1988

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

Juanita Hunter

#122 Prescriptive Privileges (12-1786)

DEC 16 1986

COALITION OF NURSE PRACTITIONERS, INCORPORATED

P.O. Box 123, East Greenbush, N.Y. 12061

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17 Clarkview Road
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December 13, 1986

16(a)

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. Bisner

Sharon A. Bisner, R.N.-C., B.S., FNP
President

Enclosures

cc: Executive Committee, CONP, Inc.

ASSEMBLY BILL (A 11211 C) PASSED June 30, 1986
SPONSORS: Assemblymen Eve, Tallon, Siegel, Murtaugh, et al.
SENATE BILL (S 3397 B) HELD IN SENATE RULES COMMITTEE, July 2, 1986

Senate Bill introduced June 16, 1986 by SENATORS LOMBARDI, DONOVAN, COOK, DALY, KEHOE, MARCHI, ROLISON, SCHERMERHORN, TULLY and VOLKER

4. (a) Health services which may be performed by a registered professional nurse, in collaboration with a licensed physician, may include diagnosis of illness and performance of therapeutic and corrective measures. Prescriptions for drugs, devices and immunizing agents may be issued by a registered professional nurse in collaboration with a licensed physician in accordance with a mutual practice agreement.

(b) Only nurses who shall have satisfactorily completed educational preparation for these health services in a nursing program approved by the department for these purposes or in a program determined by the department to be equivalent may exercise the powers specified in paragraph (a) of this subdivision.

(c) Nothing in this subdivision shall be deemed to limit the practice of the profession of nursing as a registered professional nurse pursuant to article one hundred thirty-nine of this chapter or to deny any registered professional nurse the right to do any act now authorized by that article.

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Marma L. Orr, MN, RN
Executive Director

Constituent of The American Nurses Association

NEW YORK STATE NURSES ASSOCIATION
2113 Western Avenue, Guilderland, N.Y. 12084, (518) 456-8371

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.

JPM/cg
6/30/86

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THE NEW YORK STATE NURSES ASSOCIATION

CONVENTION

FORUM ON PRIMARY CARE

October 26, 1982

FACT SHEETS

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FACT SHEET #1

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 fo 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).

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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)."

Lauren LaRoy, "Case Study #16: The Costs and Effectiveness of Nurse Practitioners," The Implications of Cost-Effectiveness Analysis of Medical Technology (Office of Technology Assessment, Congress of the United States, July 1981), p. 26.

"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."

Loretta C. Ford, "A Nurse for All Settings: The Nurse Practitioner," Nursing Outlook, 27:8 (August 1979), pp. 516-21.

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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".

U.S. Department of Health, Education, and Welfare, "Report on Licensure and Related Health Personnel Credentialing," (DHEW Publication no. (HSM) 72-11, Washington, D.C., U.S. Government Printing Office, 1971), pp. 73-77.

"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."

American Nurses' Association, "Memo to Executive Directors of State Nurses' Association and State Boards of Nursing," (New York, April 3, 1970).

"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)."

National Joint Practice Commission, "Statement on Medical and Nursing Practice Acts," (Kansas City, Missouri, February 1974).

"<u>Principles Relating to the Legal Regulation of Nursing Practice</u>

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 desireable 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

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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."

American Nurses' Association, Inc., "The Nursing Practice Act: Suggested State Legislation," G-142 IM (December 1981).

"ANA is very much aware that several state associations have been active in using the legislative stragegy 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).

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"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 word 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 1974 allowed for reimbursement for nurses only when medical acts were performed and only when they were clearly under the physician's supervision."

Loretta C. Ford, "A Nurse for All Settings: The Nurse Practitioner," Nursing Outlook, 27:8 (August 1979), pp. 516-21.

JPM:cvl
10/22/82

#122 Prescriptive Privileges (12-1786)

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Margretta M. Styles, Ed.D., R.N., F.A.A.N.
President

Judith A. Ryan, Ph.D., R.N.
Executive Director

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 18-21, 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 more 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

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drafted to be done by registered nurses, will replace the certification and recertification process.

Therefore, although NPs and CNSs 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 CNSs 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/KAM:nch

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TO: **Members, ANA Council of Primary Health Care Nurse Practitioners**

FROM: **Karen Knutson, M.S.N., R.N., C.**
Chairperson

DATE: **December 29, 1987**

RE: **Adoption of S. 101 - A Partial Victory**

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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 18-21, 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 more 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

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However, this recent victory represents a major step forward in that it recognizes the services of NPs and CNSs 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

KK/RAM:nch

#122 Prescriptive Privileges (12-1786)

NYSNA'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 NYSNA Board of Directors in early 1985 appointed a committee of the Board to study indepth 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, NYSNA 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 title 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.

NYSNA believes these are the most appropriate parameters for extending prescriptive privilege to qualified nurses and will continue to seek prescriptive authority in keeping with these principles. The experience of other states has demonstrated that limited (i.e., restrictive) statutory authorization has been a burden to the nurses and an artificial and unnecessary barrier to the effective use of the privilege.

The context, however, within which prescriptive privilege is often embedded is statutory authorization for "advanced nursing practice." The merits of such legislation have been vigorously debated in New York as well as many other states. NYSNA and the American Nurses Association have responded to proposals to define and regulate so-called advanced nursing practice on the basis to two fundamental principles: (1) Protection of the health and welfare of the public is the basic 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; (2) The recognition and certification of specialty practice falls under the purvue of the professional association. The law, therefore, should not provide for the recognition or regulation of advanced nursing practice. An autonomous, independently licensed profession such as nursing is fully capable of defining its own specialties, establishing the standards and qualifications for these practitioners, credentialing its "experts", and monitoring their performance through peer review and other established mechanisms, e.g. certification. It 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, NYSNA 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 vehicle for eliminating competition by nurses qualified to provide primary care services. Similarly, it is proven enormously difficult to construct statutory language which protects a certain title and describes a scope of practice of a limited group of nurses without restricting the practice of other equally qualified nurses.

NYSNA believes that the scope of practice of <u>all</u> nurses, including nurse specialists who as nurse practitioners and clinical nurse specialists, should be permitted to evolve in accordance with their preparation, capabilities, and the needs of society for their services. Where there are concerns for the overlapping functional 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

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these 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. NYSNA believes that protection of the nurse practice act from inappropriate or restrictive revision is among the foremost responsibilities of the professional association.

/cl
10/8/87

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DRAFT #3

ARTICLE 139
PROFESSIONAL NURSING

DRAFT #3

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]
6901. Definition of practice of nursing.
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.

§6902. Definition of practice of nursing. Now becomes §6901. 1. The practice of the profession of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential health problems through [such] services [as] *including but not limited to* case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing medical regimens prescribed by a licensed or otherwise legally authorized physician or dentist. [A nursing regimen shall be consistent with and shall not vary any existing medical regimen.]

2. The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding, health teaching, health counseling, and provision of supportive and restorative care under the direction of a registered professional nurse or licensed or otherwise legally authorized physician or dentist.

§6903. Practice of nursing and use of title "registered professional nurse" or "licensed practical nurse. Now becomes §6902. No change.

§6904. State board for nursing. Now becomes §6903. No change.

§6905. Requirements for a license as a registered professional nurse. Now becomes §6904. No change.

§6906. Requirements for a license as a licensed practical nurse. Now becomes §6905. No change.

§6907. Limited permits. Now becomes §6906. No change.

§6908. Exempt persons. Now becomes §6907. No change.

(CONT'D)

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§6909. Special provision. Now becomes §6908. 1. Notwithstanding any inconsistent provision of any general, special, or local law, any licensed registered professional nurse or licensed practical nurse who volunterily 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)

§6909. Special provision. Now becomes §6908. 1. Notwithstanding any inconsistent provision of any general, special, or local law, any licensed registered professional nurse or licensed practical nurse who volunterily 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.

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(CONT'D)

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3. 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 eight 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 masters 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.

JPM/cl
2/23/88

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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 the respective roles of non-physicians—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 1809, Elizabeth Seton founded the Sisters of Charity to provide medical care to the poor.[1] 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; and . . . be plainly dressed."[2]

Formal, hospital based nursing training began in the United States in 1872 when Women's Hospital of Philadelphia opened the first endowed school of nursing.[3] Three schools opened in 1873, and by 1909 there were more than 1000 training schools for nurses.[4] 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 spate 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.[5]

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 now 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.[6] 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.[7]

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 she or he has pursued the business and vocation 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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shall be registered by the clerk of the Court in the manner hereinafter provided.[8]

By 1923, similar legislation had been passed in all states and in Hawaii and the District of Columbia.[9]

The period from 1903 to 1938 has been described as the first, or registration, phase in the development of nursing practice legislation.[10] These early laws were characterized by four basic weaknesses.[11] First, only use of the title "registered nurse" was prohibited; non-licensed nurses could still provide services as long as they did not call themselves registered nurses. Second, the nursing boards created by these laws were generally not composed exclusively of nurses; in 1938 the boards in seventeen states still included at least one physician. Third, these laws imposed only minimal educational requirements; in 1938 graduation from high school was not a requirement for nursing licensure in nineteen states. Finally, these laws did not define nursing practice; a registered nurse was defined in terms of qualifications—one who had successfully completed the requisite training program and examination—rather than in terms of function.

In a climate of professional and economic competition, state legislatures, nursing boards, courts, and professional nursing organizations are changing the existing nursing practice laws.

The second phase in the development of nursing practice legislation began in 1938 when New York enacted a mandatory licensure statute.[12] During this phase, nurses sought to address the weaknesses inherent in the early registration laws. Additional impetus for change came from hospital administrators, who were then employing increasing numbers of graduate nurses and who recognized that many nursing functions carried out in hospitals did not require the training and expertise of nurses coming from the standard three-year training programs. Thus, the nursing practice legislation of this period is characterized by three main features. First, licensure for nurses was mandatory, rather than permissive. Second, the nurse at another level of nursing practice was recognized—the licensed practical nurse having shorter and less theoretical training than the registered nurse, and functioning with direction and supervision. These two features necessitated the third—statutory definitions of practice for both nursing levels.

The 1938 New York statute, regarded as a model and copied or modified by other states, provided:

> A person practices nursing within the meaning of this article who for compensation or personal profit (a) performs any professional service requiring the application of principles of nursing based on biological, physical and social sciences, such as responsible supervision of a patient requiring skill in observation of symptoms and reactions and the accurate recording of the facts, and carrying out of treatments and medications as prescribed by a licensed physician, and the application of such nursing procedures as involve understanding of cause and effect in order to safeguard life and health of a patient and others; or (b) performs such duties as are required in the physical care of a patient and in carrying out of medical orders as prescribed by a licensed physician, requiring an understanding of nursing but not requiring the professional service as outlined in (a).[13]

The focus of the states on developing statutory definitions of nursing prompted the American Nurses' Association, in 1955, to issue a model definition of nursing practice, which provided:

> The practice of professional nursing means the performance for compensation of any acts in the observation, care, and counsel of the ill, injured, or infirm, or in the maintenance of health or prevention of illness of others, or in the supervision and teaching of other personnel, or the administration of medications and treatments as prescribed by a licensed physician or dentist; requiring substantial specialized judgment and skill and based on knowledge and application of the principles of biological, physical, and social science. The foregoing shall not be deemed to include acts of diagnosis or prescription of therapeutic or corrective measures.[14]

The ANA definition was adopted in its entirety or with slight modifications in twenty-one states.[15] The last sentence of the definition, disclaiming intrusion into the area of medical practice, probably represents a belief that such a statement was politically necessary, although there is no indication of medical opposition to the language of the new practice acts.[16] The disclaimer proved problematic. The language was restrictive, not only for those nurses who were already practicing independently, but also because the model definition did not accurately reflect the nature of nursing practice at the time—nurses in many settings were performing acts constituting diagnosis and treatment.[17] Various mechanisms were utilized to reconcile the discrepancies; the most common was the joint statement, put forth by a committee generally composed of representatives from nursing organizations, hospital associations, and medical associations. Despite the absence of legislative authorization for the joint statements, which typically designated the functions that could be carried out by qualified nurses in specific settings, the statements were generally regarded as authoritative and were relied upon largely without serious challenge.[18]

The gap widened between actual nursing practice and statutory definitions of nursing, as nursing education began to shift from the traditional three-year hospital-based diploma program to the collegiate two-year associate degree and four year baccalaureate degree programs.[19] Furthermore, nursing specialties emerged in various fields, and graduate programs

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for nurses proliferated. In 1970 the American Nurses' Association amended its model definition to take into account the changing role of nursing in health care delivery:

> 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.[26]

This amendment marked the beginning of the third, or current, phase in the development of nursing practice legislation.[27]

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 statutory disclaimer concerning medical practice, has presented obstacles to statutory 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 bore influence, as did the women's movement, advancements in science and technology, and changes in demographic patterns of health care consumers and providers.[27] 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. Four basic approaches have been utilized by the various states.

In one approach, the statutory language authorizes the state's nurse licensing board to promulgate rules and regulations governing specific areas of advanced nursing practice.[28] Some states empower the board to issue regulations only with approval by or in conjunction with the medical licensing board. The second approach is for the statutory language to authorize additional acts by specified advanced practitioners.[29] As of 1983, thirty states provided by statute or regulation for nurse anesthetist practice;[30] forty-two states provided for the practice of nurse-midwifery;[31] thirty-four states made specific reference to nurse-practitioners;[32] and in eleven states there were provisions regarding clinical nurse specialists.[33]

In the third method of sanctioning advanced nursing practice, the statutory language authorizes delegation of responsibilities by physicians to nurses. At least one state—Maine—has included a delegation clause in its nurse practice act;[34] in most other states, delegation by physicians to non-physicians is authorized by custom and usage or by statutory or regulatory provision in the medical practice act.[35] It should be noted that, absent a provision such as that in the Maine nurse practice act, delegation does not change existing law; that is, it does not transform a non-nursing act to a nursing one, as legally defined. The act must be one which is appropriate for delegation and the delegator must select an appropriate delegatee; beyond these guidelines, custom and usage permit physicians to delegate a wide range of medical acts. The delegation method has limited value in recognizing advanced nursing practice. Although a nurse performing a delegated act does so with proper authority, the authority comes from the delegating physician, not from the nurse's status as an independently licensed professional. The method provides a mechanism to allow nurses to perform, totally at the discretion of physicians, acts which they would otherwise be unauthorized to perform, without addressing the larger issue of the appropriate scope of nursing practice.

Legislative efforts to recognize nursing's changing role have been directed primarily to sanction advanced nursing practice by nurse specialists.

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 word broadly a generic nurse practice act which purports to authorize all nursing functions. The basic premise of this approach is that the broad language can be interpreted to cover even advanced nursing practice, which often includes the performance of traditionally medical acts. Thus, enactment of specific legislation authorizing specific nursing roles or functions, in addition to the broadly worded practice act, would not only fail to expand the scope of nursing practice, but would necessarily limit it; by implication, such a specific law would narrow the authority granted by the broad statutory language. A 1983 American Nurses' Association survey reported eight states having no statutory or regulatory language pertaining to advanced nursing practice.[37]

The American Nurses' Association takes the position that developing minimum requirements for practice is the state's function. In contrast, developing guidelines and standards for specialized practice is the profession's responsibility, to be fulfilled by the professional organizations:

> 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

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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.[32]

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

The most recent model definition of nursing put forth by the American Nurses' Association is:

> The practice of nursing means the performance for compensation of professional services requiring substantial specialized knowledge of the biological, physical, behavioral, psychological, and sociological sciences and of nursing theory as 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; the restoration of optimum function; or the achievement of a dignified death. Nursing practice includes but is not limited to administration, teaching, counseling, supervision, delegation, and evaluation of practice and execution of the medical regimen, *including the administration of medications and treatments prescribed by any person authorized by state law to prescribe.* Each registered nurse is directly accountable and responsible to the consumer for the quality of nursing care rendered.[33]

This definition is intended to complement that put forth in a 1980 American Nurses' Association publication, *Nursing: A Social Policy Statement*: "Nursing is the diagnosis and treatment of human responses to actual or potential health problems."[34]

This final approach, while it is the only one which recognizes changes in nursing practice for all nurses rather than only for nurse specialists, has some problems. Nurses relying upon broad statutory language do not always feel confident that their practice will go unchallenged by physicians and, indeed, challenges have occurred.[35] Further, in the current climate of economic competition among health care providers, problems can occur in states where third-party reimbursement for nursing services is available for designated nursing specialties.[36]

Licensing and Certification

The states have employed various methods to conform nursing practice legislation to actual contemporary nursing practice. Two related issues bear mentioning, as they also influence the definition and regulation of nursing practice. These are certification and entry into practice.

Certification of nurse specialists by the various nursing specialty organizations began in 1975, after the American Nurses' Association determined that it did not appropriately fulfill this function.[37] The specialty organizations, as well as sub-groups of the American Nurses' Association, had begun in 1966 to develop standards of practice for the respective nursing specialties.[38] 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.[39]

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 advanced practice obtain certification by the appropriate national nursing specialty organizations.[40] 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 authority of the state and the function of the professional association. The state is not usurping the functions of the professional associations; rather, the state, exercising its power to safeguard the public, is giving statutory recognition, or deferring, to the role of the professional associations.

The issue concerning nurses' entry into practice arose in 1965 when the American Nurses' Association took the official position that professional nurses need baccalaureate preparation to fulfill their role successfully.[41] A target date of 1985 was established, at which time it was expected that the state nurse practice acts would require a baccalaureate degree for license as a registered nurse. In 1974, the New York State Nurses' Association became the first of the ANA state constituent associations to pass a resolution calling for a baccalaureate requirement by 1985. To date, 47 other state nursing associations have passed similar resolutions, although it is clear that none of the states will have legislation or regulations in place by the end of 1985.[42] Resistance to the proposal is strong; the issue has divided nursing as has no other.

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

The third 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 emergence of nursing specialties, the issue may be moot, at least for now. As one commentator has noted, the requirement for advanced education will most likely remain at the specialty level, rather than at the entry level:[43]

> The ideal nurse practice act would include an expanded scope of function for all nurses and provisions for specialists, including nurse practitioners, nurse midwives, nurse anesthetists, and clinical specialists. *The differentiated scope of function for the specialists means that the nurs-*

ing role is being restratified with the development of a specialty level, and that the specialty level is now being certified by the states.[44]

Nursing practice and nursing practice legislation have undergone significant changes since the emergence of trained nurses. This historical examination has shown nursing to be a dynamic, responsive field, rather than a fixed entity. Competing professional, economic, and societal forces continue to affect nursing practice and legislation governing it. Future nursing legislation will reflect the growth in technological skill as well as in autonomy which nurses continue to achieve.

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3. *Id.*
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6. *Id.* at 368–69. Formed in 1847, the American Medical Association promoted medical licensure as a means to raise the level of medical competence; raise standards of medical education; lessen competition from other healers; and increase the power and status of the profession. The first medical practice act, requiring examination and registration, was passed in Texas in 1873; by 1895 all states had passed such registration laws. *Id.* at 365.
7. Eccard, *supra* note 1, at 842, n. 16.
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9. *Id.*
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32. AMERICAN NURSES' ASSOCIATION, THE Rhode Island LEBAR, *supra* note 25, at 12. LEGISLATION (American Nurses' Association, Kansas City, Mo.) (1983) at 3.
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38. *Id.* at 845–46.
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MAY 19 1987

TESTIMONY PREPARED BY:

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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.

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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 <u>is</u> 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

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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.

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- 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;

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- 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.

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Impact of Structural Autonomy Accorded Through State Regulatory Policies on Nurses' Prescribing Practices

Marjorie V. Batey, Ph.D., F.A.A.N.
Jeanne M. Holland, M.S., R.N.

Since the initial contemporary concept of professional nurses as primary care providers (Ford, Seacat, & 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 to 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; Russo, Gururaj, 1975; Cheyovich, 1976). However, studies to date have not examined the range of activities that NPs are qualified to perform (Record, 1979) in part because some acts are 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, 1979), a requirement purported to ensure the quality of the acts performed but that also results in duplication of health care provider effort as well as the supervisory cost being built into patient care costs, and limits the autonomy of NPs.

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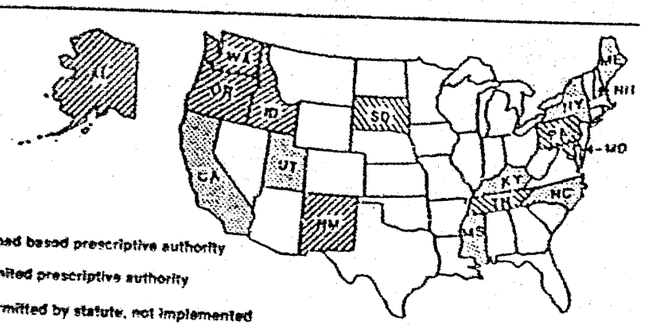

Fig. 1. Distribution of States Granting Prescriptive Authority to Selected Nurse Practitioners, 1980.

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, statutory 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 implemented in 13 of those states through regulation (See Fig. 1). Testimony of public hearings on these regulations has illustrated the philosophic positions and the judgments of special interest groups of nursing, medicine, and pharmacy on why a wide variety of legal constrains 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 underlying preparation for specialized and advanced nursing practice (broad-based authority). Within the broad-based authority states the regulations contain 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 granted prescriptive authority have a supervising M.D. and that prescriptions issued be limited to a drug formulary.

This study examines whether or not the requirements on NP prescriptive authority among the broad-based authority states, and their consequent bearing on the NPs' autonomy, make a difference in the prescribing practices of NPs. In the absence of data, policy decisions on this matter will continue to evolve from philosophic positions of special interests. 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 and cost of health services. To move to more definitive decisions in those areas, data first are needed on prescribing practices.

Authority and Autonomy

Authority is the rightful power to fulfill responsibility (Parsons, 1960; Weber, 1958). Authority derives from at least two sources: expert knowledge and position. Authority of expert knowledge may be granted informally or through formal channels such as professional practice acts via licensure, whereas authority of position usually is vested by virtue of organizational or societal status. Authority from either source is viewed as a precondition to autonomy (Batey and Lewis, 1982).

Autonomy is the "freedom to make discretionary and binding decisions within ones scope of practice and freedom to act on those decisions" (Batey and Lewis, 1982, p. 15). It is seen as having two distinct dimensions: structural and attitudinal (Hall, 1968; Katz, 1968). The structural dimension is the external reality of the freedom (i.e., the objective dimension conferred by a group, organization, or law). This is in contrast to the more subjective attitudinal dimension (i.e., the individual's perception of freedom to decide and to act). Only structural autonomy is considered in this study and only as it relates to the structure defined by state regulatory policy.

The degree of structural autonomy accorded an individual is determined by the limits placed on the discretionary and binding nature of decisions and subsequent actions (Thompson, 1967). Discretionary decision making implies that all relevant options are considered, not just those approved, preferred, or prescribed by others (Batey and Lewis, 1982; F. M. Lewis, 1977). It implies the freedom to explore and to choose among alternatives. The binding characteristic of the decision denotes freedom to make the final choice. This means that, although others may attempt to influence or change the decision, they do not have inherent veto power over it.

The freedom accorded with prescriptive authority of NPs is bounded by the constraints of state statutes or regulatory policies; these vary from state to state. It is presumed that the type of constraints influences the level of autonomy of NPs insofar as it places restrictions on the discretionary and/or binding nature of decisions related to prescribing.

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

Structural Autonomy Level	Legal Constraints: Supervising MD	Formulary	State
1 = Least	Yes	Yes	Idaho
2 = Limited	Yes	No	Alaska & New Mexico
3 = Moderate	No	Yes	Oregon
4 = Greatest	No	No	Washington

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 supervisor and approval by the supervisor of the decisions. Without consistency and approval there exists the implicit threat of withdrawal of the supervisor and, consequently, withdrawal of prescriptive authority until a new M.D. supervisor is obtained. The legal requirement of both a formulary and a supervising M.D. is judged to be the most restrictive and therefore the least autonomous condition, whereas the absence of either requirement is defined as the most autonomous condition. Ranging from least to greatest, the levels of autonomy accompanying prescriptive authority of NPs in the five states included in this study are shown in Table 1.

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

Methodology

The study design is a natural experiment in that the independent variable, structural autonomy, is manipulated by definition through the state regulations of NP prescriptive authority. The dependent variable is prescribing practices, limited in this report to (a) the incidence of prescriptions

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TABLE 2. NUMBER OF PRESCRIPTIONS RELATED TO NUMBER OF PATIENTS FOR TOTAL SAMPLE AND WITHIN AUTONOMY CONDITIONS

	Autonomy Condition: Lowest 1	2	3	Highest 4	TOTAL
Respondents	33	33	38	52	156
Clinic data days	334	326	386	522	1,568
Patients seen	3,995	3,953	4,454	6,490	18,892
Mean patients seen per day	11.96	12.13	11.54	12.43	12.05
Prescriptions given	2,432	2,630	2,939	3,984	11,985
Patients given Rx	1,874	2,029	2,197	2,995	9,095
Ratio of patients given Rx to patients seen	.469	.513	.493	.461	.481
Mean Rx given per day	7.28	8.07	7.61	7.63	7.64
Ratio of total Rx given to total patients seen	.609	.665	.660	.514	.634
Ratio of total Rx to total patients given Rx	1.30	1.30	1.34	1.33	1.32

(b) the repertoire, and (c) the therapeutic categories of drugs prescribed, (d) use of generic as opposed to tradenamed drugs, (e) form in which the prescription was issued, (f) prescription of a new treatment versus a modification of a previous treatment, and (g) NP use of M.D. consultation and referral in relation to prescribing.

Names and mailing addresses of all NPs with prescriptive authority in the five target states were obtained from the relevant board of nursing or board of medical examiners following their review of the proposed study. A letter describing the study and assuring anonymity was sent along with a consent form to that population (401 as of Spring 1981). The data instrument, directions for its completion, and a stamped preaddressed envelope were sent to all who agreed to participate (188, or 46.7% of the population). Several who did not agree volunteered their reasons: 9 individuals said that the policies of their employing organization prohibited prescribing by NPs; 2 NPs refused to use authority until employer "paid salary commensurate with added responsibility"; and 14 were not using their authority to prescribe either because of a holding nonclinical position or because they were on leave of absence. Others may have had similar reasons or they may have found the data provision too time consuming.

The data instrument—a prescription log—contained space to record a number of items: the name of each drug prescribed; whether or not drug product substitution was permitted; whether the prescription was a refill or a modification of a previous one; the form in which it was issued (written, telephone, sample, or oral); and whether or not the NP consulted with an M.D. prior to prescribing or referred client to an M.D. for the health problem underlying the prescription. Data on client age, sex, and health problem for each prescription also were obtained but are beyond the scope of this paper.

The respondents completed the logs by recording the information requested for each prescription issued (legend and over-the-counter products) for 10 clinical practice days. On each day's log they recorded the number of patients seen that day (both 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 left as recorded.*

Drugs were classified into 17 therapeutic categories through use of an adaptation of the Knoben and Wertheimer (1976) system. Their system contains 12 categories: analgesics, antidepressants, anti-infectives, antiobesity, cardiovasculars, cough and cold, diabetics, diuretics, hormones, sedatives and hypnotics, tranquilizers, and unclassified. Adaptations included changing cough and cold to respiratory so as to encompass a broader range of drugs; adding gastrointestinal, immunizations/vaccines, ophthalmics/otics/nasals, and vitamins/minerals categories (taken from Knoben and Wertheimer's unclassified category of drugs); and adding mechanical contraceptives (while not drugs, such items as intrauterine devices require prescriptions). The unclassified category was retained to include such items as anticonvulsants, nonspecific dermatologicals, topical anesthetics, diagnostics, and nonclassifiable products. All drug coding and classification was directed by the pharmacist coinvestigator.

Findings

In this presentation the primary unit of analysis is the prescription, not the cases who provided the data. Data were provided by 156 NPs; their distribution among autonomy conditions is shown in Table 2. The logs contained reports of 11,985 prescriptions issued to 9,095 patients during a total of 1,568 clinical practice days. During the total days 18,892 patients were seen, or an average of 12.05 patients per day. The larger number of respondents in Conditions 3 (N = 38) and 4 (N = 52) over Conditions 1 and 2 (N = 33 each) accounts for the variations shown in Table 2 among autonomy conditions for the number of clinical days, patients seen, patients given prescriptions, and prescriptions issued.

Of the total patients seen, 48% were given one or more prescriptions; across conditions this ranged from 46% to 51%, with the lower proportions occurring for the lowest and the highest autonomy cells. Thus level of structural autonomy did not account for the minor variation. The ratio of total patients seen to total prescriptions was .63, with little variability across the conditions. Of the patients who received prescriptions, the average number per patient was 1.32; this value was essentially constant across autonomy conditions. The latter finding is somewhat fewer than the

1.55 drugs per patient invoice (Rosenberg, Berenson, Kavalar, Gorelick, 1974) and the 1.87 drugs per visit (Koch, 1982) reported among M.D. prescribers.

Of the total 74% (8,867) were prescribed as new drug therapy and 26% (3,118) were for continuation of a previously initiated drug therapy. The highest proportion of new drug therapy (80.2% or 2,108) was found in Condition 2 and the lowest proportion (61.8%, or 1,816) occurred in Condition 3. The lowest and highest autonomy conditions were midrange, 76.2% and 77.6%, respectively. Thus the level of autonomy had no influence on the proportion of prescriptions that were a new as compared to those that were a continuation drug therapy.

A drug product's trade name was used by NPs to record 71% (8,510) of the prescriptions, and its generic name was used for the remaining 29%. McLemore and Koch (1982) found that 71.2% of M.D. prescriptions were by trade name. The use of trade name by NPs was highest in the two lower autonomy conditions (75.4% and 75.5%)—those in which MD supervision was required—and was least in the two higher autonomy conditions (70.1% and 66%). However, generic prescribing can occur either by use of a product's generic name or by use of its trade name plus identifying on the prescription that a pharmacist is permitted to use product substitution when filling it. Examined from this perspective, the data revealed that 56.2% of the total prescriptions could have been filled generically. Across autonomy conditions those proportions were: 1 = 55.3, 2 = 35.3, 3 = 60.9, and 4 = 66.8. Thus, the higher proportions of generic prescribing occurred in the two conditions that did not require M.D. supervision of the prescribing NP. The finding of less generic prescribing in Condition 2 than in Condition 1 suggests that level of structural autonomy is an insufficient explanatory variable.

Legend drugs accounted for 85.5% (10,247) of total prescriptions; an additional 2.96% (335) were for nondrug prescription entities classified as mechanical contraceptives, and 11.54 % (1,383) were for over-the-counter nonprescription drugs. M.D. prescribing has revealed use of 80% legend and 20% over-the-counter drugs (Rosenberg et al., 1974). The NP data, however, are judged to underrepresent their actual over-the-counter prescriptions since eight respondents volunteered comment that they had not recorded over-the-counter drugs, and five had done so inconsistently; the same may hold true for other respondents. The proportion of prescriptions for over-the counter drugs was essentially constant among the first three autonomy conditions (10%, 8.3% and 9.8%, respectively). Within Condition 4 over-the-counter drugs accounted for 15.8% of the total. Whether that finding represents a true higher use of over-the-counter products for drug therapy or a more complete recording of them is unknown.

TABLE 3. PERCENTAGE DISTRIBUTION OF PRESCRIPTIONS IN THERAPEUTIC CATEGORIES BY TOTAL AND AUTONOMY CONDITIONS

	Autonomy Condition: Lowest 1 (2,432)	2 (2,630)	3 (2,939)	Highest 4 (3,984)	TOTAL (11,985)
Anti-Infective	34.93	35.60	25.79	35.44	33.06
Hormone	18.85	20.21	23.28	9.85	17.26
Respiratory	16.74	13.50	7.29	19.01	14.46
Analgesic	4.91	6.40	5.63	11.55	7.61
Vitamin/Mineral	3.25	7.64	7.72	4.42	5.64
Unclassified	3.59	2.31	6.48	3.69	4.06
Gastrointestinal	3.84	2.81	2.07	3.75	3.14
Mechanical Contraceptive	2.23	4.85	4.31	1.16	2.96
Ophthalmic/Otic/Nasal	4.33	2.85	1.43	3.47	2.94
Cardiovascular	1.23	.96	3.90	1.78	2.07
Immunization/Vaccine	2.64	.64	2.92	1.48	1.88
Diuretic	1.20	.98	2.68	2.08	1.78
Tranquilizer	.70	.51	3.76	1.00	1.52
Antidepressant	.87	.13	1.52	.58	.77
Sedative/Hypnotic	.20	.61	.44	.46	.44
Diabetic	.21	.07	.75	.25	.33
Antiobesity	.29	–	.03	.03	.06
TOTAL	100.01	100.00	100.00	100.00	100.00

The legend drug product repertoire is the total number of different drug entities prescribed, determined after trade name products were reduced to generic names. The total repertoire was 443 different drug products for the 10,247 legend drug prescriptions, and 157 products for the 1,383 over-the-counter prescriptions, a relatively small repertoire considering the high number of drug products on the market. The repertoire for legend drugs in the two autonomy conditions in which NP prescriptions were limited to the formulary (1 and 3) was 228 and 239 respectively; it was 209 (Condition 2) and 289 (Condition 4) without the formulary requirement. The largest drug repertoire is noted in the highest autonomy condition; however, this finding may reflect the fact that Condition 4 also had the largest number of respondents and prescriptions represented in the data. Thus repertoire did not vary systematically either with level of autonomy or with the formulary requirement alone.

The classification of prescriptions among the 17 therapeutic categories (see Table 3) shows that 79% of all prescriptions were of five therapeutic classes—anti-infective (33.06%), hormone (17.26%), respiratory (14.46%), analgesic (7.61%) and vitamin/mineral (5.64%). Each of the remaining classes contained 4% or fewer of the total prescriptions. Comparison of this distribution with categories of drugs prescribed by M.D.s (Johnson & Azevedo, 1979; Knoben & Wertheimer, 1976; Koch, 1982; Little & Layton, 1979; Rosenberg et al., 1974) revealed that these NPs prescribed more anti-infectives, hormones, and respiratories and fewer analgesics, antidepressants, diuretics, sedatives/hypnotics, and tranquilizers than did M.D.s. Because of the marked variability among study designs and drug classification systems, a more detailed comparison was not possible.

The rank order of the drug categories within each of the four autonomy conditions is relatively consistent with that of the total. The proportion of total drugs prescribed within the categories do vary across conditions (see Table 3). For example, within Condition 3 a lower proportion of total prescriptions were for anti-infec-

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tives, respiratories, and ophthalmics/otics/nasals, while a higher proportion were for hormones, cardiovasculars, diuretics, tranquilizers, and antidepressants than was so in the other autonomy conditions. By contrast, within Condition 4 proportionately more prescriptions were for respiratories and analgesics and fewer were for hormones and mechanical contraceptives than in the other conditions. However, no systematic variation was found between level of autonomy and proportional incidence of the therapeutic categories of prescribed entities. In a separate analysis, beyond the purpose of this paper, the variation among autonomy conditions for incidence of drugs prescribed was found to be attributable to the distribution of NPs by scope of practice among autonomy conditions and to the consequent age and presenting health problems of their clients. Note in Table 4 that NPs in women's health were overrepresented in Condition 3 and those in family/community health were overrepresented in Conditions 1 and 4.

TABLE 4. SCOPE OF PRACTICE OF NURSE PRACTITIONER RESIDENTS AMONG AUTONOMY CONDITIONS

	Autonomy Condition				
	Lowest 1	2	3	Highest 4	TOTAL
Women's Health	5	13	18	9	45
Adult Practice	-		6	4	10
Family/Community	27	12	7	33	79
Pediatric	1	8	5	5	19
Psychiatric			2	1	3
TOTAL	33	33	38	52	156

Of the total repertoire of 443 legend drugs, only 21 drugs were prescribed 100 or more times. These most frequently prescribed drugs included nine anti-infectives (e.g., amoxicillin, erythromycin, penicillin VK), which accounted for 71.2% of all prescriptions for anti-infectives; six hormones (e.g., orthonovum, LoOvral, Norinyl), which accounted for 66.7% of prescriptions for hormones; and three respiratories (e.g., Dimetapp, triprolidine pseudoephedrine), which accounted for 29.9% of prescriptions for respiratories. Three additional categories each contained one of the most frequently prescribed drugs: analgesics (ibuprofen), vitamins/minerals (ferrous sulfate), and diuretics (hydrochlorothiazide). There was no systematic variation between incidence of specific drugs prescribed and level of autonomy.

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

Autonomy Condition		Consultation Prior to Prescribing N	%[1]	Referral for Same Health Problem N	%	TOTAL N	%
Lowest	1	326	13.4	150	6.2	476	19.6
	2	136	5.2	112	4.2	248	9.4
	3	253	8.5	135	4.5	388	13.3
Highest	4	332	8.3	310	7.8	642	16.1
	TOTAL[2]	1047	8.7	707	5.9	1754	14.6

[1]Percentages are based on total prescriptions issued within autonomy condition.

[2]Total percents = proportions of total prescriptions (N = 11,985).

The form in which prescriptions were issued was reported for 11,652 of them: written, 63.1%; telephoned to a pharmacy, 9.4%; oral (as over-the-counter), 6.4%; and sample, 19.9%. An additional 1.3% were recorded as sample plus written, telephone, or oral. Within the usual meaning of sample, the proportion of prescriptions in this form appears high. However, this finding may have been the result of having insufficient space to record provision of the total quantity of a prescription's product to the client. Several respondents volunteered that they had used "sample" to denote such a provision, a practice often found in state or federal programs for family planning or well child care or for special populations (e.g., migrant workers). Other respondents noted that they had marked "sample" to denote single-dose products prescribed and administered at the practice site (e.g., polio vaccine or benzathine penicillin). Level of autonomy did not influence the form of the prescription.

The final prescribing practice examined was NP use of M.D. consultation or referral. Consultation by the NP with an M.D. prior to prescribing was reported for 8.7% of the prescriptions (see Table 5). The NP referred an additional 5.9% of clients to an M.D. for the health problem for which the prescription was issued. This combined consultation/referral usage (14.6%) is lower than reported in other studies of NPs (Levine, Tangerose-Orr, Sheatsley, Lohr, Brodie, 1979, 32%; Repicky, Mandenhall & Neville, 1980, 21.8%; Sultz, Zielezny, & Matthews, 1980, 33.3%). In this study, however, the unit of analysis for consultation/referral was the prescription, while in the studies cited, it was the patient. For the prescriptions, 85.4% may be assumed to have been based on the independent decision of the NPs. There was no association between level of autonomy and either the use of M.D. consultation or the use of client referral to an M.D. for the health problem underlying the prescription (Table 5).

Summary

The manifest function of regulations that implement nurse practice acts is to protect the safety and to promote the welfare of citizens of the state in relation to their needs for health care as provided by registered nurses. Regulations governing prescriptive authority of NPs in the five states of this study were highly comparable for NP minimum educational preparation and certification in a specialty area of practice. Additional requirements—an M.D. supervisor of a prescribing NP and limiting NPs' prescribing to a drug formulary—were viewed in this study as structural constraints on NPs' performance of the prescribing act. Rather than noting qualifications (expert knowledge) an NP would bring to the prescribing act, they set limits on the NP's discretionary and binding decisions and actions. Such limits suggest that the authority to prescribe derives from a societal status position of nursing. The limited based authority states have placed NP prescribing directly as an extension of M.D. authority. The broad-based authority states that were the focus of this study have placed NP prescribing in the context of an NP's nursing license, but have varied in the level of autonomy that accompanies the authority.

If the structural constraints on the prescribing act of NPs function to protect the safety and promote the welfare of those served, then differences in prescribing practices could be expected under variable application of those constraints. With the exception of the finding of a relatively higher incidence of prescribing generically in the higher autonomy conditions, the prescribing practices analyzed in this study were not influenced by those constraints.

The data reported here do not examine the quality of the prescribing act. For that reason, and in the absence of other normative data on NP prescribing, the practices of these NPs were compared with those reported for M.D.s. They were quite comparable, whether or not a formulary or M.D. supervision was a structural requirement. Given the fact that M.D.s serve as preceptors in NP educational programs and may in other domains of nurse/physician relationships be role models in client assessment, diagnosis, and treatment, this finding is not surprising.

If the requirement of M.D. supervision is to heighten the involvement of a more experienced prescriber (an M.D.) with NP client services, then one might expect to find a higher proportion of consultation where that requirement exists. By contrast, the findings show that both the highest (Condition 1) and the lowest (Condition 2) proportion of consultations prior to prescribing occurred under this requirement. The higher proportions of combined consultation and referral also occurred in the least and the highest autonomy conditions. It is questionable that the colleagial act of consultation/referral can be mandated; rather, use of it would seem to derive from the prudent judgement of a professional, an aspect of discretionary decision making. Use of such judgement would depend less on mandate than on the qualifications of a prescriber.

If the requirement that prescribing be limited to a formulary is to constrain the range of drugs prescribed, then one might expect the NP drug repertoire to be least under that requirement. By contrast, the autonomy conditions that did not mandate a formulary revealed both the smallest (Condition 2) and the largest (Condition 4) legend drug product repertoire.

The finding that 85.4% of all prescriptions were independent of M.D. involvement is consistent with the estimate by Record (1979) that a high proportion of people seeking primary care could be managed by NPs alone. The cost implications are significant in that only a small proportion of clients seen by NPs with prescriptive authority would need to bear the additional fee for M.D. services for obtaining a prescription. Further, only a relatively small proportion of an NP's clients would have to wait on the day of appointment to obtain confirmation of diagnosis and prescription or to make an appointment on a separate date when an M.D. is available. For wage earners, such savings of time is also a cost factor since wages often are reduced for time away from work.

The finding that 56.2% of the total prescriptions could have been filled generically also has cost implications. Generally, generic products cost less than trade name products. However, allowing substitution for a trade name product is insufficient to require a pharmacist to fill the prescription with the least costly product; it only permits this to be done. If cost containment is an NP's goal when allowing drug product substitution, that goal is more likely to be achieved through use of a drug's generic name.

In summary, expanded practice in nursing is requiring states to develop nursing practice regulations on acts that traditionally have been considered the domain of the M.D. This study, through finding that the act of prescribing was not influenced systematically by the level of autonomy represented through regulatory policy, points to the need for systematic appraisal of such policies in relation to the functions they serve. If the goals of public health, safety, and welfare are to be served by nursing regulatory policies, those policies must have the capability of serving those goals.

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December 4, 1987

Martha L. Orr
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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
Francesca C. Hartnett
President
59 Brinkerhoff Street
Plattsburgh, NY 12901
518-563-6109

Needs [illegible] of NPS Survey

[illegible] Tone
certified nurse practitioners
survey of N.P. use graduate schools
students concerns - liability — how will they be able to prescribe

Purpose to Coalition
1. [illegible] [illegible] Opposite future regulations [opine letters - [illegible] [illegible] open
2. Preparation for attacks

Phone Calls
& productivity
legal [illegible]

Broader Billing - include nurse midwives, CRNA
Regional Forum / Education
get nurse practitioners to come out - use components of bills to explain
w/ pro-active — impact of bills

need someone to lead them
push components of bill - why we opposed.
Principles

Educate
Work on Exec

#122 Prescriptive Privileges (12-17-86)

Martha L. Orr, MN, RN
Executive Director

Constituent of The American Nurses Association

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 Kemsley
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:JPM/cl

#122 Prescriptive Privileges (12-17-86)

Martha L. Orr, MN, RN
Executive Director

Constituent of The American Nurses Association

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

May 26, 1987

Ellen M. Burns, President
Board of Directors
New York State Nurses Association
5 Northampton Court, Apt. G
Amsterdam, NY 12010

Dear Ms. Burns:

As the elected Executive Committee for the Functional Unit of Primary Care Practitioners, we feel it is our responsibility to bring to your attention the apparent wishes of our membership and communicate with you some critical issues regarding advanced nursing practice and prescriptive privilege legislation. Your consideration of the needs and concerns of this Organizational Unit will be sincerely appreciated.

At the unit's Annual Business Meeting on November 2, 1986, the bill A.11211C and S.9397B (identical to this years bill A.1412 and S.1314) was thoroughly discussed and a motion was passed with only one "nay" vote, to support this bill as written. Group consensus was that advanced practice authorization and prescriptive privilege statute were essential for the continued growth of nursing in the area of primary care practice and for nurse practitioners to be an efficient, legal, competitive and independent entity. This bill was considered at least functional, and at best, would assist nurses in the competition for "mid-level provider" employment positions.

The consideration of restricting the practice of nursing was discussed, and no nurse, including nurse practitioners, would support restricting the profession. However, this fear was considered by the group to be well addressed by the disclaimer in paragraph c. Thus, the Executive Committee received a mandate from our members to take any appropriate action to assist in the resolution of this critical issue for the practice of nurse practitioners.

We are very pleased that the Board has been working closely with the Task Force for Prescriptive Privileges and hope that it has provided valuable insights. Because of this, we do not feel a lengthy narrative of the historical perspective in this area is necessary. Since

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 NYSNA, the New York State Board for Nursing and the Coalition of Nurse Practitioners, there were common goals defined for prescriptive privilege legislation. These agreed upon 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 compromise and productive negotiation between the nursing groups.

We need nursing unity to advance nursing, including prescriptive privileges. Presently, nurse practitioners are totally dependant 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 NYSNA 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 major differences in 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 in paragraph c would prevent any restriction to nursing. The Association stating that the word "collaboration" would be legally interpreted as "supervision," while the Coalition states collaboration would be interpreted as a "colleague" relationship, and the profession of nursing would not be subject to physician influence. Thus, we seem to be at a standstill once again. There is a great deal of agreement regarding the desired outcomes 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 on the national level. When several nurse practitioner groups were unable to agree on how nurse practitioner needs could best be met, professional 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 NYSNA, the CONP, NYSANA and any other involved nursing organization and a professional, impartial facilitator. We realize this 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.

#122 Prescriptive Privileges (12-17-86)

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

Diane M. Plumadore, BSN, RNC, FNP
Chairman
Functional Unit of Primary Care Practitioners

Judy S. Lynch

Judy S. Lynch, MS, RN, FNPC
Vice Chairman
Functional Unit of Primary Care Practitioners

Mary Eileen Callan

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

DP/BRI/kac

#122 Prescriptive Privileges (12-1786)

seconded. Carried unanimously.

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