Approved: April 7, 1994
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chairperson Joann Flower at 1:30 p.m. on March 17, 1994 in Room 423-S of the Capitol.

All members were present except: Rep. Wells, excused

Committee staff present: Emalene Correll, Legislative Research Department
Norman Furse, Revisor of Statutes
Sue Hill, Committee Secretary

Conferees appearing before the committee:
Carl Schmitthenner, Executive Director of Kansas Dental Association
Dr. Robert Wood,Oral/Maxillofacial Surgeon, Legislative Chair, Kansas Dental Association,
Pat Johnson, Kansas State Board of Nurses
Joseph Conroy, Certified Registered Nurse Anesthetist
Robert L. Goolsbee, M.D., Medical Director, Surgicenter of Kansas City, Kansas
Dr. Taylor Markle, practicing Oral, Maxillofacial Surgeon, Topeka, Kansas
Shirley A. Norris, Kansas Association for the Education of Young Children

Others attending: See attached list

Chairperson Flower thanked everyone for their patience since the House Session worked longer than usual, she welcomed all present, and called the meeting to order at 2:05 p.m. Chair requested Conferees to be considerate of others since there is less time than anticipated, and asked Committee members to limit their questions.

Chair noted, there are some disagreements/problems yet to be worked out on **SB 683.** The Chair appointed a Sub-Committee to work at clarifying concerns/problems before the bill is brought before the full Committee next week to work the bill. She appointed Rep. Freeborn as Chair, with Rep. Scott, Rep VanFleet also serving.

Chair drew attention to **SB 722**, and requested a staff briefing. Dr. Wolff detailed the language, noting this legislation relates to dentists who administer intravenous sedation and general anesthesia in their offices. He detailed the amendments to current statutes 65 1423, that would clarify the authority of a licensed nurse assisting in the administration of the anesthesia under the direct supervision of a licensed dentist, also clarifies the role of a registered anesthetist for giving anesthesia for a dental procedure. 65 1444 is amended to authorize licensed dentists to administer intravenous sedation and general anesthesia subject to the qualification for such procedures as to be established by the Kansas Dental Board. The Senate Committee amendment is a grandfather clause, bottom of Page through the top of page 3. He detailed this language.

HEARINGS BEGAN ON **SB 722.**

Carl Schmitthenner, Executive Director of the Kansas Dental Association (KDA) gave background information on the request for this legislation. This concept has been under review by the KDA for nearly 7 years in consultation with practitioners who stand to be affected by the changes including the Kansas Society of Oral/Maxillofacial Surgeons. See (Attachment No. 1) He then introduced Dr. Wood.

Dr. Robert Wood, Oral/Maxillofacial Surgeon, and legislative Chair of KDA, offered hand-out, (Attachment No. 2). Rules and Regulations set out by the Kansas Dental Board would specify guidelines for pre-operative patient evaluation, proper monitoring devices, and availability of essential emergency equipment and medications. The provisions for delegation of duties are consistent with the Nurse Practice Act. There is a grandfathering clause for educational training for those that have a proven record of quality and safe administration of office intravenous anesthetics. Currently 47 states regulate office anesthesia. This legislation is a positive step to assure continued delivery of quality dental care and office anesthesia.

Pat Johnson, Executive Administrator, Kansas State Board of Nursing, (Attachment No. 3) stated support for the amendments contained currently in **SB 722.**

Joseph Conroy, Certified Registered Nurse Anesthetist, representing the Kansas Association of Nurse Anesthetists, (Attachment No. 4), stated their Association members believe all providers of anesthesia services should meet standards adopted by their respective licensing boards that specify education/training requirements necessary to qualify an anesthesia provider. He noted procedures, drugs, and agents used constantly are changing. As new drugs are introduced, their benefits may be enormous, so there is the potential for harm if administered incorrectly by an inexperienced provider. He detailed the educational requirements. He noted they were pleased to be involved in writing the language appearing in **SB 722** ,Sec. 1, (b) that makes the language consistent with the nurse practice act and the statutes governing the administration of anesthesia by Registered Nurse Anesthetists. He urged support.

Dr. Robert L. Goolsbee, Board Certified Anesthesiologist, drew attention to pertinent articles in his hand-out, (Attachment No. 5). He stated he firmly supports Nurse Practitioners (NPs) joining in a collaborative practice arrangement with physicians. This could potentially increase access to health care for patients in underserved areas, but does not need to be limited to such areas. He drew attention to "Guidelines" enclosure in the hand-out. General Dentists have had excellent experience in administering "awake sedation" for the local anesthetic for short procedures. Now there are changes in the complexity of surgical procedures by Oral Surgeons, (Cosmetic), and General Dentists, (Dental Implants). As these procedures have moved into more complicated and painful procedures the pressure amounts to slip into using unconscious general anesthesia. He believes this should not be allowed. He detailed existing requirements (current law) for patients undergoing general anesthesia for surgical procedures, and stated these same procedures should be required before general anesthesia in any environment. Dentists are not qualified to supervise nurse anesthetists, much less untrained nurses. Anyone administering a general anesthetic should meet the same requirements for an ambulatory surgery center. Physicians (including Anesthesiologists) pride themselves in continuing to improve and upgrade the practice of medicine. Anesthesiologists in particular being in the forefront in establishing standards of practice, guidelines for certain procedures (such as management of the difficult airway, etc.), and requiring post graduate education. We should continue to insist on a collaborative practice.

He asked, how can you "grandfather" in untrained Dental Anesthetists? He does support the basic concept of **SB 722**, that would allow dentists to upgrade.

Dr. Taylor Markle, a practicing Board Certified Oral and Maxillofacial surgeon offered hand-out (Attachment No. 6), but did indicate his verbal comments were in response to Dr. Goolsbee's testimony in regard to existing law requiring a physician evaluate the health of a patient undergoing general anesthesia for general surgery performed by a dentist, oral surgeon, or a podiatrist. Dr. Markle stated, he is associated with four hospitals in the Kansas City area, and under the definition of a physician is a M.D., a DES, or a DO, and he is required to do all histories and physicals on all his patients. He does agree with Dr. Goolsbee that anyone who administers general anesthetic in their office should meet the same requirements as is required in an ambulatory surgery center. There are currently full surgery offices that are established and that meet required criteria.

Numerous questions were asked. No, there have been no problems related to this issue, however, as a pro-active measure, dentists wish to insure continued safety, thus, the reason for requesting this legislation. It was noted this legislation will simply codify what practices have been taking place for about 40 years.

At this time Chair drew attention to other attachments.

Fiscal note on **SB 816** is recorded as (Attachment No. 7.) Written testimony from Mrs. Sharron Watson who gave testimony yesterday on **SB 683** is recorded today (again) as (Attachment No. 8). Recorded as (Attachment No.9) written testimony from Kansas Association of Osteopathic Medicine related to **SB 759 .**

Chair drew attention then to **SB 615.** A Sub-Committee had been appointed to work on concerns prior to the meeting of the full Committee in order to save time.

Rep. Samuelson called attention to **SB 451** which has been merged (amended) into **SB 615**. She explained. She noted several hours have been spent studying these proposals, staff members did a lot of research to clarify which proposals were in **SB 615,** and were not in **SB 451.** Rep. Samuelson stated, she and Chairperson Freeborn were both familiar with **SB 451**, as they both served on the Joint Committee on Children and Families. In addition to some updating language, there were a lot of policy changes, particularly as related to registered day care homes.

SB 615 -- SB 451 continued:

Rep. Samuelson continued, it is the feeling now of the Sub-Committee, these issues need more study. She stated the Sub-Committee recommends language in **SB 451** as a substitute for **SB 615.** Dr. Wolff made copies of **SB 451** available to members as discussion ensued. Rep. Samuelson pointed out the focus to providing access to affordable child care. The language changes, i.e., "boarding home for children" has been changed to "facilities for the care of children", and the number of children being cared for in a home is reduced from six to four. It was noted there would be time for continued discussion and questions after conferees had presented their testimony.

Chair thanked the Sub-Committee and staff members for all their hours of hard work on this issue.

HEARINGS BEGAN ON **SB 615.**

Shirley Norris, (Attachment No. 10) , stated her testimony was based on **SB 615**, perhaps now moot since the language in **SB 451** is being used. She stated there is nothing about **SB 451** that the Kansas Association for the Education of Young Children would find objection to. However, they do take issue with reducing the number of children in care from six to four. They do support reducing the upper age level to twelve years of age. She spoke to the issue of licensing fees, noting the proposed amendment regarding this issue would correct the inequity that a center with a capacity of 250 pays the same as a center who may have the capacity of only 40. It is their understanding, the additional funds generated would be used as recommended in the Joint Committee Report to improve automation of the licensing process, and Kansas Association for the Education of Young Children supports this recommended change also.

Carolyn Hill, Adult Services for the Department of SRS was unaware until the present time that **SB 451** was under consideration. Chairperson Flower offered her more time to study **SB 451** before making her comments.

Chris Ross-Baez, Director of Child Care Licensing/Registration, Department of Health/Environment noted her written testimony was based on **SB 615.** She would be happy to have it distributed, but noted it was moot. She has reviewed **SB 451**, and noted policy changes that involves the registration program requires that registration meet the health, safety, and welfare of the children, and that the Department has enforcement action so that they can revoke a license of a facility has violated requirements, and that the Department can adopt rules and regulations for the health, safety, and welfare of children. Since **SB 615** is their Agency bill, they would prefer to go with it, but they have substantially agreed with the changes in **SB 451,** so-----. She noted there would be a hefty fiscal note, i.e., $200,000 if registration is reduced from six children to four. She explained, i.e., if this was put back to six children, it wouldn't change the "registered homes" to "licensed homes". A big concern with **SB 451**, is that it does change the definition of "maternity hospital and maternity homes". The definition in **SB 451** is a "maternity center". The Department views "maternity center" as a birthing center, not a home that is a residential facility. They would request that **SB 451** include the definition of "maternity homes". She detailed rationale. If Committee does in fact go with **SB 451**, the Department requests the opportunity to have **SB 615** and the policy changes in it reviewed, perhaps in Interim Committee or perhaps at some other date, so that they can discuss more thoroughly the policy changes. It is the belief of the Department that some of the changes in **SB 615** are positive changes for children.

Noted: Rep. Samuelson stated, the Sub-Committee did discuss the issues brought forth from the Department of Health/Environment and it is also their view, these issues could be discussed further in Interim. The ultimate decision of course would be up to Speaker Miller.

Melva Hoffman, a foster parent who now has had her concerns answered regarding the open records stated she and the others listed as members of the Foster Parent Group would not need to give testimony. This issue is located in **SB 615, Section 21.**

Ms. Hill, Adult Services for the Department of SRS, stated the Department could generally now support the bill, however, she would like to address the $5.00 fee. It is their opinion, this does need to be set. Children cannot be left in unlicensed homes.

Questions were asked of several of the conferees, i.e., regarding different fee schedules; immunization records must be kept by the care giver; personal exemptions, medical exemption, religious exemptions regarding immunizations; terminology used generally in statutes regarding "boarding home for children" was detailed by Ms. Correll.

Ms. Correll stated, one of the major differences between **SB 615** and **SB 451** since child care licensing laws were put in place, a generic term has been used " boarding home for children" which is known today as day care homes; group day homes; family day care homes; etc. The Agency has created other categories by rules and regulations. The legislation did not specify what kind of place, what kinds of people, or age groups. One of these groups established was called "attended care". **SB 615** would have taken those rules and regulations on different categories and put them into the statutes, thereby losing a lot of flexibility.**SB 451** continues the current policy, using the generic policy, allowing the Agency to have the sub-categories they now have, or to change if needed, still allowing the Legislature to have an opportunity to overview and to make changes if desired.

Discussion held on the exemptions for inoculations; the record keeping by the care provider; records being kept on children that are brought on a drop-in basis.

HEARING CONCLUDED ON **SB 451 AND 615.**

Chair inquired if there was any objection to discussion and action being taken on **SB 722.** There was no objection.

Rep. Freeborn moved to pass **SB 722** favorably, seconded by Rep. Swall. A short discussion ensued. It was noted the Dental Board is to provide requirements for continuing education. The grandfather clause was discussed. Vote taken, motion carried.

Meeting adjourned.

The next meeting is scheduled for March 21, 1994.

VISITOR REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

DATE March 17, 1994

NAME	ORGANIZATION	ADDRESS
TAYLOR L. MARKLE	KANSAS SOCIETY OF ORAL & MAXILLOFACIAL SURGEONS	SHAWNEE
JOSEPH P. CONROY	KS ASSOC NURSE ANESTHETISTS	EMPORIA.
Carl Schmitthenner	K. Dental Assn	Topeka
Carol Macdonald	Kan Dental Board	Topeka
E Eugene Stephens	SRS/DMS	Topeka
E.J. Dorsey M.D.	KSAFAP	WAMEGO
Coral Joan Gaylor	KSAFAP	Concordia
Kenny Sutton	KSAFAP	ST. GEORGE, KS
Sara Bates	KSAFAP	Manhattan KS
Cindy Lohrding	KSAFAP	Coldwater, KS.
Donna Hoffman	KSAFAP	Kansas City, KS
Janet Schalansky	SRS/WD	Topeka
Shirley Morris	KAEYC	Topeka
Robert L Goolsbee MD	Surgicenter	Mission Hills
Mary Ellen Conlee	St. Francis Reg. Med. Center	Wichita
Bob Lampe	KS Com on Fit & Sp	Topeka
Carolyn Risley Hill	SRS	Topeka
Robert Wood	Kansas Dental Association	Topeka
ALAN COBB	Delta Dental	WICHITA

KANSAS DENTAL ASSOCIATION

Statement on S.B. 722
by Carl C. Schmitthenner, Jr.
March 17, 1994

Madam Chair and members of the Committee, I am Carl Schmitthenner, Executive Director of the Kansas Dental Association. I appreciate the opportunity to appear before you today.

S.B. 722 was introduced at the request of the Kansas Dental Association. The bill provides the Kansas Dental Board with the authority to develop appropriate qualifications for dentists who administer intravenous sedation and general anesthesia in their offices.

This concept has been under review by the KDA for nearly seven years in consultation with the practitioners who stand to be affected by the changes, including the Kansas Society of Oral and Maxilofacial Surgeons.

Despite the extensive discussion process over a number of years, concerns were raised in the Senate Public Health and Welfare Committee that resulted in the amendments you see before you. The KDA believes that no further amendment is necessary to carry out the intent of this bill -- to ensure the continued safe in-office administration of IV sedation and general anesthesia.

With me today to discuss the substance of S.B. 722 is Dr. Robert Wood, KDA Legislative Chairman. Dr. Wood is an oral and maxilofacial surgeon here in Topeka. Thank you.

5200 Huntoon
Topeka, Kansas 66604-2365
913-272-7360

PH+W
3-17-94
attm #1

Statement by Robert Wood, D.D.S.
Senate Bill 722
March 17, 1994

Madam Chairman, Members of the Committee,

I am Dr. Robert Wood. I am an oral and maxilofacial surgeon in Topeka. I am a member of the Kansas Society of Oral and Maxillofacial Surgeons. I am Chair of the Legislative Committee of the Kansas Dental Association.

The mission of the Kansas Dental Association is to promote the public health, advance the art and science of dentisty and to foster an awareness of the obligation and responsibilities of the dental profession to the citizens of Kansas.

The Kansas Dental Association and the Kansas Society of Oral and Maxillofacial Surgeons support Senate Bill 722.

This bill would allow the Kansas Dental Board to adopt appropriate rules and regulations to establish the qualifications for dentists who administer in-office intravenous sedation and general anesthesia.

Among other things, these regulations would specify quidelines for pre-operative patient evaluation, proper monitoring devices, and availability of essential emergency equipment and medications.

The provisions for delegation of duties are consistent with the Nursing Pratice Act. There is grandfathering for education training for those that have a proven record of quality and safe adminstration of office intravenous anesthetics.

Currently, there are 47 states that regulate office anesthesia. This legislation is a positive step to assure the continued delivery of quality dental care and office anesthesia for the citizens of Kansas.

PHCW
3-17-94
Attm #2

Kansas State Board of Nursing

Landon State Office Building
900 S.W. Jackson, Rm. 551
Topeka, Kansas 66612-1230
913-296-4929
FAX 913-296-3929

Patsy L. Johnson, R.N., M.N.
Executive Administrator
913-296-5752

To: The Honorable Representative Joann Flower, Chairperson and Members of the Public Health & Welfare Committee

From: Patsy L. Johnson, R.N., M.N.
Executive Administrator
Kansas State Board of Nursing

Date: March 17, 1994

Re: SB 722

The Board of Nursing is supportive of all groups of health care practitioners who take an active role in maintaining high standards of practice. The amended language in K.S.A. 65-1423 (b) (pg. 1, lines 21-30) clears up a conflict with K.S.A. 65-1163 (e) in the Registered Nurse Anesthetist Act. See attachment. The total responsibility for the anesthesia is held by the dentist, but part of the administration of the anesthesia are tasks which nurses are educated to perform. Performance of the tasks under the direct supervision of the dentist allows the dentist to continue with the dental procedure while maintaining adequate anesthesia for the patient.

The licensed nurse would still be responsible for his or her own competence in any of the procedures being carried out under the direction of a dentist.

Thank you.

I will be glad to answer any questions.

PH+W
3-17-94
attm #3

Janette Pucci, R.N., M.S.N.
Education Specialist
296-3782

Patricia McKillip, R.N., Ph.D.
Education Specialist
296-3782

Diane Glynn, R.N., J.D.
Practice Specialist
296-4325

Mark S. Braun, J.D.
Assistant Attorney General
Disciplinary Counsel
296-4325

65-1163. Application of act. (a) Nothing in this act shall prohibit administration of a drug by a duly licensed professional nurse, licensed practical nurse or other duly authorized person for the alleviation of pain, including administration of local anesthetics.

(b) Nothing in this act shall apply to the practice of anesthesia by a person licensed to the practice medicine and surgery, a licensed dentist or a licensed podiatrist.

(c) Nothing in this act shall prohibit the practice of nurse anesthesia by students enrolled in approved courses of study in the administration of anesthesia as a part of or incidental to such approved course of study.

(d) Nothing in this act shall apply to the administration of a pudendal block by a person who holds a valid certificate of qualification as an advanced registered nurse practitioner in the category of nurse-midwife.

(e) Nothing in this act shall apply to the administration of a licensed professional nurse of an anesthetic, other than general anesthesia, for a dental operation under the direct supervision of a licensed dentist or for a dental operation under the direct supervision of a person licensed to practice medicine and surgery.

History: L. 1986, ch. 183, § 13; L. 1988, ch. 246, § 15; July 1.

PH+W
3-17-94
Attm# 3-2
Pg 2 of 2

KANSAS ASSOCIATION OF NURSE ANESTHETISTS

March 17, 1994

Representative Joann Flower
Chairperson, House Public Health and Welfare
State Capitol Building
Topeka, Kansas 66612

Representative Flower and members of the Committee,

My name is Joseph P. Conroy, a Certified Registered Nurse Anesthetist from Emporia, Kansas. representing the Kansas Association of Nurse Anesthetists. This letter is in reference to Senate Bill 722, relating to the administration of intravenous sedation and general anesthetics for dental operations.

The KANA strongly supports S.B. 722. Our association believes that all providers of anesthesia services should meet standards adopted by their respective licensing boards that specify educational and training requirements necessary to qualify as anesthesia providers.

The drugs and agents we use in anesthesia change constantly. As new drugs are introduced, their benefits may be enormous but so can their potential for harm is administered incorrectly by an inexperienced provider.

The minimum qualifications for nurse anesthesia is 2 years of post-graduate study in an approved school, passage of a national certifying exam, 40 hours of continuing education every 2 years and authorization by the State Board of Nursing.

The KANA is also pleased to have been able to work with the Kansas State Board of Nursing and the oral surgeons to write language for Section 1., part (b), that would make this bill consistent with the nurse practice act and the statutes governing the administration of anesthesia by Registered Nurse Anesthetists.

In the interest of improving public safety, the Kansas Association of Nurse Anesthetists encourages your support for this bill.

Thank you for your time.

Joseph P. Conroy

Joseph P. Conroy B.A., C.R.N.A., A.R.N.P.
2614 Apple Drive
Emporia, Kansas 66801
316-342-0856

P H+W
3-17-94
attm. #4

KANSAS ASSOCIATION OF NURSE ANESTHETISTS

K.S.A. 65-1162, (a):

Except as otherwise provided in K.S.A. 1991 Supp 65-1151 to 65-1163, inclusive, and amendments thereto any licensed professional nurse or licensed practical nurse who engages in the administration of general or regional anesthesia without being authorized by the board to practice as a registered nurse anesthetist is guilty of a class A misdemeanor.

K.S.A. 65-1163, (e):

Nothing in this act shall apply to the administration by a by a licensed professional nurse of an anesthetic, other than general anesthesia, for a dental operation under the direct supervision of a licensed dentist or for a dental operation under the direct supervision of a person licensed to practice medicine and surgery.

PH+W
3-17-94
attm# 4-2
pg 2 of 2

Thursday March 17, 1994 1:30pm

House Public Health Committee

Senate Bill 722

Robert L. Goolsbee, M.D.
Mission Hills, KS
Board Certified Anesthesiologist
Medical Director Surgicenter of Kansas City
(816) 523-0100 Office
(913) 362-5619 Home

Chairman Flowers - other members of the Public Health Committee and staff.

Thank you for the opportunity to address some of the issues involved in Senate Bill 722. My remarks will be brief. I have included copies of pertinent articles relative to some of the issues.

I want you to understand that I firmly support NP's (Nurse Practioners) joining in a "collaborative practice" arrangement with physicians. This could potentially increase access to health care for patients in underserved areas but does not need to be limited to such areas. See "Guidelines" enclosure.

We are seeing a change in the complexity of surgical procedures performed by Oral Surgeons (Cosmetic) and General Dentists (Dental Implants).

General Dentist have had an excellent experience administering "awake sedation" and local for short procedures. As they move into longer, more complicated (painful) procedures the pressure mounts to slip into unconscious general anesthesia. This should not be allowed.

In a hospital or Surgical Center environment existing law requires a physician to evaluate the health of a patient undergoing general anesthesia for surgical procedures performed by a Dentist, Oral Surgeon, or Podiatrist. This should be required before general anesthesia in any environment. Dentists are simply not qualified to supervise nurse anesthetists much less untrained nurses.

We have seen problems in Kanses with nurse midwives practicing without physician supervision. We should continue to insists on "Collaborative" practices. See "Nurse Practioner Redux."

If anyone administers a general anesthetic the facility should meet the same standards established for ambulatory surgery centers. The risk of general anesthesia is the same for minor dental procedures. Most of the regulations in place today in surgical centers deal with anesthesia problems because the risks of anesthesia (cardiac arrest, brain damage, death) far exceed the risks of most surgical procedures (bleeding, infection, etc.).

PH&W
3-17-94
attm #5

Physicians (including Anesthesiologists) pride themselves in continuing to improve and upgrade the practice of medicine. Anesthesiologists in particular have been in the forefront in establishing standards of practice, guidelines for certain procedures (such as Management of the Difficult Airway, etc.), and requiring post graduate education.

How can you "grandfather" untrained Dental Anesthetist.

PH+W
3-17-94
attm #5-2
~~pg 2 of 12~~

Nurse Practitioner Redux

FOR those of us who were involved with the early nurse practitioner (NP) movement, the recent expansive embracing of advanced practice nurses is at once gratifying and thought provoking. It will be interesting to see if history repeats itself and NPs will continue to provide only a small proportion of primary care to Americans. I hope this will not be the case and that NPs soon will play a significant role in primary care. To assure the success of NPs, we might learn some valuable lessons from history.

History

As a nurse who had gone on to medical school and training in general pediatrics, I held the firm belief that the maldistribution of health care in this country could be resolved if nurses, with additional clinical training, would work with physicians as teams providing primary care. The work of Drs Henry K. Silver (a physician) and Loretta C. Ford (a nurse)[1-3] confirmed that belief, and I joined the group of nurses and physicians who spent much of our time in the 1970s educating and training physicians and NPs to work together. Unfortunately, the task was not easy because organized nursing at first rejected the idea of physicians teaching nurses skills, such as physical assessment and the diagnosis and treatment of minor illnesses, that previously fell in the domain of medicine. Such programs were viewed as plans by the American Medical Association to convert nurses into medics.[4] To further complicate the matter, many physicians were threatened by the concept of nurses' expanding their practices to include what traditionally had been "medicine."

The major impetus for the utilization of NPs came from overburdened physicians who provided health maintenance and curative care to children and from nurses' frustration with poor access to care for patients. The basic concept was an extension of public health and office-based nursing, and the belief was that with more education and training, nurses could provide greater access to primary care for underserved populations. In 1963, Siegel and Bryson[5] reported that public health nurses in California had assumed much of the responsibility for scheduled health maintenance visits in the first 6 years of children's lives. The role of the public health nurse was educational and supportive and involved only inspection with no full physical examinations being performed. These nurses managed history taking and counseling and referred illnesses or unusual situations to the pediatricians with whom they worked closely. By the late 1960s, the concept was widely applied throughout the state. A number of other reports involving public health and office-based nurses were published during the 1960s,[6-10] but the first formalized training program was that described by Silver and Ford.[1-3]

In 1971, a report of the secretary of health, education, and welfare's committee examining extended roles for nurses outlined the functions for which nurses, with additional preparation, could be responsible. In the letter of transmittal to then-secretary Elliot L. Richardson, the chair and co-chair of the committee wrote, "Nurses in extended roles are crucial if President Nixon's goal of making health care available to all our citizens is to be reached."[11] Twenty years later, a similar statement has been made for President Clinton's goal.

While pediatrics had taken the lead, other nursing educational programs designed to meet the shortage of primary health care providers for adults and families were developed in the early 1970s. These included a program called Primex for family NPs,[12] and associate programs for adult NPs. Terminology and conceptualization were not well delineated for the various programs, and training requirements varied widely. In an attempt to solve these problems, at least for pediatric NPs (PNPs), the American Nurses Association and the American Academy of Pediatrics issued a joint statement in 1971 defining the concept of the pediatric nurse associate (NPs) and establishing guidelines for short-term continuing education programs.[13] Unfortunately, the joint venture between organized nursing and pediatric medicine did not reach fruition, primarily because of a disagreement on control of PNP practice. This issue remains a major point of argument between organized medicine and nursing and was the impetus for my writing this Commentary.

While the American Nurses Association developed the first certifying examination for PNPs, many PNPs subsequently formed their own group, the National Association of Pediatric Nurse Associates and Practitioners. This group has remained closely aligned to organized pediatrics, and until early 1993, the American Board of Pediatrics provided administrative support for the PNP certification examination compiled by the nurses.

From the School of Medicine, Johns Hopkins University, Baltimore, Md.
Reprint requests to the Office of the Dean/Academic Affairs, School of Medicine, Johns Hopkins University, 720 Round Ave. Room 106, Baltimore, MD 21205-2196 (Dr DeAngelis).

directory of training programs and a registry of program graduates for PNPs were established, and 24 programs and 200 PNPs were listed in 1971.[14] By 1974, more than 1100 PNPs had graduated from the 50 programs in existence at that time.[15] The number of programs and graduates for family and adult NPs also expanded, but they were not as proliferative as those for PNPs. By 1978, the American Nurses Association Department of Statistics estimated that there were 12 000 NPs of all types.[16]

As the number of NP programs grew, it was essential to address the issue of effectiveness and appropriateness of care. A number of early studies provided some data,[14,17,18] but the study that offered the best evidence on the "effectiveness and safety" of NP practice was the Burlington randomized trial on health outcomes of patients.[19] The study involved 1598 families randomly assigned to a traditional family physician group or to an NP group working in consultation with physicians. Each NP was assigned half as many patients as the physicians. The quality of care provided by each group was assessed quantitatively by evaluating outcomes in 10 indicator conditions and the prescription of 13 common drugs. The results showed that NPs were able to safely and effectively manage 67% of their patient visits without physician consultation. The remaining 33% of the patients were appropriately referred to physicians for management. This Canadian study has been widely cited as indicating the safety and effectiveness of NPs, and to this day it remains the best designed and recorded study of its kind. In fact, none of the publications on NPs since then and none performed in the United States involves a well-designed, randomized, comparative study.

One might have thought that with all the momentum of the late 1960s and 1970s, the NP movement would have steamrolled, that NPs would be working as part of health care teams throughout the country, and that the issue of insufficient and/or maldistributed generalists would not exist. However, the early momentum stalled for probably some of the same reasons that generalist physicians did not proliferate. So here we are again with another president (and his wife) attempting to solve the nation's health care problem, and nurses in expanded roles again are expected to play a vital role. However, important issues, including numbers, practice location, cost-effectiveness, and scope of practice, must be addressed so that organized medicine and nursing will work together to assure success.

Numbers

An advanced practice nurse is a nurse who has had advanced education and has met clinical practice requirements beyond the 2 to 4 years of higher education required for all registered nurses. While currently there are more than 100 000 advanced practice nurses, like physicians the majority of them do not function as generalists. According to a recent national survey of registered nurses,[20] there are approximately 58 000 clinical nurse specialists with master's degree preparation, 26 000 nurse anesthetists, and 5000 certified nurse midwives. With rare exception, all of these nurses are hospital based and work primarily with inpatients. There are 21 000 NPs currently employed in nursing and an additional 5700 not employed in nursing. Approximately two thirds of the NPs have received advanced education and training in 9- to 12-month certificate programs and one third in 2-year master's degree programs.[20] While master's degree programs for NPs did not proliferate until the late 1970s, a total of 114 master's level and 26 certificate programs for NPs were in existence as of July 1993.[21] By comparison, there are 23 000 practicing physician assistants (PAs)[22] and 55 programs for PAs.[23] Physician generalists (family practitioners, general internists, and general pediatricians) constitute approximately one third, or 200 000, of all physicians (about the same proportion of NPs to advanced practice nurses). Stated another way, physician generalists currently comprise approximately 10 times the primary health care workforce as do NPs.

It will be interesting to observe what happens during the next decade or so as programs to stimulate more generalist physicians, NPs, and PAs take effect. While there are currently insufficient numbers of all generalist types, it is difficult to determine exactly how many of each type are needed. For example, in addition to remuneration, lifestyle, and other issues, one reason the number of physician subspecialists might have expanded so greatly in the past few decades is that generalists have readily referred patients to them because of time constraints. That is, if a generalist physician must spend 1 hour or more evaluating and treating one patient, he or she would be unable to meet the needs of the other three or four patients who could have been seen in that time. Also, with current reimbursements to generalists, spending that much time with one patient on a recurrent basis would not be financially feasible.

When physicians and NPs work as a team, the NPs can effectively care for patients who require health maintenance or health education or who have minor illnesses, and the physician is free to see the more seriously ill or medically complicated patient. Because this sort of practice currently is the exception, no data are available to assist in the determination of how many generalist physicians and NPs would be needed to provide primary care as teams.

Practice Location

The geographic maldistribution of health care in the United States is predicted to be lessened by NPs, but it is unreasonable to expect that they would provide care in rural areas to any greater extent than physicians. Generally, physicians do not practice in rural locations where they must be on call constantly, have few professional colleagues with whom to interact, and have spouses who cannot find suitable jobs. Nurse practitioners have reacted the same way. Some evidence to support this is that certificate-trained NPs are about three times (19% vs 7%) more likely to practice in rural areas compared with master's-prepared NPs.[24] The proportion of either type is not very high. However, physicians and NPs practicing as teams in rural areas could allow for more free time and for more professional colleagues. The team, rather than any individual clinician, is the key to rural practice.

Cost-effectiveness

The amount of actual cost savings to the health system that NPs can provide is not clear. According to Brown and Grimes'[25] recent meta-analysis of care, outcomes, and cost-effectiveness of nurses in primary care roles, NPs spend 25 minutes and physicians spend 17 minutes, on average, with patients. Stated another way, NPs spend about 50% more time per patient. In addition, a physician's hourly work week is approximately 60 hours[26] compared with the 40 hours worked by NPs. However, a generalist physician earns about twice as much in salary as an NP. Roughly, that translates to equal

per patient visit. Claims have been made that cost savings occur because NPs order fewer tests and pay lower malpractice fees. These differences probably result from the difference in patient case mix seen by NPs and physicians. No studies have been published that compare NPs with physicians using randomly assigned patients and controlling for differences in patient acuity to determine diagnostic tests ordered or overall cost per visit.

As they currently practice, NPs generally are effective providers of health maintenance and acute care to patients with common, minor illnesses and to those with certain chronic illnesses that require close monitoring of routine tests, education, and encouragement. Thirty-eight studies attesting to the effectiveness are included in the meta-analysis by Brown and Grimes.[25] However, almost all of these studies were performed in managed care and university-based clinics, which involve collaborative practice. There are no published randomized patient studies that show NPs, working independently, provide more cost-effective care to patients than physicians. However, in a collaborative practice, the NP can spend more time with patients and effectively manage their basic needs, and the generalist physician is free to care for patients with more complex medical problems. The result is very likely to be a more cost-effective team.

Scope of Practice

The major issue that threatens physicians and NPs working collaboratively is defining the scope of practice of NPs, that is, defining the difference between nursing, as practiced by an NP, and medicine, as practiced by a physician. The issue of independent nurse practice (ie, undertaken without outside physician control) is the crux of disagreement between organized nursing and medicine. Nurse practitioners originally were taught by physicians to perform physical examinations and to care for minor illnesses, both of which had been the realm of medicine. However, although NPs have assumed some traditional medical responsibilities, their major focus of training and the orientation of their practice differs from that of physicians. Their independence resides in their orientation and training. Currently, most NP training and education involves 6 years, including 4 years of college and 2 years in a master's program. The orientation is centered in nursing, which emphasizes the total needs of the patient and family, teaching and counseling, and maintaining health. By contrast, generalist physicians have at least 11 years of education and training, including 4 years of college, 4 years of medical school, and 3 years of residency. Their orientation is primarily toward the diagnosis and management of illness, which requires education and training far beyond what comprises the education and training of NPs.

The essence of any scope of practice is public safety. Nurse practitioners work primarily with relatively healthy populations or those with stable, chronic diseases, and most visits are centered around health promotion and maintenance. A number of studies have shown that NPs prescribe a very limited number of relatively simple medications to predominantly healthy populations.[27-29] This is as it should be since NPs are not trained extensively in pharmacology and physiology. The major distinction between NPs and physicians lies in the range of services they are capable of providing. Specifically, the difference is the physician's ability to diagnose and manage complex medical problems requiring medical intervention and the NP's ability to teach and counsel about health maintenance.

Even if NPs manage approximately two thirds of the patients in practice settings, as described in the Burlington study,[19] the other patients will require consultation with or direct care from physicians. Those are the patients that require the expertise of a clinician educated and trained in medical school and residency. Further, although NPs may be able to manage two thirds of single patient encounters without physician consultation, that is not the same as managing two thirds of the patients over time. Any single patient would probably need the expertise of a physician at some point in time. For these reasons, NPs and physicians must work as teams to provide for the total needs of each patient. Nurse practitioners are not educationally prepared and should not be expected to care independently for very ill patients. Therefore, NPs must always have direct, continuing, and unimpeded access to medical support and consultation to assure the safety of patients.

When physicians and NPs work as teams of interdependent, mutually respected professionals, the NP's clinical decision-making responsibilities are strengthened, and the physician's depth of knowledge about health teaching, family needs, and community resources are augmented. As a team, each professional aligns the functions for which he or she has been educated with those of the other professional, and each one assumes responsibility for the specific aspects of each patient's needs for which he or she is best prepared.

Legal Implications

The legality of expanding the scope of practice of nurses has been an issue at least since the early 1970s.[30-31] The practice of nursing is regulated by nurse practice acts that establish requirements for education and examination, provide for registration or licensing, and define the functions of nurses. Licensing has been defined as "the process by which an agency of government grants permission to persons to engage in given professions or occupations 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 protected."[32] Licensure remains the prerogative of the state, and currently 34 states allow for some expanded nursing practice with no supervision specifically indicated in the statute except where controlled substances are involved.[33] However, the delineation of practice responsibilities is only vaguely addressed, giving cause for debate about what practices fall within the scope of nursing vs medicine. Therein lies the issue that must be resolved before independent practice of NPs can be undertaken without controversy.

The ultimate accountability for each patient lies with the professional practicing within the scope of his or her practice, ie, the type of care for which each professional has been educated and trained. A well-educated and well-trained NP can provide health education, perform routine physical examinations, administer routine immunizations, and diagnose and treat acute, common illnesses such as streptococcal pharyngitis. The legal accountability for such practice should rest with the NP. Patients seen by the NP requiring physician consultation, if only to affirm the NP's diagnosis and/or treatment plan, are the responsibility of the physician, and he or she is legally accountable for that care. The interesting issue is who would be legally responsible if an NP fails to recognize a serious illness and/or manages a minor illness improperly. In a team setting, the accountability lies with the physician

because the patient would assume that necessary physician input is assured, and it should be. If the same problem arises in an independent NP's practice, the NP would be legally responsible. In those situations, the likelihood of problems is enhanced greatly if the NP's independent practice is to include the general public and not preselected healthy patients.

Conclusions

I believe a national committee composed of physicians and NPs should be organized and charged with defining a scope-of-practice model. This model should delineate the specific roles for NPs and generalist physicians in primary care.

Unfortunately, at this time, no well-designed studies have been performed with NPs practicing independently to determine the safety and cost-effectiveness of such practice. Such studies are essential and should be funded promptly so that decisions relating to scope of practice can be based on sound data rather than conjecture. We would not allow any scientific advancement to involve patients without proper documentation of effectiveness and safety. We must use the same principle with independent practice of NPs. In the meantime, NPs should work with physicians as teams of interdependent professionals. Such practices allow for cost-effective use of skills and knowledge of both professionals. Best of all, the patients benefit most.

Catherine D. DeAngelis, MD

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ght into the mechanism of TNF-induced fibrinolytic activation.

In a phase I (uncontrolled) study of TNF-α in human cancer patients, we have recently demonstrated the release of tissue-type plasminogen activator (t-PA, an endothelial product as determined by molecular weight analysis and enzyme-linked immunosorbent assay) at 1 hour after intravenous TNF initiation.[2] The t-PA release was immediately preceded by leukopenia in the peripheral blood at 30 minutes after TNF initiation as previously described.[3] Simultaneous measurements confirmed a temporal relationship between the leukopenia and t-PA release in three patients.[2] Prior to the leukopenia, increased CD11b expression was noted on circulating polymorphonuclear leukocytes and monocytes at 7 to 15 minutes after TNF initiation. CD11b has been associated with granulocyte-endothelial adhesion in vitro.[4] These preliminary findings suggest a TNF-induced granulocyte-endothelial interaction in vivo that is temporally related to the release of t-PA and fibrinolytic activation. This would potentially implicate circulating white blood cells in the activation of fibrinolysis in vivo.

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In Reply.—The observation of Logan et al supports the notion that the induction of fibrinolysis and coagulation by cytokines follows different pathways. Endotoxin as well as TNF causes t-PA release in vivo, before thrombin generation can be detected, and neutralization of TNF in endotoxemia inhibits t-PA release, but not thrombin formation. The temporal relationship between neutropenia and t-PA release that occurs in TNF-infused cancer patients was also observed in healthy volunteers who received a bolus TNF injection and may indicate a causal role of activated adhering neutrophils for t-PA release by endothelial cells.

This observation merits further investigation, in particular because TNF does not cause the rapid release of t-PA from endothelial cells in vitro, even in the presence of plasma or serum, which suggests that other cells may be involved in TNF-induced activation of the fibrinolytic system in vivo.

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Sushi Syncope Schusser Gets Wedeler's Valve at Vail

To the Editor.— A 68-year-old man was involved in a severe frontal impact with another skier while "wedeling" at a high rate of speed in Vail, Colo. Medical history was unremarkable, other than having developed "sushi syncope" at 63 years of age.[1] While prior to the accident he had experienced no difficulty skiing expert trails at an elevation of over 3600 m (10 000 ft), afterward he became dyspneic while walking at the base of the mountain.

On returning to sea level, he noted continued dyspnea on exertion; examination revealed V waves in the jugulars evident at 30° and a prominent murmur of tricuspid insufficiency. Transesophageal echocardiography demonstrated a flail tricuspid leaflet, and angiography revealed wide-open tricuspid regurgitation. Fortunately, his dyspnea gradually resolved, and by 3 months after the event he had returned to playing tennis without difficulty. Serial echocardiograms reveal that his right ventricular size has remained stable, and stress tests fail to demonstrate any functional limitation.

Traumatic tricuspid valve damage—an extremely rare event—is classically related to being kicked in the chest by a horse or, most commonly, a severe motor vehicle accident.[2,3] Presumably the right ventricle must be fully inflated at the time of injury; the shock to the chest results in reflux of blood through the tricuspid valve and traumatic avulsion of the tendinae chordae or the papillary muscles as the valve is overstressed. Fortunately, repair of the defect is not always necessary; this patient has not required surgical intervention and, despite his "wedeler's valve," has just returned from another 10 days' hard skiing at Vail, where he schussed without sushi and wedeled without valvular consequences.

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Lack of Physician Representation in Framing Policy on National Health Insurance—1938

To the Editor.—Health care reform is a major focus of the Clinton administration. The American people, the medical profession, various health-related industries, and the media are anxiously awaiting the report of Hillary Rodham Clinton's task force. Several past administrations also addressed health care reform. The debate was especially intense during the Roosevelt, Truman, and Johnson administrations when several "current" issues were the subject of controversy.

Access to health care and its cost have been discussed in America for decades. Moreover, the relative roles of politicians, physicians, and others with interest in the issues have been hotly debated in the past. Recently, many individuals and organizations expressed concern that Hillary Rodham Clinton's task force does not include adequate physician representation. In 1938, during an intense debate over national health insurance, *JAMA* editor Morris Fishbein, MD, responded to a letter from Alfred Cohn, MD, an influential clinical scientist at the Rockefeller Institute. Fishbein's comments[1] will sound familiar to those concerned about certain aspects of Hillary Rodham Clinton's task force.

August 23, 1938
Dear Doctor Cohn:

I have read with great interest your letter of August 17. It would be highly desirable to limit *The Journal* exclusively to scientific editorials and scientific material. However, the various attempts that are being made to make medicine a political issue in future political campaigns have forced us to use such material as came to hand, and thus to be able to reveal to the medical profession that not all of the public are in accord with the administration's point of view on this subject.

It was by order of the House of Delegates and the Board of Trustees that the Organization Section of *The Journal*, dealing with such matters, was established.

Indeed, it would be perfect if everyone who attempts to discuss the current status of medical practice had "the social experience or the scientific mind that entitle their views to count heavily." However,

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a[illegible]ational Health Conference recently called in Washington, mo[illegible]han 90 per cent of those in attendance were representatives of labor organizations, social welfare agencies, the radical press, and similar groups. These people, invited by the present administration to discuss the National Health Program, devoted most of their time to attacking the ethics, the principles, and the nature of medical practice.

We have repeatedly offered all of our facilities and all of our employees to the federal government for a serious and careful consideration of our present problems. Unfortunately, the administration has not seen fit to avail themselves of this offer.

May I assure you that I appreciate your interest in writing.

Sincerely yours,

Morris Fishbein

History can teach us much about ourselves and our times. An appreciation of history fosters humility and reminds us that many bright and well-meaning individuals of earlier generations addressed concerns that are still with us.

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The Rockefeller Archive Center granted permission to publish this letter.

1. Letter from M Fishbein to AE Cohn. In: *Cohn Papers*. North Tarrytown, NY: Rockefeller Archive Center. Record group 45b C661, box 8, folder 20.

Pulse Oximetry During Conscious Sedation

To the Editor.—As an anesthesiologist who uses pulse oximeter technology daily, I read with great interest the American Medical Association Council on Scientific Affairs report.[1] It is vital to realize that pulse oximetry reveals nothing regarding adequacy of ventilation. Although this important point was addressed briefly in the Council's report, I feel it deserves greater emphasis. Too often, physicians become complacent when arterial oxygen saturation is normal.

In pioneering work detailing physiology of apneic oxygenation, Frumin and colleagues[2] induced periods of apnea in eight subjects lasting 18 to 55 minutes while simultaneously insufflating oxygen endotracheally at rates of 200 mL/min. The lowest arterial oxygen saturation recorded was 98%, yet profound hypercarbia was documented. In one individual, apnea lasted 53 minutes and the lowest arterial oxygen saturation recorded was 98%, yet at the same time the arterial carbon dioxide tension has increased to 250 mm Hg and the arterial pH had decreased to 6.72. In another early study, Comroe and Dripps[3] were able to maintain adequate arterial oxygen saturation in a comatose patient throughout an apneic period lasting 3 hours while simultaneously insufflating oxygen endotracheally at a rate of 6 L/min. However, at the end of the apneic period, the arterial carbon dioxide tension had increased to 314 mm Hg and the arterial pH had decreased to 6.67.

These reports clearly demonstrate that monitoring a patient with pulse oximetry reveals nothing regarding adequacy of ventilation, and physicians should not become complacent when arterial oxygen saturation is normal.

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1. Council on Scientific Affairs, American Medical Association. The use of pulse oximetry during conscious sedation. *JAMA*. 1993;270:1463-1468.
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To the Editor.—I read with great interest the report by the Council on Scientific Affairs[1] on the use of pulse oximetry during conscious sedation. As pointed out, pulse oximetry has proven to be a very useful monitor in detecting desaturation events in the operating room as well as in non–operating room locations. Pulse oximetry does not substitute for good patient care; however, pulse oximetry does provide an early warning to practitioners that something is wrong, and it calls attention to the fact that they need to look at the patient. The position statement failed to emphasize that in our studies of approximately 550 anesthetized pediatric patients, half of whom had oximetry data available to the anesthesia team and the other half of whom had no oximetry data available to the team, the incidence of severe desaturation events, ie, a saturation of less than or equal to 85% for 30 seconds or longer, was threefold higher in patients whose anesthesiologists did not have oximetry data available.[2,3] Obviously this cannot be extrapolated to outcomes of morbidity and mortality since pediatric anesthetic mortality is less than one in 40 000 anesthetics. However, it clearly shows that having oximetry information available allowed the anesthesiologist to intervene in a timely fashion and prevented approximately two thirds of the major desaturation events.

Our study also confirmed the observations of Comroe and Botelho,[4] namely, that the clinician is not particularly skilled at diagnosing desaturation. We found that in half the episodes of desaturation where the patient had to be cyanotic (a saturation of less than 70%), the clinician was not able to detect cyanosis. Conversely, in half the episodes where the clinician said the patient was cyanotic, the oximetry data demonstrated that the patient could not possibly have been cyanotic (the saturation was greater than 85%). This inability to detect cyanosis may be exaggerated in situations where the physician who is taking care of the patient and performing a procedure is also in charge of sedating the patient. It is impossible to do two things well at the same time. That is the reason it is so important that something and somebody be observing the patient while the clinician is performing the proposed procedure.

Rather than suggest developing guidelines for each individual procedure, which will vary from institution to institution, emphasis should be on monitoring all patients sedated for a procedure when the drugs have the potential to cause respiratory depression. It is not the procedure that necessarily causes the problem, but the drugs.

Another important omission in the American Medical Association statement is the 1992 guidelines for children published by the American Academy of Pediatrics in 1992.[5] These guidelines address the entire issue of monitoring the sedated patient, not just the isolated issue of pulse oximetry. Pulse oximetry is a single tool in the identification of desaturation, but must be accompanied by knowledge of the patient as well as observation of respiratory efforts, degree of sedation, patency of airway, and arousability to provide useful information and a diagnosis of patient status.

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2. Coté CJ, Goldstein EA, Coté MA, Hoaglin DC, Ryan JF. A single-blind study of pulse oximetry in children. *Anesthesiology*. 1988;68:184-188.
3. Coté CJ, Rolf N, Liu LMP, et al. A single-blind study of combined pulse oximetry and capnography in children. *Anesthesiology*. 1991;74:980-987.
4. Comroe JH Jr, Botelho S. The unreliability of cyanosis in the recognition of arterial anoxemia. *Am J Med Sci*. 1947;214:1-6.
5. Guidelines for monitoring and management of pediatric patients during and after sedation for diagnostic and therapeutic procedures. *Pediatrics*. 1992;89:1110-1115.

In Reply.—As mentioned in the Council on Scientific Affairs Report on the use of pulse oximetry during conscious sedation, monitoring of ventilation, while not yet practical, would be desirable to prevent hypoxic injury during conscious sedation. We are grateful to Dr Chaney for bringing attention

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PRESIDENT'S MESSAGE

Guidelines Could Smooth Implementation of Collaborative Practice Arrangements

Melvin C. Kasten, MD, MSMA President

One key provision included in the Omnibus Health Care Bill (House Bill 564) adopted by the Missouri General Assembly last May officially recognizes the ability of physicians and registered nurses to enter into "collaborative practice" arrangements. The provision should encourage increased access to health care for patients in underserved areas, but the arrangements are not limited to such areas and can be established in any practice setting. The "collaborative practice" measure was adopted in lieu of efforts to legalize the independent practice of nursing in the state.

Physicians may enter into collaborative practice arrangements with either RNs or Advanced Practice Nurses (APNs) Although an APN can prescribe non-controlled substances while an RN cannot, both classes of nurses can only provide services within the scope of their practice and consistent with their skill, training and competence.

Due to some confusion which has arisen over this subject, the MSMA Council appointed an AD Hoc Committee on Collaborative Practice to study the issue and develop suggested guidelines for physicians to take into account when considering a collaborative practice arrangement. The Committee's report and guidelines subsequently were adopted by the MSMA Council with the caveat that the information be provided to MSMA members for their consideration.

Suggested Collaborative Practice Guidelines:

1. The supervising physician bears the authority and the responsibility for the delegated acts. Accordingly, the tasks delegated to the nurse should be within the scope of those provided by the physician.
2. Physician supervision means that nurses (or advanced practice nurses) only perform acts and procedures that have been specifically authorized and directed by the supervising physician.
3. The physician is ethically and legally responsible to ensure that all delegated activities are within the nurse's scope of practice.
4. The supervising physician must have the opportunity to exercise oversight, direction and control of the services of the nurse. Therefore, it is the responsibility of the supervising physician to direct and review the work, records and practice of the nurse on continuing basis to ensure that appropriate directions are given and understood and that appropriate treatment is rendered.
5. The physician must provide direction to the nurse in order to specify what medical service should be provided for all types of cases that the nurse is expected to see. These directions may take the form of written protocols, oral communication, in person, by telephone or by other means of electronic communication.
6. Protocols developed by the supervising physician and the nurse should include guidelines describing and delineating the nurse's functions and responsibilities. Protocols should be as specific in their guidance as the physician and nurse require for their particular practice.
7. Although it is not possible to cover all clinical situation in written protocols, there must be an understanding between the physician and nurse regarding the actions the nurse may undertake in all commonly encountered clinical situations and, especially, under what circumstances physician consultation is to be immediately obtained.
8. The development of appropriate written or oral protocols requires an initial period during which the nurse works under the close supervision of the physician. The degree of supervision should lessen only when the physician can ensure that the nurse can provide care in accordance with directions and accepted medical standards.
9. The physician and nurse must regularly review protocols to ensure they are current in regard to the physician's scope of practice, the range of tasks delegated by the physician, and evolving standards of medical practice.

10. Immediate physician consultation must be indicated for specified clinical situations and in situations falling outside those specified in written or oral protocols.
11. A physician should not enter into a collaborative practice with more than two nurses.
12. The supervising physician must review the quality of medical services rendered by the nurse regularly by reviewing medical records to ensure compliance with directions and standard of care. The physician must review a sufficient sample of nurse-written medical records with sufficient frequency to ensure compliance with the physician's directions and to protect patient welfare.
13. If the nurse orders treatment outside established parameters without the supervising physician seeing the patient, the supervising physician should personally review the case as soon as possible.
14. A nurse should not provide health care services during periods of time when the supervising physician is unavailable unless an alternate supervising physician has been designated.
15. A supervising physician should regularly visit an off-site location where the nurse is providing health care services.
16. Generally, utilization of a nurse off-site involves a supervising physician-nurse team that has had sufficient opportunity to establish a close working relationship prior to deploying the nurse to the site. The supervising physician must be available in person or by electronic communication when the nurse is caring for patients.
17. When off-site supervising is provided, the physician and nurse must establish that the lack of on-site supervision is reasonable under the circumstances. The supervising physician and nurse must ensure that distance does not become an impediment to regular and adequate review of the nurse's work.
18. When off-site care is provided, transportation and backup procedures for immediate handling of patients needing emergency care and care beyond the nurse's scope of practice should be established.

These MSMA guidelines are separate and independent from current efforts by a Joint Committee of the Board of Healing Arts and the Board of Nursing to develop regulations to further implement the language in House Bill 564. Your thoughts on the suggested guidelines are welcome. Write to me at the Association office in Jefferson City (PO Box 1028, 113 Madison St, 65102). ■

American Medical Women's Association

Carol Williams, MD Community Service Award

Carol F. Williams, MD was awarded the community service award for Missouri at the American Medical Women's Association in New York City last November. She received the award for her continued efforts to promote health care for the indigent. Dr. Williams has served as president of the St. Louis Metropolitan Medical Society and is Immediate Past President of MSMA. During her term, she gave up her lucrative private practice to work at the Carondelet Health Center in South St. Louis City to practice what she preaches and treat indigent women. Dr. Williams also has volunteered time as the newest member of the Board of Healing Arts of Missouri.

Jo-Ellyn Ryall, MD First Speaker of the AMWA House of Delegates

Jo-Ellyn M. Ryall, MD, has been elected First Speaker of the House of Delegates of the American Medical Women's Association. The office was newly created by bylaws changes in 1992. Dr. Ryall has previously been Vice-Speaker and Speaker of the House of Delegates of the Missouri State Medical Association and also President of the Eastern Missouri Psychiatric Society.

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Are CRNAs ARNPs?

by Thomas Johans, M.D.

Almost as if she was reading my editorials on CRNAs, Mary O. Mundinger, Dr.P.H., wrote an editorial in the *New England Journal of Medicine* (NEJM 330:211-213, 1994) that responds to many of my fears. In fact, she amplified them! I think this article is a definite for your "must read" list of articles. In spite of my personal disagreement with the spirit of the work, I found it to be a well-written, well-researched article guaranteed to send a chill up your spine.

What's frightening is that to a governmental bureaucrat and to a third party payer CPA, it makes sense. Please read this article! Is this the future of the anesthesiologist? The length of the article precludes my publishing it. But allow me to print the highlights:

"Advanced [registered nurse] practitioners (ARNPs) are registered nurses with specialty training, usually at the Master's level in primary care (i.e., nurse practitioners and nurse midwives) or acute care of inpatients (i.e., clinical nurse specialists). The practice of nurse practitioners has been evaluated since 1965, when the role was developed by Henry Silver, M.D. and Loretta Ford R.N. When measures of diagnostic certainty, management competence, or comprehensiveness, quality and cost are used, virtually every study indicates that the primary care provided by nurse practitioners is equivalent or superior to that provided by physicians.

"Over the past few years, state legislatures have broadened the authority of nurse practitioners to receive direct payment and write prescriptions, and the barriers to independence have fallen. As a result, nurse practitioners can establish independent practices that parallel those of primary care physicians ... I advocate a collaborative-practice structure ... a nurse practitioner and a physician provide primary health care to a group of patients, and the two professionals share authority equally for providing care within the scope of their practice. The nurse practitioner is not required to obtain the physician's approval to provide that care. When there are differences of opinion, the person with the greatest degree of professional competence holds authority; for complex diagnostic and treatment problems involving unstable and critically ill patients, this is the physician, and for prevention, access to community-based resources, health education and counseling, it is the nurse practitioner.

"Primary care no longer requires the level of training that it once did. As biomedical knowledge has grown, basic medical education has been truncated.

In spite of my personal disagreement with the spirit of the work, I found it to be a well-written, well-researched article guaranteed to send a chill up your spine.

"Although they are indistinguishable from their physician counterparts in making primary care decisions, nurse practitioners bring additional skills to the practice.

"Many states are increasing the level of authority and reimbursement for nurse practitioners. Most private insurance companies and health maintenance organizations cover the services of nurse practitioners. Forty-six states now authorize nurse practitioners to write prescriptions, although they differ widely in the degree of autonomy they grant. Twenty-one states and the District of Columbia currently provide authority to write prescription independently and 15 of those include the authority to prescribe controlled substances. The remaining states require some form of oversight by a physician.

"Most studies show that nurse practitioners can mange 80 percent (among adult patients) and 90 percent (among children) of care provided by primary care physicians. Research studies show that the overlap of 80 to 90 percent represents the number of office visits that nurse practitioners can handle completely on their own without the need for consultation or referral."

I must congratulate Dr. Mundinger for a well-thought

out answer to the blight and plight of primary care in the United States. I was also happy to see that Dr. Mundinger used the word "collaborative" correctly and explained what the ARNP had to offer the patient in communion with a physician something distinct and unique to their profession. The ARNP, she explains, "provide[s] disease prevention counseling, health education, and health promotion activities as well as to know about and use community resources, such as nutrition programs, self help or group therapy and parenting and stress reduction programs. Once the illness is resolved (by the physician?), they [ARNP] intervene with counseling about health promotion or disease prevention to maintain the patient's health." Clearly physicians do not have as a part of their training these qualities. Clearly these qualities are important to the health care management of the patient. Doctors are clearly *problem-oriented*; there is no science if there is no problem. Physicians are always open to this type of collaboration.

But Dr. Mundinger muddies the water by stating that what a primary care physician does overlaps what an ARNP does by 80%. If a true collaboration exists, then each of the professionals brings to the table something unique, that when both are put together they form a union that is better than any of the two parts alone. An overlap of 80% certainly defies the spirit of collaboration; unless she means that this collaborative practice involves only 20% of patient care? What is the rest, a competitive practice?

Are CRNAs ARNPs? Can we translate what is being said in this article to our situation with CRNAs? How much of an overlap do we have with the CRNAs? What do they bring to the table that is unique that will complement our care to the anesthetized patient? Should we allow the CRNAs to do only the "easy cases?" What's an easy case? Should we expect that for CRNAs to be ARNPs in that they have a Masters level education with something non-competitive and unique to add to the care team?

Are CRNAs ARNPs? As you can see from the *State Beat* article (page 25), CRNAs have been tagging along with the ARNPs for political power, and succeeding quite well. Florida Representative Elaine Gordon (D-North Miami) and Senator Patsy Kurth (D-Palm Bay) are sponsoring bills that will allow ARNPs and CRNAs to practice independent of physicians. This will clearly allow CRNAs to practice the full scope of anesthesiology (including ICU, respiratory therapy, consultations and pain) without the benefit of graduating from an accredited medical school, completion of an accredited medical residency program and passage of all medical licensure examinations. I shudder to think that a loved one of mine could some day be anesthetized by a college graduate with two years of anesthesia school!

Read the article and let me know what you think! ◆

Celebrate
DOCTORS DAY•1994
March 30, 1994

I am Dr. Taylor Markle. I am a practicing, Board-certified oral and maxillofacial surgeon in Shawnee, Kansas. I am President of the Kansas Society of Oral and Maxillofacial Surgeons. I graduated from UMKC School of dentistry in 1981 and graduated from the four-year OMS residency program in 1986 at UMKC. During my residency, I administered hospital-based general anesthesia for six months at Truman Medical Center for general surgery, gynecology, plastic and orthopedic surgery cases. The residency also consisted of 2 1/2 years of out-patient anesthesia training.

The Kansas Society of Oral and Maxillofacial Surgeons are very much in favor of House Bill 722.

There are several reasons for supporting this bill. The first and foremost is to protect the citizens of the Kansas that receive medications in a dental office that renders them semi-conscious or unconscious.

This bill self-regulates the dentist of this state. It would authorize the Kansas Dental Board to adopt rules and regs to establish qualifications for dentists who administer in-office intravenous sedation and general anesthesia. At this time, any licensed dentist can administer any anesthetic under the current scope of licensure.

This restriction is similar to what is already in place at hospitals in our state. Hospitals assure patients that their health providers are educated, trained, have correct monitors, emergency equipment and drugs for patient's safety.

We are attempting to provide the same assurance to the dental patients of this state. Currently, there are 47 states that regulate conscious sedation and 48 states that regulate general anesthesia.

In conclusion, the Kansas Soceity of Oral and Maxillofacial Surgeons support Senate Bill 722. We are dedicated to enhance the safety of anesthetics admininistered to the citizens of the of the state of Kansas in a dental office.

P H+W
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attm #6

STATE OF KANSAS

DIVISION OF THE BUDGET
Room 152-E
State Capitol Building
Topeka, Kansas 66612-1504
(913) 296-2436
FAX (913) 296-0231

Joan Finney
Governor

Gloria M. Timmer
Director

March 9, 1994

The Honorable Sandy Praeger, Chairperson
Senate Committee on Public Health and Welfare
Statehouse, Room 128-S
Topeka, Kansas 66612

Dear Senator Praeger:

SUBJECT: Fiscal Note for SB 816 by Senate Committee on Federal and State Affairs

In accordance with KSA 75-3715a, the following fiscal note concerning SB 816 is respectfully submitted to your committee.

SB 816 would create the Health Care Reform Legislative Oversight Committee. The purpose of the Committee would be to oversee changes in state laws and regulations made necessary by changes in federal law. To the fullest extent possible, the Committee would oversee the implementation of health care reform in the state.

The Committee would comprise 10 members of the Legislature, including five members of the Senate and 5 members of the House of Representatives. In each case, three members would represent the majority party and two members the minority party. The Secretary of Health and Environment, the Secretary of Social and Rehabilitation Services, the Director of the Budget and the Commissioner of Insurance would serve as advisors to the Committee. The Committee would be designated a joint standing committee of the Legislature.

Under provisions of the bill, the Committee would evaluate changes in federal law and cooperate with federal agencies as necessary to meet the responsibilities of the state in implementing health care reform. It would work cooperatively with relevant state and federal agencies, health care providers, payors and consumer groups in the development of an integrated health plan for

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all Kansans. It would also make recommendations regarding the state health care database developed by the Health Care Data Governing Board.

The board would also develop plans for health care cost containment and make recommendations for legislative action to integrate health care financing and coverage with other states. Also, it would recommend actions necessary to assure accessibility of services to residents of underserved areas. The Committee would study inclusion of the medical care component of workers compensation and automobile insurance into the overall health care coverage. Tort reform for medical liability would also be studied.

The Committee would appoint subcommittees, including specific administrative, insurance, employer, provider and consumer groups, as well as subcommittees for additional subject areas, as designated by the Committee. Subcommittees would meet quarterly.

The Committee would employ an executive secretary in the unclassified service. This individual would staff the Committee and provide liaison with state agencies and the Governor's Office. State agencies would provide assistance to the Committee as requested. Staff assistance would be provided by the Revisor of Statutes, the Legislative Research Department and other legislative agencies. The Committee would be designated the official contact committee for the state with reference to federal health care reform measures. All official acts of the state with regard to health care reform would be performed by the chairperson of the committee.

Estimated State Fiscal Impact				
	FY 1994 SGF	FY 1994 All Funds	FY 1995 SGF	FY 1995 All Funds
Revenue	--	--	--	--
Expenditure	--	--	$87,600	$87,600
FTE Pos.	--	--	--	1.0

The Division of the Budget estimates that passage of the bill would increase state expenditures by $87,600 in FY 1995. This amount would include $46,000 for salaries and wages for the executive secretary authorized by the bill's provisions. Also, the estimate would include $21,600 from the State General Fund for members' salary and subsistence payments. This amount assumes that the full committee would meet 4 times for 2 days at each meeting with average salary and expense reimbursements of $135 per day.

Also, with this estimate, each subcommittee would meet 4 times for 2 days at each meeting. The amount also includes $20,000 for

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other operating expenditures to support the new position created by the bill. This estimate assumes that any needed clerical support would be provided by other agencies, and additional staff would not be required. Any expenditures resulting from the passage of this bill would be in addition to amounts included in the *FY 1995 Governor's Budget Report*.

Sincerely,

Gloria M. Timmer

Gloria M. Timmer
Director of the Budget

cc: Laura Epler, Health and Environment

816.fn

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MY NAME IS SHARRON WATSON. I AM A WIFE, MOTHER AND GRANDMOTHER. I HAVE BEEN EMPLOYED BY KANSAS ALUMINUM INC., MANUFACTURERS OF KANAL WINDOWS AND DOOR PRODUCTS AS PLANT MANAGER FOR 20 YEARS. I MAKE JUDGEMENT CALLS AND DECISIONS EVERY DAY.

MOST IMPORTANT, I AM CARRIE WATSON SHEARBURN'S MOTHER.

WHEN CARRIE WAS 16, MY HUSBAND AND I MADE AN UN-INFORMED DECISION IN HER BEHALF. ON THE ADVICE OF TWO SPECIALISTS WE ALLOWED OUR BEAUTIFUL 16 YEAR OLD DAUGHTER TO RECEIVE TWO SILICONE BREAST IMPLANTS TO CORRECT A PHYSICAL DEFORMITY.

THIS IS THE RESULT OF THAT DECISION.

I'M HOLDING CARRIE'S MEDICAL HISTORY---95% OF IT TESTED AND WRITTEN IN **THE LAST TWO YEARS.**

THIS IS A LIST OF THE DISEASES CARRIE LIVES WITH BECAUSE OF SILICONE BREAST IMPLANTS.

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SHE HAS A-TYPICAL **MYASTHENIA GRAVIS,** A DEGENERATIVE MUSCLE-NERVE DISEASE THAT SHE WILL LIVE WITH THE REST OF HER LIFE. SHE HAS **SILICONE HUMAN ADJUVANT BREAST DISEASE, TOXIC CHEMICAL POISONING, LUNG DISEASE, ALTZHELMER LIKE DISEASE** FROM BRAIN DAMAGE. A-TYPICAL SIMPLY MEANS THAT IN HER LIFE TIME SHE SHOULD NEVER HAVE HAD ANY OF THESE DISEASES.

FOR YEARS WE WATCHED CARRIE'S HEALTH DETERIORATE WITH NO CLUE TO WHAT WAS TURNING A YOUNG WOMAN INTO A CRIPPLE.

THERE ARE ONE MILLION WOMEN WHO WERE NOT INFORMED BEFORE THEY CONCEIVED AND NURSED THEIR CHILDREN. THERE ARE 60,000 LITTLE BOYS WITH TESTICULAR SILICONE IMPLANTS WHOSE PARENTS WERE NOT INFORMED. THERE ARE 100,000 MEN WITH PENIAL SILICONE IMPLANTS WHO WERE NOT INFORMED AS TO THE MATERIAL USED.

WE HAVE 5 GRAND-CHILDREN AND 3 OF THOSE CHILDREN ARE CARRIE'S. ALL 3 ARE **"AT GREAT RISK"** OF HAVING AUTO-IMMUNE DISEASE AND RESEARCH BECOMES MORE FRIGHTENING EVERY DAY.

OUR DAUGHTER COULD BE YOUR DAUGHTER, OR YOUR DAUGHTER IN-LAW, AND OUR GRAND-CHILDREN COULD BE YOUR GRAND-CHILDREN.

INFORMED CONSENT WOULD GIVE ALL OF US THE RIGHT TO DECIDE OUR FUTURES. INFORMED CONSENT WILL SAVE THOUSANDS FROM BEING EXPERIMENTAL GUINEA PIGS LIKE OUR DAUGHTER AND HER CHILDREN.

IF INFORMED CONSENT BECOMES A LAW, IT MEANS WE ALL HAVE THE RIGHT TO KNOW THE PRO'S & CON'S OF SILICONE IMPLANTS. FOR YOUR INFORMATION--IN 1988 THE F.D.A. CLASSIFIED IMPLANTS AS A

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CLASS 3 MEDICAL DEVICE WHICH MEANS THEY ARE A HIGH RISK DEVICE AND REQUIRE PROOF OF SAFETY.

SHOULDN'T ANY IMPLANTED DEVICE REQUIRE PROOF OF SAFETY....IF IT WERE IN YOUR BODY.

I CANNOT TELL YOU ALL THAT IS IN MY HEART OR ON MY MIND. ITS MUCH TO PAINFUL. WHAT I CAN SAY IS IN THE LAST TWO YEARS I HAVE MET HUNDREDS OF WOMEN WHO DESPERATELY NEED MEDICAL ATTENTION AND HELP. WHAT YOU DO HERE IN TOPEKA WITH THE INFORMED CONCENT BILL WILL STOP THAT NUMBER FROM GROWING. THOUSANDS ARE WATCHING OUR EFFORTS AND THE COUNTRY WILL TAKE YOUR LEAD!

MAY I INTRODUCE MY DAUGHTER, CARRIE.....

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Kansas Association of Osteopathic Medicine

Harold E. Riehm, Executive Director

1260 S.W. Topeka Blvd.
Topeka, Kansas 66612
(913) 234-5563
(913) 234-5564 Fax

March 16, 1994

To: Members, House Public Health and Welfare Committee

From: Harold Riehm, Executive Director, Kansas Association of Osteopathic Medicine

I was remiss in not testifying on S.B 759, the Bill that established a managed care program for medicaid, throughout Kansas.

MY CONCERN IS THAT WITH THE CONSIDERABLE EXPRESSED INTEREST IN THE MAKEUP OF THE TASK FORCE PROVIDED FOR IN THE BILL, THAT THERE IS NO REFERENCE TO AN OSTEOPATHIC PHYSICIAN.

In her testimony, Secretary Whiteman suggested that the present Managed Care Task Force for Medicaid now operating as an advisory group to SRS, works well. I CONCUR WITH THAT, AND THERE IS AN OSTEOPATHIC PHYSICIAN ON THAT TASK FORCE. There are three physicians on that Task Force, two M.D.s and one D.O.

KAOM RESPECTFULLY REQUESTS THAT WE RETAIN THAT TASK FORCE AS THE ADVISORY TO SRS, OR THAT IF A NEW TASK FORCE IS CREATED, THAT THERE BE AN OSTEOPATHIC PHYSICIAN ON THAT TASK FORCE.

I regret this late request, but respectfully ask your consideration.

PH&W
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KAEYC

Kansas Association for the Education of Young Children

Written Testimony on SB 615
presented to the
House Public Health and Welfare Committee
March 17, 1994

by
Shirley A. Norris
Representing the Kansas Association for the Education of Young Children
131 NW Greenwood Ave
Topeka, Kansas 66606
Ph. (913) 232-3206

The Kansas Association for the Education of Young Children (KAEYC) is an organization whose members provide early care and education to thousands of Kansas children who are away from their parents for part or all of the day.

Members of the KAEYC Board of Directors, and I, as director of Child Care Licensing and Registration for thirty years prior to my retirement in 1990, in general support both SB 615 and SB 451, and appreciate the efforts of the Senate to merge the two proposed bills. As director, I was responsible for implementing the child care licensing and registration statutes so that I am very much aware of the need to update the language and clarify the intent of the law.

I would like to say at the outset that the responsibility of the state to safeguard children in out-of-home care was supported by a Kansas Supreme Court ruling in the case of the State of Kansas vs. Heritage Baptist Temple, Inc., et al, in 1984. (This case was appealed to the U.S. Supreme Court, which refused to overturn the decision.) The Supreme Court's decision is strengthened by New Section 1. of SB451 which codifies the state's child care policy by detailing the principles to guide the development and implementation of that policy. KAEYC urges the inclusion of this section in any amendments made to the licensing and registration statutes.

It seems particularly important to update the language defining out-of-home care of children. In the current statute, "boarding home for children" is a generic term to cover "care of one or more children under 16 years of age . . . for the purpose of providing the children with food or lodging, or both." According to an attorney general's opinion, this definition includes day care homes, but it continues to be very confusing. The definition of a day care referral agency is also not clear. Section 2. of SB 615 stipulates in statutory form the child care categories that are currently defined by regulation, which, although permitting less flexibility to the agency in defining categories of care, does clarify the intent of the law.

Another point of confusion arose because the registration statutes, **(KSA 65-517 to 65-522),** which were passed in 1980, were added at the end of the licensing statutes,so it was unclear which, if any, administrative procedures applied to registered homes, particularly because **KSA 65-516** prohibited persons with criminal records from residing, working, or volunteering in either licensed or registered facilities. To add to the confusion, additional enforcement statutes were added after the registration statutes, i.e., 65-523, 524 and 525 which specified that both licenses and certificates of registration

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could be suspended either after (523) or prior to (524) an administrative hearing, and civil fines could be levied against both licensed and registered providers (525). SB 615 moves the administrative and enforcement procedures to the end so that all categories of care clearly are covered.

Two substantive changes included in SB 451, i.e., reducing registration to four children including the registrant's own children to age 12, and taking the cap off the child care center licensing fee, were ballooned into SB 615 by KDHE and were considered by the Senate Health and Welfare Committee. The Senate agreed with lifting the cap on the fee, but returned the number of unrelated children permitted in a registered home to six, although it did leave the upper age of children at 12 rather than 16 as in the current law. It has been pointed out that this amendment will increase the number of unrelated children permitted in a registered home. However, it does make the upper age limit more consistent with the upper age specified by regulation in licensed child care homes. In regard to lifting the cap on the child care center license fee, it had always seemed somewhat unfair that a center with a capacity of 250 children should pay the same license fee as a center with forty. The proposed amendment would correct this inequity. It is our understanding that the additional funds generated would be used as recommended in the Joint Committee Report, to improve automation of the licensing process. KAEYC supports this recommended change.

Two other changes are being recommended which aren't substantive, but do remove some antiquated language which was a source of embarrassment to me, i.e., the children are no longer referred to as "inmates," and "privies" are no longer permitted.

We urge the committee to recommend this bill for passage.

Thank you.

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