Prescriptive Privileges, 12-17-86; Series I; File 122

Juanita Hunter
Dear Nursing Colleague,

The Executive Committee and the Board of Directors of the Coalition of Nurse Practitioners, Inc. have voted to proceed with legislation as written and passed by the Assembly in 1986.

The overwhelming vote and passage of A 11211 C in the Assembly with support from the New York State Nurses Association, other nursing organizations, the Department of Health, and numerous individuals further supports our decision to proceed.

The Executive Committee has come to this decision after reviewing the long history of meetings and discussions with the New York State Nurses Association, the State Board for Nursing, and other nursing groups.

We believe that all nurses would benefit from a proactive position on this legislation which advances the profession of nursing.

We look forward to meeting on Wednesday December 17, 1986 to develop a plan for cooperative mechanisms for support for this legislation.

Very truly yours,

Sharon A. Blaser

Enclosures

cc: Executive Committee, CONP, Inc.
NEW YORK STATE NURSES ASSOCIATION
2113 Western Avenue, Guilderland, N.Y. 12084, (518) 456-6371

MEMORANDUM OF SUPPORT

S.9397-B

A.11211-C

An ACT to amend the education law, in relation to professional nursing opportunity scholarships and nurse practitioners and providing for the repeal of certain provisions relating thereto upon the expiration of such provisions.

The New York State Nurses Association supports A.11211-C, S.9397-B which has been amended to address the Association's major concerns. The compromise language is the result of joint efforts by NYSNA and the bills' prime sponsors. A.11211-C, S.9397-B differs from A.11211-B, S.9397-A in that the latest version has some organizational and technical language improvements.

The original bill language dealing with "advanced nursing practice" had been of great concern to the Association. The new language eliminates those major concerns. First, all references to advanced nursing practice, state education department certification of nurse specialists and state education department regulation of nursing specialties are removed from the bills. Second, the requirement for nurse/physician mutual practice agreements is limited to the prescription privilege. Third, the remaining bill language follows that of the school health demonstration project law (Chapter 198 of the Laws of 1978).

Although the amended bills do not correct the deficiencies in the regents professional nursing opportunity scholarship section, the bill sponsors recognize those deficiencies and have declared their intent to seek additional nursing scholarships in the 1987 session. Also, the scholarship portion of A.11211-C, S.9397-B sunsets in 1991.

With these principles in mind, NYSNA supports A.11211-C, S.9397-B in order to resolve the long standing challenge to interpretation of the Nurse Practice Act.

NYSNA urges passage of this legislation.

JFM/99
6/30/86
THE NEW YORK STATE NURSES ASSOCIATION
CONVENTION
FORUM ON PRIMARY CARE
October 26, 1982

FACT SHEETS
Influence of the Federal Government on Nurse Practitioner Programs

Legislation Supporting Physician Extender Training

"Federal support for physician extender training was limited before 1970. Some early NP training programs received assistance through special project grants provided under the Nurse Training Act of 1964 (Public Law 88-581) and later, title II of the Health Manpower Act of 1968 (Public Law 90-490) (103). The National Center for Health Services Research funded the first Medex training program at the University of Washington. By the late 1960's, PA training programs were receiving funding from a variety of Federal sources, including the Office of Economic Opportunity, the Model Cities Program, the Veterans' Administration, the Public Health Service, the Department of Defense, and the Department of Labor (52). However, most physician extender training programs during this period depended on institutional or private resources.

"In the early 1970's, the Federal Government became more interested in the potential of physician extenders to address health manpower problems. Increasing concern over rising costs and the continued shortage of physicians in primary care was reflected in two major pieces of legislation aimed specifically at increasing the number of NPs and PAs. The Comprehensive Health Manpower Act of 1971 (Public Law 92-157) provided the first large Federal provision for NP and PA training programs (35). The Nurse Training Act of 1971 (Public Law 92-150) provided broadened authority for special project grants and contracts including support for training programs for NPs (99). Passage of the Nurse Training Act of 1975 further reinforced the Federal commitment by establishing a new, separate section for support for NP training. Further, in 1977, the Health Professions Educational Assistance Act of 1976 (Public Law 94-484) was amended by the Health Services Extension Act (Public Law 95-83) to provide additional grants and contracts for physician extender training programs (64). Although the Nurse Training Act of 1975 and the Health Professions Educational Assistance Act of 1976 authorized traineeships for NPs, no funds were appropriated for this purpose.

"Over the last 10 years, the Federal Government has spent $65 million to train physician extenders. Appropriations rose from $1 million in fiscal year 1969 to more than $21 million in fiscal year 1979 (20)*. It appears that support for NP training continues as of this writing. While President Carter vetoed the Nurse Training Amendments of 1978 as being too inflationary, the administration made special note of the fact that NP programs would still receive funding under a continuing resolution and therefore would not be jeopardized by the veto.

"Although the Federal Investment has been substantial, many physician extender training programs, especially NP programs, operate without Federal assistance. Some 60 percent of NP training programs and 10 percent

*In fiscal year 1979 $12 million was given to NP training programs and $9 million to PA training programs. Funding for NP training has risen steadily, but appropriations for PA training have remained at $9 million for the last several years (32).
of PA training programs currently do not receive Federal support (18). The remainder rely on institutional sources, private foundations, or funding from the States. In California, for example, funds are provided through the Song-Brown Family Physician Training Act of 1977 to a number of physician extender training programs in the State which train NPs and PAs to work in teams with family practice residents (70)."


"Although the initial goal in the first nurse practitioner project was to prepare nurses on the master's level for expert practice, teaching, and clinical research, that intent was altered in order to accommodate the pressing societal demands for health care. Shortly thereafter came an explosion of quickly generated, short-term, continuing education programs (some of which were devoid of academic standards) and products of variable quality. All of these programs used the name "practitioner." Hence, adult nurse practitioners, school nurse practitioners, family nurse practitioners, and others came into being before the first pediatric nurse practitioner project was completely evaluated. Indeed, one wonders about the impact that nursing might have had on health care if the funding agencies, HEW, and foundations had upheld academic standards and poured the millions of dollars spent for Primex and Medex and other similar programs into graduate level nursing curricula."

FACT SHEET #2

Legal Regulation of Nursing Practice

"The U.S. Department of Health, Education, and Welfare defines licensure as "the process by which an agency of government grants permission to persons to engage in a given profession or occupation by certifying that those licensed have attained the minimal degree of competency necessary to ensure that the public health, safety, and welfare will be reasonably well protected".


"In 1970, ANA counsel suggested that, in those states where there might be strict construction of the nursing practice law, a new section could be added:

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


"The National Joint Practice Commission suggested that (a) practice acts broad enough to provide flexibility should be left as they are and that joint practice statements be used to define role realignment and (b) medical and nursing practice acts with narrow definitions be restated to provide breadth and flexibility, with joint practice committees then issuing appropriate statements without further recourse to legislation (23)."


"Principles Relating to the Legal Regulation of Nursing Practice

The nursing practice act should provide for the legal regulation of nursing without reference to a specialized area of practice. It is the function of the professional association to establish the scope and desirable qualifications required for each area of practice, and to certify individuals as competent to engage in specific areas of nursing practice. It is also the function of the professional association to
upgrade practice above the minimum standards set by law. The law should not provide for identifying clinical specialists in nursing or require certification or other recognition for practice beyond the minimum qualifications established for the legal regulation of nursing."


"ANA is very much aware that several state associations have been active in using the legislative strategy to identify and describe the roles of registered nurses who engage in expanded roles. ANA has not, in the past, intervened in those activities. However, the posture of organized nursing has always been that licensure should contain only those basic provisions that have a direct relationship to the protection of the public health and safety.

"ANA believes that major strategies for the recognition of expanding nursing practice lie outside the legal realm. These strategies include voluntary professional certification, third party reimbursement mechanisms, ongoing negotiation with other disciplines, and consumer education. We, as an association, recognize that much work remains to be done if we are to put these strategies effectively into place. We must work closely with our members and especially with nurses practicing on the cutting edge if we are to promote the creative growth of nursing practice.

"At the present, however, when RN licensure is the one standard credential that undergirds the profession, it is crucial that we speak with one voice and unite around one set of principles related to the legal regulation of nursing practice."

Barbara L. Nichols and Judith A. Yates, "Memo to State Nurses' Association, ANA Board and Chairperson: Legal Regulation of Nursing Practice," (Kansas City, Missouri, April 30, 1982). (Typewritten.)

"I don't believe the time is ripe for licensure options. We must continue to look at grandfathering needs, along with new definitions of educational requirements for practice. Until we have the facilities in place, the plan in place, each state must set its own time frame. Some states will move toward changes in licensure laws, others will require only changes in rules and regulations."

Dean Lorene Fischer, "Nursing Education in the Future: A Blueprint for Nursing," (paper presented at ANA's National Convention, 1982).
"Legislative control of the nurse's expanded scope of practice began benignly and has increasingly become an issue of major proportions. Nurses cannot accept legislation that places them under physicians' supervision. Nor have they generally been willing to be registered as physician's assistants in order to expand nursing's scope of practice and secure reimbursement for medical services. Efforts to write state practice laws, which allow for collaborative arrangements, colleagueships, and team relationships, are fought for. So are reimbursement plans that identify nurses as providers of care. The federal Rural Health Act passed in 1976 allowed for reimbursement for nurses only when medical acts were performed and only when they were clearly under the physician's supervision."

TO: Members, ANA Council of Clinical Nurse Specialists  
FROM: Pat Sparacino, M.S., R.N.  
Chairperson  
DATE: December 29, 1987  
RE: Adoption of S. 101 - A Partial Victory

The ANA was successful in inserting a provision in this year's budget reconciliation legislation that will expand the ability of nurse practitioners (NPs) and clinical nurse specialists (CNSs) to certify and recertify patients in nursing homes. Unfortunately, this provision will only be in effect for two years, at which time the authority for anyone to do certifications and recertifications in nursing homes will be repealed from the law.

The ANA had been lobbying to include S. 101, the bill that would allow NPs and CNSs to perform certifications, in budget reconciliation legislation. Budget reconciliation, which passes every year, is used as a vehicle for inclusion of such provisions. ANA worked with Senator Daniel Inouye (D-HI), the sponsor of S. 101, to add the bill as an amendment to reconciliation. Over the objections of organized medicine, S. 101 was added to the bill as a Senate floor amendment in the early hours of December 10. ANA specifically adopted a strategy of trying to add the provision quietly and at the last minute in order to mitigate opposition from medical groups.

Once the amendment was included in the Senate version of reconciliation, it had to be approved by a House-Senate conference. At this point, substantial opposition from several medical groups made the issue extremely controversial. However, ANA lobbyists worked through the weekend of December 18-19, to persuade the conferees to accept S. 101. At one point, the issue appeared dead, but was resurrected through an intense lobbying effort.

As is often the case with such controversial issues, a compromise was struck. The compromise, which was included in the final version of reconciliation, would allow NPs and CNSs to certify and recertify patients in nursing homes without physician supervision. The NPs or CNSs must, however, work in collaboration with a physician. However, the provision was limited in several ways. First, it applies only to Medicaid patients, who represent the vast majority of patients in nursing homes; it does not apply to Medicare patients. Second, the authority to perform and be paid for patient visits, which ANA had also wanted, was not included. Finally, and most importantly, the conferees decided to eliminate the certification and recertification process from the law for nursing homes beginning in 1990. While still uncertain, it is believed that the new requirement for a resident's assessment for every patient, which ANA successfully
drafted to be done by registered nurses, will replace the certification and recertification process.

Therefore, although NPs and CNAs can perform the certifications and recertifications for Medicaid patients, without physician supervision, starting on July 1, 1988, that authority, as well as the authority for all certifications and recertifications, will expire on October 1, 1990. Consequently, we have achieved a victory that will exist for two years. It is possible that, before that date, an effort will be launched to overturn the decision to eliminate the certification process.

However, this recent victory represents a major step forward in that it recognizes the services of NPs and CNAs without physician supervision. Such improvements are always hard-fought and difficult to attain, and we are quite pleased with this development. While we may have only attained "half a loaf" we should still savor such a victory achieved against some fierce opposition.

cc: Constituent SNA Executive Directors
    ANA Board of Directors
    ANA Cabinet on Nursing Practice

PS/KAN:nch
TO: Members, ANA Council of Primary Health Care Nurse Practitioners
FROM: Karen Knutsen, M.S.N., R.N., C.
Chairperson
DATE: December 29, 1987
RE: Adoption of S. 101 - A Partial Victory

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cc: Constituent EMA Executive Directors
    AMA Board of Directors
    AMA Cabinet on Nursing Practice

KK/KAM: nch
Prescriptive Privileges (12-1986)

NYSHA’s Position on Prescriptive Privileges and Advanced Practice Legislation

In response to requests from the Council on Nursing Practice and the Functional Unit of Primary Care Practitioners, the NYSHA Board of Directors in early 1985 appointed a committee of the Board to study in depth the prescriptive privilege for nurses issue and make a recommendation to the full Board. At its June 1985 meeting the Board approved the subcommittee recommendation to hold a hearing on the issue at the 1985 convention in order to obtain “clearer direction” from the membership. As you know, the outcome was a resolution directing the Association to seek prescriptive privileges for nurses. Clearly, the membership concluded that prescriptive privileges for nurses is a desirable goal.

Following the 1985 convention, NYSHA began implementing the resolution by initiating a series of actions designed to explore the feasibility of a legislative approach to achieving the goal.

1) A committee of the Board held several meetings with representatives of the State Board for Nursing and the Coalition of Nurse Practitioners.

2) Legal counsel for both the Association and the State Education Department were consulted concerning the desirable parameters of any enabling legislation.

3) The Board of Directors adopted a set of principles by which any potential legislative thrust would be guided. These principles are as follows:

   a) The privilege would be limited to nurses with graduate education in nursing, in a program which specifically prepared the nurse for prescriptive authority. The State Education Department would approve the programs which met these conditions.

   b) The privilege would be unrestricted by tithe of the nurse.

   c) The privilege would be autonomous; i.e., not limited by a requirement for physician supervision/collaboration, etc.

   d) The privilege would encompass drugs, devices and immunizing agents, unrestricted by class of drugs.

   e) For a limited period of time following enactment of any legislation, nurses who do not meet the qualification of a master’s degree may qualify for the prescriptive privilege by meeting stringent alternative qualifications.

4) Meetings were held with selected legislators to explore the merits of a legislative approach in the context of the agreed principles.

NYSHA believes these are the most appropriate parameters for extending prescriptive privilege to qualified nurses and will continue its experience of other states has demonstrated that limited (i.e., restrictive) statutory authorization has been a burden to the nurses privilege.

The context, however, within which prescriptive privilege is often embedded is statutory authorization for “advanced nursing practice,” as well as other states. NYSHA and the American Nurses Association advanced nursing practice on the basis to two fundamental principles: function of licensure as a nurse. Therefore, licensure laws should contain only provisions that bear a direct and substantial relationship to the protection of the public’s health and safety; and 2) The recognition of professional association. The law, therefore, should not provide autonomous, independently licensed profession such as nursing in fully qualifications for these practitioners, credentialing its “experts,” and monitoring their performance through peer review and other is unnecessary, and it is an infringement on and denial of the profession’s independence to cede such matters to external regulatory control.

Given these beliefs about the nature of the profession and the proper balance of governmental and professional self-regulation, NYSHA has vigorously opposed efforts to enact legislation which would define and regulate the advanced practice of nursing. Again, experience of other states has demonstrated that such legislation often serves as a primary care services. Similarly, it is proven enormously difficult to construct statutory language which permits the development of a scope of practice of a limited group of nurses without restricting the practice of other equally qualified nurses.

NYSHA believes that the scope of practice of all nurses, including nurse specialists who are nurse practitioners and clinical nurse specialists, should be permitted to evolve in accordance with the needs of society for their services. Where there are concerns for the overlapping responsibilities of nurses and any other health care providers, these should be worked out through joint deliberations of all involved parties.

Recent proposed legislation violated the basic principles described above by restricting the functions of “diagnosis and treatment of illness and the performance of therapeutic and corrective measures” to a certain group of nurses. This legislation also placed
The functions under the control of physicians by requiring a supervisory relationship between the nurses and "collaborating" physicians. The Association believes that this legislation would expose many nurses to potential challenge of their customary practices and would, again, limit access to qualified nurses' services.

The needs and interests of all nurses must be considered within the fundamental context of our obligations for the protection of the public. WYSHA believes that protection of the nurse practice act from inappropriate or restrictive revision is among the foremost responsibilities of the professional association.

/c1
10/8/87
ARTICLE 139
PROFESSIONAL NURSING

An Act to amend the education law, in relation to the practice of nursing, deleting section 6901 and adding a new (3) to special provision section 6908 providing for prescriptive privileges.

Section 6900.

[Introduction.]

[6901. Definitions]

[6902. Practice of nursing and use of title "registered professional nurse" or "licensed practical nurse",]

[6903. State board for nursing,]

[6904. Requirements for a license as a registered professional nurse,]

[6905. Requirements for a license as a licensed practical nurse,]

[6906. Limited permits,]

[6907. Exempt persons,]

[6908. Special provisions,]

6900. Introduction.

No change.

6901. Definitions. As used in section sixty-nine hundred two:

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

2. "Treating" means selection and performance of those therapeutic measures essential to the effective execution and management of the nursing regimen, and execution of any prescribed medical regimen.

3. "Human Responses" means those signs, symptoms and processes which denote the individual's interaction with an actual or potential health problem.

EXPLANATION—Matter in italics (underscored) is new; matter in brackets ( ) is old law to be omitted.
9609. Special provision. Now becomes 9608. 1. Not withstanding any inconsistent provision of any general, special, or local law, any licensed registered professional nurse or licensed practical nurse who voluntarily and without the expectation of monetary compensation renders first aid or emergency treatment at the scene of an accident or any other place having proper and necessary medical equipment, to a person who is unconscious, ill or injured shall not be liable for damages for injuries alleged to have been sustained by such person or for damages for the death of such person alleged to have occurred by reason of an act or omission in the rendering of such first aid or emergency treatment unless it is established that such injuries were or such death was caused by gross negligence on the part of such registered professional nurse or licensed practical nurse. Nothing in this subdivision shall be deemed or construed to relieve a licensed registered professional nurse or licensed practical nurse from liability for damages for injuries or death caused by an act or omission on the part of such nurse while rendering professional services in the normal and ordinary course of her practice.

2. Nothing in this article shall be construed to confer the authority to practice medicine or dentistry.

3. Now becomes 2. An applicant for a license as a registered professional nurse or licensed practical nurse by endorsement of a licensed of another state, province or country whose application was filed with the department under the laws in effect prior to August thirty-first, nineteen hundred seventy-one shall be licensed only upon successful completion of the appropriate licensing examination unless satisfactory evidence of the completion of all educational requirements is submitted to the department prior to September one, nineteen hundred seventy-seven.

(CONT'D)
2. Health services which may be performed by a registered professional nurse shall include issuance of prescriptions for drugs, devices and immunizing agents pursuant to rules and regulations promulgated by the Board for Nursing.

a) A registered professional nurse applying for registration for prescriptive privilege as authorized by subdivision three of section sixty-nine hundred eighty of this article shall fulfill the following requirements:

(i) Application: file an application with the department.
(ii) License: be licensed as a registered professional nurse in this state or be eligible for same.
(iii) Education: a) have satisfactorily completed educational preparation for these health services, which includes a specific pharmacology component; and b) received a master's degree in nursing in a program registered by the department or determined by the department to be equivalent; c) pay a fee to the department deemed to be appropriate for registration authorizing prescriptive privileges.

b) A registered professional nurse who has satisfactorily completed educational preparation for these health services which includes a specific pharmacology component prior to the effective date of this legislation need not meet the requirement for a master's degree in nursing.

c) Nothing in this subdivision shall be deemed to limit the practice of nursing as a registered professional nurse pursuant to this article or to deny any registered professional nurse the right to do any act now authorized by this article.

d) This act shall take effect on first day of January next succeeding the date on which it shall become law.

JFM/cl
2/23/88
Nursing Law and Ethics

Definition and Regulation of Nursing Practice: An Historical Survey
by Jane Greenlaw, R.N., M.S., J.D.

The definition and regulation of nursing practice are issues of growing national interest. A variety of factors, including rising health care costs and consumer awareness, have combined to catalyze changes in health care delivery, with an increasing emphasis on disease prevention and cost effectiveness. These goals have necessarily focused attention on areas related to professional roles of nonphysicians—most prominently, nurses—as providers of lower cost, quality health care. In a climate of professional and economic competition, state legislatures, state nursing boards, courts, and professional nursing organizations are engaged in a process of changing, adapting, or interpreting existing nursing practice laws to meet the needs of the changing health care system.

This article reviews the history and evolution of nursing practice legislation, examines the present stage in its development, and highlights some important issues affecting contemporary nursing practice acts.

History and Evolution of Legislation
Although nursing licensure did not begin in this country until 1903, the emergence of nursing as a distinct discipline began nearly one hundred years earlier when, in 1899, Elizabeth Seton founded the Sisters of Charity to provide medical care to the poor. During most of the nineteenth century, little emphasis was placed on formal training or qualifications for nursing, as evidenced by the requirement during the Civil War that army nurses "be 30 to 50 years of age... have good health and endurance... have a matronly demeanor and good character... be plainly dressed."1

Formal, hospital-based nursing training began in the United States in 1872 when a Woman's Hospital of Philadelphia opened the first endowed school of nursing.2 Three schools opened in 1873, and by 1909 there were more than 1000 training schools for nurses.3 Modelled after the successful, much publicized training school founded in England by Florence Nightingale, the American nursing schools were seen as a means to decrease hospital operating costs while at the same time improving the quality of patient care. An unfortunate result of the effort of training schools was that the graduates of these programs had little or no opportunity for hospital employment since hospital staffing needs were met almost entirely by nursing students. Graduate nurses sought employment in private homes, competing with untrained, self-declared "nurses" who traditionally provided such care.4

The diffusion of graduate nurses outside the hospital setting precluded the development of professional identity for these nurses: it was nurse educators who, in 1894 and 1896, formed the first two national nursing organizations known as the National League for Nursing (NLN) and the American Nurses' Association (ANA). Following the example of the American Medical Association (AMA), the nursing organizations sought nursing licensure as a means to accomplish their goals of gaining control over nursing, and establishing and maintaining standards for training schools.5

Because these early efforts took place prior to the nineteenth amendment granting the franchise to women, the state constituent organizations sought and relied upon support from other groups such as state medical licensing boards, state medical societies, and suffragettes.6

The gap between actual nursing practice and statutory definitions of nursing widened, as nursing education began to shift from the traditional hospital-based diploma program to two-year and four-year degree programs.

The first nurse registration act was passed in North Carolina in 1903, creating a Board of Examiners comprised of two physicians and three registered nurses and providing:

That any nurse who may present...a diploma from a reputable training school for nurses conducted in connection with a general hospital, public or private, in which medical, surgical, and obstetrical cases are treated or in connection with one of the three state hospitals for the insane or who shall exhibit a certificate of attendance from such training school for a period of not less than two years or who shall present a certificate signed by three registered physicians, stating that the nurse has pursued the business and avocation of a trained nurse for a period of not less than two years, and is in their judgment competent to practice the same shall be entitled to registration without examination, and

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Ms. Greenlaw is an Associate Faculty of the School of Nursing, University of Rochester, in Rochester, New York, and is an Associate Editor of Law, Medicine & Health Care.
shall be registered by the clerk of the Court in the manner hereinabove provided. By 1923, similar legislation had been passed in all states and in Cleveland and the District of Columbia. The period from 1903 to 1919 has been described as the first, or registration, phase in the development of nursing practice legislation. These early laws were characterized by four basic weaknesses. First, only one of...
for nurses proliferated. In 1970 the American Nurses’ Association amended its model definition to take into account the changing role of nurses in health care delivery.

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

This amendment marked the beginning of the third, or current, phase in the development of nursing practice legislation.

Contemporary Nursing Practice Legislation

The hallmark of contemporary nursing practice legislation is the recognition of what is called nursing’s role expansion. The term “expanded role,” coupled with the common nursing disclaimer concerning medical practice, has presented obstacles to nurse change. However pragmatic or accurate these terms may have been at one time, their connotation, in retrospect, is of a fixed definition of nursing, entirely exclusive from medicine, with some nurses practicing beyond its limitations.

A variety of factors have been identified as influencing changes in nursing practice. Changes in nursing education and the emergence of nursing specialties have influenced, as did the women’s movement, advances in scientific technology, and changes in demographic patterns of health-care consumers and providers.11 While these factors have affected all nursing practice, legislative efforts to recognize nursing’s changing role have been directed primarily to sanction advanced nursing practice by nurse specialists.

The Ameri can Nurses Association has added the definition of advanced practice to its position statement on nursing practice.2 However, the term “advanced practice” has not been defined by any regulatory body. The term “advanced practice” is not recognized by all states, and some have different definitions. It is important to note that the term “advanced practice” is not a synonym for “nurse practitioner.”

The term “nurse practitioner” has been defined in most states as a registered nurse who, after completing a graduate program in nursing, has been granted advanced practice privileges by the state’s nurse practice act. Nurse practitioners are authorized to perform diagnostic and therapeutic procedures, including the administration of medications, within their scope of practice. They are required to maintain current knowledge and skills in their area of specialization and to be supervised by a physician. Nurse practitioners may also provide primary care services, including patient education, health promotion, and disease prevention.

The American Nurses Association defines “nurse practitioner” as a registered nurse who has completed a graduate program in nursing and is authorized by the state’s nurse practice act to perform diagnostic and therapeutic procedures, including the administration of medications, within their scope of practice.

The American Nurses’ Association takes the position that developing guidelines and standards for specialized practice is the profession’s responsibility.

The final method currently utilized to recognize changes in nursing practice is to add a new category of nurse practice act which permits all nursing functions. In the case of the American Nurses’ Association, this category is called “advanced practice.” The scope of practice for advanced practice nurses includes the performance of diagnostic and therapeutic procedures, including the administration of medications, within their scope of practice.

In conclusion, it is clear that the development of advanced practice nursing has been a complex and ongoing process. The role of nurses in health care delivery continues to evolve, and it is important for nurses to remain knowledgeable about the latest developments in nursing practice.
the minimum standards set by law. The law should not provide for the practice of physical therapy in nursing or for certification or other recognition for practice beyond the minimum qualifications established for the legal regulation of nursing. 

This follows the medical model for licensure, where there is no state certification or other legal or regulatory specialty for practitioners. A broad scope of practice applies to all practitioners, and specialties are regulated by professional organizations.

The more recent model definitions of nursing are put forth by the American Nurses Association (ANA) in its 'The Practice of Nursing'. The performance of practice based on specialized knowledge of the biological, physical, psychological, and sociological sciences and of nursing theory as the basis for assessment, diagnosis, planning, intervention, and evaluation in the promotion and maintenance of health, the case finding and management of illness, injury, or infirmity, and in the restoration of optimal health function; on the achievement of a dignified death and of a person's limitations to the care which may be necessary. The practice includes a wide range of duties and responsibilities, including the administration of medications and treatments prescribed by any person licensed to practice medicine. Each registered nurse is directly accountable and responsible to the professional ethics as to the quality of nursing care rendered.'

This definition is intended to complement the role put forth in a 1990 American Nurses Association statement: 'Nursing is a process involving the transaction of human responses to actual or potential health problems. In the conundrum of adaptation, the role of the nurse is the one unique to the discipline in the care of the patient. It is the nurse who recognizes changes in nursing practice for all nurses rather than only for those specialties, has some problems. Nurses relying upon the broadened role language do not always feel that their practice will go unchallenged by physicians and, indeed, challenges have occurred. Further, in the current climate of economic competition among health care providers, problems can occur in states where third-party reimbursers for nursing services are available for designated nursing specialties.'

Licensing and Certification

The states have employed various methods to confirm nursing practice certification, and the states have varying standards of practice. These standards define the scope of practice and entry into practice. Certification of nurse specialists by the various nurse specialty organizations began in 1975, after the American Nurses' Association determined that it did not appropriately fulfill this function. The specialty organizations, as well as subgroups of the American Nurses' Association, have been in the role of developing standards of practice for their respective nursing specialties. While the standards prescribe minimum levels of practice, certification is designed to recognize excellence in practice. Qualifications for certification include clinical practice for a specified period, documentation of clinical competence, and successful completion of a written examination.

In the mid-1970s, when the states began to recognize advanced nursing practice through statutory and regulatory provisions, the states also began to require that nurses in such advanced practice obtain certification by the appropriate national nursing specialty organizations. While this practice goes against the position of the American Nurses' Association that professional organizations, and not the state, should regulate the nursing specialties, it can be viewed as a reasonable compromise between the authorizations of the state and the function of the professional association. The state is not usurping the functions of the professional association, thus providing the state, exercising its power to safeguard the public, in giving some amount of recognition, or denial, to the role of the professional associations.

The most concerning are entry into practice rules in 1985 when the American Nurses' Association took the official position that professional nursing need be performed by practitioners to fulfill their role successfully. A major concern are entry into practice rules in 1985 when the New York State Nurses' Association became the first of the ANA state nursing associations to pass a resolution calling for a baccalaureate requirement by 1995. To date, other state nursing associations have passed similar resolutions, although it is not clear what all states will have legislation or regulations in place by the end of 1985. Resistance to the proposal is strong; the issue has divided nursing as no other.

The proposal to require a baccalaureate degree for a license as a registered nurse has divided nursing as no other issue.

The second or current phase in nursing practice legislation, focusing on expanded and advanced nursing practice, has taken place only after the baccalaureate requirement was proposed. As a result of the current phase, the specialty issue may be moot. As of now, the specialty issues in the states have not been resolved, requiring an examination and recognition, as was provided in Texas in 1983, by 1985 all states had passed such requirements. In 1983, the Bachelor of Science in Nursing (BSN) was not recognized. In 1983, the Bachelor of Science in Nursing (BSN) was not recognized. In 1983, the Bachelor of Science in Nursing (BSN) was not recognized. In 1983, the Bachelor of Science in Nursing (BSN) was not recognized.
TESTIMONY PREPARED BY:

Loretta Ford, R.N., M.S., Ed.D., F.A.A.N.
University of Rochester School of Nursing
for May 20, 1987 Hearing, Albany, N.Y.

This testimony registers -as a participative historian - my opposition to Bills A. 1412 and S. 1314. Experience in other states and history shows this legislation to be unnecessary, impractical, unreasonable, restrictive and costly.

The great eighteenth century philosopher, Hegel, said: "What experience and history teach is this: that people and governments have never learned anything from history."

With all due respect to this august philosopher, I am of the opinion that we - people and governments - should at least try to learn something from the past. Especially when those who made history are still available for comment.

I represent the past history of the nurse practitioner and I speak in opposition to A.1412, S.1314. As the co-founder of the movement in 1965 with Dr. Henry Silver at the University of Colorado School of Nursing, I stand witness to past events, some of which we created and others that occurred by the external design or happenstance. My intent is to describe the origins, implementation and evaluation of practice, preparation, placement and performance of nurse practitioners over the past 22 years. Of necessity, this is a brief, but I hope, substantive report of events important to consider in legislative matters relating to practice statutes.
The original nurse practitioner was a pediatric nurse practitioner model designed from a nursing base and for a nursing role in child care. The program focused on utilizing nursing philosophy, knowledge and skill and legitimized some expanded processes and tools in clinical decision-making for delivery of primary care to children in ambulatory settings - clinics, offices, schools, nurseries, homes, etc. As a Public Health Nurse, I was constantly challenged to make decisions about normal growth and development of children, to determine the seriousness of symptoms, to advise parents about healthy life styles and gather historical data on past health practices and illnesses and responses to those conditions. In order to prevent disease and disability and to promote health, a professional nurse must know and do these things.

As science progresses, new tools, information and opportunities became available for professionals to make better decisions by expanding their senses, e.g., eyes and ears. By the use of otoscopes, stethoscopes and other tools and tests, nurses gather extensive data about potential or actual health problems or assure people, especially the worried well, that they are indeed well. This type of preventive action is professional nursing practice and it has great implications for adding to the public's health and wealth. Resources - human, technological and financial - can be wisely and widely used, conserved and appropriately distributed by nurses with expanded skills.

But these nursing skills cannot be used in the interest of
the public if they are controlled by other professions through legislative fiat. Another piece of history: when we introduced the nurse practitioner we did not intend, envision, or seek a change in the state's Nursing Practice Act. I believed, and still do, that the scope of practice issues expands and contracts in accordance with the practitioner's preparation, knowledge base, technological advances, the setting and the social times. The scope of practice should not be a part of the statutes. The nature of the field is of prime importance in State Practice Acts. Professional credentialling can identify qualified practitioners, monitor their practice and protect the public through sanctions if necessary. As professional practice changes, credentialling mechanisms can easily be adapted nationally for universal quality control.

Throughout our years of developing and testing the nurse practitioner model, we never envisioned physician supervision of nurse practitioners. We taught, expected, and modelled colleagueship in preparation, practice, placement and performance. We gave recognition to both the nurse and the physician as professional practitioners who could be independent of each other and who could also function interdependently as a team if they chose.

If this 22 year living history is unbelievable, just review the written record of the 30,000 nurse practitioners who are now practicing. In over a thousand articles, books, studies, and monographs, the following information is revealed.
- The nurse practitioner is the most thoroughly studied health professional in history in terms of safety, efficiency, effectiveness, acceptance and economy;

- The quality of care delivered by nurse practitioners has been excellent;
- Patient acceptance has been uniformly high;
- The cost has been reasonable;
- Nurse practitioners have been more willing than other professionals to serve rural and poor populations;
- The nurse practitioner can function in myriads of settings and for people of all ages: primary care clinics and offices, schools, nurseries, hospitals, nursing homes, prisons, summer camps, hospices, etc.;
- Legal challenges have been very few; most are brought about by medical societies rather than malpractice suits;
- Reimbursement for services rendered has been very slow in evolving and is not universal, hampering the full utilization of nurses;
- Insurance companies have become increasingly reluctant to issue malpractice insurance, despite the lack of evidence of risk in insuring nurse practitioners;
- The federal government has supported the education of nurse practitioners, but has done little to protect its investment through reimbursement plans to utilize nurse practitioners fully;
- Increasingly industry and H.M.O.s are employing nurse practitioners because they are safe, effective, economical and humane.

New York State has been a flagship state in professional nursing practice, education and research. This state has shown - well ahead of other states - that specialty practice legislation and unwarranted control of one profession over another - can be more of a hindrance than a help in the education and practice of professional nurses.

Lest history repeat itself and prove philosopher Hegel right, I hope the people and the government of the great State of New York will heed the voice of history, and review the successful past of the nurse practitioner - for the future, learn the lessons of history well: The proposed legislation, A.1412, S.1314, are not needed, acceptable to this nurse practitioner or in the best interest of the public in health care quality, cost or access.
Impact of Structural Autonomy Accorded Through State Regulatory Policies on Nurses' Prescribing Practices

Marjorie V. Betey, Ph.D., F.A.A.N.,
Joanne M. Holland, M.S., R.N.

Since the initial contemporary concept of professional nurses in primary care providers (Ford, Spacar, & Silver, 1966), numerous studies have reported the satisfaction of patients, physicians, and nurses with the care given by nurse practitioners (NPs). They also have found that selected functions, traditionally restricted in the medical profession were fulfilled competently by these NPs (Ford and Silver, 1967; Lewis and Resnik, 1967; Lewis, Resnik, Schmidt, Waxman, 1969; Moore, Barber, & Robinson, 1973; Ross, Orman, 1975; Cheyfitz, 1976). However, studies to date have not examined the range of activities that NPs are capable of performing (Ford, 1978). In part because some functions prohibited from the scope of practice of NPs, further, most state licensure bodies and third-party reimbursement policies require that NPs act under physician (M.D.) supervision (U.S. Department of Health, Education, and Welfare, 1978), a requirement mandated to ensure the quality of the acts performed but that also results in duplication of health care provider effort as well as in the supervisory cost built into patient care costs, and limits the autonomy of NPs.

The prescription of drugs—an act considered to be an integral part of the assessment, diagnosis, and treatment cycle in provision of primary care—has been one of the acts prohibited to NPs. By fall of 1980, however, statutes amendments in 17 states had been effected to include nurses among the practitioners to whom prescriptive authority could be granted, and some form of prescriptive authority for NPs had been achieved in 12 of these states through regulation (See Fig. 1). Testimony of public hearings on these regulations has illustrated the philosophical positions and the judgments of special interest groups of nursing, medicine, and pharmacy on who a wide variety of legal constraints should or should not be imposed on the prescriptive authority of NPs. The resulting regulations vary markedly, among the states, ranging from NPs prescribing being an extension of M.D. authority (limited-based authority) to its being an authority formally accorded under the registered nurse license and through state recognition of certification and under preparation for specialized and advanced nursing practice (broad-based authority). Within the broad-based authority states the constraints place additional variation as to the degree of autonomy they accord to NPs in fulfilling the prescribing act; this is reflected through the variable requirements that each NP grant prescriptive authority has a supervising M.D. and that prescriptions issued be limited to a drug formula.

This is a question of whether or not the requirements on NP prescriptive authority among the broad-based authority states, and the criteria for granting on the NP's autonomy, make a difference in the prescribing practices of NPs as demonstrated by limited data, policy decisions on this matter will continue to evolve from philosophic positions of special interest. Beyond the baseline policies of granting prescriptive authority, the degree of autonomy accorded to NPs to fulfill the assessment, diagnosis, and treatment cycle of primary care has important implications for issues of accessibility to care and cost of health services. To move to more definitive decisions in those areas data are first needed on prescribing practices.

The freedom accorded with prescriptive authority of NPs is bounded by the constraints of state statutes or regulations, existing, in part, from state to state. It is reasoned that the type of constraints affords the level of autonomy of NPs create a conflict relationship between the prescriptive status and the binding nature of the acts related to prescribing.

The legal constraints on the prescriptive authority of NPs are those of limiting prescriptions by NPs to a drug formulary and requiring M.D. supervision of the NP. The formulary requirement is viewed as the least restrictive because, while it constrains discretionary decision-making by limiting the choice of drugs, it does not in itself influence the binding dimension of autonomy. The requirement of a supervising M.D. is judged to impact both the discretionary and binding nature of the decision since it presumes consistency of NP decisions with those of the supervising physician, approval by the supervision of the decisions. Without consistency and approval there exists the implicit threat of withdrawal of the supervising M.D. and, correspondingly, withdrawal of prescriptive authority until a new M.D. supervisor is obtained. The legal requirement of both a formulary and supervision is judged to be the most restrictive and therefore the least autonomous condition, whereas the absence of either requirement is considered to provide the best autonomous condition. Ranging from least to greatest, the levels of autonomy encompassing prescriptive authority of NPs in the five states included in this study, are shown in Table 1.

The research question is, in what degree do the various levels of structural autonomy influence the prescribing practices of NPs? In addition, selected comparisons at the findings of this study are made with those of studies of the prescriptive practice of M.D.s.

### Methodology

The study design is a natural experiment in the sense that independent structural autonomy is manipulated by policies through the state regulations of NP prescribing authority. The dependent variable is prescribing practices. Limited to the focus of this study is the incidence of prescribing practices.

### Table 1. The Levels of Autonomy Accompanying the Prescriptive Authority of Nurse Practitioners in the Five States Under Study

<table>
<thead>
<tr>
<th>Structural Autonomy Level</th>
<th>Supervising M.D.</th>
<th>Formulary Required</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 — Least</td>
<td>Yes</td>
<td>Yes</td>
<td>State</td>
</tr>
<tr>
<td>2 — Limited</td>
<td>Yes</td>
<td>Yes</td>
<td>State</td>
</tr>
<tr>
<td>3 — Moderate</td>
<td>No</td>
<td>Yes</td>
<td>State</td>
</tr>
<tr>
<td>4 — Greatest</td>
<td>No</td>
<td>Yes</td>
<td>State</td>
</tr>
</tbody>
</table>

[^1]: Authority and autonomy: Authority is the right to carry out free will and other responsibilities. Authority is the ability to act independently, to make independent decisions, and to act independently. Authority is the right to act independently, to make independent decisions, and to act independently.
TABLE 2. NUMBER OF PRESCRIPTIONS RELATED TO NUMBER OF PATIENTS FOR TOTAL SAMPLE AND WITHIN AUTONOMY CONDITIONS

<table>
<thead>
<tr>
<th>Autonomous Condition</th>
<th>Lowest</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondents</td>
<td>33</td>
<td>32</td>
<td>30</td>
<td>52</td>
<td>156</td>
<td>359</td>
</tr>
<tr>
<td>Clinic days</td>
<td>234</td>
<td>226</td>
<td>220</td>
<td>322</td>
<td>1,500</td>
<td>3,162</td>
</tr>
<tr>
<td>Patients seen</td>
<td>2,965</td>
<td>2,853</td>
<td>2,445</td>
<td>6,493</td>
<td>25,892</td>
<td>55,323</td>
</tr>
<tr>
<td>Mean patients seen</td>
<td>11.06</td>
<td>12.13</td>
<td>11.14</td>
<td>12.43</td>
<td>12.03</td>
<td></td>
</tr>
<tr>
<td>Prescriptions given</td>
<td>2,432</td>
<td>2,360</td>
<td>2,930</td>
<td>3,084</td>
<td>11,905</td>
<td>28,916</td>
</tr>
<tr>
<td>Patients given Rx</td>
<td>1,874</td>
<td>2,029</td>
<td>2,197</td>
<td>2,905</td>
<td>9,095</td>
<td>22,103</td>
</tr>
<tr>
<td>Ratio of patients Rx</td>
<td>0.69</td>
<td>0.86</td>
<td>0.96</td>
<td>1.04</td>
<td>1.04</td>
<td>1.04</td>
</tr>
<tr>
<td>Ratio of total Rx to</td>
<td>1.30</td>
<td>1.30</td>
<td>1.34</td>
<td>1.33</td>
<td>1.32</td>
<td></td>
</tr>
</tbody>
</table>

Findings

In this presentation the primary unit of analysis is the prescription. For each patient who provided the data, prescriptions were recorded 13.6% of the time, whatever the condition. The use of each drug prescribed, whether or not drug product used, was recorded. Whether the prescription was a refill or a modification of a previous one, the form in which it was written, the telephone, sample, or cash, and whether or not the patient was seen by an M.D. for the health problem underlying the prescription. Data on client age, sex, and health problem for each prescription were also obtained but are beyond the scope of this paper.

The respondents combined the logs for recording the information requested for each prescription recorded legend and over the counter products for 21 clinical practices. On each day's log they recorded the number of patients seen that day, the number prescribed, those who received a prescription and those who did not receive one.

Prior to analysis, drug names on the logs were coded as to whether they were the trade or generic name. Next, trade names of single entities or of common mixtures were reduced to generic names. Trade names of unique elements or mixtures and generic names were also reduced.

Drugs were classified into 17 therapeutic categories through use of an adaptation of the Knoben and Weisheimer system. Their system contains 12 categories: analgesics, antidepressants, antihistaminics, anticholinergics, cough and cold, diuretics, hormones, sedatives and hypnotics, tranquilizers, and ulcer cures. This system was used and the classification of drugs was made by a panel of experts who have a thorough knowledge of the drugs. This panel of experts then met to classify the drugs into the 17 therapeutic categories. The 17 therapeutic categories were: analgesics, antidepressants, antihistaminics, anticholinergics, cough and cold, diuretics, hormones, sedatives and hypnotics, tranquilizers, and ulcer cures.

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TABLE 5. NURSE PRACTITIONER CONSULTATION WITH AND REFERRAL OF CLIENTS TO PHYSICIANS IN THE CONTEXT OF PRESCRIBING

<table>
<thead>
<tr>
<th>Autonomy Level</th>
<th>Consultation Prior to Prescribing</th>
<th>Referral for Same Health Problem</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lowest</td>
<td>326</td>
<td>150</td>
<td>476</td>
</tr>
<tr>
<td>Highest</td>
<td>342</td>
<td>310</td>
<td>652</td>
</tr>
</tbody>
</table>

TOTAL = 668

*Percentages are based on total prescriptions issued within autonomy condition.

**Total percent proportion of total prescriptions (N = 11,585).

SUMMARY

The main function of regulations that implement nurse practice acts is to protect the public by ensuring the welfare of the public in the context of their needs for health care as provided by registered nurses. Regulations governing nurse autonomy authority of NPs in the states were highly comparable for nurse practitioners with autonomy prescribing authorities. This finding is consistent with the results of other studies. The level of autonomy in the study is characterized as formal and informal. The findings of this study suggested that the level of autonomy in the study was significantly higher than in the study by McMillan et al. (1988). The results of this study are consistent with the findings of other studies. The results of this study suggest that the level of autonomy in the study was significantly higher than in the study by McMillan et al. (1988). The results of this study are consistent with the findings of other studies.
COALITION of NURSE PRACTITIONERS, INC.
P.O. BOX 123, EAST GREENBUSH, N.Y. 12061

December 4, 1987

Martha L. Orr
Executive Director
MTS Nurses Association
2113 Western Avenue
Guilderland, NY 12084

Dear Martha:

This letter is to confirm our recent telephone conversation. The Association's "facilitator" proposal was discussed at our recent Executive Committee meeting and followed up with input from our Board of Directors. The decision of the Coalition is that we will not pursue this avenue at this time.

Sincerely,
Francesca C. Hartnett
President
59 Brinkerhoff Street
Plattsburgh, NY 12901
518-563-6109
#122

Prescriptive Privileges (12-17-86)

NEW YORK STATE NURSES ASSOCIATION
2113 Western Avenue, Guilderland, N.Y. 12084, (518) 456-5371

TO: Executive Committee, Functional Unit of Primary Care Practitioners
   - Diane Plumadore
   - Mel Callan
   - Louisa Ivan
   - Nancy McGinn, Chairman, Council on Nursing Practice
   - Maggie Jacobs, Secretary, Board of Directors, NYSNA
   - Tina Gerardi
   - Martha Kamkley
   - Judy Lynch
   - Ingrid Pearson

FROM: Juanita Hunter, President, NYSNA

SUBJECT: Update on Nurse Practitioner Issues

DATE: December 21, 1987

I would like to invite you to participate in a meeting on January 7 from 1:30 to 4:00 p.m. at the Veronica M. Driscoll Center for Nursing.

The purpose of the meeting is to update you on activities and approaches taken to resolve issues relative to nurse practitioners and to seek your input.

I do hope you will be able to attend. Your travel expenses will be reimbursed by the Association. Please call Kim Roberts at (518) 456-5371 at your earliest convenience about your availability.

Thank you.

JH:JFM/c1
there seems to have been some serious setbacks to the gains made thus far, it is necessary to highlight some events.

In 1985 and the spring of 1986, it appeared that some progress was being made when after several meetings with NYSHA, the New York State Board for Nursing and the Coalition of Nurse Practitioners, there were common goals defined for prescriptive privilege legislation. These goals seemed to be buried when Assemblyman Arthur Eve introduced his bill "Nursing Opportunity Scholarships and Nurse Practitioners" (A.11211) at the end of the 1986 legislative session. Because of the ensuing positions by the various nursing groups and the events of that year, there now seems to be even greater animosity and distrust. These negative feelings preclude any compromise and productive negotiation between the nursing groups.

We need nursing unity to advance nursing, including prescriptive privileges. Presently, nurse practitioners are totally dependent on a physician whenever our clients require a prescription and many of us would not be a marketable health care provider if physicians no longer choose to supply our clients with prescriptions.

The Coalition of Nurse Practitioners does not appear to oppose the philosophy of NYSHA regarding prescriptive privilege, but finds it difficult to wait for the right legislators to come along for the hope of obtaining such a "pure" bill. Actually, there does not appear to be any differentiation of philosophy but rather opposing opinions as to the effect of bill A.1412 and S.1314. The Association stating firmly that it would restrict the registered nurses’ practice, while the Coalition just as firmly states the disclaimer paragraph as a "cooperation," "collaboration" would be legally interpreted as "supervision," "colleague" relationship, and the profession of nursing would not be subject to physician influence. Thus, we seem to be at a standstill as far as we can achieve for nursing and nurse practitioners.

Because of the above issues, we would like to recommend to the Board a plan of action. The first recommendation comes from experience of the national level. When several nurse practitioner groups were unable to agree on how nurse practitioner needs could best be met, professionals and facilitators were utilized at conference which resulted in the formation of the National Alliance of Nurse Practitioners.

We would like to request a meeting with decision-making representatives from NYSHA, the CORP, NYSHA and any other involved nursing organization and a professional facilitator. We realize that we could incur substantial cost, but will not compare to the cost of a continued schism within the profession. We offer our assistance in any way that may encourage or enhance such a meeting.
Ellen M. Burns, President
May 26, 1987
Page 3

Also, we request a written legal interpretation of bill A.1412 and 
S.1314. Perhaps an opinion could be obtained from the legal counsel 
for the New York State Department of Education which is regulating 
body for our profession.

As the Executive Committee of NYSNA’s Functional Unit of Primary Care 
Practitioners, we respectfully request your quickest possible efforts 
in resolving this urgent dilemma for nursing. We will appreciate 
being kept informed of this situation and eagerly await your response. 
We sincerely thank you for your time and efforts.

Sincerely,

Diane M. Plumadore
Chairman 
Functional Unit of Primary Care Practitioners

Judy S. Lynch
Vice Chairman
Functional Unit of Primary Care Practitioners

Mary Eileen Callan
Member at Large
Functional Unit of Primary Care Practitioners

DP/BRI/kac
The rationale for the proposed 1988 Legislative Program is appended to these minutes.

MOTION Sandra Mazzie moved the Board of Directors approve the use of the titles "registered professional nurse" and "licensed practical nurse" in proposed entry into practice legislation. Seconded. Carried unanimously.

MOTION Rita Wieczorek moved the Board of Directors request that staff develop a proposed strategy for implementation of the proposed 1988 Legislative Program for review at the pre-convention Board meeting. Seconded. Carried unanimously.

B. Request of Executive Committee of Functional Unit of Primary Care Practitioners for Meeting of NYSNA and Other Organizations

On behalf of the Board of Directors, President Burns welcomed Diane Plumadore, Chairman of the Functional Unit of Primary Care Practitioners. Ms. Plumadore stated that she would address the Board concerning the request contained in the May 26, 1987 letter to President Burns from the Unit Executive Committee. The request conveyed by the letter is for the conduct of a meeting concerning so-called "advanced nursing practice" and prescriptive privilege legislation with representatives of NYSNA and other organizations and a "professional, impartial facilitator."

Board members acknowledged that several seemingly productive meetings of representatives of NYSNA, the Coalition of Nurse Practitioners and other groups took place. These discussions were suspended when the Coalition of Nurse Practitioners endorsed proposed so-called "advanced nursing practice" legislation which was restrictive and wholly unacceptable to the Association.

The Board acknowledged that, given the events of the 1987 legislative session, it is likely that groups will continue to support restrictive legislative proposals with provisions that would affect the Nurse Practice Act. Board members concurred that it would be appropriate and desirable to continue communication and discussion with other nursing organizations about any proposed legislation affecting the Act. The Board also noted that such discussion would be advisable regardless of whether prescriptive privilege legislation were part of the 1988 Legislative Program as it is approved by the Voting Body.

The Board noted that the proposal for the participation of a professional meeting facilitator has significant financial implications. The Board believes it would be appropriate for that financial responsibility to be shared with participating groups in the event it is indicated that the proposed meeting could be productive.

Following discussion,

MOTION Sandra Mazzie moved the Board of Directors refer to the Committee on Finance the request of the Executive Committee of the Functional Unit of Primary Care Practitioners for a meeting of nursing groups with a professional facilitator for study of financial implications. Seconded. Carried unanimously.

Ms. Plumadore, who was absent for part of the Board’s discussion, was requested to return to the meeting room and informed of the Board’s decision. Ms. Plumadore expressed appreciation to the Board for the opportunity to explain the concerns of the Unit Executive Committee. On behalf of the Board, Ms. Burns expressed appreciation to Ms. Plumadore for her presentation.

C. Request of Executive Committee of Psychiatric-Mental Health Nursing Clinical Practice Unit re Mandatory Reimbursement of Direct Nursing Services Legislation

The Board considered the August 1987 request to the Council on Legislation of the Executive Committee of the Psychiatric-Mental Health Nursing Clinical Practice Unit for consideration of efforts to obtain mandatory reimbursement of direct nursing services. The Board concurred that the Unit Executive Committee should be informed of the concentration on entry into practice legislation of the proposed 1988 Legislative Program and assured that the Council will continue its efforts toward securing complete reimbursement provisions for nursing services.

XVI. COMMITTEE ON FINANCE

The Treasurer reported that two Committee on Finance members and the President and President-elect, ex-officio members of the Committee, reviewed the preliminary analysis report and other materials on September 16. Because a quorum of the