresher courses — in making diagnoses and in selecting, initiating, and modifying therapies. If your school is weak in these areas, push for improvements. Of all the categories on Dr. Hearn's survey, these created the most disagreement among doctors and nurses alike.
- Help organize continuing education programs or inservice conferences at your place of employment. If you work for a doctor in private practice, keep your eyes open for suitable workshops that one, or preferably both, of you can attend.
- Ask doctors who agree with the expanded role for nurses to help plan educational programs and to serve as program participants with nurses. By including the supportive doctors, you may be able to influence those who are still dragging their feet.

Dr. Hearn warns that these steps must be taken if the old image of the nurse as the doctor's handmaiden is to be stamped out.

"Both doctors and nurses must develop similar expectations of the nurse's expanded role," Dr. Hearn warned. "If they don't, these role changes will be difficult, if not impossible."

Undermining the opposition

Dr. Hearn's survey wasn't totally serious. At times a bit of humor — albeit unintentional — poked its way through the pages.

One doctor — the one who strongly disapproved of *every* statement on the questionnaire — kept insisting on his total opposition. But buried at the end of his tirade was a grudging admission, one whose implications he probably wouldn't acknowledge, even to himself.

"I do have a very capable nursing aide," he wrote casually. "She's been with me 25 years, and she's capable of performing *every one* of the jobs you mentioned."

Admittedly, this was a backhanded acceptance of the nurses' expanded role. But to Dr. Hearn, it was another optimistic sign for the future.

"As nurses learn to communicate better, and demonstrate their knowledge and ability, I think doctors will become more comfortable with the nurses' expanded role. Then both groups will be able to use *all* of their potential for improved patient care."

As for now, however, many nurses — perhaps you or your co-workers among them — are accepting the expanded role without fanfare. Quietly — sometimes so quietly that the doctors involved aren't really conscious of the change — nurses are assuming new responsibilities.

As one confident young nurse pointed out to Dr. Hearn, "Many nurses already routinely perform the 15 tasks you listed...it's just that doctors get the credit."

PROPOSED CHANGES

IN THE

KANSAS NURSE PRACTICE ACT

Article 11. Examination, Licensure and Regulation of Nursing

K.S.A. Chapter 65, Article 11

65-1113. Definitions. When used in this act: (a) "Board" means the board of nursing.

(b) *Practice of nursing.* (1) the practice of professional nursing ~~means the performanee~~ as performed by a registered nurse for compensation or gratuitously, except as permitted by K.S.A. 65-1124 and amendments thereto, ~~of any act in the observation,~~ is a process in which substantial specialized knowledge derived from the biological, physical, and behavioral sciences is applied to: the care, treatment, ~~and~~ counsel, ~~of the ill, injured, or infirm; or in the maintenanee of health or prevention of illness of others; or in the supervision~~ and health teaching of ~~other personnel,~~ persons who are experiencing changes in the normal health processes or who require assistance in the maintenance of health of the prevention or management of illness, injury or infirmity; the execution of the medical regimen ~~or the administration of medicines and treatments~~ as prescribed by a person licensed to practice medicine and surgery or a person licensed to practice dentistry; the administration, supervision or teaching of nursing; and upon certification by the Board the performance of additional acts which shall be defined in the rules and regulations of the Board not inconsistent with the provisions of this act. ~~requiring substantial specialized judgement and skill, and based on knowledge and application of the principles of biological, physical, and social science. The foregoing shall not be deemed to include acts of diagnosis or prescription of therapeutic or corrective measures.~~

KSNA October 1977

Att. H

Sample Rules and Regulations --- for suggesstion only!

Glossary of terms.

Advanced Registered Nurse Practitioner -- An Advanced Registered Nurse Practitioner is a nurse with current active licensure as an R.N. in Kansas, who is prepared for advanced nursing practice by virtue of added knowledge and skills gained through an organized post basic program of study and clinical experience approved by the Kansas State Board of Nursing.

Board -- Unless otherwise clearly indicated is used in these regulations to mean the Kansas State Board of Nursing.

Clinical Experience -- Practice under the supervision of a qualified preceptor in the actual care of a consumer of health services.

Clinical Nurse Specialist -- A Registered Nurse who holds a minimum of a Master's degree in a nursing clinical specialty area.

Organized Post Basic Program -- A formal course of study after completion of basic nursing education in preparation for specialized and advanced nursing practice.

Qualified Preceptor -- A certified practicing Advanced Registered Nurse Practitioner, Clinical Nurse Specialist, or a currently licensed physician or surgeon who supports the concept of the expanded role of the nurse. The functions of the preceptor include supervision, teaching, and evaluation of student performance in the clinical setting.

Categories of Advanced Registered Nurse Practitioners.

Certified Registered Nurse Anesthetist
Certified Nurse Midwife
Family Nurse Practitioner
Family Planning Nurse Practitioner
Geriatric Nurse Practitioner
Pediatric Nurse Practitioner
Adult Primary Care Nurse Practitioner
Other categories as may be determined from time to time by the Board

Acts Proper to be Performed by an Advanced Registered Nurse Practitioner.

The Board authorizes the aforementioned categories of Advanced Registered Nurse Practitioners to perform particular acts, at the advanced and specialized levels recognized by the nursing profession and which are currently included in the curricula of advanced nursing education programs approved by the Board.

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Requirements for Certification.

Requirements for certification as an Advanced Registered Nurse Practitioner in the State of Kansas shall consist of the following:
(1) Active licensure as a Registered Nurse in Kansas.
(2) Documentation acceptable to the Board of one or more of the following:
(a) Satisfactory completion of a formal educational program. Such program of study shall conform to the Program Guidelines as outlined in these Rules.
(b) Certification by the appropriate specialty board or equivalent as approved by the Board.
(c) Graduation from a program leading to a Masters degree in a nursing clinical specialty area with preparation in specialized practitioner skills.
(3) Evidence satisfactory to the Board of current clinical competencies if more than one(1) year has elapsed since the completion of the nurse practitioner program. Such evidence may include written documentation attesting to said fact. Applicants not meeting specific educational requirements as outlined in these Rules may be considered on an individual basis by the Board for equivalency of education and experience.

Filing of the Application.

Application shall be made on a form prescribed by the Board together with a non-refundable fee of $_____.

Certification.

(1) When the Board has determined that the applicant meets qualifications herein, a certificate indicating the title and specialty area will be issued.
(2) No other person shall practice or advertise as, or assume the title of Advanced Registered Nurse Practitioner or use the abbreviation"A.R.N.P." or any other words, letters, signs, or figures to indicate that the person using same is an Advanced Registered Nurse Practitioner.

Renewal of Certification.

(1) Certification shall be renewed during the same period as the nurse's license to practice in Kansas.
(2) The Advanced Registered Nurse Practitioner shall provide the following for renewal:
(a) Proof acceptable to the Board of continued clinical practice at the advanced or specialized level during the preceding renewal period.
(b) Documentation of the required amount of continuing education related to the area of advanced practice.
(c) Payment of the biennial $_____fee required by the Board.
(3) Failure to renew certification as an Advanced Registered Nurse Practitioner within the current renewal period will result in termination of certification.

Reinstatement of Terminated Certificate.

To reinstate a terminated certificate, the applicant shall:
(1) File application for reinstatement on a form provided by the Board.
(2) Provide proof satisfactory to the Board of having complied with the continuing education requirement during the preceding renewal period.
(3) Pay the reinstatement fee of $_____.

Revocation, Suspension or Refusal to Certify.

The Kansas State Board of Nursing may revoke, suspend or refuse to renew the certification of any Advanced Registered Nurse Practitioner or may refuse to certify any applicant for such certification if the Board finds from competent evidence that the person fails to meet requirements for Advanced Registered Nurse Practitioners as stated herein, provided however, that prior to any such action by the Board, the nurse shall be given notice and opportunity for a hearing as provided by K.S.A. 65-1120.

Guidelines for Advanced Registered Nurse Practitioner Programs of Study.

The program of study preparing an Advanced Registered Nurse Practitioner shall meet the following requirements:
Philosophy, Purpose, Objectives.
(1) The program shall have as its primary purpose the preparation of nurses for advanced and specialized levels of nursing practice.
(2) The philosophy, purpose and objectives of the program shall be clearly defined and available in written form.
(3) The objectives reflecting philosophy shall be stated in behavioral terms and describe the competencies of the graduate.
Administration.
(1) The program shall be conducted by an accredited school of nursing which offers a baccalaureate or masters degree in nursing.
(2) Admission criteria shall be clearly stated and available in written form.
(3) Admission requirements, philosophy, objectives and criteria shall be available to the student.
(4) Policies for withdrawal, dismissal and readmission shall be available to the student.
(5) The student shall receive official evidence that indicates successful completion of the course.
Faculty.
(1) There shall be an adequate number of qualified faculty in the specialty area available to develop and implement the program and achieve the stated objectives.
(2) The faculty shall include currently practicing Advanced Registered Nurse Practitioners.
(3) Nursing faculty shall hold current licensure to practice in Kansas.
(4) Medical faculty sahll hold current licensure to practice in Kansas.
(5) Preceptors shall participate in teaching, supervising and evaluating students.

Curriculum.
(1) The course content, methods of instruction and learning experiences shall be consistent with the philosophy and objectives of the program.
(2) Outlines and descriptions of all learning experiences shall be available in writing.
(3) The program shall be at least one (1) academic year in length (nine months full time or its equivalent) which shall include a minimum of three (3) months or its equivalent (possibly a stated number of hours) of theoretical instruction in the biological, behavioral, nursing, and medical sciences relevant to the area of advanced practice, in addition to clinical experience with a qualified preceptor.
(a) The program shall include but not be limited to theory and directed clinical experience in comprehensive physical and biopsychosocial assessment; interviewing and communication skills; eliciting, recording and maintaining a health history; interpretation of laboratory findings; initiating and modifying selected medications, diets, and therapies; initiating and providing emergency treatments; assessment of community resources; and making referrals to appropriate professionals or agencies.
(b) The program shall include content relating to role realignment, legal implications of Advanced Nursing Practice, and the health care delivery system.
(c) The program shall provide supervised clinical experience in the performance of highly specialized diagnostic procedures that are essential to practice in that area.
Records.
Records of the program, philosophy, objectives, administration, faculty, curriculum, students and graduates shall be maintained systematically and be retrievable.
Evaluation.
Provision shall be made for a continuous program evaluation plan by the faculty and students.

J

Testamony Before the Special Committee on Public Health and Welfare Regarding the Nurse Practice Act.

October 18, 1977

Elizabeth C. Dayani, R.N.C., F.N.C. Chairman
Nurse Clinician/Nurse Practitioner/Clinical
Nurse Specialist Conference Group,
Kansas State Nurses' Association

Mr. Chairman and members of the Committee:

Thank you for allowing me to make this presentation. I am chairperson of the Nurse Practitioner Conference Group of the Kansas State Nurses' Association and on their behalf I would like to address the question: "Why change the Nurse Practice Act."

There are many reasons to update laws. I will discuss three reasons today.

In the past fifty years the health care needs of consumers have changed. At the turn of the century doctors and nurses devoted their energies to treating and containing communicable diseases. Improved public health measures and the discovery of antibiotics drastically changed the character of disease in our country. The leading causes of illness and death today include heart attack, cancer, stroke, hypertension, diabetes and auto accidents, and are directly related to life style. Many of these illnesses can be prevented and/or controlled by health education a role which nurses have always assumed.

As our society has become more urban, we have seen a migration of our citizens to the cities. This has resulted in a maldistribution of health care providers. Access is limited in rural and urban underserved areas. There are several alternative solutions to this situation. One is the National Health Service Corps, a federal program of voluntary service to underserved areas. Another potential solution is the education of indigenous persons who will return to their home towns to serve. Many nurse practitioners and public health nurses are serving in rural areas.

Att. J

Finally the escalating cost of health care demands a change of focus in the entire system. Currently, the greatest number of dollars are spent in treating illnesses in the acute care setting. The fee-for-service reimbursement system encourages hospitalization; the malpractice crisis promotes defensive and expensive diagnostic work; and a more informed population demand the most sophisticated care. There is no incentive in the present system to maintain wellness and prevent illness. But the system must change. We cannot continue to pay for services at the present rate of inflation. Nursing which has a focus of health and wellness is in a key position to facilitate the change.

There are approximately two hundred nurse practitioners in Kansas. The first nurse practitioner program was funded by the Kansas Regional Medical Program in January 1972. That program is located at Wichita State University. A 1975 study (Holmes, Geraldine and Bassett, Rita E. "Socio-Economics: Nurse Clinician," The Journal of the Kansas Medical Society, December, 1976, pp. 553-558), revealed that 50% of the graduates were practicing in medically underserved areas of the State of Kansas. Another program was developed at the University of Kansas College of Health Sciences, School of Nursing. And a third program is being developed by Kansas University, School of Nursing faculty in Hays, Kansas to prepare indigenous nurses who will practice in the rural areas of northwestern Kansas. In the 1975 study of nurse clinicians conducted by the Kansas Regional Medical Program cited earlier it was found that the most significant benefit to patients was improved access to health care services. Unfortunately it was also found that the vague legal status of nurse clinicians resulted in a conservative use of their abilities in some settings. The Nurse Practice Act needs to be changed to permit nurses to provide the services that they have been educationally prepared to provide and that the consumer needs.

Nurses in expanded roles function in variety of settings. For example, the nurse in the coronary care and intensive care units in hospitals monitor seriously ill patients and are prepared to implement life-saving measures. Other nurse practitioners work in doctors offices, schools, hospital outpatient clinics, public health clinics, industries and health maintenance orgainizations.

Specifically, nurse practitioners take health histories, develop a problem list and implement a plan of care that may include management or referral. For example, the pediatric nurse practitioner will perform a newborn physical and instruct the mother in well-child are; she will follow the child through an immunization schedule and, when the child becomes ill, either manage the problem herself or refer the child to a provider with greater expertise. For example, I would feel comfortable in treating an ear infection in a four year old toddler but would refer a four month old with the same problem to a pediatrician because the younger child is at higher risk for complications. The adult nurse practitioner also performs physical exams, prescribes special diet and exercises, counsels and teaches the client about his body and health needs, evaluates the status of the patient with a chronic illness, consults with other providers, and refers complicated cases. For example, if I were following a hypertensive patient, I could manage a cold in that patient but would refer him to an internist if his blood pressure became uncontrolled.

I have had the opportunity and privilege of developing and practicing in both urban and rural primary care clinics. In a day, I would see an average of fifteen patients. Since I have been prepared as a family nurse practitioner, I can see any patient male or female, adult or child, with any problem. For example, I might have scheduled one adult physical check-up, three pediatric physicals and well-child visits. I might see and treat a child with scabies, a common skin infection, and do a throat culture on another child to find out if he needs an antibiotic to cure a "strep" throat. I might have seen a young

woman for a routine Pap exam and a discussion of family planning methods. Often I would make home visit to see elderly patients who needed to have their blood pressures checked or just needed reassurance or advice about their health.

Clinic attendees were made up primarily of children, women, and senior citizens. Their most common problems include colds, ear infections, hayfever, sore throats, skin lesions, indigestion, constipation, diarrhea, hypertension, diabetes, and arthritis. After taking a health history, I would decide if I could handle the problem at the clinic or if the patient needed to be referred immediately to an emergency facility or be seen by a doctor. In the clinic where I practiced I had a physician available by telephone at all times. He was only physically present with me at the clinic one day a week. We jointly developed protocols much like standing orders that permitted me to prescribe medications for common illnesses. Whenever I had any question about a patient's medical problem I would consult with my physician colleague. Because of my preparation and experience I was able to see, assess, and treat 80-90% of the people who came to the clinic with no direct physician involvement. Patient and physician acceptance of this type practice was high. That clinic is located in Lynchburg, Tenn. and is still being run by a nurse practitioner. Under the present Nurse Practice Act in the State of Kansas, I could neither develop nor work in this type of clinic although it is apparent to me that the need for such facilities is just as great in this state especially in communities that are too small to support a doctor.

Nurses all over the country are doing these things. Why? Because there are not sufficient numbers of physicians to meet the primary health care needs of our citizens. Let me emphasize that the focus of nursing practice is wellness-maintaining health and preventing illness. But we are also managing simple problems that in the past have only been handled by physicians. This development was inevitable. With the explosion of knowledge in the health sciences, it is nutural

for each professional group to assimilate more knowledge and assume more responsibility. It is not only reasonable but necessary. At one time only physicians took blood pressures. Can you imagine the impact on the access and cost of care if this were still the case. Nurses must legally be allowed to expand their practices or the services to consumers by nurses must be significantly reduced.

In 1977, the legislature of this state allocated funds to KUMC, School of Nursing to develop an outreach nurse practitioner program in Hays, Kansas. State funds also support the established Nurse Practitioner programs in Wichita and Kansas City.

In light of the state funds that are spent to help prepare nurse practitioners, it seems very short sighted to restrict their most effective use by not modifying the Nurse Practice Act. Many other bills relating to health and providers have been passed or are being considered by the Kansas Legislature. Obviously it is the expressed intent of the legislature to extend the delivery of health services to Kansans. Why not codify this intent by accepting and promoting the modifications in the nurse practice act as proposed by the Kansas State Nurses' Association.

The members of the nursing profession are willing to assume the responsibility for regulating the practice of nursing in order to assure safe nursing practice. This will be done through rules and regulations promulgated by the Board of Nursing, accreditation of educational programs, national certification, implementation of standards of practice through quality assurance programs, and mandatory continuing education for relicensure.

We want to continue to increase the quantity and improve the quality of health services to Kansans as do you. Some provision must be made for deleting the disclaimer and allowing for additional acts so that nurses will be able to fully utilize their knowledge and skills to the advantage of the health care system.

Changes in practice usually precede changes in the law. But now it is time for the Nurse Practice Act to be changed to reflect current and common practice in nursing. On behalf of our clients and your constituents, we ask you to modify the Nurse Practice Act as proposed by the Kansas State Nurses' Association.

Thank you for your valuable time and special considersation.

K

Presented to the Special Committee
on Public Health and Welfare
October 18, 1977
by Elaine Dohmeier
Kansas Association of Hospital Schools of Nursing

Mr. Chairman and members of the committee, there is indeed a great need for the expanded role of the nurse to be defined and clarified in the Nurse Practice Act for the protection of both the nurse and the public she serves. Nursing is a rapidly changing profession and the laws governing it must be updated to coincide with the needs of our times. With additional educational preparation and clinical practice beyond that of the basic preparation given in schools of nursing, the nurse can develop the necessary skills and obtain the additional educational background to perform in a more independent fashion than normally expected and to interpret the guiding protocols in an intelligent and meaningful way.

The definition as written in the latest draft of the proposed NPA encompasses activities that can be performed by any registered nurse, but does not really address the issue of the expanded role except to say, "any additional acts which shall be defined in the rules and regulations of the Board". It would seem more appropriate to delineate the differences in basic educational preparation versus preparation for the expanded role more fully to ensure that all nurses are not permitted by law to function in an expanded role. Presumably the intent of the proposal is that the rules and regulations would clarify this issue, but it seems necessary that at least a broad statement of differentiation be included in the definition of nursing. The definition of the expanded role developed through Master Planning might be a good basis for this.

The proposed draft also states that the "additional acts" will be certified by the Board, but it does not specify how this will happen and the Board currently has no mechanism for doing this. I presume this issue is also meant to be addressed in rules and regulations. However, the presentation made by Mrs. Killian addressed this issue very well this afternoon. Also Judy's suggestion regarding the specialist certification such as the dentists have.

The reinsertion of "professional" was met with great approval by our group. It's back where it belongs.

There are many issues plaguing nursing that will have to be dealt with in the future. However, the issue of the expanded role is the one that needs our full attention now. Nurses have a right to be legally protected in the performance of those responsibilities they are required to perform. We urge your support in obtaining the necessary protection for the nurse functioning in an expanded role.

Att. K

CONNECTICUT JOINT PRACTICE COMMITTEE POSITION STATEMENTS

ENDORSED BY MEDICAL SOCIETY AND NURSES' ASSOCIATION

"The Connecticut State Joint Practice Committee has directed much of its efforts to topics of concern to medicine and nursing, including the emergence of new roles. Particular attention has been paid to licensing and certification problems, the redefinition of the Nurse Practice Act, the distribution of health manpower and the control of training programs. All of these topics have had Statewide interest to those rendering health care."

The two position statements printed below were prepared by the Connecticut Joint Practice Committee and have been endorsed by the Connecticut State Medical Society and the Connecticut Nurses' Association.

HEALTH MANPOWER

Current trends in health care delivery seem to perpetuate fragmentation of functions, creating a large variety of health care personnel who have a narrow range of skills. Patient care should be so fragmented *only* when the result is to increase quality of outcome, patient satisfaction and cost effectiveness.

When a new function *is required,* existing classes of personnel should be evaluated in order to ascertain whether the function of any could be redefined and expanded, rather than inventing a new type of health worker.

Should a new field be essential for patient care, universal criteria should be established for training programs designed to provide students with those skills and qualifications that are relevant, viable and clinically useful to the new field. These criteria must be consistent with maintaining equal or improved standards of performance and delivery of health care services. In addition, national standards for evaluation and certification of each new field, must be established promptly to avoid role confusion.

Unfortunately, certain recent trends in preparing health workers (often at public expense) violate the above principles. These trends have produced new workers with too limited a range of tasks. In addition, we have witnessed the discarding of innocent new workers as their narrow task is abandoned. This is both inhumane to the worker and inefficient for the health care system. Transfer of occupational functions from one group to another with *no* net improvement in the quality or economy of patient care makes no sense in the cost controlled environment in which we now live.

Our goal should be to place each current or new type of health manpower to the test of health care needs of the patient, effectiveness in delivery of that care, efficiency in delivery of that care, and economy, in that order.

LICENSURE OF ALLIED HEALTH PERSONNEL

There is a great discrepancy among hospitals, medical and nursing schools, colleges, technical schools, and non-hospital health agencies about titles, functions, tasks, and definitions of allied health roles. Job descriptions are often inadequate in describing actual tasks. Technology and educational curricula develop so fast that it is impossible to keep abreast of job descriptions and new credentials. When legislators enter the complicated and sensitive field of licensure in response to pressure groups, the resulting inflexibility and difficulty of repeal contribute to the confusion and cost-inefficiency. Reliance on non-expert counsel can result in expedient rather than sound legislation.

Opponents of licensure requirements of health care personnel often support their position with claims that licensure requirements create barriers to the entry of potential workers into a field or job market, foster elitism among already licensed providers, and are costly to administer.

Neither indiscriminate proliferation nor elimination of licensure is rational. Some socially more appropriate questions to answer in the issues of licensure might be:

1. Is the specific health service essential to the public good?
2. If deemed essential, how hazardous is mediocre or poorly defined performance of this service?
3. Within the health care field are there established, widely recognized and widely accepted standards for performance upon which to base the licensure of this service?
4. Is the offered service unique to the category of worker for whom new licensure is provided?
5. Are there effective mechanisms, other than licensure, available for the protection of the public interest to assure that performers of the service meet at least minimum accepted uniform standards?
6. Will the service be improved by the introduction or elimination of a licensing process? How will it affect quality and cost of health care?

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(Licensu nt.)

Licensure is in the public interest if a service is considered essential to the public's good, if poor performance is hazardous, and if individuals are unable to safeguard themselves or choose alternative services.

Until the legislature can establish a valid mechanism to evaluate the issues referred to above, the present "moratorium" in Connecticut on the new licensing or modification in licensing of health care workers should be extended. Such a mechanism must address itself to the needs of patients and be professionally sound.

MINNESOTA POSITION STATEMENTS ON NURSE PRACTITIONERS AND MEDICAL SUPPORT ROLES

ENDORSED BY MEDICAL AND NURSES' ASSOCIATIONS

Printed below are two statements prepared by the (Minnesota) MSMA-MNA Joint Practice Committee on "Nurse Practitioner/Associates and Medical Support Roles." One applies to institutional settings, the other to non-institutional (primary care) settings. Both statements have been adopted by the sponsoring associations: by the MNA House of Delegates on October 24, 1976, and by the MSMA House of Delegates on November 20, 1976.

Since the statements are similar, they are printed in parallel columns to allow comparison.

POSITION STATEMENT:

INSTITUTIONAL SETTINGS

Introductory Statement

The past few years have seen an increasing trend in the development of programs preparing registered nurses to assume an expanded nursing role i.e., NP/NA and new health occupations designed to facilitate patient care. There also have been efforts to train members of new health occupations such as the physician's assistants, and other members of existing health professions to assume new medical support roles to the physician in providing medical care. To assist in regulating the activities of such expanding or emerging health professions in Minnesota, the following statement has been prepared by the Minnesota Nurses Association-Minnesota State Medical Association Joint Practice Committee, and is submitted to their respective organizations.

A. NURSE PRACTITIONER/NURSE ASSOCIATE

1. The services of Nurse Practitioner/Nurse Associates may be available to facilitate patient care. To be identified as a Nurse Practitioner/Nurse Associate (the titles are used here synonymously) the nurse must have:

   a. Educational preparation in a university/college administered program of study with certification and/or degree credits, whose goal is to prepare the NP/NA. The programs must include supervised clinical practice and meet established guidelines for accreditation of Nurse Practitioner/Nurse Associate programs by the American Nurses Association or the National League for Nursing.

POSITION STATEMENT:

NON-INSTITUTIONAL SETTINGS

Introductory Statement

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