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 19, 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:
Written testimony from Kathy Douglas, A.R.N.P., C., Director of Student Health Center, Fort Hays State University
Mary Harness, Family Nurse Practioner, Hays
Debbie Folkerts, C.F.N.P., Concordia
Patsy Quint, State Chairman of KSNA, Advanced Practice Conference Group
Dr. Lois Scibetta, Executive Administrator, KSNA
Lois Johnson, McDonald, Kansas
Written testimony from Frank Lawler, Chairman, Kansas State Legislative Committee, AARP
Mark Intermill, Kansas Coalition on Aging
Robert Guthrie, Topeka, Kansas

Written testimony was presented to the committee from Kathy Douglas, A.R.N.P., stating that she uses set protocols when seeing patients in the absence of Dr. Cody, with whom she works. The protocols were co-written by Dr. Cody and herself and aid her in assessing, diagnosing, and prescribing medication for uncomplicated, acute illnesses and injuries. The doctor fills prescriptions which are later picked up by the students. Ms. Douglas urged the enactment of legislation that would allow nurse practitioners to continue practicing, following protocols co-written with a physician, that enable nurse practioners to order prescription medications. (Attachment 1)

Mary Harness, C.F.N.P., A.R.N.P., spoke to the committee and presented written testimony stating her organization was not promoting independent practice for nurse practitioners, nor do they feel any nurse practitioner should be allowed unlimited prescriptive privileges. However, it was felt that any nurse practitioner that a physician and nurse practitioner should be able to jointly establish guidelines and protocols for medical plans to care for clients that included prescription medications. (Attachment 2)

Debbie Folkerts, Family Nurse Practioner from Hays testified before the committee and presented written testimony (Attachment 3), stating that in rural practices the past 18 months have been very traumatic. At the present time 12 primary care physicians are attempting to care for approximately 55,000 population. Restraints in the practice of Nurse Practioners will further damage efforts to recruit physicians for this area.

Patsy Quint, KSNA, spoke to the committee and presented written testimony stating opposition to SB-23 as it is written. (Attachment 4) Ms. Quint told the committee that nurse clinicians/nurse practioners were serving in rural health clinics, health departments, student health clinics and urban health clinics offering health care to the medically indigent and also to the under served across the state. These nurses have previously functioned under standing orders or protocol which have been jointly developed by the nurse and physician with whom they work. Ms. Quint reiterated the nurse practioners prefer to practice under established protocols and do not want full prescriptive power.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

CONTINUATION SHEET

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 526-S, Statehouse, at 10:00 a.m./pXX. on January 19, 1989

Dr. Lois Scibetta, Executive Administrator of Kansas State Board of Nursing appeared before the committee and offered a balloon bill which, it was hoped would clarify the role of the Advanced Registered Nurse Practioner. (Attachment 5)

Senator Salisbury shared with the committee the purpose of introducing SB-23 by the Joint Committee on Administrative Rules and Regulations. The JCARR had reviewed temporary regulations adopted by the Board of Nursing and expressed its concern with subsections (b)(3) "....to write a prescription order without direct authorization from the responsible physician" and (b)(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 practioner." The JCARR questioned the statutory authority of the Board to adopt the language and expressed a concern that the language did not appear to accurately reflect the practice and intent of ARNPs. The following month, the Board of Nursing adopted the identical language of concern to the committee into a permanent regulation. Because the legislature statutorily directs state boards and agencies to adopt regulations and is not authorized to alter or deny a regulation, the JCARR had introduced a bill to allow the legislature to statutorily clarify the authority of ARNPs to transmit a prescription in accordance with a written protocol or to write prescriptions for unscheduled medications. The JCARR is not making a recommendation on the appropriate level of practice for ARNPs.

Following completion of testimony on SB-23 the chairman appointed a subcommittee composed of Senator Salisbury, Senator Langworthy and Senator Walker. The sub-committee will be chaired by Senator Salisbury.

Lois Johnson appeared before the committee and presented written testimony opposing SB-15. Ms. McDonald stated that after fighting for years to obtain the Division of Assets bill it was her feeling that until the controversy surrounding the Federal Catastrophic Bill was finally settled it was certainly preferable to consider amending the bill and not totally removing it from the state statutes. (Attachment 6)

Written testimony was presented to the committee from Frank H. Lawler, AARP. (Attachment 7) Mr. Lawler stated that his organization offered an alternative to the repeal provisions in SB-15, suggesting a sunset provision be added which would retain the Kansas law until such time that proposals in Congress to either repeal or amend the Catastrophic Care Act were considered. Also, amendments to Kansas law should be made that would bring it into compliance with the principal features of the current federal act, just in case of repeal of the federal law.

Mark Intermill, Kansas Coalition on Aging, told the committee that the division of assets bill passed last year had enabled a number of spouses to provide protection for themselves and the spouse forced into a nursing home situation. Due to the fact that there are already two bills before Congress which would adversely affect the implementation of the Medicare Catastrophic Coverage Act of 1988, he urged the committee to leave the Kansas statute intact until the issue of repeal of the Medicare Catastrophic Coverage Act is resolved. (Attachment 8)

Robert Guthrie spoke to the committee and presented written testimony (Attachment 9), stating that the Alzheimer's Disease Association, Topeka Chapter, feels there is no need to rush the repeal of Senate Bill 264. The Kansas legislative session will be over before we know what Congress may do.

The meeting adjourned at 10:35 a.m. and will meet January 23, 1989 at the regular time.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE

DATE January 19, 1989

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
ALLYN O. LOCKNER	SRS
Rita Rinkenbaugh Coffeyville Ks	KSBN
Patsy F. Quint Wichita Ks.	KSNA Advanced Practice Conf. Group.
Joleen Zivnuska Wichita KS	ARNP Task Force
[illegible] " "	KSBN, ARNP TF
Tom Hitchcock Topeka	Bd. of Pharmacy
Marilyn Bradt Lawrence	KINH
Dr Lois R. Scibetta	KSBN
Geo. E. Sis	SHL - Republic Co.
Rebecca Rice	KSOS
Jo Spangler	KDHE
Juanita Carlson	representing Assistance Council for Osteopathic Physicians
Sen. Janis Lee	
Tom Bell	Ks. Hosp. Assn.
Delia Ott	Planned Parenthood of Ks
GARY Robbins	Ks Opt. assn
HAROLD RIEHM	KS OSTEOPATHIC ASSN
John Peterson	Ks Assn of Prof Psychologists
HAROLD PITTS	KCOA

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE January 19, 1989

(PLEASE PRINT) NAME AND ADDRESS		ORGANIZATION
Jim McBride	Topeka	Observer
Robin Smith	Topeka	SRS
KEITH R LANDIS	TOPEKA	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS
George Goebel	Topeka	Chr. AARP Capital Area Taskforce -
Mark Intermill	Topeka	Kansas Coalition on Aging
Terri Roberts	Topeka	KSNA
Oleta M. Huston	ElDorado	Spouse of Alzhelmer's Disease
Lois Johnson	McDonald	" "

Fort Hays State University

600 Park Street   Hays, KS 67601-4099   (913) 628-4000

January 15, 1989

Sen. Roy Ehrlich
State House
Topeka, Kansas 66612

Dear Sen. Ehrlich:

I am a certified family nurse practitioner and am Director of the Student Health Center at Fort Hays State University. We employ, besides myself, two registered nurses and a part-time physician, Dr. Dorothy Cody, who sees patients for two to three hours every school day.

Dr. Cody and I have co-written a set of protocols for me to use when seeing patients in her absence. These protocols include guidelines for assessing, diagnosing, and prescribing medication for uncomplicated, acute illnesses and injuries. These range from ankle sprains to tonsillitis, urinary tract infections to bronchitis, sexually transmitted diseases to athlete's foot, etc. There are also protocols covering women's health care including performing pap smears, fitting diaphragms, treating yeast infections, and prescribing oral contraceptives. If I'm ever unsure of a diagnosis or treatment, I usually have the patient see Dr. Cody, or at the very least, consult her by phone before prescribing treatment.

Dr. Cody also acts as our pharmacist, dispensing prescription medication from our institutional drug room. She fills medication for any student that I see prior to her office hours for whom I have ordered a prescription medication. She does this after reviewing the patient's chart. The student then returns to pick up the medication.

For an example, if a student comes in with an acute, uncomplicated middle ear infection, he has two choices. He can see Dr. Cody and be diagnosed and treated with antibiotics for $1, or he can see me, be diagnosed and treated with antibiotics for $1. The difference is that Dr. Cody's time is limited each day whereas I'm generally in the office for seven to eight hours each day. There is also a longer waiting period to see Dr. Cody versus myself. On the other hand, since I don't dispense prescription medication, students do have to make a brief return visit to pick up their medication. Many students appreciate being able to come in and see me when it's convenient for their schedule rather than having to rearrange their time to fit Dr. Cody's hours.

Another advantage of having a nurse practitioner available is to serve as a back-up in Dr. Cody's absence. Dr. Cody was unable to be in the office during this past week of January 9. There were 50 students who required more assessment and treatment than a registered nurse could give. Of those 50,

SPH&W
1-19-89
Attachment 1

I had two see private physicians in Hays. Most of the remaining 48 were treated for sinusitis, bronchitis, pharyngitis, urinary tract infection, or a sexually transmitted disease. The average office visit in Hays is now $25. If all 50 had had to see private physicians, it would have cost $1250. Thanks to me, $1200 was saved this week.

As a nurse practitioner, I don't want to take the place of a doctor, diagnosing and treating complicated illnesses. I see my role as augmenting Dr. Cody, treating simple illnesses, thus allowing her more time for the more complex cases. If I cannot order prescription medication in accordance with established protocols, the people who will suffer the most are Fort Hays students, and they are the ones who can afford it the least.

I want to urge you and your colleagues to enact legislation that will allow nurse practitioners to continue practicing, following protocols co-written with a physician that enable nurse practitioners to order prescription medications. I am enclosing a copy of some of my protocols for your information. Thank you.

Sincerely,

Kathy Douglas, A.R.N.P., C.
Director

enc.

DISORDERS OF THE EARS, NOSE, AND THROAT

Acute Purulent Otitis Media

I. **Definitions.** 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. May also be flat or retracted.
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 infsufflation.

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 medication chosen.

A. Amoxicillin 500 mg. three times daily for 7 days.

or

B. Parenteral CR Bicilling 900/300

or

C. Cephradine 250 mg or cephalexin 250 mg. four times daily for 5 days. Repeat once if necessary.

or

D. If patient is allergic to penicillin derivatives, treat with erythromycin base, 250 mg. 4 times a day for 6 days.

plus

E. A decongestant and /or antihistamine combination, such as Actifed, Sudafed, Entex, Entex LA, Deconamine SR, etc.

VII. Complications

A. Serous otitis media.

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 abcess.

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

VIII. Consultation-referral

A. Severe pain.

B. Failure to improve symptomatically in 48 hours.

C. Signs of meningitis, such as
1. Lethargy.
2. Extreme irritability.
3. Stiff neck.

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

E. More than two episodes of purulent otitis media.

F. Suspicion of mastoiditis (pain, tenderness, or edema in the postauricular area).

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

IX. Follow-up. Examination in 5-7 days or if symptoms don´t improve.

OBSTETRICS AND GYNECOLOGY

Chlamydia Trachomatis Infection

I. **Definition.** Chlamydia trachomatis infection is a parasitic sexually transmitted disease of the reproductive tract mucous membrane of either sex.

II. **Etiology**

A. The causative organism is a small, obligate, intracellular, bacterium-like parasite (Chlamydia trachomatis) that develops within inclusion bodies in the cytoplasm of the host cells

B. The incubation period is unknown.

III. **Clinical features**

A. What the client present with
1. Female
   a. Vaginal discharge
   b. Dysuria
   c. Pelvic pain
   d. Post-coital bleeding
   e. Frequently asymptomatic
2. Male
   a. Dysuria
   b. Thick, cloudy penile discharge
   c. May be asymptomatic

B. Additional information to be obtained
1. Previous vaginal infections; diagnosis, treatment
2. Chronic illness
3. Sexual activity
4. History of sexually transmitted disease or pelvic inflammatory disease
5. Known contact
6. Last intercourse
7. Method of birth control, other medications
8. Description of discharge
   a. Onset
   b. Color
   c. Odor
   d. Consistency
   e. Constant vs. intermittent
   f. Relationship to sexual contact
   g. Relationship to menses
9. Use of vaginal deodorant sprays, deodorant tampons or pads, perfumed toilet tissue
10. Change in laundry soaps, fabric softener, body soap
11. Clothing: consistent wearing of tight-crotched pants
12. Personal hygiene

13. Any drug allergies

IV. **Physical Examination**

A. Vital signs including blood pressure and temperature.

B. Abdominal examination: check for guarded referred pain, rebound pain

C. External examination. Observe perineum for edema, ulcerations, lesions, excoriations, erythema

D. Vaginal examination (speculum)
1. Inspection of vaginal walls
2. Cervix (cervicitis), friability
3. Dishcharge: if present, is characteristically thick mucus at cerical os; difficult to remove

E. Bimanual examination. Pain on cervical rotation (positive Chandalier sign), fullness in adnexa, tender uterus

V. **Laboratory Examination.**

A. Wet mount

B. Chlamydia culture

C. Gonorrhea culture

VI. **Differential diagnosis**

A. Gonorrhea and other causes of vaginitis.

B. Appendicitis.

VII. **Treatment**

A. **Medication**
1. Doxycycline HCl 200mg initially, then 100 mg twice daily for 7 days.
or
2. Tetracycline HCl 500 mg 1, four times daily for 10 days.
or
3. Erythromycin 500 mg 1, four times daily for 10 days.
4. Treat partner with same medication

B. **General measures**
1. Stress no intercourse during treatment
2. Stress importance of completing medication
3. Stress hygiene: cotton underwear, loose clothing, no underwear while sleeping, wipe from front to back.
4. Stress no use of feminine hygiene sprarys, deodorants, and so forth.

5. Stress partner should be treated.

VIII. Complications

A. Pelvic inflammatory disease
   1. Pelvic abscess (ovarian)
   2. Fertility

B. Abnormal Pap smear

C. Erythromycin can cause severe abdominal pain and upset.

IX. Consultation - referral.

A. If no response to treatment as discussed above.

B. If complications develop

C. Report to Kansas Dept. of Health and Environment.

X. Follow-up. Repeat Pap smear if abnormal prior to treatment.

Senator Roy Ehrlich, other members of the Public Health & Welfare Committee,

I am here today to beg you to consider the ramifications of Senate Bill #23.

In Section I K.S.A. 65-1130, it states and has stated in the past - the State Board of Nursing shall define the expanded role of Advanced Registered Nurse Practitioners and establish limitations and restrictions on such expanded roles. I am a member of the Advanced Registered Nurse Practitioner Task Force for the State Board of Nursing and during this past year we have been working on a regulatory amendment to further clarify an already-existing list of functions of Advanced Registered Nurse Practitioners. We felt that 60-11-104 (f) "manage the medical plan of care prescribed for the clients, based on protocols or guidelines adopted jointly by the nurse practitioner and the attending physician" covered the issue of prescribing pursuant to protocols. We are not promoting independent practice for nurse practitioners, nor do we feel that any nurse practitioner should be allowed unlimited prescriptive privileges. Yet, we do feel that a physician and nurse practitioner should be able to jointly establish guidelines and protocols for medical plans of care for clients that include prescription medications. These protocols and guidelines would be individualized according to the type of nurse practitioner and physician and the client group to whom they are providing health care.

An example is the setting where I am employed. I am a Certified Family Nurse Practitioner working in a family practice clinic that serves the health care needs of some 16,000 (+) clients. Four years ago, we had five family practice physicians, now we have three physicians. This loss of physicians has become all too common in our area. The physicians have been fortunate enough to hire an additional two family nurse practitioners when they could not replace the physicians. Without the assistance in health care delivery that the nurse practitioners give the physicians, the remaining three physicians' mere survival would be in serious jeopardy.

SPH&W
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Attachment 2

There are an average of 60 patients a day through our clinic alone that would not receive health care if it were not for the assistance of the nurse practitioners.

We are not promoting independent practice but we are asking you to support nurse practitioners and commend them for the health care that they are able to provide.

In our family practice setting, the nurse practitioners are able to see infants, children, and adults and provide competent evaluation of their health care needs. Some of the patients seen have common acute illness, ie., ear infections, upper respiratory infections, tonsillitis, or bronchitis. The physicians have established treatment plans and they feel comfortable allowing the nurse practitioners to evaluate and treat these clients. If there are complications, the physicians are available for consultation. All treatment plans are ultimately co-signed by the sponsoring physician although not always before initiation of the treatment; the nurse practitioners, physicians, and clients are comfortable with this delivery of health care.

The State Board of Nursing adopted the proposed amendment 60-11-104A that defined (protocol or guideline) as a "written documents that contain a precise and detailed medical plan of care." They went on to state specifics about updating & reviewing protocols. We felt that precise and detailed medical plans of care established by the sponsoring physician and nurse practitioner would adequately protect the health care consumer.

If the State Board of Nursing does not have the authority to allow nurse practitioners to prescribe pursuant to adopted protocols established by the nurse practioner and sponsoring physician, then I ask you to assist us in obtaining that privilege. Help us through the proper channels, whether that be the State Board of Pharmacy or the Board of Healing Arts.

The ongoing health care of many Kansans is in jeopardy if you choose to vote for Senate Bill #23 that prevents nurse practitioners from prescribing pursuant to protocols established jointly by the nurse practitioner and the sponsoring physician.

Sincerely,

Mary Harness R.N., C.F.N.P., A.R.N.P.

Mary Harness, R.N., C.F.N.P., A.R.N.P.

W. 913-628-6151

HAYS FAMILY PRACTICE CENTER
2509 CANTERBURY ROAD
HAYS, KS 67601

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

Eric L. Dyck, M.D.
Fellow of the
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2509 Canterbury Road
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Richard L. Rajewski, M.D.
Fellow of the
American Academy
Family Practice

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

November 14, 1988

To Members of the State Board of Nursing

Dear Members of the Board:

Thank you for allowing me to appear at this public hearing. At the ~~September~~ Aug public hearing, I spoke in support of the new regulatory language that would clarify the use of prescriptions as part of the medical plan of care prescribed for the client, based on protocols and guidelines adopted jointly by the nurse practitioners and the attending physicians.

I again come to you to offer my support and encouragement that this new regulatory language be adopted.

As nurse practitioners, we have the support of our collaborative physicians and the physicians in our community who realize the importance of the nurse practitioner's role in serving the needs of those who otherwise would not receive health care.

Today, I come before you with signatures of support from the pharmacists in my surrounding area. They realize our need and respect our knowledge in the use of prescriptive medications.

Here is a list of those signatures on a petition of support.

Thank you for your attention and your continued support in clarifying these regulations.

I would also like to take this time to encourage my colleagues to take the time and make the effort to contact their local pharmacists and explain their role and function with their collaborative physician in establishing medical plan of care protocols that include prescriptive medications. Encourage open communication between the pharmacist and your clinic to avoid confusion or further concern about the legality of nurse practitioners writing prescriptions pursuant to adopted protocols.

Again, thank you for your time.

Sincerely,

Mary Harness, R.N., F.N.P., A.R.N.P.

MJH/gm

Copy of testimony presented Nov 1988 at the public hearing in front of the State Board of Nursing

We the pharmacists of the Hays, Kansas area have been working with Nurse Practitioners for the past several years. They are employed in collaborative practice with some of our local physicians. We have found them to be competent in their use of the privilege of prescribing pursuant to protocol.

We support the permanent adoption of the regulatory changes proposed that would allow them to continue to function in this capacity.

[illegible] RPh. 10/29/88 Wal-mart Pharmacy Hays

[illegible] RPh 10-29-88 Mayo's Pharmacy Hays Ks.

[illegible] R.Ph. 11-2-88 Hadley Regional Med Cntr. Hays, Ks.

Mary S. Sturdy, R.Ph. 11-4-88 Mayo's Pharmacy - Hays K.

Don Dawson Pharmacy - Russell, KS.

[illegible], RPh 11-5-88 Purdy Pharmacy Inc Hays

[illegible] 11/5/88 Fort Hays Pharmacy

Brent W Roberts RPh 11/5/88 Dillon Pharmacy #61

[illegible] 11-12-88 Fort Hays Pharmacy

[illegible] RPh 11/12/88 Unrein Healthmart Drug, 210 West Mill Street, Plainville, KS 67603

[illegible] RPh 11/12/88 Stockton Pharmacy - Stockton KS

I am a Family Nurse Practitioner working in a family practice center in Hays, Kansas. There are three family practice physicians and three family nurse practitioners working collaboratively to meet the health care needs of some 16,000 (+) patients.

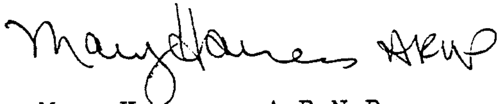
We support the new language changes that have been proposed to allow nurse practitioners to issue prescriptions pursuant to protocol. The protocols will be adopted jointly by nurse practitioners and their responsible physicians.

We feel our setting is similar to other collaborative practices where nurse practitioners work closely with physicians in providing health care.

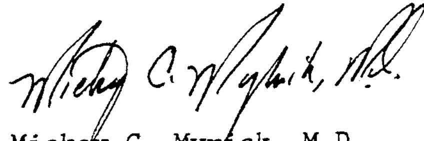
Please understand that obtaining prescriptive privileges is for the mutual benefit of nurse practitioners, the physicians with whom they work, and their patients.

There are articles available to support the need for the privileges, and also to verify how well nurse practitioners handle this privileges of writing prescriptions pursuant to protocol. I have copies of these articles ready for your review.

Thank you for allowing me to speak in support of this important issue.



Mary Harness, A.R.N.P.

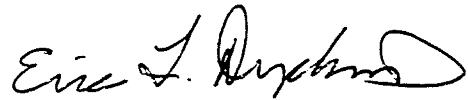


Mickey C. Myrick, M.D.

Susan Amrein, A.R.N.P.

Richard L. Rajewski, M.D.

Linda Ashton, A.R.N.P.



Eric L. Dyck, M.D.

* Copy of testimony presented at the public hearing in Aug. 1988 in front of the State Board of nursing.

Linda J. Pearson, R.N., M.S.N., C.-F...,
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.

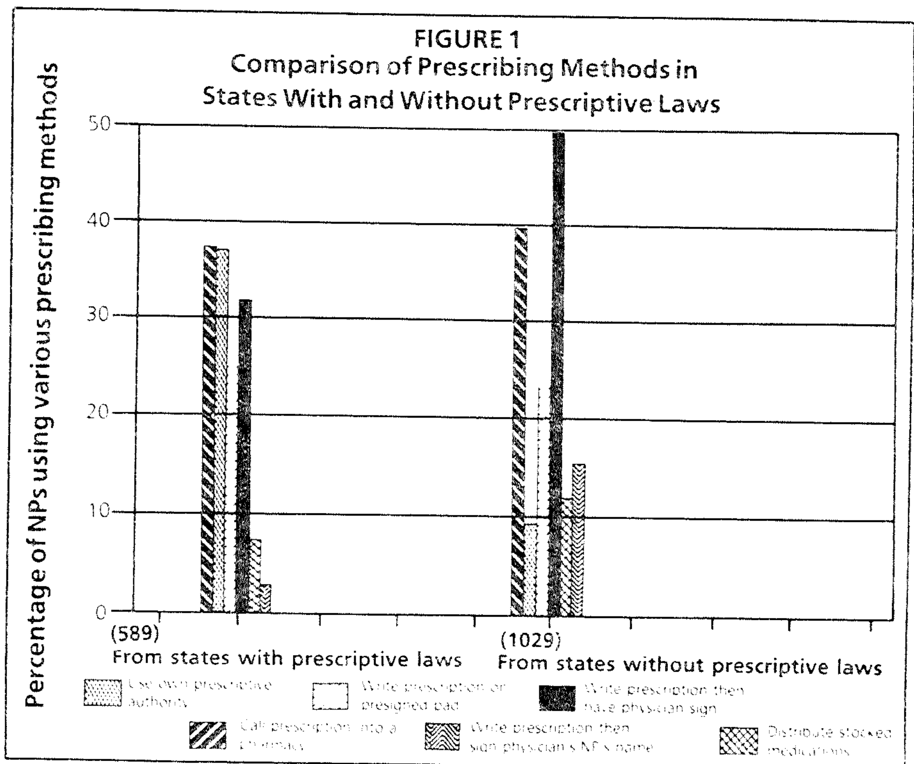


FIGURE 1
Comparison of Prescribing Methods in States With and Without Prescriptive Laws

2-6

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 health care. Perhaps our data will help to prompt 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)
- Nevadá (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)

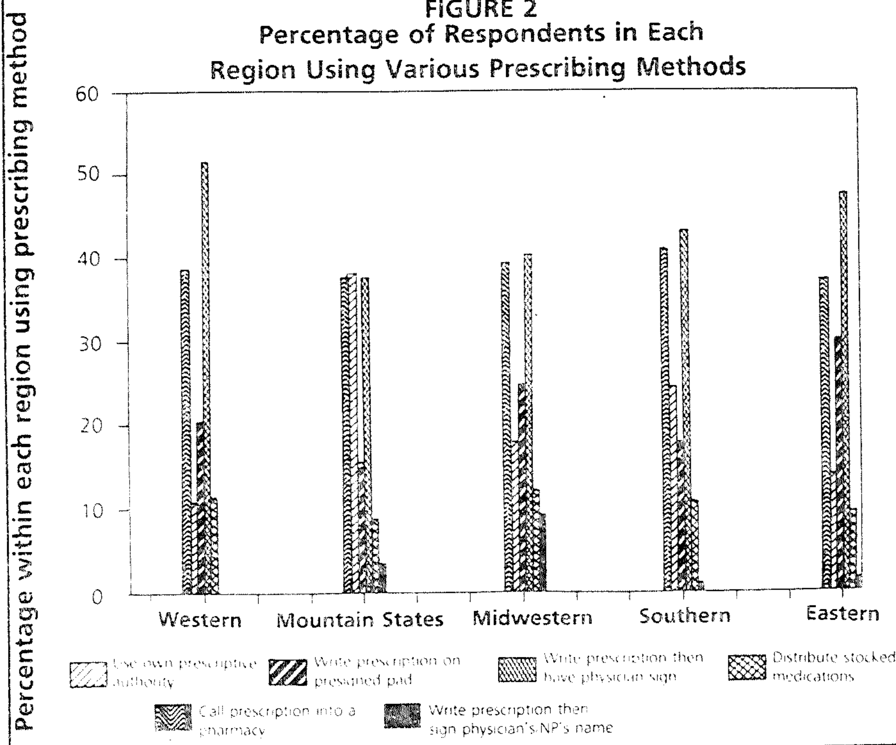


FIGURE 2
Percentage of Respondents in Each Region Using Various Prescribing Methods

MONISTAT* Dual-Pak*
Suppositories/Cream

MONISTAT* 3 Vaginal Suppositories
(miconazole nitrate 200 mg)

MONISTAT-DERM* Cream
(miconazole nitrate 2%)

INDICATIONS AND USAGE: MONISTAT 3 Vaginal Suppositories are indicated for the local treatment of vulvovaginal candidiasis (moniliasis). Effectiveness in pregnancy or in diabetic patients has not been established.

MONISTAT DERM Cream—For topical application in the treatment of cutaneous candidiasis (moniliasis).

CONTRAINDICATIONS: MONISTAT 3 Vaginal Suppositories—Patients known to be hypersensitive to the drug.

MONISTAT-DERM Cream has no known contraindications.

PRECAUTIONS: MONISTAT 3 Vaginal Suppositories—General: Discontinue drug if sensitization or irritation is reported during use. The base contained in the suppository formulation may interact with certain latex products, such as that used in vaginal contraceptive diaphragms. Concurrent use is not recommended.

Laboratory Tests: If there is a lack of response to MONISTAT 3 Vaginal Suppositories, appropriate microbiological studies (standard KOH smear and/or cultures) should be repeated to confirm the diagnosis and rule out other pathogens.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term animal studies to determine carcinogenic potential have not been performed.

Fertility (Reproduction): Oral administration of miconazole nitrate in rats has been reported to produce prolonged gestation. However, this effect was not observed in oral rabbit studies. In addition, signs of fetal and embryo toxicity were reported in rat and rabbit studies, and dystocia was reported in rat studies after oral doses at and above 80 mg/kg. Intravaginal administration did not produce these effects in rats.

Pregnancy: Since imidazoles are absorbed in small amounts from the human vagina, they should not be used in the first trimester of pregnancy unless the physician considers it essential to the welfare of the patient.

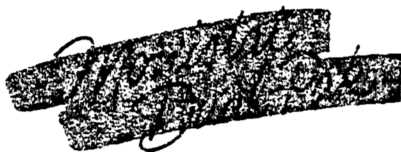
Clinical studies, during which miconazole nitrate vaginal cream and suppositories were used for up to 14 days, were reported to include 514 pregnant patients. Follow-up reports available in 471 of these patients reveal no adverse effects or complications attributable to miconazole nitrate therapy in infants born to these women.

Nursing Mothers: It is not known whether miconazole nitrate is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when miconazole nitrate is administered to a nursing woman.

MONISTAT DERM Cream—If a reaction suggesting sensitivity or chemical irritation should occur, use of the medication should be discontinued. For external use only. Avoid introduction of MONISTAT DERM Cream into the eyes.

ADVERSE REACTIONS: MONISTAT 3 Vaginal Suppositories—During clinical studies with the MONISTAT 3 Vaginal Suppository (miconazole nitrate 200 mg) 301 patients were treated. The incidence of vulvovaginal burning, itching or irritation was 2%. Complaints of cramping (2%) and headaches (1.3%) were also reported. Other complaints (hives, skin rash) occurred with less than a 0.5% incidence. The therapy related dropout rate was 0.3%.

MONISTAT DERM Cream—There have been isolated reports of irritation, burning, maceration and allergic contact dermatitis associated with application of MONISTAT DERM.



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Raritan, New Jersey 08869

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NP Prescribing Recommendations

Linda J. LaPlante, R.N., M.S.N., C.A.N.P.
Freda V. O'Bannon, R.N., M.S., C.A.N.P.

Abstract

This study was conducted to identify the impact NPs have on the selection of prescription and non-prescription drugs. Nurse practitioners without prescriptive privileges who work in adult ambulatory care settings were asked to collect data regarding patient diagnoses and recommended drug therapy over a three-day period in August 1985. Nurse practitioners recommended 2,081 new over-the-counter and prescription drugs during this study. Of these over-the-counter and prescription drugs, only 50 (2 percent of all recommended drugs) were changed after consultation with supervising physicians. Of the 50 changes, only two drugs (0.1 percent of all recommended) were changed to different drug categories. Nurse practitioner drug recommendations were well accepted by supervising physicians, as indicated by the data collected. These findings help to demonstrate that NPs without prescriptive privileges have a significant impact on drugs prescribed for patients.

Introduction

Nurse practitioners currently have prescriptive rights in 20 states,[1-2] and numerous other states are confronting the issue of nurse practitioner prescribing privileges. Currently, in states where nurses do not have prescriptive privileges, nurses rely on consultation with supervising physicians for prescriptions.

The literature clearly documents the effectiveness, safety and client acceptance of NPs.[3] It is estimated that 67 percent to 90 percent of primary health care problems can be effectively managed by NPs.[4-7] One area of research that has not been fully explored is the impact of NPs' recommendations on drugs prescribed for patients.

Purpose

This study was conceived and conducted by the authors to identify the impact nurse practitioners have on the selection of prescription and non-prescription drugs. Further, this study identifies patient health problems frequently seen by the NP that require drug therapy and the most commonly recommended drugs.

Method

Nurse practitioners working in Southern California Kaiser Permanente Medical Group Adult Ambulatory Care services were invited to participate in this study. Participating NPs work in a variety of settings including health evaluation clinics, numerous specialty clinics and acute walk-in clinics.

Participation was voluntary and confidentiality was assured. Of the 170 adult nurse practitioners who were mailed surveys, 59 (35 percent) participated in the study. Nurse practitioners were asked to collect data regarding patient diagnoses and recommended drug therapy over a three-day period in August 1985. Each participant was asked to identify the diagnoses for all patients requiring prescription or non-prescription medications. *Only those requiring new medications were included in the study.* Nurse practitioners indicated their drug recommendations and whether or not their supervising physician approved their recommenda-

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If supervising physicians [illegible]ed alternate drugs, their preferences were indicated on the survey.

Findings

Over a three-day period, 59 NPs treated 1,632 patients with 1,711 health care problems requiring new medications. These numbers are not reflective of the total number of patient visits or health care problems treated during this time period. Many patients evaluated by NPs do not require drug therapy or have been on medications which only require dosage monitoring and adjustments as needed. Nurse practitioners recommended 2,081 over-the-counter and prescription drugs during this survey. At the time the data were obtained, 1,646 (79 percent) of all drugs recommended were classified as prescription drugs and 435 (21 percent) were classified as non-prescription drugs. The average number of over-the-counter and prescription drugs for each patient was 1.3.

Of the 2,081 new over-the-counter and prescription drugs recommended by NPs, only 50 drugs (2 percent) were changed after consultation with supervising physicians. Of the 50 changes, only two drug recommendations (0.1 percent) were changed to a different drug category. Forty-three drugs (2 percent) were changed by supervising physicians to different drugs within the same drug category (e.g., in 21 cases, physicians preferred alternate antibiotics to those suggested by the NP).

The most frequently prescribed drug categories included antiobiotics (30 percent), anti-inflammatory preparations (13 percent), decongestants and antihistamines (10 percent) and antitussives (9 percent) (see Table 1). For the purposes of this study, topical and oral antibiotics were included in the antibiotic category; topical anti-inflammatory skin preparations were included with oral anti-inflammatory agents; aspirin was included with anti-inflammatory agents. Anti[illegible]sives included bronchodilators [illegible] to treat asthma. Birth control pills were included as hormones while other birth control methods were included as contraceptive devices. Antibiotic ophthalmic drugs were included in antibiotics, while all other ophthalmic preparations were included in the ophthalmic drug category. Immunizations were not included in this survey.

TABLE 1

Drug Category	Incidence	% of Recommended Drugs
Antibiotics	624	30
Anti-inflammatories	270	13
Dermatologics	229	11
Decongestants and antihistamines	208	10
Antitussives	187	9
Analgesics	125	6
Gastrointestinal	125	6
Cardiovascular	83	4
Hormones	62	3
Vitamins and minerals	62	3
Ophthalmic agents	44	2
Muscle relaxants	31	1
Sedatives	11	.5

TABLE 2

Diagnostic Category of Health Problems	Incidence	% of Health Problems
Respiratory	360	21
Genitourinary	364	21
Skin	202	12
Musculoskeletal	165	10
Gastrointestinal	148	9
Ear	129	7.5
Eye	122	7
Cardiovascular	113	6.5
Health maintenance	48	3
Neurological	42	2
Endocrine	16	1

Common Health Problems

The primary diagnostic classifications of health problems for which drugs were recommended include respiratory problems, genitourinary problems, skin problems, musculoskeletal problems, gastrointestinal problems, ear problems, eye problems, cardiovascular problems, health maintenance problems, neurological problems and endocrine problems (see Table 2).

Most Common Health Problems

The most frequently reported health problems in each diagnostic classification were identified in this study. Upper respiratory tract infections, including rhinitis, sinusitis and pharyngitis, were the most frequently seen respiratory problems (68 percent). Vaginitis was the most frequently seen genitourinary problem (38 percent). Allergic dermatitis (34 percent) was the most frequently treated skin problem. Inflammatory problems including arthritis, tendonitis and bursitis were the most common musculoskeletal problems (48 percent). Thirty percent of all gastrointestinal problems were caused by gastroenteritis. Sixty percent of all ear problems were caused by acute otitis media and acute otitis externa. Conjunctivitis (60 percent) was the most common eye problem. Hypertension accounted for 77 percent of all cardiovascular problems. Need for calcium supplement (60 percent) was the most frequent health maintenance condition requiring medication. Headaches (69 percent) were the most common neurological problems and diabetes mellitus (13 percent) the most common endocrine problem.

Most Frequently Recommended Drug Classifications for Diagnostic Categories of Health Problems

Antitussives and deconges-

t· (52 percent) were the most ntly recommended drugs for u... r respiratory tract infections. Antibiotics (60 percent) were the most frequently recommended group of drugs for treatment of bronchitis. Of all drugs recommended for urinary tract infections, 89 percent were antibiotics. Candida was the most common vaginal infection reported. Antifungal agents were recommended 100 percent of the time. Oral contraceptives made up 75 percent of all family planning recommendations. Topical anti-inflammatory/antipruritic agents (54 percent) and antihistamines (42 percent) were most frequently recommended to treat allergic dermatitis. Anti-inflammatory agents were recommended 94 percent of the time to treat inflammatory musculoskeletal conditions. Analgesics and anti-inflammatory agents (58 percent) were most frequently recommended to treat low back pain while muscle relaxants were recommended 42 percent of the time. Antidiarrheals and antispasmodics were recommended 43 percent of the time to treat gastroenteritis. Antibiotics were the most common drug group recommended to treat otitis media (67 percent) and otitis externa (93 percent). Antibiotic ophthalmic drops (68 percent) were the most common drug group recommended to treat conjunctivitis.

Most Frequently Recommended Drugs for Specific Conditions

Table 3 lists the most frequently recommended drug products for some of the most common health problems seen by NPs. When the most commonly recommended drugs were recommended by different names, both are included in the table. The number of different drugs recommended for each problem is included. This reflects the large number of available drugs with similar actions from which health care providers select.

Drug recommendations by NPs without prescribing privileges are quite similar to drugs prescribed by NPs with privileges as well as to drugs ordered by physicians.

Discussion

It is significant to note that in this study only 50 drug recommendations (2 percent) were changed after consultation with the physician. Of these, only two drugs (0.1 percent of all recommended drugs) were changed to a different dr cat y. Nurse practitioner d recommendations were well ac cepted by consulting physicians as indicated by the data collected. The authors believe these findings demonstrate that NPs without prescriptive privileges have an impact on drugs prescribed for patients.

Drug recommendations by NPs without prescribing privileges are quite similar to drugs prescribed by NPs with privileges,[8] as well as to drugs ordered by physicians.[9-10] Nurse practitioners in this study recommended an average of 1.3 drugs for each patient seen. These findings are consistent with those reported in a study by Holland et al., 1985,[8] where an average of 1.29 drugs were prescribed for each patient.

In the study described here, more than 94 percent of all recommended drugs were included in the

TABLE 3

Health Problems	Number of Different Drugs Recommended	Total Number of Drugs Recommended	Most Common Drugs Recommended
Respiratory Problems			
Acute rhinitis	29	139	Robitussin, N = 23
Pharyngitis	20	107	Pen Vee K, N = 44
Sinusitis	18	58	Amoxicillin, N = 15
Bronchitis	21	119	Erythromycin, N = 38, EES, N = 13
Genitourinary Problems			
UTI/cystitis	11	81	Septra DS, N = 41, Bactrim DS, N = 10
Candida vaginitis	7	81	Gyne-Lotrimin, N = 33, Clotrimazole, N = 22
Family planning drugs/methods	13	63	Ovcon 1/35, N = 11, Diaphragm, N = 11
Skin Problems			
Skin allergic dermatitis	20	74	Benadryl, N = 17 Hydrocortisone cream, N = 17
Fungal infections	12	51	Lotrimin, N = 16, Clotrimazole, N = 10
Cellulitis	10	41	Dicloxacillin, N-17
Gastrointestinal Problems			
Gastroenteritis	12	46	Lomotil, N = 11, Combid, N = 9
Ear Problems			
Acute otitis media	19	51	Amoxicillin, N = 13
Acute otitis externa	8	41	Cortisporin Otic Sol, N = 28
Eye problems			
Conjunctivitis	13	80	Vasocon A, N = 16, Neosporin, N = 12 Sulamyd, N = 11, Garamycin, N = 10
Cardiovascular problems			
Hypertension	17	91	Atenolol, N = 13 Tenormin, N = 9, HCTZ, N = 19

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following categories: antibiotics, anti-inflammatories, dermatological agents, decongestants/antihistamines and decongestants.

Antibiotics accounted for 30 percent of all recommended drugs. This finding is consistent with a survey by the publishers of *The Nurse Practitioner* in 1984 which found antibiotics to be the most frequently recommended drug group.[11] Anti-infectives made up 33 percent of all drugs prescribed by NPs in the study by Holland et al.[8]

The consistency of findings among these studies helps to support the appropriateness and safety of NPs' recommending/prescribing practices.

Cardiovascular drugs, hormones, ophthalmic agents, muscle relaxants and sedatives were less frequently recommended by NPs. These findings, with the exception of hormones (oral contraceptives), are consistent with those of Holland et al., 1985.[8] This difference can be explained by the fact that many of the patients in this study are provided oral contraceptives by Ob-Gyn NPs or physicians in Ob-Gyn clinics. Ob-Gyn NPs were not included in this study.

These studies all note similar findings in both the categories of drugs recommended/prescribed by NPs and the frequency with which they are recommended/prescribed. The consistency of findings among these studies helps to support the appropriateness and safety of NPs' recommending/prescribing practices.

There are now prescriptive privilege laws in 20 states.[1-2] California nurse practitioner prescriptive legislation. AB 4372 signed into law and effective Jan. 1, 1987, is an example of limited prescriptive privileges. It limits prescribing privileges to NPs working in family planning clinics or public health and Indian health clinics. There are no studies comparing drug recommending/prescribing practices of the specific groups of NPs granted prescriptive privileges in California to other California NPs who are not allowed prescriptive privileges under this legislation.

Nurse practitioners who need prescriptions for their clients find ways to obtain them regardless of the laws. However, legislators must be made aware of the numerous burdens some restrictive laws place on the NPs who are delivering safe, client-oriented, cost-effective primary health care.[12] This study helps identify the need for further research to demonstrate safe, appropriate NP recommending/prescribing practices. With new legislation regarding NP prescribing privileges, there is a real need for studies comparing prescriptive practices of NPs granted these prescriptive privileges to those NPs in the same state(s) who have not been granted these privileges. Unless studies of this nature are conducted and submitted for legislative review, NP prescriptive legislation will continue to be granted in a piecemeal, constrained manner. Studies also need to be conducted to identify regulatory criteria that relate to the safe and judicious practice of NP prescribing. It is hoped further studies will help to develop standardized criteria for NP prescribing legislation.

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Thanks to you.
United Way

These nurses weren't practicing medicine after all

Nurse practitioners are now on firmer ground when they claim their training qualifies them to make diagnoses, thanks to a recent Missouri court decision.

BY MARGARET L. HUNTER

Nurse practitioners are functioning within the scope of their licenses when they do pelvic examinations and prescribe contraceptives based on those exams. So ruled Missouri's highest court in overturning a decision that had attracted national attention. Since the nurses' activities were authorized, the court added, they did not constitute the unlawful practice of medicine.

"We believe the acts of the nurses are precisely the types of acts the legislature contemplated when it granted nurses the right to make assessments and nursing diagnoses," the Missouri Supreme Court held. Those words from the unanimous opinion referred to a 1975 law that broadened the description of nursing responsibilities and specifically eliminated language in the nursing practice act that required a doctor's on-site supervision of nurses.

Under this law, the court stated, "a nurse may be permitted to assume responsibilities heretofore not considered to be within the field of professional nursing so long as those responsibilities are consistent with her specialized education, judgment, and skill"—and a nurse practitioner's interpretation of pelvic exams and prescription of contraceptives falls within those responsibilities.

While the decision applies only to Missouri, it's certain to have an impact elsewhere. Says Sue Hilton, director of the family planning clinic that employed the nurse practitioners: "Over the past few months I've gotten the impression that everybody is watching Missouri." Interest is particularly high in states where there is similar litigation or where moves are afoot to broaden the scope of nursing practice.

Sallye Brown, executive director of the Nurses Association of the American College of Obstetricians and Gynecologists, agrees. "If the case had gone against the nurses, we expected similar suits in at least half a dozen other states." Brown notes that many nurse practitioners are working under broadly written state statutes, and, she says, the possibility of suits against them for the illegal practice of medicine are very real. "The positive decision in Missouri may diffuse some of the action against nurses," Brown concludes.

The Missouri battle began in 1980, when several physicians complained to the state medical board about a family planning clinic operated by the East Missouri Action Agency. The clinic had offices in Cape Girardeau and three other communities. It employed two NPs, Janis Burgess and Suzanne Solari, and five physicians.

The two nurses worked under standing orders provided by physicians 40 miles away. They performed pelvic exams and, based on their findings, inserted IUDs or prescribed birth control pills or vaginal medication. While they suspected the complaints came from doctors who were losing patients to the clinic, the questions considered by the medical board—and later by the courts—focused on whether they were competent to do pelvic exams and make diagnoses.

> *"A nurse may assume responsibilities heretofore not considered part of nursing."*

When the board threatened to prosecute the nurses and revoke the physician's licenses, they asked the courts to affirm the legality of their actions. The case came to trial in St. Louis Circuit Court in mid-1982.

Notably absent during the trial was any testimony that patients had in fact been harmed. But there was considerable testimony that patients *could* be harmed. Explains the medical board's lawyer, David Brydon of Jefferson City: "No one has disputed the quality of health care provided. At issue only was the nurses practitioners' legal right to provide it."

The qualifications of the two NPs also went unchallenged. At the time of the trial, Janis Burgess had six and a half years of experience at the clinic plus four and a half years of hospital experience. She had completed a nurse practitioner program in Denver and received certification in her specialty by the Nurses Association of the American College of Obstetricians and Gynecologists. Suzanne Solari had worked for three years in hospitals and three years at the clinic. She, too, was certified by NAACOG, having completed an NP program in Milwaukee.

Those credentials notwithstanding, the trial court decided in favor of the medical board. Judge Milton A. Saitz held that "graduation from medical school is a prerequisite" for interpreting the results of a pelvic exam.

Although the Missouri Supreme Court refused to define the difference between nursing and medical diagnoses, its ruling is clearly a victory for nurses and a setback for doctors.

Indeed, the fears of physicians are evident in a friend-of-the-court brief submitted by the Missouri State Medical Association. The association argued that the outcome of the case should affect only the litigants at hand. That argument was hotly disputed by the nurses' attorneys, who contended that nurses treat patients under physicians' standing orders in a wide variety of situations—for example, the public health nurse treating patients in the field, or the hospital nurse responding to a cardiac arrest.

The Supreme Court in effect agreed with the nurses, since the ruling was not strictly limited to the litigants at hand. But doctors are unlikely to acquiesce quietly to the assumption by nurses of responsibilities they consider solely theirs. As NAACOG's Sallye Brown puts it: "We won in Missouri, but the battle is far from over." ■

THE AUTHOR is a freelance writer in Columbia, Mo.

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Rx for nurse-practitioner–physician teams

A 24-year-old man comes to a clinic staffed by a nurse-practitioner. His history is that of abdominal pain, but numerous upper gastrointestinal and barium enema examinations all have yielded negative results. He smokes heavily and probably does not take the antacids that have been prescribed for him. Should the nurse-practitioner treat this patient, or should he be referred to the physician with whom the nurse-practitioner works?

More important, would the two health care practitioners agree on which one could more effectively treat this patient?

As thousands of newly trained nurse-practitioners enter the health care system in the next few years, nurse-practitioner-physician teams will not be uncommon. Such teams may offer improved patient care by combining what should be complementary attitudes and skills. "Research has shown," says Robert Fletcher, MD, "that physicians are more disease-oriented, while nurses concentrate more on psychological and social components of disease."

Do these traditionally perceived roles prevail in nurse-practitioner-physician teams? If so, does the difference in orientation affect communication of referral information? Fletcher, an associate professor of medicine and clinical epidemiology at the University of North Carolina School of Medicine in Chapel Hill, and Richard Davidson, MD, and John Hake, MD, both fellows in the Robert Wood Johnson Clinical Scholars Program at the university, conducted two studies to answer these questions.

Davidson designed a series of vignettes describing patients with clearly organic illness, mostly psychosocial illness, or organic illness complicated by psychosocial factors. (The "patient" presented at the beginning of this article is in the last category). He asked each member of 15 nurse-practitioner-physician teams in primary care settings how appropriate it would be for each member of that team to treat each of the nine patients.

Hake analyzed 226 actual referrals from nurse-practitioners to physicians at three primary-care clinics in North Carolina. By comparing the referral notes with the physician's consultation notes, he determined how many of the patients' problems and therapies as suggested by the nurse-practitioner were recognized by the consulting physician.

Nurse-practitioners' responses to the vignettes were in good agreement, Davidson found. "They most often chose the health education and psychosocial vignettes as being appropriate for themselves."

Agreement among physicians as to which patients they should treat was "moderately good," he said.

In most cases there was also good agreement between team members as to who could best treat each patient; ie, nurse-practitioners are better able to handle psychosocial problems and physicians are best equipped to treat primarily organic illness.

But, reported Davidson, "in a substantial number of cases the nurse-practitioner thought she could do more for a patient than the physician thought she could." Although data have not yet been completely analyzed, Davidson said it was his impression that these disagreements arose most often when the fictitious patients had complaints of primarily an organic nature.

The results of Hake's survey showed that such attitudes can have a detrimental effect on transmittal of referral information. Physicians recognized patient problems in the referral notes 25% less often when they were of a personal or social nature than when they were revealed by a physical finding or test. The same decrease in recognition occurred when suggested therapies were psychological or social rather than drug related.

This difficulty was particularly pronounced when the patient had multiple problems. "Given a list of problems," Hake told *JAMA* MEDICAL NEWS, "the physician will pick out those he's most familiar with."

The other major "risk factor" for poor communication, he reported, was a black patient of lower socioeconomic class.

The investigators believe that recognition of differences in attitude between nurse-practitioners and physicians can reduce conflict within primary-care teams and make them more effective in treating patients.

For instance, says Davidson, "A physician needs to know that a nurse-practitioner will probably not be happy just seeing sore throats all day." This caveat is especially pertinent in view of previous evidence that physicians in hospitals tend to use nurses as technical assistants, thereby impeding nurses' realization of caring roles.

On the other hand, says Fletcher, "A nurse-practitioner can't assume that referrals will be dealt with if they contain material not in the traditional physician's training. Hake's study showed that when nurses were talking about psychological aspects of patient care, physicians were less likely to pick up the message."

In practice, adds Hake, nurse-practitioners might enhance physician understanding of their notes by clearly identifying each specific problem—whatever its nature—in the chart.

Hake pointed out the irony of this situation to

continued on page 2479

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continued from page 2474
JAMA MEDICAL NEWS. "As primary care physicians we are usually in the position of referring patients to specialists. In the combined practice teams, on the other hand, the generalist physicians are consultants to the nurse-practitioners. Just as specialist physicians often ignore information in notes from primary-care physicians, these physicians did not recognize many factors in the nurse-practitioners' notes."

Reports on these studies were presented at the recent meeting of the American Society for Clinical Investigation in Washington, DC.

—by WILLIAM A. CHECK

Nail in the heart no match for rural medical resources

These days Bob Edwards, MD, spends most of his time at home in Telluride, Colo, finishing up his first novel. Recently he looked out the window and was startled to see a 30-year-old carpenter of his acquaintance ride by on a bicycle. Just six weeks previously, Edwards—who is a family practitioner—had been busy pouring lactated Ringer's solution into the carpenter as he lay in Telluride's Mountain Medical Center with a nail lodged in his heart.

At the time, the patient was in hemorrhagic shock, with electromechanical dissociation, cardiac tamponade, and no detectable pulse or blood pressure (BP). But "he must have been getting a little circulation," Edwards told JAMA MEDICAL NEWS. It seems that the carpenter had been using a nail-driving gun and had accidentally shot a nail into his own chest, nailing his heart to his sternum. The head of the nail was sticking out of the breastbone, and the end of it protruded from the back of the right ventricle.

At the medical center, Edwards had elevated the patient's legs, wrapped them in bandages, and administered oxygen and intravenous fluids. But the man's condition showed no improvement until Edwards placed him in Military Anti-Shock Trousers (MAST) that were then inflated. After this, the BP (90 mm Hg systolic) became discernible and the pulse palpable. Still in the MAST and attended to by emergency medical technicians, the patient was rushed to Montrose Memorial Hospital, a 75-bed facility some 39 km north of Telluride.

At Montrose Memorial, the impaled man was taken directly to the operating room. There, staff surgeon Charles Abernathy, MD, cracked the sternum, causing the nail to pop out of the heart and relieving the cardiac tamponade. He then hammered the nail out of the sternum from the side, using surgical pliers, and sutured the holes in the right ventricle.

Although penetrating wounds of the heart are relatively common, neither Abernathy nor Edwards had previously seen a projectile embedded in the heart of a living patient. Most such cases have been reported in combat victims. Interestingly, one of the few peacetime cases on record (*JAMA* 82:1840-1845, 1924) also involved a nail. George L. Davenport, MD, related that the patient, a 44-year-old machinist, was undergoing treatment in the detention ward of Chicago's Cook County Hospital in 1920 for depression after his mother's death; he drove a nail into his left breast, using his fist. An intern pulled the nail out with artery forceps, and the patient was given strychnine and camphor in oil as stimulants. Forty-five minutes later, Davenport began a rib resection, subsequently suturing a nail wound in the heart's right ventricle.

Unlike Davenport's patient, the Colorado patient endured for several hours with the nail still in his heart. He has suffered no neurological sequelae. Edwards speculates that his physical condition may have been a factor in his survival: "He's kind of a fitness nut." The major medical intervention that contributed to recovery, Edwards and Abernathy agree, was use of the MAST.

These pneumatic pants (sometimes called a G suit), similar to those worn by dive bomber pilots in World War II, have become standard equipment in ambulances traversing the five-county area served by Montrose Memorial Hospital. They are part of an innovative program described by Abernathy and other Montrose physicians in a series of articles entitled "Advances in Small Hospital Care" that constitute an entire issue of *The Surgical Clinics of North America* [59, June 1979]. Under the "Montrose Experiment," procedures usually confined to urban centers have been adapted for use in rural southwestern Colorado. The MAST are considered indispensable in this sparsely populated region, where patients often must be moved long distances before receiving blood transfusions or undergoing surgery. Properly used, the trousers cause rapid autotransfusion of about 1 L of blood into the intravascular volume of the upper part of the body (*JAMA* [MEDICAL NEWS] 225:686, 1973). Each pair costs approximately $350.

Edwards underplays his own role in keeping the patient alive, saying, "I did only what the paramedics in California do—provide advanced cardiac life support."

Abernathy likewise insists, "The patient's survival was more a tribute to the prehospital management and to our little hospital than to my technical skills."

Adds Edwards, "I still don't know how he survived the injury. Before I saw the x-rays, I assumed that the nail couldn't have penetrated the heart. After it was all over, I told him, 'You know, I thought you were going to die.' He said, 'Oh, I never thought that.' "

—by ELIZABETH RASCHE GONZÁLEZ

Public Is Served When Nurses Prescribe/ from page 1

censed or certified health care agency, a physician's office or an organized public health agency.

Ann Holmes, RN, is a certified family nurse practitioner for an obstetrical-gynecological clinic in Sioux Falls, S.D. She recently started a women's health care clinic as an extension of the ob-gyn practice.

"I've had no problem with the rules regulating prescriptive authority," Holmes said. "No pharmacy has refused my prescriptions because they know the physicians here and they know me. It's a workable arrangement."

She said the other requirements are that the nurse practitioner or nurse midwife be certified (and recertified every five years), and that the nurse sign each prescription with her or his name and professional title and the supervising physician's name.

"It is to the physicians' and the patients' advantage that I have the ability to write prescriptions," Holmes said. "The physicians here see up to 45 patients a day. I take the patients they don't have time for, the patients who require more time. We're able to care for more patients this way, and the patients get better, more personal care."

Holmes, who calls herself a nurse clinician, said she is a strong advocate of the nurse practitioner role.

"Many nurse practitioners in the state call themselves physician's assistants because the medical model pays better," she said. "I prefer to be identified as a nurse."

Oregon Adopts New Bill

Oregon nurse practitioners have had prescriptive authority since 1979. This year, however, the state Legislature adopted a bill placing administration of nurse practitioner prescription privileges within the Board of Nursing. Formerly, the Board of Medical Examiners administered those privileges.

The legislation, which was introduced by the Oregon Nurses Association, also enables the Board of Nursing to make rules regarding nurse practitioner application for prescriptive privileges and educational criteria. The board also reviews and approves applications of certified nurse practitioners seeking prescription writing privileges.

Also as a result of the new legislation, the Board of Nursing appoints and oversees an advisory council, which is comprised of representatives of nursing, medicine and pharmacy. The council is charged with developing the formulary of the drugs that nurse practitioners may prescribe.

Paula McNeil, RN, executive director of ONA, said the changes brought about by the legislation allow for consistency with the Board of Nursing's legal responsibility to regulate nursing practice. (See editorial on page 4.)

Currently, about 350 Oregon nurse practitioners have prescriptive authority.

California is the most recent state to adopt legislation authorizing nurses to write prescriptions.

California's law regulating the "furnishing and dispensing" of drugs or devices by RNs was signed into law July 24, 1986. It was sponsored by the California Nurses Association. According to the law, furnishing is prescribing drugs; dispensing is packaging and labeling of drugs for patient use.

"The law increases the scope of practice for nurses in California more significantly than any other piece of existing legislation," said Marilyn Chow, DNSc, RN, associate executive director for CNA.

The law went into effect Jan. 1, and implementation began July 1.

Under the law, any RN can dispense drugs or devices when there is an order by a licensed physician or surgeon and the RN is working in one of the following settings:

—a licensed clinic classified as a community clinic or free clinic;

—any federally operated clinic;

—any primary care clinic operated by the state or any of its cities or counties; and

—any Indian health clinic on tribal land.

Nurse practitioners may furnish drugs or devices, according to the new law, if they have:

—completed at least six months of physician-supervised experience in furnishing drugs or devices;

—completed a course in pharmacology; and

—been issued a furnishing number by the state board of registered nursing.

CNA, in cooperation with CNA Region 12 and the University of California at San Francisco, sponsored a pharmacology course July 11.

Ruth Terry, RN, of the state board of registered nursing, said 1,200 nurse practitioners are expected to apply for a furnishing number.

Other states that have prescription privilege laws and rules are Alaska, Arizona, Idaho, Maine, Maryland, Massachusetts, Michigan, Mississippi, Nevada, New Hampshire, New Mexico, Pennsylvania, Tennessee, Utah, Vermont and Washington.

2-12

Public Is Served When Nurses Prescribe

By Terry L. Selby

Nurses who are able to write prescriptions agree that it is a valuable service to their clients.

Joanne Adams, RN, a nurse practitioner in an alcoholic treatment center in Raleigh, N.C., said the ability to write prescriptions for her patients is a help for everyone involved.

"The process would be time-consuming and disruptive to patient care if I had to call a physician every time one of my patients needed medication," Adams said.

She is the primary health care provider at the facility, working under the guidelines of a supervising physician. She provides comprehensive physical exams and treats both common illnesses and acute illnesses such as diabetes and hypertension.

Adams said she is able to prescribe "just about anything I need to prescribe," with the exception of controlled substances and psychotropic drugs.

North Carolina Is First

In 1975, North Carolina became the first state to allow nurses to write prescriptions. Twenty states currently have such laws.

North Carolina's medical practice act provides that nurse practitioners are authorized to write prescriptions for drugs under rules developed by joint subcommittees of the Board of Medicine and Board of Nursing.

The nurse practitioner must have a supervising physician, who provides the nurse written protocols for prescribing drugs. Only certain types and classes of drugs listed in a formulary may be prescribed by nurse practitioners.

Like North Carolina's law, the laws that enable nurses to prescribe are generally restrictive in four ways:

- Usually nurse practitioners are the only nurses with authority to prescribe.
- The state board of nursing or another regulatory body must approve each nurse's credentials before she or he can prescribe.
- Only certain types and classes of drugs may be prescribed by nurses.
- Almost all states require nurses to be linked with a supervising or collaborative physician.

Nurse midwives and nurse practitioners in South Dakota have been able to prescribe drugs since 1979. The state's nurse practice act includes the prescription of medications as a delegated medical function. Prescribing may be done only under the supervision of a physician and only in a li-

Continued on page 24

January 17, 1989

Debra Folkerts, C.F.N.P.
1415 Highland Drive
Concordia, KS 66901

Dear Chairman & Committee Members,

My name is Debbie Folkerts. I am a Nurse Practitioner who practices with a solo Urologist in Concordia. Our practice is rural and consists of a drawing area of 12 counties. I currently hold staff privileges at five hospitals. It would be impossible for the physician I practice with to service this large of area without my services.

My functions include management of the medical plan of care, assisting with surgery, and sharing calls.

The last 18 months have been very traumatic to rural areas. In our drawing area alone in 1986, there were 30 physicians in an eight county area to care for the population of 55,000. The past 18 months this has decreased to 12 primary care physicians. The average wait to see a physician in Concordia is 3 - 4 weeks. For this reason it has become necessary for me to also see Family Practice patients to increase access to medical care.

There have been multiple studies published regarding the prescribing practices of Nurse Practitioners. The most publicized was by the University of California, which concluded the following:

1. The number of prescriptions was approximately 1/3 the number written in a primary care medical practice.

2. The majority of prescriptions were for primary prevention and fell into the categories of "comfort", "mucocutaneous discomfort" and "contraception".

3. Antibiotics constituted the largest category of prescriptions written for secondary prevention.

4. A chart audit revealed that 98-99 per cent of NP prescriptions were appropriate, consistent with the study protocol, and safe.

I would challenge Kansas Medical Society and agencies which continue to attempt to restrain the practice of Nurse Practitioners to recruit physicians to rural areas. It is our experience new physicians do not wish to practice in predominantly low medicare, low economic areas with high malpractice and low reimbursement. While physicians in metropolitan areas may consider Nurse Practitioners competition and wish to restrain their practice, physicians in rural areas seek Nurse Practitioners as colleagues to enable access to quality medical care.

I would ask that the statutory authority given to Nurse Practitioners, to prescribe under protocols, be continued.

SPH&W
1-19-89
Attachment 3

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)

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

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, UCA/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.

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3-2

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).

***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

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

‡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-1,25[illegible])

WNP	% (N-265)	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

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 Es (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.

ACKNOWLEDGMENTS

The authors express appreciation to JoAnne Saxe, graduate student in nursing, who worked as a research assistant on this project.

Primary Care Research in 1982

Primary Care Research in 1982, now available, is a collection of primary care research abstracts submitted to the Ambulatory Pediatrics Association, the North American Primary Care Research Group, the Society for Adolescent Medicine, the Society of Teachers of Family Medicine, and the Society for Research and Education in Primary Care Internal Medicine.

The research is presented in seven sections including medical education, practice, psychosocial medicine, health care delivery, patient education, clinical issues and clinical epidemiology and clinical decision-making. The 470 abstracts have been indexed and key words are added. A cumulative index from 1980 through 1982 is included.

The purpose of the volume is to disseminate work in primary care, to provide a succinct view of the state of primary care research, and to inform members of each society of the efforts of the others.

Primary Care Research in 1982 is being made available below cost thanks to the Rockefeller Foundation. To get it, simply write to: Mack Lipkin, Jr., MD, Department of Medicine, New York University School of Medicine, 550 First Avenue, New York, NY 10016—marked Attention: New Bellevue-16S. Please enclose a check for $5 for shipping and handling made out to NYU/Primary Care Research. Order now, as supplies are limited.

3-5

January 18, 1989

Senator Roy M. Ehrlich, Chairman
Senate Health and Welfare Committee

Senator Ehrlich, Members of the Committee:

Thank you for the opportunity to speak in opposion to SB 23, as written. My name is Patsy Quint, I am speaking as the state chairman of KSNA, Advanced Practice Conference Group. I also represent District 6(Sumner and Sedgwick Counties) Advanced Practice Conference Group.

The Kansas State Board of Nursing worked long and hard to develop a definition of Protocol which would clarify and set out specifications for the content of the Standing Orders or Protocol(K.A.R. 60-11-104a) to comply with the changes in the Pharmacy Act.

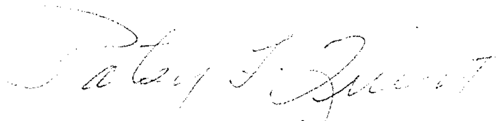
Nurse Clinicians/Nurse Practioners, serving in Rural Health Clinics, Health Departments, Student Health Clinics and Urban Health Clinics offering health care to the medically indigent and the under served across the state, have traditionally functioned under standing orders or protocol, which have been jointly developed by the nurse and the physician with whom they work. The ARNP, examines the client assigned to their care, takes a history and determines whether the client should be seen by the physician or can be treated per the jointly developed protocol, which sets forth those treatment modalities,including medications which can be prescribed, depending on symptomology and history (allergies, etc.); then calling in the prescription to the pharmacy. In the future the legal authority to write these prescription would be helpful.

I might add, that at the December 3, 1988 meeting of the state Advanced Practice Conference, held in Wichita,this question was asked of the 21 nurse clinicians in attendance. Do you want full prescriptive power? All 21 voted no. Voting yes,to "Do you prefer to practice under protocol?"

SP H&W
1-19-89
Attachment 4

K.S.A. 65-1130, authorizes the Kansas State Board of Nursing to regulate the practice of the Advanced Registered Nurse Practitioner through the Nurse Practice Act. It is my hope, that this committee will be responsive to the needs of the consumers of health and the cost effectiveness of allowing the ARNP to continue to assist in meeting those needs, by being given the legal authority through the State Board of Nursing and the Nurse Practice Act. The Nurse Practice Act is for the protection of the consumer.

Thank you, again, for allowing me this time.



Patsy Quint, Chairman
KSNA, Advanced Practice Conference Group
2805 S. 147th. St. East
Wichita, Kansas 67232
(316) 733-1915

Kansas State Board of Nursing

Landon State Office Building
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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 Rich Scibetta, Executive Administrator

RE: Senate Bill 23 - Baloon

DATE: January 19, 1989

Mr. Chairman, and members of the Committee, after the hearing on SB 23 today, the ARNP Committee of the Board met at lunch and proposed some suggested new language for SB 23. At the regularly scheduled Board meeting on 1-18-89 the Board modified and adopted the proposed changes, and asked that the attached balloon to SB 23 be forwarded to your Committee.

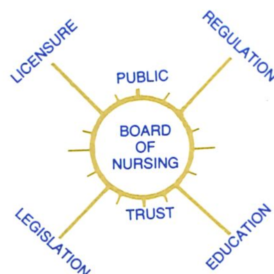
The Board of Nursing believe that the attached balloon contains specific language which clarifies the role of the Advanced Registered Nurse Practitioner related to medications.

If at all possible, it would be most helpful if the Committee could amend the permanent regulation 60-11-104a, based on the attached suggested balloon.

I would be happy to respond to questions at the convenience of the Committee.

Thank you for your consideration.

LRS:bph



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45 (2) Establish education, training and qualifications necessary fo
46 certification for each category of advanced registered nurse practi-
47 tioner established by the board at a level adequate to assure the
48 competent performance by advanced registered nurse practitioners
49 of functions and procedures which advanced registered nurse prac-
50 titioners are authorized to perform.
51 (3) Define the expanded role of advanced registered nurse prac-
52 titioners and establish limitations and restrictions on such expanded
53 role. The board shall adopt a definition of expanded role under this
54 subsection (c)(3) which is consistent with the education, training and
55 qualifications required to obtain a certificate of qualification as an
56 advanced registered nurse practitioner, which protects the public
57 from persons performing functions and procedures as advanced reg-
58 istered nurse practitioners for which they lack adequate education,
59 training and qualifications and which authorizes advanced registered
60 nurse practitioners to perform acts generally recognized by the
61 profession of nursing as capable of being performed, in a manner
62 consistent with the public health and safety, by persons with post-
63 basic education in nursing. In defining such expanded role the boar
64 shall consider: (A) The training and education required for a certif-
65 icate of qualification as an advanced registered nurse practitioner;
66 (B) the type of nursing practice and preparation in specialized prac-
67 titioner skills involved in each category of advanced registered nurse
68 practitioner established by the board; (C) the scope of practice of
69 nursing specialties and limitations thereon prescribed by national
70 organizations which certify nursing specialties; and (D) acts recog-
71 nized by the nursing profession as appropriate to be performed by
72 persons with postbasic education and training in nursing. ~~An ad-~~
73 ~~vanced registered nurse practitioner may not prescribe drugs but~~
74 ~~may transmit prescription orders in accordance with the pharmacy~~
75 ~~act of the state of Kansas.~~
76 Sec. 2. K.S.A. 1988 Supp. 65-1626 is hereby amended to read
77 as follows: 65-1626. For the purposes of this act:
78 (a) "Administer" means the direct application of a drug, whether
79 by injection, inhalation, ingestion or any other means, to the body
80 of a patient or research subject by:

72 An advanced registered nurse practitioner may transmit prescript-
73 ion orders under established protocol jointly developed with a
74 physician and in accordance with the pharmacy act of the state of
75 Kansas.

192 the licensee in the conduct of the business registered by the board
193 at the address for which the registration was issued.
194 ~~(t) "Practitioner" means a person licensed to practice medicine~~
195 ~~and surgery, dentist, podiatrist, veterinarian, scientific investigator,~~
196 ~~or optometrist licensed under the optometry law as a therapeutic~~
197 ~~licensee or diagnostic and therapeutic licensee or other person ex-~~
198 ~~pressly licensed or registered to administer, prescribe and use pre-~~
199 ~~scription-only drugs in the course of professional practice or research.~~
200 (u) "Preceptor" means a licensed pharmacist who possesses at
201 least two years' experience as a pharmacist and who supervises stu-
202 dents obtaining the pharmaceutical experience required by law as a
203 condition to taking the examination for licensure as a pharmacist.
204 (v) "Prescription" means, according to the context, either a pre-
205 scription order or a prescription medication.
206 (w) "Prescription medication" means any drug, including label
207 and container according to context, which is dispensed pursuant to
208 a prescription order.
209 (x) "Prescription-only drug" means any drug required by the fed-
210 eral or state food, drug and cosmetic act to bear on its label the
211 legend "Caution: Federal law prohibits dispensing without
212 prescription."
213 (y) "Prescription order" means: (1) An order to be filled by a
214 pharmacist for prescription medication issued and signed by a prac-
215 titioner in the authorized course of professional practice; or (2) an
216 order transmitted to a pharmacist through word of mouth, note,
217 telephone or other means of communication directed by such
218 practitioner.
219 (z) "Probation" means the practice or operation under a tem-
220 porary license, registration or permit or a conditional license, reg-
221 istration or permit of a business or profession for which a license,
222 registration or permit is granted by the board under the provisions
223 of the pharmacy act of the state of Kansas requiring certain actions
224 to be accomplished or certain actions not to occur before a regular
225 license, registration or permit is issued.
226 (aa) "Retail dealer" means a person selling at retail nonprescrip-
227 tion drugs which are prepackaged, fully prepared by the manufac-
228 turer or distributor for use by the consumer and labeled in

194 (t) "Practitioner" means a person licensed to practice medicine
195 and surgery, dentist, podiatrist, veterinarian, scientific investi-
196 gator or optometrist licensed under the optometry law as a therapudic
197 licensee or other person expressly licensed, registered or certified
198 to administer, prescribe, transmit and use prescription-only drugs in
199 the course of professional practice or research.

229 accordance with the requirements of the state and federal food, drug
230 and cosmetic acts. Such nonprescription drugs shall not include: (1)
231 A controlled substance; (2) a drug the label of which is required to
232 bear substantially the statement "Caution: Federal law prohibits dis-
233 pensing without prescription"; or (3) a drug intended for human use
234 by hypodermic injection.
235 (bb) "Secretary" means the executive secretary of the board.
236 ~~(cc)~~ "Unprofessional conduct" means:
237 (1) Fraud in securing a registration or permit;
238 (2) intentional adulteration or mislabeling of any drug, medicine,
239 chemical or poison;
240 (3) causing any drug, medicine, chemical or poison to be adul-
241 terated or mislabeled, knowing the same to be adulterated or
242 mislabeled;
243 (4) intentionally falsifying or altering records or prescriptions; or
244 (5) unlawful possession of drugs and unlawful diversion of drugs
245 to others.
246 Sec. 3. K.S.A. 65-1130 and K.S.A. 1988 Supp. 65-1626 are
247 hereby repealed.
248 Sec. 4. This act shall take effect and be in force from and after
249 its publication in the Kansas register.

(Added definition)
236 new (cc) "Transmit" means to issue a prescription order under estab-
237 lished protocols to a pharmacist through verbal note, telephone
238 or other means of communication by such practitioner.

239 (dd) "Unprofessional conduct" means:

Testimony on SB 15
By Lois Johnson, McDonald, Kansas
January 19, 1989

Senate Public Health & Welfare Committee

I am opposed to the repeal of Senate Bill 15.

I feel Kansas should amend our bill to match the Federal Catastrophic bill. We worked very hard for Kansas to have a Division of Assets law and since it became law it has helped many couples.

The Federal Catastrophic bill is still a new bill. We are reading a lot of controversy about the bill and the funding for the bill. If in the future, parts of the Federal bill is repealed, Kansas will still have a working Division of Assets for the many couples that face long term care with their spouses.

I hope you will consider amending the bill and not totally removing SB 15 from the Kansas laws.

Thank you.

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KANSAS STATE LEGISLATIVE COMMITTEE

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T E S T I M O N Y

OPPOSITION TO SB-15 INVOLVING REPEAL OF DIVISION OF ASSETS LAW

By State Legislative Committee of AARP, Kansas
January 18, 1989

After studied SB-15 and the Interim Committee's conclusions and recommendations, AARP's State Legislative Committee concurs with their objectives but we also feel obliged to oppose repeal of the Kansas law concurrently with the dates the federal Catastrophic Care Act becomes effective. The principal objections of AARP's State Legislative Committee rest upon our concern for the very unstable situation in Congress relative to the Catastrophic Care Act. Already, legislation has been prepared calling for the repeal of the Act and other congressmen are readying amendments to the Act. Under these conditions it does not seem timely to repeal the Kansas Division of Assets law. Also, we question if there was any publics awareness of plans to repeal the Kansas law. It is likely such knowledge would foster considerable citizen concern. The Kansas act was viewed as the answer to many Kansans fears for their future. It was an act that offered benefits not just for the elderly couples but for their family. We feel it is unfortunate that the legalese of the preamble of S.B.-15 does not clearly identify the intent in the bill to repeal our Division of Assets law.

As an alternative to the repeal provisions in S.B.-15, it is recommended that there be added a sunset provision which would retain the Kansas law until any proposals in Congress to either repeal or amend the Catastrophic Care Act would first be disposed of. Also, there should be amendments to the Kansas law to bring it into compliance with the principal features of the current federal act, just in case of repeal of the federal law.

The State Legislative Committee is very appreciative of the time, effort and concern given by the Interim Committee to the subject, also to all those within the state government and outside who contributed to the interim study and the proposed bill.

In conclusion, we appreciate Chairman Ehrlich and the members of the Committee giving us this opportunity to express the concerns which we feel are those of many of our fellow Kansans.

Testimony on Senate Bill 15
Senate Public Health and Welfare Committee
January 18, 1988
Presented by Mark Intermill
For the Kansas Coalition on Aging

Mr. Chairman, my name is Mark Intermill. I am the Executive Director of the Kansas Coalition on Aging. I appreciate the opportunity to address the committee this morning, and on behalf of the Kansas Coalition on Aging to express a concern regarding Senate Bill 15.

Eleven months ago, Gov. Hayden signed into law SB 264, allowing a couple to the divide their resources and income in order to provide financial protection of a spouse of a nursing home resident. The division of resources and income provisions have given Kansans who are faced with the high cost of nursing home care of a spouse with an option other than impoverishment or divorce. This protection has been beneficial to those persons who have availed themselves of it. But it has also contributed to the well-being of Kansans who are caring for their spouse at home in that it provides options for future care.

One of the factors which enabled passage of SB 264 was the presence of action in Congress on the Medicare Catastrophic Coverage Act which included a spousal impoverishment protection provision. Amendments to SB 264 made in the Kansas House of Representatives were patterned after the proposed Congressional legislation. Passage of the Medicare Catastrophic Coverage Act of 1988 resulted in the enactment of spousal impoverishment protections by the federal government. An underlying premise of Congressional action was that spousal impoverishment protection could be financed from savings in the Medicaid program that would accrue as a result of the improved Medicare benefits for low -income seniors under the provisions of the Medicare Catastrophic Illness Coverage Act. It was presumed that the improved benefits for low-income seniors would result in a reduction in Medicaid expenditures, and that those savings should be used to provide spousal impoverishment protections.

The bill before the committee today, to repeal the division of assets provision of Kansas law, is being offered because the federal law provides many of the same protections as state law. In some cases federal law provides better protection. The rationale of the proposed repeal is that the Kansas law is redundant, and that it

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may place the Secretary of Social & Rehabilitation Services in an uncomfortable situation and create confusion for persons who are considering division of resources and income as an alternative. Under normal circumstances, I would support such an effort. But there are currently two bills before Congress which would adversely effect the implementation of the Medicare Catastrophic Coverage Act of 1988. One of those bills would delay by one year the implementation of the provisions of the act not currently in effect. Another would repeal the Medicare Catastrophic Coverage Act in its entirety. The first proposal does not appear to jeopardize the spousal impoverishment protections currently in place since New Sec. 4 contained in SB 15 stipulates that the repeal of the division of resources and income provision of Kansas law would "be void if...amendments...of the federal medicare catastrophic coverage act of 1988 do not commence...on or after September 30, 1989." But, if the second bill were to be enacted after September 30, 1989, and if the provisions of SB 15 were enacted, it would appear that spouses of Kansas nursing home residents could be left without spousal impoverishment protections.

In closing, I would observe that the committee, in considering this bill, must weigh the advantages of repeal against the possibility of losing the proctections which spouses of nursing home residents in Kansas currently enjoy. I urge the committee to leave the Kansas statute intact until the issue of repeal of the Medicare Catastrophic Coverage Act is resolved. Mr. Chairman, I appreciate this opportunity to appear before the committee this morning, and I would be willing to try to answer questions.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
SENATOR ROY M. EHRLICH, CHAIRPERSON
TESTIMONY OF ROBERT C. GUTHRIE, TOPEKA, KANSAS
SENATE BILL NO. 15 - RE: PROPOSAL NO. 39
JANUARY 18, 1989

QUALIFICATIONS

My name is Robert C. Guthrie of Topeka, Kansas. I speak in opposition to Senate Bill No. 15. My brief remarks are made as a member of The Kansas Alzheimer's Disease Task Force of 1985 and a member and past president of the Alzheimer's Disease Association, Topeka Chapter. During the 1987 and 1988 Sessions of the Legislature, I testified several times before this Committee and the House of Representative Judiciary Committee. I am a retired Senior Vice President and Director of Bank IV, Topeka, formerly The First National Bank of Topeka. Preceding my banking career, I graduated from the University of Kansas with a B. S. degree in Finance.

PERSONAL EXPERIENCE

My own personal experience has been to witness, since 1982, the slow, irreversible organic disease diagnosed as Alzheimer's, slowly incapacitating my bright, talented wife. She is now in The Skilled Care Nursing unit of Aldergate Village Health Care Center here in Topeka. The point I wish to emphasize today is that throughout my service on the State Alzheimer's Task Force and as a member of the Alzheimer's Association, Topeka Chapter, I talked to many spouses and family members who saw themselves being spent into poverty. The despair brought about by this, plus the grief of the long terminal illness of a loved one was devastating. My pride in seeing Kansas be a leader in adopting legislation like Senate Bill No. 264 was considerable. The Bill passed through the Legislature without dissent.

PRESENT SITUATION

That the Kansas Division of Assets and Income Law might be repealed because Congress later passed the Medicare Catastrophic Protection Act, which also contains provisions to ease the burden of spousal impoverishment, is causing considerable worry and stress among older Kansans facing financial impoverishment. The Governor, in his State of the State Message on January 9, 1989 said that "We have been aggressive in our attempts to preserve access to the kind of health care that our citizens deserve. A major accomplishment in this regard is last year's passage of a Division of Assets Law." Quoting further Governor Hayden said "Prior to enactment of the Division of Assets Law, older Kansans were faced with the threat of seeing their life savings disappear when a spouse fell victim to a catastrophic illness.

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This situation has changed. To date more than 400 Kansans and their families have been helped by the Division of Assets initiative. Older Kansans can now be assured that poverty need not accompany a long term illness."

CONCLUSION

The Alzheimer's Disease Association, Topeka Chapter, knows that Senate Bill No. 15 embodies protective language. Repeal of K.S.A. 1988 Supp. 39-785 through 39-790 would be void if the Federal Act and payments thereunder did not commence for the calendar quarters beginning September 30, 1989, the date of repeal of the Kansas Legislation. But the Federal Act might become effective and later be amended or repealed. Based on news releases, there is growing sentiment in the Congress to amend or repeal the Federal Act.

The Kansans for whom I speak cannot see any need to rush the repeal of Senate Bill No. 264. This Kansas Session will be over before we know what Congress may do. How can Kansas members of the Legislature respond to their constituents should the benefits of Senate Bill No. 264 be allowed to slip away?

Thank You.

Robert C. Guthrie
3000 West 19th St.
Topeka, Kansas 66604