Approved 1-24-89
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by SENATOR ROY M. EHRLICH at
Chairperson

10:00 a.m./p~~m~~. on January 18, 1989 in room 526-S of the Capitol.

All members were present except:

Committee staff present:
Bill Wolff, Legislative Research
Norman Furse, Revisors Office
Clarene Wilms, Committee Secretary

Conferees appearing before the committee:
Carla A. Lee, R.N., C, Ph.D.
Joleen Zivnuska, Legislative Chairman, ARNP Task Force
Judy Reno, R.M., B.S., C.N.A., Director of Personal Health Division for Wichita-Sedgwick County Health Department
Dr. Lois Scibetta, Executive Administrator, Kansas State Board of Nursing
Terri Roberts, Executive Director, KSNA
Charlotte Peake, Family Nurse Practioner, Belleville
Cherie Branson, R.N., ARNP, MS, Director of Student Health Center, Pittsburg State University
Susan Amrein, Certified Family Nurse Practioner, Hays presenting written testimony from Richard L. Rajewski, M.D.
Written testimony by Evelyn M. Maxwell, MN, R.N., Salina

Chairman Ehrlich called the meeting to order and corrected his statement concerning committee voting on bills, stating that no vote would be taken unless a majority of committee members were present.

Carla A. Lee, appeared before the committee and also presented written testimony (Attachment 1). Ms. Lee stated that she conceptually supported SB-23 but stated the need for defining "transmit" 65-1130, line 74. Replacement of line 198-200, as previously approved, would still be relevant with some revision, such as the addition of the word "transmit."

Joleen Zivnuska testified and presented written testimony (Attachment 2) stating she worked as an OB/GYN Nurse Practitioner at Wesley Medical Center which primarily serves poverty level, indigent consumers in the Sedgwick County area, as well as many rural consumers. Ms. Zivnuska stated that prescribing per protocol has been an accepted part of practice for over a decade. Recently there has been an effort to clarify and codify the understandings under the which Nurse Pradtitioners practice. It was further stated SB-23 is not satisfactory because it fails to make the necessary distinctions. It should be explicit in allowing Nurse Practioners to prescribe per protocol as they have been doing and it must limit authority to prescribe per protocol only in conjunction with the attending physician and must expressly prohibit independent prescriptive authority.

Judy Reno testified and presented written testimony (Attachment 3). Ms. Reno related many areas where nurse practitioners function in clinics at costs far less than full-time physicians, staff health departments to serve both urban and rural medically indigent, prenatal clinics in rural Kansas and provides family planning services. Senate Bill 23 would inhibit or modify the use of Nurse Practioners' special competencies rather than facilitate the practice (the transmittal of prescription orders through jointly-developed protocol).

Dr. Lois Scibetta presented written testimony (Attachment 4) and stated that her organization felt SB-23 resulted from a misunderstanding between the joint Rules and Regulations Committee, attorneys and the Board of Nursing. The Board recently promulgated regulations 60-11-104 (a) to define Protocols and

standing orders which would allow the advanced Nurse Practitioner, under physicians' orders, (protocols) to prescribe for the patient based upon presenting physical symptoms. Should SB-23 be passed, it would result in the loss of essential services to clients, in the most vulnerable areas, the rural recessed of our state. The Board objects to lines 72-75 as the word "transmit" is not defined in the Pharmacy Act. Staff questioned the intent of items 3 and 4 Exhibit A. It was stated it was never the intent to ask for independent prescription of drugs.

Mrs. Jackie Phillips, public member of the Board of Nursing, told the committee that the ARNPs are serving in a very important capacity helping to ease the problem of lack of medical service in many rural areas. She further stated that the committee attempted to make, as clear as possible, the fact that they are nurses who want to serve under good regulations that specify what they may and may not do and requested consideration of the regulations. The committee questioned whether or not these nurses carry liability insurance and were told the nurse anesthestists were required to carry insurance and the others did so for their own protection. The training program for ARNPs has been discontinued both at Wichita State University and University of Kansas. Mrs. Phillips was asked whether or not the permanent rules and regulations were reviewed and was assured they had been. It was also requested by Senator Reilly that the insurance information be furnished to the committee concerning costs now and under an expanded practice.

Terri Roberts, KSNA, presented written testimony (Attachment 5) containing an Attorney General's Opinion, various documents relating the chronology of events for the past three years concerning the issue of ARNPs and told the committee that the Joint Committee on Administrative Rules and Regulations had submitted this bill for legislative consideration in an attempt to clarify the issue of whether or not ARNP's-Nurse Practitioners, may prescribe medications under standing orders and protocols jointly adopted with a collaborating physcian. It was further stated that SB-23 does not present a clear message regarding ARNP's prescribing under standing orders and protocol and requested rewording to accurately reflect the current practice of writing prescriptions based on standing orders and protocol jointly adopted with their collaborating physician.

Charlotte Peake presented written testimony (Attachment 6) and told the committee she was employed as a Family Nurse Practitioner working in a collaborative practice with two family practice physicians. Ms. Peake stated she follows protocols developed by the physicians and herself, not one which she had chosen independently but does not consult the physician each time she sees a patient, but relies on protocols. Senate Bill 23 would nullify the regulatory language change adopted by KSNA and would place constraints on nurse practitioners practice severely limiting their effectiveness as health care providers.

Cherie Branson, ARNP, stated she was in opposition to SB-23 within the boundaries of its present language stating ARNPs work under carefully designed protocol jointly developed with the attending physician. It was also stated that any deviation from the structured plan of care necessitates a consultation with the attenidng physician. Senate Bill 23 would not permit the continuation of the utilization of prescription privileges per protocol. (Attachment 7)

Susan Amrein spoke to the committee and presented written testimony from Richard L. Rajewski, M.D. (Attachment 8). Dr. Rajewski stated SB-23 was very important to physicians in rural communities and he and his partners had found ARNP's unequivocally qualified to distinguish simple disease states from more advanced or severe disease states and found excellent public acceptance of their role. He stated he was concerned over the constrictive attitude of this bill and urged the modifications necessary to allow ARNP's to continue prescribing medications as they and physician assistants have done in the past.

CONTINUATION SHEET

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 526-S, Statehouse, at 10:00 a.m./p.m. on January 18, 1989.

Written testimony was submitted by Evelyn M. Maxwell, MN RN, suggesting that SB-23 as proposed be rejected as it complicates a system of delivering medical care that is working well and is much needed to improve rural health care through the more extensive use of nurses in collaboration with physicians. (Attachment 9)

The meeting adjourned at 11:03 a.m. and will convene Thursday, January 19, at 10:00 a.m. at which time testimony on SB-23 will continue.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE January 18, 1989

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Dr Lois R. Scibetta	KSBN
Jacquelyn Phelps	KSBN
Richard N. Gannon	Bd of Healing Arts
Larry Buening	
Mark Intermill	Kansas Coalition on Aging
Robert C. Guthrie Topeka	Alzheimers Disease Assc. Topeka Chapt.
Sterling Waggener "	Self
Juanita Cadra Lawrence	Saunders Dan Snyder, Physicians Assistants
Charmaine Peake CFNP	Belleville Medical Clinic
Dennis Jackett CFNP	Concordia, KS
Susan Ameen CFNP	Hays, Ks
Kathy Douglas, CFNP Hays	Fort Hays State U.
Mary Hansen CFNP, ARNP Hays	Hays Family Practice Clinic
Maryjo P. Schmidt RN CFNP	Topeka Ks
Judy Reno	Wichita-Sedg. Co. Health Dept.
Patsy Zuint	Wichita Kansas KSN & Advanced Practice Nurses Group
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS
Robin Smith, Topeka	SRS
Delora Donovan Wichita	CRNA

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE January 18, 1989

(PLEASE PRINT) NAME AND ADDRESS		ORGANIZATION
Harold Riekm	Topeka	KAOM
Anne Smith	Topeka	Heinz Ebert - KAMFT
Jean McBride	Topeka	Observer
Charles Konigsberg, M.D.	Topeka	KDHE
[illegible]	Topeka	KDHS
Tom Bell	Topeka	KHA
Bob Williams	Topeka	Ks. Pharmacist's Assoc.
Tom Hitchcock	Topeka	Bd. of Pharmacy
Cary Robbins	"	KOA
Ruth Wilkin		Girl Scouts
Carla Lee		KSSN.
Rebecca Rice		KSDS
Marilyn Braeutt		KUAH

January 18, 1989

Dear Chairman Ehrlich, members of Senate Committee on Public Health and Welfare, and other conferees:

My name is Carla A. Lee, RN.,C, Ph.D., an advanced registered nurse practitioner, serving on the KSBN ARNP Committee now for approximately 5 years. Additionally, I have been working with the development of ARNP's since approximately 1969 through KRMP funded programs, federally-funded programs for Kansas, chair of the WSU Nurse Clinician Program (1973-84), and professional organization activities.

I speak in appreciation for the very strong support that the development of ARNP has and is given by the Kansas legislators. This concept was born from the 3 distinct concerns, all germane to Kansas, i.e. maldistribution of physicians; underserved clients, especially with regard to primary health care; and rural health care delivery problems. Additionally, the expected refinement of the services of health professionals emerged in the expansion of professional nursing services through the rubric of the concept of "expanded role nursing." I wish to acknowledge that the State of Kansas is a PIONEER state in formally supporting the utilization of Nurse Practitioners, noted in formalization of their role in the State Health Plan, as early as 1974, and inclusion in the Governor's Legislative Message, 1978. I also wish to acknowledge the serious and exquisite support given by the legislature in supporting the revision of the NPA as early as 1972, followed by 10 years of work to properly develop statutory and regulatory law authorizing and regulating this practice through the KSBN. Much effort and collaboration has existed with the legislative branch, other medical and health organizations, and nursing groups to effect this necessary role for a state, highly concerned with rural needs and health care.

I also wish to share that nurse practitioners serve in urban, primary care and underserved programs. But more importantly, the "experience", i.e. Proposal 60, DID work, as nurse clinicians, for example, from the WSU program were placed in 60 counties of Kansas. Approximately 200 Kansans were educated for Kansas sites, about 75 out-of-state persons, funded mostly from federal funds, were prepared, with several of these, post-program, selecting to remain in Kansas. The facilitation of appropriate laws was an important variable in placement and maintenance of persons in this role in Kansas, especially RURAL Kansas.

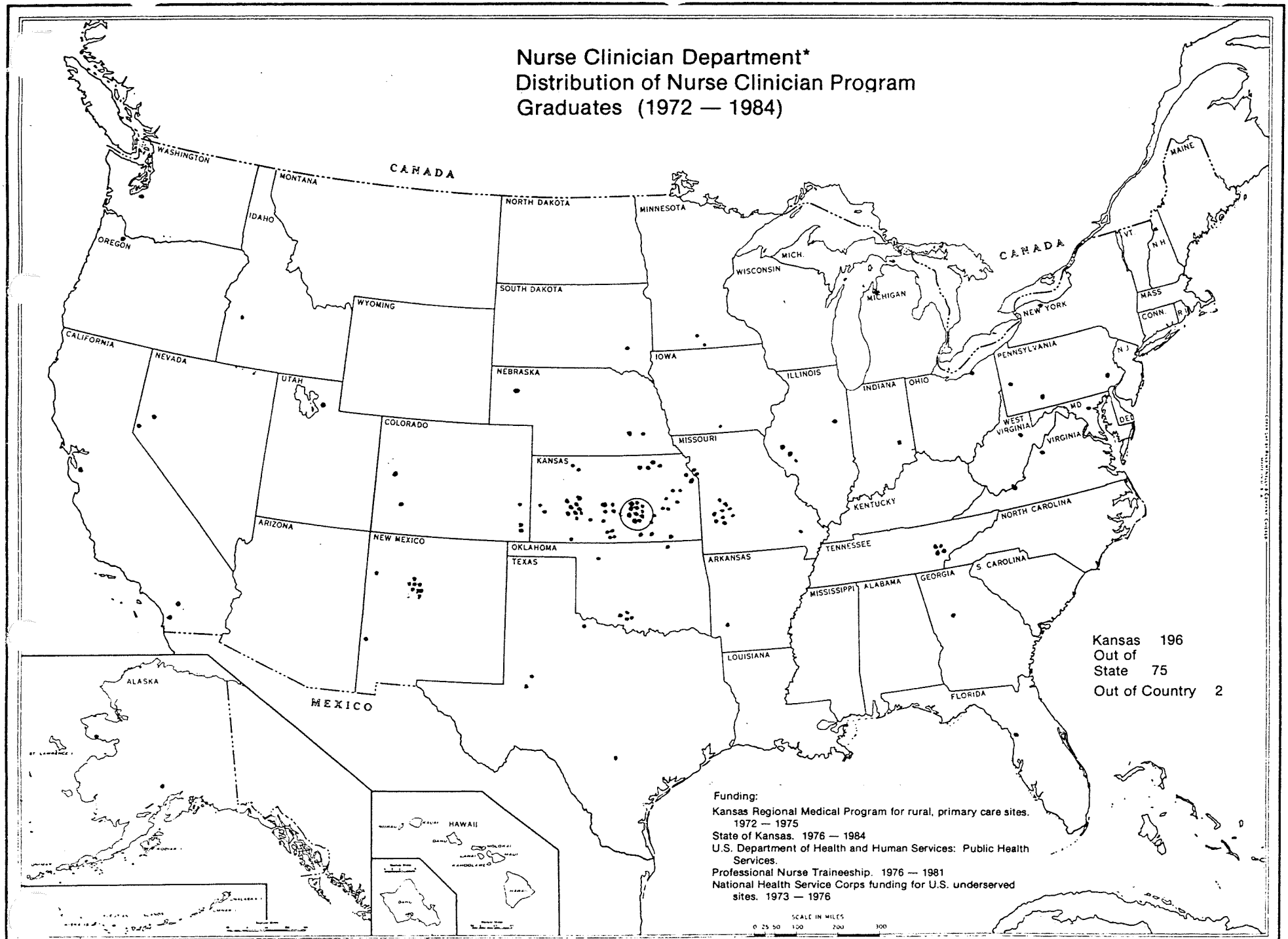
Thus, I speak in conceptual support of your current efforts regarding SB 23, concerning prescription orders, persons authorized to issue prescription orders, and concurrent pharmacy statute. Per the revision of KSA 65-1626x, passage of SB 779, 1986, the definitions of who was authorized to issue prescription orders was changed. Subsequently, the KSBN worked diligently to re-define protocol and regulations germane to ARNP practice.

It is important to note that the ARNP's have asked for only transmittal of protocol from the INCEPTION of this role, through jointly developed system with physicians. The perception of request for independent prescription has not been the case for the ARNP group. Thus, however the terminology can be written to facilitate this practice, i.e. the transmittal of prescription orders through jointly-developed protocol, I encourage you to do this. Please note in 65-1130, line 74, that the word "transmit" is utilized, which is appropriate for ARNP's, and yet in KSA 65-1626 the word is never defined. Protocol has been precisely defined in KAR 60-11-104 (a), the latter recently approved. Additionally, the replacement of line 198-200, as previously approved, would seem to still be relevant with some revision, such as the addition of the word transmit. If this language, i.e. transmit, is not determined to be relevant, please consider appropriate language that will continue to exercise your strong support for the utilization of nurse practitioners in the State of Kansas, especially in rural sites, community health departments, school settings, and clinics. The research findings of the KSBN committee found national support for the approval of said practices. Thanks for your continuing concern about the health care of Kansas, especially in rural settings.

Carla A. Lee

SPH&W
1-18-89
Attachment 1

WSU College of Health Professions



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ARNP COMMITTEE FACTS

Introduction

The American Nurses' Association, Social Policy Statement (1980) indicated that "Specialization is a mark of advancement of the nursing profession....Specialization means a narrowed focus on a part of the whole field of nursing. It entails application of a broad range of theories to selected phenomena within the domain of nursing, in order to secure depth of understanding as a basis for advances in nursing practice...." "As early as 1910, in the American Nurses' Association convention proceedings, nurses were referred to as specialist...these designations, however were based upon practical experience or indicated completion of hospital-based 'post-graduate' courses in the area of nursing....by the early 1940's...the National League for Nursing Education established a committee to study the matter. The committee produced guidelines for advanced courses in nursing."

The ARNP Committee of the Kansas State Board of Nursing recommends the following findings of fact:

The training and education required for a certificate of qualification as an advanced registered nurse practitioner prepares the nurse practitioner-nurse clinician to perform the function allowed by the proposed regulation.

Swart (1983) reported on the 1965 collaboration of a nurse and physician to develop a nurse practitioner (NP) program. This program was an expanded role with the development of the nurses' skills in physical assessment, patient teaching and well-child care under supervision. Swart further states that "Registered nurses are prepared through formal educational programs to expand the nursing role toward more comprehensive, independent practice, with direct responsibility to the client."

The American Nurses' Association requires completion of an advanced nursing program for the voluntary professional certification as either a nurse practitioner or a clinical nurse specialist. The curriculum must include pharmacology in the didactic content (Career Credential:1988).

In 60-11-108, Requirements for advanced registered nurse practitioner programs of study, the program of study is given. The regulation determines the length, curriculum and faculty requirements, methods of instruction and content including role realignment, ethical and legal implications of advanced nursing practice and the health care delivery system for the advanced registered nurse practitioner program.

The type of nursing practice and preparation in specialized practitioner skills involved in the nurse practitioner-nurse clinician category has been established by the Board of Nursing

Rosenaur et al (1984) indicated that nurse practitioners were experienced and well-educated individuals. The nurse practitioners prescribed a limited number of drugs. Each nurse practitioner and physician incorporated the drugs into existing guidelines being used in their setting of nurse practitioner practice. LaPlante and O'Bannon reported on a survey of nurse practitioners and medications. The nurse practitioners were asked to recommend a drug for a specific scenario. The physician checked the recommendation. Only two (2) percent of the nurse practitioner recommendations were changed after the physician consultation. In a study by Holland that was quoted by LaPlante and O'Bannon, it was found that nurse practitioner with or without prescription privileges recommended similar drugs.

In the Extended Role of the nurse, it was stated that nurse practitioners "differing from physician's assistants, nurses in the exted role have a great deal of academic preparation that provides them with unique problem-solving capabilities....In the practice of nurse practitioners emphasis is placed on preventive care and health maintenance....Specific responsibilities may include taking patient histories, performing physical examinations, ordering and interpreting laboartory studies, regulating medications and diet, performing health mainenance procedures, counseling in mental health teaching patients, and counseling in family planning."

Regulation 60-11-104, the functions of the advanced registered nurse practitioner in the category of nurse practitioner or nurse clinician are identified. The nurse practitioner-nurse clinician is to evaluate the physicial and psychosocial health status; assess normal and abnormal findings from the history, physicial and laboratory reports; plan, implement and evaluate care; consult with the client and health care team to provide care or referral, maintain records and reports, develop teaching plans, counsel on health maintenance, participate in evaluation. The nurse and physician are to develop protocols or guidelines to manage the plan of care. The protocols or guidelines are to be adopted, reviewed and revised by the nurse practitioner and the attending physician.

National organizations and other states which certify nurse

practitioners, prescribe the functions of the nurse practitioner-nurse clinician.

LaBarr (1988) stated that some states authorize prsecription writing to certain categories or nurse practitioners and other states have a drug formulary of the types and classes of drugs that can be prescribed.

The function allowed by the proposed regulations are recognized by the nursing profession as appropriately performed by the nurse with post-basic education and raining required for a certification of authority.

Kjervik (1985) reported that "Some states allow nurse practitioners to prescribe selected drugs." North Carolina was the first state to allow nurses to write prescriptions under written protocols with supervision by a physician (Selby: 1987). Missouri approved nurse practitioners act under standing orders and protocols (Kjervik:1985). There are more than 21 states with prescription privilege laws and rules for nurse practitioners (Selby:1987).

The Nurse Practitioner journal conducted a survey. Nurse practitioners reported that they were prescribing or recommending antibiotics, cough and cold preparations, non-narcotic analgesics, oral contraceptives, nasal decongestants, immunizations and antihistamines. Pearson (1986) reported that nurses called prescriptions into the pharmacy or wrote prescriptions on presigned prescription pads did so in states with and without prescribing laws.

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Diers, D., Hamman, A., & Molde, S. Complexity of ambulatory care: nurse practitioner and physician caseloads. Nursing Research, 1986. 35. 310-314.

Kjervik, D.K. Legal parameters of drug prescriptions by NPs. Nurse Practitioner, 1985, 10. 44-48.

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Pearson, L.J. NPs write prescriptions regardless of enabling legislation. Nurse Practitioner, 1986, 11. 6.

Rosenaur, J., Stanford, D., Morgan, W., & Curtin, B. Prescribing behaviors of primary care nurse practitioners. American Journal of Public Health, 1984, 74. 10-13

Selby, T. L. Public is served when nurses prescribe. The American Nurse, July-August, 1987. 1.

Swart, J.C. The role of the nurse practitioner. Journal of Long-Term Care Administration, 1983, 19-22.

We have been calling out prescriptions per protocol for over a decade without any compromise of patient care. This has been an established part of practice, however, we need to codify the existing practice into law.

Senate Bill 23 is not satisfactory, because it fails to make the distinctions necessary to accomplish this objective. What we are requesting is authority for prescription per protocols which have been developed with our attending physician. The proposed bill must be modified to avoid two extremes in interpretation:

1) The statutes must be explicit in allowing Nurse Practitioners to prescribe **per protocol** as they have already been doing for over the last decade.

2) The statute must **limit** Nurse Practitioner **authority to prescribe per protocol** only in conjunction with the attending physician and must **expressly prohibit independent prescriptive authority.** These two changes must also be reflected in the corresponding pharmacy act.

Nurse Practitioners of the state of Kansas are an integral part of the health care delivery system, especially among the underserved and indigent population. Authority for prescription per protocol will ensure that these services will continue.

I have the confidence of my collaborating physicians, appreciation of poverty level consumers, and I trust your support of our vital role in providing health care to low income Kansans.

Joleen Zivnuska RNC, ARNP

Joleen Zivnuska, RNC, ARNP

The University of Kansas Medical Center
School of Medicine-Wichita

Obstetrics-Gynecology
at HCA/Wesley Medical Center

January 3, 1989

To: Sedgwick County Legislative Delegation

From: Daniel K. Roberts, M.D., Ph.D.
Professor and Chairman, Department of Ob-Gyn
Chief, Ob-Gyn Service

Dear Legislators:

I assume sometime during the next legislative session you will have an opportunity to vote on a bill regarding the ability of nurse practitioners to write prescription per protocol. I urge you to support such legislation.

Nurse practitioners prescribe per protocols which have been jointly developed with their supervisory physician.

I have worked closely with Nurse Practitioners for 15 years and have full confidence in their ability to deliver excellent care to the patient population we jointly serve.

Health care is becoming increasingly unaffordable for many low income families. I am expressly concerned regarding the inability for many to obtain prenatal care if it were not available through our Maternal and Infant Projects at local Health Departments and University Teaching Clinics. Again, I emphasize that if these were reduced, our number of women presenting to our hospitals for delivery with no prenatal care would be greatly increased.

The prenatal care these Nurse Practitioners help to provide can make the difference between a healthy infant and one with long term sequela whose treatment will be financed by public assistance.

If Nurse Practitioners were denied the right to prescribe per protocol, it would have a deleterious effect on health care in Kansas especially among the poverty level consumers who do not have access to private care. Some of the present services which would be adversely effected are: Maternal and Infant Projects, Family Planning and Sexually Transmitted Disease Clinics, Well Child

and Immunization Clinics, Adolescent Health Care Services and TB Clinics in our local Health Departments, Planned Parenthood Clinics, and Student Health Services at all of our Regent Universities.

The number of women seen by our Ob-Gyn Residency Program at Wesley Medical Center would be significantly reduced if Nurse Practitioners could not prescribe per protocol.

Any reduction in the capacity of our program could cause an extreme hardship on the ever increasing indigent population who do not have access to other health care facilities.

I, therefore, urge you to take positive action to insure the continuation of Nurse Practitioners prescription authority per protocol established by and with the supervision of a physician.

Daniel K. Roberts, M.D., Ph.D.

DKR:rms

WESLEY MEDICAL CENTER
WESLEY OB/GYN CLINIC

Nurse Practitioner Treatment Protocol for Candida Vaginitis

Causative agent fungus C. Albicans may consist of two parts: (1) mycelia, which are long filamentous structures that are usually branched, or (2) canidia, which are buds, usually the size of leukocytes, but which may vary considerably in size.

S: Vulvar itching and burning, white curd-like discharge.

O: Thick white curd-like discharge, intense vulvar and vaginal pruritus and burning, rash from yeast may be present on the vulva and thigh. There may be evidence of erythema and excoriation of the skin secondary to scratching. The vaginal introitus may be inflamed and congested.

A: KOH slide for mycelia or canidia buds

P: Pregnant and non-pregnant
1) Clotrimazole (Gyne-Lotrimin), one vaginal tablet or one applicator vaginal cream per vagina hs X 7
2) Miconazole nitrate (Monistat), one applicator vaginally hs X 7
3) Monistat Dual Pak, one suppository vaginally, cream to vulva hs X 3
4) Nystatin, 500,000 units po bid x 14 - vaginal tablet 100,000 units hs X 14
5) Terconazole (Terazol) one supp. vaginally hs X 3 - vaginal cream by applicator hs X 7

TEACHING

Avoid tight or nonabsorbent clothing. Encourage cotton lined crotch panties. Avoid frequent douching, hygiene sprays and deodorants. Wipe from front to back. Complete full course of medication.

Date 9-1-88

Physician Signature

Nurse Practitioner Signature
Sylvia A. Carson, RNC, ARNP
Glen M. Zarnoska RNC, ARNP
Connie R. Luty RNC, ARNP
Debbie L. Wendt RNC, ARNP

Appendix B Example of PA Protocol

WRITTEN PROTOCOL

The following will serve as a general outline of privileges and duties between Dr. _____ and _____ RPA, and will be in force and effective from the date signed by both. The Physician Assisant may perform those acts which constitues the practice of Medicine and Surgery, modified by the Kansas State Law, and rules and regulations enacted by the Kansas Board of Healing Arts; whether through direct verbal authorization or other form of communication, or by written protocol further defined in this agreement, or in the case of an emergency situation.

The Kansas State Board of Healing Arts license number of Dr. _____ is _____. The Kansas State Board of Healing Arts registration number of _____RPA is _____. The Physician Assistant will participate in all clinical areas in which the Physician currently participates. The Physician Assistant will refer all patients to the responsible or designated physician whose condition warrants testing, diagnosis or treatment modalities which exceed the scope of practice, training, or experience of the PA. The Physician Assistant may transmit an order for prescription medication but must adhere to all state laws and rules and regulations as pertains to Physician Assistant transmittal of prescription medications. Schedule II prescriptions will only be transmitted by the Physician Assistant, after a voice order from the physician. (Schedule III-V, see below).

The Physician Assistant may supply or administer prescription only medications to patients of the practice, within the confines of acceptable standard of care. The Physician Assistant will normally see patients of the responsible Physician, but will assist in the care of other patients under the care of other who will act as alternate or designated Physicians.

Copies of this written Agreement/Protocol will be sent to the Kansas State Board of Healing Arts and maintained at and Additional copies will also be maintained with the responsible Physician, designated Physicians and with the Physician Assistant. These will be reviewed yearly and all changes will be agreed upon by both parties and copies of any changes will be incorporated into the written protocol.

Duties of the responsible Physician:

(1) Yearly performance evaluation will be discussed and documented and such documentation will be incorporated into the written protocol (but available only to the Physician and to the Physician Assistant).

2) Annually review the written Protocol, make necessary changes and document such changes in the Protocol.
3) Maintain a current license to practice medicine and surgery in the State of Kansas.
4) Report to the Kansas State Board of Healing Arts any knowledge of disciplinary hearings, formal hearings or other action taken against the PA by any state regulatory agency or professional association.
5) Report any litigation or claims alleging professional incompetency or negligence on the part of the PA to the Kansas State Board of Healing Arts.
6) Review at least weekly the records of patients treated by the Physician Assistant and document such review by signature, et cetera.
7) In the case of an emergency, unusual occurrence, or treatment in a medical care facility (hospital, outside clinic, et cetera) by the PA, the Physician will document review within 10 hours.
8) Provide for a designated Physician during the responsible Physician's absence.

Responsibility of the Physician Assistant -
The Physician Assistant will:

1) Adhere to all federal, state and local laws; and to any appropriate rules and regulations that may apply to his or her practice.
2) Must adhere to the written Protocol developed between the responsible Physician and the registered Physician Assistant.
3) Must maintain current license/registration with the State Regulatory Agency (Kansas Board of Healing Arts).

Responsibility of the designated Physician:

Any designated Physician will adhere to the before mentioned Protocol as concerns the utilization and monitoring of the Physicians Assistant's activities. All designated Physicians will adhere to all Federal and State laws.

_____ _____

_____ _____

Date Date

Rural Communities Served With Prenatal Care in 1988
Through Nurse Practitioner-Assisted OB/GYN Clinics at HCA Wesley

Abbyville
Alma
Altamont
Alvin
Amorita
Anthony
Arkansas City
Atlanta
Attica
Beloit
Buhler
Burlington
Burrton
Chanute
Clearwater
Coats
Coffeyville
Colby
Columbus
Colwich
Cunningham
Dodge City
El Dorado
Elkhart
Ellis
Emporia
Eureka
Erie
Ford
Fowler
Fredonia
Garden City
Great Bend
Grenola
Harper
Hays
Hoisington
Holcomb
Howard
Hoxie
Hutchinson
Inman
Jetmore
LaHarpe
Larned
Lindsburgh
Longton
Lucas
Lyons
Manhattan
Mankato
Marion
Mayfield
Meade
McPherson
Medicine Lodge
Montezuma
Mulvane
Newton
Norton
Olpe
Osage City
Parsons
Pittsburg
Pratt
Pretty Prairie
Protection
Reading Rock
Rose Hill
Russell
Salina
Sedan
Scott City
Sharon
Soloman
Stafford
Sterling
Toronto
Towanda
Ulysses
Valley Center
Wakeeney
Wamego
Waverly
Winfield
Wellington

TESTIMONY REGARDING
SENATE BILL #23

By
Judith M. Reno, R.N., B.S., C.N.A.
1/18/89

Senator Ehrlich and members of the committee: My name is Judy Reno. I am the Director of Personal Health Division for The Wichita-Sedgwick County Health Department. I have worked for the Health Department since 1959. When I first worked for the Department, we held STD Clinics for two hours on Monday, Wednesday and Friday. Chest Clinic was held once a week for four hours. Family Planning Clinic, twice a week for six hours. The reason for the schedules was that these were the only times that doctors could be there to provide care. In 1974-75, our Department sent staff members to nurse practitioner school as well as hired nurse practitioners. In so doing, we were able to "open" all clinics to five days a week for a total of 43 hours. This allows the working poor to receive services without missing work. The cost of two nurse practitioners with benefits is less than the cost of one full-time physician. With one physician you would still need coverage for vacations, workshops and illness.

Today, we have nurse practitioners functioning in sexually-transmitted disease clinics, prenatal clinics, family planning clinics, tuberculosis clinics, adolescent health clinics, refugee screening clinics, homeless health project and health stations. These total over 15,000 patients per year. This is true not only for Sedgwick County but for many of the Health Departments across the State.

Nurse practitioners have allowed health departments to serve both urban and rural medically indigent. Prenatal clinics in health departments in rural Kansas have shared with me that some of their patients travel over 200 miles for clinic appointments because the health department is the only place they can get prenatal care. In many departments, family planning services would not be provided if it

SPHaW
1-18-89
Attachment 3

were not for a nurse practitioner and her authorizing physician.

The eight nurse practitioners of our health department work in a collaborative relationship with our Director who is a physician as well as contracting physicians. Together, they develop new protocols and review and revise old ones at least annually. I have attached an example of only one. (See Attachment)

In 1984, The National Academy of Sciences' Institute of Medicine underlined "a need for the services of nurse practitioners, especially in underserved areas." In a report commissioned by Congress, The Institute urged that federal support be continued for the educational preparation of nurse practitioners and that state laws inhibiting nurse practitioners "in the use of their special competencies" be modified. S.B. 23 would inhibit. I am a true supporter of State control to protect the public. I believe the public will be protected with regulations that allow nurse practitioners to prescribe per protocol. It has been effective for the past fourteen years to which I can speak.

Department: Wichita-Sedgwick County Health Department
Division: Personal Health Services
Area: STD Clinic
Reference: Sexually Transmitted Diseases Treatment Guide, Centers for Disease Control, 1985

Section: Clinic Nursing
Date: March 10, 1988
Page: One

Approved by: Fred E. Tosh M.D.
Fred E. Tosh, M.D., M.P.H.

Subject: Protocol for Nurse Practitioners - Treatment of Sexually Transmitted Disease

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Purpose: To provide treatment regimens which meet the general criteria of efficacy, safety, ease of administration and relatively-low cost.

Scope: Nurse Practitioners

Policy: Protocol follows procedures adapted for Sexually Transmitted Diseases, Treatment Guidelines; Centers for Disease Control, 1985 and Chlamydia Trachomatis Infections, Policy Guidelines for Prevention and Control, Centers for Disease Control, August 23, 1985; Vol. 34, No. 35.

For additional guidance, refer to the Guidelines.

I. All STD patients will receive the following screening procedures:

A. Patient education (including AIDS information)

B. History

1. Medical history

2. Social and sexual history

3. Signature on necessary consent or information forms

C. Laboratory

1. The following is the laboratory requirements for each patient:

a. Serology for syphilis

b. Culture for gonorrhea

c. HIV (with informed consent), see procedure

2. The following are to be obtained as indicated:

a. Chlamydia

b. Wet slides

c. Pap smears

d. Dark Field

e. Herpes culture

f. Pregnancy test

g. Skin scrapings

II. GONORRHEA

A. All patients will receive the following screening procedures:

1. Interview for allergies, signs and symptoms of gonorrhea, signs and symptoms of syphillis, last sexual contact and any other pertinent data (to be done by interviewer).

2. Culture and/or smear for gonorrhea, see "Criteria and Techniques for the Diagnosis of Gonorrhea".

3. Serology (to be done by interviewer) at least every three months.

4. Pap smear for females (yearly).

5. Others to be done as indicated.

B. Nurse Practitioner may select treatment regimen if following conditions are present:

1. Positive smear (intracellular gram-neg. diplococci).

2. Positive culture.

3. Epidemiological contact (treat as uncomplicated gonorrhea).

C. Other considerations:

1. Injectable Penicilling must be given only when physician is present.

a. Patient is to remain in clinic area for 20 minutes after receiving Penicillin I.M.

2. Tetracycline is not to be used for treatment of pregnant women or children less than 8 years of age.

D. Uncomplicated urethral, endocervical, or female rectal infection

Treatment:

1. Ampicillin gm. 3.5 with Probenecid gm. 1 p.o. at one time.

OR

Procaine Penicillin 4.8 million units IM (divided doses and injected at different sites at one visit with probenecid gm. 1 PO.

COMMENT
APPG may be less desirable because of associated pain and toxicity.

OR Spectinomycin 2.0 g. IM (if allergic to penicillin).

PLUS

2. Tetracycline Hcl 500 mg. by mouth 4 times daily for 7 days. (See C.2 above.)

OR Doxycycline 100 mg. by mouth twice daily for 7 days.

COMMENT
A script must be given the patient for Doxycycline and will cost the patient approximately $20.00. It should be ordered only for patients willing and able to pay for it.

OR For patients in whom tetracycline are contraindicated or not tolerated, the single dose regimen may be followed by erythromycin base or stearate 500 mgm. by mouth 4 times daily for 7 days or erythromycin ethylsuccinate 800 mg. by mouth 4 times a day for 7 days.

ADVANTAGES	DISADVANTAGES
1. Provides adequate single dose treatment for gonorrhea.	1. Multiple day, multiple dose regimen for treatment of Chlamydial infections.
2. Effective against chlamydial infections.	2. The risk of secondary vulvo-vaginal candidiasis in women is probably enhanced.
3. Effective against pharynageal gonococcal infections.	3. Test of cure culture for gonorrhea must be delayed until 3-to-4 days after the completion of dual therapy.
	4. Unknown potential for selection of resistant strains of C. trachomatis if compliance is poor.
	5. Unknown potential for making C. trachomatis infections in those who only partially comply with treatment.

E. Rectal gonococcal infection in homosexual men

1. Treatment:

a. Aqueous procaine penicillin G 4.8 million units IM with Probenicid 1.0 gm by mouth.

OR Spectinomycin (Trobicin) 2.0 g I.M.

COMMENT
Homosexual men are less likely than heterosexual men to have co-existant chlamydial infections; therefore, additional tetracycline is or doxycycline tratment is not recommended.

F. Pharyngeal Infections

1. Treatment

a. Procaine Penicillin 4.8 million units I.M. with Probenecid gm. 1, p.o.

OR Tetracycline HCL 500 mg. q.i.d. for 7 days.

b. Ampicillin is not effective.

c. Spectinomycin is not effective

2. Follow-up cultures after treatment are essential.

G. Management of Sex Partners

1. Women and heterosexual men exposed to gonorrhea (e.g. within the past 30 days) should be examined, cultured, and treated prophylactically with one of the regimens which covers both gonococcal and chlamydial infections.

2. Homosexual men exposed to gonorrhea should be examined, cultured, and treated for gonorrhea.

H. Education

1. Prevention and transmission of venereal disease.

2. Caution regarding use of alcohol, drugs, dairy products, or having sexual relations while being treated.

3. Stress patient responsibility in contacting partners to be examined and/or treated.

4. Instructions for taking medication, including the dosage, timing, and length of the regimen. Patients must clearly understand that they must continue to take medication according to schedule, despite abatement of symptoms.

5. Advice regarding follow-up for side effects or other difficulty with medication, continued or worsened symptoms, and test of cure, if indicated.

I. Follow-up

1. Follow-up cultures should be obtained from the infected site(s) 4-to-7 days after completion of treatment.

2. In addition, cultures should be obtained from the rectum of all women who have been treated for gonorrhea.

J. Treatment Failures

1. Most recurrent infections after treatment are due to reinfections.

2. True treatment failures after therapy of Tetracycline, Ampicillin or Penicillin should be treated with

- Spectinomycin (Trobicin) gm. 2, I.M.

K. Pencillinase-Producing Neisseria Gonorrhoeae (PPNG)

1. Uncomplicated PPNG infections and their sexual contacts should be treated with

a. Spectinomycin 2.0 gm I.M.

OR Ceftriaxone 250 mg. I.M.

PLUS

b. Tetracycline Hcl 500mg by mouth 4 times daily for 7 days.

OR c. Doxycycline 100 mg by mouth 2 times daily for 7 days (see comment above).

OR d. Erythromycin base or stearate 500 mg by mouth 4 times daily for 7 days.

OR e. Erythromycin ethylsuccinate 800 mg by mouth 4 times daily for 7 days.

2. See CDC Guidelines for PPNG pharyngeal infection.

L. Disseminated Gonococcal Infections

1. Arthritis-dermatitis Syndrome

a. Treatment prescribed by physician only.

b. Ampicillin 3.5 gm. with probenecid gm. 1 p.o. followed by Ampicillin 500 mg., 4 times a day for 7 days.

OR Patients allergic to above may receive Tetracycline HCL 500 mg., 4 times a day for 7 days.

OR Doxycycline 100 mg. by mouth twice daily for at least 7 days.

PLUS

c. Patients treated with one of the above regimens should be given an additional 7 days of tetracycline, doxycycline, or erythromycin as outlined in D.1.

1. Above treatment recommended for outpatient treatment only.

2. Hospitalization may be required.

2. Follow-up

a. At physician request.

3. Meningitis and Endocarditis

a. Must be referred to private physician.

M. Gonococcal Infections in Children

1. All are to be referred to physician for treatment.

2. Child abuse must be considered.

N. Gonococcal Infections of the Eye

1. Nurse practitioner will not treat, hospitalization recommended.

2. Refer to physician or opthalmologist.

3. Treatment that can be used in hospital -

a. Aqueous Penicillin G, 10 million units IV daily for 5 days.

b. For PPNG, Cefoxitin 1 g or Cefotaxime 500 mg. IV, 4 times a day.

III. CHLAMYDIA TRACOMATIS

A. Risk Assessment

1. Individual characteristics and practices

a. Age, number of sex partners, socioeconomic status and sexual preference.

1. Sexually active women (20 years of age) and teenage males.

2. Risk of infection increases with the number of sex partners.

3. Lower socioeconomic status and ethnicity have increased risk.

4. Heterosexual men.

2. Clinical Syndromes

a. Nongonococcal urethritis (NGU)

b. Mucopurulent cervicitis (MPC)

c. Pelvic inflammatory disease (PID)

d. Epididymitis (men less than 35 years of age).

B. Screening

1. Individuals attending STD clinic who otherwise would not be offered anti-chlamydial treatment and are at high risk should be screened first.

2. Invididuals with symptomatic syndromes associated with chlaymdia should be screened next.

C. Confirmed infections (Uncomplicated Urethral, Endocervical, or Rectal Infections in Adults).

1. Treatment

a. Tetracycline 500 mg by mouth, 4 times a day for 7 days.

OR Doxycycline 100 mg, by mouth, 2 times a day for 7 days (if patient agrees and can afford).

OR (If Tetracycline contraindicated or not tolerated) Erythromycin 500 mg. 4 times a day for 7 days.

2. Management of sex partners

a. All persons exposed to C. trachomatis infection (within 30 days after their sex partner develops symptoms or has a positive clinical evaluation) should be examined for STD and promptly treated for C. trachomatis with one of the above regimens.

IV. NON-GONOCOCCAL URETHRITIS

A. For patient with symptoms and GC smear is negative, obtain a chlamydia culture and treat patient as follows:

1. Treatment

a. Tetracycline 500 mg. 4 times a day for 7 days.

OR Doxycycline 100 mg by mouth twice daily for 7 days (if patient agrees and can afford).

OR (If Tetracycline contraindicated or not tolerated) Erythromycin 500 mg. 4 times a day for 7 days.

2. Management of sex partners

a. All persons who are sex partners of patients with N.G.U. should be examined for STD and promptly treated with one of the above regimens.

V. MUCOPURULENT CERVICITIS

A. Criteria for presumptive diagnosis include

1. Mucopurulent secretion from the endocervix, which is usually yellow or green when viewed on a white cotton-tipped swap (positive swab test).

2. ≥ 10 polymorphonuclear leukocytes per microscopic oil immersion field (x1000) in a Gram-stained smear of endocervical secretions.

3. Cervicitis, determined by cervical friability (bleeding when the first swab culture is taken) and/or by erythema or edema within a zone of cervical ectopy.

B. The presence of mucopurulent encocervical exudate often reflects cervicitis due to chlamydial and/or gonococcal infection. If N. gonorrhoeae is found on Gram stain or culture of endocervical or urethral discharge, a treatment regimen effective against both gonococcal and chlamydial infection should be used. When only chlamydial infection is proven or suspected, therapy should consist of one of the regimens below.

1. Treatment

a. Tetracycline HCL: 500 mg, by mouth, 4 times a day for 7 days.

OR Doxycycline, 100 mg, by mouth, twice a day for 7 days.

OR (If tetracyclines are contraindicated or not tolerated) Erythromycin base or stearate: 500 mg. by mouth, 4 times a day for 7 days, or erythromycin ethyl succinate: 800 mg. by mouth, 4 times a day for 7 days.

C. Management of sex partners

1. Men exposed to women with MPC attributed to chlamydial infection should be evaluated for STD and treated with one of the above regimens. If N. gonorrhoeae is found, treatment should be with a regimen effective against uncomplicated gonococcal and chlamydial infection.

VI. ACUTE SALPINGITIS (PELVIC INFLAMMATORY DISEASE)

A. Nurse Practitioner may treat prior to culture confirmation if symptoms are mild.

1. Pelvic examination must be performed. (Should include bi-manual).

2. Females with marked or severe symptoms must be referred to private physician or hospital emergency room.

B. Treatment (in order of preference)

1. Procaine Penicillin 4.8 million units I.M. with Probenecid gm. 1, p.o. followed by Tetracycline 500 mg. 4 times a day for 10 days.

OR Ampicillin gm. 3.5, with Probenecid gm. 1, by mouth at one time, followed by Tetracycline 500 mg. 4 times a day for 10 days.

OR Ampicilin gm. 3.5, with Probenecid gm. 1, by mouth at one time, followed by Tetracycline 500 mg. 4 times a day for 10 days.

OR If allergic to Penicillin, Tetracycline HCL 500 mg. 4 times a day for 10 days.

C. Follow-up

1. All patients should be re-evaluated in 48-72 hours. If no improvement or worse, refer for hospitalization. For test of cure, cultures should be taken as approriate for pathogens initially isolated.

2. All PID's should be referred to investigator for contact interviews.

D. Management of sex partners

1. All persons who are sex partners of patients with PID (within the 30 days prior to onset of their symptoms or positive clinical evaluation) should be examined for STD and treated promptly with a regimen effective against uncomplicated gonococcal and chlamydial infection.

VII. EPIDIDYMITIS

A. Treatment

1. Ampicillin 3.5 g by mouth along with Probenicid 10. g by mouth

PLUS

Tetracycline HCl 500 mg by mouth 4 times daily for 10 days.

B. Follow-up (as recommended by clinic physician).

VIII. PATIENT COUNSELING

A. See I.G. above.

IX. VAGINAL INFECTIONS

A. Nurse Practitioner may select and recommend treatment for vaginitis, after appropriate screening.

1. Monila

a. Nystatin (chlortrimazole) vaginal tablets - insert 1 tablet bid 7-14 days.

b. Monistat (miconazole) - 1 tube, 1 appicator full at bedtime for 7 days.

c. Bytoconazole (femstat) vaginal cream 1 tube/applicator at bedtime for 7 days.

d. Mycolex G (clotrimazole) vagina cream 1 tube/applicator at bedtime for 7 days.

2. Trichomonas

a. Metronidazole (Flagyl) 2 gm, p.o. or 500 mg. two times a day for 7 days.

1. Do not repeat Metronidazole for 10-12 weeks.

2. No alcohol during treatment and 24 hours following treatment.

3. May treat partner with same dosage.

OR Triple sulfa cream 1 tube/appicator full, daily until gone.

OR Warm vinegar douche (2 tablespoons white vinegar to 1 quart warm water) daily 10-14 days.

OR In pregnant women, Clotrimazole 100 mg. intravaginally at bedtime for 14 days. May produce symptomatic improvement and some cures.

3. Bacterial

a. Metronidazole (Flagyl) 500 mg. two times a day for 7 days.

b. Ampicillin 500 mg. 4 times a day for 10 days.

c. Tetracycline 500 mg 4 times a day for 7 days.

d. Erythromycin 500 mg 4 times a day for 7 days.

e. Betadine douches, 1 time daily for 5-7 days.

f. Triple sulfa cream, 1 tube/applicator daily until gone.

Doxycycline, Eryc and/or EES may be substituted if primary medications are not tolerated.

Not necessary to treat male sex partner.

4. N.S.V. May RX according to above protocol depending on test results, symptoms or clinical findings.

X. PEDICULOSIS OR SCABIES

A. May be treated with lindane lotion or shampoo for scabies and other pediculocides for pediculosis.

1. Physician will call in or write prescription.

2. Pediculosis of eyelashes to be treated by physician.

B. Opthalmic yellow mercuric sulfide ointment 1/8 oz. tube. Apply at night b.i.d. for heavy infestation.

Alternate medication may be prescribed by clinic physician for any of the above.

XI. HERPES

A. Culture as indicated (see procedure).

B. May Darkfield the lesions to rule out syphilis.

C. Refer to physician for treatment as indicated.

D. Recommend pap every year if cervical Herpes.

XII. CONDYLOMA ACUMINATUM (VENERAL WARTS)

A. All patients will receive the following screening procedures

1. Serology (to exclude condylomata lata).

2. Culture for gonorrhea.

3. Others as indicated.

B. Only external warts will be treated.

1. Clients with uretheal, ano-genital or vaginal warts should be referred.

2. If extensive involvement, refer to clinic physician for evaluation and treatment.

3. Resistant or atypical warts should be referred for possible biopsy.

C. Treatment schedule

1. Podophillin (20% concentration in tincture of benzoin)

a. Retreat in 7-10 days, if necessary.

2. Liquid nitrogen.

a. Repeat in 7-10 days, if necessary.

D. Recommend Pap smear yearly on all female patients.

XIII. SYPHILIS

A. All patients will receive the following screening procedures.

1. Interview for allergies, signs and symptoms of syphilis and other pertinent data.

2. Serology - RPR on all, FTA as indicated.

3. Culture for gonorrhea.

4. Darkfield any suspicious lesions, except those in mouth.

B. Nurse practitioner may select treatment if following conditions are present:

1. Positive RPR with titer more than 1:16 or with FTA (positive) (if not previously positive).

2. Positive Darkfield.

3. Epidemiological contacts.

4. Any questionable lesions, laboratory findings, or symptoms, consult with physician.

C. Treatment schedule

1. Primary, secondary, early latent syphillis of less than one year's duration. Penicillin is treatment of choice.

a. Benzathine Penacillin G 2.4 million units I.M. at one visit (with physician present).

OR Tetracycline HCL 500 mgm, 4 times a day, p.o. for 15 days.

OR See CDC guidelines for recommendations for Penicillin allergic patients who cannot tolerate tetracycline.

2. Syphilis of more than one year's duration. (Cerebrospinal fluid examination is highly recommended before therapy.) Nurse practitioner should perform physical examination to determine degree of involvement and consult with physician before initiating treatment.

a. Benzathine Penicillin G., 7.2 million units total to be given 2.4 units I.M. weekly for three successive weeks with physician present.

OR *Tetracycline HCL 500 mg., 4 times a day, p.o. for 30 days.

OR Erythromycin (stearate, ethyl succinate or base) 500 mg., q.i.d., p.o. for 30 days.

OR See CDC Guidelines for recommendations for Penicillin allergic patients who cannot tolerate Tetracycline.

D. Follow-up

1. Serology to be drawn one month after treatment, then every 3 months for one year. Then, evaluate to determine frequency of, or need for, future serologies. If blood converts to negative, schedule follow-up may be discontinued.

E. Contact investigation

1. All syphilis patients to be referred to investigator for interviewing.

F. Re-treatment

1. Should be considered when:

a. Clinical signs or symptoms persist or recurr.

b. There is sustained fourfold increase in the titer RPR.

2. Re-treatment schedule

a. Same as recommended for syphilis of more than one year's duration.

G. Syphilis in pregnancy

1. Patients in all stages of pregnancy who are <u>not</u> alelrgic to Penicillin

a. Same treatment schedule as for non-pregnant patients.

2. Patients in all stages of pregnancy who <u>are</u> allergic to Penicillin

a. Erythromycin (stearate, ethyl succinate, or base) 500 mg, q.i.d., p.o. for 30 days.

b. Tetracycline <u>is not</u> to be used.

3. Assure that patient is receiving prenatal care.

a. Notify prenatal care provider of therapy.

H. Congenital Syphilis

1. Treatment initiated by physician only.

2. For specifics: <u>CDC Recommended Treatment for Syphilis</u>.

XIV. HIV (see Procedure).

* There is no data available which adequately documents the efficiency of drugs other than Penicillin for syphilis of more than one year's duration.

Kansas State Board of Nursing

Landon State Office Building
900 S.W. Jackson, Rm. 551
Topeka, Kansas 66612-1256
913-296-4929

Lois Rich Scibetta, Ph.D., R.N.
Executive Administrator

Bonnie Howard, R.N., M.A.
Practice Specialist

Janette Pucci, R.N., M.S.N.
Educational Specialist

TO: The Honorable Senator Roy Ehrlich, Chairman, and Members of the Senate Public Health and Welfare Committee

FROM: Dr. Lois R. Scibetta, Executive Administrator

DATE: January 18, 1989

RE: Senate Bill - 23

Thank you Mr. Chairman for the opportunity to appear today to express the concerns of the Kansas State Board of Nursing about Senate Bill 23.

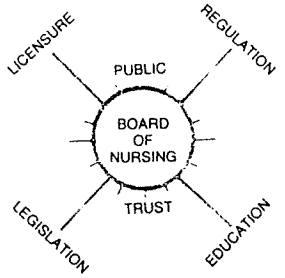
In our judgement, Senate Bill 23 resulted from a misunderstanding between the joint Rules and Regulations Committee, attorneys, and the Board of Nursing.

The Board of Nursing recently promulgated regulations 60-11-104 (a) (Exhibit A attached), to define Protocols and Guidelines (standing orders) which would allow the advanced Nurse Practitioner, under physcians orders, "protocols" to prescribe) for the patient based upon the presenting physical symptoms. K.A.R. 60-11-104a was an effort on the part of the Board to clarify an established regulation, K.A.R. 60-11-104, in effect since May, 1985, section "(f.) Manage the medical care plan prescribed for the client, based upon protocols or guidelines adopted jointly by the nurse Practitioner and the attending physcian." Kansas Nurse Practice Act, 1988 Revision, page 41. (Exhibit B attached)

The confusion arose when Pharmacists refused to fill medication prescriptions from the nurse practitioner, and because of this, we have Senate Bill 23.

In general, if this amendment to the Nurse Practice Act is passed, it will result in the loss of essential services to clients, in our most vulnerable areas, the rural recessed of our state. The Board objects to lines 72-75 The word "transmitt" is not defined in the Pharmacy Act.

As it now stands, the nurse practitioner is in effect carrying out the



SPH&W
1-18-89
Attachment 4

physicians standing orders, under protocol. It is and has been an acceptable practice in Intensive Care Units and hospitals in general.

It seems we have a problem of semantics. The Kansas State Board of Nursing is NOT requesting general prescriptive authority for advanced practitioners to function most effectively under standing orders, or protocols.

We respectively request that SB 23 in its present form be reported out unfavorably by this Committee.

Thank you for this opportunity to comment on behalf of the Board. I would be happy to respond to questions Mr. Chairman.

LRS:AB

Exhibit A.

K.A.R. 60-11-104a. Protocols or guidelines, defined:

Requirements:

(a) When used in this article, the term "protocols or guidelines" means written documents containing a precise and detailed medical plan of care.

(b) Each protocol or guideline shall, at a minimum:

(1) Contain the name~~, license and certificate number,~~ and signature of the nurse clinician or nurse practitioner and the name and ~~license number~~ signature of the responsible physician who have adopted the protocol or guideline;

(2) show the date the protocol or guideline was adopted~~; and state the minimum frequency the protocol or guideline is to be reviewed by the nurse practitioner or physician;~~ or last reviewed;

(3) specify all prescription-only drugs for which the nurse clinician or nurse practitioner is permitted to write a prescription order without direct authorization from the responsible physician.; ~~and~~

(4) specify under what circumstances, and how soon, the responsible physician must be contacted after a prescription order is written by the nurse clinician or nurse practitioner; and

(5) be maintained in an 8½ inch by 11 inch looseleaf notebook containing all protocols adopted by the nurse and doctor and kept at the nurse's principal place of practice. The notebook shall include a cover page containing:

(A) the name, license number, certificate number and telephone number of the nurse practitioner/nurse clinician and the responsible physician;

APPROVED
ATTORNEY GENERAL
By [signature] Asst.

DEPT. OF ADMINISTRATION
OCT 4 1988
APPROVED BY FDL

K.A.R. 60-11-104a

(B) the name, address and telephone number of a designated physician who agrees to direct and supervise the nurse clinician or nurse practitioner in the absence or unavailability of the responsible physician;

(C) the minimum frequency the protocols or guidelines are to be reviewed by the nurse and physician, but such time shall not be less than one year; and

(D) the minimum frequency for which prescription orders are reviewed and patient charts are co-signed, and such time shall not be more than thirty days.

(c) This regulation shall not be construed to authorize a nurse clinician or nurse practitioner to issue a prescription order for a controlled substance. ~~unless otherwise authorized by law to do so.~~

(d) Nothing in this regulation shall be construed to prohibit any registered nurse or licensed practical nurse or advanced registered nurse practitioner from transmitting a prescription order orally or telephonically, or from administering a prescription-only drug pursuant to a lawful direction of a person licensed to practice medicine and surgery, ~~a dentist,~~ dentistry, or nurse practitioner, or a nurse clinician.

(e) When used in this section, terms ~~used in this regulation~~ shall be construed to have the meanings set forth in the pharmacy act of the State of Kansas, K.S.A 1987 Supp. 65-1626.

(Authorized by K.S.A. 65-1129 and 65-1130, implementing K.S.A. 65-1130; effective, T-60-9-12-88, Sept. 12, 1988; P _____.)

APPROVED
ATTORNEY GENERAL
By _____ Asst.

DEPT. OF ADMINISTRATION
OCT 4 1988
APPROVED BY FDL

KANSAS Nurse Practice Act
Laws and Administrative Regulations

60-9-104. Approval of Continuing Education Offerings. A. Providers shall apply for approval to offer continuing education offerings on forms supplied by the Board.

B. The Board's approval shall be granted to agencies as providers for a two (2) year period, and to individuals as providers for specific programs. Agencies shall reapply for provider approval biennially.

C. Application for approval of a provider shall be made at least three months before the anticipated date of the first offering.

D. Offerings shall be no less than two (2) hours in length, and shall be taught by approved course instructors.

E. In order to be approved as a continuing education course instructor, the individual shall be a competent teacher and shall be knowledgeable, current, and skillful in the subject matter of the offering.

F. Program providers shall award certificates of achievement to participants.

G. Program providers shall submit to the Board a roster of individuals who have satisfactorily completed offerings.

H. Program providers shall maintain a record of all offerings and attendance for a two (2) year period.

I. If quality programs are not maintained to the Board's satisfaction, or if there is a material misrepresentation of any fact within the information required to be submitted to the Board by a provider, the Board shall withdraw approval from that provider. (Authorized by K.S.A. 1976 Supp. 65-1117; effective Feb. 15, 1977.)

ADVANCED REGISTERED NURSE PRACTITIONERS

60-11-101. Definition and limitations. (a)(1) An advanced registered nurse practitioner, as defined by L. 1983, Ch. 206, Sec. 6, functions in an expanded role to provide primary health care to individuals, families or groups, or some combination of these groups of clients, in a variety of settings, including homes, institutions, offices, industries, schools, community agencies, and private practice. Advanced registered nurse practitioners function in a collegial relationship with physicians and other health professionals in the delivery of primary health care services. Advanced registered nurse practitioners make independent decisions about nursing needs of families and clients, and interdependent decisions with physicians in carrying out health regimens for families and clients. Advanced registered nurse practitioners are directly accountable and responsible to the consumer.

(2) "Primary health care" is the prevention of disease, promotion and maintenance of health, assessment of needs, long term nursing management of chronic illness and referral of clients to other resources. The contact between advanced registered nurse practitioner and client may be for an episode of illness or it may be for continuous health care monitoring.

(b) The physical presence of the physician is not necessarily implied when care is given by the advanced registered nurse practitioner. (Authorized by and implementing K.S.A. 1983 Supp. 65-1113, 65-1130; effective May 1, 1984.)

60-11-102. Categories of advanced registered nurse practitioners. The four categories of advanced registered nurse practitioners certified by the board of nursing are: (a) nurse clinician or nurse practitioner;

(b) nurse anesthetist;

(c) nurse-midwife; and

(d) clinical specialist.

(Authorized by and implementing K.S.A. 1983 Supp. 65-1113, 65-1130; effective May 1, 1984.)

Exhibit B. 9-7

60-11-103. Qualifications of advanced registered nurse practitioners. To be eligible for certification as an advanced registered nurse practitioner in one of the following categories, the applicant shall hold a current Kansas license as a registered professional nurse. (a) To be certified as an advanced registered nurse practitioner in the category of nurse clinician or nurse practitioner, each applicant shall:

(1) Have graduated from a formal, post-basic nursing education program that has been approved by the state board of nursing, and that prepares the nurse to function in an expanded role. The board shall review evaluations of the applicant's performance in the program; or

(2) have a current certification which requires, as a prerequisite, a post-basic nursing education program approved by the state board of nursing.

(b) To be certified as an advanced registered nurse practitioner in the category of registered nurse anesthetist, each applicant shall:

(1) Have graduated from a formal, post-basic nursing education program that has been approved by the state board of nursing, and that prepares the nurse to function in an expanded role. The board shall review evaluations of the applicant's performance in the program; or

(2) have a current certification which requires, as a prerequisite, a post-basic nursing education program approved by the state board of nursing.

(c) To be certified as an advanced registered nurse practitioner in the category of nurse-midwife, each applicant shall:

(1) Have graduated from a formal, post-basic nursing education program that has been approved by the state board of nursing, and that prepares the nurse to function in an expanded role. The board shall review evaluations of the applicant's performance in the program; or

(2) have a current certification which requires, as a prerequisite, a post-basic nursing education program approved by the state board of nursing.

(d) To be certified as an advanced registered nurse practitioner in the category of clinical nurse specialist, each applicant shall:

(1) Have graduated from a formal, post-basic nursing education program that has been approved by the state board of nursing, and that prepares the nurse to function in an expanded role; and

(2) hold a master's degree in a nursing clinical area which prepares the nurse to function in the expanded role. (Authorized by and implementing K.S.A. 1983 Supp. 65-1113, 65-1130; effective May 1, 1984; amended, T-85-16, June 5, 1984; amended May 1, 1985.)

60-11-104. Functions of the advanced registered nurse practitioner, nurse clinician or nurse practitioner. Advanced registered nurse practitioners function in the expanded role of nurse clinician or nurse practitioner, at a specialized level, through the application of advance knowledge and skills. Each nurse clinician or nurse practitioner shall be authorized to: (a) Perform all functions defined for basic nursing practice;

(b) evaluate the physical and psychosocial health status of the client through a comprehensive health history and physical examination, using skills of observation, inspection, palpation, percussion and auscultation, and using diagnostic instruments or laboratory procedures that are basic to the screening of physical signs and symptoms;

(c) assess normal and abnormal findings from the history, physical examination and laboratory reports;

(d) plan, implement and evaluate care;

(e) consult with the client and members of the health care team to provide for acute and ongoing health care or referral of the client;

(f) manage the medical plan of care prescribed for the client, based on protocols or guidelines adopted jointly by the nurse practitioner and the attending physician;

(g) initiate and maintain accurate records, appropriate legal documents and other health and nursing care reports;

(h) develop individualized teaching plans with the client based on overt and covert health needs;

(i) counsel individuals, families and groups about health and illness and promote health maintenance;

(j) recognize, develop and implement professional and community educational programs related to health care;

(k) participate in periodic and joint evaluation of services rendered, including, but not limited to, chart reviews, patient evaluations and outcome of case statistics; and

(l) participate, when appropriate, in the joint review and revision of adopted protocols or guidelines when the advanced registered nurse practitioner is involved in the medical plan of care. (Authorized by and implementing K.S.A. 1983 Supp. 65-1113, 65-1130; effective May 1, 1984; amended, T-85-16, June 5, 1984; amended May 1, 1985.)

60-11-105. Functions of the advanced registered nurse practitioner; nurse-midwife. An advanced registered nurse practitioner functioning in the expanded role of nurse-midwife shall perform in an interdependent role as a member of a physician-directed health care team, within the framework of mutually adopted protocols or guidelines. Each nurse-midwife shall be authorized to: (a) Be responsible for the management and complete health care of the normal expanding family throughout pregnancy, labor, delivery and post-delivery care;

(b) participate in individual and group counseling and teaching throughout the childbearing cycle;

(c) participate in well-woman gynecological procedures;

(d) participate in periodic and joint evaluation of services rendered, including chart reviews, case reviews, patient evaluations and outcome of case statistics; and

(e) participate in the joint review and revision of adopted protocols or guidelines. (Authorized by and implementing K.S.A. 1983 Supp. 65-1113, 65-1130; effective May 1, 1984; amended, T-85-16, June 5, 1984; amended May 1, 1985.)

60-11-106. Functions of the advanced registered nurse practitioner; nurse anesthetist. An advanced registered nurse practitioner functioning in the expanded role of registered nurse anesthetist shall perform in an interdependent role as a member of a physician or dentist-directed health care team. Each registered nurse anesthetist shall be authorized to:

(a) Conduct a pre- and post-anesthesia visit and assessment with appropriate documentation;

(b) develop an anesthesia care plan with the physician or dentist which includes medications and anesthetic agents;

(c) induce and maintain anesthesia at the required levels;

(d) support life functions during the perioperative period;

(e) recognize and take appropriate action for untoward patient responses during anesthesia;

(f) provide professional observation and management of the patient's emergence from anesthesia;

(g) participate in the life support of the patient;

(h) participate in periodic and joint evaluation of services rendered, including, but not limited to, chart reviews, case reviews, patient evaluations and outcome of case statistics; and

(i) participate in the joint review and revision of adopted protocols or guidelines. (Authorized by and implementing K.S.A. 1983 Supp. 65-1113, 65-1130; effective May 1, 1984; amended, T-85-16, June 5, 1984; amended May 1, 1985.)

60-11-107. Functions of the advanced registered nurse practitioner; clinical nurse specialist. The primary responsibility of the advanced registered nurse

practitioner performing in the expanded role of clinical nurse specialist shall be patient care delivery to a select population in a specialty area. Each clinical nurse specialist shall be authorized to: (a) Provide direct nursing care utilizing a broad base of advanced scientific knowledge, nursing theory and skills in assessing, planning, implementing and evaluating those aspects of health and nursing care of individuals who require this specialized competence;

(b) provide indirect nursing care. Each clinical nurse specialist shall plan, guide, evaluate and direct the nursing care given by other personnel associated with the nursing functions;

(c) conduct nursing research. Each clinical nurse specialist shall create and test methods of nursing intervention and health care in the area of specialization;

(d) teach and counsel individuals or groups. Each clinical nurse specialist shall utilize theories and skills of communication and teaching learning process to increase the knowledge or functioning of individuals and groups, nursing personnel, students and other members of the health care team;

(e) serve as a consultant, and as a resource, utilizing advanced health knowledge and skills, to those who are directly and indirectly involved in patient care; and

(f) participate in periodic evaluation of services rendered, including, but not limited to, chart reviews, case reviews, patient evaluations, and outcome of case statistics. (Authorized by and implementing K.S.A. 1983 Supp. 65-1113, 65-1130; effective May 1, 1984; amended, T-85-16, June 5, 1984; amended May 1, 1985.)

60-11-108. Requirements for advanced registered nurse practitioner programs of study. (a) Each program which prepares registered nurses for advanced nursing practice that is located or offered within Kansas shall be approved by the state board of nursing.

(b) The educational program shall be a minimum of nine months or one academic year of full-time study or its equivalent, as defined by the sponsoring academic institution. The program shall contain both didactic and clinical components. The clinical component shall include a preceptorship meeting a minimum of eight hours a week for one academic year, or its substantial equivalent of practice.

(c) The philosophy, purpose and objectives of the program shall be clearly defined and available in written form.

(d) The objectives reflecting the philosophy shall be stated in behavioral terms and shall describe the competencies of the graduate.

(e) The faculty shall include a majority of advanced registered nurse practitioners who are currently certified by the board in Kansas.

(f) Each faculty member shall have earned a graduate degree.

(g) The content, methods of instruction and learning experience shall be consistent with the philosophy and objectives of the program.

(h) Course syllabi shall be available in writing.

(i) The program shall include content relating to role realignment, ethical and legal implications of advanced nursing practice, and the health care delivery system.

(j) The program shall provide clinical instruction in the performance of diagnostic procedures that are essential to practice in the area of specialization.

(k) Admission criteria shall be clearly stated, available in written form, and shall include the requirement of a current license to practice in Kansas as a registered professional nurse.

(l) Policies for withdrawal, dismissal and readmission shall be available in written form.

(m) The student shall receive official evidence that indicates successful completion of the program of study.

(n) A written plan for continuing program evaluation shall be developed,

KSNA
the voice of Nursing in Kansas

FOR FURTHER INFORMATION CONTACT:

TERRI ROBERTS, J.D., R.N.
EXECUTIVE DIRECTOR
KANSAS STATE NURSES' ASSOCIATION
820 QUINCY, SUITE 520
TOPEKA, KANSAS 66612
(913) 233-8638

S.B. 23

Senator Erhlich and members of the Senate Public Health and Welfare Committee, my name is Terri Roberts, J.D., R.N. I am a registered nurse representing the Kansas State Nurses' Association.

I have prepared a folder of information that may be helpful to you in your deliberation on Senate Bill 23. The first item I would like to bring to your attention is a chronology of events surrounding this issue. It began three years ago, at the very end of the legislative session when the Pharmacy Association and the Medical Society lobbied during the last three days of the session to change the definition of "Practitioner" in the Pharmacy Act. An Attorney General's opinion was "pending" at that time, requested by the Board of Pharmacy to clarify whether or not ARNP's could prescribe under standing orders and protocol. The Attorney General's 86-125, issued August 27, 1986, was that Advanced Registered Nurse Practitioners may not issue prescription orders pursuant to a physicians' standing orders or protocol, because they have not been granted such authority by the statutes and regulations under which they are licensed. I have included a copy of that Attorney General's opinion in your folder. The Pharmacy Board had adopted a different posture related to filling of orders prescribed by ARNP's. Their position paper is included in your packet. That position paper recognized that ARNP's-Nurse Practitioners may prescribe under standing orders and protocol, under K.S.A. 65-1626X and K.S.A. 65-1130(c)(1).

The Joint Committee on Administrative Rules and Regulations has submitted this bill for legislative consideration in an attempt to clarify the issue of whether or not ARNP's-Nurse Practitioners, may prescribe medications under standing orders and protocols jointly adopted with a collaborating physician. ARNP-Nurse Practitioners are Registered Nurses who have had formal training to prepare them as Nurse Practitioners. They function in what we refer to as the expanded role or advanced nursing practice.

The issue before you is one that will have a serious impact on the delivery of healthcare by the more than 170 Nurse Practitioners in Kansas.

S.B. 23 does not, in its present form, present a clear message regarding ARNP's prescribing under standing orders and protocol. Lines 72-75, page 2, would negate the current Regulations in place that are widely disseminated among ARNP's. The change in the Pharmacy Act (line 197 on page 6) to delete language added in 1986 "expressly licensed ..."

SPW&W
1-18-89
Attachment 5

is also an attempt to limit the Board of Nursing Regulations K.A.R. 60-11-104a.

There are a number of ARNP's here to tell you about their practice setting, clients they serve and why there is a need to adopt specific statutory language which enables them to write prescriptions based on standing orders and protocol.

Before they begin to testify, I would like to go over two issues that create confusion in discussion of this topic.

Medical Delegation is at times not well understood. Registered nurses, whether they are ARNP's or not, cannot perform medical functions that are outside the scope of the nurse practice act. For example, a physician cannot appropriately delegate prescriptive privileges to a nurse. The N.P.A. must provide for such privileges. The same would be true of surgery - a physician cannot simply by delegation, give authority to a registered nurse to do surgery.

"Transmission" in the pharmacy act is also a term that is subject to various interpretations.

The most common scenerio for the implementation of this provision is when the practitioner makes an assessment of a client, determines the medication to be prescribed and tells another person, including his/her office and/or nursing staff who then transmit the order to a pharmacy.

A legal definition has not been included in the Attorney General's opinion or elsewhere. It is not clear that transmission could include standing orders and protocol that ARNP's implement without conferring with a physician.

S.B. 23 as it is written would negate the Board of Nursing Regulations K.A.R. 60-11-104a and leave this issue subject to the definition of transmission in the Pharmacy Act. For three years, the Board of Pharmacy and Nursing and ARNP-Nurse Practitioners have struggled with lawyers' opinions on this issue.

KSNA supports legislative language that finally gives clear intent and direction.

We ask for your support in rewording S.B. 23 to accurately reflect the current practice by ARNP's writing prescriptions based on standing orders and protocol jointly adopted with their collaborating physician.

We are not seeking independent prescriptive privileges. We are committed to collaborative and interdependent relationships with physicians recognizing that both have specific practice acts governing their discipline and are individually accountable to the public they serve.

I have included, for your reference, a January, 1989 article from the Nurse Practitioner Journal analyzing Prescriptive privileges in the 50

states and D.C. Twenty-eight states, including Missouri and Nebraska, have specific provisions for this.

A research article is also included about prescribing behaviors of Primary Care Nurse Practitioners. It provides documentation of appropriate and safe prescribing patterns by them.

I would be happy to provide additional articles about this if competency is an issue.

Thank you for the opportunity to speak.

KSNA

the voice of Nursing in Kansas

The Kansas State Nurses' Association supports legislation that would allow Advanced Registered Nurse Practitioners - Nurse Practitioners (ARNP's) to prescribe medications, exculding controlled substances, under standing orders and protocol. Such standing orders and protocol would be jointly adopted by the ARNP and the responsible physician with whom a collaborative relationship exists. The ARNP/Physician would be responsible for periodic review of the clients record, including prescriptions given.

KSNA does not support independent prescriptive privileges for ARNP's.

S.B. 23 seeks to change the definition of "Practitioner" in the pharmacy act and to put prohibitive language in the statute authorizing ARNP - Nurse Practitioners that would negate current Board of Nursing Regulations allowing for prescriptions by ARNP's based on standing orders and protocol. The new language states that ARNP's may transmit orders under the pharmacy act. This new language does not specifically acknowledge the current practice by ARNP's with regard to prescription orders.

Kansas State Nurses' Association • 820 Quincy • Topeka, Kansas 66612 • (913) 233-8638
Peggy Erickson, M.N., R.N.—*President* • Terri Roberts, J.D., R.N.—*Executive Director*

ATTORNEY GENERALS OPINION ON ARNP'S WRITING PRESCRIPTIONS BASED ON STANDING ORDERS AND PROTOCOLS CONTINUES TO HAUNT KANSAS ARNP'S

By: Terri Roberts, J.D., R.N.

This is a chronology of events that have centered around the refusal of one pharmacist in one small rural community in north-central Kansas to fill prescriptions based on written protocols, called or written by an ARNP working in a collaborative relationship with three physicians. The Kansas Pharmacy Association, the Kansas Board of Pharmacy, the Kansas Medical Society, the Kansas State Board of Nursing, and the Kansas State Nurses' Association have been involved in the discussions and decisions related to this area. The Physicians Assistants have a new law that was passed in 1987 with regulations recently enacted that set tighter constraints on their practice as it relates to supervision and collaboration by their respective physician counterpart.

Spring, 1986

The Board of Pharmacy requested an Attorney General's Opinion as to whether physician assistants or ARNP's may issue, pursuant to standing orders or protocol of a physician, prescriptions for non-controlled substance medication.

The Pharmacy Association lobbied to change the definition of "Practitioner" in the definition section of the Pharmacy Act to the following language in SB 799 effective July 1, 1986:

> In order to prescribe medication, then, a person must be a practitioner. Prior to July 1, 1986, a "practitioner" was defined as follows:
>
> "'Practitioner' means a person licensed to practice medicine and surgery, dentist, podiatrist, veterinarian, scientific investigator or other person licensed, registered or otherwise authorized by law to administer, prescribe and use prescription-only drugs in the course of professional practice or research."
>
> K.S.A. 65-1626 (t) (Ensley 1985).
>
> The 1986 session of the legislature amended this provision in Senate Bill No. 779:
>
> "'Practitioner' means a person licensed to practice medicine and surgery, dentist, podiatrist, veterinarian, scientific investigator or other person licensed, registered or otherwise authorized by law *expressly licensed or registered* to administer, prescribe and use prescription-only drugs in the course of professional practice or research."
>
> K.S.A. 65-1626 (t) (L. 1986, ch. 236, 1).

The Board of Pharmacy's Attorney, Lynn Ebel, wrote a position statement for the Board of Pharmacy that supported ARNP's and PA's writing prescriptions based on standing orders and protocols. The Board of Pharmacy adopted the position statement. The opinion concluded:

"While the definition of practicing does not expressly include ARNP's and PA's, there is certainly room for inclusion in its general provision. An ARNP, in conjunction with a physician, are lawfully authorized to administer and use prescription only drugs. I would assert, that under standing orders, the authority to prescribe likewise exists for ARNP's and PA's."

August 27, 1986

The Attorney General's Office released the Attorney Generals Opinion No. 86-125 written by Rita Noll, Assistant Attorney General, which stated the following:

> Synopsis: It is our opinion that advanced registered nurse practitioners may not issue prescription orders pursuant to a physician's standing orders or protocol because they have not been granted such authority by the statutes and regulations under which they are licensed. Physicians' assistants, however, are expressly authorized to practice medicine under the direction and supervision of a physician. Since the practice of medicine includes the art of prescribing medicine, we conclude that orders under the direction and supervision of a physician. Cited herein: K.S.A. 65-1113(d), (g); 65-1626(t), (x), as amended by L. 1986, ch. 236, sl; 65-2869 (b); 65-2896e; 65-2897a (a), (c); K.A.R. 1985 Supp. 60-11-104; 60-11-105; 60-11-106.

September 21, 1986

Board of Pharmacy meeting, after discussing the Attorney General's Opinion, based upon concerns for the public health and welfare, voted to support the Board of Pharmacy's Attorneys opinion that pharmacists may fill prescriptions originated by ARNP's and PA's under pre-established protocols until such time as the legislature further clarifies this issue.

November 13, 1986

Representatives from KSNA, including Advanced Practice Chairperson, Pam Byl, met with the Kansas Medical Society Legislative Committee to identify the issues related to ARNP's writing prescriptions based on standing orders and protocols.

Spring, 1987

The House Public Health and Welfare Committee, Chairperson and legislative staff, in discussions with the Kansas Board of Pharmacy, Kansas State Board of Nursing, Kansas Medical Society, Kansas Pharmacy Association, and Kansas State Nurses' Association representatives, indicates that ARNP's who write prescriptions based on standing orders and protocols are 'transmitting" under the definition in the Pharmacy Act. This was not a legislative decree, simply informal discussion by members as indicated. The Board of Pharmacy continued to defend their position.

August 6, 1987

The Board of Pharmacy requested from the Board of Nursing a written statement regarding the KSBN position of ARNP's prescribing or transmitting a prescription pursuant to protocol. Specifically requesting that KSBN respond to both requests dealing with prescribing and transmitting.

October 20, 1987

ARNP Committee of the Board of Nursing, Elaine Harvey and Mary Harness, present at the meeting discussed and made a formal recommendation to the Board of Nursing to endorse the Attorney General's Opinion No. 86-125.

October 21, 1987

The KSBN Board Meeting, Board Member — Elaine Harvey, made a motion to endorse the Attorney Generals Opinion No. 86-125 and to have the KSBN Attorney, Mark Stafford, write a letter to the Board of Pharmacy responding to their letter.

D ber 23, 1987

The Board of Nursing staff, Janette Pucci, wrote a letter to the Board of Pharmacy indicating the following:

> "The Board of Nursing reviewed your request at their regularly scheduled meeting on October 21, 1987, concerning the prescriptive powers of advanced registered nurse practitioners (ARNP). The Board indicated that the prescriptive powers of the ARNP's should comply with the Attorney General's Opinion No. 86-125."

January 15, 1988

The Board of Pharmacy mailed agenda for their Board Meeting, January 24 - 25th, including on it the response from the KSBN as an agenda item.

January 20, 1988

KSNA Executive Director, Terri Roberts, requested Helen Chop, President of the Board of Nursing, to revisit the KSBN decision related to the endorsement of the Attorney General's Opinion No. 86-125, noting that the letter was going to be considered by the Board of Pharmacy the following weekend. KSNA staff supplied the Board of Nursing members with a copy of the AG's Opinion and was given the opportunity to present rationale for KSBN reversing their endorsement. Libby Dayani was also given an opportunity to speak about ARNP's writing prescriptions based on standing orders and protocol. The Board of Nursing, after receiving these comments went into Executive Session with their attorney, Mark Stafford, and when they returned they made the following motion:

> That the ARNP Committee was to convene and "Review the regulations regarding ARNP's and elaborate on the limitation on this role, with particular attention to the prescriptive power, protocol, transmission of orders, and guidelines."

January 25, 1988

Janette Pucci appeared before the Kansas Board of Pharmacy to inform them of the Kansas State Board of Nursings action on January 21st to refer this issue to the ARNP Committee for action.

January 27, 1988

The ARNP Committee of the Board of Nursing met and discussed the decision by the Board of Nursing to endorse the Attorney General's Opinion 86-125 related to ARNP Prescriptive Privileges. The Committee recommended:

1. That the Kansas State Board of Nursing reverse the endorsement of the Attorney General's Opinion 86-125, and
2. That the Board ask the Attorney General's Office to reevaluate the Attorney General's Opinion 86-125.

There were 12 ARNP's in attendance at this meeting and at least four of them requested that as President of the Board, Helen Chop, consider an emergency KSBN Meeting to review the ARNP Committee recommendations. Helen Chop indicated that she would take this under advisement.

March 9, 1988

9:00 a.m. — The ARNP Committee of the Board met to discuss this issue. Joan Felts chaired the ARNP Committee in Helen Chops absence. Approximately 20 ARNP's and interested parties were present and allowed to voice their concerns related to the Boards current position.

March 9, 1988

11:00 a.m. — The Board of Nursing allowed for discussion by interested parties on the agenda item "ARNP's Prescriptive Privileges." The ARNP's, Representatives of KSNA and KANA all asked the Board to consider the implications of their endorsement and reverse their position in support of the Attorney General's Opinion. The Board went into Executive Session with Attorney, Mark Stafford, and upon reconvening Board member Joann Peavler made the following motion:

I move, that in light of the ARNP Committee recommendation and the comments presented today by interested parties that the Board charges the ARNP Committee the task of defining in Regulatory form, the explanation of protocols or guidelines (expands 60-11-104f) to be presented to the May Board.

March 23, 1988

A conference call was held by the ARNP Committee of the Board to discuss the Boards charge to the committee and strategies for addressing the issues. Joan Felts, Carla Lee, and Mary Harness were the ARNP Committee members on the conference call. Staff was directed to obtain language from several other states Nurse Practice Acts on this issue.

The KSBN ARNP Task Force pre d regulations expanding the def n of protocols in the existing lation K.A.R. 60-11-104.

August 23, 1988

Hearing was held on Temporary Regulations K.A.R. 60-11-104a which clearly defines the role of prescribing under standing orders and protocols by ARNP-Nurse Practitioners. Over twenty ARNP's and several organizations testified in support of the language. KSBN adopted the regulations as temporary, with some recommendations for additional language in the permanent regulations.

September 12, 1988

Rules and Regulations Board approved the Temporary Regulations K.A.R. 60-11-104a for immediate implementation.

November 15, 1988

KSBN held a hearing on permanant regulations K.A.R. 60-11-104a, which would permit nurse practitioners to write prescriptions based on standing orders or protocol. There were several proposed changes to the temporary regulations in place for this authority. Some of the changes were clean-up, such as the addition of nurse and practitioner, the most substantive change was the addition of a new section 5 with a requirement that the protocol or guideline be maintained in 8 1/2 X 11 loose leaf notebook and have a cover page containing: the name, license number, certificate number, and telephone number of the nurse practitioner and the responsible physician, the name, address, and telephone number of a designated physician who agrees to direct and supervise the nurse practitioner in the absence or unavailability of the responsible physician, and documentation regarding the frequency of review for the protocols and the patients charts.

Before the hearing began, Mark Stafford, KSBN legal counsel gave the following explanation regarding his November 14th appearance before the Joint Committee on Administrative Rules and Regulations. Representative Marvin Littlejohn, who chairs the House Public Health and Welfare Committee and is also on the Joint Committee on Administrative Rules and Regulations, questioned (as did other legislators) the legislative authority of the Board of Nursing to promulgate these regulations.

Statements by Mark Stafford, KSBN Legal Counsel; prior to the testimony being taken on Proposed Permanent Regulations for A.R.N.P. Nurse Practitioner Prescriptive Privileges - K.A.R. 60-11-104a:

"The Educational Specialist, Janette Pucci, and myself, had a busy time over at the legislature. The Joint Committee on Rules and Regulations reviewed these regulations. There was some concern by the legislators that the Board may not have the authority to make these regulations. I think one thing is clear and that is that there is question about whether or not we do. I think there is a good argument and they agree, that there is a good argument, that the Board does have this authority. The committee would prefer that this matter be taken up by the legislature and not by the Board. I'm making no judgement and no recommendation on their request, I'm just merely a messenger because they didn't have time to get the message to the Boad by this morning. That message is that they would request that the Board not adopt the regulation at this time, so that the matter can be taken up by the legislature. They did not ask that we withdraw the temporary regulation, their feeling is that they would like to have a study of this and proceed that way. So it's just a message at this point, like I said, to make no recommendation on that."

All of the testimony presented was by ARNP's and other nurses advocating the adoption of the permanent regulations, however, most all of the conferees were unaware of the prior days reaction of the Joint Committee. The Board of Pharmacy did offer testimony asking that the regulations include the following information on the actual prescriptions: Name of the attending physician, and whether the order was under standing orders and protocol or otherwise. The Board did not take any action on these regulations, and deferred discussion of the alternatives until the December 7, 1988 Board meeting.

December 7, 1988

At the KSBN Board Meeting, a motion was made to seek an extension of the temporary regulations 60-11-104a through the Rules and Regs. Board meeting on December 16, and to implement the permanent regulations - K.A.R. 60-11-104a.

December 16, 1988

Before the Rules and Regs. Committee, KSBN staff requested an extension of the temporary regulations for 120 days. This was granted. This extends the temporary regulations K.A.R. 60-11-104a until May 10th.

Also on December 16, the Joint Committee on Administrative Rules and Regs. met and, approved a bill draft for the 1989 Kansas Legislature that would change the Nures Practice Act to prohibit A.R.N.P. - Nurse Practitioners from prescribing drugs, and a language change to the Pharmacy Act which would change the definition of "Practitioner".

S.B. 23

The substantive changes in the bill draft are as follows:

Amends Nurse Practice Act K.S.A. 65-1130 (c)(3) to add:
line 72
An advanced registered nurse practitioner may not prescribe drugs but may transmit prescription orders in accordance with the pharmacy act of the state of Kansas.

Amends the Pharmacy Act K.S.A. 65-1626 (t) to delete language added in 1986 to the definition section of "Practitioner".
line 197
(t) Practitioner" means a person licensed to practice medicine and surgery, dentist, podiatrist, veterinarian, scientific investigator,or optometrist licensed under the optometry law as a therapeutic licensee or diagnostic therapeutic licensee or other person expressly licensed or registered to administer, prescribe and use prescription only drugs in the course of professional practice or research.

TEMPORARY REGULATIONS
K.A R. 60-11-104a

ARNP's - Nurse Practitioners - Prescribing under Standing Orders and Protocol

K.A.R. 60-11-104a. Protocols or guidelines, defined; Requirements:

(a) When used in this article, the term "protocols or guidelines" means written documents containing a precise and detailed medical plan of care.

(b) Each protocol or guideline shall, at a minimum:

(1) Contain the name, license, and certificate number of the nurse clinician or nurse practitioner and the name and license number of the responsible physician who have adopted the protocol or guideline;

(2) show the date the protocol or guideline was adopted, and state the minimum frequency the protocol or guideline is to be reviewed by the nurse and physician;

(3) specify all prescription-only drugs for which the nurse clinician or practitioner is permitted to write a prescription order without direct authorization from the responsible physician;

(4) specify under what circumstances, and how soon, the responsible physician must be contacted after a prescription order is written by the nurse clinician or practitioner.

(c) This regulation shall not be construed to authorize a nurse clinician or practitioner to issue a prescription order for a controlled substance unless otherwise authorized by law to do so.

(d) Nothing in this regulation shall be construed to prohibit any registered nurse or licensed practical nurse from transmitting a prescription order, or from administering a prescription-only drug pursuant to a lawful direction of a person licensed to practice medicine and surgery, dentistry, or nurse practitioner or clinician.

(e) When used in this section, terms shall be construed to have the meanings set forth in the pharmacy act, K.S.A. 1987 Supp. 65-1626.

(Authorized by K.S.A. 65-1129 and 65-1130, implementing K.S.A. 65-1130; effective, T_____, _____.)

PERMANENT REGULATIONS
K.A.R. 60-11-104a

ARNP's - Nurse Practitioners - Prescribing under Standing Orders and Protocol

K.A.R. 60-11-104a. Protocols or guidelines, defined:
Requirements:

(a) When used in this article, the term "protocols or guidelines" means written documents containing a precise and detailed medical plan of care.

(b) Each protocol or guideline shall, at a minimum:

(1) Contain the name, signature of the nurse clinician or nurse **practitioner** and the name and signature of the responsible physician who have adopted the protocol or guideline;

(2) show the date the protocol or guideline was adopted or last reviewed:

(3) specify all prescription-only drugs for which the nurse clinician or **nurse** practitioner is permitted to write a prescription order without direct authorization from the responsible physician.

(4) specify under what circumstances, and how soon, the responsible physician must be contacted after a prescription order is written by the nurse clinician or **nurse** practitioner.

(5) be maintained in an 8½ by 11 looseleaf notebook containing all protocols adopted by the nurse and doctor and kept at the nurse's principal place of practice. The notebook shall include a cover page containing:

(A) the name, license number, certificate number and telephone number of the NP/NC and the responsible physician.

(B) the name, address and telephone number of a designated physician who agrees to direct and supervise the nurse clinician or nurse practitioner. The absence or unavailability of the responsible physician.

(C) the minimum frequency the protocols or guidelines are to be reviewed by the nurse and physician, but such time shall be not less than one year.

(D) the minimum frequency for which prescription orders are reviewed and patient charts are co-signed,and such time shall not be more than thirty days.

(c) This regulation shall not be construed to authorize a nurse clinician or **nurse** practitioner to issue a prescription order for a controlled substance.

(d) Nothing in this regulation shall be construed to prohibit any registered nurse or licensed practical nurse or advanced registered nurse practitioner from transmitting a prescription order **orally** or **telephonically,** or from administering a prescription-only drug pursuant to a lawful direction of a person licensed to practice medicine and surgery, dentistry, or nurse practitioner or clinician.

(e) When used in this section terms shall be construed to have the meanings set forth in the pharmacy act, K.S.A. 1987 Supp 1626. (Authorized by K.S.A. 65-1129 and 65-1130: implementing K.S.A. 65-113-: effective, T-60-9-12-88, Sept. 12, 1988; P _____.)

Kansas State Board of Pharmacy

503 KANSAS AVENUE, SUITE 328
P.O. BOX 1007
TOPEKA, KANSAS 66601
PHONE (913) 296-4056

STATE OF KANSAS

JOHN CARLIN
GOVERNOR

EVERETT L. WILLOUGHBY
EXECUTIVE SECRETARY

LYNN E. EBEL
BOARD ATTORNEY

BOARD OF PHARMACY OF THE STATE OF KANSAS

LEGAL POSITION PAPER

To: Board Members of the Kansas State Board of Pharmacy
Executive Secretary

From: Lynn E. Ebel, Board Attorney

ISSUE: Whether or not a physician may lawfully issue standing orders/protocol, which are to be followed by physician's assistants, or advanced registered nurse practitioners, which standing orders include the issuance of prescriptions for prescription only medication for the physician's patients.

A question has been raised as to whether or not a physician may establish, by protocol or standing orders, a course of treatment which includes the prescribing of prescription only drugs. In particular, the question relates as to whether or not a nurse practitioner (ARNP) or physician's assistant (PA) may follow a physician's standing orders, including those orders which direct, in certain instances, the issuance of a prescription.

At the outset, it is imperative that this opinion be interpreted and construed with the following points in mind:

(1) This opinion deals with standing orders/protocol which include prescribing as part of those orders; it is not concerned with the act of dispensing as that area has been previously been addressed by Attorney General Opinion Nos. 80-208 and 81-182. (Attached for your reference).

(2) This opinion is limited to standing orders/protocol which include prescribing of non-controlled substance prescription medication.

(3) The focus of this opinion is on the legal responsibility and liability of a pharmacist presented with a prescription which he or she knows has been prepared by a health professional (not a physician) pursuant to standing orders/protocol. There is not contained herein, either directly or implied, a commentary on standards of competent medical practice.

With these points in mind, I believe it would be helpful to review the licensing requirements of both physician's assistants and advanced registered nurse practitioners.

Physician's Assistants, K.S.A. 65-2896 et seq.

A physician assistant (PA) is a person registered under K.S.A. 65-2896a and who is qualified, by reason of academic training, to provide patient services under the direction and supervision of a responsible physician. (K.S.A. 65-2897a(c)). A PA may perform, under the direction and supervision of a physician, [1] acts which constitute the practice of medicine and surgery [2] to the extent, and in a manner, authorized by a responsible physician.

The statutory scheme dealing with PA's defines direction and guidance of the physician to mean the guidance, direction and coordination of PA activities, written or verbal, whether by immediate or prior arrangement. The supervising physician accepts continuous and ultimate responsibility for the actions of the PA while performing under his or her direction. (K.S.A. 65-2897a). The specific acts of prescribing and/or dispensing by a PA have not been specifically addressed in the statutes. (However, refer to footnote 2.)

Advanced Registered Nurse Practitioners (ARNP), K.S.A. 65-1130

An advanced registered nurse practitioner (hereinafter ARNP) is licensed under separate statutory authority from that applicable to registered or practical nurses. (K.S.A. 65-1130; K.S.A. 65-1115; and K.S.A. 65-1116.) An ARNP must complete specified post-basic training in education and nursing in order to qualify for ARNP status. K.S.A. 65-1131. The Board of Nursing has adopted a regulation which defines and limits the roll of the ARNP; which categorized specialties of the ARNP is recognized by the nursing profession pursuant to K.S.A. 65-1130(c)(1); and which lists the various functions of the ARNP, as nurse clinician and nurse practitioner. Those functions include:

(a) Basic nursing functions;
(b) Evaluation of both physical and psychological health status by examination, patient history, etc;
(c) Assessment of findings;
(d) Planning, implementing an evaluation of care;
(e) Consultation
(f) Management of the medical plan of care proposed for the client based on protocol guidelines adopted jointly by the ARNP and the attending physician;
(g) Initiation of records and tapes;
(h) Development of individualized teaching plans;
(i) Counseling about health and illness;

---

[1] Does not require immediate or physical presence.

[2] The Attorney General of the State of Kansas has opined that the act of dispensing is an act which constitutes the practice of pharmacy, and not the practice of medicine and surgery. (A.G. Opinions No. 80-208 and 81-182).

(j) Recognition, development and implementation of professional and community educational programs;
(k) Periodic and joint evaluation of services rendered;
(l) A joint review and revision of the adopted protocols and guidelines when the ARNP is involved in the medical plan or care. (K.A.R. 60-11-104)

While the physician maintains continuous and ultimate responsibility for the actions of the PA under his or her supervision, the ARNP, by Nursing Board regulation, is directly accountable and responsible to the consumer. (K.A.R. 68-11-101(a)(2)). This regulation does not serve to absolve the physician; nor is it determinative in the civil courts of whether or not the nurse practitioner is civilly liable for injury to or damages of the consumer. It does indicate that the ARNP is to have some extended discretionary control over and responsibility to the persons under his or her care.

Standing Order/Protocol

The Attorney General's Office of the State of Kansas opined, in 1982, that the Board of Pharmacy of the State of Kansas has no authority under the statutes to provide that the issuance of standing orders by a practitioner is outside the scope of professional practice of a physician. (A.G. Opinion 82-241.) Jurisdiction of such matters lies, instead, with the Board of Healing Arts, which Board may investigate complaints against practitioners who allegedly issue standing orders in contravention of standards of competent medical practice. Impiedly, the Attorney General further opined that the Board of Pharmacy may not exercise control or jurisdiction over the contents of such standing orders/protocol. (A.G. Opinion No. 81-241.)

Nevertheless, a pharmacist, under the law (and pursuant to regulations of the Board), has certain responsibilities, not the least of which is taking care to insure the prescriptions filled by the pharmacist are lawful. Hence, the issue presented herein, is really whether or not a pharmacist may lawfully fill a prescription issued by an ARNP or PA pursuant to standing orders/protocol. It is my legal opinion that a pharmacist may lawfully fill such a prescription.

I. Both ARNP's and PA's are authorized to perform functions traditionally reserved for physicians.

As stated herein, a PA may perform, under the direction and supervision of a physician, acts which constitute the practice of medicine. (K.S.A. 65-2897 et seq.) Prescribing is an act which constitutes the practice of medicine.[1] Supervision does not require immediate or physical presence of the practitioner, but requires, instead, guidance, direction and coordination of the PA's activities, whether written or verbal. Those activities can constitute the practice of medicine. The key is that the PA cannot exceed the scope of responsibility delegated to him or her by the physician and the physician remains ultimately and continuously liable to and responsible for the patient.

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[1] "Dispensing", on the other hand, constitutes the practice of pharmacy and may not be delegated. (A.G. Opinion No. 80-208)

The ARNP, likewise, is given authority by the statutes, to manage the medical plan of care develop (prescribed) for the patient based on protocols or guidelines adopted jointly by the ARNP and the attending physician. (K.S.A. 65-1130; K.A.R. 68-11-104.) It is probably because of the fact that standing orders/protocols are adopted jointly, that the ARNP also assumes responsibility for the patient.

II. Definitions of Prescriptions Order and Practitioner are Broad Enough to Allow Prescribing by ARNP's and PA's Pursuant to Protocol.

K.S.A. 65-1626(x) defines "prescription order" as:

> (1) An order to be filled by a pharmacist for prescription medication issued and signed by a practitioner in the authorized course of his or her professional practice; or
>
> (2) An order transmitted to a pharmacist through word of mouth, note, telephone, or other means of communication directed by such practitioner.

K.S.A. 65-1626(t) defines "practitioner" as a person licensed to practice medicine and surgery, dentists, podiatrists, or other persons licensed, registered or otherwise authorized by law to administer, prescribe, and use prescription only drugs in the course of professional practice or research.

While the definition of practitioner does not expressly include ARNP's and PA's, there is certainly room for inclusion in its general provision. An ARNP, in conjunction with a physician, and a PA, under the supervision and direction of a physician, are lawfully authorized to administer and use prescription only drugs. I would assert, that under standing orders, the authority to prescribe likewise exists for ARNP's and PA's.

I would, therefore, conclude, that an ARNP and a PA may, pursuant to standing orders/protocol, issue prescription for prescription only medications for non-controlled substances.

LEE/csn

AUG 1986

STATE OF KANSAS

OFFICE OF THE ATTORNEY GENERAL

2ND FLOOR, KANSAS JUDICIAL CENTER, TOPEKA 66612

ROBERT T. STEPHAN
ATTORNEY GENERAL

August 27, 1986

MAIN PHONE: (913) 296-2215
CONSUMER PROTECTION: 296-3751
ANTITRUST: 296-5299

ATTORNEY GENERAL OPINION NO. 86- 125

Lynn Ebel Davis
Board of Pharmacy Attorney
Kansas State Board of Pharmacy
503 Kansas Avenue
P.O. Box 1007
Topeka, Kansas 66601

Re: Public Health -- Healing Arts -- Physicians' Assistants; Issuance of Prescriptions

Public Health -- Examination, Licensure and Regulation of Nursing -- Advanced Registered Nurse Practitioners; Issuance of Prescriptions

Public Health -- Examination and Registration of Pharmacists -- Persons Authorized to Issue Prescription Orders

Synopsis: It is our opinion that advanced registered nurse practitioners may not issue prescription orders pursuant to a physician's standing orders or protocol because they have not been granted such authority by the statutes and regulations under which they are licensed. Physicians' assistants, however, are expressly authorized to practice medicine under the direction and supervision of a physician. Since the practice of medicine includes the act of prescribing medicine, we conclude that physicians' assistants may issue prescription orders under the direction and supervision of a physician. Cited herein: K.S.A. 65-1113(d), (g); 65-1626(t), (x), as amended by L. 1986, ch. 236, §1; 65-2869(b); 65-2896e; 65-2897a(a), (c); K.A.R. 1985 Supp. 60-11-104; 60-11-105; 60-11-106.

* * *

5-13

Dear Ms. Davis:

As attorney for the Board of Pharmacy, you request our opinion as to whether physicians' assistants or advanced registered nurse practitioners may issue, pursuant to standing orders or protocol of a physician, prescriptions for non-controlled substance medication. The controversy surrounding this issue was heightened by passage of 1986 Senate Bill No. 779. While this issue raises many related questions, this opinion concerns only the question as presented above.

The Board of Pharmacy is concerned whether a pharmacist may lawfully fill a prescription issued by a physicians' assistant (PA) or an advanced registered nurse practitioner (ARNP) pursuant to standing orders or protocol. Under the statutes concerning the examination and registration of pharmacists, a "prescription order" means:

> "(a) An order to be filled by a pharmacist for prescription medication issued and signed by a practitioner in the authorized course of his or her professional practice or (2) an order transmitted to a pharmacist through word of mouth, note, telephone or other means of communication directed by such practitioner." K.S.A. 65-1626(x), as amended by L. 1986, ch. 236, §1. (Emphasis added.)

In order to prescribe medication, then, a person must be a practitioner. Prior to July 1, 1986, a "practitioner" was defined as follows:

> "'Practitioner' means a person licensed to practice medicine and surgery, dentist, podiatrist, veterinarian, scientific investigator or other person licensed, registered or otherwise authorized by law to administer, prescribe and use prescription-only drugs in the course of professional practice or research." K.S.A. 65-1626(t) (Ensley 1985).

The 1986 session of the legislature amended this provision in Senate Bill No. 779:

> "'Practitioner' means a person licensed to practice medicine and surgery, dentist, podiatrist, veterinarian, scientific

> investigator or other person ~~licensed, registered or otherwise authorized by law~~ expressly licensed or registered to administer, prescribe and use prescription-only drugs in the course of professional practice or research." K.S.A. 65-1626(t) (L. 1986, ch. 236, §1).

The question is whether PAs and ARNPs fit under this definition.

I. Advanced Registered Nurse Practitioner

An ARNP is defined in K.S.A. 65-1113(g) as "a professional nurse who holds a certificate of qualification from the board [of nursing] to function as a professional nurse in an expanded role . . . ." The categories of ARNPs and the role and authority of each are set forth in K.A.R. chapter 60, article 11. An ARNP nurse-midwife and an ARNP nurse anesthetist are both authorized to "participate in the joint review and revision of adopted protocols or guidelines." K.A.R. 1985 Supp. 60-11-105(e); 60-11-106(i). An ARNP nurse clinician has authority to:

> "manage the medical plan of care prescribed for the client, based on protocols or guidelines adopted jointly by the nurse practitioner and the attending physician;
>
> . . . .
>
> "participate, when appropriate, in the joint review and revision of adopted protocols or guidelines when the advanced registered nurse practitioner is involved in the medical plan of care." K.A.R. 1985 Supp. 60-11-104(f), (1).

It is maintained that an ARNP is authorized by law to prescribe medicine since certain ARNPs have authority by regulation to manage the medical plan of care developed for the patient based on protocols adopted jointly by the ARNP and the attending physician. The question is whether, in accordance with K.S.A. 65-1626(t), as amended by L. 1986, ch. 236, §1, an ARNP is expressly licensed or registered to issue prescription orders.

An ARNP functions as a nurse in an expanded role. The definition of the practice of nursing does not include

prescribing medicines. K.S.A. 65-1113(d). As provided by regulation, certain ARNPs in their expanded role may participate in developing a health care plan and manage that plan. This grant of authority does not, however, authorize an ARNP to issue a prescription order. As we are not aware of any statute or regulation which states that an ARNP may issue prescription orders or that they may issue such an order pursuant to standing orders or protocol, we must conclude that ARNPs are not authorized by law to do so.

II. Physicians' Assistants

A PA is defined under the Healing Arts Act as "a skilled person . . . who is qualified by academic training to provide patient services under the direction and supervision of a physician who is responsible for the performance of that assistant." K.S.A. 65-2897a(c). A PA registered with the Board of Healing Arts is authorized to perform the acts outlined in K.S.A. 65-2896e:

> "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 physician's assistant. Before a physician's assistant shall perform under the direction and supervision of a physician, such physician's assistant shall be identified to the patient and others involved in providing the patient services as a physician's assistant to the responsible physician. A physician's assistant may not perform any act or procedure performed in the practice of optometry except as provided in K.S.A. 65-1508 and 65-2887 and amendments thereto." (Emphasis added.)

"Direction and supervision" is defined as follows:

> "'Direction and supervision' means the guidance, direction and coordination of activities of a physician's assistant by his or her responsible physician, whether written or verbal, whether immediate or by prior arrangement, and shall not be construed to mean that the immediate or

> physical presence of the responsible physician is required during the performance of the physician's assistant." K.S.A. 65-2897a(a).

The issue whether physicians' assistants may issue prescription orders was raised during the 1978 session of the legislature. As a result of an interim study concerning physician extenders, the special committee on public health and welfare recommended introduction of 1978 House Bill No. 2719. Section seven of the bill as introduced to the House of Representatives read as follows:

> "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."

The special committee's report on the proposed bill reads in pertinent part as follows:

> "The Committee has concluded that the scope of practice of a physicians' assistant in Kansas should be determined by the employing physician rather than by the Board of Healing Arts or by statutes. Experience in those states which have adopted a statutory 'laundry list' of responsibilities which can be assumed by the physicians' assistant indicates that this approach needlessly limits the use of the physicians' assistant.
>
> "In reaching the conclusion that the responsible physician should determine the

> scope of practice of the physicians' assistant, the Committee recognizes that the physician who employs a physicians' assistant remains legally and medically responsible for the actions of that assistant. Ultimately, only the employing physician can judge effectively how the physicians' assistant performs and the limits of his capabilities. The physician should be free to exercise judgment in such matter, fully realizing that if his judgment is faulty he retains the liability for the practice acts of the physicians' assistant.
>
> . . . .
>
> In line with its conclusion that the scope of practice of the physicians' assistant should be determined by the responsible physician, the Committee has concluded that statutory authorization should be given for physicians' assistants to prescribe legend drugs and controlled substances, except those substances in Schedules I and II of the state and federal controlled substances act. The Committee recognizes that there will be opposition to allowing the physicians' assistant to prescribe drugs. However, the members conclude that such authority should be available if the responsible physician chooses to authorize his assistant to exercise it. Again, the Committee notes that the decision to authorize a physicians' assistant to prescribe, and any limitations on such authority, is that of the responsible physician who also is legally and medically liable for the practice actions of the physicians' assistant." Report on Kansas Legislative Interim Studies to the 1978 Legislature, Vol. II, pp. 1100-1102. (Emphasis added.)

Section seven of 1978 House Bill No. 2719 was deleted from the bill by the Senate Committee on Public Health and Welfare on March 7, 1978. Minutes of that meeting read as follows:

> "Senator Talkington made a motion seconded by Senator Morris to delete New Section 7 . . . . Based on Committee reaction to testimony about the ways in which physician's assistants now write prescriptions it was noted that this seems to be OK as long as the procedure being used is technically legal and the legislators do not have to endorse it . . . . It was again noted that New Section 7 does not authorize a physician's assistant independently to write prescriptions. It is permissible only if the responsible physician authorizes it and only to the extent of his authorization. Motion carried with six voting in favor." (Emphasis added.)

It cannot be said that the senate committee intended to prohibit PA's from issuing prescriptions under the direction and supervision of their responsible physician. The above testimony indicates the committee recognized the authority of a physician's assistant, did not want to endorse this practice in the bill, but wanted to allow each physician the decision whether to allow his or her assistant to write prescriptions.

The question is whether, under K.S.A. 65-1626, as amended by L. 1986, ch. 236, §1, a PA is expressly licensed or registered to prescribe medication. The term "expressly" is defined as "in direct or unmistakable terms; explicitly; definitely; directly." Blacks Law Dictionary 522 (rev. 5th ed.). 1986 Senate Bill No. 779, which changed the definition of "practitioner," was referred to the committee of the whole in both the Senate and House of Representatives the same day it was introduced into each respective house. The language "expressly licensed or registered" was added to the bill by the House on Final Action. Therefore, there are no committee minutes to explain the purpose and scope of the amendment.

The 1986 legislature did not amend or enact a law which states that a PA may not prescribe. In outlining a PA's authority, K.S.A. 65-2896e states that a "physician's assistant may not perform any act or procedure performed in the practice of optometry . . . ." This statute was not amended by the 1986 legislature. The doctrine of expressio unius est exclusio alterius provides that if the "statute specifies one exception to a general rule or assumes to specify the effects of a certain provision, other exceptions or effects are excluded." Blacks Law Dictionary 521 (rev. 5th ed.).

Given this rule of statutory construction, it follows that PAs are not prohibited from prescribing medication because the legislature would have so stated if it had so intended.

The evidence does not show that it was the intent of the legislature to exclude PAs from issuing prescription orders by changing the definition of "practitioner." The statutes, therefore, must be examined to determine whether a PA is "expressly licensed or registered" to prescribe medicine. A prescription order must be issued and signed by a "practitioner," which is defined to include persons licensed to practice medicine and surgery. K.S.A. 65-1626(t) and (x). A provision among the healing arts statutes states that "[p]ersons who prescribe, recommend or furnish medicine or drugs" are deemed to be engaged in the practice of medicine and surgery. K.S.A. 65-2869(b). A PA is authorized to perform "under the direction and supervision of a physician, acts which constitute the practice of medicine and surgery." K.S.A. 65-2896e. Therefore, it is our opinion that physicians' assistants may issue prescription orders under the direction and supervision of a physician.

In summary, it is our opinion that advanced registered nurse practitioners may not issue prescription orders pursuant to a physician's standing orders or protocol because they have not been granted such authority by the statutes and regulations under which they are licensed. Physicians' assistants, however, are expressly authorized by statute to practice medicine under the direction and supervision of a physician. Since the practice of medicine includes the act of prescribing medicine, we conclude that physicians' assistants may issue prescription orders under the direction and supervision of a physician.

Very truly yours,

Robert T. Stephan

ROBERT T. STEPHAN
ATTORNEY GENERAL OF KANSAS

Rita L. Noll

Rita L. Noll
Assistant Attorney General

RTS:JLM:RLN:crw

Prescribing Behaviors of Primary Care Nurse Practitioners

JANET ROSENAUR, RN, MS, DENNYSE STANFORD, RN, MS, WALTER MORGAN, MD, MPH, AND BARBARA CURTIN, RN, MSN

Abstract: The prescribing practices of 18 primary care nurse practitioners (NPs) with 1,683 patients over a six-month period were examined through a randomly selected audit of over 1,700 prescriptions. The results showed that NPs prescribed a very limited number of well known, relatively simple drugs to a young, female healthy population. The prescription/visit rate was 0.26. Most drugs were initiated for the first time rather than refilled. There was minimal physician consultation regarding drug use during the visit. The results provide evidence of the ability of nurse practitioners to prescribe drugs and should aid in the further legalization of this aspect of the primary care role. (*Am J Public Health* 1984; 74:10–13.)

Introduction

Despite the growing body of empirical work on the nurse practitioner (NP) in primary care, there is a paucity of published longitudinal studies describing their prescribing practices. Repicky, *et al*, in a national survey that involved 341 NPs in an ambulatory setting, report practices that emphasize prevention focusing upon minor to moderately severe health problems, and serving a predominantly under age 30, female population.[1] Nearly 20 per cent of the NP encounters were classified as health maintenance. Over 21 per cent of patients had drugs prescribed, but no details about specific drugs were reported.

Munroe, *et al*, in an urban university-affiliated ambulatory care facility, analyzed 1,000 prescriptions written by six N.P. faculty from a selected formulary in a six month study,[2] finding:

- the patient population was predominately female, 16–30 years of age;
- the number of prescriptions was approximately one-third the number written in a primary care medical practice;
- the majority of prescriptions were for primary prevention and fell in the categories of "comfort," "mucocutaneous discomfort" and "contraception";
- antibiotics constituted the largest category of prescriptions written for secondary prevention;
- a chart audit revealed that 98–99 per cent of NP prescriptions were appropriate, consistent with the study protocol, and safe.

The State of California in 1977 approved legislation* that allowed nurse practitioners, physician assistants, and clinical pharmacists enrolled in special projects to prescribe and/or dispense drugs. The study reported here examines the prescribing practices of 18 primary care nurse practitioners; it asks the following questions:

What are the sex, age, and health characteristics of the patients receiving prescriptions?

What are the most frequently prescribed drugs?

What are the most common conditions for which drugs are prescribed?

Are there differences in prescribing related to type of NP or patient characteristics?

What activities most commonly occur during prescribing (initiating or refilling a drug, consulting with MD or pharmacist, ordering laboratory tests)?

Methods

Sample/Procedures

The prescribing behaviors of 18 primary care nurse practitioners were studied over a six-month period. This sample represents all of the practitioners who had volunteered and met the criteria to participate in a four-year prescribing project developed by a consortium of three practitioner programs.** Criteria for participation included passing a pharmacology pretest, availability of a physician preceptor and pharmacist consultant. Ten participants were family nurse practitioners (FNP), three were women's health nurse practitioners (WNP), three were pediatric nurse practitioners (PNP), and two were adult nurse practitioners (ANP). The NPs could prescribe only from a project developed formulary of 257 drugs and devices. All scheduled, controlled substances (narcotics, tranquilizers, sedatives) were excluded, but otherwise the formulary was estimated to represent 90 per cent of all drugs commonly used in primary care practice. No specific treatment protocols were developed for this study. Each NP and MD team incorporated the prescription of drugs from the formulary into existing guidelines being used in that setting for NP practice. All 18 practitioners, at the initiation of the study period, had been prescribing for a minimum of one year under California's legislation.

A total of 1,716 prescriptions representing 1,683 patient visits from July through December 1980 were included in the study. A carbon copy of every prescription written was submitted to the consortium faculty monthly, together with a list of all drugs the patient was currently taking and all current health conditions. These were audited for accuracy of format and the quality and appropriateness of drug selection.

Using a table of random numbers, 20 prescriptions were selected for inclusion in the study from each practitioner's

*California Assembly Bill 717 (AB717)

Address reprint requests to Dennyse Stanford, RN, MS, Adult Nurse Practitioner, Department of Mental Health and Community Nursing, N505Y, University of California, San Francisco, CA 94143. Ms. Rosenaur is an ANP, Associate Clinical Professor in the same department, and a doctoral student in Medical Anthropology; Dr. Morgan is Associate Clinical Professor and Medical Director, FNP-PA Program, Department of Family Practice, U-CA/Davis; Ms. Curtin is Associate Professor, Department of Nursing, FNP Program, Sonoma State University, Rohnert Park, CA. This paper, submitted to the Journal January 11, 1983, was revised and accepted for publication June 29, 1983.

Editor's Note: See also related editorial p 6 this issue.

**University of California, San Francisco (UCSF), University of California, Davis (UCD), Sonoma State University (SSU): Health Manpower Pilot Project 115 (HMPP#115).

5-17

TABLE 1—NP Characteristics (N = 18)

Characteristics	N
Basic Nursing Preparation	
B.S.	8
M.S.	6
Diploma	4
Sex	
Women	15
Men	3
NP Preparation	
C.E.	14
B.S.	3
M.S.	1
Years in Nursing	
10 or more	14
5–10	4
Years as NP	
5 or more	13
3–4	5
Practice Setting*	
Private Practice	9
Community Clinic	6
Health Department	1
College Health	1
Public Health Service	1
Practice Location	
Metropolitan**	10
Non-Metropolitan	8
% of Time Working	
Full-Time	11
Half-Time or Less	7

*Six FNPs worked in private practice and four were employed in community clinics; two PNPs were employed in private practice and one in a health department. One ANP worked in college health and one for the Public Health Service on an Indian Reservation. Two WNPs were employed in community clinics and one in private practice.

**Metropolitan counties, as defined by US Census, are those with more than 50,000 inhabitants or with a single city of that size.

group of monthly prescription reports.*** The ICHPPC/H-IDCA diagnostic classification system was adapted for use in coding the diagnosis for which a drug was prescribed. Other concurrent health conditions of the patient listed on the prescription were coded as either a self-limiting or chronic illness. No data were collected on patients not requiring a prescription nor on the physician consultant's practice. Descriptive data were collected on each prescriber through a mailed questionnaire.

Results

Demographic data for the 18 practitioners (Table 1) reveal an experienced, well-educated group of individuals, the majority of whom work full time in private practices located mostly in metropolitan areas.

As a total group, the practitioners see many patients for whom no drug is prescribed. The ANPs and PNPs see the least number of patients per month and also prescribe the fewest drugs. The majority of patients (86 per cent) in the sample received only one prescription per visit while 13 per cent and 1 per cent of the patients received two and three prescriptions per visit, respectively. Most practitioners consult directly with a physician and utilize the telephone for pharmacist consultation.

In the six-month study period, there were a total of 14,361 patient visits for all practitioners and a total of 3,790 prescriptions written, resulting in a study average of 0.26 prescriptions written per visit (WNP = 0.24, PNP = 0.32, ANP = 0.31, FNP = 0.26).

TABLE 2—Type of Health Condition Category by Which a Drug is Prescribed by Type of NP

Type of NP	N	Prevention (%)	Self-Limiting Illness (%)	Chronic Illness
ANP	206	27	59	14
FNP	900	16	69	14
PNP	233	35	64	1
WNP	316	50	43	7
TOTAL	1,655	26	62	12

$x^2 = 101$, d.f. = 6, $p < .001$

The 1,683 patients for whom drugs were prescribed had a mean age of 23.‡ Less than 5 per cent of the total population were older than 60 years of age. Practitioners saw a predominantly female population (WNP = 100 per cent, ANP = 80.3 per cent, FNP = 67.6 per cent) with the exception of the PNP group whose caseload was evenly divided between the two sexes.

The patient population seen by the study sample was quite healthy; 68.7 per cent of the study population reported no other health problem than the one for which a drug was prescribed. The 106 different health conditions were categorized into three groups. The indication for a prescription in 26 per cent of the patients was Prevention‡‡; in 12 per cent a Chronic Illness; and in 62 per cent a Self-Limiting Illness (Table 2). Of the entire patient population, 12.8 per cent had one additional self-limiting illness, 12.5 per cent had a combination of both chronic and self-limiting illness, and 12.5 per cent had one additional chronic illness; the remaining 6.1 per cent had a combination of both chronic and self-limiting illness, or more than one self-limiting or chronic illness. Table 2 displays the distribution of prescriptions among the three types of conditions according to type of NP.

Table 3 presents the distribution of the 10 most frequently occurring health conditions by NP type. Three groups of practitioners (WNPs, ANPs, and FNPs) prescribe a drug most frequently for contraceptive purposes. The PNP and WNP groups, consistent with their drug usage, prescribe for a narrow range of health conditions, with the top 10 accounting for 90 per cent of all conditions for which they prescribe drugs. The diagnostic categories most commonly seen by the ANP and FNP are very similar.

There are 181 different drugs, drug categories, or devices prescribed by the total study group. Table 4 indicates frequency distribution of the 10 most commonly prescribed drugs or devices by type of nurse practitioner.

The majority of patients (56.4 per cent) were taking only one drug; 32.5 per cent were taking two, and 11.1 per cent were taking three. The distribution of these patients among the four NP groups was similar. An analysis of variance revealed no significant differences with regard to sex, health condition, or type of prescriber activity. A significantly higher percentage of women than men were taking three

***There were four part-time (3 FNPs, 1 PNP) practitioners who routinely wrote under 20 prescriptions each month, therefore their entire monthly output was included.

‡The mean age of patients seen by the PNP group was 3.7 years, while the mean age of patients seen by the other three groups ranged from 25.7 to 27.3 years of age.

‡‡Prevention as a reason for seeking care was defined by the study to include well child care, contraception, prenatal care, and dental health.

TABLE 3—Ten Most Frequently Occurring Health Conditions by Type of NP (N-1,254

WNP	% (N-285)	PNP	% (N-211)	FNP	% (N-579)	ANP	% (N-179)
Contraception	42	Otitis Media	38	Contraception	11	Contraception	27
Vaginitis	31	Well Child Care	34	Vaginitis	8	Otitis Media	9
Prenatal Care	8	URI	4	Otitis Media	7	Dermatitis	8
Dysmenorrhea	4	Dermatitis	4	Bronchitis	6	Cystitis	7
Nausea	1	Asthma	3	Hypertension	6	URI	7
Menopause	1	Conjunctivitis	2	Cystitis	5	Hypertension	7
Cystitis	1	Thrush	1	Dermatitis	5	Vaginitis	5
Bronchitis	1	Pneumonia	1	URI	5	Pharyngitis	4
Anemia	1	Anemia	1	Pharyngitis	4	Bronchitis	3
Salpingitis	1	Acne	1	Well Child Care	4	DJD	2
TOTAL %	90		90		62		79

drugs, and there was slightly more consultation with the physician for patients using three drugs.

Of all drugs prescribed, 85.5 per cent were initiated as new prescriptions while 14.5 per cent were refills. Consultation with a physician regarding the selection of a particular drug during the visit occurred in only 5 per cent of all patient encounters. Consultation with the pharmacist, at the time of the visit, occurred less than 1 per cent of the time. There were significant differences among the four practitioner groups with regard to consultation with the physician. The PNP group consulted the most (16 per cent), whereas the WNP group consulted the least (<1 per cent); the ANP group consulted 6 per cent of the time and the FNP group consulted 4 per cent of the time.

Laboratory tests related to the prescription of a particular drug were ordered over 11 per cent of the time in the entire group. The PNP and WNP groups ordered no laboratory studies, whereas the ANP group ordered laboratory work 10 per cent of the time and the FNP group 19 per cent of the time.

Discussion

The nurse practitioners in this study prescribed a very limited number of well known, relatively simple drugs to a young, predominantly healthy female population, a finding similar to both the Repicky[1] and Munroe[2] studies.

One would expect the PNPs and WNPs to work with relatively healthy populations where many visits would be focused on health promotion rather than illness treatment. However, the ANPs and FNPs are also seeing large numbers of patients, predominantly women, for prevention-related drug or device prescription, primarily family planning. For all three of the NP types who see adults, contraception is the most frequently occurring diagnosis for which a drug or device is prescribed, and three out of the first top 10 most frequently seen diagnoses relate to women's health concerns.

Consistent with the characteristics of the patient population is the finding that hypertension, asthma, and degenerative joint disease (DJD) were the only chronic illnesses in the 10 most frequently occurring conditions for which a drug is prescribed. Previous studies have indicated that ANPs and FNPs in a primary care practice with a physician tend to see more of the maternal-child health group, while physicians see more of the multi-problem/older patient group.‡‡‡ The lack of older adults is unusual and the ANP patient profile may be related to the type of setting where the two ANPs were employed. The provider triage or patient self-selection for the nurse practitioner may also reflect nursing's better preparation in and focus on health promotion and wellness care. This study provides only a partial picture of NP practice. There are no data on the patient visits in which no drugs were prescribed.

The relatively low percentage of consultation activity with the physician is an interesting finding. Consultation in a busy practice frequently occurs prior to a particular patient visit often covering general care issues. The study group was instructed to only record this activity if the NPs consulted during the visit in relation to the selection of a particular drug or drug dosage. This procedure may cause an underestimation in the amount of actual consultation occurring. Since all NPs had been in practice over three years and 15 had remained in the same practice, it is conceivable that they

‡‡‡O'Hara-Devereaux M, Andrus LH, Quilter-Dervin P, Dervin J: Co-Practice: Family Nurse Practitioner-Family Physician. Unpublished report to Robert Wood Johnson and Kellogg Foundations, 1982.

TABLE 4—Ten Most Frequently Prescribed Drugs by Type of NP (N1051)

WNP	% (N-234)	PNP	% (N-192)	FNP	% (N-487)	ANP	% (N-138)
Diaphragm	19	Fluoride	26	Ampicillin	7	BCP	17
BCP	14	Amoxicillin	21	Actifed	7	Diaphragm	11
Betadine	7	Ampicillin	11	Erythromycin	7	Erythromycin	7
Monistat	7	Tri-Vi-Flor	6	BCP	7	Drixoral	5
Flagyl	6	Hydrocortisone	4	Penicillin	7	Penicillin	4
Vitamins	6	Erythromycin	3	Tetracycline	5	Gantanol	4
Contraceptive Jelly Cream	5	Dimetapp	3	Diaphragm	4	Lotrimin	4
Lotrimin	4	Septra	3	Benadryl	3	HCTZ	4
IUD	4	Mycostatin	3	Tri-Vi-Flor	3	Tetracycline	3
Motrin	3	Theophylline	2	Cortisporin	3	Sudafed	3
TOTAL %	74		82		52		61

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needed little consultation because they had already developed many processes of care agreements with their consultants and would be very familiar with the general group of patient problems and the appropriate pharmaceutical regimen. The higher percentage of physician consultation in the PNP group may be the result of the more critical dosage/age requirements in children. Finally, if a physician were consulted, conceivably the physician may have written the prescription, and would not use project forms.

The nearly nonexistent consultation with a pharmacist probably reflects underestimation of actual consultation. NPs were required to document on-site consultation only if it occurred at the time of the visit. Other data required by the larger State project demonstrated a great deal of telephone consultation with pharmacists.*

There are many areas where further research is needed. The small number of NPs in each type prohibits generalizing the findings of this study. It would be important to repeat the study with a larger number of practitioners who were not specially selected. It would also be useful to study the physician colleague's practice to explore the possible influences bearing upon the nurse practitioner selection of particular drugs, the use of non-pharmaceutical measures, and the selection of patients. Such studies are useful to educational programs in planning the pharmaceutical and disease management aspects of their curriculum. They also provide legislators and nurse practitioner advocates with data about nurse practitioner prescribing practices that aid in the legal recognition of this function in California and other states.

*Pharmacist Conference Form E, (HMPP#115) (data collected on frequency of pharmacist consultation).

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2. Munroe D, Pohl J, Gardner HH, Bell RE: Prescribing patterns of nurse practitioners. Am J Nursing 1982, 82; 10:1538–1540.

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AN NP EXCLUSIVE

How Each State Stands on Legislative Issues Affecting Advanced Nursing Practice

Editor's Note: *This article presents the results of a survey designed to see how states compare on three key questions regarding legal and prescriptive authority and reimbursement policies. Such a nationwide comparison of these important issues has heretofore been lacking in recent literature. Limited quantities of this article are available for $2 each. Please make your check payable to* The Nurse Practitioner, *3000 Northup Way, Suite 200, Box 96043, Bellevue, WA 98004. — Linda J. Pearson, R.N., M.S.N., C-F.N.P.*

Legal authority, reimbursement policies and prescriptive authority for nurse practitioners vary from state to state. This prompted *The Nurse Practitioner: The American Journal of Primary Health Care* to compile a table listing current legislative information on advanced nursing practice in all 50 states (plus Washington, D.C.) to facilitate a comparison between the states. While compiling this table was no easy task, the credit and many thanks must go to the many nurses around the nation who answered by phone or letter *The Nurse Practitioner*'s request to report on their state.

Every attempt has been made to produce an up-to-date, accurate accounting on each state. For most of the states, the interpretation of its statute was obtained from a representative of the state nursing organization's NP Special Interest Group, from a representative of an NP organization within the state, or from a member of the State Board of Nursing. Information was verified wherever possible, with our state contacts. The Journal welcomes feedback and will print any validated corrections or updates.

Respondents were asked to report on the status of legal authority in their state, the status of third-party reimbursement for RNs and NPs within the state, and the status of prescriptive authority within the state (see Table 1, pp. 28-34). The table includes a key to abbreviations used.

It is interesting to note differences among the states in how they authorize advanced practice for NPs. *The Nurse Practitioner* survey found that **in 34 states NPs are regulated by the Board of Nursing through specific regulations. In eight states NPs function under a broad Nurse Practice Act scope of practice, and in eight other states NPs are regulated by both the Board of Nursing and the Board of Medicine.** In one state NPs are authorized to practice under the Education Act.

The status of third-party reimbursement for NPs also varies among the states. **In 19 states third-party reimbursement to NPs is legislatively addressed and in 14 other states NPs are currently working intently on obtaining legislative authorization. In six states NPs are receiving direct reimbursement from insurance companies in spite of no legislative authorization.** Twelve states have not addressed the third-party reimbursement question.

In 28 states NPs currently have legislative authority to prescribe (three of these states are working on final implementation of the authorizing rules and regulations). Where the phrase "no current legislative authority" is listed for a particular state, NPs are still prescribing (see *The Nurse Practitioner,* November 1986, 11:11, "NPs Write Prescriptions Regardless of Enabling Legislation," pp. 6-7).

Almost every respondent from states without prescriptive authority explained that the majority of NPs in their state still obtain prescriptions for their patients through one or more of the following mechanisms: 1) by asking a physician to write a specific script for the NP's patient; 2) by calling in the prescription under the physician's name; 3) by co-signing the physician's prescription pad; 4) by using pre-signed prescriptive pads; and/or 5) by using protocols jointly worked out with the NP, physician colleague and dispensing pharmacist.

TABLE 1
Legal Authority, Reimbursement and Prescriptive Authority for Advanced Nursing by State

	Practice (see key)	Reimbursement (see key)	Rx (see key)
Alabama	Covered under the administrative code of the NPA; the BON promulgated R&Rs for specialty practice (NPs, CNMs and CRNAs) in 1982.	Third-party reimbursement legislation drafted in 1986; passed the House but failed to get out of committee in the Senate. The bill has not been reintroduced.	No current legislative authority.
Alaska	NPs have statutory authority to practice as NPs.	A non-discriminatory clause in the Insurance Law allows for third-party reimbursement to NPs.	NPs have independent prescriptive authority including controlled drugs (Schedule II-V).
Arizona	A definition for NPs is outlined in the BON R&Rs addressing extended nursing practice. Currently only NPs are addressed.	Registered NPs and other certified registered nurses can receive third-party reimbursement under law effective until 1990. NPs plan on lobbying to renew law.	NPs have full prescriptive and dispensing authority upon application and fulfillment of criteria established by the BON. The enabling statute allowing CNPs to prescribe is in the pharmacy statute with corresponding R&Rs in the NPA. NPs are provided their own DEA # and may prescribe Schedule II and III drugs (limited to a 48-hour supply per patient) and Schedule IV and V (a one-month supply with no refills per patient). Other drugs may be refilled five times or up to one year before the patient must see an MD for medication re-evaluation.
Arkansas	NPA legitimizes practice for NPs, CRNAs and CNMs; there are separate R&Rs for NPs.	Some private carriers do reimburse RNs directly; Medicaid reimburses CNMs directly, but not NPs.	No current legislative authority; Board of Pharmacy did pass a special waiver for a limited number of drugs for women's health NPs who work for the Department of Health. These prescriptions are pre-printed and cannot be altered. The NPs sign a physician's name and then their own.
California	The BON issues certificates to CNMs and CRNAs. NPs who meet the BON requirements are so designated on their licenses.	Psychiatric clinical nurse specialists are eligible to receive third-party reimbursement. On a pilot basis, NPs are eligible to receive Medicaid reimbursement for services delivered in nursing homes.	NPs who have satisfactorily completed at least six months of MD-supervised experience in furnishing drugs or devices *and* who have satisfactorily completed a course in pharmacology *and* who have been issued a furnishing number by the BON may furnish certain drugs or devices incidental to the provision of family planning services.
Colorado	There is no title protection or specifications for advanced practice within the NPA. The act is broad to cover NPs; scope of advanced practice is based on RN's own determination of education and amount of physician supervision necessary to safely conduct practice.	New legislation allows third-party reimbursement to any RN; billed services qualify for reimbursement only if the type of service has a history of being reimbursable to another health care provider (i.e., a fiscally neutral bill).	No current legislative authority for RNs prescribing.

Key to Abbreviations Used in Table

BON - Board of Nursing
BOM - Board of Medicine
CNM - Certified Nurse Midwife
CRNA - Certified Registered Nurse Anesthetist
R&Rs - Rules and Regulations
NPA - Nurse Practice Act
ARNP - Advanced Registered Nurse Practitioner

Practice - Respondents answered question, "What is the status of legal authority for advanced practice in your state?"
Reimbursement - Respondents answered question, "What is the status of reimbursement for nursing services in your state, including NPs?"
Rx - Respondents answered question, "What is the status of prescriptive authority for nurses in advanced practice in your state?"

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	Practice	Reimbursement	Rx
Connecticut	Though advanced practice is not recognized in NPA, nurses in advanced practice must be certified, based on a declaratory ruling by the BON.	Nurses in advanced practice are reimbursed for services rendered based on state statute.	There is no current legislative authority for nurses in advanced practice to prescribe; however, legislation will be introduced in the 1989 session (opening the NPA) in order to introduce advanced practice and prescriptive authority legislation.
Delaware	In 1985 the NPA was amended to require the BON to write R&Rs for expanded-role nurses. The implementation (by the end of 1989) of R&Rs will require mandatory BON listing of NPs — they will be titled ARNPs.	CNMs obtained legislative authority under the Board of Health for third-party reimbursement in October 1988. Other advanced practice RNs intend to petition soon for authority.	All RNs can apply (with their delegating physician) to a joint-practice committee of the BON and BOM to have their protocols (including a list of prescriptive drugs to be prescribed by the RN) approved. Accepted protocols must be re-evaluated every year.
District of Columbia	NP practice is defined in the Health Occupations Revision Act (1986); NPs are under jurisdiction of the BON. NPs must work in collaboration with physicians or osteopaths.	There is no current legislative authority for NPs to receive third-party reimbursement. However, legislation is currently pending for mental health clinical specialists.	The D.C. statute provides for prescriptive authority for NPs. R&Rs are currently pending.
Florida	NPs are certified by the BON as "Advanced Registered Nurse Practitioners."	NPs receive Medicaid and Champus reimbursement. Mental health clinical specialists, CNMs and CRNAs receive third-party reimbursement.	Prescriptive privileges were obtained for NPs in May 1988 as a result of a decision by the BON/BOM joint committee; controlled substances are excluded.
Georgia	The NPA gives authority to the BON to set R&Rs for NPs, CRNAs, CNMs and clinical specialists in psych/mental health. The current R&Rs specify that NPs should work within protocols that have been jointly developed by the NP and collaborating MD or agency. The protocols are not currently evaluated by any state licensing board; in the 1989 session the NPA is being opened to clarify "protocols." The BON expects agencies to have a policy statement for the NP's scope of practice consistent with general geographic location, and appropriate for the NP's level of education, experience and on-site evaluation.	NPs are not approved providers because there is no legislative statute for third-party reimbursement.	No current legislative authority, though language in proposed NPA (to be introduced in 1989) will, if passed, grant prescriptive authority to NPs.
Hawaii	There is no specific language for advanced practice in the NPA.	NPs are reimbursed for federal programs (i.e., Champus) only.	No current legislative authority.
Idaho	Legality for the NP is jointly promulgated by BON and BOM. Nursing is evaluating proper timing of the goal to introduce legislation eliminating the requirement for joint promulgation of R&Rs.	No current legislation for direct third-party reimbursement for NPs or RNs; the Idaho Nurses' Association is actively working to change this. Certified NPs may apply for a Medicaid reimbursement number.	Prescribing is allowable for certified NPs with written practice protocols; NPs may not prescribe controlled substances.
Illinois	The NPA's definition of nursing practice contains no reference to advanced practice, though NPA legislative transcript (1984) intent includes all nursing specialties. Nursing practice must stay within "the scope permitted by law and within the RN's own educational preparation and competencies."	There is no third-party reimbursement unless the NP works in a certified rural health clinic — the NP can then directly bill both Medicare and Medicaid.	No current legislative authority.

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	Practice	Reimbursement	Rx
Indiana	NP practice is defined in NPA with qualifications "as determined by BON"; the BON has not yet adopted R&Rs.	NPs cannot directly receive third-party reimbursement.	No current legislative authority.
Iowa	Advanced-practice administrative rules are in the NPA. ARNPs are licensed by the BON.	There is "permissive option" legislation which permits third-party reimbursement for NPs.	No current legislative authority.
Kansas	Advanced practice recognition is voluntary for ARNPs (CNMs, NPs and clinical nurse specialists). There is mandatory recognition for CRNAs.	NPs can be reimbursed by Medicaid for assessment screening and case management of technology-dependent children. Third-party payers reimburse CRNAs and CNMs.	NPs may prescribe under jointly adopted protocols between the nurse and physician. The BON will adopt R&Rs for permanent regulations allowing for ARNPs to prescribe following jointly agreed upon protocols with "the responsible physician," excluding controlled substances.
Kentucky	State law licenses ARNPs (including nurse practitioners, nurse midwives and nurse anesthetists).	State law is lenient in directly reimbursing NPs in primary care and rural health centers. Direct physician contact is required in private settings.	A 1988 bill allowing ARNPs to prescribe was narrowly defeated in legislative committee. NPs are gearing up for reintroduction in the interim session in early 1989.
Louisiana	R&Rs for NPs are promulgated by the BON.	There is only Medicaid reimbursement for CNMs.	No current legislative authority.
Maine	Specific regulations for NPs granted by BON; NPs are seeking revision this year with the goal of minimal regulation for advanced practice.	None for NPs but legislation was adopted to include reimbursement to master's-prepared, certified psych/mental health nurse specialists only.	Prescriptive authority is approved by BOM (NPs have their own DEA #). Limits in prescribing formulary by exclusion (i.e., narcotics).
Maryland	NPs are certified to practice through the BON; requirements include passing a nationally certified exam and written agreement with a responsible MD (the agreement is reviewed by an equally represented joint MD/NP committee).	Per legislation passed in 1986, all nurses are entitled to reimbursement for services as long as they are practicing within their legal scope of practice. Medicare is pending; approval by the state legislature is anticipated shortly.	NPs prescribe medications as agreed upon in writing with physicians. The NP uses his or her own signature on the prescriptive pad; a list of NPs "certified to practice" is sent to pharmacists. There was a question several years ago whether the pharmacy regulations allowed "filling" of scripts written by NPs, but the attorney general's opinion was that NP scripts were as acceptable as any other provider's.

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Rx - Respondents answered question, "What is the status of prescriptive authority for nurses in advanced practice in your state?"

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	Practice	Reimbursement	Rx
Massachusetts	Since 1975, nurses with additional education approved by the BON may perform certain additional acts under R&Rs approved by the BON and BOM. This includes NPs, CNMs, CRNAs and psychiatric nurse/mental health clinical specialists.	Psychiatric nurse/mental health clinical specialists and midwives are currently reimbursed due to state law. Bills are pending before the Legislature on reimbursement for NPs and CRNAs.	NPs, after registering with the Department of Public Health, may prescribe for patients in long-term-care facilities as well as for chronic-disease patients in their homes, if this would avoid their being institutionalized.
Michigan	The BON has R&Rs for nurse specialty certification — only nurses certified in a specialty field may present themselves to the public as nurse specialists using the title of nurse anesthetist, CNM and NP.	Two attempts so far to get legislative enactment have failed; however, several nurses have obtained a provider number and are receiving direct reimbursement.	A January 1980 attorney general decision interpreted the statutes to allow physicians to delegate the prescribing of drugs to RNs.
Minnesota	NP authority to practice is covered under a broad NPA; there is no separate category for advanced practice.	CNMs and CRNAs already have legislative authority for reimbursement. NPs and clinical nurse specialists in psych/mental health just received legislative authority for reimbursement in the 1988 legislative session.	CNMs just received authority to prescribe in 1988. NPs hope to try in the next few years for their own prescriptive authority.
Mississippi	NPs are regulated by the BON. R&Rs regarding NP practice are jointly promulgated by BON and BOM. A BON-sanctioned committee structure (consisting of NPs and consulting MDs) evaluates (every two years) each NP's "protocols" (written statement of the types of medical diagnoses and treatments anticipated for their practice).	CRNAs and NPs (in rural health clinics) receive federal funding reimbursement. NPs have worked hard to obtain legislative enablement for Medicaid reimbursement, but so far no success. The third-party reimbursement law for NPs was first passed in the early '80s but that law had a "sunset" clause and required an MD sponsor co-signature on the form. The '88 legislative session removed the "sunset" clause but retained requirement for MD co-signature.	NPs have statutory prescriptive authority granted by BON; the prescriptive authority is based on the accepted "protocol" which lists the treatments and medications the NP expects to prescribe in his or her practice. NPs are not allowed to prescribe controlled substances.
Missouri	Advanced practice is permitted based on broad language of the NPA, and a decision by the Missouri Supreme Court.	Medicaid reimburses CNMs directly with no direct reimbursement for other nurses. Blue Cross/Blue Shield has a statutory non-discriminatory policy for licensed health care providers. Whether other types of insurance reimburse NPs depends on the company policy.	There is no statutory prescriptive authority. Authority is granted through standing orders/protocols with cooperating physicians.
Montana	Nurse specialists (NPs, CNMs and CRNAs) are recognized by the BON to practice after completion of specific curriculum requirements plus successful completion of a certifying exam by a recognized certifying body.	Nurse specialists have third-party reimbursement for all the areas and services for which a policy would reimburse an MD.	No current legislation authorizing prescriptive authority; however, nurse specialists are working hard on this issue and are identifying the changes needed and the most effective way to make the necessary changes.
Nebraska	NPs are certified as CNPs on approval by the BON and BOM. CNPs and MDs must have joint approval of their "practice agreement" contract. The practice agreement must include the NP's scope of practice and the practice arrangement with the MD. NPs must have written protocols for clinical entities seen. Changes must go through the Department of Health (BON).	Except where federally mandated there is no state legislation for third-party nursing reimbursement.	NPs may prescribe as specified on the "practice agreement" form. Drugs prescribed must be listed on NPs' protocols and may not include Schedule II drugs. The NP must use an Rx pad containing the MD's name preprinted at the top; the signature contains NP name/MD name.

	Practice	Reimbursement	Rx
Nevada	An advanced practitioner of nursing (APN) is recognized by BON (title includes CNMs). Applicant must have graduated from a year or longer program, be accredited by a board-approved organization, and submit a signed agreement (including the scope of practice and protocols) between the APN and the collaborating MD. After 1988 all APN applicants must hold a BSN and after 1995 must hold an MSN. The BOM has R&Rs for MDs working with APNs.	NPs and CRNAs have received third-party reimbursement since 1985. Some other nurses in private practice also receive third-party payment.	APNs may prescribe (since 1983) if they submit to the BON documentation of 1,000 hours as an APN under a supervising MD and a signed statement from the MD. The APN can then prescribe any meds (excluding controlled substances) listed in his or her protocol (developed by the supervising MD at the site and updated yearly).
New Hampshire	NPs are registered with the BON as ARNPs (if they are a graduate of an NP program and have passed a certifying exam acceptable to the board).	All major insurance companies must by law reimburse ARNPs (not all RNs). Some insurers reimburse ARNPs at 100 percent and others at 90 percent. The law does not apply to companies that are self-insurers.	An ARNP who functions in connection with protocols established jointly with a "collaborative physician" may prescribe medications from the official formulary which has been jointly agreed upon by the BON and BOM. ARNPs are assigned DEA #s.
New Jersey	NPs practice under RN licensure with BON guidelines for primary care NPs.	There is third-party reimbursement (for services traditionally reimbursed to MDs) for RNs and NPs who are not employed as salaried personnel.	Legislation is currently pending which will authorize prescriptive privileges for NPs.
New Mexico	NPs have been defined in the NPA for more than 10 years. Functions and responsibilities are detailed in the R&Rs from the BON.	Reimbursement has been in effect for CNMs and CRNAs. Statutory authority for third-party reimbursement was passed in 1987 for clinical nurse specialists and NPs.	NPs have prescriptive privileges with their own signature in accordance to written protocols with physician supervision. NPs are listed at the BON, Board of Pharmacy and BOM.
New York	Specific legislation amending the Education Act to authorize NPs' title and scope of practice will become effective April 1, 1989.	Reimbursement mechanisms are under discussion with state agencies for NPs to be recognized providers for Medicaid participants. NPs believe that the existing model ("obstetrician and CNM") will be applicable to "NP and collaborating physician."	The new law specifies Rx authority for NPs in a collaborative relationship with MD and with written practice agreement and protocols. The law states "prescribed drugs, devices and immunizing agents" without restriction (i.e., controlled substances). Regulations to implement the new law are being developed.
North Carolina	NPs apply to a Joint Practice Subcommittee of the BOM and the BON to obtain approval to practice as an NP. NPs may own their own private practice as long as they contract with an MD (not necessarily on site) to act as medical backup.	NPs receive Champus payment only.	NPs may write prescriptions with limited refills from an approved list of drug categories (i.e., no narcotics or chemotherapy medications). Authority to prescribe (NP is assigned a prescriptive #) is given at time of approval to practice as an NP.
North Dakota	Advanced practice for NPs and clinical nurse specialists is regulated by the BON after demonstrated advanced education and certification.	A bill for nurse reimbursement was passed in the 1985 legislature but amended to make it useless. The bill will be reintroduced in the 1989 legislative session.	No current legislative authority.

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	Practice	Reimbursement	Rx
Ohio	With the 1988 revised NPA the BON now has authority to establish criteria for specialty certification of RNs with advanced education and experience. No R&Rs have been developed to date.	Some RNs including NPs are receiving reimbursement as a result of direct negotiations with insurance companies; there is no proposed legislation at this time.	There has been no legislation introduced.
Oklahoma	NPs are defined in NPA and regulated by BON; NPs must have successfully completed a program approved by BON.	There is no current legislation for third-party reimbursement for NPs.	There is no current legislative authority.
Oregon	Authority for NP practice is granted through the NPA and regulated by BON. Scope of practice is very broadly defined in statute; a master's degree is required for entry into NP practice.	NPs are directly reimbursed by third-party payers by law. Exceptions include HMOs, PPOs, etc., which has been a problem. The Oregon Supreme Court recently ruled that Worker's Compensation insurance must consider NPs as independent health care providers and reimburse them without physician referral or supervision.	NPs have prescribing authority which is regulated by BON. A council consisting of NPs, MDs and pharmacists determines the formulary from which NPs can prescribe. NPs must have a postgraduate pharmacology course to be certified to prescribe.
Pennsylvania	Expanded-role nurses can function and practice under the 1974 NPA. When an NP's practice is composed of both the nursing and medical model (a decision determined by the individual licensee), the NP requests a joint review (by the BON and BOM). The BON and BOM use jointly promulgated R&Rs to determine if the NP is recognized as a certified RN practitioner (CRNP). The BON (looking at the current community standard of nursing practice) provides informed opinions on individual RN requests of their scope of nursing practice; these answers help each nurse determine whether his or her practice is nursing- or medical-model-based.	Reimbursement exists for the following six categories of RNs: enterostomal therapists, CRNAs, CRNPs, clinical specialists, psychiatric nurses, and community health nurses. Reimbursement is dependent on whether or not the third-party insurance policy covers billed services.	NPs have petitioned the BON to meet with the BOM to set up R&Rs. Prescriptive authority is possible within the current law but not yet implemented through R&Rs.
Rhode Island	Advanced practice is covered under the NPA.	Currently, psychiatric clinical specialists are the only directly reimbursed group.	Legislation passed in the 1988 session will allow CNMs to prescribe.
South Carolina	Advanced-practice nurses must be officially recognized by the BON and must have MD preceptors to practice in the extended role.	No current legislation; NP groups are intently looking at how to introduce reimbursement legislation into the Legislature.	No current prescriptive authority but a written proposal to allow advanced-practice RNs to prescribe is currently being negotiated with the BOM.
South Dakota	NPs must apply to a joint committee between the BON and BOM and osteopathic examiners in order to become certified nurse practitioners (CNPs). The joint board committee contains an equal representation of nurses and MDs. CNPs must work under the supervision of an MD.	The insurance law since the early '80s specifies that NPs and CNMs can receive third-party reimbursement. The most prominent payer, Blue Cross/Blue Shield, has assigned provider numbers to NPs.	CNPs may prescribe because prescribing is considered a delegated medical function. CNPs and their supervising MD must submit their "practice agreement" (including the list of medications the CNPs will prescribe, and the CNPs' scope of practice) to the joint board; the agreement is filed with the BON.
Tennessee	RNs functioning in an expanded role assume personal responsibility for their acts. RNs who manage the medical aspects of a patient's care must have written medical protocols, jointly developed by the nurse and the sponsoring MD(s). The detail of medical protocols varies in relation to the complexity of the situations covered and the preparation of the RN using them.	Legislation providing for direct Medicaid reimbursement was passed for CRNAs in 1987 and for CNAs in 1988. There is no law to mandate reimbursement from private payers, though some NPs receive reimbursement on an individual basis.	Master's-prepared NPs who are certified through ANA, ACNM and NAACOG and who have specified pharmacology courses may apply to BON for a "certificate of fitness" with privileges to write and sign prescriptions and/or issue non-controlled legend drugs. "Certificate of fitness" must also be approved by the Primary Care Advisory Board for the site of practice, and recorded by Division of Health related boards.

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	Practice	Reimbursement	Rx
Texas	Advanced practice (CNM, CRNA, clinical nurse specialists and all NPs) is regulated by the BON under the title of "Advanced Registered Nurse Practitioners."	There is no direct third-party reimbursement except CNMs have Medicaid reimbursement.	No current legislative authority.
Utah	NPs are licensed by BON; since 1987 all NPs must be master's-prepared.	There are no restrictions prohibiting third-party reimbursement to NPs. NPs are reimbursed by some insurance companies; NPs have not organized to challenge the others.	All NPs in practice with an MD can apply for prescriptive privileges. The MD need be only in telephone contact with the NP (i.e., does not need to be in the office). Protocols are developed by the MD and NP and are submitted for approval to the prescriptive board consisting of three NPs, three MDs and a pharmacist.
Vermont	Advanced practice is controlled by BON under NPA with exceptions addressed within the R&Rs in the administrative text.	Blue Cross/Blue Shield reimburses NPs and CNMs utilizing a provider number.	No current legislative authority.
Virginia	The Medical Practice Act authorizes advanced practice under R&Rs jointly promulgated by BON and BOM (includes NPs, CNMs, clinical specialists and CNAs).	There is no current legislative requirement to pay NPs. Third-party reimbursement for CNS in psych/mental health will be up for legislative action this year.	No current legislative authority.
Washington	Advanced practice is authorized by the BON R&Rs for ARNPs.	There is reimbursement for nursing services since 1974 for disability and in 1981-83 for health care contractors.	Legislation for prescriptive authority is authorized under the BON and entails additional certification beyond the ARNP.
West Virginia	NPA addresses nurse midwives and nurse anesthetists only; other nurses in advanced practice operate according to NPA which is subject to interpretation.	There is third-party reimbursement legislation for NPs; however, the R&Rs have never been promulgated.	No prescriptive privileges at this time; however, NPs are intently researching the issue.
Wisconsin	NPs function under an NPA with a broad description of nursing practice; there is no specific definition of advanced practice.	None specified legislatively. Champus reimburses NPs, and home health RNs bill under their own provider number. NPs are working on legislation for reimbursement for nursing home visits; however, the current political makeup of the Senate precludes this at this time.	No current legislative authority.
Wyoming	The NPA gives authority for BON to recognize advanced-practice nurses after demonstrated advanced education and certification.	NPs are planning to introduce reimbursement legislation into the Legislature in the January 1989 session.	No current legislative authority.

BON - Board of Nursing
BOM - Board of Medicine
CNM - Certified Nurse Midwife
CRNA - Certified Registered Nurse Anesthetist
R&Rs - Rules and Regulations
NPA - Nurse Practice Act
ARNP - Advanced Registered Nurse Practitioner

Key to Abbreviations Used in Table

Practice - Respondents answered question, "What is the status of legal authority for advanced practice in your state?"
Reimbursement - Respondents answered question, "What is the status of reimbursement for nursing services in your state, including NPs?"
Rx - Respondents answered question, "What is the status of prescriptive authority for nurses in advanced practice in your state?"

5-26

Linda J. Pea[illegible]n, R.N., M.S.N., C.-F.N.
Editorial Director

NPs Write Prescriptions Regardless of Enabling Legislation

Last summer we sent out a questionnaire with the June issue of *The Nurse Practitioner*. From the responses to this questionnaire, we planned to select approximately 200 nurse practitioners from all regions of the country and from a variety of practice sites to participate in an ongoing research project. We had no idea that the response would be so great. Within the first two months of sending out the questionnaire, we received a total of 1,929 responses. There were an additional 171 responses that arrived too late for data analysis. And questionnaires keep dribbling in even now. We collected a wealth of information, and decided to analyze the most interesting data and share it with you. Of the 1,929 tabulated responses, we had to remove 241 from the analysis because the questionnaires were incomplete.

Table 1 shows the number of respondents from each state grouped by region. Although we received a significant number of responses from each region, the East was the most heavily represented. The majority of respondents work in ambulatory clinics or offices and see patients of all ages.

Prescriptive Practice in States With and Without Laws Granting Prescriptive Privileges

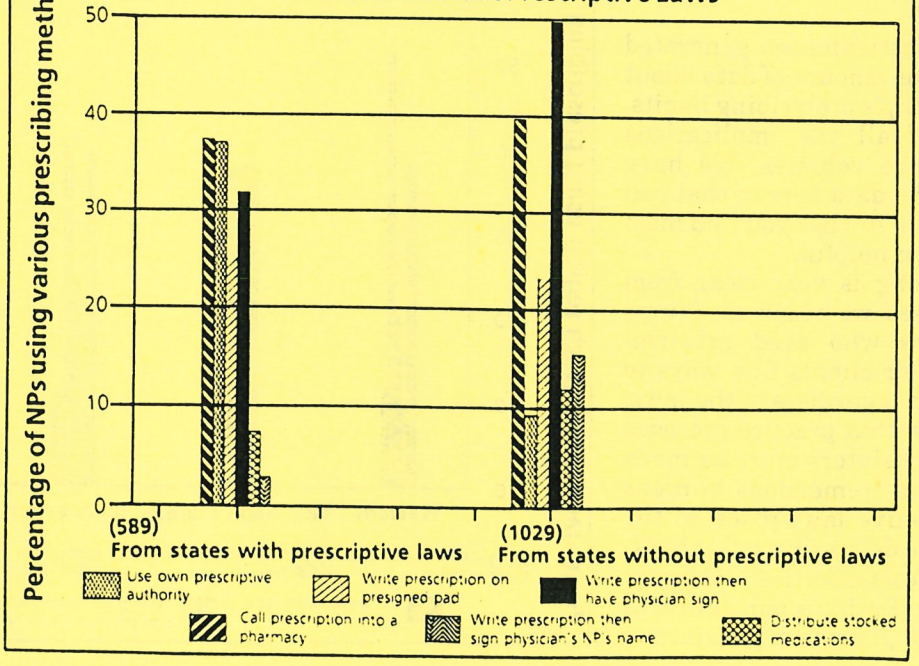
The most fascinating data we gathered concerned the methods used by respondents to obtain prescriptive products for clients. We divided the respondents into two groups: those from states with some sort of prescribing law and those from states without a prescribing law. We wanted to see if there were any significant differences in the prescriptive practices of these two populations. Figure 1 shows the percentage of each prescriptive method used by all the NPs.

The method of calling the prescription into the pharmacy is used approximately as often by NPs in states with prescribing laws as in those without. Similar findings are also evident among NPs from states with prescribing laws and from states without prescribing laws who write a prescription on a presigned prescription pad. It's interesting to note that whether or not a state has a prescribing law doesn't seem to affect those prescribing methods.

More of those nurse practitioners who reported that they write a prescription and then get a physician's signature and those who reported that they write the prescription then sign the physician's/NP's name came from states without enabling legislation. Clearly, physicians and pharmacists recognize that nurse practitioners' patients need prescriptive products.

It is not surprising that more NPs who reported using their own prescriptive authority came from states with prescribing laws. NPs in states without enabling legislation reported that they used this method if they worked in institutional settings (HMOs, veteran's hospitals or the military) where they had the authority to prescribe. Distributing stocked medications to clients was not a method reported frequently by either group, but it is used more frequently by NPs from states without prescribing laws.

FIGURE 1
Comparison of Prescribing Methods in States With and Without Prescriptive Laws



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Comparison of Prescriptive Methods by Region

Figure 2 shows the data on prescriptive methods used by respondents from the five regions. It is interesting to note that the respondents from the West reported that they write the prescription and then get a physician's signature more than respondents in any other region. The relative percentage of prescriptive method choice is very similar in the West and the East.

From the data in Table 1, it is possible to calculate the percentage of NPs within each region who come from states with prescribing laws (the West, 10 percent; Mountain states, 59 percent; the Midwest, 14 percent; the South, 27 percent; and the East, 57 percent). The Mountain states region has the highest percentage of respondents reporting use of their own prescriptive authority. Even though the percentage of respondents from states with prescribing laws in the East is almost as high as in the Mountain states region, the NPs in the Mountain states use their own prescriptive authority more often.

Respondents from the Midwest reported that they write the prescription and sign the physician's name far more than NPs in any other region. NPs from all the regions reported distributing stocked medications with approximately the same frequency.

Conclusion

The questionnaires generated a tremendous amount of data about our readership's prescribing habits. Analysis of all the implications would require volumes. We have presented the data here so that you can take from it what you find most interesting or helpful.

One thing is very clear from the responses we received. Nurse practitioners who need prescriptions for their clients find ways to obtain them regardless of the laws. We all know that practice precedes the law. Legislators must be made aware of the tremendous burdens some restrictive laws place on the NPs who are delivering safe, client-oriented, cost-effective primary ...th care. Perhaps our data will ...rompt state legislators to write laws validating the prescriptive practices of NPs. If so, it will have been an unintended accomplishment. We will continue in our efforts to describe nurse practitioner practice so that law makers, the public and other health care providers can better appreciate the important role NPs play in this country's health care system. We thank you for your help towards these ends. ○

TABLE 1
Respondent Demographics

Numbers in ( ) represent the number of respondents from each region and state.

Western Region (198)
Alaska (3)
California (179)
Hawaii (0)
Oregon (0)
Washington (6)
Nevada (10)

Mountain States Region (175)
Idaho (15)
Montana (5)
Wyoming (8)
Colorado (59)
New Mexico (20)
Arizona (47)
Utah (21)

Midwestern Region (325)
Minnesota (36)
Wisconsin (48)
Illinois (68)
Iowa (10)
Missouri (20)
Michigan (42)
Indiana (39)
Ohio (22)
Kansas (17)
Oklahoma (10)
Nebraska (5)
North Dakota (4)
South Dakota (4)

Canada (2)

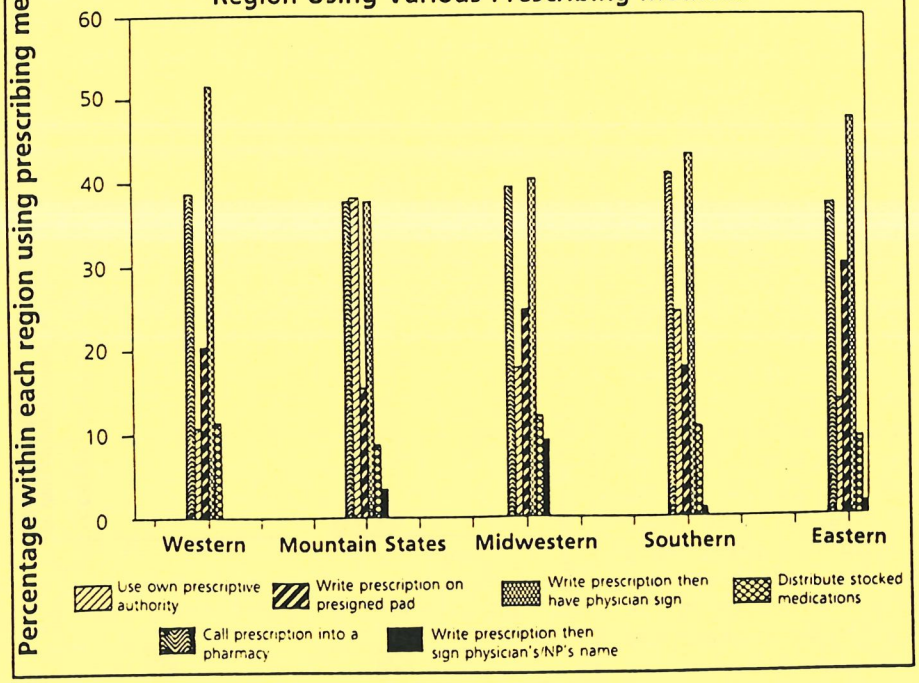
Southern Region (358)
Arkansas (8)
Louisiana (7)
Mississippi (8)
Texas (74)
Alabama (17)
Georgia (43)
Florida (77)
Kentucky (26)
North Carolina (53)
South Carolina (10)
Tennessee (35)

Eastern Region (628)
West Virginia (10)
Virginia (48)
Maryland (69)
Rhode Island (13)
New Jersey (32)
Pennsylvania (85)
Maine (16)
Washington, D.C. (7)
New York (150)
Massachusetts (129)
Connecticut (38)
New Hampshire (18)
Vermont (9)
Delaware (4)

Sites
Ambulatory Clinic/Office (892)
Hospital Outpatient Clinic (190)
Hospital Inpatient Clinic (94)
Occupational Health (88)
Public Health (148)
School Health (134)
Teaching (50)
Nursing Home/Hospice (48)
HMO/VA Service (41)

Patient Population
All Ages (662)
Women Only (294)
Children Age 0-6 (6)
Children School-Age (33)
Children Age 0-18 (178)
Adults Only (391)
Older Adults Only (122)

FIGURE 2
Percentage of Respondents in Each Region Using Various Prescribing Methods



Chairman Ehrlich, Committee Members:

My name is Charlotte Peake and I am a Family Nurse Practitioner practicing in rural north central Kansas in the town of Belleville. It is a collaborative practice with two family practice physicians.

The physicians who employ me rely on me to see patients in the office, assist them with the care of our hospitalized patients, and assist with emergency patients among other duties.

When I see a patient in the office that needs a medication prescribed, I follow protocols which my physicians and I have developed together. The medication which the patient receives after I see him is one that the physician has chosen and included in the protocol, not one which I have independently chosen to give the patient. At the same time, it should be noted that I do not consult the physician each time I see a patient, but rather rely on the protocols which we have jointly developed.

Protocols are not new or unique to Kansas. There are actually several books published which consist of protocols. One which nurse practitioners and their physicians frequently refer to is by Hoole, titled "Patient Care Guidelines for Nurse Practitioners". When the rules and regulations in the Nurse Practice Act were initially written with the phrase "manage the medical plan of care prescribed for the client, based on

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protocols or guidelines adopted jointly by the nurse practitioner and the attending physician", the intent for medications to be listed and included as part of the treatment plan was always there. The definition developed by the Board of Nursing recently simply clarifies this and actually tightens the language by requiring that they be on file, contain the license numbers of the practitioners and physicians and that they be reviewed in a timely fashion. It is also to be noted that this regulation does not authorize a nurse practitioner to issue a prescription order for a controlled substance.

My concern Chairman Ehrlich and committee members is that the portion of Senate Bill 23 which reads "**An advanced registered nurse practitioner may not prescribe drugs but may transmit prescription orders in accordance with the pharmacy act of the state of Kansas**" will nullify the regulatory language change adopted by the Kansas State Board of Nursing this past December and in so doing would place constraints on nurse practitioners practice severely limiting their effectiveness as health care providers.

As Senator Frey stated in written testimony to the Board of Nursing this last summer in his support of the language change, "Studies have shown that nurse practitioners provide safe, high quality care, are well accepted by the consumer and are cost effective. They should be viewed as a solution to a portion of the many complex problems facing our state's health care needs."

We are not asking to be able to prescribe, but rather to be able to issue prescription orders per protocol. Unnecessary constraint in this area will limit the ability of nurse practitioners to function in the role for which they have been trained.

Thank you for hearing my testimony. I will be happy to answer any questions which you may have regarding this important issue.

CONTACT DERMATITIS DUE TO POISON OAK OR POISON IVY

Definition: An acute dermatitis resulting from contact with the resin of poison oak or poison ivy.

Etiology: Most cases come from contact with the leaves of the plant; however, cases may come from digging in ground that contains the growing plant. An outbreak may also result from contact with the smoke of burning plants, unwashed contaminated clothes, dried (uprooted) plants that still retain resin, or a pet that has had contact with the plant.

Clinical features:

A. pruritic vesicles usually appear on the extremities
B. early eruption may be erythematous and raised without vesicles.
C. linear streaks of erythema or vesicles are usually seen where plant has brushed across skin.

Laboratory studies: none

Differential diagnosis:

A. other contact dermatitides
B. insect bites

Treatment:

A. Advise patient on the following preventive measures:
   1. Be familiar with the appearance of the plant & how to avoid it.
   2. Wash all clothes worn at the time of contact
   3. If known exposure occurs in the future, immediately wash contact area to prevent or minimize clinical symptoms.

B. General Measures. Tell patient to do the following:
   1. Soak the affected area in saline or use cold compresses 20 minutes 4 times a day.
   2. Apply a drying lotion (e.g. calamine lotion) after each soak or cold compresses
   3. Avoid topical lotions containing antihistamines or benzocaine derivatives. These ingredients add nothing and may act as allergens.
   4. Use an oral antihistamine for sedation and as an antipruritic in moderate to severe cases.
   5. If there is no weeping, apply 1% hydrocortisone cream 4-6 times a day sparing over area.
   6. Use Medrol Dosepack 21 tablets, 6 day schedule for severe cases and cases involving the eyes, face, mucus membranes and genitalia, following physician consultation.

Pittsburg State University
Student Health Services and Wellness Programs
1801 South Joplin • Pittsburg, Kansas 66762 • 316/231-7000, Ext. 4452

TO: JOINT COMMITTEE ON ADMINISTRATIVE RULES AND REGULATIONS

FROM: CHERIE BRANSON, RN, ARNP, MS
DIRECTOR OF STUDENT HEALTH CENTER

RE: SENATE BILL 23

DATE: JANUARY 18, 1989

Senator Erhlich, members of the committee, colleagues, and guests. My name is Cherie Branson, I am the director of the Student Health Center at Pittsburg State University. I am, also, an advanced registered nurse practitioner. My purpose is to testify in **oppostion** of Senate Bill 23 within the boundaries of its present language. I do so on behalf of Pittsburg State University and student health officials at Fort Hays University, Wichita State University, Kansas State University, and Kansas University. My repesentration addresses my personal interest to preserve the a vital scope of practice necessary to the advanced registered nurse practitioner.

First and foremost, thank you for the opportunity to express my concerns regarding Senate Bill 23. It is my belief that we are here today because we are commited to the common goal of safe, economical consumer care. Therefore, I commend your dedication towards the efforts to resolve and clarify the terminology in regards to **prescriptions privileges per protocol.** I believe that the general content of the bill is favorable. I would raise the question to you, as legislators, does the language actually delineate the practice of Advanced Registared Nurse Practitioners? It is my opinion, it does not. Perhaps, the response to the language has created a misinterpretation of the intention. This is where the confusion lies, not with what it is that we do, but the terminology we use to describe it.

There are nine (9) advanced registered nurse practitioners serving clients at five (5) different Kansas Regent's Universities. All of us have met the educational requirements as defined K.A.R 60-11-103(1). Two of these nurse practitioners have advanced degrees, one has a masters in nursing, and another has a master's degree who is currently enrolled in doctoral studies. Currently, we provide services to an approximate number of staff, student, and faculty population over 70,000 consumers. As we continue to manage this client population, we do so with prescription per protocol. We do not desire unlimited prescriptions privileges.

We, as nurse practitioners, manage clients using carefully designed protocol that is jointly developed with our attending physician. These protocols are developed to comply with K.A.R.60-11-104(f). Some of the protocols, utilized in my practice, do contain prescription only drugs. These prescription drugs are not my personal choice; they are the choice of my attending physician. I have taken the liberty of attaching some various protocols that are used in our daily practice (yellow enclosure). Each disease modality lists a specific plan of action based on the objective and subjective findings. **Any deviation from this structured plan of care necessiates a consultation with the attending physician.** It is my opinion that Senate Bill 23 would not permit us to continue the utilization of prescription privileges per protocol.

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I have, actively, been involved in the public hearings held by the Kansas State Board of Nursing concerning the adoption of K.A.R 60-11-104a. During the past year, I have had the opportunity to make contact with many Advanced Registered Nurse Practitioners statewide. I am also chair of the Task Force for the Advancement of ARNP's. Therefore, I feel I am justified in stating that I have not come in contact with any practitioner expressing the desire for unlimited prescription privileges. Some may use different jargon to describe this scope of practice, such as "transmit per protocol". However, the mechanics of the practice is consistent. I would like to emphasize that the issue is not the name or label that is placed on this function, but it is recognized that intent is the same. Perhaps the term "prescription privileges per protocol" has been intrepretated as requesting prescription privileges, or the ability to "originate" a prescriptions. It is not our intent to prescibe.

I would like to request, if I may, careful consideration to line number 72,73,74, and 75 of Senate Bill 23. My intrepretation views a possibility this bill will extinquish K.A.R. 60-11-104(a). There is no mention of prescription orders by protocol. It would be my recommendation that **"per protocol jointly developed with the attending physician"** would provide clarity. I do not believe there is question as to whether the practitioner "writes or phones" these legend drugs to the pharmacist. Rather, the act is recognized and conducted according to established protocol. This is an interdependent practice, NOT an independent practice.

The advanced nurse practitioner's ability to use prescription per protocol approach provides marked advantages to student and campus population:

1) Time out of the classroom is greatly reduced for the students as advanced registered nurse practitioners are readily able to begin therapy at the onset of symptoms; therefore, the physician is able to focus on the more complex cases. Once again to reiterate, a deviation, from the medications listed on my protocol, necessitates a consultation with the attending physician.

2) Cost containment is an additional area in which advanced registered nurse practitioners are vital. If prescription per protocol is not utilized for antibiotics, such as penicillin, for uncomplicated strep throat, this condition may be treated inadequately. As a result, students often postpone a visit to the physician because of added expenses, jeopardizing their health.

3) As previously addressed, five of our regent's institutions employ nine advanced registered nurse practitioners. If a physician were used to maintain the same types of services, I would expect that each institution would be charged with a appropriate operational adjustments. As a result of a budget increase, I could expect two potential outcomes: 1) An increase in cost could make an even more difficult financial burden for students to attain an education; or 2) the secession of services that nurse practitioners were able to incorporate using prescription only drugs.

It is my belief, and it is a belief shared by my colleagues that our function will be limited if Senate Bill 23 is adopted with its present language.

Once again, I would like to reiterate that we are not requesting unlimited prescription privileges, nor are we seeking independent practices. We function as an interdependent part of the health care team.

The students of Kansas and I urge favorable consideration based on the comments that I presented today. I would happy to stand for additional questions.

PROTOCOL: ACUTE PURULENT OTITIS MEDIA
STUDENT HEALTH SERVICES
PITTSBURG STATE UNIVERSITY

I. **Definition.** Infection in the middle ear, with accumulation of seropurulent or purulent fluid in the middle-ear cavity.

II. **Etiology.** The majority of cases are due to bacterial infection. It is not possible clinically to identify those patients with sterile exudate.

III. **Clinical features**

A. Symptoms

1. Earache.
2. Symptoms of an upper respiratory infection.
3. Fever.
4. Decreased hearing.
5. Sometimes, no symptoms.

B. Signs

1. Bulging of any portion of the tympanic membrane with accumulation of exudate in the middle-ear cavity.
2. Disappearance of the malleus (bony landmarks). The short process is often lost first.
3. Perforation of the tympanic membrane, resulting in the presence of exudate in the external canal and distortion of the tympanic membrane. (This must be distinguished from primary otitis externa without otitis media, which is more common in the adult.)
4. Bullae of the tympanic membrane.
5. Decreased or absent movement of the tympanic membrane with insufflation.

Note: Injection or erythema of the tympanic membrane and disappearance or distortion of the light reflex may accompany these signs but are not alone sufficient to diagnose acute purulent otitis media.

IV. **Laboratory studies.** None.

V. **Differential diagnosis**

A. Erythema of the tympanic membrane associated with an upper respiratory tract infection.

B. Serous otitis media.

C. Otitis externa.

VI. **Treatment.** Ask whether patient is allergic to the medication chosen.

A. Amoxicillin capsules, 250 mg 3 times a day for 10 days.

or

B. If patient is allergic to penicillin derivatives, treat with 80 mg trimethoprim, 400 mg sulfamethoxazole tablets, two tablets 2 times a day for 10 days.

VII. **Complications**

A. Chronic serous otitis media (persistent middle ear effusion).

B. Persistent purulent otitis media.

C. Mastoiditis.

D. Chronic otitis media with perforation of the tympanic membrane.

E. Extension into the central nervous system, leading to meningitis or brain abscess.

F. Cholesteatoma formation associated with chronic otitis media and marginal or pars flaccida perforation.

VIII. **Consultation-referral**

A. Ruptured tympanic membrane.

B. Severe pain.

C. Failure to improve symptomatically in 48 hours.

D. Signs of meningitis, such as:

1. Lethargy.
2. Extreme irritability.
3. Nuchal rigidity

E. Persistent purulent otitis media, despite adequate course of antibiotics.

F. More than two episodes of purulent otitis media.

G. Suspicion of mastoiditis (pain, tenderness, or edema in the post-auricular area in older children and adults).

H. Chronic otitis media with persistent intermittent drainage through perforation of the tympanic membrane.

IX. **Follow-up.** Examination in 3 weeks.

Dr. Ron Seglie, MD

Aug 18, 1988
Date Reviewed

Cherie Branson, RN, ARNP, MS

9-12-88
Sent to Wanda Mattley
Kathy Douglas

1. VAGINITIS

	d. Monilia (Candida Albicans)
SUBJECTIVE	May Include: 1. Discharge with or without odor. 2. Vulvar and/or vaginal irritation itching burning or excoriation. 3. History of recent use of abtibiotics, oral contraceptives, other durgs, or diabetes mellitus. 4. Pregnancy or suspected pregnancy. 5. Dyspareunia. 6. Dysuria.
OBJECTIVE	May Include: 1. White semi-adherent curdy discharge present on vaginal walls, cervix and/or vulva. 2. Erythematous and/or excoriated vulva and/or vagina.
LABORATORY	1. Microscopic evaluation of normal saline (or 20% potassium hydroxide) wet mount reveal monilial hyphae and spores.
ASSESSMENT	Monilia
PLAN	1. Monistat Dualpak Sig: ÷ suppository intravaginally at HS X 3 days apply cream locally PRN for vulvar exciation or itching. 2. Miconazole Nitrate 2% (Monistat) vaginal cream, 47 gm tube. Sig: 1 applicator full in vagina HS X 7 days. 3. Order FBS for 3 or more monilial infections within 1 year. 4. May repeat therapy if necessary.
PATIENT EDUCATION	1. Stress importance of completing medication. 2. Advise patient not to interrupt treatment during menses. 3. Temporarily avoid intercourse if irritation is moderate or greater. 4. Counsel on importance of perineal hygiene. 5. Advise patient not to use tampons during treatment with vaginal cream. 6. RTC if symptoms persist. 7. Refer partner to PMD if symptomatic.
REFER TO MD	1. Persistent or recurrent infection. 2. Extreme excoriation. 3. Suspected infection in absence of microscopic confirmation.

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7/87
revised 2/88

SIGNATURE Pamela M. Calcasieu
Mary Jane Whelan, RSCNP

7-6

Labette Co. Health Dept. Parsons, Ks.

Hemophilus Vaginitis, Bacterial Vaginitis
Nonspecific Vaginitis, Gardeneralla

Subjective:

May include:

1. Malodorus discharge.
2. Discharge usually does not cause burning or itching.
3. Dyspareunia.
4. Vulvar irritation.
5. Not related to menses.

Objective:

May include:

1. A grayish-green, thin, pasty discharge which may be blood-streaked and malodorous adhering the the vaginal wall.
2. Inflammation and irritation of the vaginal tissue and introitus.
3. Foreign body in the posterior fornix (tampon, sponge, diaphragm, grass).
4. No relationship to menses.

Laboratory:

May include:

1. Pap smear to rule out inflammatory changes.
2. G.C.
3. UCG

Must include:

1. Wetmount showing clue cells.

Plan:

1. Metronidazole (Flagyl) 500mg bid x 7 days or:
2. Triple sulfa cream (Sultrin) one applicatorfull bid x 2 weeks (check for sulfa allergy) or:
3. May douche daily with disposable vinegar and water.

Client Education:

1. See client education sheet.

CLIENT EDUCATION

Hemophilus Vaginitis, Bacterial Vaginitis,
Nonspecific Vaginitis, Gardeneralla

Definition:

This is a inflammation of the vagina caused by the bacterium Hemophilus Vaginitis.

Etiology:

The organism, Hemophilus Vaginalis, is a many shaped non-motile bacillus that grows best in a low-oxygen atmosphere. Transmission of the infection is probably through sexual contact. Both partners are frequently infected. Ten to forty percent of women are asymptomatic.

Care of current infection and prevention of recurrences:

All medication should be taken.

Alcohol consumption is contraindicated when taking metronidazole (Flagyl) for 48 hours after treatment.

Use good personal hygiene and wipe from front to back after a bowel movement.

Avoid sexual intercourse during treatment or use a condom until treatment is complete.

Use of a pad when creams or suppositories are used is more comfortable, do not use tampons.

Return to clinic if symptoms persist.

03/87

I. Definition. Superficial fungal infection of the oral cavity in infants.

II. Etiology. The causative organism in Candida albicans, which is usually acquired from the following sources:

A. Mother's vagina during birth.

B. Other infants, by contamination of caretaker's hands or objects shared by babies.

C. Adult with vaginal candidiasis, through contamination of her hands.

D. Patient's own candidal diaper dermatitis.

E. Oral broad-spectrum antibiotic therapy (e.g., ampicillin), as a side effect.

III. Clinical features

A. Symptoms

1. Often none.

2. With extensive involvement, pain during feeding and swallowing.

B. Signs

1. White, irregularly shaped plaques appear in the buccal mucosa, lips, palate, and gums. They may produce a confluent white coating on the tongue.

2. Lesions are removable, leaving an inflamed base.

3. The patient may have candidal diaper dermatitis (moist, red, occasionally scaling rash with a sharp border and satellite red papules or pustules).

IV. Laboratory studies. Potassium hydroxide preparation of scrapings of lesions reveals budding yeast with or without hyphae. This study usually is not needed when typical lesions are present.

V. Differential diagnosis. Milk or food particles remaining in the mouth of the patient.

VI. Treatment. Advise parent on the following measures:

A. Control of source of infection

1. Wash hands thoroughly between handling of different infants in newborn nursery and before handling any baby.

MB

2. Do not have infants share clothing, pacifier, or nipples.

3. Examine and treat contact with vaginitis.

4. Treat candidal diaper dermatitis.

B. Oral antifungal therapy. Use nystatin (Mycostatin) oral suspension (100,000 units per milliliter) in a dosage of 2 ml orally 4 times a day for 1 week (1 ml in each side of mouth, not in back of throat, so that medication is in contact with the lesions for as long as possible). It may help to rub a portion of the dose on the lesions with a cotton swab. This oral antifungal treatment may be repeated for another week if there is not marked improvement.

VII. Complications

A. Feeding problems due to pain.

B. Candidal diaper dermatitis or perioral dermatitis.

C. Spread of infection to other infants in nursery or home.

VIII. Consultation-referral

A. Failure to respond to 2 weeks of therapy.

B. Failure to thrive.

IX. Follow-up. Return visit in 1 week if the infection is not markedly improved.

pb

David C Brown MD

y C. Myrick, M.D.
Fellow of the
American Academy of
Family Practice

Eric L. Dyck, M.D.
Fellow of the
American Academy of
Family Practice

HAYS FAMILY PRACTICE CENTER

2509 Canterbury Road
Hays, Kansas 67601

Telephone (913) 628-6151

Richard L. Raj M.D.
Fellow of ...
American Academy of
Family Practice

John N. Dorsch, M.D.
Diplomate of the
American Board of
Family Practice

January 16, 1989

The Honorable Roy Ehrlich
Chairman of the Public Health & Welfare Committee
Kansas State Senate
State Capitol Building
Topeka, KS 66612

Dear Senator Ehrlich:

I am writing this letter to express my concern to you and the members of your committee regarding Senate Bill #23. As this bill deals with the training, qualifications, and practice of Advanced Registered Nurse Practitioners, it is a bill of extreme importance to me and most other physicians in rural communities. Section I of this bill concludes with the following amendment: "An Advanced Registered Nurse Practitioner may not prescribe drugs but may transmit prescription orders in accordance with the Pharmacy Act of the state of Kansas." This statement is of considerable concern to me for an Advanced Registered Nurse Practitioner cannot effectively practice in her expanded role without having a certain degree of prerogative to prescribe appropriate drugs for mild to moderate disease processes. My partners and I have served as preceptors for the Advanced Registered Nurse Practitioner program here in Hays, which has been a satellite of the University of Kansas Medical Center, at least since 1979. Having been involved in their training as well as employing nurse practitioners over several years, we find that they are unequivocally qualified to distinguish simple disease states from more advanced or severe disease states, refer the more severe disease states on to a physician, and manage the milder disease states in accordance with the directives we have established for them. We have found excellent public acceptance of the nurse practitioner role and know of no instance where a patient suffered unduly because of treatment managed by an Advanced Registered Nurse Practitioner. Even though there is almost always a physician in the clinic during the time that our nurse practitioners are seeing patients, it would be extremely disruptive and, indeed, seriously detract from good patient care for our Nurse Practitioners to interrupt our routine each time they need an antibiotic for a throat or ear infection.

Perhaps I am reading this bill in a much more constrictive attitude than is intended. However, it is my understanding that the current Pharmacy Act allows nurses to transmit a prescription only under direct case-by-case physician orders. If this applies to Advanced Registered Nurse Practitioners, it is inappropriate for the best interests of the patients.

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1-18-89
Attachment 8

January 16, 1989

The Honorable Roy Ehrlich

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I would urge your committee to make whatever modifications to Senate Bill #23 are necessary to allow Advanced Registered Nurse Practitioners to continue prescribing medications as they and physicians assistants have done in the past. It would, however, be most appropriate that the bill stipulate that those drugs to be prescribed be delineated in established, written protocols between the nurse-practitioner and the supervising, licensed, health care professional authorized by law to write prescriptions.

I thank you for your consideration.

Sincerely,

Richard L. Rajewski, M.D.

RLR/gm

Kansas Academy of Family Physicians

818 Carriage Parkway, P.O. Box 20597 • Wichita, Kansas 67208 • (316) 651-2238

Walter D. Bettis
Executive Director

August 21, 1988

Lois Rich Scibetta, Ph.D., R.N.
Kansas State Board of Nursing
Landon State Office Building
900 S.W. Jackson, Rm 551
Topeka, Kansas 66612-1256

Dear Dr. Scibetta:

The Kansas Academy of Family Physicians wishes to submit the following resolution for your consideration:

Whereas Advanced Registered Nurse Practitioners have become an accepted and vital aid in the delivery of primary health care to the people of Kansas and

Whereas to effectively deliver that care, it is appropriate that they be privileged to dispense and/or prescribe certain treatment plans to include prescription-only medications under protocol with their responsible, licensed physician

Be it resolved that the Kansas Academy of Family Physicians supports the proposed regulation changes regarding ARNP's, a a copy of which is enclosed.

Thank you.

Respectfully submitted,

Richard L. Rajewski, M.D.

Enc.

cc: Walter D. Bettis
D. Ray Cook, M.D.
Larry R. Anderson M.D.

to the employee, in addition to the latter's claim for workers compensation. However, it appears that the physician is still not liable to the employer.

The Ohio courts are consistently departing from conventional workers' compensation doctrines, i.e., accepting the dual capacity doctrine. Recently their Supreme Court held that physicians who negligently examined workers' compensation claimants could be sued by the claimant; no longer would such a physician be immune to suit.

Epilogue

All of these erosions represent a changing perspective of what constitutes a physician-patient relationship, and the legal rights of the patient.

Notes

1. Larson A (1981) The Law of Workmen's Compensation, § 65.10 at 135
2. *Cudahy Packing Co* v *Parramore*, 236 US 418, 423 (1923)
3. *Lindsay* v *George Washington University*, 279 F 2d 819 (DCC 1960)
4. *McAlister* v *Methodist Hospital of Memphis*, 550 SW 2d 240 (1977)
5. *Zick* v *Industrial Commission*, 444 NE 2d 164 (III Sup Ct 1982; rehearing denied, 1983)
6. *Jenkins* v *Sabourin*, 311 NW 2d 600 (Wis Sup Ct 1981)
7. *Jefferson Medical College Hosp* v *Savage*, 7 Pa Cmwlth 35, 298 A 2d 694 (1972)
8. 2 Larson A (1981) The Law of Workmen's Compensation, § 72.90
9. 2 Larson A (1981) The Law of Workmen's Compensation, § 72.80 at 14-229
10. 2 Larson A (1981) § 72.80, at 226.23
11. *Duprey* v *Shane*, 39 Cal 2d 781, 249 P 2d 8 (1952)
12. *Guy* v *Arthur H. Thomas Co*, 55 Ohio St 2d 183, 378 NE 2d 488 (1978)
13. *D'Angona* v *County of Los Angeles*, 166 Cal Rptr 177, 613 P 2d 238 (1980)
14. *Tatrai* v *Presbyterian University Hospital*, 439 A 2d 1162 (Pa 1982)
15. *Botwinick* v *Ogden*, 451 NYS 2d 141 (NY Sup Ct App Div, 1982)
16. *Weber* v *State of New York*, 429 NYS 2d 380 (1980)
17. *Wright* v *United States*, 717 F 2d 254 (CA 6, March 1982)

17a. *Wright* v *District Court In and For the County of Jefferson*, 661 P 2d 1167 (Colo Sup Ct 1983)

18. *McNeil* v *Diffenbaugh* et al, 43 NE 2d 377 (Ill App 1982)
19. *Thomas* v *Kenton*, 425 So 2d 396 (La Ct of App 1982)
20. *Boyle* v *Breme*, 461 A 2d 1164 (NJ Sup Ct 1983)
21. *Babich* v *Pavich*, 411 A 2d 218 (1979)
22. *Budzichowski* v *Bell Telephone Company of Pennsylvania*, 469 A 2d (Pa Sup Ct 1983)
23. *McDaniel* v *Sage*, 419 NE 2d 1322 (Ind App 1981)
24. 453 NE 2d 693 (Ohio Sup Ct 1983)
25. *Oiner* v *Diamond M Company*, 500 F Supp 619 (1980)

Med Law (1986) 5:61–75

Medicine and Law

Nurse Practitioners: Functions, Legal Status and Legislative Control

Jon M. Studner and Harold L. Hirsh

American University, Washington College of Law, Washington, DC 20016, USA

Abstract. Particularly over the past two decades, health care and its delivery have undergone revolutionary changes. One of these changes has been the emergence of the nurse as a health care deliverer, brought about by developments in medicine and the practices of physicians, as well as the change in the status of women. What has evolved is a kind of "super nurse" – the nurse practitioner. She trains for a longer period of time, gains greater expertise, is more knowledgeable, and functions as a substitute or extra practitioner. Until the nurse practitioner began to be perceived by physicians as a threat, she was encouraged to pursue these higher goals. Once she had achieved this lofty status, physicians began to show signs of regret and withdrew their encouragement and support. As this partnership deteriorated into conflict, it became necessary for the law to intervene. To some extent, the legal situation made this necessary, but public opinion also demanded clarity. The authors review the history of the nurse practitioner, her accomplishments, the agonies, toils, and tribulations she has suffered, and her legal status. The result can best be illustrated by the American song, "How you gonna get 'em back on the farm once they've been to Paris", which reflects both the agony and the ecstasy involved in the problem dealt with in this article.

Without a doubt, the nursing profession can and must occupy a larger and more effective place in the delivery of health services for the American people [1]. Nurses constitute the largest single group of professionals within the framework of American Health personnel [2]. Because of the many different areas of health care in which nursing is involved, it is quite evident that expansion of nursing roles in conjunction with other members of the health professions (e.g., nutritionists, physicians, etc.) would greatly increase the quality of health care afforded the American public.

By far the greatest opportunity for this new expansive role or nursing is in the delivery of primary health care [3]. Sackett and associates [4] used an experimental

model to analyze the impact of primary care by nurse practitioners. The results of this experiment were positive, indicating that a "large number of patients did not require the skill and management of a physician" [5].

The federal government, by adopting the Nurse Training Act of 1971 [6], indicated the necessity for expansive roles in health care – including nurse practitioners. This Act provided funds for specialized nursing programs. Various programs established to fulfill this need have been started throughout the country to train pediatric nurse practitioners, family nurse practitioners, maternity nurse practitioners, midwives, adult care practitioners, primary care practitioners and others [7].

"To write of the nurse practitioner is to write of the nurse – for every nurse who practices his or her profession is a nurse practitioner" [8]. More specifically, however, from the new and expansive roles of the nurse practitioners there emerges a group of nurses who have decided to pursue their profession independently of any major health institutions (i.e., hospitals and clinics) and without direct physician supervision – the "independent nurse practitioner" [9]. Although, to date, there has not been a tremendous influx into this expanded area, there have been nurses who, either individually or in groups, have attempted to offer to the public this unique form or nursing care.

Because independent nursing practice is still in an embryonic stage, many questions relating to the legal status and civil liability of such an enterprise have been unanswered. The following deals with specific areas of the law that may affect such a practice.

Functions of a Nurse Practitioner

Generally, a nurse practitioner is a registered nurse who has completed a program which includes "communications and interviewing (history taking); basic physical examination including basic patho-physiology; positive health maintenance; care during acute and chronic phases of illness; management of chronic illness; health teaching and counseling; role realignment and establishment of collaborative roles with physicians and other health care providers; and [utilization of] community resources."

Nurse practitioners are currently being trained and educated to work in different settings. The nurse practitioner acts independently in dealing with the needs of a patient, under the supervision of physician, for all delegated medical functions.

Delegated medical functions are usually in accordance with a written protocol. One state has defined a medical protocol as

A signed agreement between a nurse practitioner and a physician, which designates the medical conditions that may be diagnosed and treated by the nurse practitioner without direct physician contact with the patient. The protocol gives explicit diagnostic measures, as well as prescriptive or treatment measures, that may be implemented by the nurse practitioner for each condition. Similarly, the protocol specifies conditions which should not be treated by the nurse practitioner, but referred to the physician.

In accordance with such "protocol", a nurse practitioner may perform detailed physical examinations, order laboratory tests for diagnostic purposes and assess the results of such tests.

Assessment has been defined as "the observation and evaluation of significant changes in a patient's physical condition or the determination of the relative significance of a patient's complaints." Assessment by nurse practitioners is necessarily a more "sophisticated" and "exact" analysis than traditional "nursing assessment" performed by registered nurses because of the nurse practitioner's advanced training and education.

Thus in arriving at a diagnosis, or "process of ascertaining a disease or ailment by its symptoms," a nurse practitioner may, if protocol permits, telephone in a prescription or order medical devices. If a nurse practitioner determines that a patient's symptoms indicate a condition not within protocol, the patient should then be referred to an appropriate health care provider.

A nurse practitioner is therefore differentiated from a registered nurse by increased education and training; which confer greater diagnostic responsibilities. The delegated medical functions a nurse practitioner performs, under the supervision of a physician, differ from nurse clinician's or physician's assistants. A nurse clinician or physician's assistant does not undertake to perform any "delegated functions" through a protocol as a nurse practitioner does.

Along with the increased responsibility of "delegated functions" leading to diagnosis, a nurse practitioner can augment physician provided medical services. This is accomplished by relieving the physician of the burden of primary medical examination, treatment, and daily rounds. This added responsibility, along with undertaking physicians functions, has led to great concern in the medical, nursing, and legal profession that nurse practitioners may actually be practicing medicine without a license.

Historical Development Leading to Legislative Ambiguities

In the early 1960's, health care providers and planners in the United States became aware of "the growth of specialization and the decline of the general practitioner." Many countries including Canada, Argentina, Finland, Poland, Yugoslavia and the United Kingdom use non-physicians as health care providers. This, coupled with the shortage of physicians and the spiraling costs of medical care led to the possibility of training nurses as well as other non-physicians to perform some of a physician's routine tasks.

The nursing profession welcomed such a change. Since the end of World War II, nurses had been accorded increasingly more "professional" status. Numerous functions including blood transfusions and intravenous injections formerly designated as "medical" were re-classified as "nursing" duties.

Along with the growth of nursing responsibilities, courts recognized that nursing was, in fact, a profession wherein nurses who commited malpractice should be held to a professional standard of care.

In 1932, prior to increasing nurse responsibilities, a court stated, "nurses are not supposed to be experts in techniques of diagnosis or treatment." By 1955, while

some increasing medical functions had been granted to nurses, a court noted: "[a] nurse should be able to diagnose sufficiently to know whether it is a condition within her authority to treat." The most modern view of nursing is illustrated by the following statement: "The practice of nursing is a highly regulated profession in this state ... and therefore the applicable standard of care is that of reasonable professional."

The first program to train nurse practitioners was developed at the University of Colorado in 1965. To date approximately 140 programs exist in the United States. Many of these programs have received federal funding. As is evidenced by the budget of the United States government for 1981, nurse practitioner training programs continue to be considered "high priority."

Nurses view the opportunity to assume delegated medical functions not as a chance to become quasi-doctors, but as a "logical extension of the nurses traditional function of assisting patients to adjust to illness."

Traditionally malpractice actions involving nurses were usually cases where a patient fell and injured themselves, suffered burns as a result of negligent supervision, or where an innoculation was administered improperly.

By virtue of assuming delegated medical functions, nurse practitioners might now be held liable for errors in diagnosis and for the failure to refer patients to the proper health care provider for treatment when necessary.

The possibility also exists that a nurse practitioner could be found criminally liable for practicing medicine without a license. However, this cause of action would probably be defeated based upon a constitutional void-for-vagueness argument.

The reason such extensive liability exists is because of the legal ambiguities and lack of definitive standard surrounding nurse practitioners.

Nurse Practice Acts

The practice of nursing is established and regulated in the individual states by their respective Nurse Practice Acts and the common law. The various acts:

> (1) establish educational and examination requirements, (2) provide for licensing or regulation of individuals who have met the above requirements and (3) define the functions of the professional nurse in general and specific terms. They also set up public boards of nursing practice to administer the Practice Acts [10].

The above cited criteria establishes the parameters within which the independent nurse practitioner may practice. A description of the great diversity in these laws is almost impossible except on a state-by-state basis since there is no pattern to the situation whatsoever. An analysis of the varied legislation in this area can best be accomplished by dividing particular nursing acts into four basic groupings with slight variations in each – traditional; those establishing the independent practitioner as a separate entity; those requiring the independent practitioner to act in collaboration with or at the direction of a physician; those which have provided expanded roles for registered nurses in general.

Traditional Nursing Practice Acts

The "Traditional Acts" consist of statutes which describe nursing practice in very general terms. Some states couch their nursing acts in "nonexpansive" terms [11]. Of these, some statutes are so restrictive that they specifically prohibit the independent nurse practitioner from practicing autonomously. Some if not all of the statutes define the practice of professional nursing in such a way so as to relegate the registered nurse to the status of an "instrument" of the physician:

> The practice of professional nursing means the performance for compensation of any act in the observation, care, and counsel of the ill, injured, or infirm, or in the maintenance of health or prevention of illness of others, or in the supervision and teaching of other personnel or the administration of medications and treatments as prescribed by a licensed physician or dentist, requiring substantial specialized judgment and skill and based on knowledge and application of the principles of biological, physical, and social sciences.
>
> The foregoing shall not include acts of diagnosis or prescription of therapeutic or corrective measures [12].

Under the above cited statute, an independent nurse practitioner cannot practice as such and, at best, can only achieve a position as an "associate" within a medical partnership [13].

Other statutes, in what may be termed the "Traditional" or "Non-Expansive category", are not as restrictive but, because of the way in which they were drawn and lack of judicial interpretation, an independent nurse practitioner must have the constitution of an explorer forging into uncharted areas.

Legislative Control to Clarify Nurse Practitioner's Legal Status

Three alternative legislative amendments have been proposed to clarify the legal status of nurse practitioners. They include total re-definition, waiver, and additional Act amendments.

Waiver

Since all jurisdictions have pre-existing statutes concerning nurses, one possible alternative would be to temporarily waive all pre-existing provisions for a period during which data would be gathered on the use of nurse practitioners to provide a solid base for permanent legislation. This approach was taken by California when it enacted the Health Pilot Projects Act.

The Act provided for training in new health care roles even if functions went beyond legal definition. The plan worked well in California and greatly expanded the role of nurses.

Such a drastic approach may not be needed today since legislatures have had the advantage of years of information gathering and may best serve by passing alternative or supplemental legislation involving nurse practitioners.

Re-definition

Another possible approach to clarify the legal status of nurse practitioners is a total re-definition approach. In February 1980, the American Nurses Association suggested the following legislation should be adopted:

> A professional nurse may also perform additional acts, under emergency or other special conditions, which may include special training, as are recognized by the medical and nursing professions as proper to be performed by a professional nurse under such conditions, even though such acts might otherwise be considered diagnosis and prescription.

The main advantage of this type of definition is its language, while not so radical as to offend traditionalists, provides for future changes in nursing practice.

Additional Amendments

The most popular method to define legal status of nurse practitioners is an additional amendments approach. The amendment provides that professional nurses may perform acts under "special medical protocol" which would otherwise be outside the scope of nursing practice.

Since this approach was implied, 18 states including Alabama, Arizona, Florida, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Nebraska, Nevada, North Dakota, Oregon, South Carolina, South Dakota, Vermont, Washington and Wyoming have amended their definition to include "Additional Act" language.

The American Nurses Association has suggested the following additional Act language:

> The practice or nursing means the performance for compensation of professional services requiring substantial specialized knowledge of the biological, physical, behavioral, psychological, and sociological sciences and of nursing theory as a basis for *assessment, diagnosis, planning, intervention,* and *evaluation* in the promotion and maintenance of health; the case finding and management of illness, injury, or infirmity; the restoration of optimum function; or the achievement of a dignified death. Nursing practive includes but is not limited to administration, teaching, counseling, supervision, delegation, and evaluation of practice and execution of the medical regimen, including the administration of medications and treatments prescribed by any person authorized by state law to prescribe.

This amendment has great advantages because it especially takes notice of acts and responsibilities never before attributed to nurses which nurse practitioners are trained and expected to perform.

However, the improper performance of any of these new functions will lead to liability in tort due to malpractice claims. As such a standard of care for nurse practitioners must be ascertained.

Expanded Nursing Practice Acts – An Overview

Fortunately, however, more and more states have revised their Nursing Practice Acts to include new definitions of professional nursing. Under such expansive definitions, the independent nurse practitioners may proceed with much less validation than their predecessors in delivering a comprehensive plan of nursing care. There are at least 30 states which have formulated new parameters for nursing

care [14], but the statutory language varies considerably among the respective states. These statutes, which afford the independent nurse practitioner the most responsibility, specifically permit nursing diagnosis, treatment and even the prescription of medical, therapeutic or corrective measures. The requirements for nurses to practice within these newly defined roles vary.

The statutes which have created expanded roles for the nursing profession can be further categorized under three general subsections. The first grouping consists of three states which have created a new nursing entity – the "nurse practitioner" [15]. In doing so, the legislatures have incorporated into the statutes additional educational requirements for any registered nurse aspiring to undertake an independent practice of nursing. These requirements afford the nurse practitioner a barometer by which to determine what will be required of him in regard to a minimum standard of education and experience, thus dispelling some degree of uncertainty as to the minimum standard of care.

A second subdivision within the expanded nursing practice acts require the independent nurse practitioner to work either in collaboration with or under the supervision of a physician or dentist when implementing a medical regimen or performing those functions based on medical diagnosis and prescription of therapeutic or corrective measures [16]. Maine's Nursing Act provides that a physician can delegate the "responsibility of diagnosis of illness or prescription of therapeutic or corrective measures" to a nurse practitioner [17]. This type of statute places obvious limitations on a nurse practitioner's autonomous treatment of patients. Even in states such as New Mexico, which has created an entity entitled the "Certified Nurse Practitioner", the Nursing Practice Act provides that "[t]he Certified Nurse Practitioner shall be personally responsible and shall act only under the supervision of a physician or surgeon, licensed to practice in New Mexico, for acts beyond those of professional nursing" [18].

The third subdivision of what has been termed as the "Expansive Nursing Practice Acts", is the largest [19]. These statutes have simply redefined the role of the professional nurse without specifically differentiating between a registered nurse and an independent nurse practitioner. New Jersey's Nursing Act is typical of the legislation found within this subdivision. It provides:

> The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing medical regimen as prescribed by a licensed or otherwise legally authorized physician or dentist [20].

A great many of the states which have enacted expanded nursing acts have done so in a general manner whereby a board of medical and nursing professionals delineates the requirements for the new role. It has been suggested within the nursing profession that "the responsibility and authority to define or re-define the practice of nursing should rest with the nursing community" [21]. The combined board, as described above, is at least a step in that direction. Other states require nurses who aspire to become nurse practitioners to obtain additional "education and training . . . [in programs] that are recognized" by a joint medical and nursing board [22]. Such programs are to be authorized by the board of nursing through its rules and regulations.

The most important part of redefining nursing care is the opportunity given to the nurse practitioner to use his or her diagnostic and treatment skills. The majority of statutes that do permit diagnosis speak in terms of "nursing diagnosis". New Hampshire, instead of distinguishing between medical and nursing diagnosis, allows nurses to engage in diagnosis and prescription "under emergency or other special conditions" (as defined by a board comprised of medical and nursing professionals) [23]. In this instance, the nurse practitioner must seek guidance from the state board to delineate the scope of "special conditions."

The question then presented is what constitutes "nursing diagnosis" and "treatment". The definitions afforded the independent practitioner vary in degree of specificity (if they exist at all) within the respective statutes. New York's definition of treatment and diagnosis is, if possible, typical: As used in section sixty-nine hundred two:

> 1. "Diagnosing" in the context of nursing practice means that identification of and discrimination between physical and psychological signs and symptoms essential to effective execution and management of the nursing regimen. Such diagnostic privilege is distinct from a medical diagnosis [24].

It would appear that with the new responsibility of nursing diagnosis comes an extension of a nurse's civil liability. There exists a fine line between making a nursing diagnosis and what may be termed a medical diagnosis (for which one may be prosecuted for practicing medicine without a license).

What diagnostic procedures should be performed? Under what circumstances will the law impose civil liability on the independent nurse practitioner in the area of diagnosis? What is negligent diagnosis? These and other questions must be answered in order for independent practitioners to fully understand the ramifications of their revolutionary role.

Standard of Care for Nurse Practitioners

Since state legislatures control the legal status of nurse practitioners, no common standard of care has been determined by the courts.

"Malpractice is the neglect of a ... nurse to apply that degree of skill and learning in treating a patient which is customarily applied in treating and caring for the sick or wounded in the same or similar community" [25]. Although in today's world the emphasis is on a "national standard" [26], most states still retain some form of the locality rule [27]. Some states have either partially or entirely abolished the locality rule [28] and there appears to be a definite trend in that direction. Many courts have held that the standard to be applied for nursing care is one which is general rather than local in nature [29]. Obviously, this will vary by jurisdiction.

Since, under many of the revised nursing statutes, the independent nurse practitioner's practice is limited by a combined nursing and medical board, and in many cases conditioned upon additional education or experience, the independent practitioner would at least be held to the standard of care of those independent practitioners throughout the state. Given the fact that the American Nursing Association has a tremendous influence upon the state nursing associations (and

their constituents), one may see a general, as opposed to a local, standard applied by the courts in determining the standard of care required of the independent practitioner. This may be analogized to the tendency of the courts to apply a general standard of care to a class of medical specialists when determining the applicable standard of care [30]. Regardless of whether the practitioner has achieved the required higher educational or training requirements, it is axiomatic that one who holds himself or herself out as a specialist will be held to the standard of care of those practicing within that specialty, i.e., independent nurse practitioner (whether it be family, maternal or other nursing care) [31].

"It would seem that at least insofar as the functions of a ... nurse are medical in character, the same rules as to proof of malpractice apply, as to physicians and surgeons" [32]. The applicable standard of care is to be established by members of the same profession. But in *Hiatt* v. *Groce* [33] the expert testimony was not furnished by a physican, but rather by a nurse. This, however, is atypical and testimony concerning the applicable standard of care is usually elicited from one of the same profession, especially when dealing with a licensed profession [34]. Expert testimony is not, however, required where the negligence alleged would be within the *common knowledge* of the jury [35] or in a case involving the doctrine of res ipsa loquitur.

Because of the nature of the independent nurse practitioner's practice, the standard of care will differ from that of a floor nurse in a hospital. As previously noted, the area which may present the most difficulty to the independent practitioner is in the area of nursing diagnosis and treatment.

Diagnosis/Treatment

The crux of the nurse-practitioner's problem in diagnosis and treatment is the ability to judge when to seek a medical consultation. Heretofore nursing liability in this area usually restricted itself to a nurse's failure to notify a physician of a change in a patient's condition [36]. The court in *Hiatt v. Groce* [37] held a hospital nurse liable for injuries to a patient when the nurse failed to notify the physician that birth was imminent, which failure resulted in plaintiff's giving birth unattended. *Hiatt* stands for the proposition that a nurse must, even on a fundamental level, use some type of diagnostic process, even if only tangentially related to the requirements of her position.

This presents a two-fold problem concerning liability: (1) failure to use proper diagnostic procedure and (2) failure to refer the patient to a physician rather than implementing a regimen of nursing care.

At first the courts were reluctant to hold physicians liable for negligent diagnosis [38]. The first case to substantially deviate from the protective attitude of the law toward the medical profession was by way of dictum in *Hicks* v. *United States* [39]. The court in *Hicks* stated:

> Where the symptoms are consistent with either of two possible conditions, one lethal if not attended to promptly, due care demands that a doctor do more than make a cursory examination and then release the patient [40].

The question of causation, however, presented a more difficult problem. The court dealt with this issue by stating that "if there was *any substantial* possibility of survival and the defendant has destroyed it, he is answerable" [41]. The court went on to state that the plaintiff need not show that the resultant effect was a certainty but rather a medical probability [42].

It follows that "only if a patient is adequately examined is there no liability for an erroneous diagnosis" [43]. The physician has a duty to make use of any and all diagnostic aids available to establish a firm basis for the diagnosis and treatment [44]. There is no reason why a court would not likewise requiring the same duty of care of an independent nurse practitioner in performing nursing diagnosis and treatment (where permitted by statute). Therefore, if a nurse practitioner failed to diagnose a patient's condition in accordance with the applicable standard of care, she or he would be liable not only for implementing the wrong treatment [45] but also for failing to refer the patient to a physician [46].

The nurse practitioner will not be held liable for a mere error in judgment [47]. For only if one

> does not avail himself of the scientific means and facilities open to him for collection of the best factual data upon which to arrive at . . . his diagnosis. the result is not error of judgment but negligence in failing to secure an adequate factual basis upon which to support his diagnosis or judgment [48].

The nurse practitioner who fails to use proper diagnostic procedures may be held liable if there is a causal relationship between the negligent diagnosis and the resultant injury. This may arise in two cases. First, when the nurse fails to direct the patient to a physician's care and second when she or he retains the patient but administers an improper nursing regimen based upon the erroneous diagnosis. In no instance will a nurse practitioner, who arrives at a nursing diagnosis by the same means as a reasonably prudent practitioner within the same factual situation, be held liable for error in judgment or treatment. "For there is a vast difference between error of judgment and negligence in the collection and securing of data essential to arriving at a proper conclusion or judgment" [49]. A nurse cannot "guarantee" either a successful treatment or a correct diagnosis [50].

To date there exists no case law interpreting the "Expansive Nursing Practice Acts", nor the role of the independent nurse practitioner. *Cooper* v. *National Motor Bearing Co.*, may however, give some insight into what will be required of an independent nurse practitioner in the case of diagnosis and referral. The facts in *Cooper* are as follows.

The court stated that a nurse should be able to diagnosis efficiently to know whether it is a condition within her authority to treat as a first aid case or whether it bears danger signs that should warn or to send the patient to a physician. In holding her liability the court stated that:

> A patient is entitled to an ordinarily careful physical examination. such as the circumstances. the condition of the patient. and the nurse's opportunities for examination will permit. If there is a reasonable opportunity for examination. and the nature of the injury or alignment can be discovered by the exercise of ordinary care and treatment. then the nurse is answerable for failure to make such discovery.

If a nurse. although not possessing the requisite skill. knowledge and ability of an independent nurse practitioner. holds him or herself out an independent nurse

practitioner, he or she will be held to the higher standard of care of an independent nurse practitioner. In the case of *Stahlin* v. *Hilton Hotels Corp.*, the court made this extremely clear. In *Stahlin* the defendant that identified herself as a nurse examined the plaintiff and informed that his problem was one of a heart condition. The following morning the plaintiff was semi-comatose and rushed to a hospital. He was later diagnosed as having a subdural hematoma and subsequently suffered residual brain damages. The defendant Mrs. Fredarica Anderson identified herself to the plaintiff as being a nurse when in fact she was not. The court's charge to the jury in *Stalin* would have a grave effect upon those nurses who do not possess the requisite education training and skill required of an independent nurse practitioner. but still hold themselves out as such.

> The failure of Fredarica Anderson to apply and possess the knowledge and use and use the skill and care that is oridinarily used by reasonably and well qualified nurses under similar circumstances is a form of negligence which we commonly refer to as malpractice.

This should serve as a warning for unqualified persons contemplating an independent practitioner practice. *Stahlin* v. *Hilton Hotels Corp.* [51] may however, give some insight into what would be required of an independent practitioner in a case of diagnosis and referral. The facts in *Stahlin* are as follows:

> The plaintiff. who was staying at the defendant hotel. had fallen and hit his head while in his room. He had been drinking that afternoon. Bishop, who shared the room with the plaintiff, noticed a bruise on the plaintiff's head. Plaintiff later began to vomit. Bishop at this juncture called down to the hotel desk to request help. Mrs. Anderson soon arrived and identified herself as a nurse. She examined the plaintiff's head and took his temperature and blood pressure. She was told of plaintiff's heart condition and the pills he took to "thin the blood." She told the plaintiff to stay in bed for 12 hours. The following morning the plaintiff was semicomatose and was rushed to the hospital. He was diagnosed then as having a subdural hematoma. Plaintiff as a result suffered residual brain damage. Mrs. Anderson charged 15 dollars for night calls within the hotel. She was not, in fact, a nurse [52].

The *Stahlin* case presents almost a perfect analogy to what would be expected of an independent nurse practitioner had she been called. One of the purposes recognized in the 1971 report by the H.E.W. for extending roles of nurses was to relieve doctors of unnecessary work. That is, the nurse serves as a screening agent and decides whether or not, given the surrounding circumstances, the patient needs either medical or simply nursing care.

The independent nurse practitioner must be qualified to recognize signs symptomatic of a medical disorder and in such a case refer the patient to a physician.

Related Cases

In *Butler* v. *Louisiana State Board of Education* [55], the Louisiana Court of Appeal stated "the law is settled that nurses and medical technicians who undertake to perform medical services are subject to the same rules relating to duty of care and to liability as are physicians in the performance of service.

Butler, did not involve a nurse or nurse practitioner. A high school biology teacher was liable regarding a school project involving blood extraction. However,

based upon the courts statement. it is evident that nurse practitioners acting under medical protocol would be liable as well for malpractice.

In *Fraijo* v. *Hartland Hospital* [56], a California case, a woman died after a severe attack of asthma. Her family sued physicians and registered nurses, alleging that a shot of Demerol which the treating physician ordered "as needed" was dangerous to persons with asthma. It was further alleged the nurse's discretion to give the injection was the proximate cause of death.

The lower court judge offered a jury instruction that read "a physician or nurse is not negligent simply because their efforts prove unsuccessful," and that "where there is more than one recognized diagnosis or treatment . . . a physician or nurse is not negligent if, in exercising their best judgment, select one of the approved methods, which later turns out to be the wrong selection." Judgment was rendered in favor of defendants. Plaintiff charged error in applying a doctor's standard to a nurse.

The Court of Appeals held it would apply a nursing standard and the jury instruction was permissible. The court noted in every dispute involving nurse malpractice should be "analyzed in terms of what action by the nurse is being complained of."

A recent decision of the Supreme Court of Massachusetts, *Gugino v. Harvard Community Health Plan* [57], addressed the issue of proper standard of care for nurse practitioner malpractice.

In *Gugino*, a woman wearing a Dalkon Shield developed an infection requiring a complete hysterectomy. Plaintiff alleged the nurse practitioner had mis-diagnosed her condition twice causing an increased delay for surgery.

A medical malpractice board found a triable issue, and the Supreme Court of Massachusetts addressing the issue upon its own motion, held the same standard of care should apply to defendant physician and defendant nurse practitioner.

Thus it appears evident that along with the increased training and functions nurse practitioners are responsible for, a nurse practitioner will be held to a high standard of care equivalent to a physician when undertaking a physician's duties.

Conclusion

Although courts have followed the trend of the increasing functions of a nurse by proportionately increasing the standard of care, the legislative branches of state government by non-action provide a stagnant approach to the nurse practitioners role in health care.

Once the legislatures clear the legal status of nurse practitioners by adopting standard legislation health care treatment will be more cost effective. Not only will more health care providers be available to treat sick individuals, but the public will overcome the fear of not being treated by a physician, but by a well-qualified nurse practitioner.

Regardless of which method of legislative amendment states decide to follow, any change in this situation is better than none at all.

Notes

1. Secretary's Committee to Study Extended Roles for Nurses (1971) Extending the scope of nursing practice. DHEW Publ No (HSM) 73–2037
2. *Id* (There are well over one million active and inactive nurses)
3. *Id* at 8
4. Sackett (1974) The Burlington trial of the nurse practitioner: health outcomes of patients. Ann Int Med 80:137–142. (Giving full data and statistics of study)
5. Family nurse practitioners: preliminary answers and new issues. Ann Int Med 80:267, 268: For further discussion on the effectiveness of the independent practitioners' practice. *see* Secretary's Committee to Study Extended Roles for Nurses. DHEW Publ No (HSM) 73–2037 (1971) Editorial. Dr. Richard J Morriss. Ann Int Med 80:123. (Sackett's reply is also included therein)
6. PL 92-158. Laws of 92nd Congr 1st ses. 85 stat 465. [T]o develop training programs, and train for new roles, types or levels of nursing personnel, including programs for the training of pediatric nurse practitioners or other types of nurse practitioners
7. For a complete listing of specialty nursing programs *see:* Preparing registered nurses for expanded roles. DHEW Publ No (NIH) 74-31 (1974) (includes both certificate and masters programs); write: "Careers Program", American Nurses' Association, Inc. 2420 Pershing Rd. Kansas City, MO 64108
8. Robinson A (1973) The nurse practitioner: expanding your limits. RN Magazine November: 27–34
9. Beware the Circling Opportunists (Journal-editorial 4 NYSNA Journal, No 1 at 5 (July 1973); A nurse by any other name . . . . Med World News January 12:73–75 (1972)
10. De Angelis, Curran (1974) The legal implications of the extended roles of professional nurses. Nurs Clin North Am at 404
11. La Rev Stat § 97:911 et seq (Supp 1977); Code of Va § 54-671 et seq (Supp 1977); Arkansas Stat Ann § 72-745 (1975); Del Code Ann Tit 24 § 1901 et seq (Supp 1976); Gen Laws of RI § 5-34-1 (Supp 1976); Tenn Code Ann. § 63-740 (Supp 1976); Ohio Rev Code Ann Tit 47 § 4723.06 (Supp 1977); Mich Stat Ann. § 14.642 (2) (Supp 1977); Ky Rev Stat § 314.011 (Supp 1977); Kan Stat Ann, § 65-1113 (Supp 1976); DC Ann Tit 1 § 2-401 et seq (Supp 1976); Rev Civ Stat of Texas. § 4518 (Supp 1976); W Va Code, § 30-7-1 et seq (Supp 1977); Wisc Stat Ann, § 441.10 (Supp 1977); Fla Stat Ann, § 458.13 (Supp 1977); Miss Code. § 73.15-5 (Supp 1977); Ill Ann Stat. § 35.35 A (Supp 1977); Hawaii Rev Stat. § 457-1 et seq (Supp 1968); Ann Code Md. § 291 (Supp 1977); Oklahoma Stat Ann Tit 59 § 567.3 (Supp 1977–1978)
12. Gernal Law of RI § 5-34-1 (d)
13. *See* Thomas: Nurse associate in a neurosurgical practice (the practitioner in this article is, however, given much more latitude than that provided under the RI statute)
14. Oregon Rev Stat § 678.035 (Supp 1975); Idaho Code § 54-1402 (Supp 1977); Alaska. Tit 8 § 08.68.400 (Supp 1976); Code of South Carolina. Tit 40-41, § 40-33-10; Me Rev Stat Ann 32, § 3102 (Supp 1977); Vt Stat Ann Tit 27, § 1551 et seq (Supp 1977); Cal Code Ann. § 2725 (Supp 1976); Conn Gen Stat Ann. § 20-87a (Supp 1976); ND Century Code Ann. § 43-12.1-02 (Supp 1977); Ariz Stat Ann, § 32-1601; Minn Stat Ann. § 148.171 (Supp 1977); NH Rev Stat Ann. § 326-B:2 (Supp 1975); Utah Code Ann. § 58-31-4 (Supp 1977); New Mex Stat Ann. § 67-2-3 (Supp 1975); NJSA 45:11–23 (Supp 1977); Colo Rev Stat. § 12-38-202 (Supp 1977); SD Codified Laws, § 36-9-3 (Supp 1977); Rev Stat of Nebraska. § 71-1, 132.04 et seq (1976); Iowa Code Ann. § 152.1 et seq (Supp 1976); Code of Ala. § 34-21-1 (Supp 1977); Fla Stat Ann. § 464.021 (Supp 1976); Ind Stat Ann. § 25-23-1-1 (Supp 1977); Rev Code of Mont. § 66-1222 (Supp 1977); Pa Stat Ann Tit 63, § 212 (Supp 1968); Rev Code Wash Ann. § 18.88.010 (Supp 1976); NY Ed Laws, § 6901 (McKinney Supp 1977–1978); Ann Laws of Mass. § 74-81C (Supp 1977); Nev Rev Stat. § 632.010 (1973); Ga Code Ann § 84-930 (Supp 1977); Wyo Stat Ann § 33-343.1 (Supp 1977)
15. Oregon Rev Stat § 678.035 (Supp 1975); Idaho Code § 54-1402 (Supp 1977); Alaska. Tit 8 § 08.68.400 (Supp 1976)
16. Me Rev Stat Ann 32, § 3102 (Supp 1977); Vt Stat Ann Tit 27, § 1551 et seq (Supp 1977); Cal Code Ann, § 2725 (Supp 1976); Conn Gen Stat Ann. § 20-87a (Supp 1976); ND

Century Code Ann. § 43-12.1-02 (Supp 1977); Ariz Stat Ann. § 32-1601; Minn Stat Ann. § 148.171 (Supp 1977); NH Rev Stat Ann. § 326-B:2 (Supp 1975); Utah Code Ann. § 58-31-4 (Supp 1977); Code of SC, Tit 40-41, § 40-33-10

17. Me Rev Stat Ann 32, § 3102 (Supp 1977)
18. New Mex Stat Ann, § 67-2-3 (Supp 1975)
19. NJSA 45:11–23 (Supp 1977); Colo Rev Stat, § 12-38-202 (Supp 1977); SD Codified Laws, § 36-9-3 (Supp 1977); Rev Stat of Nebraska, § 71-1, 132.04 et seq (1976); Iowa Code Ann, § 152.1 et seq (Supp 1976); Code of Ala, § 34-21-1 (Supp 1977); Fla Stat Ann, § 464.021 (Supp 1976); Ind Stat Ann, § 25-23-1-1 (Supp 1977); Ann Missouri Stat Ann, § 335.016; Rev Code of Mont, § 66-1222 (Supp 1977); Pa Stat Ann Tit 63, § 212 (Supp 1968); Rev Code Wash Ann, § 18.88.010 (Supp 1976); NY Ed Laws, § 6901 (McKinney Supp 1977–1978); Ann Laws of Mass, § 74-81 C (Supp 1977); Nev Rev Stat, § 632.010 (1973)
20. NJSA 45:11–23 (Supp 1977)
21. NYSNA J, vol 4, no 1 at 6
22. Code of SC, Tit 40–41, § 40-33-10
23. NH Rev Stat Ann, § 326-B:2 (Supp 1975)
24. NY Ed Law § 6901 (Supp 1977–1978, McKinney)
25. *Valentin* v *La Société Française de Bienfaisance Mutuelle de Los Angeles*, 172 P 2d 359, 362 (Cal 1946)
26. Accountability of the nurse. Speeches presented during the 48th Convention of the ANA at 8 (1973)
27. Univ San Fran Law Rev 7:163 (1972); Miss Law Rev 43:587 (1972)
28. *McGulpin* v *Bessmer*, 24 Iowa 119, 43 NW 2d 121 (1950); *Pederson* v *Dumouchel*, 72 Wash 73, 431 P 2d 973 (1967); *Brune* v *Belinkoff*, 354 Mass 102, 235 NE 2d 763 (1968); *Wiggins* v *Piver*, 276 NC 134, 171 SE 2d 393 (1970); *Naccarato* v *Grob*, 384 Mich 248, 180 NW 2d 788 (1970); *Douglas* v *Bussabarger*, 73 Wash 2d 476, 438 P 2d 829 (1968); *Gridley* v *Johnson*, 476 SW 2d 475 (Mo 1972); *Cavallaro* v *Sharp*, 84 RI 67, 121 A 2d 669 (1956)
29. *Duling* v *Bluefield Sanitarium, Inc*, 142 SE 2d 1754 (W Va 1965)
30. *Handley* v *Martinez*, 151 W Va 977, 158 SE 2d 159; *Fernandez* v *Baruch*, 96 NJ Super 125, 232 A 2d 661 (1967); *Belk* v *Schweizer*, 268 NC 50, 149 SE 2d 565 (1966)
31. *See* eg *Carbone* v *Warburton*, 11 NJ 418, 94 A 2d 860 (1953)
32. *Leonard* v *Watsonville Community Hospital*, 291 P 2d 496 (1956)
33. *Hiatt* v *Groce*, 523 P 2d (1974 Ky)
34. *Sanzari* v *Rosenfeld*, 34 NJ 128, 167 A 2d 625 (1961) (This case did, however, recognize an overlapping in knowledge between two licensed professions)
35. *Easterling* v *Walton*, 208 Va 214, 156 SE 2d 787 (1967); *Grosjean* v *Spencer*, 258 Iowa 685, 140 NW 2d 139 (1966); *Graham* v *St Lukes Hosp*, 46 Ill App 2d 147, 196, NE 2d 355 (1965) (also jurisdictions that permit res ipsa loquitur in malpractice cases)
36. *Valentin* v *La Société Française de Bienfaisance, Inc*, 172 P 2d 1359 (1946) (supervisory nurse failed to notify physician that patient had been showing signs of tetanus from which patient subsequently died)
37. 523 P 2d 320 (Kan 1974)
38. Seton Hall Law Rev 505, 516 (1972)
39. 368 F 2d 626 (4th Cir 1966)
40. *Id* at 629
41. *Id* at 632
42. *Id*
43. *Id* at 630
44. *See* eg *Price* v *Neyland*, 320 F 2d 674 (DC Cir 1963)
45. *Kelly* v *Carroll*, 36 Wash 2d 482, 494, 219 P 2d 79, 86 (1950)
46. *See Stahlin* v *Hilton Hotels Corp*, 484 F 2d 580 (1973)
47. *Clark* v *United States*, 402 F 2d 950 (1968)
48. *Smith* v *Yoke*, 412 Pa 94, 194 A 2d 167, 173 (1963)
49. *Carti* v *United States*, 402 F 2d at 953
50. *Wilkinson* v *Vesey*, 110 RI 606, 295 A 2d 676, 682 (1972)
51. 484 F 2d 580 (1973)
52. 484 F 2d at 583

53. *Id* at 584
54. *Id* at 585
55. *Butler* v *Louisiana State Board of Education*, — SE 2d — (La App 1975)
56. *Franjo* v *Harland Hospital*, — Cal Rptr — (1976)
57. *Guigino* v *Harvard Community Plan*, 403 NE 2d 1106 (Mass Sup Jud Ct 1980)

Addendum

Since this article was submitted for publication, the following information became available.

The Missouri Supreme Court has issued a decision that buttresses a revision to the state's nursing practice law that provides for an expansion of authorized nursing activities in the state. A portion of the revised law eliminated a requirement that doctors directly oversee nursing functions. The state's Board of Registration for the Healing Arts took exception to the activities being performed by nurses who worked for a family planning agency since it felt that the services they provided were an unauthorized practice of medicine subject to a different state law.

In this case it was found that the services provided by the nurses included, among other things, the following: the taking of medical histories; the performing of breast and pelvic examinations; the lab testing of PAP smears, gonorrhea cultures, and blood serology; the provision of contraceptive information; the dispensing of certain medication; and the provision of counseling services and community education. All services provided by the nurses were performed according to written standing orders and protocols authorized by doctors. The nurses would refer patients to doctors for further examination if conditions were discovered that contraindicated standing orders.

In ruling in favor of the nurses, the court said that the broadening field of the nursing profession recognized by the court carries with it the profession's responsibility for continuing high educational standards and the responsibility of nurses to conduct themselves in a professional manner. The court noted that the hallmark of professionals is knowing the limits of their professional knowledge. Therefore, nurses who reach the limitis of their knowledge or who reach the limits prescribed by a doctor's orders should refer patients to physicians, the court said.

There was no evidence that the assessments and diagnoses made by the nurses in this case exceeded their professional limits, the court pointed out. Having found that the nurses did not exceed what the revised law authorized, the court said that their activities did not constitute the unlawful practice of medicine (*Chaiyarat Sermchief et al.* v. *Mario Gonzales et al.*, Missouri Supreme Court, No. 64692, November 22, 1983).

A new law in Nevada allows nurse practitioners to apply to the state nursing board for prescribing privileges at the same time they apply for certification. Once approval is received, they apply to the state's pharmacy board for registration, enabling them to write prescriptions under limited conditions. Protocols must be established between individual NPs and collaborating physicians to identify which patients may be served, the specific drugs and devices the NP can prescribe, and when patients must be referred directly to the doctor (Medical Economics, October 17, 1983, p 15).

Evelyn M. Maxwell, MN, RN
414 Wayne Avenue
Salina, Kansas 67401
Telephone 913-827-3304

January 14, 1989

Members of the Senate Public Health and Welfare Committee
Topeka, Kansas.

RE: Senate Bill No. 23.

1. In the course of professional practice, the ARNP uses authorizations in the form of standing orders and protocols in a manner similar to that which should also apply to physician assistants. However, physician assistants are not mentioned in this legislation. Line 72-75, and 194-198,

2. According to this bill, administration of medication requires either a practitioner or the patient. Line 78-84.

To eliminate from the definition of "practitioner" lines 197-199 "or other person expressly licensed or registered to administer, prescribe and use prescription only drugs in the course of professional practice or research" would require the personal administration of medications by the physician, dentist, podiatrist, vet, investigator and optometrist. Physicians would be reluctant to do this on a 24 hr. basis. Also, it is contrary to long established practice in hospitals and nursing homes, new regulations regarding group home medication administration, and against the proposed legislation HB 2012 for home care attendants.

3. I suggest that the course of study in which the expanded role nurse is prepared and which is regulated by the State Board of Nursing, and the criteria by which the nurse is licensed is adequate to safeguard the public. "Specialty Certification" exists for many areas of nursing practice through the American Nurses Association and through nurse specialty organizations. Duplication on the state level is unnecessary and expensive.

4. I suggest that SB 23 as proposed be rejected. It complicates inexorably a system of delivering medical care that is working well and which is needed <u>as it is</u> to improve rural health care through the more extensive use of nurses in collaboration with physicians.

Please kill SB 23.

Sincerely,

Evelyn Maxwell

SP&W
1-18-89
Attachment 9