

## **Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety**

---

### **Executive Summary**

The Federation of State Medical Boards (the Federation) is a national non-profit association whose membership includes all medical licensing and disciplinary boards in the United States, and the U.S. territories. The Federation acts as a collective voice for 70 member medical boards in promoting high standards for medical licensure and practice.

At the Federation's April 2003 Annual Meeting the House of Delegates approved a resolution that the Federation establish a special committee to enumerate issues to be considered by State medical boards and legislative bodies when addressing scope of practice initiatives relating to persons without a license to practice medicine. In response, the Federation established the Special Committee on Scope of Practice in July 2003. The Committee was charged with developing an informational guide outlining patient safety and quality of care issues that should be considered by health care regulatory boards and legislative bodies when making decisions about changes in scope of practice, and when dealing with proposals to bypass established regulatory standards in order to extend health care services to underserved areas.

### **Overview**

Scope of practice changes are among the most highly charged policy issues facing state legislators and health care regulators. Debates on scope of practice can be contentious and are influenced by a variety of factors, including: fluctuations in the health care workforce and specific health care specialties; geographic and economic disparities in access to health care services; economic incentives for physicians (M.D., D.O.) and other health care practitioners; and consumer demand. Requests to create, change, or expand scope of practice should be supported by a verifiable need for the proposed change. Patient safety and public protection must be the primary objectives when evaluating these requests.

The Institute of Medicine (IOM) reports from 2001<sup>1</sup> and 2003<sup>2</sup> recognize the complexity of scope of practice issues across disciplines and urge state regulators to allow for innovation in the use of all types of clinicians in meeting patient needs in the most effective and efficient way possible. Further, the IOM encouraged use of interdisciplinary teams to optimize patient care. The Pew Health Commission Taskforce on Health Care Workforce Regulation<sup>3</sup> called for States to explore pathways to allow all professionals to provide services to the full extent of their current knowledge, training, experience and skills.

The American Medical Association adopted a report on physician and non-physician licensure and scope of practice.<sup>4</sup> Likewise, the American Osteopathic Association adopted a policy statement on expanding scopes of practice for non-physician clinicians.<sup>5</sup> Both organizations emphasize the importance of physician oversight and actively track scope of practice initiatives, as do other health professional organizations.

Several states and Canadian regulatory authorities have enacted or examined criteria to assess the need for scope of practice changes. State legislative and policy initiatives have generally sought to formalize objective measures for use in evaluating scope of practice requests.

All discussions about changes in scope of practice should begin with a basic understanding of the definition of the practice of medicine and recognition that the education received by physicians differs in scope and duration from other health care professionals. Non-physician practitioners may seek authorization to provide services that are included in the definition of the practice of medicine under existing state law. In evaluating these requests, policy makers should examine a variety of issues, including: economic impact on health care delivery; standards for education, training and examination; practice parameters; and regulatory mechanisms. Patient safety and accountability should be the most important factors in establishing expectations and limitations associated with scope of practice changes.

## **FSMB Recommendations**

The Federation has formulated a set of Guidelines to be used by State regulatory boards and legislatures when considering requests for creation or expansion of scopes of practice. The Guidelines are designed to assist policy makers in assuring that all practitioners are prepared, by virtue of education and training, to provide services authorized in their scopes of practice in a safe, effective and cost efficient manner.

The Guidelines recommend that State regulators and legislators review the following factors when considering scope of practice initiatives in the interest of public health and patient safety:

- existence of a verifiable need for the proposed scope of practice change;
- existing scopes of practice and the effect of requested changes on public health and safety;
- formal education and training purported to support scope of practice changes and the existence of a formal process for accreditation;
- existing or proposed regulatory mechanisms such as licensure, certification and registration;
- the advisability of allowing independent practice or requiring collaboration or supervision;
- the advisability of interaction and cooperation between affected regulatory boards in evaluating issues that involve multiple practitioners, in investigating complaints, and in recommending appropriate discipline;
- requirements for full and accurate disclosure by all health care practitioners as to their qualifications to provide health care services;
- accountability and liability issues relating to scope of practice changes;
- details, rationale, and ethics of any proposals to bypass licensing or regulatory requirements in allowing scope of practice changes, the implications for other practitioners, and the effect on patient safety; and
- financial impact and incentives related to and affecting the scope of practice changes.

## **Conclusion**

State legislatures and State regulatory boards are urged to develop tools to evaluate requests for scope of practice changes fairly and consistently so that decisions are made in the best interest of the public. Policy makers should use the guidelines outlined in this Report and should call upon the expertise of experienced and knowledgeable practitioners, health regulators, and policy makers as appropriate when evaluating requests and formulating recommendations for approval and implementation, or denial, of scope of practice changes.

# **Assessing Scope of Practice in Health Care Delivery:**

## **Critical Questions in Assuring Public Access and Safety**

---

### **Section I. Background and Key Factors**

#### **Introduction**

Scope of practice defines those health care services a physician or other health care practitioner is authorized to perform by virtue of professional license, registration, or certification. Health care professionals' scopes of practice sometimes overlap reflecting shared competencies.

For the purposes of this document, physicians include M.D.s and D.O.s. Health care practitioners include, but may not be limited to, acupuncturists, anesthesiologist assistants, certified clinical nurse specialists, certified nurse midwives, certified registered nurse anesthetists, chiropractors, homeopaths, naturopaths, nurse practitioners, occupational therapists, optometrists, pharmacists, physical therapists, physician assistants, podiatrists, psychologists, and other non-physician practitioners that have unique and important roles in providing healthcare. Some practitioners are authorized to practice independently within their scope of practice and others are required to work under the supervision of or in collaboration with a licensed physician or other health care practitioner.

Decisions regarding scope of practice may be influenced by a variety of factors, including workforce needs, financial and economic motivations, and consumer demand. The rationale for all decisions regarding scope of practice expansion and/or creation must support the ultimate goal of protecting public health and patient safety.

#### **Definition of the Practice of Medicine**

State Medical Practice Acts define what constitutes the practice of medicine in that State. Generally, the definition of the practice of medicine is consistent among the States though particular details do vary from State to State. Additionally, other healthcare regulatory Boards may have similar language

in their own definitions of practice. The Federation of State Medical Boards defines the practice of medicine in the *Essentials of a Modern Medical Practice Act* as:

- advertising, holding out to the public or representing in any manner that one is authorized to practice medicine in the jurisdiction;
- offering or undertaking to prescribe, order, give or administer any drug or medicine for the use of any other person;
- offering or undertaking to prevent or to diagnose, correct and/or treat in any manner or by any means, methods, or devices any disease, illness, pain, wound, fracture, infirmity, defect or abnormal physical or mental condition of any person, including the management of pregnancy and parturition;
- offering or undertaking to perform any surgical operation upon any person;
- rendering a written or otherwise documented medical opinion concerning the diagnosis or treatment of a patient or the actual rendering of treatment to a patient within a State by a physician located outside the State as a result of transmission of individual patient data by electronic or other means from within a State to such physician or his or her agent;
- rendering a determination of medical necessity or a decision affecting the diagnosis and/or treatment of a patient; and
- using the designation Doctor, Doctor of Medicine, Doctor of Osteopathy, Physician, Surgeon, Physician and Surgeon, Dr., M.D., D.O. or any combination thereof in the conduct of any occupation or profession pertaining to the prevention, diagnosis or treatment of human disease or condition unless such a designation additionally contains the description of another branch of the healing arts for which one holds a valid license in the jurisdiction.

## **Practice Arrangements**

Health care practitioners may be authorized to practice independently, be required to collaborate, be required to be supervised, or practice under a combination of these provisions. High quality patient care depends on the contributions of and interactions among a wide variety of health care practitioners. There is no universally recognized description of these practice arrangements, however, a general description of each follows.

## **Independent Practice**

Health care practitioners may be authorized by State law and/or regulation to practice independently or without supervision. By virtue of education, training and experience, independent practitioners are deemed to be capable of delivering patient care safely and effectively within their prescribed scopes of practice.

Health care practitioner groups may approach State legislatures seeking independent practice. Such practitioners typically base their arguments for independent practice on factors such as consumer demand for their services, an undersupply of specific health care practitioners or services, unmet needs in rural settings, changes in reimbursement policies, and other related justifications. Regardless of compelling arguments presented to support a change in scope of practice, patient safety and public protection must always be the primary considerations for policy makers and regulators.

## **Collaboration**

Health care delivery occurs in a complex environment in which practitioners do not work in isolation. The American Nurses Association has endorsed a definition that “Collaboration is the process whereby physicians and nurses plan and practice together as colleagues, working interdependently within the boundaries of their scopes of practice with shared values and mutual acknowledgement and respect for each other’s contribution to care for individuals, their families, and their communities.”<sup>2</sup> Collaboration is also common between physicians and other health care practitioners and can be an effective means for providing safe and competent health care. The concept of collaboration acknowledges that scopes of practice often overlap within the health care delivery system.

The nature of collaboration varies greatly by State. In some States, collaboration is not defined, but is implicit to the relationship articulated in relevant practice acts. Other States define it similarly to supervision and others require formal practice agreements with defined relationships that may include specific penalties for failure to collaborate. States may also make distinctions in the level of collaboration required based on geographical area or practice settings. Statutory requirements for collaboration do not follow any general format, and range in flexibility and application under State law.

## **Supervision**

Physicians and other health care practitioners may be authorized by State law and regulation to supervise the practice of other practitioners. The supervising physician or health care practitioner is required to provide professional oversight and direction sufficient to assure the safety of the patient and the delivery of appropriate care. Supervised services must be provided in the context of an established practitioner/patient relationship and based on guidelines that may be defined in standing orders, protocols, utilization plans, or algorithms. State definitions and requirements for supervision vary significantly among practitioners and among the States. Supervisory arrangements may provide for: written guidelines for supervision including who and what services are to be supervised; the proximity of the supervisor to performance of supervised services; periodic review of practitioners and patient charts and records; a predetermined plan for handling emergency situations; and the designation of an alternate supervisor in the absence of the primary supervisor.

Supervision can be either direct or indirect depending on the type of medical services involved. Generally, direct supervision requires the supervisor to be physically on the premises and readily available. Indirect supervision typically requires the supervisor to be physically on the premises or readily available by electronic communication and/or able to be on the premises in a specified period of time and from a limited distance.

Supervising practitioners must assure that those practicing under their supervision are qualified based on education, training and experience to perform services and are practicing within their defined scope of practice. Performance of supervised services should be held to the same standard of care applied to the supervising practitioner. Policy makers may want to address limiting the number of practitioners that may be supervised and whether supervised practitioners can supervise third party providers.

## **Accountability**

Regardless of the practice arrangement, a comprehensive system of accountability is necessary for patient protection. Collaborative and supervised practices necessitate collaboration in accountability and regulation. Such collaboration requires physicians and other health care practitioners to embrace a higher level of cooperation than has typically been the case in most States in regard to establishing scopes of practice, developing rules and regulations, investigating complaints and sharing complaint information. Further, States should implement a process for joint development of rules by all the boards whose practitioners are involved that encourages discussion of expectations, limitations and enforcement relating to proposed regulations. States should also consider authorizing or mandating

that health regulatory boards share complaint information and establishing reporting requirements among such boards. Practice arrangements involving multiple practitioners must be supported by improvements in traditional lines of communication and cooperation among professionals and their regulatory boards.

## **Section II. Scope of Practice Guidelines**

The authority for oversight of health care services lies within the purview of State law and regulation. The guidelines in this document are intended to identify and to clarify issues that should be thoughtfully considered by both State regulatory boards and legislatures when considering requests for scope of practice changes. Changing or creating a new scope of practice for a health profession necessitates establishment of a legitimate need for the change, along with a systematic review of the impact of the proposed change on public health, safety, and welfare. Patient safety and public protection must be the primary objectives in making decisions on scope of practice.

It is important for boards and legislatures to recognize that there are often significant differences in the prerequisites, the scope, and the duration of education provided to other health care practitioners when compared with that provided to physicians. Policy makers must ensure that all practitioners are prepared, by virtue of education and training, to provide the services authorized in their scope of practice in a safe, effective, and economical manner.

### **Defining Scope of Practice**

“Scope of practice” is defined as the activities that an individual health care practitioner is permitted to perform within a specific profession. Those activities should be based on appropriate education, training, and experience. Scope of practice is established by the practice act of the specific practitioner’s board, and the rules adopted pursuant to that act.

### **Reviewing Existing Scope of Practice**

Requests to expand or otherwise change the scope of practice for health care practitioners should begin with a careful, objective review of the existing scope of practice and an assessment of what

additional services the change in scope of practice will authorize. Policy makers should also review the scope of practice recommended by the practitioners' national professional organization.

### **Relevant Questions and Action:**

- Establish that there is a need for scope of practice expansion and whether there are alternatives available within the existing health care system.
- Identify underlying factors prompting scope of practice expansion.
- Is there empirical or published evidence to support the safety and effectiveness of the scope of practice expansion? Has there been an evidence-based risk-benefit analysis of the proposed change?
- Review the current State practice act, rules, and policies relating to scope of practice.
- Review scope of practice recommended by the practitioner's national professional or other national health care professional organizations.
- Review any case law relating to practitioner's scope of practice.
- Determine the number and variety of practitioners affected by the expansion and assess the impact on public health.
- Review outcomes, if available, of similar scope of practice initiatives in other states.

### **Independent Practice**

Health care practitioners authorized to practice independently are considered to have sufficient education and training to provide independent patient care safely. In the context of their practice, such practitioners must be prepared to evaluate individual patient cases objectively and refer those that require knowledge beyond their education and training to a physician or other health care expert in the relevant field. Serious patient harm can result when patients delay seeking medical care or when practitioners delay referring patients with complicated illnesses that require more advanced training, expertise, and experience.

### **Relevant Questions and Action:**

- Is independent practice appropriate considering the practitioner's education, training and experience?
- To what extent should collaboration with other practitioners be specified in regulations?
- To what extent should the requirement and timing of referral be specified in regulations?

## **Collaborative Practice**

The parameters for collaborative practice among practitioners should allow s all practitioners to practice within the boundaries of their respective scopes of practice and those parameters should be documented in a written protocol.

### **Relevant Questions and Action:**

- To what extent should the requirements for collaborative practice be clearly and explicitly defined?
- Should the requirement for collaborative practice be written into the rules governing the activities of the practitioner groups involved?
- Should there be specific written consequences for failure to collaborate?

## **Supervised Practice**

Health care practitioners may be authorized to provide specific health care services under the supervision of a physician or other health care practitioner. To assure patient safety, supervision may be required as a condition of the practitioner's authorization to provide specified services. The appropriate level of supervision, if requested, depends on the type of services being provided, the nature of the practice setting, and the type of provider being supervised. The ratio of practitioners to supervisors should be determined based on the nature of the services being provided, the nature of the practice setting, the tenets of good patient care, requirements for adequate supervision, and legal responsibility. State laws, regulations, and terminology relating to supervision vary greatly. Policy makers should review state requirements relating to supervision.

### **Relevant Questions and Action:**

- Is supervision needed, and should It be required?
- Who should provide supervision? What would be the nature and extent of the supervision?
- What qualifications and competencies should the supervisor be expected to have?
- Should the terms of the supervisory agreement be documented in writing?
- How would the supervision requirement be enforced?

- What is the appropriate level of supervision? Direct or indirect?
- Should the supervisor be required to be in the room? On site? Immediately available?  
Available by electronic means? Available within a specific time period or distance?

Supervisors may be accountable for the actions of practitioners under their supervision. In addition, practitioners who are supervised may be legally accountable and liable for their own actions regardless of whether the supervisor is also accountable. All health care practitioners must be held to established standards of practice and accountability.

### **Referral to a Physician**

Health care practitioners must be willing and able to identify symptoms, conditions, diseases and complications that are beyond their training and expertise and be required to refer those patients to a licensed M.D. or D.O., or other certified expert in the relevant field, especially when treating patients with complex diseases.

### **Relevant Questions and Action:**

- Failure to refer a patient appropriately must be subject to regulatory action. How is that requirement to be specified and enforced?
- In a collaborative practice arrangement, how is a difference in opinion, diagnosis, or treatment to be resolved? Whose opinion or decision prevails?

### **Minimum Education, Training, and Examination**

Consumers must be able to trust that all practitioners authorized to provide health care services are qualified, capable, and competent. Appropriate regulatory assessment of practitioners' qualifications is an important safeguard that enhances public safety and engenders this trust.

Policy makers must assure that scope of practice changes are justified by appropriate and relevant education, training, examination, and experience. Decision makers should examine the formal education and training received by practitioners and inquire about the existence of accreditation processes and requirements for accreditation. A review and validation of a health care professions' education and training requirements should be sought from an objective, independent body or an established and recognized accrediting organization.

## **Relevant Questions and Action:**

- What competencies (clinical knowledge, judgment, and skills) are required for practitioners to provide services safely and competently?
- Evaluate whether the existing education and training assure needed competencies? Is the education from an approved and formally accredited institution having standards accepted by an independent and recognized educational organization or institution?
- What are the prerequisites and the core education needed in terms of undergraduate and post-graduate education and clinical experience?
- Is the expanded scope of practice appropriate for the practitioner's education, training and examination requirements? How does that education and training compare to that of other practitioners providing the same services?
- What provisions exist to ensure that practitioners maintain competency in the provision of services? Should continuing education relevant to expanded scope of practice be required? Should subsequent periodic review or examinations be required?

## **Licensure, Certification, Registration**

Licensure, certification, and registration are proven and effective means to regulate health care professions through: designation of minimum standards for entry into practice; requirements for renewal; demonstration of continuing competency; prescribed procedures for enforcement of established practice standards; and discipline of problem practitioners.

Practitioners who are not formally regulated and who function outside State regulatory mechanisms must be subject to the same rigorous practice standards or other regulatory scrutiny as regulated practitioners. Policy makers should evaluate the potential for patient harm from unregulated practitioners.

## **Relevant Questions and Action:**

- If practice is unregulated, should consideration be given to licensure, certification, registration, or other regulation?
- What is the potential harm from unregulated practice?

- Are there published standards of practice, such as national guidelines or practice acts and rules?
- Are license, certification, or registration standards appropriate to ensure that practitioners are qualified to provide services safely?
- Are there resources available to assist the public in evaluating the qualifications of licensed or unlicensed practitioners?

## **Regulation**

The complexity of relationships among health care practitioners coupled with increasing need for collaboration raise questions about the traditional structure of health care regulation. The 2001 Institute of Medicine (IOM) report *Crossing the Quality Chasm; A New Health System for the 21 st Century*,<sup>3</sup> asserts that “scope of practice acts and other workforce regulations need to allow for innovation in the use of all types of clinicians to meet patient needs in the most effective and efficient way possible.”

The 2003 IOM report *Health Professions Education: A Bridge to Quality*,<sup>4</sup> acknowledges that “efforts to change scope of practice acts are often the focus of turf battles among professions fought out in State legislatures; the result is distrust and hostility among professions that are supposed to be collaborating to provide coordinated care.” The Pew Commission Taskforce on Health Care Workforce Regulation’s 1998 report, *Recreating Health Professional Practice for a New Century*,<sup>5</sup> made several recommendations regarding scope of practice. In particular, it recommended the creation of a national advisory body to develop standards for uniform scopes of practice and continuing competency standards for health care professions. In response these reports, the Federation has developed this document and recommends these guidelines.

Some States have addressed interaction among practitioners by creating ad hoc or joint committees that oversee issues that affect multiple practitioners and span the authority of more than one regulatory board. States should consider developing a system for joint review of scope of practice initiatives by state health regulatory authorities. While cooperation in regulation may be viewed by

some practitioner groups as inconsistent with the philosophy of independence and self-regulation, patient safety is best served by enhanced communication and cooperation.

### **Relevant Questions and Action:**

- How can interaction and cooperation between regulatory boards best be encouraged and achieved in evaluating requests for scope of practice changes?
- Is there a mechanism that will assure a fair, expert, and objective appraisal of the need for and impact of any request for change in scope of practice?

If questions arise about regulatory authorities, jurisdictions, or unlicensed practice, state regulatory boards should consult with the State Attorney General's office.

### **Complaints and Disciplinary Action**

Complaint investigations and disciplinary processes are the responsibility of individual regulatory boards. Provisions for communication among boards on cases involving multiple practitioners vary greatly among the States. States should reduce barriers to cooperation and communication among health regulatory boards. Consideration should be given to implementing a system for joint review of complaints involving multiple practitioners and authorizing sharing of complaint information among regulatory boards. Such cooperation would make the regulatory system more efficient and effective.

### **Relevant Questions and Action:**

- What information can now be shared among regulatory boards?
- What information should be shared between relevant regulatory boards?
- Should sharing of complaint and/or disciplinary information and action be mandatory?
- What are the barriers to information sharing?
- What are the consequences for failing to share important information?

### **Disclosure and Public Awareness**

Policy makers should not assume that health care consumers are able to access or to assess the credentials and competencies of the various practitioners offering health care services. Consumers generally assume that the practitioner performing a service is properly trained, competent and

practicing appropriately. Consumers trust that services being offered are safe, and that the practitioners are qualified to provide them.

Whether the practitioner performing a service is a physician or other health care practitioner, consumers should be informed about the education and credentials of the practitioner and the name of the supervising practitioner, if there is one. Full and accurate disclosure in the provision of health care services aids consumers in making more responsible health care decisions and may encourage questions about delivery of and accountability for the services received. Consumers should also be informed as to whether or not the practitioner is under the jurisdiction of a regulatory board.

### **Relevant Questions and Action:**

- In what practice environment will consumers receive proposed services? A licensed health care facility? A private office?
- Will practitioners be subject to credentials review within their practice environment?
- Does the public have a means to evaluate the qualifications of the practitioners performing proposed services?
- What disclosures should practitioners be required to make to consumers?
- Do consumers have access to disciplinary information through a regulatory board?
- Are there appropriate safeguards in place to protect consumers from false and misleading advertising?

### **Liability**

Liability statutes and case law vary significantly from state to state. Policy makers should review state liability laws and evaluate how they apply in cases where multiple practitioners are involved in patient care. Statutes should clearly specify how liability will be determined when patient harm occurs or when questions about quality of care arise. For example, supervising practitioners may be liable for the acts of those under their supervision if they fail to provide adequate and reasonable supervision. Also, supervised practitioners may also be held independently liable. In addition, independent practitioners should be individually liable for their own diagnosis and treatment recommendations and for failure to refer patients when appropriate.

### **Relevant Questions and Action**

- Do current liability statutes adequately protect the public? Is that liability clearly defined?
- How do scope of practice changes impact the potential liability of practitioners?
- Should practitioners be required to have malpractice insurance to demonstrate financial responsibility, or both?
- Is liability insurance available and affordable?

### **Economic Impact**

Policy makers should consider how scope of practice changes will affect the supply of physicians and other health care practitioners and the cost of goods and services provided by those practitioners. The potential economic and social benefits of scope of practice changes must be weighed against any potential harm to health care consumers.

### **Relevant Questions and Action:**

- Has there been an evidence based risk-benefit analysis of the proposed scope of practice change?
- To what extent will the proposed change affect the availability, accessibility, cost, delivery, and quality of health care?

### **Section III. Protecting Underserved Patients**

Health care practitioners frequently emphasize improving access to health care services for underserved patient populations when requesting scope of practice changes. Other policy initiatives have proposed to create exceptions to state licensing standards with the intent of encouraging practitioners, some who do not meet established standards, to locate in underserved areas. As scope of practice has been address in previous sections, this section addresses proposals to bypass licensing and certification standards.

State licensing and certification standards set minimum qualifications for practitioners to practice and are an important mechanism for public protection. Generally, license applicants must complete specified education requirements, satisfy postgraduate training requirements, and successfully complete designated examinations.

Several States have considered creating exceptions to licensure standards as a solution to practitioner shortage problems in rural areas, densely populated urban centers, and areas having large vulnerable patient populations. Exceptions to established standards create a double standard that compromises patient safety and is inconsistent with current national efforts to reduce the incidence of medical errors and address the availability and affordability of malpractice insurance. Further, such a double standard is ethically unacceptable.

While access to medical care is a critical public health issue, the primary consideration must always be protection of patients who rely on State regulation to protect them from unqualified practitioners. Authorizing licensure for practitioners who do not meet established minimum standards or enabling practitioners to practice beyond what is appropriate for their education, training and experience, can compromise public safety for the State's most vulnerable patient populations.

States should explore other policy alternatives to encourage physicians and other qualified practitioners to practice in underserved areas, such as: reimbursement enhancements; scholarships; loan repayment programs; supplemental reimbursements for bi-lingual practitioners; rural health networks; special taxing districts; individual, business, or corporate support; and other incentives. Technical innovations such as telehealth networks may also be appropriate alternatives for addressing underserved populations.

In the final analysis, it is the State's responsibility to establish and to enforce standards for health care delivery by physicians and other health care professionals in order to protect the public from unqualified practitioners.

### **Relevant Questions and Action:**

- Are there alternatives to encourage practitioners to serve underserved populations? Scholarships? Volunteerism? Special taxing districts? Loan repayment programs? Telehealth services? Awards and recognitions? Individual, business, or corporate support?
- Do proposed alternative plans create an unethical or potentially harmful double standard?

### **Section IV. Conclusions**

Scope of practice expansion is a controversial topic for State policy makers. State health care regulatory boards should participate actively in the review and analysis of requests for scope of

practice changes. Without board participation, legislatures lose the benefit of the regulatory board's expertise in important debates about health care delivery and regulation.

States and State boards must develop tools to evaluate requests for scope of practice changes fairly and effectively so that appropriate decisions are made on behalf of health care consumers in the State. In doing so, policy makers should use the guidance outlined in this Report and also call upon experienced and knowledgeable practitioners, board members, and policy makers for expert help in evaluating requests and formulating recommendations for appropriate implementation or denial of proposed scope of practice changes.

While many arguments can be made to support scope of practice changes, the primary considerations should be patient safety, public protection, and competent and effective health care delivery.

Additionally, policy makers are challenged to develop outcome measures that afford a means to evaluate whether scope of practice changes truly accomplish their intended results.

---

## **Glossary of Terms**

**Physician** A doctor of allopathic or osteopathic medicine.

**Health Care Practitioner:** Includes, but may not be limited to, acupuncturists, anesthesiologist assistants, certified clinical nurse specialists, certified nurse midwives, certified registered nurse anesthetists, chiropractors, homeopaths, naturopaths, nurse practitioners, occupational therapists, optometrists, pharmacists, physical therapists, physician assistants, podiatrists, psychologists, and other non-physician practitioners that have unique and important roles in providing healthcare.

**License:** A formal, legal permission to do that which is specified in the license document.

**Registration:** A list of individuals representing a specific type or scope of activity.

**Supervision:** To oversee or direct professionally a body of work, directly or indirectly, within specified rules and regulations.

**Collaboration:** The process whereby physicians and other health care practitioners plan and practice together as colleagues, working interdependently within the boundaries of their scopes of practice.

**Accreditation:** Certification by an independent professional organization of having met certain specified standards.

**Certification:** Declaration that something is true, is accurate, and meets specified standards.

**Accountability:** Being answerable to others for one's actions.

**Responsibility:** Being answerable to oneself for one's actions.

**Liability:** The state of being legally accountable.

**Scope of practice:** Definition of the rules, the regulations, and the boundaries within which a fully qualified practitioner, with substantial and appropriate training, knowledge, and experience may practice in a field of medicine or surgery, or other specifically defined field. Such practice is also governed by requirements for continuing education and professional accountability.

---

## Special Committee on Scope of Practice

### Members

James A. Bolton, PhD, Chairman President Medical Board of California, Division of Licensing	Kathy Apple, MS, RN Executive Director National Council of State Boards of Nursing
Nancy Achin Audesse Executive Director Massachusetts Board of Registration in Medicine	Harry C. Beaver, MD President Virginia Board of Medicine
Carole A. Frier, DO Member Iowa Board of Medical Examiners	Charles L. Garrett, MD President North Carolina Medical Board
William V. Harrer, MD President New Jersey State Board of Medical Examiners	Joseph E. Johnston, MD Member Mississippi State Board of Medical Licensure

C. Grant La Farge, MD Secretary New Mexico Medical Board	John C. Leatherman, MD Member Oklahoma State Board of Medical Licensure and Supervision
Carl M. Myers, MD President Missouri State Board of Registration for the Healing Arts	Tully C. Patrowicz, MD Member Florida Board of Medicine
Larry Price, DO Vice President Texas State Board of Medical Examiners	Kent Nebel, JD Director of Legal Affairs Iowa Board of Medical Examiners
Ex-Officio Thomas D. Kirksey, MD – FSMB Past Chair Doris C. Brooker, MD – FSMB Chair	Staff: Lisa Robin Vice-President, Leadership and Legislative Services Jeanne Hoferer Manager, Legislative Services

## References

[1](#) *Crossing the Quality Chasm: A New Health System for the 21 st Century*, The Institute of Medicine, National Academy Press, 2001.

[2](#) *Health Professions Education: A Bridge to Quality*, The Institute of Medicine, Committee on Health Professions Education Summit, National Academies Press, 2003.

[3](#) *Reforming Health Care Workforce Regulation: Policy Considerations for the 21 st Century*, Report of the Pew Health Professions Commission’s Taskforce on Health Care Workforce Regulation, December 1995, ix.

[4](#) Report 1-I-00, *Physician and Nonphysician Licensure and Scope of Practice*, adopted by the AMA House of Delegates in 2000.

[5](#) *Non-physician Clinicians*, American Osteopathic Association, Policy Statement, July 2000.

*Essentials of a Modern Medical Practice Act*, The Federation of State Medical Boards of the U.S., Inc., Revised 2003.

[2](#)*Nursing Trends and Issues*, American Nurses Association, Vol. 3, No. 5, May 1998.

[3](#)*Crossing the Quality Chasm: A New Health System for the 21 st Century*, The Institute of Medicine, National Academy Press, 2001, Chapter 9.

[4](#)*Health Professions Education: A Bridge to Quality*, The Institute of Medicine, Committee on Health Professions Education Summit, National Academies Press, 2003, Chapter 5.

[5](#)*Recreating Health Professional Practice for a New Century*, Fourth Report of the Pew Health Professions Commission, December 1998, xvii

©Copyright 2005 by the Federation of State Medical Boards of the United States, Inc.