Community Based Nursing Service As An Alternative-Background Forces and Current Practice.

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3. Emphasis on Prevention and Maintenance Care and Cost-effective Health Care.

The advancement of knowledge and technology, especially with the discovery of Sulfa drugs and antibiotics coupled with improvements in general economic and living conditions of people has caused shifts in health care needs of population.

Previous focus in preventive medicine and public health field on communicable disease prevention has become irrelevant in the face of decreasing incidents of infectious diseases in general and increase in the importance of degenerative and accidental and self-inflicted health problems. There has been a great concern of the impact of physical and psychological human environment and the life styles of individuals on health status of people.

At the realization of the fact that with presently avaliable knowledge and technology and relatively limited resources, power of medicine to improve health status of modern man is limited, and at the same time, realization of the pathetic discrepancy between the advances of health sciences and health level of people together, once again emphasis on prevention and maintenance care has been revived.

In most of the literature, one can find that quality care has been equated with comprehensive care plans which include preventive and maintenance health care as well as diagnostic and curative care. The Health Maintenance Organization Act and recent nursing organizational stances on National Health Insurance Plans all speak to the need of improving preventive and health maintenance care.

Saward and Greenlick argues that the name Health Maintenance Organization must be considered as politicized euphemism since the vast majority of the work of any such organization that fulfills the requirements being laid down will be sickness care, and on the assumption that man is mortal, it will probably remain so into the suture. However he admits that the H.MO. is intended to provide the inherent motivation for any prevention.[81]

Regardless of some cynisism among observers the shift of focus to prevention and promotion

※ 본 논문은 지난호에 이어 게재함.

81) Earnest W. Saward, Merywyn R. Greenlick, Health Policy and the H.M.O. Barriers and Facilitators to Quality Health Care, Spring 1975, p. 62.

of health seems to have special relevancy of heath in considering the fact that attainment of higher level of health relates nore to the general social, economic and environmental factors and individual behaviors and less to the quantity or quality of health care avalilabe. It has been noted by many observers that little evidence exists that personal health services provided in any current system materially affect the health status of popuatlion.[82]

New knowledges and new approaches in prevention have to be developed so that whole psychosocial and motivational systems can be taken into consideration in planning for the health care that will have lasting effect.

As multiple health workers start to work together and true collaboration and colleagueship develop in enhancing the mutual goal of extending quality care, new knowledges will be brought in and various approaches likely to be tested and there will be a greater hope in advancing quality of health care for the benefit of clients and the health professionals altogether than what one can expect from previously uniprofessionally deminated system.

Other related rationale for the shifting emphases lie in the rising concern of health cost. From the analysis of medical costs, it was found that hospital cost was leading in inflationary rise, thus health maintenance care as a means for reducing the utilization of hospital was conceived to be economically valid.

Much systematic evaluation of the effectiveness of health care will be needed before any valid conclusion as to the cost-effective pattern of health care with quality assurance can be drown. Some reduction in hospital utilization and higher utilization rate of preventive services has been reported among H.M.O.s enrollees, but the data are yet too scant to suggest any conclusive evidence for the efficiency and cost-effectiveness of such pattern of health care.

B. Nature and Scope of Nursing Practice in Primary Care.

The 1971 Secretary's Report on Extending Scope of Nursing Practice states that there is an ever widening area of independent nursing practice involving nursing judgment, procedures, and techniques. This is due to natural evolution, commencing with the nurse's assumption of certain activities carried out under medical direction, and the subsequent relaxation or removal of that direction-"In this period of rapid transition, the identical procedure performed on a patient may be the practice of medicine when carried out by a physician or the practice of professional nursing when carried out by a nurse."[83]

Opinions and terminologies used differ in defining the role of nursing in expanded capacity yet the trends explicitly speaks for the area of overlapping responsibility and cooperative decision making between medicine and nursing in health care beyond traditional territoriality of professions.

In the joint statement of A.N.A. and American Academy of Pediatrics on the Guidelines for Pediatric Nurse Associates programs, following responsibilities of a nurse practitioner has been delineated.

1. Secure a health history.
2. Perform comprehensive pediatric appraisal including physical assessment and developmental

83) U.S. Dept. of Health, Education and Welfare, Extending the Scope of Nursing Pratice: A Report of the Secretary's Committee to Study Extended Roles for Nurses: 1971.

82) Ibid., p. 75.

evaluation on children from birth through adolescence.

3. Record findings of physical and developmental assessment in a systematic and accurate form.
4. Advise and counsel parents concerning problems related to child-bearing and growth and development.
5. Advise and counsel youth concerning mental and physical health.
6. Provide parents and other family members with the opportunity to increase their knowledge and skills necessary for maintenance or improvement of their families' health.
7. Cooperate with other professionals and agencies involved in providing services to a child or his family and when appropriate coordinate the health care given.
8. Identify resources available within the community to help children and their family, and guide parents in their use.
9. Identify and help in the management of technologic, economic and social influences affecting child health.
10. Plan and implement routine immunizations.
11. Prescribe selected medications according to standing orders
12. Assess and manage common illness and accidents of children.
13. Work collaboratively with physicians and other members of the health team in planning to meet the health needs of pediatric patients.
14. Engage in role redefination with other members of the health team.
15. Delegate appropriate health care tasks to nonprofessional personnel.[84]

Although the nature of nursing practice vary according to their education and practice setting some common denominators can be found in all expanded nursing practice in primary health care:

1. Securing of a health-illness history
2. Assessment of physical, psychosocial and enviornmental needs.
3. Determining and screening abnormalities and make referrals to physicians for further diagnosis and treatment. Though most of nurse practitioners do perform physical examinastions the extent to which they are utilized varies a great deal depending largely on the education and practice orientation of each setting
4. Initiate laboratory tests, x-rays and examine specimens as they see fit for the formulation of tentative diagnosis of the condition
5. Formulate a care plan to be followed by health care personnel and patients and their families in order to help them protected from further ailment, live optimally with the conditions they have and assist in their restoration to maximum functioning
6. Counsels patients and families in all pertinent areas of concern, provide informations and instruct necessary techniques of self care; and
7. With physician's supervision or medical protocol, she will prescribe and manage most of simple abnormalities and common diseases and take in charge of total maternal and child care in normal prenatal intrapartal and post partal progressions.

Among all different nurse practitioners, private nursing practice seems to have somewhat

84) Guidelines on Short-Term Continuing Education Programs for Pediatric Nurse Associates: A Joint Statement of the A.N.A. Division on Maternal and Child Health Nursing Practice and the American Academy of Pediatrics. American Journal of Nursing Co. March1971.

different fremework for their practice. First of all they address themselves to the health care problems of middle class population and not specified category of disease problems but to an overall health care needs. They do not claim themselves to be primary care practitioners, rather the focus of care is placed on maintenance and preventive and wellness care. Unlike most nurse practitioners, in primary care, they do not follow medical model of practice focusing on pathological view point, but rather assessment and nursing diagnosis are done from the perspective of totalistic view of patient, family, their goals of life, values and life styles all interacting with given environment. Their approaches begin with assessment of condition and establishing the goal of care with patients and families investigating all the whys and whats and deciding on the approaches and roles each should play. Final services offered will be according to professional judgment but with realization that "the patient can be assisted just as far as he wants to go.

Some variations of private practice are seen in one group nursing practice where the practitioners concentrate their effort on consultation services and educational programs to individuals, groups and institutions.

In general they believe they are practicing genuine nursing, neither expanded or extended role-thus there is no dependency or interdependency in their practice, there can only be a collaboration among different health workers.

Nurse Practioners with long term ongoing relation with the patients and families as a characteristic will become a principal health personnel to coordinate all the contributions of other health personnel according to the assessed needs and expressing wants of the patients and families. In so doing, she will share the power of decision making with the patients and their families in planning and implementing their care and problem solving. As an advocate of the patients, her care will be flexible, adaptible and keenly responsive to the changing needs of clients.

Her strong care-orientation of nursing and newly acquired technical diagnostic and treatment skills, she certainly seem to have a great potential for extending the health care to a greater number of people and for the humanizing of health care in whole health care system. It has been estimated that nurses in primary care can handle from 60—70% of all the health care problems independently with medical protocols as a guide.[85] And contrary to the concerns of some leaders in nursing, Linn concludes from her study that nurses educated for extended roles retain nursing values and orientation.[86]

Implied in the concept of expanded nursing role is an element of autonomy and colleagial collaboration in the practice of health care delivery. In practice however, the nature and scope of nursing practice and its implied autonomy and collaboration depends largely on the practice setting and the kinds of people she find herself to work with. It is a very difficult concept to be internalized to the level of operation since any change in a role will inevitably demand concommitant changes in others in a role relationship and if the new roles are not sanctioned and institutionalized by others in role relationship the change process would cease to proceed.

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*from the interview with Dr. Mary Kohnkey at NewYork University, Feburary 10, 1976.

85) Kibrick Editorial, Nursing '73 Time For New Leadership. Nursing Outlook 21 : January 1973.

86) Lawrence S. Linn Care v s. Cure: How the Nurse Practitioner views the Patient, Nursing Outlook 22 : 641—4, Oct. 1974.

The true change takes time, ingenuity, dire commitment, and is a slow, painful process for all involved as evidenced in Thomstad and Cunningham's experience in developing new working relationships.[87]

Glenn and Goldman's study of Task Delegation to physician Extenders and Hocking, Hassanein and Bahr's Willingness of Psychiatric Nurses to Assume the Extended Role all speak to the same point[88][89]

Need for a better collaboration and recognition of their expertise by their physician and administrative counterparts were also expressed by many nurse practitioners during my personal interviews and visits to various health care settings. Malkemes with recognition of this problem, proposes Resocialization Model for Nurse Practitioner Preparation with the concept of concomittant change in the nurse, the setting, and the delivery of health services.[90]

Regardless of some difficulties expressed important role changes have been observed in nurse practitioner-physician practice in Ontario experimental study: Nurse practitioners spent more time in clinical activities; doctors delegated more professional activities to nurse practitioners; a reduction in the proportion of activities carried out exclusively by physicians; and more activities were performed interchangeably in the nurse practitioner-physician group than the con ventional nurse-physician group. Except for renumeration, job satisfaction among experimental physicians and nurses remained high after one year of experience with new method.[91]

There is also a report of a study by McCormack on attitudes of professional nurses toward primary care in which 88.5% of nurses responded primary care role for nurses as desirable and 85% saw as improvement of professional image, and if the credit toward a master's degree was given, 70% responded they would seriously consider enrolling in a program for an additional education.[92] Bullough and Linn also reported role changes and general satisfaction of nurses in nurse practitioner roles as the result of their studies.[93][94]

C. Administrative Structures and Mechanism of Financing

Adminstrative structures under which nusing practices are placed differ according to the sources of financing, target population and the nature of practice.

Independent private nurse practitioners usually practice as a solo practitioner, partnership or a group corporation. Besides their legal binding as professional practice there is no specified organizational patterns. They can practice in offices or have only an answering service. The

87) Beatrice Thomstad, Nicholas Cunningham, Barbara Kaplan, Changing the Rules of the Doctor-Nurse Game, Nursing Outlook 23 : 42267, July. 1975.

88) John K. Glenn, Jay Golman Task Delegation to Physician Extenders-Some Comparisons. American Journal of Public Health, 66 : 64—7, Jan. 1976.

89) Lrma L. Hocking, Ruth Stephenso Hassanein, Sr. Rose, Therese Bahr. Willingness. of Psychiatric nurses to Assume the Extended Role.

90) Lois C. Malkemes Resocialization: A model for Nurse Practitioner Preparation Nursing Outlook, 22 : 90, Feb. 1974.

91) Walter O. Spitzer, Dorothy J. Kergin et al. Nurse Practitioner: Ontario Trial.Health Dimension: Barrier and Facilitators. p. 116.

92) Regina C. McCormack, Ronald L. Grawford, Attitudes of professional Nurses Toward Primary Care, Nusring Research 18 : 542 November-December, 1969.

93) Bonnie Bullough, Is the Nurse Practitioner Role a source of Increased work Satisfaction? Nursing Research 23 : 14, Jan. Feb. 1974.

94) Lawrence S. Linn Expectations V.S. Realization in the Nurse Practitioner Role, Nursing Outlook 23 : 1666—71, March 1975.

services are made available either 24 hours a day and seven days a week, or at designated office hours during week days only. The services can be delivered at patient's homes or at the office clinics, hospitals, or any institutions which requested consultative services. Services are offered on fee-for-service basis.

Visiting Nurse Service of New York, probably the largest employing agency for nurse practitioners in community-based nursing service, is also the America's largest voluntary agency in public health committed to home health services for those who have health problems requiring nursing care and treatment which can safely be given at home. Patients are referred to V.N.S. from hospitals and physicians or by self-referrals. V.N.S. has a close collaboration with each patient's doctors through nurse practitioners responsible for individual patient's care. Policies are determined by a voluntary board of directors comprised of not less than 36, no more than 55 members and a number of board-appointed special committees, including executive, medical advisory, education, personnel, pension, finance, development and support, public relations, nominating and housing committees. Established policies are administered by a paid staff, headed by an executive director who is appointed by the board and is an experienced and qualified public health nurse with demonstrated ability in administration and professional leadership.

Home care services are provided by qualfied nurses, family nurse practitioners, mental health nurse clinicians. In addition to nursing staffs, the agency offers the services of home health aides, physical therapists, speech pathologists social workers and consultants in such specialized areas as nutrition and maternal and child health. A staff physician is also available to give care to selected patients unable to obtain other medical supervision and to provide consultation and guidance to staff nurses.

The agency has been reimbursed for much of this service by Medicare, Medicaid, Private insurance plans, other third party payers or by the patient themselves, and contributions from people in the community to an annual campaign are applied toward the deficit incurred by the agency in providing these unreimbursed services.[95]

V.N.S. also has many joint projects which showed promise of extending reimbursable services to patients ill at home. These include: Human Resources Administration, Home Care Pilot Project; R.N. Supervision for Home Makers, House Keepers; shared coordinated home care services with hospitals and Grant for "Model" of home health services as one of the most important projects ever undertaken by V.N.S.N.Y.-a One year grant by the Regional Medical Program entered into in December1974.[96]

Other voluntary agencies such as Maternity Center Association and Frontier Nursing Service are organized in similar fashion addressing themselves specifically to the health care needs of mothers and children with voluntary board of directors as the policy making body assisted by various advisory committees, including medical board, and executed by board appointed professional staff. Like V.N.A., they are mainly nursing service agencies responding to wide range of health care needs throughout the maternity cycle including prenatal, perinatal, and postnatal care of mothers and babies, conducting normal deliveries and treating minor common illness under the guidance of medical protocols and/or with consultation and supervision

95) V.N.S.N.Y. Fact Pack.

96) V.N.S.N.Y.Brochure, 1974.

of physicians. They also have affiliation with a general hospital for back up medical services.

While Frontier Nursing Service is concentrating on direct nursing services to the community and education of nursing personnel-nurse-midwifery and family nurse practitioner programs, Maternity Center Association concentrates its effort on developing and operating demonstration programs of family-centered maternity care which is safe satisfying and economical, and on whole range of supportive services for the improvement of the quality of maternity services such as supporting research activities, sponsoring conferences and seminars for health profess ionals, offering financial assistance to midwifery students, education and sharing of informations to the public and government leaders, offering counseling services to various groups and institutions, and publish educational materials used by parents and professionals in the U.S. and other countriss.

The services of both agencies are financed through endowments, membership fees and reimbursements by third party payers and individual families. The maternity service at Childbearing Center of Maternity Center Association is rendered at a fixed package cost which is supposed to be much lower than traditional hospital care. Booth Maternity Center also has a similar service aim and organization pattern except its affiliation with a specific religious group and its focus on institutional care.

Government funded community health agencies are usually organized after medical model, aimed at specific target population, experimental in nature, controlled largely by medical profession and, in majority of the cases affiliated with medical schools and their medical centers except H.M.O.'s group practice models and some O.E.O. neighborhood health centers. Their services are mostly comprehensive in nature dealing with the whole range of health and medical problems. In these settings nursing roles tend to focus on physician extender functinos. Nurse practitioner's partipation in medical diagnosis and treatment accentuated, and nurses seem to identify with physicians more closely than in other practice settings. While her scope of practice broadens, her autonomy in decision makings about her own practice can be argued as shrinking because she is carrying out the whole range of delegated functions for which the final decision always lies with physicians. Quite true! Ostergard and his colleagues view that pattern recognition and execution of prescribed activities are not in the realm of professional judgment, thus functions carried out by women's Health Care Specialists, which including nurse practitioners, are neither diagnosis, nor treatment, and they always function under the supervision of physicians.[97] On the other hand, one may also argue from the perspective on enlarged on-the-spot decision makings within specified limits set by protocols and other policies of each practice setting.

Problem of financing will be closely related to government budget and subject to cutbacks and fluctuations in times of tight economic conditions.

Triage, coordinated home care project of Connecticut has been started with a very different kind of orientation and arrangement which is in line with Buell's principle of coordinated community planning for human services[98] in a small scale. Central to Buell's proposition is that

97) Donald R. Ostergard, John E. Cunning, John R. Marshall Trainingand Function of a Women's Health Care Specialist, a Physician's Assistant, or Nurse Practitioner in Obstetrics and Gynecology. American J. of Ob. and Gynn. 121 : 1029—37, April 15, 1975.

98) Bradley Buell et al. Community Planning for Human Services. Greenwood Press Pub. Westport, Connecticut, 1973.

vast network of health, welfare and recreation services can should be more effectively planned and organized to prevent these community-wide problems. From their study they found that a relatively small segment of population were intensely subjected to all human services and there were active interrelationships between the major human problems such as dependency, ill-health, maladjustment, and recreational needs.

The Triage project, under the auspices of Council on Human Services, state of Connecticut, was initiated as a pilot project to coordinate a system of care for elderly residents in their homes. The project is under way now with the directorship of a nurse clinician. On the staff, there are fiscal and assistant fiscal worker, a secretary and a medical transcriptionist beside five field teams of nurse clinicians, social service workers and a community coordinator, and five physician advisors are available.

Major functions of Triage are stated as: 1. Full assessment of needs, 2. Nursing diagnosis, 3. Referral and 4. Follow up of older residents to assist in coordinated delivery of the full spectrum of care. Nothing sounds extra ordinary, however, their approaches toward meeting human needs are impressive.

Their primary objectives include; 1. Provision of single-entry mechanism by which the elderly can have their physical, social, psychological and life-support needs evaluated; 2. develop necessary preventive and supportive services; 3. integrate the efforts of service providers to give coordinated care; 4. Create financial support as needed for the full spectrum of services; 5. demonstrate the value of basic preventive and supportive services and the cost effectiveness of coordinated care. Nurse practitioner's assessment of needs include not only the whole realms of physical health needs; but also environmental needs, socialization and transportation needs, and need for coordination of home-delivered meals.

Services of Home makers, Home health aides, visiting nurses, and transportation etc. beside physical health care have been made available through the Triage coordinated home care services.[99] Though cost-effectiveness may still cause much debates the goal of humanizing care may find a short cut in this approach. V.N.S. has been involved in the "Grant for Model of Home Health Services" and it was understood that their approach is basically the same as illustrated above.

As evidenced in the preceding, it is my contention that nursing has a unique contribution to make in the event that the concept of coordinated human service gets wide acceptance and measures are taken to facilitate the nation-wide plannings toward a better service for mankind.

In place of conclusion, I would like to quote Hochheiser's queries and try to answer from what I have gathered from personal investigation on the subject. "Will the nurse make it possible to care for an increased number of people? Will the care be acceptable? Who will be the consumers? Will the model be acceptable to both nurses and physicians? Will it be economically feasible?... Can the nurse practitioner-physician team provide better quality of care than the traditional provider model? are the basic questions Hochheiser raised for the Nurse Practioner Research Conference held in Farmington, Conn. University of Connecticut Health Center in May 1974.[100]

Although there are still too few factual informations available through more comprehensive

99) Joan L. Quinn. Triage: Coordinated Home Care For the Elderly Nursing Outlook 23 : 570—3, September, 1975.
100) Louis Hochheiser. Nurse Practitioner: A Model For Evaluation? Nursing Outlook 23 : 177, March, 1975.

research to answer all the questions, there are accumulating evidences that give affirmative answers to each questions.

Beginning with the Frontier Nursing Service of Kentucky and Outpost Nurses in Canada to recent nurse-midwifery practice in Mississipi and experimental rural medical care delivery system in Terrance County, New Mexico, to count a few, are good examples of extending health care by nurses to the underserviced populations with marked reduction in mortality rates as the result of nursing intervention.[101][102][103] Nursing as the largest group of health profession has a great potential to extend health care when nursing as a profession decides to move in this direction and as the society in general recognizes nursing/contribution to the health care needs of the nation.

McMullan speaking of accountability states that "Nursing education must be responsive not only to the student's rights as consumer but also to the peoples right to health care that will meet their full range of need," emphasing that Baccalaureate programs that produce generalist professional nurses must today Provide curriculum content necessary to prepare a nurse who can begin to practice as a primary health care provider.[104] Today there are many undergraduate and graduate programs beginning to incorporate nurse practitioner concept in their curriculum and there is also a continuing growth in short term nurse practitioner programs and nurse midwifery programs for registered nurses[105] According to Lubic's figure, there were 26 nurse-midwifery services and educational programs at the end of 1970 in the U.S. and by mid 1974, the total number has grown to 106.[106] Thus there is a strong evidence that nursing will be able to extend primary health care to a greater number of people in the United States.

In regard to the acceptability of care, a study indicated that 85% of the Ghetto populations was willing to have the first medical examination carried out by a nurse or other nonphysician.[107] A high degree of acceptance has been shown in California study of patient compliance which indicated 89% compliance among families seeing pediatric nurse practitioners as compared to 56% compliance among families seeing a physician.[108] There are also evidences of high acceptance in nurse-midwifery practices, geriatric triage programs and private nurse practice by the recipients of care. The consumer of nurse practitioner services are found to cut accross all socio-economic classes and age groups with whole range of health care needs. Private nurse practitioners mostly address themselves to the health care needs of middle class population[109] and nurse-midwifery practice seem to attract people from all walks of life.[110] Depending on practice settings, the patients encountered will vary in their health care needs and socioeconomic background and

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101) Helen Tirpak The Frontier Nursing Service: An Advanture in the Delivery of Health Care, Dissertation University of Pittsburg, 1972.

102) Marie C. Meglen, Helen V. Burst Nurse-Midwives Make a Difference Nursing Outlook, 22 : 38669, June. 1974.

103) Richard A. Reid, Betty J. Eberle, Lois Gonzales, Naomi L. Quenk, Robert Oseasohn, Rural Medical Care: An experimental Delivery System. AJPH 65 : 266—71 Mar.

104) Dorothy McMullan "Accountability and Nursing Education" Nursing Outlook, 23 : 501—3, August, 1975.

105) Katherine B.Nuckolls, Who Decides What the Nurse Can do? Nursing Outlook 22 : 626—31, Oct. 1974.

106) Ruth Watson Lubic Nurse-Midwifery in Contest, Maternity Center Association p. 2.

107) Introduction: Organization For Health Care, Medicine in the Ghetto, p. 268.

108) Lewis Bailit, Bush Hochheiser, Assessing the Quality of Care, Nursing Outlook, 23 : 153, March, 1975.

109) Jocelyn Greenidge, Ann Zimmern, Mary Kohnke and Rita Rafferty, Jean Carner, Independent Group Nursing Practice, Nursing Outlook, 21 : 228—35, April, 1973.

110) Sharon Schindler Rising, A Consumer-Oriented Nurse-Midwifery Service, Nursing Clinics of North America, 10 : 251—61, June. 1975.

geographic areas. As "one door-one class" ideal of national health insurance plan matures, it can be assumed that there will be more conglomeration of population, in all health care delivery system.

Though there have been some studies dealing with the satisfaction of physicians and nurses in the new models of practice and they mostly indicate fair amount of satisfaction for both groups, there is yet no conclusive evidence that the professionals as a whole accept the new models of practice with changing roles and relationships. The best evidence we now have of acceptance is the rapid growth rate of various nurse practitioner programs and utilization of their services in various health care delivery systems. Nursing and Medicine as professional groups still have a long way to go before they could really decide among themselves whether this is the way for each to go. It is only after repeated documentation of the effectiveness of any new model that we can expect any degree of willing acceptance, and as long as there is a lack of acceptance by professionals involved the change will not last very long even if the consumer satisfaction is high.

The economic feasibility of the nurse practitioner concept can only be determined after the whole implication of introducing a new type of health care become clear. A small bit of informations seem to suggest that cost reduction is a possibility. Lewis and Resnick reported that there reduction in hospitalization among patients who have been under the care of a nurse practitioner as compard to physician's patients and there are also evidences of a remarkable reduction in unit price of maternity care and community-based ambulatory health care, however, these costs are only a small part of the total cost involved in developing a new project. Furthermore, it is difficult to know what factors have been actually involved in cost reduction. In the absence of objective data derived from systematic research as to the quality and cost-effectiveness of any unit service, it seems impossible to discuss economic feasibility with any amount of certainty. For the moment private nursing practice has been faced with an unfavorable economic condition largely because of the third party reimbursement policy, and it is interesting to note that most of private nurse practitioners retain their original jobs, though some expresses their needs to demonstrate is greater than economic gains, it may be argued from both directions.

The question of better quality of care will be difficult to answer in the absence of any reasonable definition of quality and appropriate measurement to assure that quality. Outcome assessment that looks beyond the boundary of persons delivering the care to the nature and quality of care that is delivered has been suggested as the focus of research yet the quality as expressed in patient's well being would be most difficult to be assessed taking into consideration that a high subjectivity, variability, and the latent quality of well being as the characteristic of human life. However, nurses strong commitment to the concept of patients advocate expressed in a lot of the available literatures and reports of practitioners themselves, and in the claims of "individually tailored" nursing care approaches together with seemingly high consumer satisfaction seem to indicate a better quality of care can be achieved through the new model of collaborative health care practice.

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〈27페이지에서〉

료 될 수 없는 백혈병 또는 전이 된 암 치료에 사용되는 데 암치료를 위하여 점차로 중요하게 생각되어 지고 있다.

화학요법은 단독 또는 수술이나 방사선요법과 함께 사용되는 데 이들 약들의 작용기전은 불분명하며 신생세포뿐만 아니라 정상세포에도 독성이 높고 해로운 것이 유감이다. 빨리 증식하는 세포들은 이 약들에 매우 민감하며, 구강이나 위장관 점막에 자극을 받아 궤양이 생기거나 조혈기능이 억제되는 것을 볼 수 있다. 이러한 약들은 alkylating제, 대사길항제와 호르몬제들로 alkylating제는 세포의 핵내에 작용하여 D.N.A 입자를 변화시켜 세포성장과 재생에 저해를 초래하며, 대사길항제는 정상세포의 반응을 방해하여 세포의 구조와 기능에 필수적인 특정화학물의 형성을 막는다. 호르몬제는 암세포의 화학적 환경을 변화시켜 신생세포의 성장을 돕는 호르몬의 역행작용을 한다.

그러나 이외에도 면역학적 치료방법이 계속연구 단계에 있다.

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