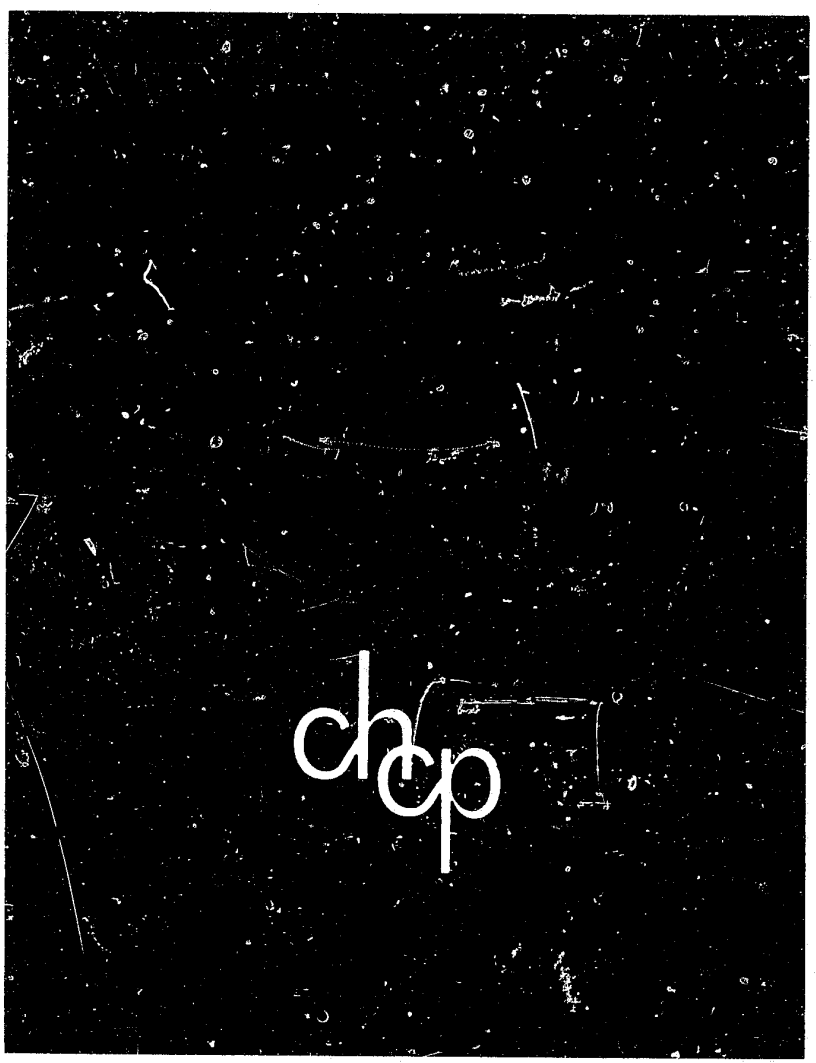

CORRECTIONAL HEALTH CARE PROGRAM

Correctional Health Care Program

RESOURCE MANUAL

MID-LEVEL PRACTITIONERS IN CORRECTIONAL INSTITUTIONS: AN ANALYSIS OF LEGISLATION

MICHIGAN DEPARTMENT OF CORRECTIONS
OFFICE OF HEALTH CARE

LAW ENFORCEMENT ASSISTANCE ADMINISTRATION
UNITED STATES DEPARTMENT OF JUSTICE

CORRECTIONAL HEALTH CARE PROGRAM

RESOURCE MANUAL

MID-LEVEL PRACTITIONERS IN CORRECTIONAL INSTITUTIONS: AN ANALYSIS OF LEGISLATION

Prepared by:

Hilary P. Viets, M.P.H.

Marilyn R. Lindenauer, M.P.H.

Department of Medical Care Organization
The School of Public Health
The University of Michigan

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MANUALS AVAILABLE IN THIS SERIES

Correctional Health Care: An Annotated Bibliography

Correctional Health Care Facilities: Planning, Design, and Construction

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   Florida Statutes Annotated, Osteopathic Physicians' Assistants.
   Florida Statutes Annotated, Chapter 464, Nursing.
   Florida Administrative Code, Rules for Advances and Specialized Nursing Practice.
   Florida: Office of the Attorney General, Communication dealing with physicians' trained assistants and the nursing law.

3. The Illinois Physicians' Assistants Practice Act.
   State of Illinois Rules and Regulations for Physicians' Assistants.
   Illinois Statutes Annotated, Professional Nursing.
   State of Illinois, Registered Nursing Rules and Regulations.

4. Michigan Physicians' Assistants Act (Public Act 420, 1976).
   Michigan Medical Practice Act (Public Act 421, 1976).
   Michigan Osteopathic Practice Act (Public Act 407, 1976).
   Michigan Compiled Laws Annotated, Registered Professional Nursing and Specialty Certification.

5. Nebraska Revised Statutes on Physicians' Assistants.
   Nebraska Physicians' Assistants Rules and Regulations (Medical Board).
   Nebraska Revised Statutes, Practice of Nursing.

6. Nevada Revised Statutes: Physicians; Assistants; Technicians.
   Nevada Revised Statutes: Osteopathic Physicians' Assistants.
   Regulations for the Certification of Physicians' Assistants by the Board of Medical Examiners of the State of Nevada
   Nevada: Opinion of the Attorney General, March 10, 1976.
   Nevada Revised Statutes, Registered Nursing.
   Nevada State Board of Nursing, Registered Nurse Practice Rules.

7. General Statutes of North Carolina, Practice of Medicine.
   Directions for Submitting Application (to the North Carolina Board of Medical Examiners) for Physician Assistants -- includes Rules in Subchapter 32D -- Approval of Assistant to Physician.
   General Statutes of North Carolina, Article 9, Nurse Practice Act.
   Directions for Submitting Application for Registered Nurses Performing Medical Acts -- includes Rules in Subchapter 32E -- Approval of Registered Nurse Performing Medical Acts.
   Commentary of the Board of Medical Examiners of the State of North Carolina Regarding Pnysician Assistants and Nurse Practitioners.
   North Carolina: Attorney General Opinion, February 24, 1977.

*under separate cover

8. General Laws of Rhode Island, Chapter 54, Physician Assistants.
General Laws of Rhode Island, Nurses.
Rhode Island Board of Nurse Registration, Registered Nursing Rules, on the performance of intravenous procedures and closed chest cardiac resuscitation by registered nurses.

9. Tennessee Code Annotated, Chapter 6, Medicine and Surgery.
Tennessee Code Annotated, Professional Nursing defined.
Tennessee Board of Nursing, Rules on Discipline of Licensees.

10. Washington Revised Code Annotated, Chapter 18.71A, Physicians' Assistants.
Washington Revised Code Annotated, Chapter 18.57A, Osteopathic Physicians' Assistants.
Washington Administrative Code, Board of Medical Examiners Rules on Physicians' Assistants.
Washington Revised Code Annotated, Registered Nursing.
Washington Administrative Code, Rules on Certified Registered Nurses.

11. Wisconsin Statutes Annotated, Chapter 488, Medical Practices.
Wisconsin Administrative Code, Medical Examining Board Rules, Chapter Med. 8.
Wisconsin Statutes Annotated, Practice of Professional Nursing.
State of Wisconsin Board of Nursing, Position Papers on Nurse Practitioners and Advanced Registered Nurse Practitioners.

A C K N O W L E D G E M E N T S

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C H C P P R O J E C T S T A F F

Michigan Department of Corrections
Office of Health Care

University of Michigan
School of Public Health
Department of Medical Care Organization

Michigan State University
Colleges of Human and Osteopathic Medicine
Department of Community Health Science

American Medical Association
Division of Medical Practice
Program to Improve Health Care in Correctional Institutions

University Research Corporation

FOREWORD

The issues of adequacy, accessibility, and quality of health care service delivery in correctional institutions are increasingly receiving well-merited attention. Long plagued by neglect and paucity of resources, most correctional agencies throughout the country have recognized the need for clear direction in addressing these issues. The unique characteristics of prison populations and facilities pose a problem in applying directly the standards and policies which prevail in community health care settings. Once the basic ingredients common to good health care practice have been identified, the challenge remains of their adaptation without essential compromise to the correctional environment. Implementation of a system which meets statutory and professional standards is the responsibility of correctional health care administrators in the 1980's.

Through a grant from the Law Enforcement Assistance Administration, the Michigan Department of Corrections has provided technical assistance to ten states with a view to improving their health care system for residents of correctional institutions. This manual is one of a series published under auspices of the grant. Together, the manuals will support and extend the training sessions and technical assistance efforts of the past two years. Their purpose is to define concisely the major elements which must constitute a comprehensive health care program for a correctional agency.

There is no substitute for proper planning, adequate resources and good management. These manuals can assist in the planning effort to identify the kind of resources which will comprise an adequate program. In addition, they address the alternatives which must be considered, the integration of various components, and establish a foundation for the decisions which must be made by each agency.

The manuals have been compiled by persons who are experts in their professional field and by persons active in the delivery of health services to correctional residents. There are too many divergencies among correctional agencies to permit a single approach to be universally applicable. For this reason, the manuals are intentionally broad in scope and will require careful analysis and specification by each user.

A health care system does not stand alone and isolated from its environment. It can succeed only through a cooperative and carefully planned effort which involves health care personnel, staff of the correctional system, community health resources, and residents as interested consumers of the services. Where multiple institutions exist within a state correctional agency, appropriate central direction and coordination are essential for coherent and consistent form and quality of the services provided. It is at this level, in particular, that the overall planning, resource development and management of policy should occur.

These manuals are written in a simple "how-to" format and are intended to be self-explanatory. Local regulatory agencies and other community and professional health resources can be helpful in their interpretation and application.

The goal which has prompted development and issuance of this manual and of others in the series has been attainment of professional quality health care for residents of correctional institutions comparable to that available in the community. The sponsors will consider their efforts well rewarded if, as a result, changes are implemented which improve access and cost-effective delivery of needed health services.

Jay K. Harness, M.D.
Director
Correctional Health Care Program

INTRODUCTION

A. Objectives of the Manual

This document is intended as a reference source for the correctional health care administrator concerning mid-level practitioners. The manual has four objectives.

First, the manual describes the legal aspects of practice for two kinds of mid-level practitioners: physicians' assistants and nurse practitioners. Each of the eleven states that participated in the Correctional Health Care Program will find suggested sources for additional clarification of the legal environment.

Second, this manual details the important features of state statutes and regulations regarding physicians' assistants and nurse practitioners. In several of the less clearly specified areas of practice, the statutes and regulations may not provide completely satisfactory answers to questions which are asked; in other instances, the requirements for compliance with laws are clearly defined. While there are many difficult questions involved in practical application of the principles and requirements set forth in state laws, the material in this manual provides a starting point for considering how physician extenders might be used in correctional institutions. Ultimately, the advice and opinion of legal counsel should always be sought with reference to specific problems and before any major program is undertaken.

Third, while this manual describes both the legal requirements for and limitations on the inclusion of physician extenders in the health service programs of correctional institutions, it also establishes a framework for examining the legal context of practice for the larger classification of auxiliary health manpower. Many of the same types of issues and questions which are raised with respect to nurse practitioners and physicians' assistants may be applied with equal effectiveness to the analysis of legislation on other types of allied health

personnel, such as dental hygienists, dental assistants, physical therapists, and emergency medical technicians, to name a few. The sources of information listed for physician extenders are often the same sources to which one would turn for information on other categories of auxiliary health manpower.

Finally, an appreciation of the legal issues involved in employing physician extenders may prove helpful to the administrator when developing internal policies and procedures, establishing job descriptions and clarifying licensure requirements.

Correctional health care administrators who wish to influence their state's legislation pertaining to mid-level practitioners may find that a perusal of the language and requirements in other states' statutes and regulations would be informative and useful.

B. Format of the Manual

The next section of this Introduction presents a brief overview of the development of mid-level practitioners and the potential for their use in the correctional setting.

Chapter I describes the legal framework that is necessary to understand the requirements governing the practice of mid-level practitioners. Since the analysis in this manual is based on the framework described, an understanding of it and the terms used will enhance the usefulness of the manual.

Chapters II and III contain information on the regulatory authorities and "conditions on practice" (or functioning) of physicians' assistants and nurse practitioners; Chapter II deals with physicians' assistants and Chapter III with nurse practitioners.

Table 1 in Chapter II presents the status of physicians' assistants legislation and administrative rules and regulations in all eleven Correctional Health Care Program states. Statutes are classified as either "general delegatory" or "regulatory", using the guidelines described in Chapter I, B.(1), Authorization

for Practice.

Following Table 1 is a series of questions and answers concerning "conditions on practice" for physicians' assistants. The questions are as follows:

1. What types of services may physicians' assistants provide?

2. Are physicians' assistants subject to a formal approval process by state regulatory authorities whereby they are required to meet specified educational, experiential, or other requirements or qualifications for practice?

3. What are the requirements for supervision or consultation with physicians who delegate the performance of services to physicians' assistants?

4. Must physicians be approved by state regulatory authorities to utilize physicians' assistants?

5. Do the statutes or rules distinguish tasks which may be performed by physicians' assistants pursuant to standing versus direct orders?

6. What tasks or types of services cannot be delegated to physicians' assistants?

7. May drugs be prescribed by physicians' assistants?

8. Must physicians' assistants obtain the informed consent of patients to whom they provide services?

9. How many physicians' assistants may work under the supervision or direction of one physician?

10. Do the statutes or regulations discuss the provision of services by physicians' assistants in hospitals or other institutions or facilities?

Each of the above questions is answered for each of the Correctional Health Care Program states.

Following the above list of questions and answers for each state is Table 2, which provides the citations for each state's authorizing legislation for physicians' assistants as well as the names and addresses of regulatory boards which have a role in controlling the practice of physicians' assistants in the various states.

Chapter III reviews the legal status of the expanded role of registered nurses performing medical functions, which are outside the traditional scope of nursing

care services. Two observations are in order. First, the volume of material describing the functions and responsibilities of nurse practitioners from a legal perspective is considerably less than the amount of available material describing conditions on practice for physicians' assistants. Second, analysis of conditions on practice for nurse practitioners is difficult because, in many cases, the language lacks specificity or clarity. Therefore, Chapter III begins with a discussion which provides examples of the language in nursing practice acts which deal with nurse practitioners or other specialists functioning in expanded roles. This discussion is followed by Table 3, which summarizes the status of the expanded role of registered nurses in the Correctional Health Care Program states. There is a brief examination of the conditions on practice of nurse practitioners in three states for which it was possible to suggest answers to questions: Florida, North Carolina, and Wisconsin.

Finally, Table 4 provides a list of citations for the portions of state nursing laws which describe the scope of practice for registered (professional) nurses, as well as the regulatory boards for these practitioners. Those states whose nurse practice acts provide for an expanded rather than traditional nursing role for registered nurses are marked with an asterisk. Where available, excerpts of relevant portions of state statutes and regulations as well as other supporting materials pertaining to nurse practitioners are included in each state's supplementary material.

The supplementary materials (bound separately for each state) contain reference materials, such as copies of statutes or excerpts from statutes which form the basis for the analyses on conditions on practice, as well as copies of administrative rules, where they have been issued and were available. Florida, for exampie, is currently engaged in revising its health statutes and therefore regulations were not available. The statutory citations and excerpts are as current as it was possible to provide at the time of this printing. Copies of regulations or pro-

posed regulations may always be obtained from the state regulatory boards listed in Tables 2 and 4, or from law libraries in the state.

C. Mid-level Practitioners in the Correctional Setting: An Overview

Health workers such as physicians' assistants, nurse practitioners, child health associates, and Medex are known collectively by such titles as physician extenders and mid-level practitioners. The term "physician extender" is used to denote personnel whose training and experience permit them to perform duties which complement, supplement, or substitute for those traditionally performed by physicians. These personnel are also referred to as "mid-level practitioners" because their education and training clearly place them above the average office assistant or traditionally trained nurse, but below the level of physicians. They extend the productive capacity of physicians just as dental hygienists and dental assistants extend the productive capacities of dentists. There are also a variety of professional and technical workers in such allied health fields as emergency medical care, respiratory and physical therapy, and radiology; however, these personnel usually do not have the scope of general function or training comparable to the formally trained mid-level practitioner.

Mid-level health workers are trained to provide routine diagnostic and screening services such as taking medical histories, conducting physical examinations, ordering and performing laboratory studies and tests, and formulating medical treatment plans. Similarly, physicians' assistants and nurse practitioners are qualified to provide a variety of other clinical services which include administering immunizations and injections, providing emergency services such as suturing and care of wounds, and performing additional therapeutic, medical and nursing functions.

This manual focuses on two groups of mid-level practitioners who are involved in the delivery of medical care services that would otherwise be performed by physicians: physicians' assistants and nurse practitioners. The designation

"nurse practitioner" currently describes the nurse whose formal education extends past that required for basic state licensure as a registered nurse. Nearly all states have made an effort to legally acknowledge the provision of medical services by nurses functioning in "expanded roles". Physicians' assistants represent a relatively new health occupation. They are trained to perform medical tasks which are delegated to them by supervising physicians or set out in predetermined plans or protocols.

In some states, there are many similarities in the types of services and conditions under which physicians' assistants and nurse practitioners work, as in North Carolina, for example. In other states, physicians' assistants and nurse practitioners function in very different ways, both in terms of duties performed and the conditions under which their services are provided. Services and the conditions of practice may also vary within occupational classificiations. In Washington, for instance, there are several types of physicians' assistants: some are authorized to perform tasks which are technical in nature or speciality-related, while others function as assistants to physicians who provide a broad spectrum of general medical or primary care services.

Many hospitals, clinics, and solo physicians have begun to employ mid-level practitioners (MLPs) to share patient care responsibilities with the physician. There is no reason why this trend should not extend into correctional facilities as well. In many correctional institutions, however, tradition remains. Physicians perform intake health evaluations; examine all individuals who wish to be seen at sick call; he/she is responsible for identifying medical problems, initiating treatments and following up on special studies and referrals. Systems which rely so heavily on physicians must be able to respond with appropriate levels of physician coverage. However, few correctional systems have been successful in recruiting and retaining sufficient numbers of physicians to enable them to adequately meet the health care needs of their resident populations.

Controlled populations with predominantly routine medical care needs, such as those typically found in correctional institutions, exemplify the type of setting for which nurse practitioners and physicians' assistants are particularly well-suited. Much of what a physician does during his evaluation and care of patients is routine and repetitious and could be carried out with equal competence by mid-level providers. In delegating routine medical functions to MLPs, physicians can concentrate their abilities on more serious and complex illnesses and extend their services to a much larger group of patients. The use of mid-level practitioners would allow for the creation of a delivery system which evaluates health problems through a series of encounters with increasingly sophisticated medical providers. Less hurried examinations might lead to more accurate diagnoses and physicians, the most costly primary care resource, would be permitted to concentrate on those patients who truly require their higher level of skill and training. Provider satisfaction would likely be increased at all levels, since each would be allowed to utilize the full range of their technical skills.

The diagnostic and therapeutic services which nurse practitioners and physicians' assistants can provide, and the conditions under which they may assume these traditionally medical functions vary according to a number of factors. These factors include: credentials (education, training and experience) of the individual practitioner, parameters of state laws and willingness of the supervising physician to delegate medical tasks. State medical practice acts, state nursing practice acts and state regulations tie the medical practice of physician assistants and nurse practitioners directly to that of physicians and limit the medical services that MLPs can perform. Legislation and regulations vary from state to state, but in general require an identified physician supervisor to be legally responsible for the professional activities of the new health professionals.

A considerable body of literature has developed in the past decade regarding patient and physician acceptance of mid-level practitioners and the potential

impact of NPs and PAs on the productivity of physicians and on the availability of health services. Investigators have also attempted to evaluate the effects associated with the use of mid-level providers on the quality of health services. Two publications which consider the issues surrounding the use of new health professionals have been prepared by Ann Bliss and Eva Cohen[1] and by David Lawrence[2]. Briefly summarized, patients appear to be satisfied with the care provided by NPs and PAs[3]. Physicians also have shown acceptance of new health professionals.[4] Although highly dependent upon the practice setting and the physician specialty studied, the addition of new health professionals to a physician's practice has in many cases resulted in productivity increases.[5,6] Studies of quality of care provided by these mid-level practitioners suggest that the processes and outcomes of care are not adversely affected and may, in fact, be improved.

In the 1970s, the federal government made a major commitment to encourage development of training programs for NPs and PAs through the Nurse Training Acts (1971, 1975, 1978), the Comprehensive Health Manpower Act of 1971 and the Health Service Extension Act of 1977. In the past decade, approximately 10,000 to 15,000 nurse practitioners and physicians' assistants have been trained and at the present time approximately 175 to 200 formal programs are preparing practitioners for careers in primary care. It has been estimated that presently 1,500 nurse practitioners and 1,000 physicians' assistants are graduated annually.

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1. Bliss, A. and Cohen, E., Eds "The New Health Professionals", Aspen Septems Corp., Germantown, MD, 1977.

2. Lawrence, D., "PAs and NPs: Their Impact on Health Care Access, Cost and Quality", Health and Medical Care Service Review 1(2), 1-12, March/April 1978

3. Ruby, G., "Consumer Acceptance of NPs and PAs", Institute of Medicine Resource Paper, Washington, D.C., National Academy of Sciences, January 1977.

4. Ibid., "Physician Acceptance of NPs and PAs", Institute of Medicine Resource Paper, as above, June 1977.

5. Institute of Medicine, "A Manpower Policy for Primary Health Care", Washington, D.C., National Academy of Sciences, May, 1978.

6. Sheffer, R., "The Productivity of PAs", Scheffer, R., Research in Health Economics, Vol. 1, Greenwich, CT, JAI Press, 1979.

Mid-level practitioners evolved in response to physician shortages predicted in the late 1960s. Today the supply of physicians has increased considerably in response to federal initiatives and support for medical education. The possibility of an oversupply of physicians is now being suggested and questions are being raised about the future role of MLPs. If there is an oversupply of physicians, nurse practitioners and PAs may encounter difficulty finding employment.

For many years, prisons have been medically underserved. Pressure from the courts is providing strong incentives to improve prison health care services. There are reasons to believe that, even with an increased supply of physicians, recruitment will remain a problem in the prison setting. However, new health practitioners represent a health manpower resource which has demonstrated an ability to expand the services available to patients and improve patient care.

As the number of training programs increases and the supply of MLPs increases, correctional health care administrators should evaluate the potential for employing such personnel as one of the available alternatives for alleviating the problem of medically underserved prison populations.

A majority of states presently provide some form of authorization for the performance of medical functions by nurse practitioners and physicians' assistants. However, the laws and regulations of MLPs are still in a state of flux. Since the duties and responsibilities of mid-level practitioners are so closely related to enabling legislation for expanded medical delegation it is reasonable to expect that as additional legislation evolves so too will the roles of mid-level practitioners. The remainder of this manual will address itself to the legal context of practice for NPs and PAs in the eleven states participating in the Correctional Health Care Program.

CHAPTER I

LEGAL REQUIREMENTS FOR THE PRACTICE OF PHYSICIANS' ASSISTANTS AND NURSE PRACTITIONERS

A. Types of Legislative and Judicial Authority

The medical functions which nurse practitioners and physicians' assistants perform and the circumstances under which they work vary according to a number of factors. These factors include the education, training, and experience of the individual; the duties which supervising physicians believe are appropriate to delegate to them; the legal parameters of a state's laws; and general "custom and usage". The degree of independence under which nurse practitioners or physicians' assistants function also varies, and depends in large part upon the specific combination of limitations and authorizations provided by state statutes and regulations.

This manual describes the legal framework governing the practice of nurse practitioners and physicians' assistants in the eleven Correctional Health Care Program (CHCP) participating states: Colorado, Florida, Illinois, Michigan, Nebraska, Nevada, North Carolina, Rhode Island, Tennessee, Washington, and Wisconsin.

Four major components of the legal framework for physician assistant and nurse practitioner practice may be identified:

(1) Statutory law. The original enabling legislation for physician assistants and nurse practitioners provides the basic authorization for practice by specifying such things as: the types of functions which may be delegated by physicians to nurse practitioners and the physicians' assistants; the requirements for supervision of the personnel providing the services; and explicit prohibitions on the performance of specific acts, tasks, or functions by nurse practitioners or physicians' assistants. Statutes vary greatly in their degree of clarity and specificity.

(2) Administrative rules or regulations. Depending upon the nature of the authorizing statute, administrative agencies charged with the responsibility for implementing the enabling legislation may have either a narrow scope of authority

to develop and apply the legislation or may be granted broad powers to define the specific conditions of practice, such as scope of practice and conditions of supervision. Where broad, discretionary powers are granted, the rules (rather than the statutes) provide the basic information which defines how a physician's assistant or nurse practitioner is to function.

(3) Interpretation of statutes and rules. Further specificity of the actual meaning of a statute and its rules may be provided through formal or informal opinions of the state's Attorney General's Office.

(4) Court decisions (case law). The final interpretation of any statute is always provided by the courts.

The discussion which follows is based primarily on the legal standards for practice which are established by state statutes and regulations, rather than by other sources of authority. Although several opinions by State Attorneys General are included as part of the manual's supplemental reference materials, this manual does not deal with the body of existing opinions, nor with case law, which is not yet very extensive. Needless to say, clarification of legislative intent or statutory construction by a state's Attorney General is an essential part of a state's regulatory framework.

B. Physicians' Assistants and Nurse Practitioners: Authority and Function.

Later chapters of this manual distill material from statutes, regulations, and other available resources in order to provide two types of information: (1) a description of the statutory and regulatory provisions which provide initial authorization for practice by physician extenders, and (2) identification of the functions which physician extenders are permitted to perform as a consequence of the basic authorizing statutes and rules. Following is a brief discussion explaining the legal concepts related to authority for practice and "functions" of PAs and NPs.

(1) Authorization for Practice. Laws regulating the practice of medicine and osteopathy specifically prohibit individuals who are not formally trained and licensed in these professions from providing any of the services normally considered to be a part of those professions. Because physicians' assistants do not have the training of a physician and would not qualify to be licensed as a physician, they would legally be precluded from providing medical or osteopathic services unless some specific legal exception were made. Two types of legal recognition or authorization for physicians' assistants to practice may be provided: (a) inclusion of a general delegatory clause in existing statutes regulating medical and osteopathic practice, or (b) enactment of a specific, separate statute for physicians' assistants similar to the law regulating medical and osteopathic practice.

A general delegatory clause allows physicians to delegate the performance of medical acts to personnel who function under the physician's supervision and control and for whose performance the physician is ultimately responsible. The functions to be delegated may or may not be described in statute, depending on the level of specificity of the law. In general, the statute does not provide for the specific, individual regulation of the personnel to whom functions are to be delegated separate from that which the physician is to provide.

A regulatory statute, by contrast, provides for: (a) the regulation of the personnel performing such functions through establishment of educational and practice standards, (b) an administrative authority to implement the statute, and (c) other provisions commonly associated with a general licensing statute including, most importantly, some formal process of certification, registration, or licensure. Statutory authority of the regulatory type may be found in the medical or osteopathic practice acts or in a separate regulatory statute for physicians' assistants. It is essential to distinguish between the state licensure, certification, or registration laws which are the subject of this discussion, and the voluntary certification standards and programs which may be offered to the same group of practitioners by professional associations or non-governmental

agencies, but which do not operate with the force of law.

With regard to authorizations to practice for nurse practitioners, identification of specific authorizing language is more difficult. Traditionally, nurse practice acts have included a clause prohibiting nurses from performing acts of medical diagnosis or treatment. Insofar as licensure as a registered nurse is a prerequisite for nurse practitioners, one approach to authorizing the performance of medical functions has been to remove this prohibition on medical diagnosis and treatment from the practice acts. A number of other approaches have been taken through both practice acts and rules, as will be described in Chapter III. These include: (a) amending the definition of nursing practice, called the scope of practice, to include language similar to "additional acts recognized by medicine and nursing as proper to be performed by nurse practitioners", or "medical acts delegated by physicians", or "acts requiring additional education and training"; (b) writing provisions directed specifically towards nursing specialties such as nurse practitioners and in some states providing certification for those specialties; (c) developing rules and regulations for nurse practitioners under the authorities provided to nursing boards or to joint practice committees of medical and nursing boards; and (d) providing standardized procedures under which nurse practitioners may operate.

(2) Functions of Physicians' Assistants and Nurse Practitioners.

The majority of states have taken actions to authorize the performance of medical functions by nurse practitioners and approximately forty-five states have provided a legal basis for the practice of physicians' assistants. The functions of physicians' assistants, or the "conditions on their practice", include: (a) the authorized scope of services, whether delineated through a detailed listing of tasks in statute or specified by an administrative agency acting under statutory mandate to identify the services to be performed; (b) the conditions of supervision of a physician assistant's practice, including the frequency of review of activities

and the physician proximity required of the supervising physician; (c) answers to such questions as whether or not physicians' assistants may prescribe drugs and if so, what classes of drugs and under what conditions; (d) the types and extent of restrictions on services which physicians may not delegate or which are explicitly prohibited in statute; and (e) the use of written protocols to permit physicians' assistants to function on rounds, in hospitals or in other institutions.

There are fewer questions concerning NPs "conditions of practice" because treatment of specific questions in the statutes and rules is more limited. Questions which are asked in the analysis of conditions on the practice of nurse practitioners in this manual follow the same lines as those for physicians' assistants.

CHAPTER II

PHYSICIANS' ASSISTANTS: ANALYSIS OF STATE LEGISLATION AND REGULATION IN ELEVEN C.H.C.P. STATES

Table 1. STATUS OF PHYSICIANS' ASSISTANTS LEGISLATION AND ADMINISTRATIVE RULES IN ELEVEN STATES.

STATE	NATURE OF STATUTE	ADMINISTRATIVE RULES AND REGULATIONS
COLORADO	GENERAL DELEGATORY	No Rules have been issued.
FLORIDA	REGULATORY*	No current Rules; Rules being revised.
ILLINOIS	REGULATORY	Yes - Promulgated by Department of Registration and Education, 1977.
MICHIGAN	REGULATORY	No current Rules; Rules being revised.
NEBRASKA	REGULATORY	Yes - Promulgated by the Board of Medical Examiners, 1973.
NEVADA	REGULATORY	Yes - Promulgated by the Board of Medical Examiners, 1976.
NORTH CAROLINA	REGULATORY	Yes - Promulgated by the Board of Medical Examiners, 1975.
RHODE ISLAND	REGULATORY	No Rules promulgated, although the Dept. of Health has authority to do so.
TENNESSEE	GENERAL DELEGATORY	No Rules.
WASHINGTON	REGULATORY	Yes - Washington Administrative Code 308-52-130 to 135, 1977.
WISCONSIN	REGULATORY	Yes - Wisconsin Administrative Code Med. 8.01-.11.

*Due to be repealed July 1, 1979 pursuant to the Regulatory Reform Act of 1976.

CONDITIONS ON PRACTICE: PHYSICIANS' ASSISTANTS — COLORADO

1. *What types of services may physicians' assistants provide?*

In Colorado, physicians' assistants are allowed to practice under an exemption to the prohibition against practicing medicine without a license. This exemption, which is contained in the section defining the practice of medicine, permits:

> (1) The rendering of services under the personal and responsible direction and supervision of a person licensed under the laws of this state to practice medicine, but nothing in this exemption shall be deemed to extend the scope of any license, and this exemption shall not apply to persons otherwise qualified to practice medicine but not licensed to so practice in this state.....

There is no further definition of "services" in the statute, and since regulations covering physicians' assistants do not exist, it is not clear which medical services may be performed. The meaning of the phrase "nothing in this exemption shall be deemed to extend the scope of any license" is also unclear.

2. *Are physicians' assistants subject to a formal approval process by state regulatory authorities whereby they are required to meet specified educational, experiential, or other requirements?*

No. Colorado's law is of the "general delegatory" type: the medical practice board is not invested with authority to license or grant other formal recognition to physicians' assistants or other types of personnel who might be authorized to practice by the general delegatory clause.

3. *What are the requirements for supervision or consultation with physicians who delegate the performance of services to physicians' assistants?*

Physicians' assistants may render services only under the "personal and responsible

QUESTION #3 (continued) COLORADO

direction and supervision" of a licensed physician. The key terms "direction" and "supervision" are used in statutes as a primary condition upon the delegation of functions to allied health personnel by physicians. Here, supervision and direction must be "personal and responsible", but no further definition is provided by the statute.

4. *Must physicians be approved by state regulatory authorities to utilize physicians' assistants?*

No, not under "general delegatory" authorization.

5. *Does the statute or rules distinguish tasks which may be performed by physicians' assistants pursuant to standing versus direct orders?*

No.

6. *What tasks or types of services cannot be delegated to physicians' assistants?*

Again, there is no indication of the types of medical care services which physicians' assistants may provide.

7. *May drugs be prescribed by physicians' assistants?*

The prescribing of drugs by physicians' assistants is not addressed in the statute.

COLORADO

8. *Must physicians' assistants obtain the informed consent of patients to whom they provide services?*

The statute does not address this question.

9. *How many physicians' assistants may work under the supervision or direction of one physician?*

Not mentioned in the statute.

10. *Does the statute or regulations discuss the provision of services by physicians' assistants in hospitals or other institutions or facilities?*

No, there is no discussion of utilization of physicians' assistants in hospitals. On the other hand, the wording of the statute is such that services rendered "under the personal and responsible direction and supervision" of a licensed physician in an institution presumably would not be prohibited.

CONDITIONS ON PRACTICE: PHYSICIANS' ASSISTANTS FLORIDA

1. What types of services may physicians' assistants provide?

Florida statutes provide for the certification of physicians' assistants for both allopathic (M.D.) and osteopathic (D.O.) physicians. The authorizing language of the two separate chapters is essentially identical. A "physicians' assistant" is defined (in the medical practice act) as:

> a person who is a graduate of an approved program or its equivalent and is approved by the board to perform medical services under the supervision of a physician or group of physicians approved by the board to supervise such assistant. (Sec. 2(d))

The PA's scope of services is described by the following provision:

> (Sec. 3) Performance by physician's assistant. -Notwithstanding any other provision of law, a physician's assistant may perform medical services when such services are rendered under the supervision of a licensed physician or group of physicians approved by the board, in the specialty area or areas for which the physician's assistant is trained or experienced.....

In Florida, the scope of practice of physicians' assistants is limited by law to "the specialty area or areas for which the physician's assistant is trained or experienced". Another section in statute (458.135(5)(c)) indicates that the specialty classification or classifications will be shown on the PA's certificate of approval.

2. Are physicians' assistants subject to a formal approval process by state regulatory authorities whereby they are required to meet specified educational, experiential, or other requirements?

Yes, these qualifications are to be detailed in applications which must be submitted by physicians to the Board of Medical Examiners or Board of Osteopathic Medical Examiners to obtain approval to supervise physicians' assistants.

QUESTION #2 (continued) FLORIDA

(Sec. 6) Application Approval. -The board shall formulate guidelines for the consideration of applications by a licensed physician or physicians to supervise physicians' assistants. Each application made by a physician or physicians shall include all of the following:

(a) The qualifications, including related experience, of the physician's assistant intended to be employed;

(b) The professional background and specialty of the physician or physicians; and

(c) A description by the physician of his, or physicians of their, practice and the way in which the assistant or assistants are to be utilized.

The board shall approve an application by a licensed physician to supervise a physician's assistant when the board is satisfied that the proposed assistant is a graduate of an approved program or its equivalent, is fully qualified by reason of experience and education to perform medical services under the responsible supervision of a licensed physician, and the public will be adequately protected by the arrangement proposed in the application.

In addition, there is reference in the statutes to "certification of a physician's assistant in a specialty area" and the payment of a fee for such certification, although there is no description of the application or procedure for such certification. PA certificates must be renewed annually.

3. *What are the requirements for supervision or consultation with physicians who delegate the performance of services to physicians' assistants?*

"Supervision means responsible supervision and control, with the licensed physician assuming legal liability for the services rendered by the physician's assistant. Except in cases of emergency, supervision shall require the easy availability or physical presence of the licensed physician for consultation and direction of the actions of the physician's assistant. The Board of Medical Examiners shall further establish rules and regulations as to what constitutes responsible supervision of the physician's assistant. (Medical Practice Act, Fla. Stat. Ann/ §458.135 (2)(c))

In addition, the law is quite specific concerning several additional conditions which must be met in order to utilize a PA. Specifically:

(Sec. 3) .....Any physician's assistant certified under this section to perform services may perform those services only:

QUESTION #3 (continued) FLORIDA

(a) In the office of the physician to whom the physician's assistant has been assigned, where such physician maintains his primary practice;
(b) When the physician to whom he is assigned is present;
(c) In a hospital where the physician to whom he is assigned is a member of the staff; or
(d) On calls outside said office, on the direct order of the physician to whom he is assigned.

4. *Must physicians be approved by state regulatory authorities to utilize physicians' assistants?*

Yes, as described under Question #2. A physician's authorization to supervise a physician's assistant is valid for one year, and may be renewed.

5. *Does the statute or rules distinguish tasks which may be performed by physicians' assistants pursuant to standing versus direct orders?*

No. The statute does state that physicians' assistants may perform services "on calls outside (the physician's office), on the direct order of the physician to whom he is assigned", but there is no reference to the performance of functions according to standing orders.

6. *What tasks or types of services cannot be delegated to physicians' assistants?*

Aside from the restriction that physicians' assistants confine their performance of services to the specialty area or areas for which they are trained or experienced, there are no other limitations on the types of services which may be provided.

7. *May drugs be prescribed by physicians' assistants?*

This question is not addressed in the statute or rules.

FLORIDA

8. *Must physicians' assistants obtain the informed consent of patients to whom they provide services?*

This question is not addressed in the Florida statutes (or rules) under consideration.

9. *How many physicians' assistants may work under the supervision or direction of one physician?*

Florida statutes for both medical and osteopathic physicians' assistants provide clear legal boundaries concerning the question of how many PAs may practice under the supervision of physicians:

> (Sec. 6(d)). The board shall certify no more than two physicians' assistants for any physician practicing alone; four physicians' assistants for two physicians practicing together formally or informally; or a ratio of two physicians' assistants to three physicians in any group of physicians practicing together formally or informally.

10. *Does the statute or regulations discuss the provision of services by physicians' assistants in hospitals or other institutions or facilities?*

Yes. The statutes do indicate that where a supervising physician is a member of a hospital's staff, provision of services by a PA or PAs is permitted. Although there is no language which deals with employment of PAs by a hospital, presumably this would be legal, as long as the "physician to whom he (the PA) is assigned" is a member of the hospital staff.

CONDITIONS ON PRACTICE: PHYSICIANS' ASSISTANTS ILLINOIS

1. What types of services may physicians' assistants provide?

Section 4754 of the Physicians' Assistants Practice Act is quite specific concerning the permitted scope of practice of physicians' assistants, and the rules which supplement the statute are similarly specific.

> (4754.) Section 3. Physicians' assistants. "Physician's assistant means any person not a physician who is certified to perform medical procedures under the supervision of persons licensed to practice under "The Medical Practice Act". A physician's assistant may perform such medical procedures within the specialty of the supervising physician, and control over such physicians' assistants as will assure that patients receiving medical care from a physician's assistant shall receive medical care of the highest quality. Physicians' assistants shall be capable of performing a variety of tasks within the specialty of medical care under the direct supervision of a physician. Physicians' assistants cannot exercise independent judgment for purposes of diagnosis and treatment of patients. Nothing in this Act shall be construed as relieving any physician of the professional or legal responsibility for the care and treatment of persons attended by himself or by physician's assistants under his supervision. Physicians' assistants shall have only those powers and rights set forth in this Act and the exercise of any powers beyond those set forth shall constitute a violation of this Act. (Amended by P.A.* 80-811, §1, eff. Sept. 20, 1977.)

Clearly, this language authorizes the performance of "medical procedures within the specialty of the supervising physician", and under the "direct supervision" of a physician. The statute proscribes the "exercise of independent judgment for purposes of diagnosis and treatment of patients".

The administrative rules spell out in detail what tasks a physician's assistant is allowed to do.

> Rule V. Permitted Tasks of Physician's Assistant
>
> Section 1. The Physician's Assistant shall, under the Supervising Physician's direction and supervision, augment the Supervising Physician's data gathering abilities in order to assist such Supervising Physician in reaching decisions and instituting care plans for the Supervising Physician's patients.
>
> Section 2. If the Supervising Physician has satisfied himself as to the ability and competency of the Physician's Assistant, then, the Supervising Physician may, with due regard to the safety of the patient

*P.A.=Public Act

QUESTION #1 (continued) ILLINOIS

and in keeping with sound medical practice, delegate to the Physician's Assistant, and the Physician's Assistant may perform, under the direction, supervision, and responsibility of such Supervising Physician, subject as otherwise provided by the PA Practice Act and these Rules and Regulations, such medical procedures and other tasks as are usually performed within the normal scope and characteristics of the Supervising Physician's practice which do not require the exercise of independent medical judgment.

Section 3. On follow-up care, hospital visits, nursing home visits, attending of the chronically ill at home, and in similar instances where a therapeutic regimen or other written protocol has been established by the Supervising Physician, the Physician's Assistant may check and record the patient's progress within the confines of the established regimen or protocol and report the patient's progress to the Supervising Physician. When a new problem arises or established parameters are exceeded, the Physician's Assistant shall bring such matters to the Supervising Physician's attention promptly, and the Supervising Physician shall then undertake a personal review of the patient's condition and the problems of such patient.

2. *Are physicians' assistants subject to a formal approval process by state regulatory authorities whereby they are required to meet specified educational, experiential, or other requirements?*

Yes. Under terms of statute,

(4757.) Section 6. (Applications for certification--Qualifications - Fees). Each applicant for a physician's assistant certificate shall:

1. Hold a currently valid National Commission on Certification of Physicians' Assistants certificate as provided in Section 10.
2. Submit evidence under oath satisfactory to the Department that:
   (a) He is 21 years of age or over;
   (b) He is of good moral character;
   (c) He has the preliminary and professional education required by this Act;
   (d) He is free of contagious diseases.
3. Designate specifically the name, location, and kind of professional schools, colleges, or institutions attended and the courses which he has satisfactorily completed.

Furthermore, Section 4758 provides standards of educational requirements to be met by applicants for PA certification.

QUESTION #2 (continued) ILLINOIS

(4758.) Section 7. Educational requirements. Except as otherwise provided in this Act, the minimum standards of educational requirements prior to certification shall consist of the following:

(a) Successful completion of a 4-year course of instruction in a high school, or its equivalent, as determined by the examining committee; and

(b) Successful completion of a specialized course for physicians' assistants approved by the Committee on Allied Health Education and Accreditation of the American Medical Association's Council on Medical Education and the examining committee provided for in this Act.

The examining committee shall have the power to waive the specialized training provided for in this Section, if the committee determines that any prior training and experience of the applicant is the equivalent of such specialized training or the requirements set forth by the National Commission on Certification of Physicians' Assistants.
(Amended by P.A. 80-811, §1, eff. Sept. 20, 1977.)

The state issues certificates to two kinds of physicians' assistants, described as follows, in the rules:

"Physician's Assistant in Medicine" refers specifically to any person not a physician licensed under the Medical Practice Act to whom the Department has issued a Physician's Assistant in Medicine Certificate authorizing such person to perform medical procedures and tasks, subject to the laws of the State of Illinois and the Rules and Regulations of the Department, under the supervision of a physician licensed to practice medicine in all of its branches under the Medical Practice Act in force in the State of Illionois (which certificate is hereinafter called "Physician's Assistant in Medicine Certificate").

"Physician's Assistant to Chiropractor" refers specifically to any person not a physician licensed under the Medical Practice Act to whom the Department has issued a Physician's Assistant to Chiropractor Certificate authorizing such person to perform medical procedures and tasks subject to the law of the State of Illinois and the Rules and Regulations of the Department, only under the supervision of physician licensed under the Medical Practice Act in force in the State of Illinois to treat human ailments without the use of drugs or medicines and without operative surgery (which certificate is hereinafter called "Physician's Assistant to Chiropractor Certificate").

Rule II, Section 3 elaborates on the educational requirements for the certification of both kinds of physicians' assistants, but is not substantially different from Section 4758 of the Illinois Physician's Assistant statute.

All certificates issued under the Illinois Physician's Assistant Act must be renewed every two years after their issuance. (Sec. 4766).

ILLINOIS

3. *What are the requirements for supervision or consultation with physicians who delegate the performance of services to physicians' assistants?*

The Physicians' Assistants Practice Act provides that a physician shall exercise such "direction, supervision and control" over physicians' assistants as "will assure" that patients receiving medical care from a physician's assistant shall receive medical care of the highest quality.

In the rules, "direction, supervision and control" are specifically defined:

> Rule VI. Supervision of Performance
>
> Section 1. The Physician's Assistant shall occupy space, for office purposes, in any office of the Supervising Physician or in the same suite in which any office of the Supervising Physician is maintained. Except as provided in the preceding sentence, the Physician's Assistant shall not maintain an office independent of, or physically separate from, any office of the Supervising Physician.
>
> Section 2. The Supervising Physician shall provide direct, active and continuing surveillance of the activities of the Physician's Assistant to insure that the Supervising Physician's directions and advice are in fact being carried out. The Supervising Physician shall personally review each patient's medical problems and the historical and physical data with respect thereto furnished to him by a Physician's Assistant employed by such Supervising Physician.
>
> Section 3. The PA Practice Act shall not be construed to require the continuous and constant physical presence of the Supervising Physician so long as such Supervising Physician and the Physician's Assistant are or can be in easy contact with each other by telephone, radio or telecommunication.

4. *Must physicians be approved by state regulatory authorities to utilize physicians' assistants?*

No. In Section 4 of Rule I "Supervising Physician" refers to a physician validly licensed under the Medical Practice Act, as heretofore or hereafter amended, in force in the State of Illinois ("Medical Practice Act"):

> a) to practice medicine in all of its branches; or
> b) to treat human ailments without the use of drugs or medicines and without operative surgery in the State of Illinois.

QUESTION #4 (continued) ILLINOIS

The rules state, however, that a Physician's Assistant shall not perform any medical procedure or other task delegated by Supervising Physician until written notice of the employment of such Physician's Assistant by the Supervising Physician shall be filed, or caused to be filed, with the Department by such Supervising Physician. (Rule IX, Section 1.)

5. *Does the statute or rules distinguish tasks which may be performed by physicians' assistants pursuant to standing versus direct orders?*

No, this distinction is not made in the statute or in rules.

6. *What tasks or types of services cannot be delegated to physicians' assistants?*

Physicians' assistants are precluded from providing optometric services according to Sec. 4760:

> No rule or regulation shall be adopted under this Act which allows a physician's assistant to perform any act, task or function primarily performed in the lawful practice of optometry under "The Illinois Optometric Practice Act" approved June 15, 1951, as amended. (Amended by P.A. 80-811, §1, eff. Sept. 20, 1977.)

Furthermore, the administrative rules contain a whole list of prohibited tasks.

Rule VIII states that a physician's assistant may not:

> -Supplant the Supervising Physician in the interpretation and integration of medical data or in the decision-making process required to establish a diagnosis and therapeutic plan for any such patient.
> -Perform any procedure or task which the Supervising Physician is not qualified, whether by law, competence, experience or otherwise, to perform.
> -Perform any procedure or task which is not a normal or characteristic procedure or task in the Supervising Physician's practice.
> -Independently prescribe any treatment or a regiment thereof.
> -Supplant or replace the Supervising Physician in making visits in the hospital, clinic, nursing home, emergency room or home, without the specific consent of the patient having first been obtained.

QUESTION #6 (continued) ILLINOIS

-Independently initiate or change any orders on a patient's chart in hospitals, clinic, nursing homes or other places where patient charts are used.
-Treat any patient before such Physician's Assistant has communicated with the Supervising Physician regarding the condition of such patient and received orders or directions from the Supervising Physician with respect to the treatment of such patient, except as may be provided in specific written protocols approved by the Department.
-Perform acupuncture in any form.
-Independently delegate to another a task assigned to such Physician's Assistant by the Supervising Physician.
-Perform endoscopic examinations and procedures, or either.
-Bill patients for the services of such Physician's Assistant.
-Perform surgery or surgical procedures.
-Perform spinal punctures.
-Perform abortions.
-Violate the confidentiality of patient information.

7. *May drugs be prescribed by physicians' assistants?*

This question is not taken up in statute; rules, however, deal in detail with this question. Rule VII states that physician assistants may not:

1) Prescribe, order or dispense medication, except as may be provided in specific written protocols approved by the Department.
2) Sign prescriptions on behalf on the Supervising Physician.
3) Have prescription blanks available that have been presigned or stamped by the Physician, or
4) Order the refilling of a presc 'ption.

8. *Must physicians' assistants obtain the informed consent of patients to whom they provide services?*

Yes. The rules are clear and specific regarding patients' informed consent.

Rule III provides that:

> It shall be the responsibility of the Supervising Physician to insure that the patient's consent for which provision is hereinafter made, is obtained.

QUESTION #8 (continued) ILLINOIS

No Physician's Assistant shall render any medical services to, nor any other tasks as hereinafter provided for, any patient, unless:

(a) The Supervising Physician or such Physician's Assistant shall inform said patient:
  i) that such Physician's Assistant is NOT a physician.
  ii) that the Supervising Physician has delegated to such Physician's Assistant certain tasks, describing them, which the Supervising Physician is authorized to delegate under the PA Practice Act, and
  iii) that such services will be rendered by such Physician's Assistant; and

(b) Said patient has consented thereto and evidence or note of such consent has been placed with or in patient's record.

9. *How many physicians' assistants may work under the supervision or direction of one physician?*

No more than one physician's assistant shall be employed by a physician. No physician shall be allowed to supervise more than one physician's assistant. (Sec. 4756.)

10. *Does the statute or regulations discuss the provision of services by physicians' assistants in hospitals or other institutions or facilities?*

Yes. According to the Act:

(4756.) Section 5. Number and supervision of assistants. No more than one physician's assistant shall be employed by a physician. Physicians' assistants shall be employed only under the supervision of persons licensed to practice under "The Medical Practice Act" and engaged in private clinical practice, or in clinical practice in public health or other community health facilities. Physicians' assistants may be employed by the Department of Mental Health and Development Disabilities. Each physician's assistant employed by the Department of Mental Health and Developmental Disabilities shall be under the direct supervision of a fully licensed physician employed by such Department who is engaged in the full-time clinical practice of medicine in direct patient care. Duties of each physician's assistant employed by such Department are limited to those within the scope of practice of the supervising physician who is fully responsible for all physician's assistant's activities. No physician shall be allowed to supervise more than one physician's assistant. (Amended by P.A. 80-811, §1, eff. Sept. 20, 1977.)

It appears from this Section that at the least, a precedent has been set for employment of physicians' assistants by departments of state government other than the Department of Mental Health and Developmental Disabilities; and that such employment would be legal under conditions in which appropriate supervision is provided.

CONDITIONS ON PRACTICE: PHYSICIANS' ASSISTANTS MICHIGAN

1. What types of services may physicians' assistants provide?

In Michigan, physicians' assistants may provide services in the fields of medicine and osteopathy under conditions described in Public Acts 407 (the osteopathic practice act), 420 (the physicians' assistants act), and 421 (the medical practice act of 1916). A physician's assistant is defined as "a person approved by the committee (on physicians' assistants) to provide medical care services under the supervision of approved physicians". "Medical care services" means those services within the scope of practice of those physicians licensed and approved by either of the boards of medicine or osteopathic medicine, except those services which each board respectively determines may not be delegated by a physician in order to protect the health and safety of patients. Therefore, the scope of services which may be provided may be restricted by rules promulgated by the boards at a future date.

To the extent that particular selected medical care services require extensive medical training, education, or ability or pose serious risks to the health and safety of patients, the board may prohibit or otherwise restrict their delegation or may require higher levels of supervision. (P.A. 407,421).

On the other hand, should a physician wish to delegate services in a specialty area for which the physician feels a physician's assistant is qualified, this delegation may be permitted as long as prior approval has been obtained from the board of medicine or osteopathy.

> A physician may apply for an amendment to an approval at any time in a manner and on a form prescribed by the board. Application for an amendment to an approval shall be submitted when:
>
> (a) A substantial change occurs from the original application with regard to the plan for supervision, the plan for emergency situation, or the designated alternative physician.
>
> (b) A substantive change is desired in the delegation of functions to or supervision of a physician's assistant, including the delegation of functions within a specialty area that requires

*P.A.=Public Act

QUESTION #1 (continued) MICHIGAN

specialized education, training, or experience; the delegation of medical care services limited by rule; or, to the extent that a physician's assistant demonstrates greater training, education, and ability, such that additional medical care services could be delegated to them with lower levels of supervision than those required by this act and rules promulgated under this act. (P.A. 407,421).

2. *Are physicians' assistants subject to a formal approval process by state regulatory authorities whereby they are required to meet specified educational, experiential, or other requirements?*

Yes. Under the authority of the Committee on Physicians' Assistants as described in P.A. 420, individuals wishing to practice as a physician's assistant or to use the title "physician's assistant" must meet the requirements specified in the statute and by the committee. (Sec. 8(6)).

Sec. 10. (1) An applicant for approval under this act shall apply in a manner and on a form prescribed by the committee.
(2) An applicant seeking approval by the committee shall:
(a) Be 18 years of age or older.
(b) Be of good moral character, such that the person is able to serve the public as a physician's assistant in a fair, honest, and open manner.
(c) Be a graduate of an approved program; or be a licensed, certified, registered, approved, or other legally recognized physician's assistant in another state with qualification substantially equivalent to those established by the committee; or have the education, training, or experience prescribed by this act or the rules of the committee as determined by an examination or evaluation authorized by the committee, as provided in Section 11 (4).

Sec. 11. (1) To determine whether an applicant for initial approval has the appropriate level of skill and knowledge as required by this act, the committee shall require the applicant to submit to an examination which shall include those subjects the general knowledge of which is commonly and generally required of a graduate of an accredited physicians' assistants program in the United States. The committee may waive the examination requirement for graduates of approved programs where such applicants have taken a national examination and achieved a score acceptable to the committee as demonstrating the level of skill and knowledge required by this act. The committee also may waive the examination for applicants who are licensed, certified, registered, approved, or otherwise legally recognized as a physician's assistant in another state, when the committee determines that the other state has qualifications, including completion of a national or state approved examination for physicians' assistants that are substantially equivalent to those established by this act. For

QUESTION #2 (continued) MICHIGAN

the purpose of this section, the committee shall not, in any case, preclude applicants from taking an examination because of lack of specific previous education, training or experience.
(2) The nature of an examination shall be determined by the committee and may include the use of national examinations where appropriate. The use of examinations or the requirements for successful completion shall not permit discriminatory treatment of applicants.
(3) A person who fails to pass an examination shall be afforded an opportunity for reexamination, not more than 3 times, on the portions of the examination that person failed to pass. Reexamination may occur at a regularly scheduled examination.
(4) The committee shall provide for equivalency and proficiency testing and other mechanisms whereby credit may be given to applicants for past training, education, or experience in health fields. Standards may include standards for formal education and proficiency examinations, training, education, or experience which will be considered equivalent to completion of formal education requirements.
(5) The committee shall provide for the recognition of the certification or experience consistent with this act acquired by physicians' assistants in other states who wish to practice in this state.
(6) The committee may conduct or cause to be conducted, investigations necessary to determine the qualifications of an applicant for approval. An applicant may be required to furnish additional documentation and information upon a determination by the committee that the documentation or information is necessary to evaluate the applicant's qualifications.

Approval or renewal of approval is valid for not more than 2 years. (Sec. 13(2)).

3. *What are the requirements for supervision or consultation with physicians who delegate the performance of services to physicians' assistants?*

Under Michigan law, the requirements for supervision are based on a definition which has four components.

"Supervision" means the overseeing or participation in the work of another where at least all of the following are present:
(i) The continuous availability of direct communication either in person or by radio, telephone, or telecommunications between the physician's assistant and an approved physician.
(ii) The existence of a predetermined plan for emergency situations, including the designation of a physician licensed by either of the boards to supervise a physician's assistant in the absence of an approved physician.
(iii) The availability of an approved physician on a regularly scheduled basis to review the practice of the physician's assistant, to review charts and records, and to further educate the physician's assistant

QUESTION #3 (continued) MICHIGAN

in the performance of his services.
(iv) The provision by the supervising physician of predetermined procedures and drug protocol.

P.A. 420 states explicitly in Sec. 17 that:

> Except in emergency situations, a physician's assistant shall provide medical care services only under the supervision of an approved physician or properly designated alternative physician, and only when those services are within the scope of practice of the supervising physician and are delegated by the supervising physician.

Furthermore, both the medical and osteopathic practice acts provide that a physician may be disciplined by the board for failure to supervise a physician's assistant in accordance with the requirements outlined in statute or by the board. The law states that "a physician may not delegate ultimate responsibility for the quality of medical care services, even if the services are provided by a physician's assistant".

4. *Must physicians be approved by state regulatory authorities to utilize physicians' assistants?*

Yes. As alluded to previously, only physicians who have been approved by either the medical or osteopathic practice boards may utilize PAs.

> "Approved physician" means a physician licensed to practice (osteopathic) medicine and surgery under this act who is approved by the board to supervise physicians' assistants and to delegate the performance of medical care services to physicians' assistants where the delegation is consistent with the training of physicians' assistants.
>
> (1) A physician shall not utilize or supervise a physician's assistant in the practice of (osteopathic) medicine without first obtaining written approval from the board.
> (2) To obtain approval a physician shall make application to the board in a manner and on a form prescribed by the board, which shall include:
> (a) The name of the physician and his business address as it appears on his annual registration certificate.
> (b) Information regarding the professional background and specialty of the physician.
> (c) The physician's plan for supervision of physicians' assistants

QUESTION #4 (continued) MICHIGAN

which at a minimum shall describe his proposed plan for review of the physician's assistant's activities and availability to the physicians' assistants he supervises.

(d) Sites of possible use of physicians' assistants.

(e) A plan to supervise the physician's assistant in the absence or unavailability of the approved physician.

(f) The name, signature, and other information the board deems appropriate concerning the physician to provide supervision in the approved physician's absence.

(g) A plan for emergency situations in which a physician is not available.

(3) Within 10 days after receipt of the completed application, the board may issue a temporary approval in writing. A final determination shall be made as soon thereafter as is reasonably possible.

(4) The board shall cause to be conducted investigations necessary to determine whether an application should be issued or continued.

(5) The board may request that modifications in an initial application be made before the approval is given. (Sec. 13, P.A. 407; Sec. 19, P.A. 421).

An approval may be renewed:

An approval to supervise physicians' assistants is dependent upon the existence of a current license and registration to practice (osteopathic) medicine and shall terminate and be renewed bienially on the same date that the physician's license terminates and is renewed, unless the board deems it necessary to establish a different date for administrative convenience.

(2) A physician shall apply for renewal of approval in a manner and on a form prescribed by the board, which shall include:

(a) The name of the physician and his business address as it appears on his annual registration certificate and the physician's current license number.

(b) The names of the physicians' assistants for whom the physician had a primary supervisory responsibility since the last approval or renewal.

(c) Any changes or desired amendments in the current approval. (Sec. 15, P.A. 407; Sec. 21, P.A. 421).

5. *Does the statute or rules distinguish tasks which may be performed by physicians' assistants pursuant to standing versus direct orders?*

Not explicitly. In the section on supervision requirements, however, it is specified that predetermined procedures and drug protocols are to be provided by supervising physicians to physicians' assistants.

MICHIGAN

6. *What tasks or types of services cannot be delegated to physicians' assistants?*

Michigan statute includes clear prohibitions against the performance by PAs of certain optometric services, as follows:

> A physician's assistant shall not:
> (a) Perform acts, tasks, or functions to determine the refractive state of the human eye, or the treatment of refractive anomalies of the human eye or both.
> (b) Determine the spectacle or contact lens prescription specifications required to treat refractive anomalies of the human eye, or determine modification of spectacle or contact lens prescription specifications, or both.
> (c) A physician's assistant shall not be precluded from the performance of routine visual screening or testing, postoperative care or assistance in the care of medical diseases of the eye under the supervision of an approved physician. (Sec. 16, P.A. 420).

In addition, until rules are promulgated by the medical and osteopathic boards which deal with the delegation of the function of prescription of drugs, physicians' assistants are prohibited from prescribing controlled substances. The conditions under which other drugs may be prescribed are delineated under Question #7.

7. *May drugs be prescribed by physicians' assistants?*

Yes, under the following conditions:

> A physician's assistant may prescribe drugs as a delegated act of a supervising physician, but shall do so only in accordance with procedures and protocol for such prescription established by the boards in rules. Until these rules are promulgated, a physician's assistant may prescribe a drug other than a controlled substance as defined by Act No. 196 of the Public Act of 1971, as amended, being Sections 335.301 to 335.367 of the Michigan Compiled Laws, or federal law, as a delegated act of the supervising physician. Whenever delegated prescription occurs, the supervising physician's name must be used, recorded or otherwise indicated in connection with each individual prescription so that the individual who may choose to dispense or administer the prescription shall know under whose delegated authority the physician's assistant is prescribing drugs. (Sec. 17(3), P.A. 420).

MICHIGAN

8. *Must physicians' assistants obtain the informed consent of patients to whom they provide services?*

There is no mention of such a requirement in statute.

9. *How many physicians' assistants may work under the supervision or direction of one physician?*

Statute clearly states that "a physician shall neither supervise nor employ more than two physicians' assistant at any one time". A clinic, hospital, extended care facility, and other health care institution or organization may employ more than two physicians' assistants, but a physician in the institution or organization shall not supervise more than two physicians' assistants. (Sec. 19, P.A. 407; Sec. 25, P.A. 421).

10. *Does the statute or regulations discuss the provision of services by physicians' assistants in hospitals or other institutions or facilities?*

Yes.

> A physician's assistant shall provide medical care services only in those medical care settings where the approved physician regularly sees patients, but the physician's assistant shall not be precluded from making calls or going on rounds in private homes, public institutions, emergency vehicles, ambulatory care clinics, hospitals, intermediate or extended care facilities, health maintenance organizations, nursing homes, or other health care facilities to the extent permitted by the bylaws, rules, or regulations of the facilities or organizations under the supervision of an approved physician. (Sec. 17(2), P.A. 420).

CONDITIONS ON PRACTICE: PHYSICIANS' ASSISTANTS NEBRASKA

1. What types of services may physicians' assistants provide?

In the state of Nebraska:

> Physician's assistant shall mean any person who graduates from an approved program or its equivalent as determined by the board and who the Board (of Examiners in Medicine and Surgery) with the concurrence of the Department (of Health of the State of Nebraska) approves to perform medical services under the supervision of a physician or group of physicians approved by the board to supervise such assistant..... (Sec. 71-1, 107.16(4)).

In addition, Section 71-1, 107.17 reads:

> Notwithstanding any other provision of law, a physician's assistant may perform medical services when he renders such services under the supervision of a licensed physician or group of physicians approved by the board, in the specialty area or areas for which the physician's assistant shall be trained or experienced.....

As in Florida, the practice of PAs may encompass activities in the specialty area or areas in which the physician's assistant is qualified by training or experience. A subsequent section of the statute indicates that:

> The board may recognize groups of specialty classifications of training for physician's assistants. These classifications shall reflect the training and experience of the physician's assistant. The physician's assistant may receive training in one or more such classifications which shall be shown on the certificate issued. (Sec. 71-101, 107.19(2)).

Rules and regulations adopted by the board do not elaborate as to which specialty classifications these are, however. Rule 4.1(4) requires physicians applying for a certificate of approval to supervise a physician's assistant to include:

> A description by the supervising physician of his, or physicians of their, practice and the way in which the assistant or assistants shall be utilized.

Once the certificate of approval is issued,

QUESTION #1 (continued) NEBRASKA

"(it) shall specifically name those medical services, specialty areas or areas of training in which a physician's assistant may engage."

Rule 4.2 continues:

The physician's assistant shall not engage in any medical services, specialty areas or areas of training other than those specifically listed on the certificate of approval and shall engage in any medical services only if the same have been specifically delegated to him by the supervising physician and are a part of the approved academic program from which the physician's assistant graduated.

2. *Are physicians' assistants subject to a formal approval process by state regulatory authorities whereby they are required to meet specified educational, experiential, or other requirements?*

Yes. PAs are authorized to practice "through the application of a licensed physician or physicians for approval" from the Board of Examiners in Medicine to supervise PAs.

(1) The board shall formulate guidelines for the consideration of applications by a licensed physician or physicians to supervise physicians' assistants. Any application made by a physician or physicians shall include all of the following:
   (a) The qualifications, including related experience, of the physician's assistant intended to be employed;
   (b) The professional background and specialty of the physician or physicians; and
   (c) A description by the physician of his, or physicians of their, practice and the way in which the assistant or assistants shall be utilized.

(2) The board, with the concurrence of the department, shall approve an application by a licensed physician to supervise a physician's assistant when the board is satisfied that the proposed assistant is a graduate of an approved program or its equivalent as determined by the board, is fully qualified to perform medical services under the responsible supervision of a licensed physician, and the public shall be adequately protected by the arrangement proposed in the application. (Sec. 71-1, 107.20).

Both PAs and the supervising physician or physicians must apply to the board on an annual basis for renewal of their certifications.

NEBRASKA

3. *What are the requirements for supervision or consultation with physicians who delegate the performance of services to physicians' assistants?*

Supervision is defined as:

> responsible supervision and control, where the licensed physician assumes legal liability for the services that the physician's assistant renders. Except in cases of emergency, supervision shall require the easy availability or physical presence of the licensed physician for consultation and direction of the actions of the physician's assistant.....(Sec. 71-1, 107.16(5)).

Board rules and regulations do provide clarification as to the meaning of "responsible supervision and control":

> RULE 3. SUPERVISION
>
> 3.1 RESPONSIBLE SUPERVISION AND CONTROL. Physicians' assistants shall be under responsible supervision and control which shall mean: (1) a physician's assistant shall perform only medical services assigned by the supervising physician to the physician's assistant; (2) adequate medical evaluation of the nature and quality of the services rendered by the physician's assistant shall be the responsibility of the supervising physician; and (3) the physician's assistant cannot assume most of, or all of, the practice of medicine for which the supervising physician is responsible.

The rules also describe exceptions to the requirement for physical presence ("easy availability") of the supervising physician when the physician's assistant is functioning:

> 3.2 RESPONSIBLE SUPERVISION. Easy availability means that the immediate personal supervision or physical presence of the supervising physician is not essential in all instances. However, the presence of the supervising physician shall be required except in the following situations:
> (1) So long as the physician's assistant functions in the office of the physician to whom the physician's assistant is assigned;
> (2) So long as the supervising physician maintains responsible supervision - in the opinion of the board - at the location of his place of primary practice;
> (3) In a duly licensed hospital, with the approval of the governing board of the hospital in which the physician to whom he is assigned is a member of the medical staff thereof; or

QUESTION #3 (continued) NEBRASKA

(4) On calls outside the hospital or the supervising physician's office; provided: (a) specific services to or for designated patients as specifically named by the physician are assigned on a daily basis; and (b) the geographical locations of such function of the physician's assistant are identical to the place of primary practice of the supervising physician.

The exception to the requirements for physical presence are based on statutory provisions which identify the locations in which physicians may provide services as identical to those above:

Any physician's assistant certified under the provisions of Sections 71-1, 107.15, 71-1, 107.29 to perform services may perform those services only:
(1) In the office of the physician to whom the physician's assistant is assigned, where such physician maintains his primary practice;
(2) When the physician to whom he is assigned is present;
(3) In a hospital, with approval of the governing board of such hospital, where the physician to whom he is assigned is a member of the staff; or
(4) On calls outside such office, on the direct order of the physician to whom he is assigned and with the approval of the governing board of any affected hospital.

4. *Must physicians be approved by state regulatory authorities to utilize physicians' assistants?*

Yes, as described in Question #2. Every certificate of approval to supervise a physician's assistant expires on October 1 of each year.

5. *Does the statute or rules distinguish tasks which may be performed by physicians' assistants pursuant to standing versus direct orders?*

No. There is no discussion of the types of acts, tasks, or functions which physicians' assistants might perform in "semi-independent" (under standing order) or "dependent" (under direct order) modes.

NEBRASKA

6. *What tasks or types of services cannot be delegated to physicians' assistants?*

There are no specific tasks indicated in the statute or administrative rules which cannot be delegated to physicians' assistants, as long as a physician's assistant does not ".....engage in any medical services, specialty areas or areas of training other than those specifically listed on the certificate of approval....." (Rule 4.2).

7. *May drugs be prescribed by physicians' assistants?*

This topic is not addressed in either statute or rules.

8. *Must physicians' assistants obtain the informed consent of patients to whom they provide services?*

This issue is not covered in statute or in rules.

9. *How many physicians' assistants may work under the supervision or direction of one physician?*

The board will certify no more than two physicians' assistants for any practicing physician. (Sec. 71-1, 107.20(3)).

10. *Does the statute or regulations discuss the provision of services by physicians' assistants in hospitals or other institutions or facilities?*

Yes, as indicated under Question #3, requirements for supervision. Services may be provided on calls outside a physician's office as well as in hospitals in which a physician is a staff member, and subject to the approval of the governing board.

QUESTION #10 (continued) NEBRASKA

Employment of a physician's assistant by a hospital could be permitted, as long as the physician to whom the PA is assigned is a member of the staff.

CONDITIONS ON PRACTICE: PHYSICIANS' ASSISTANTS NEVADA

1. What types of services may physicians' assistants provide?

In Nevada, both the Board of Medical Examiners and the State Board of Osteopathic Medicine formally recognize physicians' assistants. The medical statute authorizes physicians' assistants to:

> .....perform such medical services as he is authorized to perform under the terms of a certificate issued to him by the board, if such services are rendered under the supervision and control of a supervising physician. (Sec. 630.271).

The osteopathic medical statute authorizes physicians' assistants to ".....perform medical services under the supervision of an employing osteopathic physician". (Sec. 633.101).

2. Are physicians' assistants subject to a formal approval process by state regulatory authorities whereby they are required to meet specified educational, experiential, or other requirements?

Yes, as previously indicated. In statute, Section 630.273 states that:

> 1. The board may issue a certificate to properly qualified applicants to perform medical services under the supervision of a supervising physician. The application for a certificate as a physician's assistant shall be cosigned by the supervising physician, and the certificate is valid only so long as that supervising physician employs and supervises the physician's assistant.

Furthermore, regulations specify that:

> 1. DURATION: The duration of the certificate shall be for a period of one (1) year; provided, however, upon termination of employment by the supervising physician the certificate shall automatically terminate. The supervising physician shall immediately notify the Board of the termination of employment and the physician's assistant shall immediately return the certificate issued to him to the Secretary of the Board.

QUESTION #2 (continued) NEVADA

> The supervising physician and the physician's assistant shall submit to the Board upon demand therefore a summary of the reasons and circumstances of termination of employment.
> 2. RENEWAL: The certificate may be renewed annually at the discretion of the Board upon application therefore by the physician's assistant, cosigned by the supervising physician.

With regard to the qualifications for inital certification as a physician's assistant, Section 630.275 describes the content of regulations regarding the certification of physicians' assistants, including:

> -educational and other qualification of applicants;
> -the required approved academic program for applicants;
> -the procedures for applications for and the issuance of certificates;
> -tests or examination of applicants by the board;
> -the duration, renewal and termination of certificates; and other matters.

For additional information as to these matters, refer to Sections C., D., E., G., and J of the Regulations for the Certification of Physicians' Assistants by the Board of Medical Examiners; and the Rules and Regulations for Osteopathic Physicians' Assistants (send written request to Board of Osteopathic Medicine).

3. *What are the requirements for supervision or consultation with physicians who delegate the performance of services to physicians' assistants?*

With regard to supervision of physicians' assistants, the language of the Nevada statute is restricted to a definition of the term "supervising physician":

> "Supervising physician" means an active physician licensed in the State of Nevada who cosigns the application for certification of a physician's assistant and who employs and supervises the physician's assistant. (Sec. 630.025).

Rules, however, deal with the responsibilities of the supervising physician in detail.

QUESTION #3 (continued) NEVADA

SECTION 1. SUPERVISION OF MEDICAL SERVICES

1. The supervising physician shall be responsible for all medical activities of the physician's assistant and
   (a) He shall insure that the physician's assistant is clearly identified to the patients as a physician's assistant;
   (b) He shall insure that the physician's assistant will perform only those medical services appropriate to the specific training and experience of the physician's assistant and as approved by the Board and set forth in the certificate;
   (c) He shall insure that the physician's assistant does not represent himself in any manner which would tend to mislead the general public or the patients of the supervising physician.

2. The supervising physician shall, on a regular basis, review the patient records of the physician's assistant and initial these records. He will be available at all times for consultation with his assistant. Such consultations may be direct, or indirect, such as by telephone.

4. When a physician's assistant is permitted by the Board to practice in a location other than the regular office address of his supervising physician, the supervising physician shall:
   (a) On a daily basis, review the work done by the physician's assistant either directly or by telephonic communication; and
   (b) At least once weekly shall spend part of a day physically in the satellite office to act as consultant to the physician's assistant, and to review and initial the medical records of the assistant.

5. The supervising physician shall supervise the performance of his assistant in a hospital or nursing home in accordance with the by-laws, rules and regulations of the specific hospital or nursing home.

6. In the absence of the supervising physician, it shall be the responsibility of the supervising physician to designate a qualified substitute physician. If the absence shall exceed seventy-two (72) hours, the supervising physician will notify the Board of Medical Examiners as to the designated substitute.

4. *Must physicians be approved by state regulatory authorities to utilize physicians' assistants?*

Under Nevada law, a physician who wishes to employ and supervise a PA must cosign that person's application for certification as a PA but there is no separate process for approval as a "supervising physician".

QUESTION #4 (continued) NEVADA

2. Each application shall be cosigned by the supervising physician who wishes to employ and supervise the assistant. Included with the application the supervising physician shall indicate his specialty and professional training and his type of practice. (Board of Medical Examiners Rules, Sec. D).

5. *Does the statute or rules distinguish tasks which may be performed by physicians' assistants pursuant to standing versus direct orders?*

No.

6. *What tasks or types of services cannot be delegated to physicians' assistants?*

Section F of the Medical Rules deals with standards for services, and includes the following:

1. A physician's assistant shall be permitted to perform medical services which he is qualified to do by his education, training and experience, as approved by the Board and set forth in the certificate issued by the Board.
2. A physician's assistant is not authorized to perform those specific functions and duties delegated or restricted by law to persons licensed as dentists, chiropractors, podiatrists and optometrists under Chapters 631-634, 635, and 636, respectively of NRS, or as hearing aid specialists.

The osteopathic medical statute also states that osteopathic physicians' assistants may perform only services which ".....pertain to the practice of osteopathic medicine and not to the practice of any other healing art regulated in this state or to the business of selling or fitting hearing aids". (Sec. 633.461).

7. *May drugs be prescribed by physicians' assistants?*

The prescription of drugs by PAs is not addressed in statute. Board rules do specify that:

QUESTION #7 (continued) NEVADA

> 3. The supervising physician shall sign all prescriptions for controlled substances. All medication orders for legend drugs shall be prescribed by the supervising physician. The physician's assistant shall possess, administer, or dispense controlled substances or dangerous drugs outside the physical presence of the supervising physician only if so permitted by law, and if so permitted, only to the extent and subject to the imitations expressly set forth and specified on the certificate issued by the Board. (Section 1).

From this rule and examination of other statutes in Nevada it becomes apparent that laws relating to controlled substances, poisons, dangerous drugs and devices deal with the dispensing of these drugs by non-physician health providers. An Attorney General's opinion issued March 10, 1976 in Carson City (included in the appendix) concludes that a physician's assistant may not carry, possess, administer or dispense controlled substances, poisons, or dangerous drugs outside the physical presence of the supervising physician.

8. *Must physicians' assistants obtain the informed consent of patients to whom they provide services?*

The Physicians' Assistants provisions contain no special applications regarding informed consent. See Question #3, Section 1, paragraphs (a) and (c).

9. *How many physicians' assistants may work under the supervision or direction of one physician?*

> 2. A supervising physician shall not cosign for, employ or supervise more than one physician's assistant at the same time, except that a supervising physician practicing in a township whose population is less than 16,000 as determined by the last preceding national census of the Bureau of the Census of the United States Department of Commerce, may supervise not more than two physician's assistants at the same time. (Sec. 630.273).

NEVADA

10. *Does the statute or regulations discuss the provision of services by physicians' assistants in hospitals or other institutions or facilities?*

Although the medical statute does not discuss possible sites of practice for physicians' assistants, Rules (cited under Question #3, Supervision) do delineate supervision requirements for physicians' assistants practicing in satellite offices, hospitals, and nursing homes (Rules 1, 4, and 5). Clarification as to the legality of using PAs in correctional institutions might be sought from the boards. It should be noted, however, that the statute defines a "supervising physician" as "an active physician.....who employs and supervises the physician's assistant". This would appear to preclude institutions from directly employing physicians' assistants. Also, a PA's certificate of approval is "valid only so long as that supervising physician employs and supervises the physician's assistant". However, a physician employed by a correctional facility could probably employ a PA as his assistant. In those circumstances, the correctional facility would contract with the physician for his services and those of his PA.

CONDITIONS ON PRACTICE: PHYSICIANS' ASSISTANTS NORTH CAROLINA

1. *What types of services may physicians' assistants provide?*

The state of North Carolina authorizes, in statute and in regulations, the use of physicians' assistants.

> The term "assistant to a physician" herein used refers to auxiliary, paramedical personnel who are functioning in a dependent relationship with a physician licensed by the board and who are performing tasks or combinations of tasks traditionally performed by the physician himself. Examples of such tasks would include history taking, physical examination, and treatment, such as the application of a cast.

This statement regarding the tasks which can be delegated to a physician's assistant is in the North Carolina rules and regulations (Subchapter 32D.001). The statute also states that:

> The services of the assistant are limited to assisting the physician in the particular field or fields which the assistant has been trained, approved and registered..... (G.S. 90-18)

2. *Are physicians' assistants subject to a formal approval process by state regulatory authorities whereby they are required to meet specified educational, experiential, or other requirements?*

Yes. The Board of Medical Examiners of North Carolina approves physicians' assistants. In order to be approved by the board, the rules state that an individual must

> (1) Be of good moral character;
> (2) Give evidence that he/she has successfully completed a training program recognized by the board;
> (3) Give evidence of being currently certified by the National Commission on Certification of Physicians' Assistants if graduated from a recognized training program after December 31, 1980. NCCPA certification shall be maintained and documented at the time of annual registration. Applicants who have graduated prior to December 31, 1980, shall be exempt from NCCPA certification.

QUESTION #2 (continued) NORTH CAROLINA

Individuals who meet these requirements must then submit an application, accompanied by a fee, to the Board of Medical Examiners, for formal certification as a physician's assistant.

> Application for approval of an assistant must be made upon forms supplied by the board and must be submitted by the physician with whom the assistant will work and who will assume responsibility for the assistant's performance.

In a detailed pamphlet entitled "Commentary of the Board of Medical Examiners of the State of North Caroline Regarding Physicians' Assistants and Nurse Practitioners", the board states that:

> Application and registration of the PA is considered a shared act of the PA and the responsible physician or group of physicians, each party agreeing to the terms and provisions specified in the application and registration.

Physicians and their assistants must re-register annually, and pay a small fee.

3. *What are the requirements for supervision or consultation with physicians who delegate the performance of services to physicians' assistants?*

The term "supervision" is defined by the North Carolina Board of Medical Examiners as incorporating physician backup to assistants to physicians performing medical acts in the following ways:

(1) Continuous availability of direct communications by radio, telephone or telecommunications;

(2) The backup physician shall be available on regularly scheduled basis for:

- (a) referrals;
- (b) review of their practice between conferences incorporating:
  - (i) consultation
  - (ii) chart review and cosigning records to document accountability:
    - (A) daily chart review except for situations that might be given individual consideration;
    - (B) prescribing within that practice setting, standing orders and drug protocol for interval between conferences to be part of this regular review and documentation;
  - (iii) continuing education;

(3) A predetermined plan for emergency services.

QUESTION #3 (continued) NORTH CAROLINA

These regulations are quite specific in regard to supervision of a physician's assistant. In its "commentary", however, the Board has further clarified the responsibilities of supervision within specific settings, as follows:

A. Office, with physician on premises--
In such settings it is required that the physician ordinarily be available for immediate on-site consultation with the PA about any question relating to patient care.
The physician must regularly and systematically review and sign clinical records of patients seen by the PA, checking for accuracy and completeness, and evaluating the suitability of the plan of management.
If the physician is temporarily out of the area and not available for direct or telephone consultation with the PA, another licensed physician recognized by the Board in the original application will be designated as "on call" for such consultation. Although this might be a telephonic consultation, for urgent matter direct personal attendance of this physician must be achievable within a reasonable period of time, i.e., a period of minutes rather than hours.

B. Office, no physician usually on premises (e.g. rural clinics)--
This setting differs from the previous description in that no physician is usually on-site for direct consultation.
The isolated setting of these sites places additional responsibilities on the PA and the supervising physician. Both are expected to be particularly attentive to the level and quality of supervision, and to back-up services, which must be available without delay.
Some form of written protocols or instructions must be available covering those conditions commonly encountered. These may take the form of a standard published volume designed for such purpose, such as Patient Care Guidelines for Family Nurse Practitioners by Hoole, Greenberg, and Pickard, but if so, it is required that the PA and all responsible physicians have reviewed the volume and agree regarding the appropriateness of the instructions contained therein. In addition, standard reference volumes must be available at the remote office for use by the PA.
The responsible physician must be available to the PA at all times by telephone and must be willing and able to respond to an emergency call for assistance. If the responsible physician is temporarily not immediately available, by reason of vacation, attendance at an out-of-town meeting, or other similar circumstance, another physician previously approved by the Board and willing and able to supervise at that time must be designated and the PA so informed. It is essential that the additional covering physician be aware of his/her supervisory responsibility, and of the capability of the individual whom the physician has agreed to supervise. If by

QUESTION #3 (continued) NORTH CAROLINA

> reason of emergency or personal illness the responsible physician must leave the practice area or otherwise interrupt the agreed-to supervisory activities, the services of another duly licensed physician may be enlisted to act as an additional supervising physician. The Board should be notified promptly of this action over the signatures of both physicians, with a request for the Board's approval of the revised supervisory mechanism.
>
> All charts in the remote office must be regularly and systematically reviewed. The frequency with which this review is conducted will be determined by the Board on the basis of the specific need of the practice site. Patients with difficult or obscure problems must be referred to the responsible physician or another Board approved physician or group of physicians for management.

4. *Must physicians be approved by state regulatory authorities to utilize physicians' assistants?*

Not directly; the Board issues joint approval of the physician's assistant and the supervising physician(s). (Sec. #2).

5. *Does the statute or rules distinguish tasks which may be performed by physicians' assistants pursuant to standing versus direct orders?*

Yes, the rules specify several times where standing orders are required in order for physicians' assistants to perform certain tasks. (One major area where standing orders are necessary is in the prescribing of drugs - See Question #7). Also, the Board's "commentary" regarding the responsibilities of supervision for physicians' assistants clearly states that:

> When a PA is expected to make independent medical judgments, disease-specific or problem-specific standing orders are required and must be on file at each site in which the PA/NP is permitted to make such independent medical judgments.

For more specific requirements regarding standing vs. direct orders at particular medical sites, see Questions #3 and #10.

6. *What tasks or types of services cannot be delegated to physicians' assistants?*

The statute and rules do not list specific tasks a physician's assistant may not perform. The responsibility for delegating tasks lies with the supervising physician, as long as such tasks are within ".....the particular field or fields for which the assistant has been trained, approved and registered".

7. *May drugs be prescribed by physicians' assistants?*

Yes, within the lengthy and detailed limits outlined in the North Carolina statute and regulations. The statute states:

> (b) Physician assistants are authorized to write prescriptions for drugs under the following conditions:
> (1) The Board of Medical Examiners has adopted regulations governing the approval of individual physician assistants to write prescriptions with such limitations as the board may determine to be in the best interest of patient health and safety;
> (2) The physician's assistant has current approval from the board;
> (3) The Board of Medical Examiners has assigned an identification number to the physician's assistant which is shown on the written prescription; and
> (4) The supervising physician has provided to the physician's assistant written instructions about indications and contraindications for prescribing drugs and a written policy for periodic review by the physician of the drugs prescribed.
> (c) Physician's assistants are authorized to compound and dispense drugs under the following conditions:
> (1) The function is performed under the supervision of a licensed pharmacist; and
> (2) Rules and regulations of the North Carolina Board of Pharmacy governing this function are complied with. (Sec. 90-18.1).

The rules explain further that:

> When the proposed medical functions of an assistant to a physician shall include the prescribing of drugs, the supervising (backup) physician and the assistant shall review the formulary approved by the board, and shall acknowledge in the application to the board that they are familiar with the formulary and that such

QUESTION #7 (continued) NORTH CAROLINA

> formulary will be a part of and incorporated in the approved standing orders. Changes in the formulary are to be approved by the board. In regard to changes, the approved formulary may include any over-the-counter or non-prescription drug.

The current approved formulary is attached on the following page. The board comments on the use of this formulary as follows:

> The physician must approve each prescription for a drug not included in the approved formulary before the prescription is issued by the PA/NP to the patient.
>
> The formulary is intended to set limits on those medications for which the PA/NP may issue written prescriptions. It is not intended to preclude the inclusion in standing orders of vaccines, intravenous fluids, or other parenteral medications which in the opinion of the supervising physician are appropriate for a PA/NP to administer in the office or hospital setting without prior consultation with the physician. If the physician wishes to include in the standing orders medications which do not fall within the scope of the formulary, a list of such medications must be submitted to the Board with a request for approval. The Board will not authorize the inclusion in standing orders of any controlled substances.

The rules also contain instructions for physicians' assistants prescribing drugs not included in the formulary.

> Prescriptions, except controlled substances may, upon specific orders of the supervising physician given before the prescription is issued, be written and issued by such assistant for the use by patients of drugs which are not included in the formulary. Such prescriptions shall be signed by the assistant with a notation thereon that the same was issued upon the specific order of the supervising physician. For example: Mary Smith, PA, on order of John Poe, M.D.

8. *Must physicians' assistants obtain the informed consent of patients to whom they provide services?*

This question is not addressed in statute, rules, or board commentary.

APPROVED FORMULARY

For the Writing of Prescriptions by Persons Approved
To Prescribe Drugs Under the Provisions of G.S. 90-18.1

No controlled substances (Schedule II, II-N, III, III-N, IV, V) defined by the Federal Controlled Substances Act may be prescribed.

No parenteral preparations (except Insulin) may be prescribed.

Any pure form or combination of the following generic classes of drugs may be prescribed, unless the drug or class of drug is listed as excluded from the formulary. No drugs or classes of drugs that are excluded may be prescribed.

ANTIHISTAMINES

ANTI-INFECTIVE AGENTS
Drugs excluded under this generic category:
Amebacides
—Carbarsone
—Diiodohydroxyguin
—Emetine
--Glycobiarsol
Chloramphenicol

Oxacillin
Minocycline
Pediatric Tetracycline
Clindamycin
Plasmodicides
—Amodiaquine
—Chloroquine
—Hydroxychloroquine
—Primaquine
--Pyrimethamine

ANTINEOPLASTIC AGENTS
All agents are excluded under this generic category.

BLOOD FORMATION AND COAGULATION
Drugs excluded under this generic category:
Anticoagulants

CARDIOVASCULAR DRUGS

CENTRAL NERVOUS SYSTEM DRUGS
Drugs excluded under this generic category:
Psychotherapeutic agents
Antidepressants
Tranquilizers
Benactyzine
Lithium
Respiratory stimulants
Cerebral stimulants
Sedatives and hypnotics
Pentazocine

DIAGNOSTIC AGENTS

ELECTROLYTIC, CALORIC AND WATER BALANCE

ENZYMES

EXPECTORANTS AND COUGH PREPARATIONS

EAR, EYE, NOSE AND THROAT PREPARATIONS
Drugs excluded under this generic category:
Any preparation containing an excluded drug.

GASTROINTESTINAL DRUGS

HORMONES AND SYNTHETIC SUBSTITUTES
Drugs excluded under this generic category:
Parathyroid hormones and synthetics
Pituitary hormones and synthetics

OXYTOCICS
All agents are excluded under this generic category.

RADIOACTIVE AGENTS
All agents are excluded under this generic category.

SKIN AND MUCOUS MEMBRANE PREPARATIONS
Drugs excluded under this generic category:
Any preparation containing an excluded drug.

OTHER CRITERIA:

According to N. C. General Statute 90-18.1, written standing orders must be used.

Every prescription and every refill must be entered on the patient's chart. A refill can be authorized by telephone if the refill is entered on the patient's chart and countersigned by the physician within 72 hours.

Amount of drug can be no more than 100 dosage units or a 90 days supply, whichever is less.

11/2/76

9. *How many phsyicians' assistants may work under the supervision or direction of one physician?*

The statute states that ".....no more than two assistants may be currently registered for any physician". (Sec. 90-18. (13)(3)).

10. *Does the statute or regulations discuss the provision of services by physicians' assistants in hospitals or other institutions or facilities?*

The statute and rules do not discuss this question in depth, except with regard to physicians' assistants ordering medications and tests in health care facilities.

> (d) Physicians' assistants are authorized to order medications, tests and treatments in hospitals, clinics, nursing homes and other health facilities under the following conditions:
> (1) The Board of Medical Examiners has adopted regulations governing the approval of individual physicians' assistants to order medications, tests and treatments with such limitations as the board may determine to be in the best interest of patient health and safety;
> (2) The physician's assistant has current approval from the board;
> (3) The supervising physician has provided to the physician's assistant written instructions about ordering medications, tests and treatments, and when appropriate, specific oral or written instructions for an individual patient, with provision for review by the physician of the order within a reasonable time, as determined by the Board, after the medication, test or treatment is ordered; and
> (4) The hospital or other health facility has adopted a written policy, approved by the medical staff after consultation with the nursing administration, about ordering medications, tests, and treatments, including procedures for verification of the physicians' assistants' orders by nurses and other facility employees and such other procedures as are in the interest of patient health and safety. (Sec. 90-18.1).

The Board of Medical Examiners "commentary", however, discusses this question in great detail, as follows:

> C. Hospital
> The Board recognizes that although the PA/NP can function in a hospital,

problems may arise out of the inter-relationships with other licensed and unlicensed personnel employed within this setting.

The functions of the PA/NP in this setting are also regulated by bylaws and regulations of the hospital and of its medical staff. Many hospitals establish a special associate medical staff membership category and require that any PA/NP desiring to function within the hospital must first apply for and be accepted to such membership.

The usual process is that the application for such associate membership is filed by both the PA/NP and the supervising physician, reviewed for personal and professional qualifications by the credentials committee, and presented for approval by the medical staff. This process serves two purposes: assuring the medical staff that the PA/NP meets professional and ethical standards, and publicizing the presence of the PA/NP to the medical staff and the hospital administration.

Initial workup of patients is often delegated to the PA/NP. This is an appropriate function if reviewed and countersigned by the physician on the physician's next visit to the hospital, almost always within 24 hours. These workups should meet the same standards as those already set for the physician staff of the hospital. The physician's countersignature indicates agreement with the findings recorded by the PA/NP. Inasmuch as the physician is accountable for clinical findings recorded in medical records all critical entries by the PA/NP must be assiduously confirmed. For instance, if a patient with hypertension has been admitted for investigation of recent attacks of faintness and weakness, the physician should independently determine the precise nature of the symptoms, inquiring about their frequency, duration, precipitating factors, relationship to medications and other pertinent factors. The physician should independently examine, for example, the ocular fundi, the cardiovascular system, ascertain that the blood pressure has been measured in the supine and erect positions, and perform an appropriate neurological examination.

On the other hand, the supervising physician may or may not choose to inquire about the patient's family history or to examine, for instance, the ears, nose or throat if it has been previously established that the PA/NP is capable of gathering and recording such data and has already done so in this case.

Writing of initial orders may be delegated to the PA/NP. These activities are very important in that they impinge on the function of others, such as the registered and licensed practical nurses assigned to the ward. State law requires that all standing orders must be on file and available to the nurse accepting such orders, as a means of assurance that these orders are emanating from the responsible physician and that they are within the authority which this physician has delegated to the PA/NP. All orders should be checked and countersigned by the responsible physician on the physician's visit to the hospital, usually within 24 hours.

The initial orders which the PA/NP might be authorized to write on a patient are of several types:

(a) Status orders - indicating the condition of the patient, and usually used by the hospital staff to regulate visitors, to transmit to callers, etc. (e.g. "condition fair").

QUESTION #10 (continued) NORTH CAROLINA

(b) Activity orders - indicating the degree of restriction of position or activity of the patient (e.g. "bed rest").
(c) Diet and fluid orders - indicating the amount and type of food and/or oral fluids (e.g. "low salt diet" or "force fluids").
(d) Test and procedure orders - indicating those tests and procedures necessary for care of the patient (e.g. "urinalysis in a.m." or "schedule for I.V. urogram").
(e) Ward observation and measurement orders - indicating those procedures to be carried out by hospital staff personnel (e.g. "BP twice daily in supine position" or "record fluid intake and output").
(f) Medication orders - indicating those drugs which are to be given to the patient, usually by the hospital nursing staff assigned to administer medications (e.g. "tetracycline, 250mg. capsule, by mouth four times daily" or "procaine penicillin, 1.2 million units, by intramuscular injection, stat").

The Board suggests that a responsible physician might consider standing orders of a blanket type covering those types of orders which would require less supervision. These might include order of types a, b, c, and d as described above. Orders of type e (ward observation and measurement orders) might require more specification, but still be of the blanket type. Medication orders from the approved formulary might also be included under the blanket formula.

Such standing orders might take the following form:
"Jane A. Doe, Nurse Practitioner, is hereby authorized to write the following type orders on patients admitted under my responsibility --

a. Status orders
b. Activity orders
c. Diet and fluid orders
d. Test of blood, urine or stool; radiologic examinations including contrast studies; radioisotopic studies, and electrocardiograms. This shall not include authorization to order computerized tomography studies, bronchoscopy, fiberscopic examinations or other invasive procedures.
e. Ward observation and measurement orders, with the stipulation that if these are to be carried out for over 24 hours, these must be countersigned by me.
f. Medication orders for those drugs included on diagnosis - specific standing orders. No controlled substances are to be administered without prior approval by the supervising physician. Any other drug orders must be individually approved by me after telephonic or personal communication, which should be so stated on the order.

Signed_____, M.D."

The above standing orders should cover the majority of those orders of a routine or "housekeeping" variety, which are necessary for efficient operation of a unit for patient comfort, and carry little risk in case of error. Still other standing orders could be written for specific clinical conditions which are frequently encountered on the individual physician's service. These orders could be in the form of standard "sets" of orders for a given clinical diagnosis, such as a patient with acute appendicitis or a myocardial infarction.

Included also should be orders to cover those rare but urgent situations arising in any hospital environment. These can never be adequately covered in a set of standing orders, and the only advice which can be given is that the patients' interests must take precedence, and the PA/NP and the nurse involved must work out each solution ad hoc. There are, however, a number of suggestions and observations:

A nurse, in a given situation, may refuse to follow a given order, said to be authorized by the physician, but not, in the nurse's opinion, adequately documented; instead she may suggest that the PA/NP give the emergency medication. This would be done under the name and authority of the responsible doctor, as though the doctor had been present and personally administered the medication.

The PA/NP working in the hospital setting might be delegated any of a wide variety of procedures to be performed on patients under the care of the responsible physician.

It is required that the PA/NP has received adequate and proper instruction in the performance of each such procedure, and that the responsible physician has personally observed and is satisfied that the PA/NP performs each procedure with requisite skill, and proper safeguards against complication.

The PA/NP is often delegated the task of writing the discharge summary on a patient under the care of the responsible physician. All such summaries must be carefully read and countersigned by the physician. The physician is reminded that this function is not only an excellent opportunity to review the case, but can also serve as an important review of the PA/NP's role in the hospital setting. Delegation of this task should be done with great care and forethought.

E. Nursing Home or Extended Care Facility

Employment of the PA/NP in a nursing home or similar long stay facility involves some of the same problems encountered in the hospital; but because there is less turnover of patients, the problems are usually of a less acute nature.

Such facilities are suitable sites for the utilization of the PA/NP, either on a full or part-time basis, under proper supervision by the responsible physician.

As in the hospital settings, the initial workup of newly admitted patients is often delegated to the PA/NP. These workups should meet the same standards required of physicians. It is required that all abnormalities are validated by the responsible physician. The workup should be countersigned by the supervising physician within 24 hours. This countersigning indicates agreement with the findings as recorded by the PA/NP.

The writing of orders is subject to the same rules and restrictions as were described in Section D above. The reader is referred to Section D for details.

CONDITIONS ON PRACTICE: PHYSICIANS' ASSISTANTS RHODE ISLAND

1. *What types of services may physicians' assistants provide?*

In the state of Rhode Island, the law authorizes the use of physicians' assistants as follows:

> Notwithstanding any other provisions of law, a physician assistant may perform medical services when such services are rendered under the supervision of a registered physician.

Later on in the statute, it is further explained that:

> Physician assistants, depending upon their level of professional training and experience, as determined by a supervising physician, may perform medical services of a general nature in assisting general practitioners in solo practice, in group practices, or in health care facilities.

Nowhere, however, are "medical services" described or clarified in more detail. No rules and regulations have been promulgated by the Department of Health relating to physicians' assistants, although the Board of Approval and Certification of Physician Assistant Programs within the Health Department has explicit authority to issue rules relating to educational program approval and the supervision of physician assistant trainees.

2. *Are physicians' assistants subject to a formal approval process by state regulatory authorities whereby they are required to meet specified educational, experiential, or other requirements?*

Yes. In Rhode Island, physicians' assistants must be graduates of educational training programs which have been approved by the Board of Approval and Certification of Physician Assistant Programs within the Department of Health. The board develops standards for physician assistant training programs, then issues certificates of approval to those programs which meet these standards.

QUESTION #2 (continued) RHODE ISLAND

The law also states that:

> In developing criteria for program approval, the board shall give consideration to, and encourage, the utilization of equivalency and proficiency testing and other mechanisms whereby credit is given to trainees for past education and experience in health fields. The board, in developing criteria for approved programs and in approving such programs may accept as approved programs those that have been certified by a nationally recognized accrediting agency or organization.

3. *What are the requirements for supervision or consultation with physicians who delegate the performance of services to physicians' assistants?*

Under Rhode Island law, the "supervision of a registered physician" is required for physicians' assistants, and

> Such supervision shall be continous but need not be in the personal presence of the supervising physician or physicians.

No further elaboration is given.

4. *Must physicians be approved by state regulatory authorities to utilize physicians' assistants?*

No. Physicians, however, upon employing an assistant, must notify the board immediately, with "forms designed and made available by the board" (Sec. 5-54-6). The supervising physician must also notify the board "upon termination of employment" of an assistant.

5. *Does the statute or rules distinguish tasks which may be performed by physicians' assistants pursuant to standing versus direct orders?*

No.

6. *What tasks or types of services cannot be delegated to physicians' assistants?*

A physician's assistant cannot perform tasks in the following areas:

(a) The practice of dentistry or dental hygiene;
(b) The practice of manipulative therapy or chiropractic;
(c) The practice of optometry.

7. *May drugs be prescribed by physicians' assistants?*

This question is not addressed in the statute.

8. *Must physicians' assistants obtain the informed consent of patients to whom they provide services?*

This question is not addressed in the statute.

9. *How many physicians' assistants may work under the supervision or direction of one physician?*

A registered physician in Rhode Island may not supervise more than two physicians' assistants at one time. Nor shall any one physician employ more than two physicians' assistants at any one time.

10. *Does the statute or regulations discuss the provision of services by physicians' assistants in hospitals or other institutions or facilities?*

The law specifically states that physicians' assistants may aid physicians ".....in solo practice, in group practice, or in health care facilities". Furthermore,

> Where a physician assistant is employed by a health care facility the legal responsibility for his actions and omissions shall be in the employing facility. Such physicians' assistants shall be supervised

QUESTION #10 (continued) RHODE ISLAND

by registered physicians. Such physicians' assistants employed by health care facilities shall not be utilized as the sole medical personnel in charge of emergency or outpatient services or any other clinical service where a physician is not regularly available.

CONDITIONS ON PRACTICE: PHYSICIANS' ASSISTANTS TENNESSEE

1. What types of services may physicians' assistants provide?

In Tennessee, as in Colorado, physicians' assistants are allowed to work under an exemption to the statutory definition of legal medical practice. The exemption reads as follows:

> Nothing in this chapter shall be so construed as to prohibit service rendered by a physician's trained assistant, registered nurse, or a licensed practical nurse if such service is rendered under the supervision, control and responsibility of a licensed physician.

There is no further definition in the statute of the types of "service" a physician's assistant may perform, and no regulations exist in Tennessee covering the practice of physicians' assistants.

2. Are physicians' assistants subject to a formal approval process by state regulatory authorities whereby they are required to meet specified educational, experiential, or other requirements?

No. Tennessee's law is of the "general delegatory" types. This allows physicians' assistants to practice in the state, but does not invest the medical practice board with licensing authority or the authority to grant other formal recognition to physicians' assistants.

3. What are the requirements for supervision or consultation with physicians who delegate the performance of services to physicians' assistants?

"The supervision, control and responsibility of a licensed physician" are required as necessary conditions under which a physician's assistant may legally practice. Specific requirements for supervision, however, are not stated in the statute, and, therefore, remain unclear.

TENNESSEE

4. *Must physicians be approved by state regulatory authorities to utilize physicians' assistants?*

No; not under "general delegatory" authorization.

5. *Does the statute or rules distinguish tasks which may be performed by physicians' assistants pursuant to standing versus direct orders?*

No.

6. *What tasks or types of services cannot be delegated to physicians' assistants?*

The statute does not specify the tasks that physicians' assistants may or may not provide.

7. *May drugs be prescribed by physicians' assistants?*

The prescribing of drugs by physicians' assistants is not addressed in the statute.

8. *Must physicians' assistants obtain the informed consent of patients to whom they provide services?*

The statute does not address this question.

9. *How many physicians' assistants may work under the supervision or direction of one physician?*

This is not specified in the statute.

TENNESSEE

10. *Does the statute or regulations discuss the provision of services by physicians' assistants in hospitals or other institutions or facilities?*

There is no discussion of utilization of physicians' assistants in hospitals. However, the wording of the statute is such that services rendered by the physician's assistant "under the supervision, control and responsibility of a licensed physician" within an institution presumably would not be prohibited.

CONDITIONS ON PRACTICE: PHYSICIANS' ASSISTANTS WASHINGTON

1. What types of services may physicians' assistants provide?

In Washington, both the Board of Medical Examiners and the Committee of Osteopathic Examiners formally recognize physicians' assistants. The authorizing language of the two separate chapters is essentially the same. A "physician's assistant" is defined by statute as:

> A person who is enrolled in, or who has satisfactorily completed, a board approved training program designed to prepare persons to practice medicine (or osteopathic medicine) to a limited extent.

The statutes limit the practice of a physician's assistant to "the performance of those services for which he is trained". (Sec. 18.71A.020(1) and 18.57A.020(1)). The administrative rules for medical physicians' assistants specify three different classifications, each with its own duties, tasks, and degree of independence from the supervising physician. The classifications are labeled A, B, and C, as follows:

> (a) Type A, Assistant to the Primary Physician. The type A assistant is capable of collecting historical and physical data, organizing the data, and presenting them in such a way that the physician can visualize the medical problem and determine appropriate diagnostic or therapeutic measures. He is also capable of assisting the physician by performing diagnostic and therapeutic procedures and coordinative the roles of other more technical assistants. While he functions under the general supervision and responsibility of the physician, he may under certain circumstances and under defined rules, perform without the immediate surveillance of the physician. He is, thus, distinguished by his ability to integrate and interpret findings on the basis of general medical knowledge to exercise a degree of independent judgment.
> (b) Type B, Assistant to the Specialist. The type B assistant while not equipped with general knowledge and skills relative to the whole range of medical care, possesses exceptional skill in one clinical specialty. He is capable of collecting and organizing data and performing appropriate diagnostic or therapeutic measures pertaining to his specialty. In his specialty he has a degree of skill beyond that normally possessed by a type A assistant. Because his knowledge and skill are limited to a particular specialty, he is qualified for independent action only within the field of that specialty.
> (c) Type C, Technical Assistant. The type C assistant is capable of performing a specific function within a given field or specialty. He cannot operate over the broad range of medical care as would the type A assistant or within an entire specialty as would the type B assistant. He cannot exercise the degree of independent synthesis and judgment

QUESTION#1 (continued) WASHINGTON

> of which type A and B assistants are capable but may exercise a degree of independent judgment and may be capable of a degree of independent action within the limited scope of his activities. (Washington Administrative Code 308-52-130(2)).

Furthermore, the statute provides that a physician's assistant may perform acupuncture, if the board determines that the proper qualifications for such such practice have been met. "Acupuncture" is defined in the Washington statutes as:

> .....the insertion of needles into the human body by piercing the skin of the body for the purpose of relieving pain, treating disease, or to produce analgesia, or as further defined by rules and regulations of the board.

2. *Are physicians' assistants subject to a formal approval process by state regulatory authorities whereby they are required to meet specified educational, experiential, or other requirements?*

Yes. The Board of Medical Examiners and the Committee of Osteopathic Examiners are both authorized, by statute, to set up formal approval processes for physicians' assistants:

> The board shall adopt rules and regulations fixing the qualifications and the educational and training requirements for persons who may be employed as physicians' assistants or who may be enrolled in any physician's assistant training program.
>
> The board shall, in addition, adopt rules and regulations governing the extent to which physician's assistants may practice medicine during training and after successful completion of a training course.

Applications for approval by the medical or osteopathic boards must be submitted jointly by the supervising physician and the assistant. Such approval must be renewed annually.

Applications for the approval of a physician's assistant must be accompanied by a fee, and must contain a detailed "utilization plan" for the physician's assistant. The medical rules describe such a plan, as follows:

QUESTION #2 (continued) WASHINGTON

> The application for registration of a physician's assistant must include a detailed plan describing the manner in which the physician's assistant will be utilized. The board will grant specific approval for the tasks which may be performed by the assistant based upon the curriculum of the program from which the assistant graduated as contained in the files of the board. No assistant shall be registered to perform tasks not contained in the program approval unless evidence satisfactory to the board is submitted demonstrating that he has been trained in that function and his competence has been properly and adequately tested. Request for approval of newly acquired skills may be considered at any regular meeting of the board. (WAC 308-52-130(4)).

The board has the right to modify such a plan however it sees fit. Furthermore, the board (medical or osteopathic) has the right to withdraw approval for a physician's assistant "whenever it appears to the board that a physician's assistant is being utilized in a manner inconsistent with the approval granted....." (Sec. 18.71A.040 and Sec. 18.57A.040).

In such a case, a hearing may be requested and must be held if it is requested.

3. *What are the requirements for supervision or consultation with physicians who delegate the performance of services to physicians' assistants?*

On the question of supervision, the Washington statutes state:

> That each physician's assistant shall practice medicine only under the supervision and control of a physician licensed in this state, but such supervision and control shall not be construed to necessarily require the personal presence of the supervising physician at the place where services are rendered.

The administrative rules elaborate on the requirements for supervision, as follows:

> (6) Supervising Physician, Responsibility. It shall be the responsibility of the supervising physician to insure that:
>
> (a) The best interests of the patients are served by the utilization of a physician's assistant.
>
> (b) Adequate supervision and review of the work of the physician's assistant is provided.
>
> (i) The supervising physician shall review at least weekly all patient care provided by the physician's assistant if such care is rendered without direct consultation with the

QUESTION #3 (continued) WASHINGTON

physician and shall countersign all notes made by the physician's assistant.

(ii) In the temporary absence of the supervising physician, the physician's assistant may carry out those tasks for which he is registered, if the supervisory and review mechanisms noted above are provided by a delegated alternate physician supervisor.

(iii) The physician's assistant may not function as such if these supervisory and review functions are impossible. (WAC 308-52-130(6)).

4. *Must physicians be approved by state regulatory authorities to utilize physicians' assistants?*

Yes. The application procedure for approval is described in Question #2, and the application must be accompanied by a fee and a "utilization plan" for the physician's assistant. Such approval is valid for one year, and may be renewed annually.

5. *Does the statute or rules distinguish tasks which may be performed by physicians' assistants pursuant to standing versus direct orders?*

No. The classifications of physicians' assistants, mentioned in Question #1, differentiate degrees of "independence" and "dependence" in relation to the supervising physician, but there is no specific mention of standing versus direct orders.

6. *What tasks or types of services cannot be delegated to physicians' assistants?*

Washington statutes state that neither medical nor osteopathic physicians' assistants may perform tasks in the following areas:

(1) The measurement of the powers or range of human vision, or the determination of the accommodation and refractive state of the human eye or the scope of its functions in general, or the fitting or adaptation of lenses or frames for the aid thereof.
(2) The prescribing or directing the use of, or using, any optical device in connection with ocular exercises, visual training, vision

QUESTION #6 (continued) WASHINGTON

training or orthoptics.
(3) The prescribing of contact lenses for, or the fitting or adaptation of contact lenses to, the human eye.
(4) Nothing in this section shall preclude the performance of routine visual screening.
(5) The practice of dentistry or dental hygiene.
(6) The practice of chiropractic procedures including the adjustment or manipulation of the articulations of the spine.
(7) The practice of podiatry.
(Sec. 18.71A.060 and Sec. 18.57A.060).

Also, physicians' assistants are limited to the specific services within their classification, and to the tasks detailed in each individual's "utilization plan".

7. *May drugs be prescribed by physicians' assistants?*

Yes, within the limits specified by the administrative code, as follows:

A physician's assistant may issue written or oral prescriptions as provided herein when approved by the board and assigned by the supervising physician.
(1) Except for schedule two controlled substances as listed under federal and state controlled substances acts, a physician's assistant may issue prescriptions for a patient who is under the care of the physician responsible for the supervision of the physician's assistant.
(a) Written prescriptions shall be written on the blank of the supervising physician and shall include the name, address and telephone number of the physician. The prescription shall also bear the name and address of the patient and the date on which the prescription was written.
(b) The physician's assistant shall sign such a prescription by printing the name of the supervising physician, signing his or her name followed by the letters "PA" and registration number.
(2) A physician's assistant employed or extended privileges by a hospital, nursing home or other health care institution may, if permissible under the bylaws, rules and regulations of the institution, write medical orders, except those for schedule two controlled substances, for inpatients under the care of the physician responsible for his supervision. In every case, medical orders so written shall be countersigned by the supervising physician within forty-eight hours, but such countersignature shall not be required prior to the execution of any such order.
(3) To be authorized to issue prescription for schedule three through five controlled substances, a physician's assistant must be registered with the board of pharmacy and the drug enforcement administration.
(WAC 308-52-135).

WASHINGTON

8. *Must physicians' assistants obtain the informed consent of patients to whom they provide services?*

Yes, in Washington it is necessary that a physician's assistant receive a patient's informed consent before medical care is given. (WAC 308-52-130§5(e)).

9. *How many physicians' assistants may work under the supervision or direction of one physician?*

It depends on the physician's assistant's classification. The rules state:

> (i) No physician shall supervise more than one graduate physician's assistant categorized as type A or type B without authorization by the board.
> (ii) The number of type C physicians' assistants who may be supervised by a single physician shall be set individually for each category established by the board. (WAC 308-52-130 §(5(a))).

10. *Does the statute or regulations discuss the provision of services by physicians' assistants in hospitals or other institutions or facilities?*

Yes, the regulations are quite clear on this issue.

> A physician's assistant working in or for a hospital, clinic or other health organization shall be registered and supervised by a supervising physician in the same manner as any other physician's assistant and his functions shall be limited to those specifically approved by the board. His responsibilities, if any, to other physicians must be defined in the application for registration.

The topic of drug prescription by physicians' assistants in hospitals or other institutions is discussed in Question #7.

CONDITIONS ON PRACTICE: PHYSICIANS' ASSISTANTS WISCONSIN

1. What types of services may physicians' assistants provide?

The state of Wisconsin legally recognizes a physician's assistant as "an individual certified by the board (Board of Medical Examiners) to perform patient services under the supervision and direction of a licensed physician". (Ch. 448.01(6)). "Patient services", according to the rules and regulations promulgated by the Council on Physician Assistants and written into the Wisconsin Administrative Code, means the following:

> (a) The initial approach to a patient of any age in any setting is to elicit a personal medical history, perform an appropriate physical examination, and record and present pertinent data in a manner meaningful to the physician.
> (b) Performing, or assisting in performing,or both, routine laboratory and related studies as appropriate for a specific practice setting including the drawing of blood samples, performing urinalyses, and taking electrocardiographic tracings.
> (c) Performing routine therapeutic procedures including injections, immunizations, and suturing and care of wounds.
> (d) Instructing and counseling patients on physical and mental health, and on diet, disease, treatment, and normal growth and development.
> (e) Assisting the physician in the institutional setting by assisting at surgery, making patient rounds, recording patient progress notes, accurately and appropriately transcribing or executing standing orders or other specific orders at the direction of the supervising physician, consistent with applicable regulations of the institution and compiling and recording detailed narrative case summaries.
> (f) Assisting in the delivery of services to patients by reviewing and monitoring treatment and therapy plans.
> (g) Independently performing evaluative and treatment procedures necessary to provide an appropriate response to life threatening emergency situations.
> (h) Facilitating referral of patients to other appropriate community health facilities, agencies, and resources. (Med 8.02 (7)).

The rules comment clearly on the scope of practice for a physician's assistant:

> The scope of practice of a physician's assistant shall not exceed the definitions of "patient services" as set forth in Med. 8.02(7) Wis. Adm. Code, nor the physician's assistant's training and experience, nor the scope of practice of the supervising physician.

WISCONSIN

2. *Are physicians' assistants subject to a formal approval process by state regulatory authorities whereby they are required to meet specified educational, experiential, or other requirements?*

Yes. The Council on Physician Assistants and the Medical Examining Board are responsible for approving, examining and certifying physicians' assistants, as well as certifying educational programs for physicians' assistants.

The formal approval process includes several steps, as specified in rule Med 8.10.

First, an individual must be "of good professional character" and must have "successfully completed a formal physician's assistant educational program approved by the board".

Second, the individual must take an examination.

> Examination may be both written and oral. The council shall advise the board as to content of the examinations required under this subsection and passing grades therein, and the board shall provide for such content and such passing grades. In lieu of its own examinations, the board may make such use as it deems appropriate of examinations prepared, administered, and scored by national examining agencies. The board designates the council as its agent for conducting examinations.

In the event of failure, the individual may take one re-examination.

Third, if the individual passes the exam, he/she is issued a certificate as a physician's assistant.

> At the time of initial certification and at the time of each annual registration thereafter, each physician's assistant shall list with the council the name and address of the physician supervising that physician's assistant, and shall also notify the council of any change of supervising physician within 10 days following such change.

3. *What are the requirements for supervision or consultation with physicians who delegate the performance of services to physicians' assistants?*

The Wisconsin Code provides that the "entire practice" of a physician's assistant

QUESTION #3 (continued) WISCONSIN

shall be under the supervision of a licensed physician. (Med. 8.05). Accordingly,

> (6) "Supervision" means to co-ordinate, direct, and inspect continually and at first hand the accomplishments of another, or to oversee with powers of direction and decision the implementation of one's own or another's intentions. (Med 8.02).

4. *Must physicians be approved by state regulatory authorities to utilize physicians' assistants?*

No, such approval is not required by statute or rules.

5. *Does the statute or rules distinguish tasks which may be performed by physicians' assistants pursuant to standing versus direct orders?*

No.

6. *What tasks or types of services cannot be delegated to physicians' assistants?*

The statute lists prohibited practices for physicians' assistants as follows:

> No physician's assistant may perform patient services, except routine screening, in:
>
> (a) The practice of dentistry or dental hygiene,
> (b) The practice of optometry,
> (c) The practice of chiropractic,
> (d) The practice of podiatry. (Ch. 448.21(1)).

Also, the Wisconsin Code prohibits "the practice of acupuncture in any form" by physicians' assistants.

WISCONSIN

7. *May drugs be prescribed by physicians' assistants?*

No; "the independent prescribing or dispensing of any drug" by a physician's assistant is prohibited". (Med. 8.11).

8. *Must physicians' assistants obtain the informed consent of patients to whom they provide services?*

This question is not addressed in the statute or the rules.

9. *How many physicians' assistants may work under the supervision or direction of one physician?*

Rule Med 8.08 advises that

> No physician may supervise more than 2 physician's assistants, but a physician's assistant may be supervised by more than one physician. In the case of exception to this rule, a written plan for the supervision of more than 2 physician's assistants by a licensed physician must be filed with, reviewed, and recommended for approval by the council, and approved by the board.

10. *Does the statute or regulations discuss the provision of services by physicians' assistants in hospitals or other institutions or facilities?*

Neither the statute nor the rules specifically discuss the provision of services by physicians' assistants in hospitals or other institutions. However, certain language in the rules implies that such provision of services is indeed allowed:

> If the employer of a physician's assistant is other than a licensed physician, such employer shall provide for and not interfere with the supervision required in Med 8.05 Wis. Adm. Code.

In this case, the "employer.....other than a licensed physician" could very likely be a hospital or other type of health care institution.

(For a discussion of proper supervision, see Question #3.)

TABLE 2: TITLES AND CITATIONS FOR STATE PHYSICIANS' ASSISTANT STATUTES AND REGULATORY BOARDS

Colorado	
Board of Medical Examiners 1525 Sherman St., Rm. 132 Denver, CO 80203 (303) 839-2468	Colorado Revised Statutes 12-36-106(3) (1974)
Florida	
Board of Medical Examiners Oakland Building, Suite 220 2009 Apalachee Parkway Tallahassee, FL 32301 (904) 488-7614	Florida Statutes Annotated 458.135 (West 1977) Medical PAs
Board of Osteopathic Medical Examiners Oakland Building, Suite 200 2009 Apalachee Parkway Tallahassee, FL 32301 (904) 487-1336	Florida Statutes Annotated 459.225 (West 1978) Osteopathic PAs
Illinois	
Department of Registration and Education Springfield, IL 62786 (217) 785-0800	Illinois Statutes Annotated Chap. 111 4751 to 4770 (Smith-Hurd 1978)
Michigan	
Physician's Assistants Committee Department of Licensing and Regulation 905 Southland, P.O. Box 30018 Lansing, MI 48909 (517) 373-3848	Michigan Statutes Annotated 14.718(Callaghan 1978) Michigan Compiled Laws Annotated 338.1951 1978 (West 1978)

Nebraska

Board of Examiners in Medicine and Surgery
Department of Health, Bureau of Examining Boards
State Office Building
301 Centennial Mall South
P.O. Box 95007
Lincoln, NB 68509

(402) 471-2115

Nebraska Revised Statutes
71-1, 107.15 to 71-1, 107.29 (1976)

Nevada

Nevada State Board of Medical Examiners
P.O. Box 7238
Reno, NV

(702) 329-2559

Nevada Revised Statutes
630.003 - .275 (1977) Medical PAs

Board of Osteopathic Medicine
c/o Dr. D'Amico, Secretary-Treasurer
P.O. Box 38
Zephyr Cove, NV 89448

(702) 882-0777

Nevada Revised Statutes
633.011 - .461 Osteopathic PAs

North Carolina

State Board of Medical Examiners
222 N. Pierson St., Suite 214
Raleigh, NC 27601

(919) 833-5321

North Carolina General Statutes
90-18(13) - 18.1 (1975 and CS 1978)

Rhode Island

Board of Approval and Certification of Physicians' Assistants Programs
c/o Department of Health
Cannon Building, Room 104
75 Davis St.
Providence, RI 02908

(401) 277-2827

Rhode Island General Laws
5-54-1 to 5-54-7 (1976)

Tennessee

Board of Medical Examiners
Public Health, State Office Building
Room 320
Ben Allen Road
Nashville, TN 37216

Tennessee Code Annotated
63-608 (1976)

Washington

Board of Medical Examiners
Department of Licensing and Regulation
P.O. Box 9649
Olympia, WA 98504

(206) 753-2205

Washington Revised Code Annotated
18.71A.010 - 18.71A.080 (West 1978)
Medical PAs

Board of Osteopathic Medicine and Surgery
Department of Licensing and Regulation
P.O. Box 9649
Olympia, WA 98504

(206) 753-2205

Washington Revised Code Annotated
18.57A.010 - 18.57A.070 (West 1978)
Osteopathic PAs

Wisconsin

Medical Examining Board
1400 E. Washington Ave.
Madison, WI 53702

(608) 266-2811

Wisconsin Statutes Annotated
448.01 - 448.40 (West 1978)

CHAPTER III

NURSE PRACTITIONERS: A REVIEW OF THE STATUS OF THE EXPANDED ROLE FOR REGISTERED NURSES

ANALYSIS OF CONDITIONS ON PRACTICE FOR NURSE PRACTITIONERS IN THREE STATES: FLORIDA, NORTH CAROLINA, AND WISCONSIN

A. General Discussion

As explained in the introduction, the lack of specificity in the language used to authorize the practice of nurse practitioners makes analysis difficult. For that reason, this chapter begins with a general discussion using examples of language used in various nurse practice acts which deal with expanded roles of nurses. This is followed by a brief review of conditions of practice in three states for which it was possible to provide an analysis: Florida, North Carolina, and Wisconsin.

Nurse practitioners are registered professional nurses (R.N.s) who (1) have a formal program of advanced training beyond the level required for initial licensure as an R.N., and in addition to performing nursing tasks, (2) can perform certain kinds of medical tasks, and (3) may be officially recognized as performing in an expanded role. Official recognition of "nurse practitioners" or "nurse specialists", which also include nurse midwives and nurse anesthetists, for example, is reflected by legal acknowledgement through statute or administrative rules.

Some states have neither a statute nor rules which acknowledge nurse practitioners as such; yet, these states may be moving towards legal recognition of the nurse practitioner, as in Wisconsin, for example, where policy proposals have been developed by the State Board of Nursing. In other states, statutes or rules may exist which describe an expanded nursing and medical role for nurses, but no official certification exists specifically for nurse practitioners.[1]

The traditional role for nurses, defined by statute, has usually included the prohibition of "acts of (medical) diagnosis or the prescription of therapeutic or corrective measures".[2] The purpose of such a prohibition is to separate nursing functions from medical functions. Several state laws still contain this

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[1] Trandel-Korenchuk, Darlene M. and Keith M., "How State Laws Recognize Advanced Nursing Practice", Nursing Outlook, November, 1978; pp. 713-719.

[2] Trandel-Korenchuk, p. 713.

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1 OF 2

type of limiting language, as does Tennessee, for instance:

> "The foregoing (scope of nursing practice) shall not be deemed to include acts of medical diagnosis or the development of a medical plan of care and therapeutics for a patient."[3]

Another example is the Illinois law:

> "The foregoing shall not be deemed to include acts of medical diagnosis or prescription of therapeutic or corrective measures which are properly performed only by physicians licensed in the state of Illinois."[4]

In the rules of these two states, however, there are provisions which seem to allow some flexibility toward expanding the nursing role. The rules and regulations of the Tennessee State Board of Nursing provide that:

> Registered nurses, duly licensed by the State of Tennessee who practice nursing in this state are not prohibited from expanding their roles by the Nursing Practice Act. However, R.N.s functioning in an expanded role assume personal responsibility for all of their acts. R.N.s who manage the medical aspects of a patient's care must have written medical protocols, jointly developed by the nurse and the sponsoring physician(s). The detail of medical protocols will vary in relation to the complexity of the situations covered and the preparation of the R.N. using them.[5]

Here, the meaning of "medical aspects of a patient's care" is not defined, and it is uncertain whether this rule is meant to, or functions to, encourage nurses to seek an expanded role.

In Illinois, a section of the rules, entitled "Standards of Practice for the Registered Nurse" contains the following provision allowing registered nurses to:

> 13. Accept responsibility for new and expanded functions only after assurance that:
> (a) The group delegating the functions is ready to do so.
> (b) The individual assesses own readiness to accept responsibility.
> (c) Adequate instruction and practice to assume responsibility to administer the new function safely has been provided.[6]

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[3] Tennessee Code Annotated §63-740 (1976).

[4] Illinois Statutes Annotated, Chap. 111 §305 (1) (Smith-Hurd).

[5] Tennessee Rules and Regulations for Registered Nurses, Sec. 1000-1-.04 (3).

Here, one wonders who is allowed to act as the "group delegating the functions", and where the nurse will obtain "adequate instruction and practice" to be able to take on expanded functions. This second question may be partially answered in another section of the rules. It is possible that such "instruction" could be part of a "career advancement program", as described below:

> Within the context of the Illinois Nursing Act, a limited number of special programs, developed specifically for career advancement will be given temporary approval to proceed as experimental in nature. During this period of temporary approval, such a program will be closely supervised and required to submit periodic detailed reports. After the program has been evaluated and its educational soundness established, full approval may be granted for its continuance.[7]

The statute relating to nursing practice in the state of Rhode Island[8] does not contain the traditional wording mentioned above which limits registered nurses from performing medical acts. On the other hand, it does not contain language which explicitly authorizes the registered nurse to expand her role to include medical functions. The administrative rules offer little clarification either way. The rules do allow for the performance of two discrete medical procedures by registered nurses: intravenous procedures and closed chest cardiac resuscitation.[9]

Nursing practice laws in Colorado, Nebraska, Nevada and Washington all appear to contain specific provisions for expanding the role of registered nurses by allowing the performance of medical functions under certain conditions. Registered nurses in Colorado are authorized to practice within the following scope of practice:

> (9) "Practice of professional nursing" means the <u>diagnosing</u> and <u>treating</u> of <u>human responses</u> to actual or potential health problems through such services as:
> (a) <u>Case finding</u>, health teaching, health counseling, and initiation of health care;

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[7] Illinois Nursing Rules, Part VI.

[8] General Laws of Rhode Island §5-32-1.

[9] Rules and Regulations of the Rhode Island Board of Nurse Registration and Nursing Education, pp. 5 & 6.

(b) Providing nursing that is supportive and restorative to life and well-being directly to the patient or through the supervision and teaching of other nursing personnel or assistants;
(c) Executing medical regimens as prescribed by a licensed or legally authorized physician or dentist;
(d) Requiring specialized knowledge, skill, and judgment for the application of principles of biological, physical, social, and behavioral sciences.[10]

Here, the underlined words are defined in the statute[11], and the definitions seem to permit certain kinds of diagnostic and therapeutic functions for registered nurses. However, Colorado has no nursing regulations to clarify the statute.

In Nebraska, the statutory wording is clear and follows the form of the American Nurses Association's (ANA) proposal for language authorizing an expanded role for registered nurses.[12] The Nebraska law states that a registered nurse's practice may include:

> Performing such additional acts as are recognized by the nursing and medical professions as appropriate to be performed by the registered nurse. Such acts shall be authorized under rules and regulations promulgated by the Board of Nursing and Board of Examiners in Medicine and Surgery and implemented by the Board of Nursing.[13]

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[10]Colorado Revised Statutes §12-38-202.

[11]Colorado Revised Statutes §12-38-202, "Definitions".

> "Case finding" means the use of knowledge and skill of observation to come to the conclusion that a condition exists for which nursing care is indicated or for which referral for other health care is required.
>
> "Diagnosing" within the terms of this part 2 means the identification of and discrimination between physical and psychological signs or symptoms essential to the effective execution and management of a nursing regimen.
>
> "Human responses" means those signs, symptoms, and processes which denote the individual's reaction to actual or potential health problems.
>
> "Medical regimen" means that aspect of care which implements the medical plan as prescribed by a licensed or otherwise legally authorized physician or dentist.
>
> "Nursing regimen" means a systematic therapeutic plan designed by nursing personnel to carry out the practice of nursing.
>
> "Treating" means the selection and performance of those measures essential to the effective execution and management of the nursing regimen and the execution of the medical regimen.

[12]Trandel-Korenchuk, Nursing Outlook, p. 714.

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.

[13]Nebraska Revised Statutes §71-1, 1, 132.05 (h) (1975).

Unfortunately, the rules and regulations for this section have not yet been promulgated; they are being challenged in the Nebraska courts[14]. In the absence of approved rules it is difficult for registered nurses to know exactly how they may function in an expanded role.

The Nevada statute states:

> A professional nurse may also perform additional acts, under emergency or other special conditions prescribed by regulations adopted by the board, which shall include special training, as are recognized by the medical and nursing professions as proper to be performed by a professional nurse under those conditions, even though the acts might otherwise be considered diagnosis and prescription, but nothing in this chapter authorizes professional nurses to perform those functions and duties specifically delegated by law to those persons licensed as dentists, podiatrists, optometrists or chiropractors.[15]

This is further clarified by the rules and the State Board of Nursing of Nevada as follows:

> C. Independent Practice
>
> To practice independently the professional registered nurse shall have educational preparation beyond the basic educational program in nursing as determined by the Board. This additional preparation shall be appropriate to the area of practice and shall include theory and clinical practice. When such practice includes medical diagnosis or prescription, it should be in collaboration with a licensed physician. It is recommended that this collaborative agreement between physician and nurse be in writing.[16]

These rules also provide for the evaluation of advanced educational program. An expanded role for R.N.s in Nevada, therefore, seems to be clearly defined and relatively complete.

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[14] Phone conversation with the Nebraska State Board of Nursing, June 25, 1979.

[15] Nevada Revised Statutes §632.010 (7) (1977).

[16] Minimum Requirements for Licensure of Registered and Practical Nurses, Sec. 111 (C).

In Washington, the statute on nursing practice allows:

> (2) The performance of such additional acts requiring education and training and which are recognized jointly by the medical and nursing professions as proper to be performed by nurses licensed under this chapter and which shall be authorized by the board of nursing through its rules and regulations.[17]

The administrative regulations on certified registered nurses read as follows:

> Scope of practice of certified registered nurses. The board recognizes advanced and specialized acts of nursing practice as those described in the scope of practice statements for nurses certified by national associations approved by the board listed in WAC 308-120-310 (1).
>
> WAC 308-120-310 Certification programs approved by the board.
> (1) The board approved certification programs from the following national associations, which programs exist as of June 2, 1977:
> (a) American Association of Nurse Anesthetists
> (b) American College of Nurse Midwives
> (c) American Nurses Association
> (d) National Association of Pediatric Nurse Associates and Practitioners[18]

The Washington regulations are different from those in the other states discussed in that certification for registered nurses in expanded roles in Washington is provided by national association. Trandel and Korenchuk, a nurse-lawyer team, comment on this approach:

> This approach attempts to provide a national standard for approved duties for nurses, while at the same time standardizing a testing device to insure minimal competency.
>
> The Washington scheme falls short, however, because some of the national certification tests are not evidence of minimal competency for licensure and entry into advance nursing practice; rather they are recognition of achievement of high standards of nursing practice within a specialized field, with qualification going beyond requirements for licensure. When questioned specifically if the ANA sponsors a national certification exam for entry into a specialized or advanced practice area, a spokesman denied this, adding, "nor does ANA currently sponsor a certification program for which the purpose would be certification for entry into specialized practice". The Washington law, taken at face value, requires national certification before entry into CRN practice. That certification, however, can only be achieved after

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[17] Washington Revised Code Annotated §18.88.030 (2).

[18] Washington Administrative Code 308-120-310.

> showing evidence that advanced practice has been performed with excellence. This contradiction could therefore only mean that some other system must be legally recognized in the state to acknowledge the new nurse practitioner, and such a system does not exist at this time.[19]

The three Correctional Health Care Program participating states not yet discussed provide official authorization for the practice of nurse practitioners. The Michigan nursing statute, which became effective in September of 1978, authorizes the board of nursing to certify nurse practitioners, but the board has not yet promulgated its rules or regulations. The authorizing language in the Michigan law reads as follows:

> Registered professional nurse; specialty certification; fields.
> Sec. 17210. The board of nursing may issue a specialty certification to a registered professional nurse who has advanced training beyond that required for initial licensure and who has demonstrated competency through examination or other evaluative processes and who practices in one of the following health profession specialty fields: nurse midwifery, nurse anesthetist, or nurse practitioner.[20]

Florida and North Carolina have statutes and rules which recognize "nurse practitioners" as specialized nurses with advanced training; these laws are discussed in depth in the section on conditions of practice. The model proposals for recognizing nurse practitioners which the Wisconsin Board of Nursing has drawn up are also discussed in detail.

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[19]Trandel-Korenchuk, Nursing Outlook, p. 719.

[20]Michigan Statutes Annotated §14.15 (17210) (1978).

CONDITIONS ON PRACTICE: NURSE PRACTITIONERS FLORIDA

1. What is the status of nurse practitioners in the state?

Nurse practitioners are legally recognized in Chapter 210-11 of the Florida Administrative Rules and Regulations; and in Section 464.021 of the Florida Statutes, under the allowed expanded role of nurses.

The rules define a nurse practitioner as follows:

(1) Advanced Registered Nurse Practitioner

An Advanced Registered Nurse Practitioner is a nurse with current active licensure as an R.N. in Florida, who is prepared for advanced nursing practice by virtue of added knowledge and skills gained through an organized post basic program of study and clinical experience approved by the Florida State Board of Nursing.

The statutory authorization allows advanced R.N.s to perform "such additional acts requiring education and training which are recognized jointly by the medical and nursing professions....."

2. In what areas/categories may nurse practitioners be employed?

This question is answered in the rules:

210-11.02 Categories of Advanced Registered Nurse Practitioners.
(1) Certified Registered Nurse Anesthetist
(2) Certified Nurse Midwife
(3) Family Nurse Practitioner
(4) Family Planning Nurse Practitioner
(5) Geriatric Nurse Practitioner
(6) Pediatric Nurse Practitioner
(7) Adult Primary Care Nurse Practitioner
(8) Other categories as may be determined from time to time by the Board.

3. What types of services/procedures may nurse practitioners provide?

A general statement regarding the types of services a nurse practitioner may

QUESTION #3 (continued) FLORIDA

provide is found in the rules.

> 210-11.03 Acts Proper to be Performed by an Advanced Registered Nurse Practitioner. The Board authorizes the categories of Advanced Registered Nurse Practitioners to perform particular acts, at the advanced and specialized levels recognized by the nursing profession and which are currently included in the curricula of advanced nursing education programs approved by the Board.
>
> In addition, the Board authorizes Advanced Registered Nurse Practitioners to perform such additional acts as may be recognized by the Advisory Committee, as proper to be performed by an Advanced Registered Nurse Practitioner.

Specific tasks are not outlined in rules or statute.

4. *Are nurse practitioners subject to a formal approval process by state regulatory authorities whereby they are required to meet specified educational, experiential, or other requirements?*

Yes. Nurse Practitioners are certified by the State Board of Nursing. Requirements for certification are specified as follows, in the rules:

> 210-11.04 Requirements for Certification. Requirements for certification as an Advanced Registered Nurse Practitioner in the State of Florida shall consist of the following:
>
> (1) Active licensure as a Registered Nurse in Florida.
>
> (2) Documentation acceptable to the Board of one or more of the following:
>
> (a) Satisfactory completion of a formal educational program. Such program of study shall conform to the Program Guidelines outlined in the Appendix to these Rules.
>
> (b) Certification by the appropriate specialty board or equivalent as approved by the Board.
>
> (c) Graduation from a program leading to a Master's degree in a nursing clinical specialty area with preparation in specialized practitioner skills.
>
> (3) Evidence satisfactory to the Board of current clinical competencies if more than one (1) year has elapsed since the completion of the nurse practitioner program. Such evidence may include written documentation attesting to said fact. Applicants not meeting specific educational requirements as outlined in these Rules and Appendix may be considered on an individual basis by the Board for equivalency of education and experience.

QUESTION #4 (continued) FLORIDA

Nurse practitioners must pay a fee upon initial certification, and must re-register annually, paying a smaller fee each year.

5. *What are the requirements for the relationship between nurse practitioners and physicians (in terms of supervision, consultation, and the like)?*

None are outlined in the rules or in the statute.

6. *May nurse practitioners prescribe drugs?*

This question is not addressed in the rules or the statute.

CONDITIONS OF PRACTICE: NURSE PRACTITIONERS NORTH CAROLINA

1. What is the status of nurse practitioners in the state?

Nurse practitioners are legally recognized in the nursing and medical statutes, as well as in the administrative rules, of North Carolina.

The nursing statute reads:

> Nursing by registered nurse requires specialized knowledge, judgment, and skill, but does not require nor permit except under supervision of a physician licensed to practice medicine in North Carolina medical diagnosis or medical prescription of therapeutic or corrective measures.

And the medical statute, in more positive terms, allows:

> (14) The practice of nursing by a registered nurse engaged in the practice of nursing and the performance of acts otherwise constituting medical practice by a registered nurse when performed in accordance with rules and regulations developed by a joint subcommittee of the Board of Medical Examiners and the Board of Nursing and adopted by both boards. (1858-9, c.258, s.2; Code, s.3122; 1885, c.117, s.2; c.261; 1889).

The nurse practitioner is referred to as a "nurse practitioner" and as a "registered nurse performing medical acts" in North Carolina. The rules state:

> The term "registered nurse" as used herein refers to a registered nurse who is functioning and performing medical tasks or combination of tasks at the direction of or under the supervision of a physician licensed to practice medicine in North Carolina, and which nurse is approved by the board as being qualified by training and experience to perform the functions and tasks outlined in the application at the direction of or under the supervision of a physician.

And the Board of Medical Examiners, in the preface to its "Commentary Regarding Physician Assistants and Nurse Practitioners" says:

> It is recognized that the nurse practitioner is a health professional who is also independently licensed to provide nursing care. This commentary does not relate to those nursing acts, tasks or functions which might be performed by registered nurses who also have special skills as nurse practitioners. It relates only to medical acts, which may be performed only under the supervision of a licensed physician or a group of such physicians.

(continued) NORTH CAROLINA

2. *In what areas/categories may nurse practitioners be employed?*

None are specified separately in rules or statute.

3. *What types of services/procedures may nurse practitioners provide?*

Beyond the general discussion of tasks in Question #1, no specific services are outlined in the rules or in the statute.

4. *Are nurse practitioners subject to a formal approval process by state regulatory authorities whereby they are required to meet specified educational, experiential, or other requirements?*

Yes. Nurse Practitioners are certified by the Board of Medical Examiners of North Carolina. Each NP must present an application of approval to the Board in order to be certified. The application must be:

> ....signed by such person and signed by the physician who is supervising the medical acts or performance of, showing and certifying:
> (1) that the person for whom approval is requested has been licensed as a registered nurse by the North Carolina Board of Nursing;
> (2) a general description of the medical functions, tasks, and duties which such registered nurse will be expected to perform;
> (3) that such registered nurse has received and has satisfactorily completed a formal course or courses of training and instruction in the procedures and practices which such nurse will be expected to perform as approved by the board, or that such registered nurse has received and successfully completed such other training and instruction as may be approved by the board;
> (4) the extent and nature of supervision by a doctor licensed to practice medicine of the performance of the medical functions and tasks which such registered nurse will be expected to perform; and
> (5) that such registered nurse is qualified to perform properly the medical functions, tasks, and duties described in the Application for Approval, and the approval of such application by the Board of Medical Examiners has been recommended by the Board of Nursing.

QUESTION #4 (continued) NORTH CAROLINA

Certification requires an initial fee, as well as a smaller yearly fee to be paid at annual certification renewal.

5. *What are the requirements for the relationship between nurse practitioners and physicians (in terms of supervision, consultation, and the like)?*

Supervision for the nurse practitioner is similar to the supervision required for the physicians' assistant in North Carolina.

The term "supervision" is defined as incorporating physician backup to registered nurses performing medical acts in the following ways:

(1) Continuous availability of direct communication by radio, telephone or telecommunications;
(2) The backup physician shall be available on a regularly scheduled basis for:
  (a) referrals;
  (b) review of the registered nurses' practice between conferences incorporating:
    (i) consultation;
    (ii) chart review and cosigning records to document accountability; prescribing within that practice setting, standing orders and drug protocol for interval between conferences to be part of this regular review and documentation;
    (iii) continuing education;
(3) A predetermined plan for emergency services.

Also, the Board's "Commentary" designates specific supervisory responsibilities for the nurse practitioner in different settings. (For supervision in a hospital or institutional setting, see Question #10 for physicians' assistants in North Carolina).

III. SETTING

A. Office, with physician on premises

In such settings it is required that the physician ordinarily be available for immediate on-site consultation with the NP about any question relating to patient care.

The physician must regularly and systematically review and sign clinical records of patients seen by the NP, checking for accuracy and completeness, and evaluating the suitability of the plan of management.

QUESTION #5 (continued) NORTH CAROLINA

If the physician is temporarily out of the area and not available for direct or telephone consultation with the NP, another licensed physician recognized by the Board in the original application will be designated as "on call" for such consultation. Although this might be a telephonic consultation, for urgent matters direct personal attendance of this physician must be achievable within a reasonable period of time, i.e., a period of minutes rather than hours.

B. Office, no physician usually on premises (e.g. rural clinics)

This setting differs from the previous description in that no physician is usually on-site for direct consultation.

The isolated setting of these sites places additional responsibilities on the NP and the supervising physician. Both are expected to be particularly attentive to the level and quality of supervision, and to backup services, which must be available without delay.

Some form of written protocols or instructions must be available covering those conditions commonly encountered. These may take the form of a standard published volume designed for such purpose, such as Patient Care Guidelines for Family Nurse Practitioners by Hoole, Greenberg and Pickard, but if so, it is required that the NP and all responsible physicians have reviewed the volume and agree regarding the appropriateness of the instructions contained therein. In addition, standard reference volumes must be available at the remote office for use by the NP.

The responsible physician must be available to the NP at all times by telephone and must be willing and able to respond to an emergency call for assistance. If the responsible physician is temporarily not immediately available, by reason of vacation, attendance at an out-of-town meeting, or similar circumstance, another physician previously approved by the Board and willing and able to supervise at that time must be designated and the NP so informed. It is essential that the additional covering physician be aware of his/her supervisory responsibility, and of the capability of the individual whom the physician has agreed to supervise. If by reason of emergency or personal illness the responsible physician must leave the practice area or otherwise interrupt the agreed-to supervisory activities, the services of another duly licensed physician may be enlisted to act as an additional supervising physician. The Board should be notified promptly of this action over the signatures of both physicians, with a request for the Board's approval of the revised supervisory mechanism.

All charts in the remote office must be regularly and systematically reviewed. The frequency with which this review is conducted will be determined by the Board on the basis of the specific need of the practice site. Patients with difficult or obscure problems must be referred to the responsible physician or another Board approved physician or group of physicians for management.

(continued) NORTH CAROLINA

6. *May nurse practitioners prescribe drugs?*

Yes, within the lengthy and detailed limits outlined in the North Carolina statute and regulations. The statute states:

> (b) Nurse practitioners are authorized to write prescriptions for drugs under the following conditions:
> (1) The Board of Medical Examiners and Board of Nursing have adopted regulations developed by a joint subcommittee governing the approval of individual nurse practitioners to write prescriptions with such limitations as the boards may determine to be in the best interest of patient health and safety;
> (2) The nurse practitioner has current approval from the boards;
> (3) The Board of Medical Examiners has assigned an identification number to the nurse practitioner which is shown on the written prescription; and
> (4) The supervising physician has provided to the nurse practitioner written instructions about indications and contraindications for prescribing drugs and a written policy for periodic review by the physician of the drugs prescribed.
> (c) Nurse practitioners are authorized to compound and dispense drugs under the following conditions:
> (1) The function is performed under the supervision of a licensed pharmacist; and
> (2) Rules and regulations of the North Carolina Board of Pharmacy governing this function are complied with.

The rules explain further that:

> When the proposed medical functions of a registered nurse include prescribing of drugs, the supervising (backup) physician and the registered nurse shall review the formulary approved by the North Carolina Board of Nursing and the Board of Medical Examiners of the State of North Carolina, and shall acknowledge in the application to the Board that they are familiar with the formulary, and that such formulary will be a part of and incorporated in the approved standing orders. Changes in the formulary are to be approved by the Board. In regard to changes, the approved formulary may include any over-the-counter or non-prescription drug.

The current approved formulary is included in this section. The Board comments on the use of the formulary as follows:

> The physician must approve each prescription for a drug not included in the approved formulary before the prescription is issued by the NP to the patient.

QUESTION #6 (continued) NORTH CAROLINA

> The formulary is intended to set limits on those medications for which the NP may issue written prescriptions. It is not intended to preclude the inclusion in standing orders of vaccines, intravenous fluids, or other parenteral medications which in the opinion of the supervising physician are appropriate for a NP to administer in the office or hospital setting without prior consultation with the physician. If the physician wishes to include in the standing orders medications which do not fall within the scope of the formulary, a list of such medications must be submitted to the Board with a request for approval. The Board will not authorize the inclusion in standing orders of any controlled substances.

The rules also contain instructions for NPs prescribing drugs not included on the formulary.

> Prescriptions, except controlled substances, may, upon specific orders of the supervising physician given before the prescription is issued, be written and issued by such registered nurse for the use by patients of drugs which are not included in the formulary. Such prescriptions shall be signed by the registered nurse with a notation thereon that the same was issued upon the specific order of the supervising physician. For example: Mary Smith, R.N., on order of John Poe, M.D.

APPROVED FORMULARY

For the Writing of Prescriptions by Persons Approved
To Prescribe Drugs Under the Provisions of G.S. 90-18.1

No controlled substances (Schedule II, II-N, III, III-N, IV, V) defined by the Federal Controlled Substances Act may be prescribed.

No parenteral preparations (except Insulin) may be prescribed.

Any pure form or combination of the following generic classes of drugs may be prescribed, unless the drug or class of drug is listed as excluded from the formulary. No drugs or classes of drugs that are excluded may be prescribed.

ANTIHISTAMINES

ANTI-INFECTIVE AGENTS
Drugs excluded under this generic category:
Amebacides
—Carbarsone
—Diiodohydroxyguin
—Emetine
—Glycobiarsol
Chloramphenicol

Oxacillin
Minocycline
Pediatric Tetracycline
Clindamycin
Plasmodicides
—Amodiaquine
—Chloroquine
—Hydroxychloroquine
—Primaquine
—Pyrimethamine

ANTINEOPLASTIC AGENTS
All agents are excluded under this generic category.

BLOOD FORMATION AND COAGULATION
Drugs excluded under this generic category:
Anticoagulants

CARDIOVASCULAR DRUGS

CENTRAL NERVOUS SYSTEM DRUGS
Drugs excluded under this generic category:
Psychotherapeutic agents
Antidepressants
Tranquilizers
Benactyzine
Lithium
Respiratory stimulants
Cerebral stimulants
Sedatives and hypnotics
Pentazocine

DIAGNOSTIC AGENTS

ELECTROLYTIC, CALORIC AND WATER BALANCE

ENZYMES

EXPECTORANTS AND COUGH PREPARATIONS

EAR, EYE, NOSE AND THROAT PREPARATIONS
Drugs excluded under this generic category:
Any preparation containing an excluded drug.

GASTROINTESTINAL DRUGS

HORMONES AND SYNTHETIC SUBSTITUTES
Drugs excluded under this generic category:
Parathyroid hormones and synthetics
Pituitary hormones and synthetics

OXYTOCICS
All agents are excluded under this generic category.

RADIOACTIVE AGENTS
All agents are excluded under this generic category.

SKIN AND MUCOUS MEMBRANE PREPARATIONS
Drugs excluded under this generic category:
Any preparation containing an excluded drug.

OTHER CRITERIA:

According to N. C. General Statute 90-18.1, written standing orders must be used.

Every prescription and every refill must be entered on the patient's chart. A refill can be authorized by telephone if the refill is entered on the patient's chart and countersigned by the physician within 72 hours.

Amount of drug can be no more than 100 dosage units or a 90 days supply, whichever is less.

11/2/76

CONDITIONS OF PRACTICE: NURSE PRACTITIONERS — WISCONSIN

1. What is the status of nurse practitioners in the state?

The information used to answer these questions comes from two position papers endorsed and adopted by the Wisconsin State Board of Nursing. At the present time the Wisconsin State Boards of Nursing, Medicine and Pharmacy are considering the questions involved in officially authorizing nurse practitioners.

> There are no statutory provisions for the recognition of the nurse practitioner in the State of Wisconsin in the form of credentialing, certification, or licensure. Also, there is no generally accepted definition or concensus of opinion regarding a Nurse Practitioner's title, role, or functions, or the qualifications and educational preparation for such a designation. Programs offering post-graduate work in nursing for the registered professional nurse offer various curricula and designations, e.g., practitioner, associate, assistant, and specialist. There are registered professional nurses functioning in an expanded and extended role in various health care settings on the basis of expertise developed through experience and/or staff development/ inservice and other continuing education programs. Some registered professional nurses are establishing an independent practice patterned after the model proposed by Dorthea Orem and implemented by Lucille Kinlein. Others are practicing similar to the Physicians' Assistants, as described in Med. 8, Wisconsin Administrative Code, and are employed by or under the general or special supervision or direction of a physician or group of physicians.
>
> -from Position Paper #1
> Endorsed, January 18, 1978

> An Advanced Registered Nurse Practitioner is a registered nurse who is currently licensed to practice professional nursing in Wisconsin, who is prepared for advanced nursing practice by having acquired additional knowledge, skills and abilities in completing an organized post baccalaureate program of study and clinical experience approved by the Wisconsin State Board of Nursing. The nurse practitioner shall:
>
> (a) be capable of providing a wide variety of health care and services;
> (b) hold a master's degree in nursing, with an emphasis in a category of Advanced Registered Nurse Practitioner;
> (c) provide evidence of having a high degree of advanced knowledge, skill, abilities and competence in a specialized practice discipline of nursing.
>
> -from Position Paper #2
> Adopted, July 19, 1978

(continued) WISCONSIN

2. *In what areas/categories may nurse practitioners be employed?*

Categories of Advanced Registered Nurse Practitioners

Recognition is provided for the accepted professional certification categories as sponsored by the Division of Practice of the appropriate professional organizations in the areas of:

(a) Gerontological
(b) Adult and Family (Primary Health)
(c) Maternal, Gynecological-Neonatal
(d) Pediatrics
(e) Medical-Surgical
(f) Community Health
(g) Psychiatric - Mental health
(h) Administration - Nursing:
    (1) educational
    (2) service
(i) Education
(j) Certified Registered Nurse Anesthetists who hold current licensure as a registered nurse in Wisconsin are accepted by the Board as meeting the requirements
(k) Other categories as may be determined as appropriate by the Board.

-from Position Paper #2
Adopted, July 19, 1978

Remember, this material is all informational, and not yet fully official.

3. *What types of services/procedures may nurse practitioners provide?*

Functions or Acts to be Performed by an Advanced Registered Nurse Practitioner

The Board authorizes the performance of particular acts at the advanced and specialized levels of practice recognized by the nursing profession and which are determined appropriate and currently included in the curricula of advanced level nursing education programs approved and accredited by the Board.

In addition, the Board authorizes Advanced Registered Nurse Practitioners to perform such additional acts as may be determined and recognized by the Joint Practice Committee established for such purposes, to include state board representation from, but not limited to - medical examining, nursing and pharmacy.

-From Position Paper #2
Adopted, July 19, 1978

(continued) WISCONSIN

4. *Are nurse practitioners subject to a formal approval process by state regulatory authorities whereby they are required to meet specified educational, experiential, or other requirements?*

The following, from Position Paper #2, is a recommended set of requirements for certification of nurse practitioners by the Wisconsin State Board of Nursing.

Requirements for Certification

Requirements for certification as an Advanced Registered Nurse Practitioner (ARNP) in the State of Wisconsin shall consist of the following:

(a) currently licensed as a Registered Professional Nurse in Wisconsin;
(b) satisfactory completion of a formal academic program designed to prepare registered professional nurses in specialized areas and advanced level of practice in administration, education, or clinical practice. Such programs of study shall include or meet the following criteria:
  (1) provide a high degree of knowledge, skill, ability and competence in a specialized and advanced practice discipline in nursing;
  (2) curriculum to have both theory and supervised clinical practice components (if applicable);
  (3) academically qualify to grant a master's degree or higher level (e.g., Ph.D);
  (4) such programs of study is specialized and advanced practitioner preparation shall conform to the 'Program' guidelines delineated in subsection of these rules (to be developed);
(c) Certification by the appropriate category specialty standards and requirements or equivalent as approved by the Board (to be developed);
(d) Applicants not meeting specific requirements as determined in sections of 1) preparation; 2) functions; 3) categories; and 4) requirements delineated in these rules and regulations may be considered on an individual basis by the Board for equivalency of education, experience or performance.

5. *What are the requirements for the relationship between nurse practitioners and physicians (in terms of supervision, consultation, and the like)?*

....when functioning in an extended and/or expanded role to include acts of medical diagnosis, treatment or prescriptions of medical therapeutic or corrective measures, is required to have physician collaboration or support and to perform in these areas within approved written protocols. Such acts shall be authorized by the rules and regulations jointly pro-

QUESTION #5 (continued) WISCONSIN

mulgated by the Wisconsin state boards of medical examiners, nursing and pharmacy.

(1) In each organization, facility, or agency providing health care and services in which the practice of the A.R.N.P. involves acts of medical diagnosis, treatment, or prescribing - there shall be a committee appointed for the purpose of establishing policies and protocols for these practices.

(2) The committee shall include, but not be limited to representation from: medical staff member practicing in specialty area; nurse practitioner in specialty area; administration.

(3) All nurse practitioners, in matters pertaining to these areas defined in the scope of medical practice, shall be directly responsible to the established committee or designated support physician for these areas of practice.

-From Position Paper #2
Adopted, July 19, 1978

6. *May nurse practitioners prescribe drugs?*

This question is not addressed in any of the recommended policies in the Wisconsin State Board of Nursing position papers.

TABLE 3: STATUS OF THE EXPANDED ROLE FOR REGISTERED NURSES IN ELEVEN STATES

STATES	OFFICIAL RECOGNITION OF NURSE PRACTITIONERS	EXPANDED ROLE AUTHORIZED BY STATUTE	EXPANDED ROLE AUTHORIZED BY RULES & REGS.	COMMENTS
COLORADO	NO	YES	---*	No Rules
FLORIDA	YES	YES	YES	-----
ILLINOIS	NO	NO	YES*	Rules seem to authorize expanded role to a limited extent; Needs interpretation by experts.
MICHIGAN	YES	YES	DON'T KNOW*	Rules are currently being written.
NEBRASKA	NO	YES	DON'T KNOW*	Rules are currently being contested in court.
NEVADA	NO	YES	YES	-----
NORTH CAROLINA	YES	YES	YES	-----
RHODE ISLAND	NO	DON'T KNOW*	NO*	Statute seems limited and needs interpretation by experts; Rules don't clarify statute.
TENNESSEE	NO	NO	YES*	Rules seem to authorize expanded role to a limited extent; Needs interpretation by experts.
WASHINGTON	NO*	YES	YES	The statute does, however, authorize "certified registered nurses" which appear to be similar to nurse practitioners.
WISCONSIN	YES*	YES	DON'T KNOW*	Nursing Board has drafted and approved proposals recognizing nurse practitioners; Rules not written yet.

*see comments in last column

Table 4. TITLES AND CITATIONS FOR STATUTES ON SCOPE OF PRACTICE FOR REGISTERED NURSES AND REGULATORY BOARDS.

COLORADO	
State Board of Nursing 1525 Sherman St. Denver, CO 80203 (303) 839-2871	Colorado Revised Statutes 12-38-202 (1974)
*FLORIDA	
Dept. of Professional and Occupational Regulation Division of Professions, Board of Nursing 111 Coast Line Drive East, Suite 504 Jacksonville, FL 32202 (904) 359-6331	Florida Statutes Annotated 464.105 (4) (West 1977)
ILLINOIS	
Dept. of Education and Registration Springfield, IL 62786 (217) 785-0800	Illinois Statutes Annotated Chap. 111 3405 (Smith-Hurd 1975)
*MICHIGAN	
Dept. of Licensing and Regulation Board of Nursing 905 Southland, P.O. Box 30018 Lansing, MI 48909 (517) 373-1600	Michigan Statutes Annotated 14.15 (17210) (Callaghan 1978) Michigan Compiled Laws Annotated 333.17210 (West 1978)
*NEBRASKA	
State Board of Nursing State House Station, P.O. Box 95065 Lincoln, NB 68509 (402) 471-2001	Nebraska Revised Statutes 71-1, 1, 132.05 (1975)
*NEVADA	
State Board of Nursing 1201 Terminal Way, Room 203 Reno, NV 89502 (702) 786-2778	Nevada Revised Statutes 632.010 (1977)

*Indicates statute provides for expanded RN role. Otherwise, cited sections provide scopes of practice for initial licensure as a registered nurse.

*NORTH CAROLINA

State Board of Medical Examiners
222 N. Pierson St., Suite 214
Raleigh, NC 27601

(919) 833-5321

North Carolina General Statutes
90-18 (14) - 18.2 (1975 and CS 1978)

North Carolina General Statutes
90-158 (3) (1978)

RHODE ISLAND

Board of Nurse Registration and
Nursing Education
c/o Dept. of Health
Cannon Building, Room 104
75 Davis Street
Providence, RI 02908

(401) 277-2827

General Laws of Rhode Island
5-34-1 (1974)

TENNESSEE

State Board of Nursing
Dept. of Public Health
State Office Building
Ben Allen Road
Nashville, TN 37216

(615) 741-7256

Tennessee Code Annotated
63-740 (1976)

*WASHINGTON

State Board of Nursing
Professional Licensing Division
P.O. Box 9649
Olympia, WA 98504

(206) 753-3726

Washington Revised Code Annotated
18.88.030 (West 1976)

*WISCONSIN

Board of Nursing and Division of Nurses
Dept. of Licensing and Regulation
1400 E. Washington Avenue
Madison, WI 53702

(608) 266-3735

Wisconsin Statutes Annotated
441.11 (1) (West 1978)

*Indicates statute provides for expanded RN role. Otherwise, cited sections provide scope of practice for initial licensure as a registered nurse.