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#31 Comparison of Nurse Pract Legislation

STATE OF NEW YORK

11211

IN ASSEMBLY

May 15, 1986

Introduced by COMMITTEE ON RULES -- (at request of M. of A. Eve) -- read once and referred to the Committee on Higher Education

AN ACT to amend the education law, in relation to the advanced practice of nursing

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Section sixty-nine hundred two of the education law is amended by adding a new subdivision three to read as follows:

3. The practice of registered professional nursing by a nurse who has received a certificate issued by the department authorizing advanced practice may include the diagnosis of illness and physical conditions and the performance of therapeutic and corrective measures within a specialty area of nursing practice in collaboration with a licensed physician including the issuance of prescriptions for drugs, devices and immunizing agents provided such services are performed in accordance with a mutual practice agreement ~~between the nurse performing~~ the services and ~~the physician~~. Nothing in this subdivision shall be deemed to limit the practice of the profession of nursing as a registered professional nurse as defined in subdivision one of this section.

§ 2. Such law is amended by adding a new section sixty-nine hundred ten to read as follows:

§ 6910. Certificates for advanced registered nurse practice. 1. A registered professional nurse applying for a certificate authorized by the provisions of section sixty-nine hundred two of this chapter shall fulfill the following requirements:

a. Application: file an application with the department:

b. License: be licensed as a registered professional nurse in the state of New York:

c. Education: have satisfactorily completed educational preparation for provision of these health services in a program registered by the department or in a program determined by the department to be equivalent:

EXPLANATION--Matter in italics (underscored) is new; matter in brackets [ ] is old law to be omitted.

LBD15161-02-6

NURSE PRACTITIONER ASSOCIATION OF WESTERN NEW YORK

STATEMENT OF PURPOSE OF THE NURSE PRACTITIONER ASSOCIATION OF WESTERN NEW YROK.

The Nurse Practitioner Association of Western New York was organized in 1977 for the following purpose:

- Improve the quality and delivery of primary health care through organized efforts of nurse practitioners. A nurse practitioner is a nurse having advanced skills in assessment of the health-illness status of individuals. This is accomplished by history taking, physical examination and the nursing process of health management and counseling.

- Promotes an awareness of the relatively new role of the nurse practitioner to allied health professionals, and encourage active consumer participation toward a goal of his or her optimum level of wellness.

- Represent nurse practitioners to professional, educational, governmental and community groups.

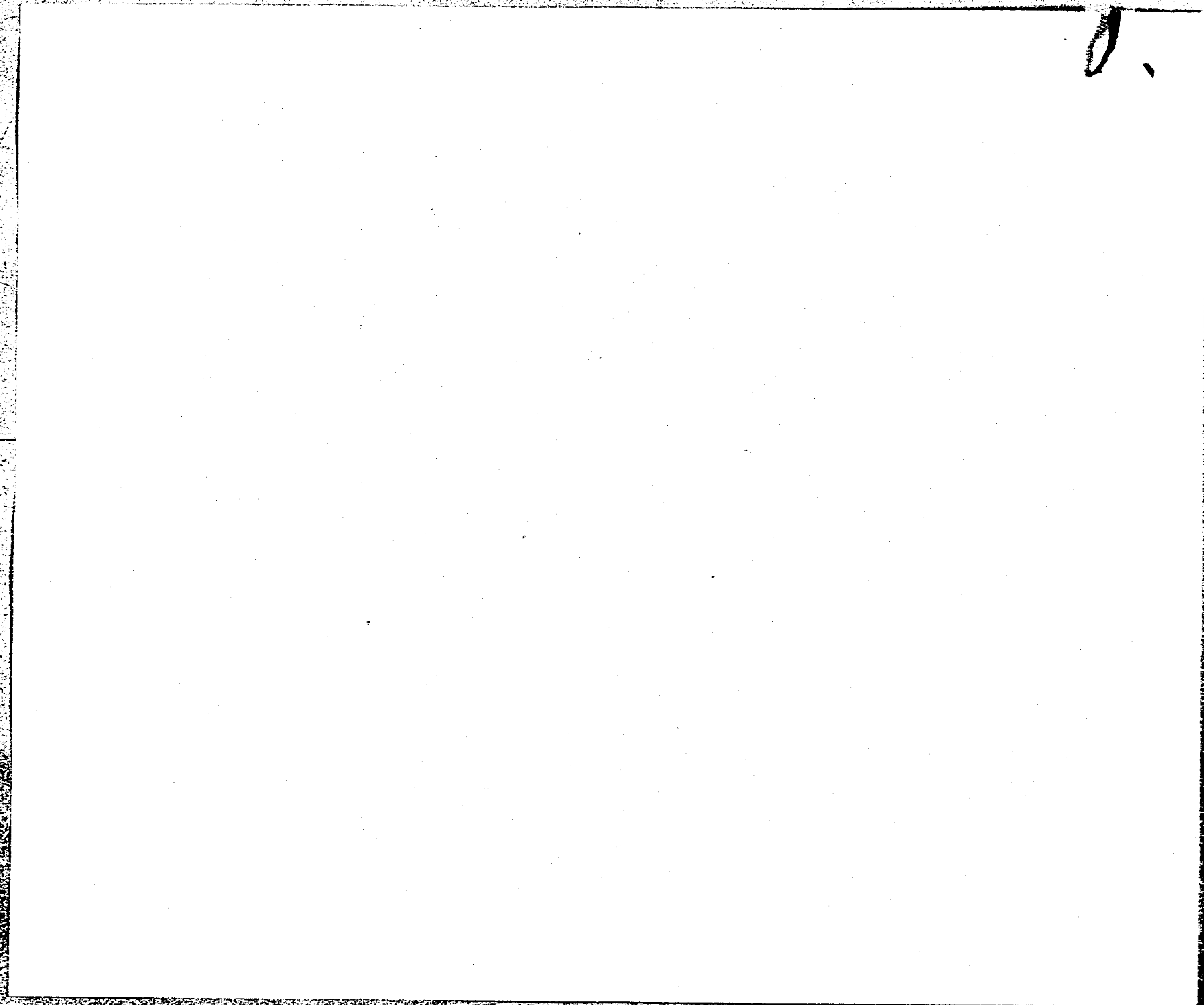
- Encourage nurse practitioner participation in continuing education to maintain and improve knowledge and skills required to function competently.

- Inform members of latest developments in local state and national legislation, and stimulate changes which affect the practice of primary health care by nurse practitioners.

- Enhance the economic security and general welfare of nurse practitioners that is comensurate with their practice responsibilities.

- Provide members with a forum for discussion of issues and the function of action plans in relation to quality primary health care.

31
Comparison(
Nurse Pract
Legislation



31
Comparison of
Nurse Pract
Legislation

SEP 30 1981

TESTIMONY

Presented before the New York State Assembly, Committee on Higher Education and Committee on Health Joint Hearing on the New York Nurse Practice Act.

Clark D. Haber, M.D.
New York City

Ladies and Gentlemen:

I am a physician practicing medicine in New York City. My background is in Family Practice, Emergency Medicine, and Occupational Medicine. I am here to testify on practicing within the scope of the Nurse Practice Act, and why it is a misnomer to refer to this as "expanded nursing practice," from the perspective of a practicing physician.

Over the past few years, there have been several policy statements and unofficial opinions expressed by national and local leaders within organized medicine which have surprised me by their apparent departure from the ideals of medical practice and health care in which I believe and which I assumed were held by the leaders in my field and other fields concerned with health care. There is much concern, in all circles, with overutilization of covered health care services and the runaway escalation of the costs of such services; there is a tendency for each discipline to view its own services as indispensable. What is needed, to lower health care costs for self-paying, insured and publicly funded patients alike, is a system which encourages entering the health care system at the preventive level, before illness ensues. The mother who can spend fifteen minutes with her family physician or nurse learning how to deal with her baby's sniffles is less likely to come for advice to an emergency room, where the staffing and equipment, and charges, are geared toward treating a child in status asthmaticus. But to do this there must be health professionals willing to provide such preventive services, which there will never be in great numbers unless Blue Shield and Medicaid will pay for such services without requiring evidence of an illness diagnosis. A crucial priority in health care is to remove the obstacles from obtaining preventive and health maintenance services, not only through massive public education, but also by pressure on the health insurance industry and the legislators, so that the need for and the motivation for utilization of more costly therapeutic and inpatient services will decline. I have seen several examples of innovative funding of health maintenance services, such as prepaid HMO's; industrial health departments providing periodic physicals, screening programs, health education services and fitness programs for employees; and family practice centers run by physicians, nurses, or hospitals which provide a multidisciplinary range of services. In the state of Pennsylvania, some such family practice centers receive reimbursement for visits from Medicaid at a higher rate than that for the standard physician's office visit as an incentive to provide such a range of services. In each of the above examples, it is common to find much of the health care provided by non-physician providers, particularly nurses.

31 Comparison of Nurse Pract Legislation

However, there has been considerable resistance to the introduction of such programs, and to the participation of nurses in the delivery of comprehensive health care. An example of what I consider to be an anti-health stance is the formal policy statement on "physician extenders" promulgated by the American Academy of Family Physicians, Board of Directors last August (American Academy of Family Physicians Reporter, October 6, 1980, p. 7). I was at once shocked and mortified that an organization of family physicians who purport to have the best health interests of the American public at heart could state publicly that "independent practice by any type of extender would deprive the patient of the breadth and depth of expertise which is essential to quality medical care," and advocate depriving the public of access to competent health care by practitioners in other disciplines. It is evident from the policy statement, particularly the part which states that "physician extenders should function only under the direction and responsible supervision of a practicing, licensed physician and all reimbursement for those services should be through the supervising physician," that the primary motivation behind this position is financial. Physicians, as a group, have every reason to feel threatened by the competition for patients and dollars which a well-trained and highly motivated group of health professionals now present. As has been seen in many communities where nurse practitioners and nurse midwives are involved in independent practice, there is a distinct possibility that the public, when given the opportunity to make their own comparisons in the open marketplace, might just conclude that the "health care" provided by family physicians, especially many of those in solo practice who haven't the faintest idea what other health professionals have to offer, isn't all that "comprehensive" after all, that the same services provided by physicians tend to be more expensive than when provided by nurses, and that family physicians, while perhaps to a lesser extent than physicians in other fields, still tend to avoid practice in the areas of greatest need. From my own experiences with three Family Practice residency programs and from working with physicians practicing in several quite dissimilar communities, as well as my experiences working with nurses from diploma, associate, baccalaureate, master's, and doctoral programs, I can honestly say that I have seen examples of good and bad practice among physicians and nurses, but have found very few family practices run by physicians which could truly be said to offer comprehensive health care, and no examples of nurses who, in their practices, deprived the patient of any "essential breadth or depth of expertise." One reason, of course, is that nurses tend to refer patients with medical problems to physicians, while physicians rarely refer patients with nursing problems to nurses, if indeed they recognize the problems at all.

Implicit in the term "comprehensive" is the assurance that all phases of health will be considered and dealt with, including nutrition; family and occupational life style; medical illness and surgical illness and injury (both chronic and acute, whether treatment is ambulatory or inpatient), and the patient's and family's reactions to it, and rehabilitation following it, and education to prevent its occurrence or reoccurrence; the appropriate use of medications, both prescription and patient; drug and alcohol abuse; childbirth, growth, and development, aging, and dying; learning disorders; emotional problems, both normal and pathological; dental, visual, hearing, and foot problems, etc. The notion that any single practitioner, no matter how broad his or her training, or even any single discipline, can adequately provide for this range of health care single-handedly seems rather foolish and short-sighted. What is needed is

the open-minded cooperation of health professionals from a variety of disciplines, each of whom is cognizant of his area of knowledge as well as his limitations. Whether the delivery of this health care is accomplished by a hospital, an interdisciplinary agency directly employing many professionals, a group practice including several professionals, or a combination of individuals and/or institutions freely interacting is less important than the willingness among the practitioners involved to share their knowledge and the responsibility for protecting the patient's health. It is contemptible for any group to presume that they have the right to define, interfere with, or supervise either the training or practice of another professional group, or to attempt to control their activities by working politically for restraints on their practice or restraints on their ability to earn a living. The American Academy of Family Physicians has done just that by egocentrically referring to nurses as "physician extenders," and by seeking to restrict them to "providing limited care, always under the direction and responsible supervision of a practicing, licensed physician with all reimbursement for services being through the responsible supervising physician." This posture is appropriate when referring to a physician's assistant, who is trained specifically as a paraprofessional whose primary function is to assist the physician in his or her practice and who is not licensed to practice any profession independently. Thus, a physician's assistant is a "physician extender."

However, this terminology, and the idea of restricting practice to "limited care" only under medical supervision, is highly inappropriate when referring to any licensed registered nurse, who is recognized in all states as a independent professional. A nurse midwife who delivers babies as well as providing comprehensive prenatal and postpartum care is no more a "physician extender" than is a family physician providing the same services an "obstetrician extender." A family nurse practitioner who performs a routine physical examination or provides well baby care is no more a "physician extender" than is a family physician providing the same services an "internist extender" or a "pediatrician extender." For that matter, a physician who provides his own patients with nutritional counselling or teaches them how to care for their own post-op dressings or stomas is as much a "nurse extender" as is a nurse performing these same functions a "physician extender." The point is that many health care functions can be performed well by many different professions, and have been for generations. This reality is recognized in our professional practice laws. The responsibility for assuring that any individual is competent to practice what he has learned rests with the educators and licensing and certifying boards within his field, not with those from other disciplines, and the judgment as to which discipline is adequately qualified or best qualified to perform any health related service is one which must be left to the individual patient to decide for himself, and for society to legislate only when necessary.

The term "nurse practitioner" is frequently misleading. The need to label and divide nurses is a defensive tactic many physicians resort to when they feel threatened in what they perceive as their exclusive right to dictate health care policy. In the strictest sense, any nurse who possesses an R.N. license, the minimum requirement for legal unsupervised practice, is a nurse practitioner. The use of certification exams by the American Nurses' Association and the various states in several specialty areas such as psychiatric-mental health, emergency, pediatrics, family practice, etc., has allowed a mechanism for recognizing clinical competence beyond the legal minimum. The development of clinical

31 Comparison of Nurse Pract Legislation

training programs in physical assessment for nurses has provided an alternative, and for some an easier, route to such competence than the accepted routes of extensive clinical experience or the sound educational background of a bachelor's (or higher) degree. The recognition of this competence by the public, the government, and the medical profession has created job opportunities for nurses with such competence in both salaried positions and independent practice. However, certification in itself does not, in most cases, change or expand a nurse's legal right to practice nursing (except in anesthesia and midwifery). Rather, it provides nurses with a way to demonstrate to the public and/or to potential employers that they have attained a certain level of competence. Nurses, rather than being condemned and fought for moving ahead in defining and certifying to the public the level of competence which they have attained, should be commended and supported. What hypocrisy, then to object to any payment at all to a professional nurse practicing within the scope of his or her education and specialty training, as governed by the relevant state Nurse Practice Act, unless a physician is given the opportunity to supervise that practice and filter all fees through his or her own pockets! This stance treats the nurse as a nonprofessional or paraprofessional, and is as absurd as suggesting that all family physicians prescribing tranquilizers or setting fractures, as permitted by their licenses, be supervised by and reimbursed through a supervising psychiatrist or orthopedist.

I am not referring here to the extension of a practice beyond the limits for which a professional is trained or licensed, which would be illegal. However, family physicians defend their right to provide supportive psychotherapy and prescribe psychotropic drugs for patients who, in their judgement, do not require the specialized services of a psychiatrist. In the same way, a clinical psychologist or a psychiatric nurse clinical specialist, either of whom has had much more educational preparation and experience in psychotherapy and diagnosis of emotional disorders than the average physician, has the right to provide either supportive or in-depth psychotherapy without prescribing drugs for those patients who, in their judgement, do not require the specialized services of a physician. Likewise, the family or pediatric nurse practitioner has the right to perform health maintenance physicals and to advise supportive and restorative treatment, including non-prescription drugs. In both cases, the non-physician health care provider also has the responsiblity to refer to a physician any patient needing medical diagnostic examinations or tests, medical or surgical treatment, or (since Medicine still holds a virtual monopoly on hospital admitting privileges for medical and even non-medical treatment) hospitalization. The point that physicians resisting independent practice by nurses, seem to be missing is that by supporting the widespread and responsible practice by such professionals they would be vastly increasing their pool of potential referrals and, in effect, trading off a large number of time consuming routine exams and visits for a smaller (or larger) number of more profitable work-ups and treatments. They would be letting go of Medicine's strangle hold on "comprehensive health care," which they are ill-prepared to provide anyway, allowing it to develop freely as an interdisciplinary effort as society's needs and expectations grow, and concentrate on delivering excellent "medical care." There is plenty of room for diversity within Medicine, for generalists as well as superspecialists, and plenty of opportunity for expanding or refining the delivery of medical services (such as the American Academy of Family Physicians patient education program and ILGWU project, or Surgery's support of outpatient surgical centers),

and no need for physicians to continually step on the toes of other health professionals who can help both the physician and the patient to achieve their goals.

It is a shame when physicians are unwilling to listen to views which differ from their own, or when leaders in medicine use their power to obfuscate the real issues and create opposition to progressive developments in health care by evoking the spectre of nurses usurping the functions or position of physicians. For example, an editorial entitled "Psychiatric Nurse Psychiatrists" in the American Family Physician, November, 1976, p. 73, suggested that psychiatric nurse clinical specialists were endeavoring to "practice psychiatry without medical supervision" and raised several related points which, through innuendo and oversimplification, placed these specialists' educational preparation as well as the ANA's position on nursing practice, and proposed legislation on selective public funding for already legal and existing nursing services, in an unfavorable light. However, editor Walter H. Kemp refused to publish my letter which pointed out the inaccuracies and prejudices in his superficial 450 word editorial unless it was shortened to a mere 250 words, which would have been totally inadequate to address the issues, much less clarify them. The effect that a concise but poorly researched and unrebutted editorial can have on shaping physician's opinions is frightening.

It is also somewhat frightening to contemplate the effect that a concise and polished testimony before a legislative committee, presented by a group of organized physicians whose true goals may be at variance with society's needs for comprehensive health care, can have on the resulting legislation. A careful reading of the Lombardi, Eve, and State Education Department proposals under consideration by this committee gives one the distinct impression that the mechanism of certification and the guidelines for physician involvement in the nurse's practice are designed to protect the physician's control over the scope of nursing practice, both directly, and through organized medicine's influence on the regulatory powers given to the commissioner of education, and to insure that the physician profits from any health care provided by nurses in the so-called "expanded role," rather than to protect the public. This will inevitably increase the cost of such services. Furthermore, the whole concept of creating a certification exam or a specified educational preparation under the control of the state education department, rather than recognizing the legitimate authority of the American Nurses' Association and the State Board of Nursing to set educational standards within their own profession, as similar organizations do in other health professions, has the effect of creating dissent between newly defined groups of nurses who could otherwise be working together to improve all nursing care. These three proposals, despite language denying that they limit the practice of nursing, may restrict the right of a nurse to continue to provide any services which fall within the new definition of "expanded practice," just because the nurse hasn't taken the specific course as outlined in the proposed legislation, even though she may be educationally prepared to perform some or all of these services by virtue of her formal baccalaureate or master's education in nursing. The Governor's Primary Health Care Proposal, on the other hand, reaffirms the right of all nurses to practice up to their educational preparation, and deserves your support.

The preceding comments have been offered in the interest of presenting a viewpoint somewhat different from that usually advanced by physicians with regard to the role of nursing in the health care system, but one which I believe represents the perspective of a significant number of physicians.

Thank you very much.

COMPARATIVE ANALYSIS OF THE STATE EDUCATION BILL ON EXPANDED PRACTICE OF NURSING
AND THE
STATUTORY DEFINITION OF PHYSICIAN'S ASSISTANTS

Since 1972, the State Education Department has consistently refused to interpret the Nurse Practice Act as it was intended - that is, to allow for the expanded practice of nursing. Rather, the Department has worked diligently to revise the Act, modeling it after the physician's assistant definition.

Below is a comparison of the similarities between the State Education Bill and the Physician's Assistants Law. In some instances, there are only semantic differences and in others, greater restriction is placed on nursing practice than physician's assistant practice.

SED BILL	PHYSICIAN'S ASSISTANTS AND SPECIALIST'S ASSISTANTS	COMPARISON
"The scope of practice of a registered professional nurse may be expanded by a written authorization issued by the department in one or more special areas of expanded nursing practice....The Commissioner, with the approval of the Board of Regents, may adopt regulations establishing special areas of expanded practice...."	"Based on his education, training and experience background, a registered physician's assistant will be identified in one or more of the following clinical fields....medicine, surgery, pediatrics, obstetrics/gynecology."	The Commissioner is given the power to determine the areas of practice. Very likely, they would be medical, surgical, pediatric, obstetrical, psychiatric and mental health and gerontology. Nothing insures that, however, and the areas could be fewer or different. The selection of areas of practice would thereafter be the prerogative of the Commissioner and not the nursing profession.
"Registered professional nurses authorized to engage in expanded practice may diagnose illnesses, perform therapeutic or corrective measures, issue prescriptions for drugs other than controlled substances, and immunize patients against preventable diseases. The expanded practice shall be conducted only in collaboration with a licensed physician, and only in accordance with written agreements between the nurse performing the services and the physician. The written agreement shall define the nature of the collaboration, and be available upon request to patients....	"A registered physician's assistant or a registered specialist's assistant may perform medical services, but only when under the supervision of a physician. Such supervision.... shall not necessarily require the physical presence of the supervising physician.... Prescriptions and medical orders may be written by a registered physician's assistant....when assigned by the supervising physician. Except for controlled substances...., a registered physician's assistant may write prescriptions for a patient who is under the care of the physician	The key words in these sections are collaboration and supervision. The difference is one of semantics, since later on the bill gives the Commissioner the power to identify the *specific services* which may be performed by the nurse and the *form* and *content* of the written agreements required. The nurse is, thereby, more restricted and controlled than the physician's assistant. The SED bill limits the expanded practice of the nurse to non-hospital settings while the physician's assistant is allowed to write controlled substance orders for inpatients in

(over)

COMPARISON OF PRIMARY CARE PRACTITIONER LEGISLATION IN 1981

	Governor's Bill	Eve's Bill	Lombardi's Bill	SED's Bill
	S.6361 Senator Pisani *S.6525 Senator Donovan* *A.7721 Assemblywoman Shaffer*	*A.2165 Assemblyman Eve*	*S.6650 Senator Lombardi*	*(no number at this time)*
1. General Effect	Preserves autonomy achieved in 1972 revision of Nurse Practice Act.	Severely erodes autonomy achieved in 1972 revision of Nurse Practice Act.	Markedly erodes autonomy achieved in 1972 revision of Nurse Practice Act.	Same as Eve's bill.
2. Precedent	Parallels language of School Health Bill of 1978.	Unprecedented.	Unprecedented.	Unprecedented.
3. Definition of Nursing	Remains intact.	Amends definition of nursing section of Nurse Practice Act. (§6902) Adds "expanded practice category."	Amends definition of nursing section of Nurse Practice Act. (§6902) Adds "expanded practice category."	Same as Eve's and Lombardi's bills.
4. Restrictions	Requires collaboration with MD. Otherwise *not restrictive* of nursing autonomy.	Requires collaboration and written agreement with MD. Gives Commissioner new controls. *Highly restrictive* of nursing autonomy.	Requires collaboration and memorandum of understanding with MD. Gives Commissioner new authority. *Restrictive* of nursing autonomy; severely limits practice.	Requires collaboration and written agreements with MD. Gives Commissioner new authority. *Restrictive* of nursing autonomy; limits practice.
5. Effect on Quality of Care	Improves potential for high quality through direct nurse-client accountability.	Maintains status quo of dual accountability and high potential for ambiguity.	Same as Eve's bill.	Same as Eve's bill.
6. Effect on Health Care Costs	Improves potential for reducing costs through the opportunity of allowing autonomous nursing practice.	Maintains status quo of insuring MD intermediary cost.	Same as Eve's bill.	Same as Eve's bill.

#31 Comparison Nurse Pract Legislation

(Continued, Page 2)

SED BILL	PHYSICIAN'S ASSISTANTS AND SPECIALIST'S ASSISTANTS	COMPARISON
The Commissioner, with the approval of the Board of Regents, may adopt regulations establishing special areas of expanded practice identifying the general and specific services which may be provided by registered professional nurses in such areas of practice, the procedure for approval of expanded practice, the form and content of the written agreements required...., and the records required to be maintained by the registered nurse and collaborating physician."	responsible for the supervision of the registered physician's assistant.... A registered physician's assistant employed or extended privileges by a hospital may, if permissible under the by-laws, rules and regulations of the hospital, write medical orders, including those for controlled substances, for inpatients under the care of the physician responsible for his supervision."	addition to his other services. Nursing practitioners in outpatient (hospital) clinics and emergency rooms would not be included in this legislation.
"No more than two registered nurses may enter into such agreement with the same physician."	"No physician may employ or supervise more than two registered physician's assistants and two specialist's assistants in his private practice."	Written agreement and collaboration with a physician is required so that those nurses providing independent primary care (e.g., psychiatric/mental health) would be denied that choice.

JPM/jep
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31
Comparison Nurse Pract. Legislation

76

STATEMENT

of

THE NEW YORK STATE NURSES ASSOCIATION

on

THE REGENTS' JULY 1981 LEGISLATIVE PROPOSAL RELATING TO THE EXPANDED PRACTICE OF NURSING

by

SUSAN J. FRALEY, M.S., R.N., PRESIDENT-ELECT

to

Special Regents' Hearing
September 11, 1981
Albany, New York

Good afternoon. I am Susan Fraley, President-elect of The New York State Nurses Association. Earlier today Association President Elaine Beletz presented a statement in behalf of the Association at the Regents' regularly scheduled annual Legislative Conference. The Association learned of this separately scheduled hearing focusing on the Regents' latest legislative proposal relating to the expanded practice of nursing late last week. Because of the significance of this proposal for the public and entire nursing community the Association deemed it necessary for our position on this matter to be made known to those in attendance at this special hearing. Thus I am here at this time to reiterate the Association's views as embodied in its testimony to the Board.

At its June 1981 meeting the Board of Regents approved for review and comment yet another proposal it believes may resolve the continuing controversy regarding the legal authority of registered professional nurses to provide primary health care services. Unlike previous Department-authored measures this proposal omits explicit reference to physician supervision of nursing practice and refers instead to collaboration between nurses and physicians. The Association welcomes and deeply appreciates this gesture of recognition of professional nurses' legitimate independence.

Nonetheless, the Association must vigorously protest multiple wholly unacceptable components of this proposal. The bill purports to permit nurses to more fully utilize their skills, but in reality it severely restricts nurses' rights to do so.

First, it amends the current definition of nursing by adding a statement descriptive of functions and responsibilities allegedly not embraced in the current definition and explicitly authorizes the Department to authorize only particular nurses to perform these functions. Clearly, this is an inappropriate and unnecessary restriction of existing lawful authority.

31 Comparison of Nurse Pract. Legislation

Secondly, it authorizes the Department and physicians to define the nature and scope of nursing practice, to codify such definitions and mandate their implementation through "written agreements." On its face, this requirement is totally oppressive and most assuredly incapable of rational administration. Clearly, it ignores the fact that neither physicians nor the Department are or should be qualified to define nursing practice. Pragmatically, it renders nurses hostages in capricious political-professional trade-offs.

Third, under the guise of preventing physicians from establishing "medicaid-mill type" practices, it limits the ratio of "collaborating" nurses and physicians to 2 to 1. The Association must prohibit the naive attempt to use the Nurse Practice Act and registered professional nurses as the policing agents of the medical profession. For those who suggest that the ratio is designed not simply to police physicians, but to protect nurses from exploitation, let me assure you that professional nurses are unquestionably capable of protecting both themselves and the public's access to their services.

Fourth, the bill confers upon the Commissioner of Education awesome and unprecedented power to establish educational requirements for nursing practice, define generic and specialty areas of nursing practice and specify the settings in which and the circumstances under which nurses may render their services. It appears obvious the Department would never dare contemplate or propose such onerous regulation of any other bona fide health profession. The nursing profession must ask: Is nursing being used as the first target in some Departmental scheme to extend its reach and control? or, Does the Department seriously regard the nursing profession as essentially incapable of the self-definition, direction and regulation characteristic of legitimate professions?

Advancement of this proposal is in a very real sense one more anti-climactic event in a sequence which resembles a serious hoax upon the public and the profession. Legislative sponsors of the 1972 definition of nursing practice, the legislative body which approved that measure and the Governor who signed it into law have clearly acknowledged its authorization of the "expanded" practice of nursing. Nonetheless, because legal counsel of the State Education Department has denied that interpretation, the Department has engaged in systematic efforts to restrict the practice of nursing and revise the Nurse Practice Act to return nurses not merely to physician-handmaiden status but to the more topical physician-assistant status. The Department has created and disseminated such a persuasive propaganda

cloud that it has thoroughly confused the public, educational institutions, other health professions and even some members of the nursing community. Further, it has literally badgered and harangued nursing practitioners and clinical nursing specialists to the point that some are resigned to the necessity of accepting untenable restrictions on their practice as the price to be paid for the privilege of offering services desperately needed by the public.

For years the current Governor and his advisors have attempted to remedy this tragic situation through appropriate clarifying legislation. Despite its sure knowledge that no such legislation is needed, the Association has joined with and vigorously supported the Governor's efforts. Even these good-faith demonstrations are rejected by the Department as its demands for complete control over nursing persist. The nursing community recognizes the Department's position serves the vested interests of other groups and agencies which also seek to ensure that nurses remain dependent upon or dominated by other health professions and health care institutions. The profession cannot - and will not - participate in this sham. To do so would be abject betrayal of the profession's public trust and the legitimate rights of professional nurses. The Association reiterates its unqualified support of Governor Carey's proposal (A.772, S.6361 and S.6525) and emphasizes its vigorous opposition to the Department's latest proposal as circulated in Commissioner Frank Abbott's July 19, 1981 memorandum.

Dr. Beletz has informed the Regents of the Association's desire for continuing dialogue on this matter. I heartily endorse that invitation.

Thank you for your attention.

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Comparison of
Nurse Practice
Legislation

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STATEMENT

of

THE NEW YORK STATE NURSES ASSOCIATION

by

ELAINE E. BELETZ, Ed.D., R.N., PRESIDENT

to

NEW YORK STATE ASSEMBLY COMMITTEE ON HIGHER EDUCATION
and
NEW YORK STATE ASSEMBLY COMMITTEE ON HEALTH

at

PUBLIC HEARING

September 22, 1981
New York, New York

Good morning. I am Elaine E. Beletz, President of the New York State Nurses Association. On behalf of the Association's approximately 28,000 members, I extend deepest appreciation for the opportunity to share our views with you at this hearing.

INTRODUCTION

The Association is aware that the Assembly Higher Education and Health Committees are giving careful attention to the nursing profession's capacity to serve society and to the legislative framework necessary to insure public access to qualified nursing services. At the outset of this series of statewide hearings, we wish to respectfully but urgently call these facts to the Committee's attention:

1) Historically, although nursing care services have been regarded as essential social services nursing practitioners have been grossly undervalued and undercompensated vis-a-vis other bona fide health professions;

2) Historically, nursing practitioners have been expected to function more as physician assistants and institutional facilitators than as providers directly responsible to clients for nursing services;

3) Persistent erosion of the nursing role has resulted in gross confusion over the nature, scope and value of nursing education, nursing practice and nursing care services;

4) As a result professional nurses today are literally captives - not only of rigidly defined or interpreted legal networks governing their practice and reimbursement for that practice, but also of institutionalized systems that frustrate and deny nurses' exercise of their lawful scope of practice;

5) The current alleged nursing shortage dramatizes the complex educational, legal, economic and organizational problems and issues confronting nursing practitioners and the profession;

#31 Comparison Nurse Pract Legislation

6) At a time of shrinking high school populations and simultaneous increase in demand for qualified nursing practitioners, nursing is a markedly less desirable career choice than such professions as medicine, law, pharmacy and dentistry;

7) The problems confronting nursing in New York State are not unique - unless judicious, responsible leadership is exerted nursing shortages throughout this country will exacerbate, seriously threatening public safety;

8) Historically, the nursing profession and the legislature of this state have together established laws governing nursing practice which have protected public and professional interest and served as models for legislation throughout this country.

The Association is convinced there are definitive solutions to those problems which now inhibit public access to qualified services and threaten the very integrity of nursing practice. Clearly, legislative intervention is essential. Equally clearly, deep controversies and habit-worn traditions within and without the nursing community must be overcome. On behalf of the nursing profession, I emphasize the Association's willingness to work diligently with you toward these ends.

NEEDED LEGISLATIVE INITIATIVES

Taken as an entity, the New York State Nurses Association's 1981 Legislative Program constitutes a remarkably simple and logical response to problems which have plagued health and nursing care for decades and now threaten serious destabilization of nursing care services. In October the Association's voting body will adopt the specific components of its 1982 legislative program. It is anticipated the program will include four measures introduced in 1981 as well as a mandate to protect and affirm registered professional nurses' rights to provide primary health care services.

NYSNA PROGRAM BILLS

I. The 1985 Proposal (S.3456, A.7463) - This measure would revise Article 139, Title VIII, of the Education Law to ensure that educational requirements for nursing licensure are in conformity with the state of the art, with social and educational trends of society and other learned professions and, most importantly, with the public's need for and right to the services of skilled, qualified nurses. The measure would (a) maintain the system established in 1938 of two licensed careers in nursing, (b) recognize the competencies and expertise of registered nurses and practical nurses licensed prior to the effective date of changes in educational requirements and fully protect the licenses and practice privileges of these individuals and (c) establish prospective requirements of the baccalaureate degree in nursing for the license to practice professional nursing and the associate degree in nursing for the license to practice associate nursing.

The Association knows questions have been raised whether there is "proof" that licensees who are hospital diploma and associate degree nursing graduates are not currently qualified to practice and whether absent such "proof" there is justification for revision of educational qualifications. Let me emphasize, the Association is confident these individuals are qualified to practice. Indeed, that is the basis of grandfather provisions recognizing and protecting their authorization to practice. In the Association's view, justification of the merits of the 1985 Proposal rests not upon the competencies of current and former licensees, not upon comparative scores on licensing examinations and not upon questions that seek finite, empiric data that are not now, and will not in the foreseeable future be, available. Rather, the justification rests in such obvious phenomena as mind-boggling advances in health science and technology, startling increases in the level of education and general intellectual competence of the population at large, predictable increases in the complexity of health

31
Comparison
Nurse Pract
Legislation

care and the need for professional nurses to continue to be educated at a level which both commands public respect and enables nurses to function competently and confidently.

We respectfully call your attention to the fact that establishment of prospective educational requirements by other health professions has proceeded on the basis of common consensus regarding obvious societal trends and their implications for the professions. Further, the Association invites your attention to the fact the National Commission on Nursing, an independent multi-disciplinary commission, has concluded and recommended that "Baccalaureate education for professional nursing practice is a desirable goal."[1] And, we reiterate: nursing alone among the traditional and more-recently-acknowledged professions is denied baccalaureate education as a threshold entry requirement.

The Association offers the 1985 Proposal as a mechanism for nursing accountability in the future, not as an allegation of current or past dereliction. As we have in the past, we urgently request your Committee's support of the bill.

II. Removal of the Exemption Clause Authorizing Attendants to Practice Nursing (S.1480, A.1942) - This measure would repeal a clause first included in the Nurse Practice Act in 1938 which permits attendants in institutions under the jurisdiction of or subject to visitation by the Department of Mental Hygiene to practice nursing under medical or nursing supervision. Through such repeal, clients of particular public sector institutions would be assured of services comparable to those currently mandated for clients in all other institutions. Stated more bluntly, a discriminatory and indefensible double standard would be struck down. Further, adoption of this measure would protect attendants now expected to assume responsibilities far beyond their preparation. Finally, it would affirm the indisputable realities that (a) the medical profession is not prepared to supervise the practice of nursing and (b) the medical profession does not, and should not be expected to, assume responsibility for such supervision.

III. Financial Support for an Educational Mobility Program for Registered Professional Nurses (S.5349, A.7374) - This bill is designed to provide financial assistance to colleges and universities to improve or initiate high quality educational opportunities for registered nurses seeking bachelor's degrees in nursing. The nursing profession is deeply indebted to the Honorable Assemblymen Mark Allen Siegel and James Tallon, Chair of the Assembly Higher Education and Health Committees, respectively, for their sponsorship and energetic support of this bill.

IV. Provision of Third Party Reimbursement for Non-Institutionalized Nursing Services (S.5251-A, A.7249-A) - This modest amendment of the insurance law would make available to the public the right to select a registered professional nurse to provide non-institutionalized services specified in insurance policies which fall within the scope of practice of the nurse. The measure would not alter current institutional insurance reimbursement statutes and practices. Despite its limitations in scope, this bill would increase current public options for health care access and provide for cost containment and reduction by reducing unnecessary institutional and physician services.

NURSES AS PRIMARY HEALTH CARE PROVIDERS

Legislative sponsors of the current definition of nursing practice, the legislative body which approved that measure and the Governor who signed it into law have clearly acknowledged its authorization of the "expanded" practice of nursing. (Attached to this testimony as Appendices I and II, respectively, are copies of Honorable Governor Nelson A. Rockefeller's Approval Memorandum filed with 1972 Senate Bill 8274 and Honorable Senator Joseph R. Pisani's Preliminary Memorandum on Legislatively Intended Interpretation of "Professional Nursing Practice" of 1978.) Nonetheless, because legal counsel of the State Education Department has denied that interpretation, the Department has engaged in systematic efforts to restrict the practice of nursing and revise the Nurse Practice Act to return nurses not merely to physician-handmaiden status but to the more topical physician-assistant status. The

Comparison of Nurse Pract Legislation #31

Department has created and disseminated such a persuasive propaganda cloud that it has thoroughly confused the public, educational institutions, other health professions and even some members of the nursing community. Further, it has literally badgered and harangued nursing practitioners and clinical nursing specialists to the point that some are resigned to the necessity of accepting untenable restrictions on their practice as the price to be paid for the privilege of offering services desperately needed by the public.

For years the current Governor and his advisors have attempted to remedy this tragic situation through appropriate clarifying legislation. In the 1981 session the Governor's Program included a measure to clarify the legal status of nurses practicing as health care providers without altering the legal definition of nursing (A.7721, S.6361 and S.6525 introduced by Assemblywoman Shaffer, Senators Joseph Pisani and James Donovan). Despite its conviction that no legislation is needed, the Association has joined with and vigorously supported the Governor's efforts. But even these good-faith demonstrations are rejected by the Department as its demands for complete control over nursing persist.

At its June 1981 meeting the Board of Regents approved for review and comment yet another proposal it believes may resolve the continuing controversy regarding the legal authority of registered professional nurses to provide primary health care services. Unlike previous Department-authored measures this proposal omits explicit reference to physician supervision of nursing practice and refers instead to collaboration between nurses and physicians. The Association welcomes and deeply appreciates this gesture of recognition of professional nurses' legitimate independence.

Nonetheless, the Association vigorously protests multiple wholly unacceptable components of this proposal. The bill purports to permit nurses to more fully utilize their skills, but in reality it severely restricts nurses' rights to do so.

First, it amends the current definition of nursing by <u>adding</u> a statement descriptive of functions and responsibilities allegedly not embraced in the current definition and explicitly authorizes the Department to permit only particular nurses to perform these functions. Clearly, this is an inappropriate and unnecessary restriction of existing lawful authority.

Secondly, it authorizes the Department and physicians to define the nature and scope of nursing practice, to codify such definitions and mandate their implementation through "written agreements." On its face, this requirement is totally oppressive and most assuredly insusceptible of rational administration. Clearly, it ignores the fact that neither physicians nor the Department are or should be qualified to define nursing practice. Pragmatically, it renders nurses hostages in capricious political-professional trade-offs.

Third, under the guise of preventing physicians from establishing "medicaid-mill type" practices, it limits the ratio of "collaborating" nurses and physicians to 2 to 1. The Association protests this naive attempt to use the Nurse Practice Act and registered professional nurses as the policing agents of the medical profession. For those who suggest the ratio is designed not simply to police physicians, but to protect nurses from exploitation, let me assure you professional nurses are unquestionably capable of protecting both themselves and the public's access to their services.

Fourth, the bill confers upon the Commissioner of Education awesome and unprecedented power to establish educational requirements for nursing practice, define generic and specialty areas of nursing practice and specify the settings in which and the circumstances under which nurses may render their services. It appears obvious the Department would never dare contemplate or propose such onerous regulation of any other bona fide health profession. The nursing profession <u>must</u> ask: Is nursing being used as the first target in some Departmental scheme to extend its reach and control? <u>or,</u> Does the Department seriously regard the nursing profession as essentially incapable of the self-definition, direction and regulation characteristic of legitimate professions?

The nursing community recognizes the Department's position serves the vested interests of other groups and agencies which also seek to ensure that nurses remain dependent upon or dominated by other health professions and health care institutions. The profession cannot - and will not - participate in this sham. To do so would betray

#31 Comparison Nurse Practice Legislation

the profession's public trust and the legitimate rights of professional nurses. The Association reiterates its unqualified support of Governor Carey's proposal (A.7721, S6361 and S.6525) and emphasizes its vigorous opposition to the Department's latest proposal as circulated in Commissioner Frank Abbott's July 19, 1981 memorandum as well as its opposition to similar proposals advanced by others in the 1981 legislative session (A.2165-A and S.6650).

The Association is keenly aware of the respect and support Assemblymen Siegel and Tallon have expressed for the autonomy of nursing practice. Obviously, such support is somewhat rare and received with the profession's utmost gratitude. Needless to say, the Association hopes you will find the Governor's Bill a suitable resolution of this protracted problem.

SUMMARY

Impediments to effective and efficient nursing practice are pervasive, complex and reflective of ill-informed and discriminatory attitudes toward the value of and public's need for nursing care services. Trends in nursing education as well as the utilization, reimbursement and general recognition of professional nurses suggest an imminent nursing shortage of potentially devastating dimensions and duration. The New York State Nurses Association's legislative priorities promise responsible resolution of current and predictable problems. The Association urgently requests the Assembly Higher Education and Health Committee's support of its legislative program.

I reiterate the Association's appreciation of your interest in our views. I would be pleased to respond to any questions you may have or provide you with any additional information you desire. Thank you.

EEB:wmb
9/21/81

REFERENCES

[1]National Commission on Nursing. Initial Report and Preliminary Recommendations Chicago: National Commission on Nursing, 1981.

#31: Comparison of Nurse Pract. Legislation

TABLE 1 (CONT'D.)

WESTERN STATES	YEAR EXPANDED ROLE RECOGNIZED	BOARD REGS.	EXPANDED DEFINITION OF R.N.	PROTOCOLS	STATE CERTIFICATION: NP or BLANKET SPECIALTY CERTIFICATION	STATE CERTIFICATION: SPECIFIC MENTION: MIDWIVES	STATE CERTIFICATION: SPECIFIC MENTION: ANESTHETISTS	STATE CERTIFICATION: NAT. CERT. RECOGNIZED	STATE CERTIFICATION: PRESCRIPTION DRUGS	REMARKS
Montana	1976	—	—	—	—	Yes	—	—	—	
Nevada	1973	Nurs	Yes	Yes	N.P.	—	—	recog.	Protocol*	*Controlled substances only with Board of Med. approval
New Mexico	1975	Nurs	Yes	—	N.P.	Yes	Yes	recog.	Yes	
Oregon	1973	Nurs	Yes	—	N.P. including FNP; PNP; ANP; GNP; Psych/ Mental Health N.P.; Women's Health N.P.; School Health N.P.; College Health N.P.	Yes*	—	—	—	*As an N.P.
Texas	1979	Nurs	—	—	Advanced N.P.	—	—	—	—	Regs. being challenged by Med. & Hosp. Association
Utah	1975	—	Yes	—	—	Yes	—	—	—	
Washington	1975	Nurs & Med	Yes	—	Certified R.N.	Yes	Yes	required	CRN with 30 hrs. pharm.	Advanced R.N. & specialized R.N discontinued 1980
Wyoming	1975	Nurs & Med	Yes	Yes	—	—	—	—	—	Midwives, anest. and N.P. included in common regs.

TABLE 1

WESTERN STATES	YEAR EXPANDED ROLE RECOGNIZED	BOARD REGS.	EXPANDED DEFINITION OF R.N.	PROTOCOLS	NP or BLANKET SPECIALTY CERTIFICATION	STATE CERTIFICATION: SPECIFIC MENTION: MIDWIVES	STATE CERTIFICATION: SPECIFIC MENTION: ANESTHETISTS	STATE CERTIFICATION: NAT. CERT. RECOGNIZED	PRESCRIPTION DRUGS	REMARKS
Alaska	1974	Nurs & Med	—	—	Advanced NP Adv. N.P. in remote location	—	—	required*	Yes-Class I and II	*Interim preceptorship permits issued until nationally certified
Arizona	1973	Nurs & Med	Yes	—	PNA;FNP;ANP OB-GYN NP	Yes	—	recog.	Pre-packaged in rural areas	Exam required-Nat. exam can be used
California	1974	Nurs	Yes	Yes	Including ANP; PNP; OB-GYN-NP; FNP	Yes	—	recog.	Experimental projects only	
Colorado	1974	—	Yes	—	Advanced practice of nursing	Yes	—	recog.	—	
Hawaii	1979	Nurs	—	—	Expanded role*	Yes	Yes	recog.	—	*ANA standards for clinical specialists and N.P.'s used
Idaho	1971	Nurs & Med	Yes	Yes	N.P.	*Yes	Yes	—	With protocol	*Midwives considered a N.P. specialty

TABLE 1 (CONT'D.)

MIDWESTERN STATES	YEAR EXPANDED ROLE RECOGNIZED	BOARD REGS.	EXPANDED DEFINITION OF R.N.	PROTOCOLS	NP or BLANKET SPECIALTY CERTIFICATION	STATE CERTIFICATION: SPECIFIC MENTION: MIDWIVES	ANESTHETISTS	NAT. CERT. RECOGNIZED	PRESCRIPTION DRUGS	REMARKS
North Dakota	1977	Nurs	Yes	—	—	—	—	—	—	
Ohio	—	—	—	—	—	—	—	—	—	
Oklahoma	—	—	—	—	—	—	Yes	*required	—	*For anesthetists
South Dakota	1972	Nurs & Med	Yes	—	N.P.	Yes	Yes	*required	Yes	Practice agreement required *National cert. for anesthetists
Wisconsin	—	—	—	—	—	—	—	—	—	Board memo indicates N.P. congruent with law.
NORTHEASTERN STATES										
Connecticut	1975	—	Yes	—	—	—	—	—	—	
Delaware	1978	Nurs	—	—	ARNP	—	—	recog.	—	Statement by Board of Nursing—no law or regulations yet.
Maine	1974	Nurs	Yes	—	Nurse Associate or N.P.	—	Yes	—	as agent of M.D.	

TABLE 1 (CONT'D.)

MIDWESTERN STATES	YEAR EXPANDED ROLE RECOGNIZED	BOARD REGS.	EXPANDED DEFINITION OF R.N.	PROTOCOLS	NP or BLANKET SPECIALTY CERTIFICATION	STATE CERTIFICATION: SPECIFIC MENTION: MIDWIVES	ANESTHETISTS	NAT. CERT. RECOGNIZED	PRESCRIPTION DRUGS	REMARKS
Illinois	1975	Board of Opinions on prof. nursing	Yes	—	—	—	—	—	—	
Indiana	1974	Nurs & Med	Yes	—	—	—	—	—	—	
Iowa	1976		Yes	—	ARNP-including FNP; School N.P.; PNP; Mental Health N.P.	*Yes	*Yes	—	—	*Types of ARNP
Kansas	1978	Nurs	Yes	—	ARNP	—	—	—	—	
Michigan	1978	Nurs	Yes	—	N.P.	Yes	Yes	required	—	
Minnesota	1974	—	Yes	—	—	—	—	—	—	
Missouri	1976	—	Yes	—	—	—	—	—	—	
Nebraska	1974	Nurs & Med	Yes	—	—	—	—	—	—	Board of Nursing blocked from promulgating rules by Attorney General

31. Comparison of Nurse Pract Legislation

TABLE 1 (CONT'D.)

SOUTHERN STATES	YEAR EXPANDED ROLE RECOGNIZED	BOARD REGS.	EXPANDED DEFINITION OF R.N.	PROTOCOLS	NP or BLANKET SPECIALTY CERTIFICATION	STATE CERTIFICATION: SPECIFIC MENTION		STATE CERTIFICATION: NAT. CERT. RECOGNIZED	PRESCRIPTION DRUGS	REMARKS
						MIDWIVES	ANESTHETISTS			
Alabama	1975	Nurs	Yes	—	—	Yes	Yes	required*	—	*Can practice while waiting results of first writing of exam in anes.
Arkansas	1979	Nurs	—	—	Reg. N.P.	—	Yes	recog. for anest.	—	
Florida	1975	Nurs & Med	Yes	Yes	ARNP (FNP; Fam.Plan; PNP;Geriatric N.P., Adult Primary Care N.P.)	*Yes	*Yes	—	—	*Categories of ARNP
Georgia	1979	Nurs	—	Yes	N.P.*	Yes	Yes	required	—	*Rules in draft form - master's degree by 1990
Louisiana	1976	Nurs	Yes	—	Advanced Prac. of Nurs. (Primary nurse associates; clinical specialists)	Yes	Yes	recog.	—	
Kentucky	1978	Nurs	Yes	—	ARNP	Yes	—	required	—	
Maryland	1974	Nurs	yes	—	—	—	—	—	—	
Mississippi	1976	Nurs & Health	—	Yes	PNP or PNA; ANP; Family Planning N.P.; FNP;Primary Care N.P.; OB-GYN N.P.	Yes	Yes	required*	—	*Graduates of NP, Anest. & Midwifery Programs--can practice up to 18 months while they attain nat certification.

TABLE 1 (CONT'D.)

NORTHEASTERN STATES (CONT'D.)	YEAR EXPANDED ROLE RECOGNIZED	BOARD REGS.	EXPANDED DEFINITION OF R.N.	PROTOCOLS	NP or BLANKET SPECIALTY CERTIFICATION	STATE CERTIFICATION: SPECIFIC MENTION		STATE CERTIFICATION: NAT. CERT. RECOGNIZED	PRESCRIPTION DRUGS	REMARKS
						MIDWIVES	ANESTHETISTS			
Massachusetts	1975	—	—	Yes	N.P. Psych/ Mental Health Clinical Spec.	Yes	Yes	—	—	
New Hampshire	1974	Nurs & Med	Yes	—	ARNP, (PNA; FNP; OB-BYN N.P.; Pediatric Nurse Clinician, Community Health; Psych/ Mental Health)	*Yes	*Yes	**required	emergency use	*Midwife one type of ARNP **National cert. required for nurse anesthetists & midwives
New Jersey	1974	Nurs*	Yes	Yes	—	—	—	—	—	Guidelines
New York	1972	Nurs	Yes*	—	—**	Yes	Yes	—	—	*Guidelines for N.P. Programs **Special provisions for school nurse practitioners. Counsel to State Education Dept. has ruled diagnosis and treatment illegal.
Pennsylvania	1973	Nurs & Med	Yes	—	Cert. Reg. N.P.	Yes*	Anes.	required for anes.	—	*Medical Board exam given.
Rhode Island	Not yet*	—	—	—	—	—	—	—	—	*No prohibition against diagnosis and treatment
Vermont	1974	—	Yes	Yes	—	—	—	—	—	

31
Comparison/
Nurse Pract
Legislation

TABLE 1 (CONT'D.)

SOUTHERN STATES (CONT'D.)	YEAR EXPANDED ROLE DEFINITION	BOARD REGS.	EXPANDED DEFINITION OF R.N.	PROTOCOLS	NP or BLANKET SPECIALTY CERTIFICATION	STATE CERTIFICATION: SPECIFIC MENTION		NAT. CERT. RECOGNIZED	PRESCRIPTION DRUGS	REMARKS
						MIDWIVES	ANESTHETISTS			
West Virginia	*	Nurs	—	—	ARNP*	Yes	Yes	—	—	*Draft-not adopted yet
OTHER JURISDICTIONS										
Guam	—	—	—	—	—	—	—	—	—	
Puerto Rico	—	—	—	—	—	—	—	—	—	
Virgin Islands	—	—	—	—	—	Yes	—	—	—	
Washington, D.C.	—	—	—	—	—	Yes	—	—	—	

ABBREVIATIONS:

ARNP - Advanced Registered Nurse Practitioner
ANP - Adult Nurse Practitioner
FNP - Family Nurse Practitioner
PNA - Pediatric Nurse Associate
PNP - Pediatric Nurse Practitioner
RN - Registered Nurse
OB-GYN NP - Obstetrical-Gynecological Nurse Practitioner

#31 Comparison of Nurse Pract Legislation

TABLE 1 (CONT'D.)

SOUTHERN STATES (CONT'D.)	YEAR EXPANDED ROLE RECOGNIZED	BOARD REGS.	EXPANDED DEFINITION OF R.N.	PROTOCOLS	NP or BLANKET SPECIALTY CERTIFICATION	STATE CERTIFICATION: SPECIFIC MENTION		NAT. CERT. RECOGNIZED	PRESCRIPTION DRUGS	REMARKS
						MIDWIVES	ANESTHETISTS			
North Carolina	1973	*Med & Nurs	—	—	FNP; Family Planning N.P., PNP	*Yes	—	*required	Special formulary	*Statutory power is Med. Board-nursing only recommends *Midwives a type of N.P. *National certification for midwives
South Carolina	1975	Nurs	Yes	Yes	—	Yes	Yes	*required	—	*For nurse midwives and anest. Board statements for acute cas care N.P.; additional acts for licensed practical nurses; Psych/mental health clin. spec.; comm. health clin. spec.; FNP; Family Plann. N.P.; Occupa. Health N.P.; PNP; School N.P.
Tennessee	1972	Nurs	—	Yes	—	—	—	—	—	
Virginia	1975	*Med & Nurs	—	Yes	N.P. (FNP & PNP programs approved)	—	Yes	—	—	*Statutory coverage of N.P. in Med. Practice Act

TABLE 1 (CONT'D.)

WESTERN STATES	YEAR EXPANDED ROLE RECOGNIZED	BOARD REGS.	EXPANDED DEFINITION OF R.N.	PROTOCOLS	NP or BLANKET SPECIALTY CERTIFICATION	STATE CERTIFICATION: SPECIFIC MENTION		NAT. CERT. RECOGNIZED	PRESCRIPTION DRUGS	REMARKS
						MIDWIVES	ANESTHETISTS			
Montana	1976	—	—	—	—	Yes	—	—	—	
Nevada	1973	Nurs	Yes	Yes	N.P.	—	—	recog.	Protocol*	*Controlled substances only with Board of Med. approval
New Mexico	1975	Nurs	Yes	—	N.P.	Yes	Yes	recog.	Yes	
Oregon	1973	Nurs	Yes	—	N.P. including FNP; PNP; ANP; GNP; Psych/Mental Health N.P.; Women's Health N.P.; School Health N.P.; College Health N.P.	Yes*	—	—	—	*As an N.P.
Texas	1979	Nurs	—	—	Advanced N.P.	—	—	—	—	Regs. being challenged by Med. & Hosp. Association
Utah	1975	—	Yes	—	—	Yes	—	—	—	
Washington	1975	Nurs & Med	Yes	—	Certified R.N.	Yes	Yes	required	CRN with 30 hrs. pharm.	Advanced R.N. & specialized R.N discontinued 1980
Wyoming	1975	Nurs & Med	Yes	Yes	—	—	—	—	—	Midwives, anest. and N.P. included in common regs.

#31
Comparison of Nurse Pract Legislation

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WESTERN STATES	YEAR EXPANDED ROLE RECOGNIZED	BOARD REGS.	EXPANDED DEFINITION OF R.N.	PROTOCOLS	NP or BLANKET SPECIALTY CERTIFICATION	STATE CERTIFICATION: SPECIFIC MENTION		NAT. CERT. RECOGNIZED	PRESCRIPTION DRUGS	REMARKS
						MIDWIVES	ANESTHETISTS			
Alaska	1974	Nurs & Med	—	—	Advanced NP Adv. N.P. in remote location	—	—	required*	Yes-Class I and II	*Interim preceptorship permits issued until nationally certified
Arizona	1973	Nurs & Med	Yes	—	PNA; FNP; ANP OB-GYN NP	Yes	—	recog.	Pre-packaged in rural areas	Exam required-Nat. exam can be used
California	1974	Nurs	Yes	Yes	Including ANP; PNP; OB-GYN-NP; FNP	Yes	—	recog.	Experimental projects only	
Colorado	1974	—	Yes	—	Advanced practice of nursing	Yes	—	recog.	—	
Hawaii	1979	Nurs	—	—	Expanded role*	Yes	Yes	recog.	—	*ANA standards for clinical specialists and N.P.'s used
Idaho	1971	Nurs & Med	Yes	Yes	N.P.	*Yes	Yes	—	With protocol	*Midwives considered a N.P. specialty

TABLE 1 (CONT'D.)

MIDWESTERN STATES	YEAR EXPANDED ROLE RECOGNIZED	BOARD REGS.	EXPANDED DEFINITION OF R.N.	PROTOCOLS	NP or BLANKET SPECIALTY CERTIFICATION	STATE CERTIFICATION: SPECIFIC MENTION		STATE CERTIFICATION: NAT. CERT. RECOGNIZED	PRESCRIPTION DRUGS	REMARKS
						MIDWIVES	ANESTHETISTS			
North Dakota	1977	Nurs	Yes	—	—	—	—	—	—	
Ohio	—	—	—	—	—	—	—	—	—	
Oklahoma	—	—	—	—	—	—	Yes	*required	—	*For anesthetists
South Dakota	1972	Nurs & Med	Yes	—	N.P.	Yes	Yes	*required	Yes	Practice agreement required *National cert. for anesthetists
Wisconsin	—	—	—	—	—	—	—	—	—	Board memo indicates N.P. congruent with law.
NORTHEASTERN STATES										
Connecticut	1975	—	Yes	—	—	—	—	—	—	
Delaware	1978	Nurs	—	—	ARNP	—	—	recog.	—	Statement by Board of Nursing—no law or regulations yet.
Maine	1974	Nurs	Yes	—	Nurse Associate or N.P.	—	Yes	—	as agent of M.D.	

TABLE 1 (CONT'D.)

MIDWESTERN STATES	YEAR EXPANDED ROLE RECOGNIZED	BOARD REGS.	EXPANDED DEFINITION OF R.N.	PROTOCOLS	NP or BLANKET SPECIALTY CERTIFICATION	STATE CERTIFICATION: SPECIFIC MENTION		STATE CERTIFICATION: NAT. CERT. RECOGNIZED	PRESCRIPTION DRUGS	REMARKS
						MIDWIVES	ANESTHETISTS			
Illinois	1975	Board of Opinions on prof. nursing	Yes	—	—	—	—	—	—	
Indiana	1974	Nurs & Med	Yes	—	—	—	—	—	—	
Iowa	1976		Yes	—	ARNP-including FNP; School N.P.; PNP; Mental Health N.P.	*Yes	*Yes	—	—	*Types of ARNP
Kansas	1978	Nurs	Yes	—	ARNP	—	—	—	—	
Michigan	1978	Nurs	Yes	—	N.P.	Yes	Yes	required	—	
Minnesota	1974	—	Yes	—	—	—	—	—	—	
Missouri	1976	—	Yes	—	—	—	—	—	—	
Nebraska	1974	Nurs & Med	Yes	—	—	—	—	—	—	Board of Nursing blocked from promulgating rules by Attorney General

TABLE 1 (CONT'D.)

SOUTHERN STATES	YEAR EXPANDED ROLE RECOGNIZED	BOARD REGS.	EXPANDED DEFINITION OF R.N.	PROTOCOLS	NP or BLANKET SPECIALTY CERTIFICATION	STATE CERTIFICATION: SPECIFIC MENTION		STATE CERTIFICATION: NAT. CERT. RECOGNIZED	PRESCRIPTION DRUGS	REMARKS
						MIDWIVES	ANESTHETISTS			
Alabama	1975	Nurs	Yes	—	—	Yes	Yes	required*	—	*Can practice while waiting results of first writing of exam in anes.
Arkansas	1979	Nurs	—	—	Reg. N.P.	—	Yes	recog. for anest.	—	
Florida	1975	Nurs & Med	Yes	Yes	ARNP (FNP; Fam. Plan; PNP; Geriatric N.P., Adult Primary Care N.P.)	*Yes	*Yes	—	—	*Categories of ARNP
Georgia	1979	Nurs	—	Yes	N.P.*	Yes	Yes	required	—	*Rules in draft form - master's degree by 1990
Louisiana	1976	Nurs	Yes	—	Advanced Prac. of Nurs. (Primary nurse associates; clinical specialists)	Yes	Yes	recog.	—	
Kentucky	1978	Nurs	Yes	—	ARNP	Yes	—	required	—	
Maryland	1974	Nurs	yes	—	—	—	—	—	—	
Mississippi	1976	Nurs & Health	—	Yes	PNP or PNA; ANP; Family Planning N.P.; FNP; Primary Care N.P.; OB-GYN N.P.	Yes	Yes	required*	—	*Graduates of NP, Anest. & Midwifery Programs--can practice up to 18 months while they attain nat certification.

TABLE 1 (CONT'D.)

NORTHEASTERN STATES (CONT'D.)	YEAR EXPANDED ROLE RECOGNIZED	BOARD REGS.	EXPANDED DEFINITION OF R.N.	PROTOCOLS	NP or BLANKET SPECIALTY CERTIFICATION	STATE CERTIFICATION: SPECIFIC MENTION		STATE CERTIFICATION: NAT. CERT. RECOGNIZED	PRESCRIPTION DRUGS	REMARKS
						MIDWIVES	ANESTHETISTS			
Massachusetts	1975	—	—	Yes	N.P. Psych/Mental Health Clinical Spec.	Yes	Yes	—	—	
New Hampshire	1974	Nurs & Med	Yes	—	ARNP, (PNA; FNP; OB-GYN N.P.; Pediatric Nurse Clinician, Community Health; Psych/Mental Health)	*Yes	*Yes	**required	emergency use	*Midwife one type of ARNP **National cert. required for nurse anesthetists & midwives
New Jersey	1974	Nurs*	Yes	Yes	—	—	—	—	—	Guidelines
New York	1972	Nurs	Yes*	—	—**	Yes	Yes	—	—	*Guidelines for N.P. Programs **Special provisions for school nurse practitioners. Counsel to State Education Dept. has ruled diagnosis and treatment illegal.
Pennsylvania	1973	Nurs & Med	Yes	—	Cert. Reg. N.P.	Yes*	Anes.	required for anes.	—	*Medical Board exam given.
Rhode Island	Not yet*	—	—	—	—	—	—	—	—	*No prohibition against diagnosis and treatment
Vermont	1974	—	Yes	Yes	—	—	—	—	—	

#31 Comparison Nurse Pract Legislation

TABLE 1 (CONT'D.)

SOUTHERN STATES (CONT'D.)	YEAR EXPANDED ROLE DEFINITION	BOARD REGS.	EXPANDED DEFINITION OF R.N.	PROTOCOLS	STATE CERTIFICATION				PRESCRIPTION DRUGS	REMARKS
					NP or BLANKET SPECIALTY CERTIFICATION	SPECIFIC MENTION		NAT. CERT. RECOGNIZED		
						MIDWIVES	ANESTHETISTS			
West Virginia	*	Nurs	—	—	ARNP*	Yes	Yes	—	—	*Draft-not adopted yet
OTHER JURISDICTIONS										
Guam	—	—	—	—	—	—	—	—	—	
Puerto Rico	—	—	—	—	—	—	—	—	—	
Virgin Islands	—	—	—	—	—	Yes	—	—	—	
Washington, D.C.	—	—	—	—	—	Yes	—	—	—	

ABBREVIATIONS:

ARNP - Advanced Registered Nurse Practitioner
ANP - Adult Nurse Practitioner
FNP - Family Nurse Practitioner
PNA - Pediatric Nurse Associate
PNP - Pediatric Nurse Practitioner
RN - Registered Nurse
OB-GYN NP - Obstetrical-Gynecological Nurse Practitioner

TABLE 1 (CONT'D.)

SOUTHERN STATES (CONT'D.)	YEAR EXPANDED ROLE RECOGNIZED	BOARD REGS.	EXPANDED DEFINITION OF R.N.	PROTOCOLS	STATE CERTIFICATION				PRESCRIPTION DRUGS	REMARKS
					NP or BLANKET SPECIALTY CERTIFICATION	SPECIFIC MENTION		NAT. CERT. RECOGNIZED		
						MIDWIVES	ANESTHETISTS			
North Carolina	1973	*Med & Nurs	—	—	FNP; Family Planning N.P., PNP	*Yes	—	*required	Special formulary	*Statutory power is Med. Board-nursing only recommends *Midwives a type of N.P. *National certification for midwives
South Carolina	1975	Nurs	Yes	Yes	—	Yes	Yes	*required	—	*For nurse midwives and anest. Board statements for acute cas care N.P.; additional acts for licensed practical nurses; Psych/mental health clin. spec.; comm. health clin. spec.; FNP; Family Plan. N.P.; Occup. Health N.P.; PNP; School N.P.
Tennessee	1972	Nurs	—	Yes	—	—	—	—	—	
Virginia	1975	*Med & Nurs	—	Yes	N.P. (FNP & PNP programs approved)	—	Yes	—	—	*Statutory coverage of N.P. in Med. Practice Act