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Why clinician scope of practice matters for reproductive health

Under an evidence-based model, the outer bounds of a clinician's scope of practice—the activities that a health care practitioner is permitted to perform—would be based upon whether “the profession can provide [the] proposed service in a safe and effective manner.”¹ However, when the politicized spheres of reproductive health care and scope of practice meet, decisions are often based on a combination of ideology and protection of professional “turf” rather than professional capacity and freedom of personal conscience.

Of the approximately 200,000 licensed certified nurse midwives (CNMs), nurse practitioners (NPs) and physician assistants (PAs)² currently practicing in the United States, the majority of these clinicians provide primary care to women of reproductive age who are at risk for unintended pregnancy.³ These clinicians care for patients in diverse settings, with high numbers serving poor and underserved populations.⁴ Therefore, ensuring that scope of practice restrictions do not unnecessarily prevent these well-qualified, appropriately trained clinicians from providing the full spectrum of reproductive health services is essential to sustain and promote access to early pregnancy care.

What is scope of practice?

Scope of practice has been described as “defined spheres of activity within which various types of health care providers are authorized to practice”⁵ or “those health care services a... health care practitioner is authorized to perform by virtue of professional license, registration, or certification.”⁶ Scope of practice underpins the entire framework of our health provider licensing system and basically addresses the questions of: who can do what

for whom in what clinical setting and under what circumstances?

Many factors and processes interact to shape the legally recognized scope of practice of APCs. There is significant variation among the states (and sometimes even within the same state) in the legal authority for health care providers' professional services.

In most states, for each group of licensed health care providers, the basis of regulation resides in what is typically called a practice act. This statute, enacted by the state legislature, determines that, to protect the public, only those who meet specified requirements, usually including successful completion of educational programs and a professional examination resulting in licensure, can perform certain services or functions. The practice act sets out the rights and responsibilities of licensees and, in varying degrees of specificity, states what those license holders are authorized to do in their professional roles.

The practice act also establishes an administrative agency (such as the Board of Nursing or PA Practice Committee of the Board of Medicine) comprised principally of practitioners and educators from the regulated profession, as well as public members, and gives it a variety of powers: to determine who meets the qualifications for licensure; to gather, analyze, and disseminate information on the licensed profession's practice; to ensure licensees' compliance with requirements and standards; and importantly, to implement the legislature's intent by adopting and enforcing rules and regulations designed to further that intent.

Given the dynamic nature of professional practice, the rapid evolution of clinical knowledge and techniques and the ongoing expansion of educational curricula, licensing boards must constantly “update” their interpretations and applications of practice act provisions and policies. Boards provide Advisory Opinions and Policy Statements and promulgate rules and regulations that establish more detailed rights and responsibilities than those typically found in the original practice act. In addition, through their enforcement functions in individual adjudications or disciplinary actions, licensing boards must grapple with the interpretation and application of policy to new and unique facts and circumstances. Decisions in disciplinary actions affect not just the licensee involved, but also the entire profession through development of precedent. Finally, boards often are in the best position to identify the need for revisions to the practice act itself, and they can recommend proposals for statutory modifications to the legislature.

Defining scope of practice: Authority v. evidence-based schemes

Physicians were the first health care providers to secure licensure in all the states, and their legislatively recognized scope of practice—the “practice of medicine”—swept the entire human condition into their exclusive domain. The unlimited scope of physician authority is reflected in this typical definition of the practice of medicine:

A person is practicing medicine if he does one or more of the following:

- (1) Offers or undertakes to diagnose, cure, advise or prescribe for any human disease, ailment, injury, infirmity, deformity, pain or other condition, physical or mental, real or imaginary, by any means or instrumentality;*
- (2) Administers or prescribes drugs or medicinal preparations to be used by any other person;*
- (3) Severs or penetrates the tissues of human beings.⁷*

This all-encompassing medical scope of practice, combined with physicians’ simultaneously obtained authority to supervise, direct, and delegate to all other kinds of health care providers, forced subsequent legislatively recognized health care providers, such as APCs and others, to settle for narrowly confined scopes of practice “carved out” from the universe of the practice of medicine. Even then, physician supervision or referral was usually required.

This authority-based scheme continues to affect scope of practice today, in decidedly asymmetrical ways. For example, as research and innovation expand effective treatment modalities, physicians are able to provide those treatments without having to seek revision in their legal scope of practice. In contrast, health care providers such as APCs not only must acquire the knowledge and ability to provide these new interventions but also must confirm that these tasks are within their scope of practice as it is currently defined. If not, these providers must engage in the time-consuming process of legislative or administrative modification of their scope.

This inefficient process for advancing scope of practice limits the availability of care for patient populations served by APCs and unnecessarily interrupts the continuity of care for patients who must be referred to physicians or specialists for services that would otherwise be within the scope of practice of their primary care providers.

Legislators, licensing boards, and professional organizations are well aware of the legislative and regulatory dynamics reference to this “historical” definition of physician scope of practice can unleash. Each effort to revise a particular profession’s scope of practice to more accurately reflect ever-increasing clinical abilities is met with the argument of historic authority—that is, “This is medicine, and therefore only physicians can do it.”

Of course, given the undifferentiated, universal, and timeless scope of practice legally authorized

in medical practice acts,⁸ the “This is medicine” portion of the argument isn’t inaccurate. However, the second prong of the argument (“... and therefore only physicians can do it”) is both inaccurate and irrelevant to the question of who is competent to do what.

Fortunately for health care providers, and for the public they serve, the tide is turning slowly but inevitably toward emphasizing evolving ability and competence rather than static, historic grants of exclusive authority. This modern evidence-based framework “rests on the premise that the only factors relevant to scope of practice decision-making are those designed to ensure that all licensed practitioners be capable of providing competent care.”⁹ Importantly, it emphasizes public protection as the principal priority of scope of practice regulation and assumes the necessity of collaboration among and overlap between professions.

Furthermore, it acknowledges the dynamic nature of scope of practice and, therefore, suggests that practice acts should base licensure on the demonstration of training and competence.¹⁰ Under this evidence-based model policymakers would consider the historical basis, education and training, evidentiary base for practice and competence, and the regulatory environment in order to assess scope of practice advances.¹¹ Such a shift from an authority to evidence-based scheme bodes well for APCs and the public’s access to health care.

Scope of practice and access to reproductive health care

The application of an evidence-based approach to the determination of which clinicians may perform medication and aspiration abortion could contribute substantially to the availability of these medical services. As NPs’, CNMs’ and PAs’ practice and skills have evolved over time, their scopes of practice have advanced to comfortably include the skills, knowledge and

expertise necessary to provide comprehensive early abortion care.

However, the politicization of this relatively safe procedure has led some state legislators to exclude it from the legal scope of practice of clinicians other than physicians.¹² These ideologically based determinations that early abortion procedures, which are relatively safe and uncomplicated compared to others deemed to be within APC scope of practice, contradict the evidence that APCs are fully capable of safely performing medication and early aspiration abortion.¹³

Regardless of one’s ideological views about abortion, scope of practice determinations about whether APCs have the clinical ability (and hence ought to be granted legal authority) to provide abortion should be based in evidence alone. Allowing all qualified clinicians to provide abortion will make abortion safer and more accessible to medically underserved populations and patients who receive primary care from APCs. In addition, it will allow all clinicians to follow their own conscience and professional judgment in making the decision of whether to provide abortion services to their patients.

Therefore, women’s health advocates and clinicians alike should seek to better understand the players and processes involved in scope of practice determinations. This will promote competency-based decisions that will allow clinicians to provide their patients with the full range of reproductive health services appropriate with their professional training, education, and competency attainment.

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Endnotes

¹ Association of Social Work Boards, Federation of State Boards of Physical Therapy, Federation of State Medical

- Boards, National Board for Certification in Occupational Therapy, National Council of State Boards of Nursing & National Association of Boards of Pharmacy. (2006). *Changes in Healthcare Professions' Scope of Practice: Legislative Considerations*. Available at www.ncsbn.org/ScopeofPractice.pdf [Accessed August 28, 2009].
- ² NPs, PAs, and CNMs are referred to under the umbrella term of advanced practice clinicians (APCs) throughout the remainder of this paper.
 - ³ Taylor, D., Safriet, B., & Weitz, T. (2009). *When Politics Trumps Evidence: Legislative or Regulatory Exclusion of Abortion from Advanced Practice Clinician Scope of Practice*. *Journal of Midwifery & Women's Health*. Vol 54, no. 1. In 2004 APCs saw six times as many women in publicly funded family planning clinics as did physicians. Forst JJ, Frohwirth L. *Family Planning Annual Report: 2004 Summary Part 1*. New York, NY: The Guttmacher Institute, 2005.
 - ⁴ Taylor, *supra* at 6.
 - ⁵ Safriet, B. (2002). Closing the gap between can and may in healthcare providers' scope of practice: A primer for policy-makers. *Yale Journal on Regulations* 19, 301.
 - ⁶ Federation of State Medical Boards. (2005). *Assessing scope of practice in health care delivery: Critical questions in assuring public access and safety*. Dallas, TX.
 - ⁷ Washington Revised Code §18.71.011.
 - ⁸ Even though physicians' legally defined scope of practice remains exceedingly inclusive and authorizes them to perform virtually any kind of medical or health intervention, most physicians do not and would not engage in such unfettered practice. A combination of extralegal constraints, including common sense, professional judgment, professional ethics, institutional credentialing systems, voluntary accreditation standards, and malpractice insurance provisions, reinforces self-restraint to keep physicians from practicing beyond the boundaries of their abilities.
 - ⁹ Association of Social Work Boards et al., *supra* at 15. Though not binding, this document provides information and guidance to health policy decision makers and is the product of a working group on scope of practice comprised of representatives of associations of regulatory/licensing boards of six healthcare professions.
 - ¹⁰ *Id.* at 8-10.
 - ¹¹ *Id.* at 11-14.
 - ¹² For more information on provider-specific restrictions for abortion, see ANSIRH's Key Legal Barriers to Provision of Abortion by Advanced Practice Clinicians for more information on abortion provider restrictions. Available at: www.ansirh.org/_documents/issue_briefs/ansirh_brief2legal.pdf.
 - ¹³ Taylor, *supra* at 6.