Approved February 10, 1983
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Senator Jan Meyers at
Chairperson

10 a.m./~~p.m.~~ on February 8, 1983 in room 526-S of the Capitol.

All members were present~~except~~

Committee staff present:

Emalene Correll, Norman Furse, and Bill Wolff

Conferees appearing before the committee:

Dr. Lois Scibetta, Kansas State Board of Nursing
Lynelle King, Kansas State Nurses' Association
Evelyn Smith, Conference Group on Advanced Practice of KSNA
Judith Hanson, Registered Nurse and Nurse Practitioner
Helen Cochran, Wichita, Kansas
Joan Denny, RN, Certified Nurse Midwife, Topeka
Bob Storey, Legislative Agent, NASW

Others present: see attached list

Bob Storey, Legislative Agent, NASW, requested that the committee introduce a bill authorizing opticians and optometrists to enter into a franchising agreement to fit contact lenses, when there is no prescription change.

Senator Ehrlich moved that such a bill pertaining to the dispensing of contact lenses be introduced. Senator Francisco seconded the motion and it carried.

SB 13 - providing for issuance of certificates of qualification for advanced registered nurse practitioners

Dr. Lois Scibetta, Executive Administrator, Kansas State Board of Nursing, testified in support of SB 13. She distributed testimony stating that the Board continues to support the concept of advanced nursing practice, and urges that SB 13 be reported favorably. The testimony also included a statement called "The President's Message", reprinted from The Journal of the Kansas Medical Society, January, 1983, and a copy of KSBN's response to that statement. (Attachment #1).

Senator Meyers asked Dr. Scibetta to define the difference between "medical practice" and "nursing practice". Dr. Scibetta said that the physician is responsible for diagnosis of diseases, and in a nursing diagnosis you are talking about a patient in terms of health status. Sometimes, because of protocols, the two overlap.

Lynelle King, Executive Director, Kansas State Nurses' Association, testified in support of SB 13, and said that this is an excellent bill. She distributed testimony stating KSNA's support of SB 13, along with a copy of an article from the Florida Journal of Medicine, and an article entitled "The Memphis Chronic Disease Program". (Attachment #2).

Ms. King introduced Evelyn Smith, Chairperson of the Conference Group on Advanced Practice of KSNA, who testified in support of SB 13. She

distributed testimony which stated that one of the greatest benefits of the role of nurse practitioners has been greater access of health care to consumers, and that good nursing care is complementary to medical care and not in competition with it. (Attachment #3).

Judith Hanson, Registered Nurse and Nurse Practitioner, distributed testimony in support of SB 13, without amendment. Ms. Hanson said that she would prefer that the nurse practitioner had a reasonable input into the care given to a patient without a law mandating that a certain function be performed "because it is a doctor's order". (Attachment #4). She also distributed testimony from Dr. William N. Haffner, Butler County Surgical Group, El Dorado, Kansas, and Katherine R. Specht, RN, MSN, Director of Nursing Services, Susan B. Allen Memorial Hospital, El Dorado, Kansas, stating their support of SB 13. (Attachments #5 and #6).

Helen Cochran, a consumer from Wichita, Kansas, testified in support of SB 13. She said she views the nurse-clinician as a liaison between the doctor and patient, and the nurse-clinician is able to take more time with a patient.

Joan Denny, RN, and certified Nurse-Midwife, testified in support of SB 13. Ms. Denny stated that she received the third ARNP registration, and had practice midwifery six years when she lost her position because of the court case and her subsequent lack of ability to practice. She said that in Kansas it is neither legal nor illegal to practice midwifery. It is in limbo, and the role cannot be expanded without some definition. She explained that a competent nurse-midwife always practices with a competent physician, and in some instances a group of nurse-midwives have incorporated and have hired physicians.

There were several questions concerning protocol with medical doctors and the training of a nurse-midwife.

Lynelle King gave a brief overview of an article about the nurse-clinician, reprinted from The Journal of the Kansas Medical Society, which summarized the benefits resulting from utilization of the nurse-clinician.

Senator Meyers concluded the public hearing.

Senator Johnston moved to introduce a bill which would allow no more people into the medical school scholarship program at Kansas University. Senator Chaney seconded the motion and it carried.

Norman Furse, Revisor of Statutes office, distributed copies of a memorandum decision involving Kansas Medical Society v. Kansas State Board of Nursing. (Attachment #7).

SB 51 - profits resulting for acts in violation of the controlled substances act subject to forfeiture

Norman Furse and Senator Bogina briefly reviewed SB 51, which allows confiscation of certain possessions if they are acquired in drug trafficking.

The meeting was adjourned.

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2-8-83

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Dr Lois Rich Lenhertz	KSBN
Judith Hanson R.N.P.	Butler County Surgical Group
Helen Cochran	Consumer
Heather Hull	RN
Sister Rose Theresa Bahr, R.N.	KU Sch of Nsg Christian Science Committee on Publication for Kansas
KEITH R. LANDIS	
Rejean Des Bois R.N., C	Women's Med. Cen. P.A. - Joint Practice OB-Gyn
Linda Schill RN-FNP	Family Practice Joint Practice - work in office with Dr Carl Tompkins - Newton
Bob Storey	Marco Optical Co.
Jennifer Carr	R.N. (S.C.M - British Midwife)
Joan Denny	Nurse-Midwife
Barbara McKenzie RN-FNP	RN - FNP
Jeanette Pericolo RN, BSN	Joint Practice with Dr Mitchell Saliens
Harold E. Kleton	Ks Assn Osteopathic Med
Michele Hinds	Legis. Intern
Judy Rummels	RN
Dick Hummel	Ks Health Care Assn.
Ken Schafermeyer	Ks Pharmacists Ass'n
Roger L. Miller	Ks Pharmacists Ass'n
Sandra J. Mitchell	Ks State Nurse Assoc

2-8-83 #1

KANSAS STATE BOARD OF NURSING

BOX 1098, 503 KANSAS AVENUE, SUITE 330
TOPEKA, KANSAS 66601
Telephone 913/296-4929

TO: The Honorable Jan Meyers, Chairman, and members of the Senate Public Health and Welfare Committee

FROM: Dr. Lois Rich Scibetta, R.N., Executive Administrator

DATE: February 8, 1983

RE: Senate Bill 13 - Advanced Registered Nurse Practitioners

Madam Chairman, my name is Dr. Lois Rich Scibetta, and I am the Executive Administrator of the State Board of Nursing. I am speaking in support of Senate Bill 13. For several years, the Board of Nursing has supported the concept of advanced nursing practice and for a short time certified Advanced Registered Nurse Practitioners.

The Board continues to support the concept of advanced practice and would urge that the Committee report Senate Bill 13 favorably. The public has a right to choose the type and extent of health care which they want and are willing to pay for.

Thank you. I will be happy to answer any questions which the Committee may have.

Attach. 1

KANSAS STATE BOARD OF NURSING

BOX 1098, 503 KANSAS AVENUE, SUITE 330
TOPEKA, KANSAS 66601
Telephone 913/296-4929

TO: The Honorable Jan Meyers, Chairman, and members of the Public Health and Welfare Committee

FROM: Dr. Lois Rich Scibetta, R.N., Executive Administrator

DATE: January 28, 1983

RE: Senate Bill 13 (ARNP) and the "The President's Message," The Journal of the Kansas Medical Society, January, 1983.

The Board wanted to bring this statement to the attention of the Committee. Please note that in paragraph two, "The District Court, in concurrence with the Kansas Medical Society position, ...etc." This statement is not exactly true. The statement implies that the court ruled on the substance of the regulations, while in fact the court ruled on the constitutional issue only. The merits of the regulations were not reviewed.

The Board also wishes to point out that we do not believe nursing practice should be supervised by physicians, nor do we believe that the physician is the director of the health care team. We recognize that the physician is responsible for medical care.

The Board of Nursing will be preparing a written statement in response to the president's message.

The Journal of the Kansas Medical Society:

Jan. 1983

The President's Message

Dear Colleague:

As the Legislature opens its 1983 session, some issues from the past remain unresolved. One such matter is the issue of nurse practitioners.

The Kansas District Court, in concurrence with the KMS position, recently voided the nurse practitioner law and regulations. In overview, the act was so vague that no one could interpret what a nurse practitioner could do and under what circumstances.

The House of Delegates has twice expressed its support for the concept of allowing nurses privileges and responsibilities concomitant to their training and experience. However, they have clearly stated that nurse practitioners should not be allowed to practice independent of physician review or supervision. KMS efforts to work with the Kansas State Nurses Association to effect a constructive compromise have been unsuccessful. Essentially, we believe the law and regulations should contain language that clearly defines the line of authority for patient care with the physician as supervisor or director of the health care team.

In order to design a new law to establish an equitable system for the delivery of optimum patient care by all members of the health care delivery team, legislators need to understand all aspects of the matter. It is important that you inform your senator and representative of your criteria for legislation that will define future medical practice in Kansas.

We will keep you advised of the status of this matter. In the meantime, your communication with your legislator is essential to our effort to bring about an appropriate resolution to this matter.

Benjamin F. Riddel MD

President

#2

KSNA
the voice of Nursing in Kansas

Statement of Kansas State Nurses' Association
by Lynelle King, R.N., M.S., Executive Director
Before the Senate Public Health and Welfare Committee
February 8, 1983

Requesting a Favorable Vote for SB 13

Madam Chairperson and members of the Committee, my name is Lynelle King and I represent the Kansas State Nurses' Association, the professional organization for Registered Nurses in Kansas. Today is a special day for us: the 71st anniversary of KSNA, which was formed in Wichita on February 8, 1912. The purpose it was formed is still one of our main purposes; to foster high standards of nursing care to citizens of Kansas. The first bill KSNA sponsored, which was passed in 1913, set up the Board of Nursing and set standards for practice of nursing in Kansas. We have a long credible history of support for legislation to uphold and increase standards - and SB 13 is true to that tradition.

As reviewed by your staff yesterday, this Committee and the Kansas legislature has repeatedly made the policy decision to support through legislation the advanced registered nurse practitioner roles. Our legal counsel assures us that the SB 13 fully meets the conditions set down by the court, taking care of the technical problems the court found with the previous law. We compliment and thank the Interim Committee and staff for the excellence of SB 13 and urge you to pass it as is, unamended.

Federal funds (from the former HEW and HHS) have been prioritized for education of advanced nursing roles for some years; the University of Kansas and Wichita State University have programs to prepare nurse practitioners; nurse practitioners work with more than 100 physicians in Kansas; as in other states, nurse practitioners, including nurse midwives and nurse anesthetists, have found high acceptance among consumers. Our conferees include consumers and physicians (in person and through letters) as well as advanced nurses:

Evelyn Smith, R.N., educator of nurse practitioners (Wichita State University)
Helen Cochran, Wichita - consumer of nurse practitioner care
Judy Hanson, El Dorado, nurse practitioner in practice with a physician (Dr. Haffner)
Dr. John Harvey, Emporia, who works with nurse practitioners
Lenore Rowe, consumer of nurse practitioner care and members of Joint Board of Health, Emporia
Abby Horak, Nurse Practitioner, Lyons County Health Department, Emporia

Attached are articles for your further understanding of the nurse practitioners' role its purposes and benefits including studies which showed patients cared for by nurse practitioners had better controlled diabetes, and high blood pressure, and decreased their need for hospitalization by 50%.

LK/mb

Kansas State Nurses Association • 820 Quincy • Topeka, Kansas 66612 • (913) 233-8638
Carolyn K. Vath, R.N., M.S. — *President* • Lynelle King, R.N., M.S. — *Executive Director*

Atch. 2

SPECIAL ARTICLE

Nurse practitioners: a national perspective

Barbara L. Nichols, M.S., R.N.

During the past 15 years, multiple social forces served as the impetus for the introduction of and support for the concept of nurse practitioners. Initial goals were increased access to care, provision of health maintenance and prevention of illness at less cost, and increase of nurses' skills, especially in the area of health appraisal. The traditional nursing role was expected to be maintained and improved by the addition of these new capabilities. As a result of these changes, both nurses and physicians have explored the mix between the *interdependence* of both nurses and physicians in the provision of health care services and the *independence* of nurses in the provision of nursing care services and the independence of physicians in the provision of medical care services.

There is, of course, nothing new in the concept of nurses and physicians working together; they have been doing so for more than 100 years. Likewise, there is nothing new in the concept of nurses and physicians working independently of each other, as they have also been doing that for almost a century. Lillian Wald's Henry Street Settlement was established in 1895, and Margaret Sanger's birth control clinic, in 1916. These are two well-known examples of nurses practicing nursing without a direct relationship with a physician..

Registered nurses provide direct care to patients utilizing the nursing process. They work in a collegial and collaborative relationship with other health professionals to determine health care needs, and they assume responsibility for nursing care. In the course of their nursing practice, they assess the effectiveness of actions taken, identify and carry out systematic investigations of clinical problems, and engage in periodic review of their own contributions to health care and those of their professional peers.

The Author

BARBARA L. NICHOLS, M.S., R.N.

Ms. Nichols is serving her second term as president, American Nurses' Association. She is Director, Hospital Wide Inservice Education, St. Mary's Hospital Medical Center, Madison, Wisconsin.

Development of Nurse Practitioner Concept • Let us examine, from an analytical perspective, the concept of nurse practitioners as it developed nationally and in the State of Florida. The role of the nurse practitioner was first demonstrated at the University of Colorado in 1965. A special educational program prepared registered nurses to obtain and record a health and medical history, to perform a physical examination, and to manage minor childhood diseases under the supervision of a pediatrician. The intent of the first nurse practitioner demonstration project was to determine the safety, efficacy, and quality of a new mode of nursing practice designed to improve health care to children and families and to develop a new nursing role — that of the pediatric nurse practitioner.[1] A similar program was established at the University of Kansas Medical Center, directed toward nurse management of adult patients with chronic illness.[2]

Nursing is a problem-solving, decision-making process, not a role or a series of competencies or tasks attributed to a title.

The initial goal in the first nurse practitioner project was to prepare nurses on the master's level for expert practice, teaching and clinical research; however, the societal demands for health care services changed that goal. Short-term, continuing education programs to prepare nurse practitioners were funded by the federal government and others. The success of these projects encouraged the development of others, and soon there were programs for family nurse practitioners, school nurse practitioners, adult nurse practitioners, and maternal nurse practitioners, among others.

The social climate of the late 1960's and the early 1970's focused on the need to provide increased access to needed health services for all citizens. In his health message of 1971, the President of the United

Continued

States noted the significant contribution that specialized nurse practitioners could make in extending health services. The Secretary of Health, Education, and Welfare (now Health and Human Services) emphasized federal support for this concept and convened a committee to study extended roles for nurses. The committee report, "Extending the Scope of Nursing Practice," was published in 1971.[3]

Numerous studies have reported on the utilization, evaluation, and patient acceptance of nurse practitioners. The studies revealed that patients accepted care by nurse practitioners very well[4,5,6] and that utilization of nurse practitioners led to increased physician productivity[7] or gained time that could be used by physicians for other purposes.[8,9]

The critical issue, however, was whether the care provided by nurse practitioners was safe, adequate, and/or of sufficient quality to ensure good patient care. In a one-year study comparing the performance of nurse clinicians under staff physician supervision and the performance of interns and residents under the same supervision, Bessman[10] reported no differences in the quality of care between the physician house staff system and the nurse clinician program as measured by specific biomedical parameters, morbidity and mortality.

To remain viable, primary health care nursing must be complementary and additive to medical care, not a substitute.

Similar results were obtained by Sackett, et al.,[11] comparing nurse practitioner care with family physician care. In that study, the close comparability of mortality rates and physical, social, and emotional function between the two groups supported the conclusion that patients randomly assigned to receive first-contact, primary care from a nurse practitioner enjoyed favorable health outcomes as compared to patients receiving conventional care.

Further validation was provided by Komaroff, et al.,[12] and Gorden[13] who studied both the care provided by nurse clinicians, and that given a control group by attending physicians in a clinic on a time appointment basis. Their studies revealed that among the patients of the nurse clinicians there were fewer lapses in care, proportionately fewer patients whose health conditions were rated as unstable one year after their initial visit, and none whose health condition was judged as deteriorated.

Hastings, Vick, et al.,[14] reported on the introduction of six primary care nurse practitioners into a large jail health service in Dade County. The system's primary care volume capacity doubled, the average cost of each patient visit decreased by about one third, and the technical quality of primary care improved continuously during a three-year period while patient outcomes, patient satisfaction levels, and overall mortality rates remained unchanged.

Florida first considered the concept of nurse practitioners in 1973, when Representative Gwen Cherry introduced H.B. 2416, which created a category of "advanced registered nurse practitioners" who had specialized preparation in an area of nursing and which allowed them to have in their possession prescription drugs for emergency use.

Nurses often have a more holistic, general psychosocial orientation, in contrast to the traditionally pathophysiological focus of physicians, as specified by medical diagnoses.

At the urging of the medical and nursing communities, further work on the bill was postponed pending a total revision of the nursing practice act. A task force established in 1974 drew from the "Criteria for Joint Position Statements on Practice" (adopted by the Florida Medical Association and the Florida Nurses Association) and also from a "Statement on the Scope of Nursing Practice" (adopted by the Florida State Board of Nursing) to develop a nursing practice act that incorporated the concept of nurse practitioners. Successful passage of H.B. 1829 in 1975 ratified the legislative commitment to the nurse practitioner concept. The title used in the legislation is "advanced registered nurse practitioner."[15]

Definitions of Nurse Care • Terms to describe nurses who give care to patients have proliferated in the past several years. Such proliferation can be related to advancements in nursing theory and in technology, as well as the desire of nurses to identify more specifically the scope of their practice. Rather than clarifying nursing practice, however, these terms and definitions have tended to confuse the levels of practice within the nursing profession as well as to confuse consumes and other professionals.

In Florida, as in other states, attempts to further clarify the issues through legislation have frequently resulted in only more confusion. Lists of proposed functions and activities perhaps appropriate in certain practice settings cannot be applied in general to all settings. The nurse practitioner concept is not one specific role. Rather, it is a composite of a variety of roles, each one composed of both basic and advanced independent nursing functions and interdependent delegated medical functions.

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Several illustrations emphasize this point. One is that of the nurse anesthetist. This practitioner is very familiar to most physicians. The nurse anesthetist is clearly performing an interdependent, delegated medical function when administering anesthesia in the operating room under the general supervision of the chief of anesthesiology. On the other hand, in preoperative teaching about effects of anesthesia or postoperative counsel on breathing exercises, the nurse anesthetist is performing an independent nursing function. However, when the nurse anesthetist functions in the delivery room, such delineations become hazy. Is the source of the interdependent delegated medical function the distant anesthesiologist or the delivering obstetrician who has no expertise in the administration of anesthesia? What if the delivery is being performed by a nurse-midwife and not by a physician?

A second example is the clinical specialist in psychiatric and mental health nursing, who is recognized as an advanced registered nurse practitioner in Florida. This practitioner may not be familiar to most physicians. The clinical specialist is prepared at the master's or doctoral level in nursing and functions primarily in an independent advanced nursing role, providing intensive psychotherapy to individuals, families, and groups. Only occasionally will this nurse refer clients to a consulting physician or psychiatrist for prescription of appropriate medication or admission into protective or residential treatment.

The increased use of geriatric nurse practitioners has been a key to improving the quality of care in nursing homes.

Yet another illustration is that of the geriatric nurse practitioner. This nurse may function as an expert practitioner, clinical teacher, consultant, and/or change agent. Her activities may include giving direct care to patients, conferring with families, teaching the nursing staff, planning and evaluating care, managing medications, and utilizing appropriate resources. The increased use of geriatric nurse practitioners has been a key to improving the quality of care in nursing homes. As one geriatric nurse practitioner commented, "What I do is separate from medicine; I practice nursing. When I'm dealing with patients, I deal with health and health behaviors. I recognize myself as accountable to the patient, his family and myself. When I feel that other professional consultations (medical, dietary, occupational therapy, dental) are needed; I tell the patient, who then decides whether to get the consultation."[16]

Although these roles — the nurse anesthetist, the clinical specialist in psychiatric and mental health nursing, and the geriatric nurse practitioner — as illustrated are quite different, in Florida as in some other states, each is recognized as an advanced registered nurse practitioner.

Primary Health Care • Many nurse practitioners provide primary health care services. In 1971, primary care was defined as (a) a person's first contact in any given episode of illness with the health care system that leads to a decision of what must be done to help resolve his problem; and (b) the responsibility for the continuum of care, i.e. maintenance of health, evaluation and management of symptoms, and appropriate referrals.[17]

The primary health care services that nurse practitioners provide include the following: (1) assessment of real and potential health hazards and current health status; (2) sound clinical judgments based on assessment of physical, psychological, emotional, spiritual, social, and environmental needs of the client; (3) analysis of health behavior related to personality, lifestyle, and culture; (4) teaching, counseling, and assisting individuals and families to assume responsibility for the prevention of illness and the promotion, maintenance, and restoration of health; (5) development, implementation, and periodic evaluation of therapeutic plans to promote satisfactory patient outcomes; (6) consultation, referral, and collaboration with other health care disciplines involved in the delivery of total patient care; (7) design, implementation, participation in, and evaluation of research activities in primary care; (8) leadership as change agents in exploring nontraditional methods of delivery of care so as to promote more comprehensive patient care while maintaining safe, high-quality, accessible health care.[18]

As a means of demonstrating accountability, the primary health care nurse practitioner contributes to and participates in the evaluation of services given, utilizes the standards of nursing practice, engages in peer review, acquires certification, participates in continuing education to maintain knowledge and skills required to function competently, and encourages the active participation of patients in attaining individual optimum levels of wellness.

To remain viable, primary health care nursing must be complementary and additive to medical care, not a substitute. The public must be informed of the distinctive contribution of nurses, and nurses must take pride in that distinctiveness. Health promotion, education for health self-care, and the optimal functioning of human beings are at the core of nursing. Just as the *content* of their respective practice differs, the *style* of practice of nurses and physicians differs. Nurses often have a more holistic, general psychosocial orientation, in contrast to the traditionally pathophysiological focus of physicians, as specified by medical diagnoses.

continued

Nursing is a problem-solving, decision-making process, not a role or a series of competencies or tasks attributed to a title. It is often the case that some tasks can be performed by more than one group of professionals. Further, a task that has been exclusively under one professional domain can readily become the responsibility of others as knowledge and use concerning it expands. There are many examples of this in health care. It is the basic nursing process that has been unrecognized and undervalued, and now urgently needs to be articulated. The future of nurses as providers of health care depends upon it.[19];

The ANA View • The American Nurses' Association considers nursing a practice discipline interested not in the diagnosis and treatment of disease, but rather in providing nursing care related to human responses to actual or potential health problems. ANA supports full utilization of nurses' knowledge and skills in acute care, in the management of chronic disease, and in the maintenance of health. ANA recognizes that nurses in practice are now providing a set of patient care services that reflect a blend of some of the diagnostic and management skills that were previously, traditionally, and publicly reserved to physicians. However, the American Nurses' Association asserts that these practitioners are first of all nurses — performers of a set of skills related to those patient responses that achieve desired outcomes of health care. The American Nurses' Association does not consider the nurse practitioner or other nurses functioning in independent settings as substitutes for physicians, and does not view such activities as being outside the scope of nursing.[20]

Expanded Roles vs. Extended Roles • Two terms have been used, sometimes interchangeably and often erroneously, in regard to the scope of nursing practice in the last decade: *expanded roles* and *extended roles*. In 1981, in *Nursing: A Social Policy Statement*,[21] the American Nurses' Association implied that "expanded role" means new additions to nursing practice that expand its boundary outward into new, heretofore uncharted territory but related to its recognized domain. Clinical specialists in nursing, for example, work in expanded roles. The term "extended role," on the other hand, means that the practice of nurses merges into or overlaps the work of some other profession. Physical assessment, when it was first taught to nurses by physicians, constituted an extended role. Nurses soon recognized the importance of adding systematic, comprehensive, physical assessments to their already well-developed psychosocial assessment skills. As practiced now by most nurses, assessment is a nursing activity to aid in data collection in order to plan for management of patient care. In much earlier days, taking a blood pressure reading was a physician activity, then an extended role of nurses, and now a routine nursing activity. There are few activities in the health care field that are not shared by more than one profession. What tends to remain constant is the phenomenological focus for the practice of the profession.[22]

Accompanying changes in practice have been corresponding changes in education. Continuing education programs for nurse practitioners served as testing grounds for curriculum and as forerunners for clinical practice in a variety of settings;[23] baccalaureate nursing programs began to incorporate these concepts into their basic curriculum. Baccalaureate nursing students are learning to develop a comprehensive data base, to make judgments on the physical and psychosocial status of patients, to record their findings, and to use these to develop and to implement nursing care plans to the level of their scientific preparation and stage of professional development. Graduate nursing students learn a specialty practice with management of care and leadership for other persons providing nursing care. They learn to direct and implement health services, interpret research findings, and consult with colleagues and consumers.

The challenge for nurses and physicians is to look to the future and to plan together for a rational system of health care delivery that will allow each profession to provide its unique functions to the consuming public.

The challenge for nurses and physicians is to look to the future and to plan together for a rational system of health care delivery that will allow each profession to provide its unique functions to the consuming public. The intersections — interprofessional and intraprofessional — are fluid, shifting, changing, and they will never be otherwise. On the other hand, the core, the focus, and the phenomena to be diagnosed and treated tend to be more stable and unchanging, and they need to be better understood and articulated.[24]

That human beings, whether healthy or ill, need nurses and physicians and their services can scarcely be denied. Both types of practitioners are needed in varying numbers and proportions. Utilizing each discipline to its fullest potential, while recognizing the differences as well as interdependence, will pave the way toward the mutual objective of both nurses and physicians: improved patient care.

continued

Acknowledgements

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● Ms. Nichols, 2420 Pershing Road, Kansas City, Mo 64108.

Special Communication

The Memphis Chronic Disease Program

Comparisons in Outcome and the Nurse's Extended Role

John W. Runyan, Jr., MD

IN PREVIOUS communications, the service program in Memphis and Shelby County (Tennessee) for the continuing care of patients with selected chronic diseases has been described.[1-3]

Since the report in 1970,[2] more than 140,000 patient-visits to the decentralized facilities have been made, and patients under regular care now exceed 9,000. The number of urban and rural neighborhood and satellite clinics, which are operated by the Health Department, has been increased to 20, with several more planned.

Although the main efforts have been service oriented and directed toward meeting the medical needs of a large chronically diseased population, [redacted] measurements of the effectiveness and acceptability of continuing care to patients in the program and its effects on the course of the chronic illnesses have been presented recently.[3] This report extends these observations but is primarily concerned with making certain comparisons between patients receiving care in decentralized facilities staffed by specially trained nurses and those rendered care in a more conventional manner in the outpatient clinics of the City of Memphis Hospitals.

PATIENTS AND CLINIC SETTINGS

These observations were made on two groups of patients with combinations of three conditions: diabetes mellitus, hypertension, or cardiac disease. The group who received their maintenance medical care principally in the decentralized facilities is called the "study group" and those who received their care in the hospital outpatient clinics are referred to as the "control group." Included in the first group were the 1,006 patients transferred from the hospital clinics to the decentralized facilities located closest to their home over a period of a year beginning Sept 1, 1969; the 498 patients who comprised the second group included all patients who met the following criteria: they had adequate records, sufficient duration of observations, the observations had been made in the same period in a hospital outpatient clinic for chronic disease, and the clinic was staffed by internists. Patients in the hospital outpatient clinic (the medical facility most convenient to their home) had been referred for continuing care after their conditions had been stabi-

Table 1.—Population Characteristics

	No. of Patients	
	Study Group* (n = 1,006)	Control Group† (n = 498)
Men	231	124
Women	775	374
Diabetes‡	797	410
Hypertension‡	515	409
Cardiac disease‡	555	226

*Maintenance care principally in decentralized facilities; mean age of patients, 59 years (range 12 to 93).

†Maintenance care principally in the hospital clinic; mean age of patients, 64 years (range, 15 to 94).

‡The sum of these numbers exceeds the total patients because of multiple diseases in the same patient.

Table 2.—Diabetes-Cardiac Disease-Hypertension Category—Diastolic Blood Pressure in the Study and Control Groups (mm Hg)

Age Group, yr	Study Group					Control Group				
	Mean Before Transfer	SE	Mean† Change	SE	P‡ Value	Mean Before Transfer	SE	Mean Change	SE	P Value
30-39	92.0	3.4	18.7	4.7	NS	...	...	...	...	...
No.	3					1				
40-49	103.0	3.8	−13.6	4.2	<.01	95.0	3.9	−2.3	3.5	NS
No.	17					8				
50-59	95.8	2.1	−7.1	2.7	<.02	95.9	2.8	0.5	2.7	NS
No.	45					35				
60-69	92.4	1.7	−7.3	2.1	<.01	88.5	1.8	0.3	2.6	NS
No.	52					38				
70-79	84.1	2.7	−6.2	2.9	<.05	86.1	2.4	0.8	2.4	NS
No.	27					44				
Over 80	90.0	6.7	−18.7	8.2	NS	80.4	4.1	−0.8	3.8	NS
No.	6					15				
Mean age, yr	61.2	0.9				66.4	0.9			
No.	162					143				

*No patients in age group 10 to 29 years had blood pressure data analyzed.

†Probability of a mean change this different from zero; NS indicates not significant at the .05 level.

‡Mean change derived from after-transfer minus before-transfer blood pressure, mm Hg.

From the Division of Health Care Sciences, departments of medicine and community medicine, University of Tennessee College of Medicine, Memphis.

Reprint requests to 800 Madison Ave, Box GA150, Memphis, TN 38163 (Dr. Runyan).

Table 3.—Analysis of Age-Adjusted Changes In Diastolic Blood Pressure and Blood Glucose—All Patients

Disease Categories	No. of Patients		Blood Pressure		Blood Glucose	
	Study	Control	F Value*	P	F Value	P
Diabetes only	94	20	...	...	13.11	<.001
Hypertension only	139	36	31.14	<.001	...	...
Diabetes-cardiac disease	14	26	...	...	0.05	NS†
Diabetes-hypertension	132	17	...	...	4.37	<.05
	158	26	6.87	<.025	...	...
Cardiac disease-hypertension	216	194	21.27	<.001	...	...
Diabetes-cardiac disease-hypertension	123	114	...	...	0.17	NS
	150	141	15.87	<.001	...	...

*With significant F values, the study group reductions in blood glucose and blood pressure were always greater than those in the control group.

†NS indicates not significant at the .05 level.

Table 4.—Hospital Days per 1,000 Patients per Year

	Study			Control		
	Before	After	% Change*	Before	After	% Change
Diabetes	3,319	1,680	−49.4	1,261	2,107	+67.1
Hypertension	2,509	1,196	−52.3	1,966	2,671	+35.9
Cardiac disease	3,074	1,560	−49.3	2,129	3,084	+44.9
Total	3,439	1,603	−53.4	2,499	3,573	+43.0

*Percent change = ([after value − before value]/[before value]) × 100.

Table 5.—Total Hospital Days—Analysis by Age Decades, Study vs Control

Age Decade	Study			Control		
	Before	After	% Change	Before	After	% Change
10-29	204	77	−62.3	60	155	+158.3
30-39	486	210	−56.8	80	169	+111.3
40-49	864	256	−70.4	271	167	−38.4
50-59	1,370	725	−47.1	504	471	−6.5
60-69	1,383	680	−50.8	602	707	+17.4
70-79	797	365	−54.2	597	1,199	+100.8
Over 80	321	138	−57.0	238	274	+16.1

lized in various other clinics in the hospital. Some had been participants in phase three drug-evaluation studies (antihypertensive and antidiabetic drugs) in the past. None of the patients was a participant at the time of these evaluations. The first clinic visit in the year beginning Sept 1, 1969, was considered the reference date or point of "transfer" of the patients. Observations extend for two years before and after transfer. As the need arose, both study and control patients were referred to the various hospital speciality clinics or to the General Medicine Clinic if a detailed reevaluation was indicated.

The two populations were of similar socioeconomic backgrounds, with comparable men-to-women ratios (Table 1). Hypertension was more prevalent in the control group while cardiac disease was more prevalent in the study group. The mean age of the study group was 59 years and of the control group, 64 years. Because of the frequent occurrence of multiple diseases in the same patients and incomplete data on some patients, the totals in the analysis of blood pressure and blood glucose vary from the figures given in Table 1.

STATISTICAL METHODS

Preliminary testing indicated minimal base-line variable differences between the study and control groups and also few differences by sex. Consequently, all comparisons were made with men and women combined. However, there were significant differences in age in some of the patient subgroups and to allow for these, age-adjusted comparisons were made. Our major interest was in the analysis of variable changes, ie, after-transfer values minus before-transfer values in the study and control groups. The significance of these variable changes within the two groups by decades of age was tested with the paired t test. Age-adjusted comparisons of variable changes in the study and control groups were made by the analysis of covariance with patient age as the control variable.

RESULTS

Clinic Visits and Professional Contacts

As previously reported,[5] professional contacts increased in frequency in the study group after transfer from the medical center to decentralized facilities with home visits. In contrast, clinic visits were found to decrease after the transfer date in the control group, with 6,488 visits/1,000 patients/yr before transfer and 5,503 visits after transfer. Accurate information on emergency room use is not available for the control group, but in the study group this use decreased.[6]

Blood Glucose and Diastolic Blood Pressure Levels

We analyzed the data relating to diastolic blood pressure and blood glucose for patients in the following disease groups: hypertension only, diabetes only, diabetes-cardiac disease, diabetes-hypertension, hypertension-cardiac disease, and diabetes-cardiac disease-hypertension.

The method of analysis of the data relating to diastolic blood pressure and blood glucose is illustrated by Table 2, which gives the data on diastolic blood pressure for the diabetes-cardiac disease-hypertension category of patients. The mean blood pressures prior to transfer and the mean changes in blood pressure following transfer are shown by age decades. The mean change in blood pressure is calculated from the patients' distribution of after-transfer values minus before-transfer values. Hence, a negative (−) value for mean change shows that the patients, on the average, had a lower blood pressure after transfer. The standard errors (SEs) of the means are also shown. The *P* values indicate whether the mean changes within a particular

age decade differ significantly from zero.

Table 2 shows that the study group of patients in all age decades except the 30- to 39-year-old age group (only three patients) had lower blood pressures after transfer and that these reductions were significant in all ages except among those 30 to 39 and over 80 years of age. In the control group blood pressures were reduced among those 40 to 49 and over 80 years of age, but none of the changes differed significantly from zero. Overall, the control group was significantly older than the study group ($P<.05$).

The data for the variable changes in Table 2 and for the other five disease groups listed above are summarized in Table 3, which shows the age-adjusted comparisons between the study and control groups.

Table 3 shows that study patients with hypertensive disease always experienced significantly greater age-adjusted reductions in diastolic blood pressure as compared to the control subjects. Reductions in blood glucose levels were found in the study group in all disease categories that included diabetes when compared to control subjects, but the F values were only significant in two disease categories: diabetes and diabetes-hypertension.

Hospital Inpatient Utilization

The number of hospital days/1,000 patients/yr for patients in each disease category in the study group for the two-year period before transfer was greater than in the control group (Table 4). In the two-year period after transfer, the study group, who were provided maintenance care in decentralized facilities, utilized approximately 50% fewer hospital days, while the control group showed an increase in hospital days for each disease category. The data relating to total hospital days in the study and control groups by age decades are shown in Table 5 and the age-adjusted changes are shown in Table 6. The analysis of the changes in hospital utilization (Table 6) after transfer in the study group showed that utilization was reduced in all age decades, whereas the control group only experienced reductions in the 40- to 59-year-old age groups.

For an overall comparison of the two groups, we tested the age-adjusted changes in hospital utilization by the analysis of covariance with the age of each patient as a control value (Table 5). The changes consisted of the number of hospital days after transfer minus before transfer hospital days in the study and control groups. This calculation showed that in all three main disease categories, the study patients had significantly reduced hospitalization compared to the controls.

Primary Causes for Hospital Utilization

The three major disease categories—hypertension, diabetes, and cardiac disease—were examined without regard to associated diseases (Table 7). We analyzed the data in these broad categories because of the relatively small numbers of patients hospitalized when broken down into the previously analyzed categories plus cardiac disease only. For the study group, some of these data in a different form have been presented but without the control group data.[1] In the study group with *diabetes*, hospital days devoted to the categories of (1) diabetic acidosis and severe infections, and (2) peripheral vascular disease and amputations declined (61% and 68%, respectively) after transfer, while in the control group the number of hospital days for the first category increased 17% and for the second category, decreased 13%. Number of hospital days resulting from vascular and renal diseases increased in both study and control groups but increased to a greater extent in the control group. In the study group with *hypertension*, hospital days for stroke, organic heart disease, and congestive heart failure decreased after transfer, while an increase occurred in the control group. Both study and control groups showed an increase in hospital utilization after transfer for patients with renal insufficiency and myocardial infarction. In those with *cardiac disease*, hospital utilization in the study group for organic heart disease and congestive heart failure decreased after transfer, while a significant increase in hospital utilization occurred in the control group. Also, hospital days for

Table 6.—Total Hospital Days—Analysis of Age-Adjusted Changes, Study vs Control

Disease Group	No. of Patients		F* Value	P
	Study	Control		
Diabetes	223	103	24.73	<.001
Hypertension	271	170	17.09	<.001
Cardiac disease	205	181	18.44	<.001

* The F values reflect a greater decrease in hospital utilization in the study patients following transfer.

Table 7.—Hospital Days per 1,000 Patients per Year

	Study			Control		
	Before	After	% Change	Before	After	% Change
Diabetes						
All causes	3,319	1,680	−49.4	2,728	4,838	+77.3
Diabetic acidosis-Infections	900	350	−61.1	587	688	+17.2
Peripheral vascular disease and amputation	626	201	−67.9	436	379	−13.1
Renal, cardiovascular	388	505	+30.2	355	1,523	+329.0
Hypertension						
All causes	2,509	1,196	−52.3	2,395	3,238	+85.2
Stroke	281	102	−63.7	72	201	+179.2
Myocardial infarction	54	56	+3.7	80	239	+198.8
Renal	56	139	+148.2	0	93	
Organic heart disease and congestive heart failure	136	131	−3.7	411	699	+70.1
Cardiac disease						
All causes	3,074	1,560	−49.3	2,594	3,739	+44.1
Myocardial infarction	89	87	−2.2	80	269	+236.3
Renal	87	216	+148.3	0	60	
Organic heart disease and congestive heart failure	366	221	−39.6	465	857	+84.3

myocardial infarction increased in the control group.

Mortality

Although a two-year period of observation has limited value in terms of mortality data, 7% of the study population and 11% of the control population died in this period. As would be expected, those 70 years of age and older had the higher death rates in both study and control populations. However, there were no statistically significant differences in death rates in the two populations when examined by age decades.

COMMENT

A number of factors may have contributed to some of the differences in the measurements, observations, and patient-care experiences in the two populations with combinations of the three conditions: diabetes, hypertension, and cardiac disease. Were the study and control populations dissimilar enough to account for these differences? The mean age in the control group was significantly higher than that in the study group. However, comparisons were made by age decade and analysis of covariance that removed age differences as a factor in the observed outcome. On the other hand, in examining some of the clinical features of the diabetic population in the preceding two years, it was seen that incidence of a history of diabetic acidosis and amputations was higher in the study group than in the control group; also, the study group had higher blood glucose levels before transfer and more days spent in the hospital. In both the *hypertensive and cardiac disease* populations, hospital utilization was greater for the two-year period before transfer in the study group than in the control group. Hospital utilization for renal disease with its recognized relationship to both diabetes and hypertension was more prevalent in the study population before transfer. Although the problems of relating two populations with multiple risk factors are recognized, the data do not suggest that the study population were at less risk than the control population, and there is evidence that the opposite may have been the case.

Those in the study group received maintenance care in decentralized facilities by nurses, and therefore, several factors were introduced that are considered to have favored the outcomes observed. Professional care and advice are easier for the patients to obtain when the barrier to care of a rigid appointment system, characteristic of the hospital clinic, is removed. Patients are given the opportunity to call, if in need of medical assistance, and appropriate advice is given or home visits are made, if found advisable. During 1973, more than 8,000 home visits to these chronically diseased patients were made. The same medical protocols and opportunities to obtain selected laboratory tests prevail whether the patient is seen in the decentralized clinic or home. Missed appointments are followed up. Drugs are actually dispensed directly to the patient when being seen by the nurse, which gives the opportunity for patient education and counseling, and it is believed that patient compliance is greatly enhanced as a result. Goals of therapy for hypertension and diabetes and the means to achieve them are stipulated in the protocols used by the nurses. Physicians' attitudes toward hypertensive therapy have been commented on,[4] even though the benefits of therapy have generally been recognized since reports of the Veterans Administration study on hypertension conducted by Freis.[7,8] In in-service training sessions and the protocols, the early recognition of cardiac failure and digitalis intoxication with appropriate follow-up action is emphasized to the nurses, and this factor may contribute to the favorable experience with patients with cardiac disease in the study group.

Prevention of diabetes and essential hypertension is not a reality at present. Control of these diseases, which is possible but not always attained in a public hospital setting, leads to a reduction in those complications that are associated with increased mortality, morbidity, and hospital utilization.[7-9] The Memphis Chronic Disease Continuing Care Program makes available to patients in a systematic manner the basics of good medical practices: accessibility to care, patient education and counseling, follow-up, home visits, selected effective medications, laboratory test monitoring at intervals, realistic goals of therapy, and appropriate referrals and contacts with the back-up physicians and the medical center.

The observations in this report give further support to the concept introduced nearly 12 years ago that nurses can effectively share a large and increasing responsibility in chronic disease care. In the EDITORIAL in THE JOURNAL[3] relating to the Memphis Program, the question was asked "should the nurse, even after special training, have this much autonomy in the regulation of uncontrolled glycosuria, the delicate balancing of blood pressure between too high and too low with potent antihypertensive drugs and the adjustment of digitalis dosage?" With detailed protocols and physician and medical-center backup, the data presented here indicate that this question can be answered in the affirmative.

These investigations were supported in part by a grant from the Robert Wood Johnson Foundation.

George S. Lovejoy, MD, Director of the Memphis and Shelby County Health Department and the staff of City of Memphis Hospital, helped in program development and collection of data. Marion G. Baker assembled the data. Harry Robinson, ScD, assisted with statistics.

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My name is Evelyn Smith. I am chairperson of the Conference Group on Advanced Practice of KSNA. I am an educator of advanced practitioners at Wichita State University and also a family nurse practitioner in practice.

I would like to thank the interim Health and Welfare Committee members and staff who gave considerable time and thought to the ARNP legislative issue this past summer.

The role of advanced nurse practitioner has been in existence since 1965. In Kansas we are fortunate to have the training of nurse practitioners in University settings. This has given considerable credibility to the role. One of the greatest benefits of the role has been greater access of health care to consumers. That was the reason for the inception of the role. Since that time nurses have found a unique opportunity to expand on their former nursing skills to meet gaps in the health care system. Good nursing care is complementary to medical care not in competition with. Teaching in areas of family problems, health counseling, parenting roles are some of the skills which are taught to nurses. They are also taught the limitations of the role.

Too much emphasis has been placed on the medical regimen in this issue. The advanced education and training a nurse receives to teach patients about health, prevention of disease, parenting, nutrition are areas which were formerly ignored in health care and not received by this generation from family due to growing mobility and distances between members of the extended family.

Fears of some physicians that nurses will over step their bounds are ungrounded by the fact that suits have not appeared in the courts in Ks. Judge Allen ruled on the language of the old bill not on the practice of ARNPs.

There are approximately 135 physicians that I know of working with nurse practitioners in the State of Kansas in either physician offices,

community health settings or minor emergency rooms. This figure is taken from Wichita State University lists of graduates. Those from KU added to that should make a sizable list.

In an evaluation study I conducted this past year between August and December, 112 questionnaires were sent to physician employers in order to measure their opinions about nurse practitioners. As in any questionnaire, response rate is low. But from the 36 who did respond, 100% felt that the nurse practitioner was adequately prepared for the role. One hundred percent felt that their patients accepted the nurse practitioner. One physician commented that though the purpose of employment of a nurse practitioner was not to increase the number of patients seen, employment had indeed increased the number of patients seen. Another stated he was surprised at the satisfaction he received from his job after working with a nurse practitioner. Seventy percent stated there was an increase in the amount of patient education given to patients. Eighty-four percent agreed that employment of a nurse practitioner allowed them to concentrate on more complex cases. Eighty-five percent strongly agreed that they were able to see more patients with a nurse practitioner in the office. These physicians were asked about nurses taking call. They did not feel it was the responsibility of the role for nurse practitioners to take call.

I think the examples I have cited indicates that physicians and nurses working together for better health care has been a reality and that together they have worked out where the thrust of each other's role should be.

I am in favor of passage of SB 13 in order to continue the ARNP status in Kansas.

#4

BUTLER COUNTY SURGICAL GROUP P.A.
GENERAL, VASCULAR & THORACIC SURGERY
OFFICES
105 EAST 5TH
AUGUSTA, KANSAS 67010
PHONE 775-6391
123 NORTH ATCHISON
EL DORADO, KANSAS 67042
PHONE 321-5630
WILLIAM N. HAFFNER, M.D.
YONG U LEE, M.D.

February 7, 1983

Senate Health & Welfare Committee
State House
Topeka, Kansas 66612

Fellow Kansans:

I am a Nurse Practitioner currently practicing in a Surgical - Emergency setting in El Dorado, Kansas. This is not a job, this is a profession.

In my role as an advanced nurse I have a great deal of patient contact with emphasis on thorough patient education, histories and physicals, laboratory & radiological studies and assistance in appropriate surgical cases as so designated by the surgeons in my group.

I do work under protocols as established between the surgeons and myself with the emphasis being placed on improved quality and quantity of care given to the patient.

I do ask your support for Senate Bill 13 and that the supervisory role by the physician be left in the Rules & Regs. I have an outstanding professional relationship with the surgeons at Butler County Surgical Group and I support them as well as my profession. I would not like to see a Nurse Practitioner in a setting where the statute may present a problem for the Nurse Practitioner to function or perform professionally and appropriately in a situation that the Nurse Practitioner may feel uncomfortable with regard to nursing judgements or standards or be pressured into performing occasional procedures or actions that are not agreed upon collaboratively between the physician and Nurse Practitioner. I would prefer that the Nurse Practitioner had a reasonable input into the care given to a patient without a law mandating that a certain function be performed "without questions asked" or because it is "a doctor's order".

I feel that a good working relationship between the physician and the Nurse Practitioner does not present the above stated problem -- but the problem does indeed exist as many nurses so well have experienced.

I enjoy patient contact and felt a need for furthering my education to improve the quality of care I could give to patients. I have obtained this through expanded nursing conferences, seminars and courses - some of these courses are physician level courses that I attend along with the surgeon but again the main emphasis is on quality of care given to the patient. I feel a responsibility to society to give them the best medical-nursing care and the advanced nursing level presents an excellent media for this.

I want the ARNP to remain in effect to allow for control of the Nurse Practitioner role and title to one who is educated, trained, and licensed to do so and not to be given to anyone who intends to assume such a title without meeting the educational requirements or qualifications for the advanced level nurse.

Respectfully submitted,

Judith Hanson R.N./N.P.

Judith Hanson, R.N., N.P.

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#5

BUTLER COUNTY SURGICAL GROUP P.A.

GENERAL, VASCULAR & THORACIC SURGERY

OFFICES

105 EAST 5TH
AUGUSTA, KANSAS 67010
PHONE 775-6891

1200 NORTH ATCHISON
EL DORADO, KANSAS 67042
PHONE 321-5630

WILLIAM N. HAFFNER, M.D.

YONG U. LEE, M.D.

February 7, 1983

Senate Health & Welfare Committee
State House
Topeka, KS 66612

Gentlemen:

This letter is being written in regard to Senate Bill #13. I wish to make two points in regard to this bill:

#1 Support of Advanced Nursing.
#2 Control of Advanced Nursing.

The Butler County Surgical Group, P.A. has had a Nurse Clinician in its' employ for approximately eighteen months. The purpose of hiring a Nurse Clinician (Nurse Practitioner) had three goals; #1 Increase quality of patient care, #2 Better utilization of physician time and #3 Reduction of physician liability by more careful and thorough patient education. In all three areas the Nurse Clinician concept has worked extremely well. Patients have received the Nurse Clinician very well, and have been impressed with the increased quality that she adds to the physician group. The physicians of the group have been able to better utilize their time by turning their attention to more serious and difficult surgical problems. There has also been a significant reduction of physician liability through patient education by significantly improved informed consent, post-operative instruction, and generally improved physician/patient relationship. I strongly advocate the development and proper use of the Nurse Clinician.

Regarding the control of advanced nursing, historically the professions of nursing and physicians have always worked together for the sole objective of the highest possible quality care for the patient. I firmly believe that any movement to segregate the two professions would result in fragmentation of patient care and therefore deterioration of quality. Nursing is gradually moving out of the hospital environment creating some of the current-day controversies. I firmly believe that if physicians and nurses are allowed to work independently, patient care will fragment and therefore deteriorate. For that reason, I strongly feel that any movement that would allow nurses to practice independent of physicians would be detrimental to the patient and therefore oppose the concept of working independently.

Thank you for your attention.

Sincerely,

William N. Haffner, M.D.

William N. Haffner, M.D., F.A.C.S.

WNH/mh

Atch. 5

SUSAN B. ALLEN MEMORIAL HOSPITAL
EL DORADO, KANSAS 67042

February 7, 1983

Senate Health and Welfare Committee
Kansas State House
Topeka, Kansas 66612

Senators:

This letter acknowledges my support of Senate Bill 13, as it is now written. The supervision role by the physician must continue to be defined in the Administrative Regulations of the Kansas State Board of Nursing, not mandated by a law.

The Advanced Registered Nurse Practitioner role is a vital function in the acute care hospital setting. The quality of individualized nursing care to the patient is greatly improved and hospital nursing staff benefits serendipitously from the ARNP's increased knowledge and clinical expertise.

Thank you for your attention.

Sincerely,

Katherine R. Specht

Katherine R. Specht, R.N. M.S.N.
Director of Nursing Services

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2-8-83 47

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IN THE DISTRICT COURT OF SHAWNEE COUNTY, KANSAS
Fourth Division

KANSAS MEDICAL SOCIETY, Plaintiff,	)	
v.	)	No. 81 CV 647
KANSAS STATE BOARD OF NURSING, Defendant.	)	

MEMORANDUM DECISION

This action was commenced by the Kansas Medical Society against all of the members of the Kansas State Board of Nursing, hereinafter referred to as the Board, in their official capacities for judgment pursuant to K.S.A. 77-434 and K.S.A. 60-1701, et seq declaring K.A.R. 60-10-101 to 60-10-109, inclusive, invalid and for an injunction barring any further use or implementation of said regulations or, in the alternative, declaring K.S.A. 65-1113(g) and K.S.A. 65-1128 unconstitutional and invalid and the regulations promulgated pursuant to said statute are also invalid.

This case was submitted to the Court upon a written stipulation which was filed March 15, 1982, the depositions of Elaine B. Harvey and Orpha Patricia Diamond, answers to interrogatories propounded to the defendants, documents furnished in response to plaintiff's request for production of documents, 1977 Interim Committee minutes of the Special Committee on Public Health and Welfare of the Kansas Legislature, minutes of the meetings of both the house and senate committees on Public Health and Welfare of the Kansas Legislature held during the 1978 legislative session, the briefs of the parties prepared by counsel with attached exhibits and arguments of counsel heard by the Court May 4, 1982, all of which has been carefully considered by the Court.

K.S.A. 65-1113(g) and K.S.A. 65-1128 were enacted into law by the 1978 session of the Kansas Legislature as a part of Chapter 240 of the Laws of Kansas of 1978 which amended the law of Kansas relating

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to the examination, licensure and regulation of nursing in Kansas.

Prior to the 1978 amendments to the law, Kansas law provided for the examination, licensure and regulation of professional nurses and practical nurses, as defined by the statute. The 1978 amendments to the law added a new classification of nurse called "advanced registered nurse practitioner" or "ARNP" which is defined by K.S.A. 65-1113(g) as follows:

> "'Advanced registered nurse practitioner' or 'ARNP' means a registered professional nurse who holds a certificate of qualification from the board to function as a registered professional nurse and in an expanded role, and such expanded role shall be defined by rules and regulations adopted by the board within the scope of the provisions of article 11 of chapter 65 of the Kansas Statutes Annotated and acts amending the provisions thereof and acts supplemental thereto."

K.S.A. 65-1128 which was new section 2 of Chapter 240 of the Laws of Kansas of 1978 provides for certification as an ARNP, as follows:

> "No registered professional nurse shall announce or hold himself or herself out to the public as an advanced registered nurse practitioner unless he or she has complied with requirements established by the board and holds a valid certificate of qualification as an advanced registered nurse practitioner in accordance with the provisions of this section.
>
> "The board shall establish standards and requirements for any registered professional nurse who desires to obtain a certificate of qualification as an advanced registered nurse practitioner. Such standards and requirements shall include, but not be limited to, standards and requirements relating to the education and training of advanced registered nurse practitioners. The board may require that some, but not all, types of advanced registered nurse practitioners hold an academic degree beyond the minimum academic requirement for qualifying for a license to practice as a registered professional nurse. The board may give such examinations and secure such assistance as it deems necessary to determine the qualifications of applicants.
>
> "Upon application to the board by any registered professional nurse in this state and upon satisfaction of the standards and requirements established by the board, the board may issue a certificate of qualification to such applicant authorizing the applicant to hold himself or herself out to the public as an advanced registered nurse practitioner and to perform the duties of an advanced registered nurse practitioner. The application to the board shall be upon such form and contain such information as the board may require and shall be accompanied by a fee, to be established by rules and regulations adopted by the board, to assist in defraying the expenses in connection with the issuance of certificates"

"of qualification as an advanced registered nurse practitioner, but the fee shall not be less than thirty dollars ($30) nor more than fifty dollars ($50) for an original application, and not more than twenty dollars ($20) for the renewal of a certificate of qualification as an advanced registered nurse practitioner. The secretary-treasurer of the board shall remit all moneys received by or for him or her pursuant to this section to the state treasurer as provided by K.S.A. 74-1108."

K.S.A. 65-1113(g) provides that an ARNP is a registered professional nurse who holds a certificate from the board of nursing to function in an "expanded role" and that such "expanded role" shall be defined by rules and regulations adopted by the board of nursing within the scope of article 11 of Chapter 65 of K.S.A. The term "expanded role" is not defined by any of the provisions of article 11 of Chapter 65 of K.S.A. and therefore, in sum, by virtue of article 11 of Chapter 65, as amended by the 1978 legislature, an ARNP is a registered professional nurse certified by the board to function in an "expanded role" as defined by rules and regulations adopted by the board of nursing.

In response to the enactment of K.S.A. 65-1113(g) and K.S.A. 65-1128 the board adopted K.A.R. 60-10-101 to 60-10-109, inclusive, providing for categories, qualifications, functions of the ARNP and providing for certification and requirements for advanced registered nurse practitioner programs of study as well. A copy of K.A.R. 60-10-101 to 60-10-109, inclusive is attached and incorporated herein.

The plaintiff has attacked the constitutionality of K.S.A. 65-1113(g) and K.S.A. 65-1128, and since the rules adopted by the board were adopted by virtue of the authority of these statutes which are under constitutional attack in this case, it seems that the consideration of this case should logically commence with a consideration of whether these statutes are constitutional. The plaintiffs claim that K.S.A. 65-1113(g) and K.S.A. 65-1128 are unconstitutional is based upon Article 2, Section 1, of the Constitution of the State of Kansas which provides:

"The legislative power of this state shall be vested in a house of representatives and senate."

Though the legislative power of the state belongs to the legislature, the Supreme Court said in its opinion in the case of Gumbhir v. Kansas State Board of Pharmacy, 228 Kan. 579 (1980), at page 584:

> ". . .it appears the legislature may enact general provisions for regulation and grant to state agencies certain discretion in filling in the details, provided it fixes reasonable and definite standards to govern the exercise of such authority."

In the case of State ex rel v. Bennett, 222 Kan. 12, (1977), a case cited by the plaintiff, the Supreme Court was confronted with the issue of the sufficiency of the legislative standards established by the legislature for the control of delegated legislative power. The court's opinion referred to the definition for such standards which is found in another case cited by the plaintiff, State ex rel v. Hines, 163 Kan. 300 (1947) at page 309 which is quoted as follows:

> "Standards are difficult to define because of the variable nature thereof. They have been referred to as conditions, restrictions, limitations, yardsticks, guides, rules, broad outlines and similar synonymous expressions hereinafter set forth. It has been held that in the creation of administrative tribunals the power given them must be 'canalized' so that the exercise of the delegated power must be restrianed by banks in a definitely defined channel. Ordinarily the standards must be sufficiently fixed and determined so that in considering whether a section of a statute is complete or incomplete the test is whether the provision is sufficiently definite and certain to enable one reading it to know his rights, obligations and limitations thereunder. For present purposes it may be said that a standard is a definite plan or pattern into which the essential facts must be found to fit before specified action is authorized. We can be certain of one test--a legislative fiat which provides that an administrative agency shall consider the elements which might affect legislation and then act as it sees fit--does not fix a standard."

Though this definition of standards may contain grey areas, it is clear that any delegation of legislative power must be limited and any delegation of legislative power which permits an administrative agency to act as it sees fit is not sufficient and is in invalid

under Article 2, Section 1 of the Constitution of the State of Kansas which reserves the legislative power of this state to the legislature.

Article 11 of Chapter 65 of K.S.A. does not define the term "expanded role" and therefore the board is permitted to expand the role of an ARNP to any extent it sees fit. There is no limitation of the extent to which the role of the ARNP may be expanded by the board and therefore the delegation of legislative authority under K.S.A. 65-1113(g) and 65-1128 does not fix standards which are necessary to govern the exercise of the authority delegated to the board under the constitution.

It is therefore the judgment of the Court that K.S.A. 65-1113(g) and K.S.A. 65-1128 are unconstitutional and invalid because these statutes violate Article 2, Section 1 of the Constitution of the State of Kansas, and that K.A.R. 60-10-101 to 60-10-109, inclusive, promulgated under said statutes are also invalid.

This memorandum shall serve as the Journal Entry.

Dated this 21st day of June, 1982.

Adrian J. Allen, Judge -
Fourth Division District Court
Shawnee County, Kansas