Closing the Gap Between *Can* and *May* in Health-Care Providers' Scopes of Practice: A Primer for Policymakers

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A gap has developed within the United States health care industry between the abilities of non-physician care providers and the activities government regulation allows them to perform. Dominant provider groups extensively lobby state legislators in order to obtain scope-of-practice monopolies, which confer exclusive control over their areas of interest and exclude other equally-capable groups from performing such services. As a result, the excluded providers' skills are under-used, creating a systemic inefficiency. This Essay explores the development of the current scope-of-practice system and discusses possible solutions, including a review of current reforms in Colorado and Ontario, Canada.

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Introduction

For the past two decades, no set of domestic policy issues has received more attention than the financing and delivery of adequate health

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care to those who need it. The fundamental questions are straightforward—who can do what to whom, and where and when, and get paid for it?—but the answers have been elusive. Periodic crises concerning skyrocketing costs, questionable quality, and inadequate availability of care have dominated the media and policymaking agendas, leading to episodic and uncoordinated gestures toward reform. Some of these efforts have resulted in incremental improvements, but none has succeeded in cutting through the Gordian knot at the heart of the system. Why is this set of issues so apparently intractable, and how can policymakers go about designing a rational alternative? By focusing on one specific strand of the tangle—the so-called "scope of practice" defining each health-care provider's lawful sphere of activity—this brief Essay will explore some of the dynamics that drive our currently dysfunctional system and offer illustrative possibilities for reform.

Let us begin, then, by thinking about how the typical health-care reform story plays out. For the most part, a new problem is recognized, not in its early stages, but only after it has fully developed and begun to create stresses elsewhere in the cat's cradle of relationships we call "the health care delivery system." At this juncture, the usual stakeholders are galvanized into action. Individual providers' professional groups, institutional providers' organizations, employers' associations, insurance and financing federations, specialized consumer advocacy groups, pharmaceutical and medical device manufacturers, and legislative and regulatory entities both state and federal—all weigh in with supposed solutions. The rhetorical palette of the resulting public debate usually tends toward the inspirational and abstract, emphasizing such high-minded principles as "protection of the public," "patients' rights," "accountability and quality," "equitable access," and "professional obligation." At the same time, behind the scenes, conversations assume a different tone, one that concentrates on professional autonomy and control, turf, competition, market share, and financial self-interest. The regulatory "solution" to the crisis du jour is usually an unhappy mixture of the two, with some measures that genuinely promote the public good and others that advance the agendas of special interests.

It is not surprising that these proposed remedies are multi-factored, because the origins of the problem are similarly complex. Issues of access, cost, and quality are closely intertwined, in terms of historical development, current practice, and regulatory policy. Often, policymakers must address one particular facet of a problem with a woefully inadequate view of the larger picture. What are the practical and legal contexts in which the problem arose? What forces will be set in motion by the proposed solution, and how are they interconnected? If policymakers are not given the information they need to tackle these larger questions, their

policy prescriptions are likely to be no more than marginally effective and riddled with unintended consequences.

Nowhere, perhaps, is this dynamic more pronounced than in the area of what is commonly known as "scope of practice"—the legislatively-defined spheres of activity within which various types of health-care providers ("HCPs") are authorized to practice. Consider, for example, the plight of state legislators asked to address the quite understandable need for school nurses to administer prescribed drugs to specified students at appropriate times of day. Ready or not, the legislators will soon be overwhelmed by a chorus of conflicting voices. They will hear from organizations of pharmacists and physicians who claim, "that's our job," and "they're not qualified to do that." They will hear from school principals and state Medicaid administrators, insurance companies and public health officers, arguing over "who will pay for these drugs and this service?" They will hear from state and federal drug control agencies and the state pharmacy board, each insisting on jurisdiction over the record-keeping, security, storage, and labeling of the drugs in question. They will hear from the association of school counselors who assert that they, too, should be permitted to administer these drugs to students and to be paid for their services.

Lost in the resulting cacophony, of course, are the central concerns prompting the policymaking effort. A sane starting point would be to ask: "Do students genuinely need these services provided at school? If so, who is appropriately qualified to provide them?" Instead, the legislative process turns into a protracted battle about professional turf protection and control over services and money.

Were such situations rare rather than common, little would be lost in muddling through them as they arose. The dysfunctional dynamic captured by this example, however, has for years been the rule rather than the exception in state legislatures across the country—and often in Congress and federal agencies as well. The battles generally focus on modifying the scope of practice of one or another group of licensed HCPs: What are those providers legally authorized to do, and under what conditions or restrictions, if any? Frequently, the answers also affect the rate and terms of payment available to the providers.

The ferocity and frequency of these extremely costly[1] battles have frustrated, exhausted, befuddled, and cowed many a seasoned legislator.

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1 The costs include campaign donations to state and federal legislators, direct lobbying expenditures, and public "information" campaigns, including full-page ads in national newspapers. For example, the Pew Health Professions Commission Taskforce on Health Care noted that "[a] four-year dispute between ophthalmologists and optometrists over who could treat certain eye diseases with what medications in California reportedly cost over $1.8 million in campaign contributions alone to state legislators." L.J. FINOCCHIO ET AL., PEW HEALTH PROFESSIONS COMM'N, STRENGTHENING CONSUMER PROTECTION: PRIORITIES FOR HEALTH WORKFORCE REGULATION 26 (1998) [hereinafter

And with good reason. Whenever scope-of-practice issues arise, legislators are bombarded by heavily-financed lobbying efforts emanating from state and national professional associations, individual health care providers (who are also voters), and interested citizens. All of them demand legislation that will "serve and protect the public" by expanding, limiting, or maintaining—the preferred alternative, of course, being a function of the potential impact of the proposed change on their immediate interests—the authority of a particular group of HCPs to do and to get paid for doing "*X*." "*X*" could include one or more of a wide range of actions: prescribing drugs from a limited formulary for common conditions such as a pediatric earache or mild depression, or ascertaining and certifying the existence of physical impairments that would qualify for handicapped parking permits, or diagnosing and "declaring" death, or determining the need for and authorizing the provision of physical therapy, or fitting and providing orthotics, or realigning dislocated joints, or giving immunizations and flu shots to elderly people, or cleaning teeth. Together with scores of other equally specific "body-part" requests for legislative approval, these demands are thrust upon legislators who are both ill-prepared and disinclined to decide what is safe, what is effective, and what is cost-effective—and therefore to determine which groups of providers should be authorized to give what kinds of care.

In order to grapple successfully with these recurring scope-of-practice issues, both legislators and administrative regulators need to understand that—contrary to what their own experiences may have led them to believe—the various licensed health-care professions are not genetically pre-ordained to fight one another to the death. Rather, these battles are the logical, but not inevitable, consequence of a particular history and the misallocation of authority to which it has given rise. These battles originated in the development of the licensure laws in this country, and they are perpetuated both by the static nature of law itself and by the powerful forces of professional autonomy and control, cultural and social status, personal income, power politics, gendered professional roles, and uni- (rather than multi-) disciplinary education and training.

These dynamics cannot be overcome by simple legislative fiat, of course, but they are sustained by a central feature of our current licensure and scope-of-practice scheme that legislators can and must address: the glaring, compelling, and growing gap between the legal authority afforded

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TASKFORCE REPORT]. I was an active member of the Commission and the group that authored this report. The sheer number of scope-of-practice bills introduced in the state legislatures each year provides a staggering array of spending "opportunities" for various professional interest groups: In 1997, over 1,600 such bills were introduced, and a summary of some of the bills introduced in the 2000 and 2001 legislative sessions encompasses sixteen single-spaced pages. *See* STEPHANIE NORRIS, HEALTH POLICY TRACKING SERVICE, SCOPE OF PRACTICE AND PRESCRIPTIVE AUTHORITY (2001); LEGISLATIVE TRACKING SERVICE, 1997 LEGISLATIVE REVIEW (1997).

many HCPs, on the one hand, and their clinical abilities, on the other. The law defines who may provide various services, but it has not kept up very well with the corollary question of who is able.

In fact, the training and skills of all HCP groups have increased dramatically in recent years, tracking our growing understanding of effective treatments for diseases and disabling conditions, of preventive measures, and of health-promotion strategies. Among these professional groups, however, only physicians are free of the burden of having to reconcile their clinical abilities and their legal authority. That is, they have a monopoly on authority, if not ability. All others, including both long-established and emerging professions, must constantly choose between two unattractive alternatives: foregoing the safe practice of what they have been educated and trained to do, or risking legal sanction for stepping outside the boundaries of their legislatively-defined, static, circumscribed, and outdated scopes of practice. This double dichotomy—between legal authority and clinical ability, and between physicians and all other HCPs—is the motive force behind the needless and never-ending legislative and regulatory battles that cripple our current system. Even more importantly, this double dichotomy means that many qualified HCPs cannot give safe and effective care to people who want and need their services. We all pay a huge price for the consequences, measured in extra real dollars spent on health care, in lack of access to qualified service-providers, and in the constant antagonism among health care professionals who should be working cooperatively to provide optimal care.

While no individual essay could possibly exhaust the topic, I believe that a little history and a few well-chosen examples will go a long way in assisting policymakers who find themselves caught up in these recurring, scorched-earth debates over scope of practice. I hope, too, that this approach will enable interested, reform-minded public consumers to better understand the wastefulness of many current, overly restrictive laws. In the following Parts, I will briefly describe the historical antecedents of our current licensure laws, known as "practice acts," and demonstrate why turf battles among HCP groups are inevitable whenever modifications are proposed to existing scopes of practice. I will also review some examples of legislation that exalts authority over ability, perpetuates the "physician-only" paradigm, ignores the demonstrated competence of all other HCPs, and thus demonstrates the dysfunctional, wasteful, and often absurd results of the current scheme. Finally, I will suggest some principles that should guide efforts to reform scope-of-practice laws and highlight two examples of progressive licensure schemes that focus on shared abilities rather than exclusive authority.

I. How Did We Get Here? The Historical Context

To protect the public from potentially harmful health services rendered by unqualified people, each state has enacted licensing laws, or practice acts, governing most HCP groups. Typically, these laws do three things: (1) They define the practice of the profession in question; (2) they limit that practice to people who satisfactorily complete a specified training regime and pass an examination; and (3) they restrict to license holders both the use of the professional title or credentials and the performance of the defined practice functions.

Across the country, physicians (also known as medical doctors or "MDs") were the first HCPs to secure licensure. By the early-1900s, so-called "medical practice acts" had been adopted in each state, and, being first on the scene, physicians, perhaps understandably, swept the entire human condition within their purview. In almost every state, their legislatively-recognized scope of practice gave them exclusive domain over "the practice of medicine."[2] The following medical practice act is representative of the breath-taking range this includes:

> Definition of 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;
> (4) Uses on cards, books, papers, signs or other written or printed means of giving information to the public, in the conduct of any occupation or profession pertaining to the diagnosis or treatment of human disease or conditions the designation "doctor or medicine," "physician," "surgeon," "m.d." or any combination thereof . . . .[3]

(One element missing from this example, but common to many other medical practice acts, is the provision that the actions in question must have been undertaken for compensation.[4])

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2 For an excellent description of the evolution of organized medicine's licensure activities and an analysis of the resulting economic, cultural, political and social authority of physicians, see PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 102-12 (1982).

3 WASH. REV. CODE ANN. § 18.71.011 (West 2001).

4 *See, e.g.*, OHIO REV. CODE ANN. § 4731.34(3)(a)-(b) (West 2001):

Once medicine's scope of practice was thus comprehensively defined in law, almost any activity directed at "health or sickness"—especially if done for compensation—was deemed to be the practice of medicine. Licensed physicians, then, had obtained what sociologist Eliot Freidson has aptly characterized as "the exclusive right to practice."[5] Having obtained that right, physicians turned their attention to other HCPs who were "useful to the physician and necessary to his practice, even if dangerous to his monopoly."[6] To meet the need and defuse the danger, physicians obtained statutory authority to "control . . . those occupations' activities so as to limit what they could do and to supervise or direct their activities."[7] This authority to supervise or direct other HCPs, combined with the authority to "delegate"[8] medical procedures and tasks to non-physicians, persists to this day. It underpins the legislative infrastructure that continues to subvert even the best efforts to develop a rational, effective scheme that promotes the highest and best use of all trained HCPs.

But back to history for a moment. Under this skewed regime, even the simplest of everyday health-care functions fell within the definition of medical practice, so no one else could do them absent the supervision of, or delegation by, a licensed physician. Only two or three decades ago, even a registered professional nurse could not take blood pressure, start an IV, or draw blood unless "ordered" to do so by a physician. Otherwise, the nurse would be deemed to be practicing medicine (by "diagnosing" or "penetrating the tissues of human beings") without a medical license. Indeed, up until the mid- to late-1970s, only physicians (who were usually medical students moonlighting in department stores) had the authority to pierce ears for would-be earring wearers![9] Obviously, nurses and many

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Examines or diagnoses for compensation of any kind, direct or indirect; (b) Prescribes, advises, recommends, administers, or dispenses for compensation of any kind, direct or indirect, a drug or medicine, appliance, mold or cast, application, operation, or treatment, of whatever nature, for the cure or relief of a wound, fracture or bodily injury, infirmity, or disease.

5 ELIOT FREIDSON, PROFESSION OF MEDICINE: A STUDY OF THE SOCIOLOGY OF APPLIED KNOWLEDGE 47 (1970).

6 *Id.*

7 *Id.*

8 *See, e.g.*, GA. CODE ANN. § 43-34-26(b)(9) (2001) ("Nothing in this chapter shall be construed to prohibit: . . . the delegation by a physician to a qualified person . . . of any acts, duties, or functions which are otherwise permitted by law or established by custom; and the performance of such acts, duties, or functions by such a person . . . ."). For a general treatment of the "delegation of medical acts," see Daniel. B. Hogan, *The Effectiveness of Licensing: History, Evidence, and Recommendations*, 7 LAW & HUM. BEHAV. 117 (1983).

9 *See, e.g.*, 1979 Ohio Op. Att'y Gen. 79-002 (advising that "ear piercing does not constitute the practice of medicine" under the medical practice act).

other kinds of HCPs had the clinical ability to do these tasks safely; what they lacked was the legal authority.[10]

Over time, other HCP groups—both established (nurses, pharmacists, optometrists, and nurse midwives) and emerging (nurse practitioners, podiatrists, physical therapists, and clinical psychologists)—sought legal recognition of their expertise and the corresponding authority to practice. But they soon discovered that, legally speaking, they faced a totally pre-empted field because the original medical practice acts defined medicine in global, undifferentiated terms to include all diagnosing, treating, prescribing, or curing. As a result, each of these other HCP groups was relegated to a scope of practice that was by definition "carved out" of medicine's universal domain. Typically, this carving-out was accomplished by focusing on a single part of the body (e.g., podiatrists/feet and dentists/teeth) or on one small subset of functions pertaining to a body part (e.g., optometrists/corrective lens). Even providers whose professional training embraced the health of the "whole person," such as nurses, could avoid the preemption problem only by resorting to creative word-games—by referring to nursing "assessments"[11] rather than "diagnoses," for example, or by "furnishing" rather than "prescribing" drugs. And even these small, artificially constrained scope-of-practice niches were usually achieved only after organized medicine had secured legislatively-mandated physician referral or supervision requirements.

This, then, is the history of our current scope-of-practice regime, and it makes clear the immense importance of these historical artifacts: the pervasive medical practice acts that remain on the books in every state. These acts are the "dark matter" of the health-care universe, not often seen or thought about, yet exerting a gravitational force that continues to skew all attempts to modify non-physician scopes of practice. If everything is medicine by legal definition, physicians have no need to amend their own practice acts to allow for new treatments or newly established sub-specialties. At the same time, other HCPs (sometimes known as "non-physician providers" or "physician extenders," two phrases that neatly capture the whole irrational dynamic[12]) are repeatedly forced to ask their legislators to "reopen" their scope-of-practice laws, with all of the

10 I have described elsewhere the development of the regulation of professional nurses, moving from early "registration-only" laws, to dependent practice "as prescribed by a licensed physician," to more independent practice parameters based on nursing judgment, skill, and techniques. See Barbara J. Safriet, *Health Care Dollars and Regulatory Sense: The Role of Advanced Practice Nursing*, 9 YALE J. ON REG. 417, 442-45 (1992), and sources cited therein.

11 Hence, the common practice of a nurse saying, "The patient appears dead," an assessment, rather than saying, "The patient is dead," a diagnosis.

12 The use of "non-physician providers" and other similar terms, to describe a wide array of professional health care providers has very real consequences. In addition to lumping together several distinct professionals in a totally undifferentiated way, the terms strongly reinforce the normative status of the physician—there is the physician, and then there are the non-physician "others."

attendant risk and expense, in order to obtain legal authority to deploy the expanded abilities they have gained from ever-more-sophisticated education and training. The inter-professional conflict that inevitably results from this imbalance has been described succinctly by the Pew Taskforce on Health Care Workforce Regulation:

> Due to different educational and regulatory histories, the various professions are uniquely situated and view regulation and potential changes differently. Medicine is the only profession with state practice acts that cover all of health care services. With this exclusivity, little or nothing exists that can be added to the medical act and medicine has no incentive to delete anything. From this position, medicine can see every request for regulatory change from any other profession or occupation as a challenge or confrontation. With all-inclusive practice authority, the profession also has the credentials, expertise and political influence to comment on potential impacts of changed laws on patients, clients and consumers.[13]

To understand that organized medicine perceives physicians' legal prerogatives to be both exclusive and inviolate, one need only review the official statements of the largest national medical organization, the American Medical Association ("AMA"). In response to legislative efforts to expand the scopes of practice for some HCPs and allow them to be paid directly, for example, the AMA has adopted several resolutions which direct the organization to

- "oppose[] enactment of legislation to authorize the independent practice of medicine by any individual who has not completed the state's requirement"[14] for medical licensure,
- "oppose any attempt at empowering nonphysicians to become unsupervised primary medical care providers and be directly reimbursed . . . ,"[15] and
- "support[] medical doctors against efforts advanced by alternative providers seeking increased medical control of patients by legislatively expanding their scopes of practice without physician direction and state boards of medical examiners oversight."[16]

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13 TASKFORCE REPORT, *supra* note 1, at 23.

14 Am. Med. Ass'n, H.D. Res. H-35.988 (1982).

15 AM. MED. ASS'N, *Independent Nursing Practice Models*, PROCEEDINGS OF THE HOUSE OF DELEGATES 141, 152 (1990).

16 *Prepared Statement of Jan Stewart CRNA, ARNP on Behalf of the American Association of Nurse Anesthetists Before the House Judiciary Committee*, FEDERAL NEWS SERVICE, June 22, 1999; *see also* Am. Med. Ass'n, H.D. Res. H-160.947 (2000).

These policies, which are "to be pursued through all appropriate legislative and other advocacy activities,"[17] sanction self-styled "see bill, kill bill" strategies and "scope-of-practice firefights"[18] to keep others from "encroach[ing]" upon or "stray[ing]" into the realm of medicine.[19] In short, "AMA delegates consider the matter akin to war and are fighting back."[20]

This point of view will not be unfamiliar to the countless legislators and agency staff members who have repeatedly heard organized medicine's most consistent argument against expanding the scope of practice for any other providers: "That's the practice of medicine,"[21] and "only we can do it."[22] "If you want to do it, go to medical school."[23] As I have noted elsewhere: "[S]uch comments are both deeply troubling and instructive because they bespeak both professional self-interest and a profound misapprehension of the issue. No one would deny that people who wish to practice medicine should go to medical school. Rather . . . , the question is exactly what the practice of medicine, and what it is not."

Or, put more precisely, the question is what is exclusively[24] the practice of medicine and what is not, because those activities "carved out" by various HCP groups do not thereby vanish from physicians' all-encompassing scope of practice. Many things that are, by definition, the practice of medicine are also—in fact and in law—the practice of

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17 Am. Med. Ass'n, H.D. Res. H-360.988 (2000).

18 Jay Greene, *Physician Groups Brace for Allied Incursion*, AM. MED. NEWS, Dec. 11, 2000, at 1.

19 Jay Greene, *AMA To Fight Nonphysician Scope of Practice Expansions*, AM. MED. NEWS, Jan. 3/10, 2000, at 8.

20 LaCrisha Buttle, *Nonphysicians Gain Clout*, AM. MED. NEWS, Jan. 17, 2000, at 1, 26.

21 *See, e.g.*, Am. Soc'y of Anesthesiologists, *HCFA Publishes Proposed Hospital Conditions Eliminating Nurse Anesthetist Supervision Rule*, PRESIDENT'S UPDATE, Dec. 31, 1997, at 1, 3 (statement of former American Society of Anesthesiologists President William Owens) ("Either the practice of anesthesiology is the practice of medicine or it is not."). *But see*, Op. Tex. Att'y Gen. JC-0117 (1999) ("The Board of Nurse Examiners may regulate the selection and administration of anesthesia and the maintenance of anesthetized patients by certified registered nurse anesthetists . . . . ").

22 *See, e.g.*, Am. Med. Ass'n, H.D. Res. 216 (1998) ("Resolved, [1.] That anesthesiology is the practice of medicine. [and 2.] That the American Medical Association seek legislation to establish the principle in federal and state law and regulation that anesthesia care requires the personal performance or supervision by an appropriately licensed and credentialed doctor of medicine, osteopathy, or dentistry.").

23 *See, e.g.*, Am. Med. Ass'n, *supra* note 16. ("Many health care workers seek to legislate their ability to practice medicine, rather than obtain a high level of expertise and competence through medical school education and training . . . .").

24 *See, e.g.*, David M. Mirvis, *Sounding Board: Physicians' Autonomy—The Relation Between Public and Professional Expectations*, 328 NEW ENG. J. MED. 1346, 1347 (1993):

> [N]urses, clinical pharmacists, and other allied health professionals are now educated and trained to perform many tasks previously assigned only to physicians. In these areas, physicians have a right to *autonomy* because of their knowledge, but it is *not an exclusive right*. Instead, it is a right to be *shared* with other appropriately credentialed professionals.

(emphasis added).

optometry, or nursing, or clinical psychology, or . . . . Properly understood, this is a regulatory train wreck in the making.

II. Where Are We? Current Problems Resulting from Medicine's Legislative Preemption

Many detrimental consequences flow directly and inevitably from the historical antecedents and present-day realities I have described. The most obvious is the built-in inter-professional conflict cum playground argument—"it can't be yours because it's mine"—but there are many more. They, too, arise from the disjunction between legally recognized authority and clinical competence in providers' scopes of practice.

As is abundantly clear from the illustrative medical practice act quoted above, physicians' legally defined scope of practice is overly inclusive. It is undifferentiated, universal, and timeless, so a licensed medical doctor is authorized to undertake virtually any kind of medical or health intervention. For example, an MD may practice gynecology, oncology, orthopedics, pediatrics, retinal surgery, or psychiatry on alternating days, through treatment modalities that are decades old or were invented yesterday—all under the same generic medical license he obtained years ago. Of course, the vast majority of physicians do not and would not engage in such unfettered practice, but it is not the law that constrains them. The medical practice acts speak only of medicine; they do not limit individuals to any sub-parts or specialties[25] or require any subsequent demonstration of competence as new treatments arrive on the scene. Rather, it is a combination of generally effective, extralegal constraints that limits physicians to only those areas of practice in which they know they are qualified. These constraints include common sense and decency, professional judgment, professional ethics,[26] institutional credentialing systems, voluntary accreditation standards, malpractice insurance restrictions and conditions, and, more recently, a better-informed patient cohort. In sum, it is self-restraint, rather than lack of authority, that keeps physicians from practicing beyond the bounds of their abilities.

The scope-of-practice situation of other HCPs is a mirror image of that of physicians. Where medical practice acts are too inclusive, almost all other kinds of licensed providers must contend with overly restrictive

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25 *See, e.g.*, Conn. State Med. Soc'y v. Conn. Bd. of Exam'rs in Podiatry, 546 A.2d 830, 837 (Conn. 1988) (noting the "marked contrast" between the podiatry statutes which "authorize the practice of podiatry and define its limits" and the medicine and surgery statutes "wherein the scope of practice of medicine and surgery is not defined").

26 *See, e.g.*, AM. MED. ASS'N, PRINCIPLES OF MEDICAL ETHICS (June 2001), *available at* http://www.ama-assn.org ("A physician shall be dedicated to providing competent medical care," and "[a] physician shall uphold the standards of professionalism."). One assumes that knowingly practicing beyond the bounds of one's training and knowledge would violate one or both of these principles.

scope-of-practice laws. These providers are not limited by ability, for they have not yet been permitted to approach, much less exceed, the bounds of their competence. Instead, they are limited by authority—or, more precisely, by the lack of it. Health care-related knowledge continues to expand as research yields new inventions and improves old ones. And just as physicians' skills have evolved as a consequence, so too have those of other providers.[27] Yet, when these other professionals seek a corresponding expansion of their legal authority, as reflected in their statutorily defined scopes of practice, they are stymied by both the inertia of the legislative process and the medical-preemption dynamic described earlier. As a result, what they are able to do is always several years (or more) ahead of what they are permitted to do. The sum total of wasted professional assets represented by this disparity is staggering—and growing.

Another legal problem intrinsic to overly restrictive scope-of-practice laws borders on the absurd: How are providers to achieve expanded scopes of practice by demonstrating that they can safely and effectively do what they are not yet authorized to do? Few would be willing to follow the obvious but perilous path of demonstrating that they have competently done something that is clearly beyond the scope of their current legal authority. This conundrum is especially acute when the asked-for expansion would eliminate mandatory physician supervision or direction. No matter how well-educated or capable of independent practice, the provider in such a situation is likely to encounter a predictable response from organized medicine to any study data mustered as evidence: "Since the data must reflect legally 'supervised' practices, they prove nothing

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27 The expanded professional education and clinical abilities of pharmacists are illustrative of the increased knowledge domains of health care providers. In 1992, the American Association of Colleges of Pharmacy voted to make the transition from the Bachelor of Science in Pharmacy to the Doctor of Pharmacy ("Pharm.D.") as the entry-level professional degree. After 2003, the American Council of Pharmaceutical Education will only accredit Pharm.D. programs. The Pharm.D. requires four years of professional study (including at least two semesters of supervised clinical experience), following at least two years of college-level pre-pharmacy study. With their increased training, pharmacists are qualified to take on new roles, including drug monitoring and disease management for defined conditions (such as diabetes, asthma, and anti-coagulant therapy), as well as collaboration with clinical care teams, research on health outcomes, and participation in drug utilization review programs. As a study by the U.S. Health Resources and Services Administration has noted,

> Through [disease management] programs and with physician collaboration, pharmacists can provide a range of services including assessing the patient, ordering drug-therapy related laboratory tests, administering drugs, and selecting, monitoring, and adjusting medication regimens. These programs usually involve a series of regularly scheduled visits with the pharmacist and often follow disease-specific management guidelines.

BUREAU OF HEALTH PROFESSIONS, DEPARTMENT OF HEALTH AND HUMAN SERVICES, THE PHARMACIST WORKFORCE: A STUDY OF THE SUPPLY AND DEMAND FOR PHARMACISTS 34 (2000), *available at* ftp://ftp.hrsa.gov/bhpr/nationalcenter/pharmacy/pharmstudy.pdf (last visited Apr. 28, 2002).

with respect to your capacity to practice safely and effectively on your own license."

Of course, as detailed in the *Pew Taskforce Report*,[28] there are ways to overcome this legal catch-22. HCP groups may offer evidence from other states and practice settings (such as military and veterans' health systems[29]) where the requisite legal authorization for independent practice already exists, and legislatures may sanction special demonstration and information-gathering projects. But, while these approaches are helpful, they too are vulnerable to irrational argument and political manipulation. A history of safe and effective practice in another jurisdiction, for example, will sometimes be dismissed by opponents of change as inapposite and irrelevant; the simple argument that "we do things differently in this state" appeals simultaneously to the high-minded public-spiritedness of some legislators and the regional chauvinism of others. In addition, of course, special projects to gather information or demonstrate competence are costly to the groups involved—first, in the effort to gain legislative permission in the face of well-coordinated opposition and, later, in the effort to complete the projects successfully.

Another ubiquitous problem, both within and among states, is the seemingly endless variation in the scopes of practice governing providers other than physicians. This diversity, too, is a direct result of the ad hoc, profession-by-profession carving-out process described earlier, and it is exacerbated by the American tradition of looking to the states to regulate HCPs. Every state licenses a growing array of provider groups, and the legislative recognition afforded each of them varies enormously in its timing and expansiveness. And this is so, notwithstanding the existence of

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28 *See* TASKFORCE REPORT, *supra* note 1, at 25-33, 48-53.

29 A recent (and pathbreaking) example of state legislation, influenced in part by a U.S. Department of Defense pilot program, grants clinical psychologists prescriptive authority as of July 1, 2002. New Mexico House Bill 170, 2002 N.M. Laws 100, grants doctorally trained psychologists who have additional pharmacological training and who have passed a national certification examination on pharmacology in the diagnosis, care, and treatment of mental disorders the right to apply for a two-year "conditional prescription certificate." Under the terms of the conditional certificate, the psychologists may prescribe psychotropic medication, but *only under the supervision* of a licensed physician. After the successful completion of two years of prescribing psychotropic medications, as certified by the supervising physician, the psychologists can renew the conditional certificate, or apply for a "prescription certificate," which allows psychologists to prescribe psychotropic medications *without physician supervision*. Under both certificates, the psychologist must "maintain an ongoing *collaborative* relationship [defined as 'a cooperative working relationship'] with the health care practitioner [physician, osteopathic physician, or nurse practitioner] who oversees the patient's general medical care." While many implementing details (including guidelines to be jointly established by the Board of Psychology Examiners and the Board of Medical Examiners) remain to be finalized, this legislation is noteworthy for at least three reasons: (1) It is the first state legislation granting psychologists authority to prescribe drugs for mental health care; (2) it provides for a legislatively-recognized continuum from supervised to independent practice; and (3) it properly distinguishes between supervision and collaboration, the latter being a desired goal for all health care providers, including physicians. *See also* Erica Goode, *Psychologists Get Prescription Pads and Furor Erupts*, N.Y. TIMES, Mar. 26, 2002, at F1.

national educational accreditation standards, not to mention national licensure or certification examinations, all of which, one might have thought, should suffice to signal common abilities and competencies across state lines. The net result is a regulatory patchwork in which two providers who have completed the same educational program and passed the same licensure examination, and who now treat the same kinds of patients and conditions, are nevertheless subject to very different scopes of practice. Provider One in state *A*, say, is restricted to a dependent practice in which he must be "supervised" or "directed"[30] by an on-site physician, with no authority to prescribe even the most commonly indicated drugs and no way to get paid for his services other than indirectly, through the physician. Provider Two in state *B*, however, may independently diagnose, treat, and prescribe over-the-counter, legend and controlled schedule drugs, with hospital admitting privileges and direct reimbursement from third-party payers.

While one might attribute these seemingly irrational disparities solely to the state-based licensure system, that justification evaporates when one considers the large scope-of-practice variations within states. Intriguingly, a provider's legal authority (though, presumably, not ability) within a single state will sometimes shift along three axes: (1) the geographic location of the practice (e.g., rural areas, inner cities, or other places where there is a dearth of HCPs), (2) the type of patients treated (e.g., persons eighteen years of age or older, individuals who are unable to receive regular health services, or the home-bound), and (3) the financial or institutional nature of the practice setting (e.g., long-term care facilities, school-based health clinics, nursing homes, correctional facilities, nursery schools, mental health residential facilities, or adult foster homes).[31] While these scope-of-practice distinctions are doubtlessly designed to facilitate access to quality care for disadvantaged people, such rampant variations amount to a distortion of the licensure laws, which are simply supposed to inform the public about who is competent to do what. Instead, the logic of these intra-state distinctions leads ineluctably in one of two directions: If a duly licensed HCP has authority to do something in the inner city but not in the wealthier suburbs, she is either practicing beyond the boundaries of her competence in the first situation or is being artificially and foolishly constrained in the second for reasons having nothing to do with her ability. A provider's governmentally assessed and certified clinical competence

30 For a discussion of the detrimental effects of supervision or direction requirements, see William M. Sage & Linda H. Aiken, *Regulating Interdisciplinary Practice*, *in* REGULATION OF THE HEALTHCARE PROFESSIONS 71, 77 (Timothy S. Jost ed., 1997) ("The effects of these provisions vary widely. Many are largely ignored in practice, while others merely increase costs to patients through higher overhead or explicit billing of supervisory services to payors.").

31 For examples of legislation specifying practice authority by reference to the nature of the practice site, see NORRIS, *supra* note 1.

cannot in fact—and should not in law—fluctuate depending upon her location on one side or the other of an imaginary line or upon the corporate structure of the practice setting.

It seems incontestable that these mismatches between ability and authority cause confusion, unfairness, and significant waste,[32] even within individual states. The problems grow exponentially, however, when two or more state practice acts collide. There are, of course, obvious disincentives to interstate mobility for individual HCPs; no matter how attractive such a move might otherwise be, few would eagerly relocate to a state where their professional ambit would be drastically reduced by a crabbed scope-of-practice law.[33] In addition, the crazy quilt of licensure laws has repeatedly been identified as the greatest legal impediment to "telepractice" or "telehealth" systems that would allow HCPs to monitor, diagnose, and treat patients at distant sites through telecommunications technology.[34] The unrealized potential of these systems provides a remarkably revealing example of the ways in which conflicting scope-of-practice laws stifle the promise of new technologies and practice modes, thus denying consumers

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32 For example, even though a nurse practitioner ("NP") is fully trained and able to diagnose, treat and prescribe for a wide range of primary and secondary conditions, a restrictive practice act and restrictive federal reimbursement conditions could force the NP to have to "refer" the patient to a physician for a duplicate examination or have the physician "sign" the prescription which the NP appropriately had selected. This process results in needless costs, increased inconvenience for the patient, and redundant utilization of skilled clinicians' time.

A pervasive federal reimbursement scheme for Medicare limits payment for NPs' services "incident to" a physician's services to treatments of only those conditions initially diagnosed by a physician. If, then, during a follow-up visit for treatment by the NP, the NP diagnoses an additional condition, no treatment can be given and billed to the government until the patient is yet again seen and diagnosed by the physician. And this applies to the most common of ailments, like "pink eye" or upper respiratory tract infections. This limitation results in needless time spent by the providers and the patient, and it also produces a serious potential for good-faith, but faulty, billing, thus triggering false claims scrutiny by the federal government. 42 U.S.C. § 1395x(s)(2)(A)-(B) (2000). For a comprehensive analysis of "incident to" and other compensation difficulties faced by "nonphysician" providers, see Alice G. Gosfield, *Highest and Best Use: Nonphysician Practitioners and Physicians Under Medicare*, *in* HEALTH LAW HANDBOOK 89 (Alice G. Gosfield ed., 1999).

33 For studies demonstrating a positive correlation between the number of practitioners in a jurisdiction and the progressivity of a state's practice laws, see Carol S. Weissert, *The Political Context of State Regulation of the Health Professions*, *in* THE U.S. HEALTH WORKFORCE 81, 87 (Marian Osterweis et al. eds., 1996) (citing Edward S. Sekscenski et al., *State Practice Environments and the Supply of Physician Assistants, Nurse Practitioners, and Certified Nurse-Midwives*, 331 NEW ENG. J. MED. 1266 (1994)). Also, see TIM HENDERSON & TERESA CHOVAN, INTERGOVERNMENTAL HEALTH POLICY PROJECT, REMOVING PRACTICE BARRIERS OF NONPHYSICIAN PROVIDERS (1994), for an analysis of the negative effects that restrictive legal and regulatory provisions have on access to primary care provided by "nonphysician" providers.

34 *See generally* TELECOMMUNICATIONS AND INFORMATION ADMINISTRATION, U.S. DEP'T OF COMMERCE, TELEMEDICINE REPORT TO THE CONGRESS (1997), *available at* http://www.ntia.doc.gov/telemed (last visited Apr. 28, 2002); U.S. GENERAL ACCOUNTING OFFICE, TELEMEDICINE: FEDERAL STRATEGY IS NEEDED TO GUIDE INVESTMENTS (1997), *available at* http://www.gao.gov/archive/1997/n397067.pdf (last visited Apr. 28, 2002); S.S. Huie, *Facilitating Telemedicine: Reconciling National Access with State Licensing Laws*, 18 HASTINGS COMM. & ENT. L.J. 377 (1996); Wendi Johnson et al., *Telemedicine: Diagnosing the Legal Issues*, *in* HEALTH LAW HANDBOOK 55 (Alice G. Gosfield ed., 2001).

improved access to high-quality health care at a reduced cost. As matters now stand, a full-fledged telehealth system would remain largely idle even if the requisite financial and technical infrastructure were already in place, thanks to the regulatory nightmares engendered by multiple and conflicting licensure laws.

These, then, are the most pernicious aspects of the scope-of-practice laws currently in effect. For historical, rather than logical, reasons, physicians enjoy an overly expansive scope of practice, while all other HCPs are overly restricted. In recent years, these flaws have been steadily compounded by the proliferation of different practice laws in different states, and varying scope-of-practice provisions within states. The scientific underpinnings of the health disciplines do not change with political boundaries, nor does the capacity of individuals to learn and to act upon that knowledge. The only thing that changes is the authority conferred or withheld by each jurisdiction.

When thus stripped down to its essence, this state of affairs seems indefensible. Indeed, it calls into question the very purposes of licensing and regulation. How does this jumble of conflicting and restrictive laws really protect the public from harm? If it occasionally manages to do so, it is in the manner of a blunderbuss destroying a gnat: a hugely inefficient means to the end, and one that inflicts great collateral damage. But when one looks at the system through a different pair of glasses, the picture becomes clearer. Without attributing malice or bad faith to any of the individual actors in the drama, one can discern how the forces of history have combined with those of the legislative process and the predictable self-interest of the first organized group on the scene to protect the latter's professional autonomy, exclusivity, status, income, and control. As one legal commentator noted after serving for five years as a public member of a state medical board:

> In my experience, regulation has too often served the profession first and the public second or not at all. It has enforced orthodoxy and slowed innovation more often than protecting the public. . . .
>
> I can't imagine the hours I have spent listening intently to the differences between the ophthalmologist and the optometrists, or . . . to the turf battles between the various branches of medicine or nursing. Looking back on it, few of these arguments had anything to do with competency or public safety. It was monopoly and money and not safety and skill that usually were at stake.[35]

35 JOST, *supra* note 30, at viii; *see also* Sue A. Blevins, Cato Institute, *The Medical Monopoly: Protecting Consumers or Limiting Competition?*, POLICY ANALYSIS No. 246, Dec. 15, 1995, at 1.

This is undeniably a damning characterization. But it is, alas, substantiated by numerous statutes and regulations that do, in fact, transparently protect professional control (and income) with little or no focus on public protection.[36] Consider the following illustrations.

III. Scope-of-Practice Regulation in Action: A Few Examples

In 1992, the Georgia legislature enacted a statute,

> prohibit[ing] persons other than doctors, dentists, podiatrists, and veterinarians from performing any surgery, operation, or invasive procedure in which human or animal tissue is cut, pierced or otherwise altered by the use of any mechanical means, laser, ionizing radiation, medication administered by injection, or the removal of foreign bodies from within the tissues of the eye.[37]

Violation of the statute constituted a felony, punishable by a fine of between $500 and $1,000, or imprisonment from two to five years, or both.[38] The public need for and purpose of this provision were not readily apparent, to say the least. But the statute would have, among its many ramifications, mooted then-circulating proposals to increase the scope of practice of optometrists and advanced practice nurses. (It would also, by the way, have criminalized the legislators' later consumption of their chicken dinners.)

In expedited court proceedings[39] involving the Georgia Medical, Nursing and Optometric Associations and the Georgia Attorney General, the statute was declared unconstitutional for failing to meet even the most minimal requirements of due process and equal protection. As the Georgia Supreme Court noted:

> All parties concede that the literal language of § 43-34-1 violates due process and equal protection in that it is so broad that it prohibits much conduct that there is no rational basis to prohibit . . . , including the administering of shots by nurses, the self-injection of insulin by a

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36 For a succinct essay questioning the public-spiritedness of the health care licensing scheme, see Blevins, *supra* note 35, at 1. Judge Richard Posner, in a case reviewing an Illinois statute which prohibited psychologists from being included in hospital medical staffs, also stated, "[T]here is now a large body of scholarly literature which questions the wisdom of occupational licensure . . . . The scholars have found that governmental restrictions on the professions create barriers to entry, reduce competition, and raise professional incomes, without bringing about compensating increases in the quality of professional services." Ill. Psych. Ass'n v. Falk, 818 F.2d 1337, 1341 (7th Cir. 1987).

37 Miller v. Medical Ass'n of Ga., 423 S.E.2d. 664 (Ga. 1992) (citing GA. CODE ANN. § 43-34-46 (2001)).

38 § 43-34-46.

39 *Miller*, 423 S.E.2d at 664.

> diabetic, the drawing of blood, the piercing of ears, embalming, and the tattooing of skin, to name a few.[40]

Despite arguments by the Medical Association of Georgia, the court refused to craft a narrowing interpretation, finding that "the statute is so wide-ranging in its impact that we cannot possibly make one interpretation of the statute that we would be certain would render it constitutional and effectuate the legislative intent in enacting the statute."[41] This last observation necessarily draws into question the real purpose of the law—Had the court been able to identify any credible public safety rationale, it would not have been forced to rule out the possibility of reconciling the statute with minimal constitutional standards.

In contrast to the Georgia statute, which was clearly designed to limit even the most everyday practices to physicians alone, Ohio recently enacted a law[42] whose purpose was "to open up the market for patients who want to use acupuncture as complementary or alternative medicine."[43] (Before this time, not surprisingly, acupuncture had been the sole province of those licensed to practice medicine or podiatry.[44]) The new law tellingly attempts to blend innovative thinking with the deference historically accorded to medicine. It

- defines acupuncture,
- prohibits anyone other than a physician or acupuncture student from practicing acupuncture without a valid certificate of registration issued by the state medical board,
- limits the issuance of such certificates to people designated as Diplomats in Acupuncture by the National Certification Commission for Acupuncture and Oriental Medicine, and
- authorizes an acupuncturist to practice only under the general supervision of a physician who has made a written referral or prescription setting out the conditions or restrictions to be placed on the course of treatment.

Compared to what went before, this law is a vast improvement. It expands the universe of providers who may perform acupuncture and

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40 *Id.* at 665.

41 *Id.* (emphasis in original).

42 OHIO REV. CODE ANN. §§ 4762.01-4762.99 (West 2000).

43 Linda Lou, *Opening Paths for Acupuncture: More Therapists Now Licensed to Treat a Wider Variety of Ills*, THE PLAIN DEALER, July 30, 2001, at E1 (quoting Bill sponsor, Representative Kirk Shilling).

44 *See* State v. Rich, 339 N.E.2d 630, 632 (Ohio 1975) ("[T]he insertion of needles beneath the skin to alleviate pain, infirmity, or disease, commonly known as acupuncture, constitutes the practice of medicine within the meaning of [the medical practice act].").

protects the public by conferring the legal authority to practice on only properly trained professionals. But a careful re-reading of the statute reveals one glaring exception—physicians. The law explicitly exempts[45] physicians from having to demonstrate their competence in acupuncture as a condition of their authority to practice it. Yet, it allows nationally certified acupuncturists to practice only under the supervision of a physician, who need have no expertise whatsoever.

This scheme is truly remarkable in its exaltation of authority over ability. In their defense, we may surmise that the Ohio legislators assumed the requisite knowledge and expertise on the part of physicians, since acupuncture had always fallen within the broad statutory definition of "medicine." But any such assumption would be baseless in Ohio as elsewhere, because acupuncture is neither a standard part of medical school curricula, nor one of the subjects included in national medical licensing examinations. Furthermore, it is clear that the legislature did not assume such universal competence when it came to money: While all physicians are permitted to "supervise" acupuncturists to whom they refer patients, they are eligible for workers' compensation reimbursement for such referrals "only if the physician has attained knowledge in the treatment of patients with acupuncture, demonstrated by successful completion of a course of study in acupuncture . . . ."[46]

While this statute promotes the laudable goal of increasing public access to, and choice among, well-trained HCPs, it also illustrates several common pitfalls in the regulation of providers. To begin with, it vividly demonstrates the sometimes-absurd results that flow from a lack of congruence between HCPs' demonstrated ability and legal authority. Further, like the many statutes of which it is typical, it reinforces the supposed universality of "medicine" as defined by legislatures—a universality contravened by both everyday practice and common sense. Finally, statutes like this one perpetuate the professional ascendancy of medicine by legally enforcing physicians' dominance over all other HCPs. In Ohio, the public interest was undeniably served by the requirement that acupuncturists be demonstrably competent. It seems fair to suppose, however, that another purpose altogether was served by the additional provisions conferring supervisory authority on physicians while excusing them from even the most cursory requirement that they prove their own competence in acupuncture.

There are many other examples of what can happen when the law fails to distinguish between practice authority and clinical ability. One of them—podiatry—provides an especially vivid illustration of the almost-

45 OHIO REV. CODE ANN. § 4762.02 (West 2000) ("Certificate of Registration; Exemptions, (B) . . . this section does not apply to a physician . . . .").

46 OHIO REV. CODE ANN. § 4762.12 (West 2000).

comical extreme to which the logic of our current regulatory regime can lead. Podiatric physicians, originally known as chiropodists, are typically governed by practice acts defining the practice of podiatric medicine and surgery as "the diagnosis and the medical, surgical, mechanical, manipulative, and electrical treatment of ailments of the human foot."[47] This includes the authority to administer and prescribe drugs, and to use local anesthesia. Amputation of the toes and parts of the foot is usually permitted, but amputation of the entire foot is not.[48]

In the absence of further clarification, however, the legal question becomes: "what is a foot?" Does it include the ankle, or those tissues, ligaments and tendons connecting the ankle and the foot, or those leg bones (the tibia and the fibula) that terminate at the ankle or foot? This definitional question and the supplemental question of who decides it—the legislature, the podiatry or medical board, or the courts—have provoked a good deal of costly and time-consuming controversy. While the arguments sometimes seem to echo the old song about how "the leg bone is connected to the thigh bone," the resulting determinations have significant practical consequences for podiatrists.

According to the American Podiatric Medical Association, the foot is "a complex structure made up of 26 bones, [33] joints, 107 ligaments, and 19 muscles and tendons,"[49] and podiatric medicine involves "practice on the lower extremities, primarily the feet and ankles."[50] The association further notes that "podiatric physicians are licensed . . . to treat the foot and its related or governing structures . . . [and] the vast majority of states also include ankle care as part of the podiatric physician's scope of practice."[51] These statements by the professional association are both clear and descriptive; however, even they introduce additional ambiguities such as "related or governing structures" and "lower extremities." It is easy enough to understand why a professional association would so describe its own practice, because all professions would prefer to leave room for procedures and treatments arising out of expanded abilities. The more troublesome fact, for purposes of this Essay, is that these statements are no more obscure than many to be found in official podiatric practice acts.

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47 WASH. REV. CODE ANN. § 18.22.035(2) (West 2001).

48 *See, e.g.*, COLO. REV. STAT. § 12-32-101(3)(b) (2001) ("The 'practice of podiatry' does not include the amputation of the foot or the administration of an anesthetic other than a local anesthetic.").

49 Am. Podiatric Med. Ass'n, *Highlights*, *at* http://www.apma.org (last visited Apr. 8, 2002).

50 Am. Podiatric Med. Ass'n, *About the Association*, *at* http://www.apma.org/about.html (last visited Apr. 8, 2002).

51 Am. Podiatric Med. Ass'n, *Podiatric Medicine: The Physician, The Profession, the Practice*, *at* http://www.apma.org/podiat.html (last visited Apr. 8, 2002).

Several podiatry acts authorize diagnosis and treatment of "ailments of the human foot," without defining what is meant by the foot.[52] Unfortunately, however, any scope-of-practice regime that revolves around anatomical real estate rather than professional ability requires a degree of legislative specificity that is unlikely to be forthcoming, for reasons of both expertise (or lack of it) and politics. As a result, the task of articulating such anatomical definitions is thrust upon administrative agencies and courts.

The resulting processes and conclusions are seldom tidy or consistent. Most often, these issues arise when medical associations challenge the authority of podiatry boards to "fill in the gaps" by issuing rules[53] or declaratory orders setting forth what treatments are included within podiatry's scope of practice. Alternatively, these issues sometimes arise in malpractice cases centering on the question of whether a podiatrist's treatment of the ankle is outside the scope of practice and therefore constitutes negligence per se.

The agencies and courts that have grappled with these issues have been faced with a dual interpretive challenge: First, what is a foot? Second, is that determination a matter of law or of fact, and pursuant to a common or a specialized understanding? Two cases are illustrative.[54] In the first, the podiatry board of Connecticut had ruled that "the ankle is part of the foot, and the foot is part of the ankle,"[55] relying upon a requested attorney general's opinion that "whether the ankle is . . . part of the foot, or vice-versa"[56] was an issue of fact best decided by the board. Having thereafter determined (presumably as a matter of fact) that "the ankle and foot are inseparable,"[57] and that the term "foot" had a technical or anatomical meaning, the board concluded that podiatrists' scope of practice included treatment of the ankle. Upon review, however, the Connecticut Supreme Court disagreed, looking instead to the "well accepted and common meaning" of the term "foot," reflected in basic English dictionaries, as that portion of the anatomy which falls "below the ankle joint."[58] Under this analysis, the Court determined that the board had no special expertise

52 *See, e.g.*, TEX. STAT. CODE ANN. § 202.001(a)(4) (Vernon 2001); WASH. REV. CODE ANN. § 18.22.035(2) (West 2001).

53 *See, e.g.*, Bd. of Podiatric Med. v. Fla. Med. Ass'n, 779 So. 2d 658, 660 (Fla. Dist. Ct. App. 2001) (upholding a Board rule defining the statutory term "leg" to mean "the entire lower extremity, extending from the head of the femur to the foot, but does not include the hip joint").

54 Conn. State Med. Soc'y v. Conn. Bd. of Exam'rs in Podiatry, 546 A.2d 830 (Conn. 1988); Tenn. Med. Ass'n v. Bd. of Registration in Podiatry, 907 S.W.2d 820 (Tenn. 1995).

55 *Conn. State Med. Soc'y*, 546 A.2d at 831 n.2.

56 *Id.* at 831.

57 *Id.* at 837 n.7.

58 *Compare* Op. Tex. Atty. Gen. No. JC-0441, 2001 WL 1635277 (Dec. 17, 2001) (reaching the same conclusion that the Texas Podiatry Board exceeded its authority in issuing a rule that defined "foot" to include "the tibia and fibula in their articulation with the talus" but deeming the term "foot" to have acquired a "*technical meaning*" rather a common meaning. (emphasis added)).

which required judicial deference,[59] and it concluded that the board had contravened the legislature's intent by effectively expanding podiatry's scope of practice.

A Tennessee court reached a similar conclusion, finding both that the podiatry board's declaratory order (that treatment of structures adjacent to the foot was within the definition of podiatry) was not supported by substantial and material evidence, and that the board had exceeded its authority in attempting to expand the scope of podiatry.[60] In reviewing what one judge characterized as "a confused state of affairs,"[61] the court pointed out several examples of "inconsistent and contradictory" reasoning by the board, noting that

- "the ankle cannot be part of the foot if the foot is below the ankle,"[62] and
- "if the structures connect the foot with another structure, they obviously cannot be entirely within the substance of the foot,"[63] and
- "the ankle cannot be both a part of the foot and an adjacent structure."[64]

The accuracy (and, perhaps, profundity) of these statements by the court is not the issue. Rather, that there was a situation in which it was reasonably appropriate, and perhaps even necessary, to make them demonstrates the absurdity of the underlying legal scheme. In this case and the Connecticut case, the courts focused on parsing body parts as legal, factual, or mixed law-and-fact questions, and both courts deemed irrelevant evidence introduced in the boards' proceedings which demonstrated that podiatrists had long been treating ankle sprains in both states. While this disregard of evidence of clinical practice and ability was perhaps appropriate for judicial review of these particular administrative actions,[65] such legal

59 *But see* Jaramillo v. Morris, 750 P.2d 1301, 1306 (Wash. Ct. App. 1988) (holding that the term "foot" was *ambiguous*, and therefore the Podiatry Board's declaratory ruling interpreting treatment of the foot to include surgery on the ends of the tibia and fibula was entitled to "considerable judicial deference").

60 Subsequent legislative amendments to the Podiatry Act indicated that the Tennessee legislature concurred with the board's, and not the court's, interpretation of the scope of practice, as the definition of podiatry was expanded to include treatment of "the human foot, ankle and soft tissue structures . . . ," including "Achilles tendon repair." TENN. CODE ANN. § 63-3-101(a) (2000).

61 *See* Tenn. Med. Ass'n v. Bd. of Registration in Podiatry, 907 S.W.2d 820 (Tenn. 1995) (Todd, J., concurring).

62 *Id.* at 822.

63 *Id.* at 823.

64 *Id.*

65 *But see* Jaramillo v. Morris, 750 P.2d 1301, 1303 (Wash. Ct. App. 1988) (deferring to the Podiatry Board's expertise, noting with seeming approval reliance on evidence that the kind of surgery in question (on the ends of the tibia and fibula) was "common to a podiatrist's practice in Washington and nationwide").

niceties merely highlight the continued elevation of defined authority over demonstrated ability.

Ironically, a principal feature of a now-abandoned scope-of-practice scheme noted in the Connecticut Supreme Court's review of the legislative history of podiatry/chiropody regulation is far preferable to that embodied in many current laws. Prior to its repeal in 1937, the Connecticut Podiatry Act included in its practice statement the "treatment of functional disturbances of the feet as taught and practiced in the schools of chiropody recognized by the examining board."[66] Thus, the legal parameters of podiatry's practice authority were explicitly tied to the education and training of its practitioners. In this, ability and function guided legal authority and form, and, one assumes, issues turned not on judges' guesstimates of the "connection of the ankle bones to the leg bones," but rather upon the trained ability of podiatrists to treat these bones.

IV. Where Should We Go from Here? Some Recommendations for Change

Measures like these, combined with conflicting scope-of-practice laws and the inter-professional conflicts set in motion by history, demonstrate the overwhelming need for major policy changes. Given entrenched interests and almost-rote patterns of behavior, individual HCPs and their organizations will not eagerly embrace reform, but change is essential if "protection of the public" is to be anything more than a gossamer-thin disguise for professional self-interest embedded in law. It is therefore legislators and regulators who must take the lead.

One of the most urgently needed policy reforms is greater consistency in scope-of-practice laws. Instead of the widely disparate practice parameters encountered by most providers both between and within states, policymakers should promote uniform regulation for each profession. And the scope of practice conferred upon each should be as expansive as possible, consistent with safe and effective practice, for only then will health-care consumers reap the benefits of increased access to high-quality care at reduced cost. (And, in weighing alternatives, policymakers would be well-advised to look to the evidence of safe practice in those states "using the least restrictive practice acts for each profession."[67]) This approach would be consistent with—in fact, it would build upon—existing commonalities of education, training, and licensing examination standards within each profession. Increased uniformity would lead to greater understanding of professional roles and abilities among the respective

66 Conn. State Med. Soc'y v. Conn. Bd. of Exam'rs in Podiatry, 546 A.2d 830, 836 (Conn. 1988) (emphasis added).

67 TASKFORCE REPORT, *supra* note 1, at 28.

HCP groups and the general public, more options for consumers, increased mobility for providers, and optimal utilization[68] of the human and other resources that together make up our "health care delivery system." And the normative, rather than mandatory, nature of uniformity would guide the states, while preserving their traditional "responsibility for enacting and implementing practice authority legislation for the health professions."[69]

Increased uniformity must be accompanied by increased flexibility in the regulatory process in order to facilitate the functional expansion of existing roles and the recognition of emerging roles as health care continues to evolve.[70] Every regulatory scheme should include clear standards and mechanisms for the demonstration of expanded professional competence. This approach would accomplish three things. It would acknowledge the reality of ever-increasing knowledge and skills among all HCPs and spare legislators the headache of having to proceed as if each such occasion were the first and last. It would also eliminate the gymnastics now required of HCP groups who seek expanded scopes of practice but whose best evidence of competence is past practice that was, by definition, illegal. Additionally, the availability of such mechanisms, together with the articulation of standards for recognition, would at least partially re-align the balance between objective, practice-based assessments of competence and raw political power.

Finally, any attempt at reform must explicitly acknowledge, and accommodate, existing and evolving overlaps among the professional competencies of various HCP groups. It should by now be obvious that our "exclusive" scope-of-practice system has resulted in debilitating pathologies, both legal and practical. Indeed, if one steps outside of our own particular history, it is easy to see that a regulatory system will be deeply flawed from the outset if its fundamental purpose is to confer legal validation on the claims of private groups to exclusive ownership of various spheres of knowledge and competence. And the flaw is only magnified when such assertions of exclusive authority are legally defined to include an assumption of universal ability as to each member of the group. Such a system is factually unfounded, legally indefensible—and, let us remember, bad for the health of the American people. By perpetuating a "mine, and therefore not yours" practice culture, current laws erect, rather

68 *See* INSTITUTE OF MEDICINE, CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY (2001); *U.S. Health Care Delivery System Needs Major Overhaul To Improve Quality and Service*, NAT'L ACAD. NEWS, Mar. 1, 2001 ("America's health system is a tangled, highly fragmented web that often wastes resources by providing unnecessary services and duplicating efforts, leaving unaccountable gaps in care and *failing to build on the strengths of all health professionals*." (emphasis added)).

69 TASKFORCE REPORT, *supra* note 1, at 29.

70 *See generally* CATHERINE DOWER ET AL., CENTER FOR THE HEALTH PROFESSIONS, PROFILING THE PROFESSIONS: A MODEL FOR EVALUATING EMERGING HEALTH PROFESSIONS (2001).

than remove, barriers to inter-professional collaboration, practice, and respect. They also continue to divert attention and resources from the business at hand: seeing to the well-being of people who need health care, rather than refereeing among the claims of the various professionals who would provide it.

I have no doubt that policymakers seeking to effectuate these reform principles will encounter major opposition. After all, laws that emphasize uniformity, flexibility, and shared professional competence will threaten some, perhaps many, entrenched interests. Others will dismiss these goals as unnecessary or unachievable. While I hope that the necessity is by now obvious to readers of this Essay, it is appropriate to ask: "Is this doable?" Yes, it is, and I would like to close by offering two examples of reform efforts that have incorporated these goals.

V. Real Change Is Possible: Two Examples of Progressive Scope-of-Practice Regulations

A. *Colorado: Regulating Psychotherapy and the Mental Health Professions*

After dealing with years of disputes arising from conflicting prerogatives and scopes of practice, Colorado took full advantage of a scheduled "sunset review" to fashion an innovative regulatory scheme covering all mental health-care providers other than physicians. Among its many noteworthy provisions, the 1998 legislation[71] established public-member majorities on the boards charged with regulating each profession, articulated uniform grounds for discipline to be used by all boards, created the "Confidential Letter of Concern" as an additional disciplinary option available to boards, and mandated the disclosure of specified information[72] to clients. These aspects alone would warrant special praise because they address many of the concerns that have long been associated with professional licensure generally.[73] The truly remarkable provisions of the legislation, however, seek to resolve some of the thorny scope-of-practice problems described above.

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71 COLO. REV. STAT. ANN. § 12-43-201-710 (West 2002).

72 § 12-43-214.

73 *See, e.g.*, TASKFORCE REPORT, *supra* note 1, at v-vi.

Recommendation 3—Individual professional boards in the states must be more accountable to the public by significantly increasing the representation of public, non-professional members. Public members should be at least one-third of each professional board.

Recommendation 4—States should require professional boards to provide practice-relevant information about their licensees to the public in a clear and comprehensible manner. Legislators should also work to change laws that prohibit the disclosure of malpractice settlements and other relevant concerns to the public.

To begin with, the legislative drafters recognized that the regulation of HCPs does not have to be an all-or-nothing proposition. Rather, they understood that statutory requirements governing various provider groups can and should be directly tied to the goal of forestalling harm to the general public. The legislation therefore establishes gradients of regulation: Psychologists, professional counselors, marriage and family therapists and social workers are licensed or registered (depending upon education, training, successful examination and degree of independence or supervision), while unlicensed psychotherapists are listed in a state-compiled database.

For the licensed or registered HCP groups, the legislation confers the legal right to use particular titles and articulates the scope of practice applicable to each category. Significantly, the scopes are phrased broadly ("includes, but is not limited to"[74]), and one actually provides for continued professional evolution by adding that the "practice also may encompass other current or developing modalities and techniques that are consistent with this scope."[75] Furthermore, while practice in each group is limited to license-holders, their scopes of practice are shared or overlapping, rather than exclusive: "Nothing in this article shall be construed to prohibit any member of any other profession who is duly licensed or certified pursuant to the laws of this state from rendering service consistent with his or her training and professional ethics"[76] or "to prevent the practice of psychotherapy by unlicensed persons who are listed with the state . . . ."[77]

In addition to providing for licensed or registered mental-health professionals, the law also acknowledges and seeks to regularize the practice of unlicensed psychotherapists and extends some regulatory oversight to their activities.[78] No unlicensed psychotherapist may practice in Colorado unless listed in a state database maintained by the State Grievance Board.[79] To be listed, applicants must meet minimum requirements of education, experience or examination,[80] including completion of a jurisprudence workshop and examination. These practitioners are subject to the same requirements of confidentiality and

74 COLO. REV. STAT. ANN. § 12-43-403(2) (West 2001).

75 § 12-43-406(1).

76 § 12-43-219(1).

77 § 12-43-505(5).

78 § 12-43-701(3). The definition of "psychotherapy" includes "treatment, diagnosis, testing, assessment, or counseling in a professional relationship" of mental, emotional, relational, attitudinal, conditions. The definition contains the following statement: "It is the intent of the general assembly that the definition of psychotherapy . . . be interpreted in its narrowest sense to regulate only those persons who clearly fall within the definition set forth in this subsection."

79 § 12-43-702.5(3).

80 § 12-43-702.5.

privileged communications that govern other mental-health professionals, and to the same grounds for discipline.[81]

What has the Colorado legislation accomplished? A great deal, indeed. First, it has led to a reduction in the number of formal and informal intra/inter-professional turf squabbles between mental health professionals. In addition, the law establishes a comprehensive, appropriately nuanced, scheme for the regulation of mental health-care providers. It defines the practices of the various disciplines without limiting the ability of other groups to practice their professions. It provides for the evolution of professional abilities by framing the scopes of practice broadly. And it protects the public by extending the imperative of confidentiality to all regulated providers; by mandating disclosure of information concerning therapeutic methods and techniques, as well as likely duration and cost; by providing for the appropriate discipline of practitioners, whether licensed or unlicensed; and—remember the fundamental purpose of licensure?—by offering a reliable indicium of who is trained and able to do what. The rightness of this legislative approach is captured in one of the law's general provisions, which speaks directly and clearly to the all-too-uncommon reconciliation of legal authority and professional ability. It says simply this: "Notwithstanding any other provision of this article, no licensee, registrant, or unlicensed psychotherapist is authorized to practice outside of or beyond his or her area of training, experience, or competence."[82]

This provision is as sensible as it is extraordinary. By defining practice authority in terms of ability, this law correctly reorients the regulatory focus from providers' status to their training and skills. This is a simple conceptual shift, but it is essential to the project of regulatory reform. The Colorado legislation should inspire policymakers in other states as they seek to improve their own laws governing HCPs.

B. *Ontario: The Regulated Health Professions Act*

In 1991, the province of Ontario, Canada enacted the long-considered and precedent-setting Regulated Health Professions Act[83] ("RHPA") that established a wholly new regulatory framework for all of the health-care professions. Among its stated objectives were promoting high-quality care, making the regulated health-care professions accountable to the public, giving patients access to HCPs of their choice, and achieving regulatory equality by making all HCPs adhere to the same purposes and public-interest principles.

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81 § 12-43-222.
82 § 12-43-202.
83 The Regulated Health Professions Act, R.S.O., ch. 18 (1991) (Can.).

In pursuit of these objectives, the RHPA "shift[ed] from profession-centered regulation to public interest regulation,"[84] and replaced a regulatory framework that some legislators had described as a congeries of individual practice acts reflecting "monopolistic scopes of practice"[85] (discussed more fully below). Indeed, one of the RHPA's "central organizing concepts," designed to promote flexibility and ensure the provision of quality care, "[was] the replacement of monopolistic or exclusive scopes of practice with a system of controlled acts. These controlled acts can be authorized to two or more professions where their scopes overlap."[86]

The RHPA established a common organizational and operational framework for regulating Ontario's twenty-three regulated health-care professions. It simultaneously created a new body, the Health Professions Regulatory Advisory Council (none of whose members may be regulated HCPs) that continuously evaluates regulatory effectiveness and advises the Minister of Health and Long-Term Care on needed reforms.[87]

The RHPA's common framework is complemented by (1) a procedural code that applies to all HCPs, and (2) a series of separate, profession-specific enactments authorizing each professional regulatory College[88] to set and enforce standards for their individual professions. The net result is a creative and comprehensive scheme that should be of broad interest to policymakers committed to progressive regulation.

For purposes of this Essay, however, I wish to focus especially on the RHPA's provisions addressing scope-of-practice issues, which include a number of innovative and effective features. As the drafting committee noted in explaining its rationale, the then-current regulatory system had both failed to protect the public and discouraged flexibility and innovation.

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84 Rob Alder, *Foreword* to HEALTH PROFESSIONS REGULATORY ADVISORY COUNCIL, ADJUSTING THE BALANCE: A REVIEW OF THE REGULATED HEALTH PROFESSIONS ACT (2001) [hereinafter ADJUSTING THE BALANCE].

85 HEALTH PROFESSIONS LEGISLATION REVIEW COMMITTEE, GOVERNMENT OF ONTARIO, STRIKING A NEW BALANCE: A BLUEPRINT FOR THE REGULATION OF ONTARIO'S HEALTH PROFESSIONS (1989) [hereinafter STRIKING A NEW BALANCE].

86 ADJUSTING THE BALANCE, *supra* note 84, at 18.

87 This Council has many of the features of the National Policy Advisory Group recommended in the Pew Taskforce Report. *See, e.g.*, TASKFORCE REPORT, *supra* note 1, at 11-13, 27-29.

> Recommendation 1—Congress should establish a national policy advisory body that will research, develop and publish national scopes of practice and continuing competency standards for state legislatures to implement.
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> Recommendation 7—The national policy advisory body . . . should develop standards, including model legislative language, for uniform practice authority acts for the health professions. These standards and models would be based on a wide range of evidence regarding the competence of the professions to provide safe and effective health care.

88 These Colleges are somewhat akin to a combination of state licensing boards and professional associations in the United States.

The new scheme, in contrast, was "based on the principle that the sole purpose of professional regulation is to protect the public interest," and not to enhance any profession's economic power or to raise its status.[89] In effectuating this principle, the RHPA abandoned the previous licensing acts that had conferred an exclusive scope and right of practice on each health-care profession. These various acts were replaced by a multi-faceted scope-of-practice mechanism that draws upon both the general framework and the profession-specific acts described above. This regulatory mechanism, which consists of five components, has now operated successfully for almost a decade. And a formal multi-year review of the system's effectiveness reflected unanimity on the scope-of-practice provisions: "One of the more notable findings to emerge from HPRAC's consultation process was the fact that no submissions suggested that the RHPA controlled acts system should be discarded or that Ontario should return to the previous system of monopolistic or exclusive scopes of practice."[90]

The first component is a series of statutory scope-of-practice statements—one for each of the regulated professions—which set out "what the profession does; the methods it uses; [and] the purposes for which it does it."[91] The Nursing Act statement, for example, reads as follows: "The practice of nursing is the promotion of health and the assessment of, the provision of care for, and the treatment of health conditions by supportive, preventive, therapeutic, palliative, and rehabilitative means in order to attain or maintain optimal function."[92] Such statements, by providing a context for each profession's practice, are equally valuable to the public, government regulators, and the professions themselves. Most importantly, these statements do not claim or confer "exclusive" practice authority for any one profession; rather, they recognize overlaps in practice. They say only "this is what we do," not "this is what we do, and therefore no one else can do it." This non-exclusive approach acknowledges that other health-care professions can provide the same services through overlapping practices. And, by so acknowledging, this approach forestalls many of the "turf" issues that bedevil regimes based upon mutual exclusivity.

The second and third components of Ontario's scope-of-practice mechanism, "controlled acts" and "authorized acts," are clearly interrelated. Together, they add up to a fundamental and remarkable transformation of regulatory policy by shifting the focus from who to what

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89 STRIKING A NEW BALANCE, *supra* note 85, at 13-14.

90 ADJUSTING THE BALANCE, *supra* note 84, at 19.

91 STRIKING A NEW BALANCE, *supra* note 85, at 3.

92 An Act Respecting the Regulation of the Profession of Nursing, R.S.O. ch. 32, § 3 (1991) (Can.).

is potentially dangerous to the public—a far more relevant and objectively answered question. By thus shifting its focus, the legislature was able to identify a number of health-care activities that, by their very natures, pose a significant risk of harm if not performed by qualified providers. The RHPA specifies thirteen such activities as "controlled acts."[93] They include, for example, setting or casting a bone fracture; prescribing, dispensing, selling, or compounding a drug; performing a procedure on tissue below the dermis; and managing labor or delivering a baby. Controlled acts may be performed only by regulated providers authorized to do so by their own profession-specific acts.[94] Services or activities not falling within the ambit of one or more of these controlled acts are deemed to be in the public domain and may therefore be performed by anyone.

This concept of controlled and authorized acts is central to the RHPA framework. It eliminates the old exclusive-scope-of-practice scheme and explicitly allows for shared authority over controlled acts, as between two or more health-care professions, if their relevant professional knowledge and skills overlap.[95] Thus, some regulated professions—dieticians, for example—have no authority to perform controlled acts, while other professions are authorized to perform a few or many. And even if a profession as a whole has the authority to perform a controlled act, the profession's College may still determine that a given individual or class within the profession should not be permitted to do so.

The last two components of RHPA's scope-of-practice mechanism are the "title protection" and "harm" clauses. The former clause provides that only members of each regulated health-care profession may use certain specified titles and prohibits anyone else from either using, or claiming to possess the qualifications signified by, those titles. The "harm clause"[96] is something of a safety net, designed to cover potentially dangerous services not explicitly encompassed by the controlled acts provisions. It imposes limits on the giving of any health treatment and

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93 The Regulated Health Professions Act, R.S.O., ch. 18, § 27(2) (1991) (Can.).

94 Controlled acts can be delegated, as appropriate. *See* §§ 27-30; *see also* The College of Physicians & Surgeons of Ontario, *Policy Statement #1: The Delegation of Controlled Acts*, *in* MEMBERS' DIALOGUE, special insert (1999), *available at* http://www.cpso.on.ca/Policies/delegation.htm (last visited Apr. 28. 2002).

> The RHPA requires the physician to confine medical practice to those areas of medicine in which he or she is suitably trained and experienced. Since the physician is under an obligation to delegate the performance of controlled acts only where it is clinically appropriate and necessary in the circumstances, it follows that a physician may only delegate those controlled acts for which he or she personally has the required knowledge, skill and judgment to perform.
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> Therefore, it would be inappropriate for a physician to delegate to someone else the performance of a controlled act he or she is not capable of performing personally, and which does not form part of his or her regular practice and daily competence.

95 ADJUSTING THE BALANCE, *supra* note 84, at 18.

96 § 30(1).

advice "in circumstances in which it is reasonably foreseeable that serious physical harm may result." Uniquely, the harm clause applies "to unregulated practitioners and the general public as well as to regulated health professionals acting outside their scope of practice."[97]

With the RHPA, Ontario has created a sophisticated and effective mechanism for regulating health-care providers' scopes of practice. Several of the law's individual features are remarkable in their own right—particularly its focus on controlled acts rather than exclusive scopes of practice. Taken together, they add up to a regulatory system that should be (and has been[98]) a model for policymakers charged with protecting the public's health and freedom of choice while containing costs and promoting professional evolution within the health-care professions.

Conclusion

I hope I have succeeded in offering practical insights for policymakers to use in their continued struggle with proposed reforms in the regulation of health care providers. By understanding the origins and continued effects of the "first in time, first in right" dynamic produced by the omnibus medical practice acts, and by recognizing that there are models that both value public protection more than professional prerogatives and allow clinical ability to guide legal authority, policymakers can be better positioned to promote truly effective changes in the scope-of-practice laws. And the influence of these laws permeates the entire health care system. The availability of competent, affordable health care surely depends on many factors, but chief among them must be the rationality of the education, utilization and payment systems for the human care providers. Reconfiguring the practice laws will not address all the daunting health care issues, but it will correct a widespread, needlessly wasteful, and continually divisive problem.

While I am optimistic that these reforms can be accomplished, my experience cautions against exuberance. Some of the reasons are well-captured in a remarkably pertinent article, entitled *Will Disruptive Innovations Cure Health Care?*[99] that was published not long ago by two physicians and one professor of business administration. Let me conclude by sharing some of their comments, which echo my own thoughts.

From their opening statement that "[h]ealth care may be the most entrenched, change-averse industry in the United States,"[100] to their

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97 ADJUSTING THE BALANCE, *supra* note 84, at 34.

98 *See, e.g.*, Health Professions Act, R.S.A., ch. H-7 (2000) (Can.).

99 Clayton M. Christensen et al., *Will Disruptive Innovations Cure Health Care?*, HARV. BUS. REV., Sept.-Oct. 2000, at 102.

100 *Id.* at 102.

concluding observation that "disruption is the fundamental mechanism through which we will build a higher quality, more convenient, and lower cost health care system,"[101] these authors have reinforced the central themes of the scope-of-practice tussles I have reviewed. Extracting lessons from patterns of industrial innovation,[102] they note that disruptive innovations—that is, "cheaper, simpler, more convenient products or services that . . . meet the needs of the vast majority of users"[103]—have over time "been one of the fundamental mechanisms through which the quality of our lives has improved."[104] These sorts of innovations take hold by "enabling a larger population of less-skilled people to do in a more convenient, less expensive setting things that historically could be performed only by expensive specialists in centralized, inconvenient locations."[105]

How do these lessons apply to health care generally, and to scope of practice specifically? The authors offer several examples:

> We need diagnostic and therapeutic advances that allow nurse practitioners to treat diseases that used to require a physician's care . . . or primary care physicians to treat conditions that used to require specialists.[106]
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> As specialist physicians continue to concentrate on curing the most incurable of illnesses for the sickest of patients, less-skilled practitioners could take on more complex roles than they are currently being allowed to do. Already, a host of over-the-counter drugs allow patients to administer care that used to require a doctor's prescription. Nurse practitioners are capable of treating many ailments that used to require a physician's care. And new procedures like angioplasty are allowing cardiologists to treat patients that in the past would have needed the services of open-heart surgeons.[107]

In reviewing the effects of these kinds of innovations in the treatment of diabetes and coronary artery disease, the authors note efficiency gains, "But more important, no compromises in quality were made."[108]

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101 *Id.* at 112.

102 Examples include personal computers (rather than mainframes), the telephone (rather than the telegraph), photocopying (rather than printing), and the box camera (rather than the black-cloaked, tripod-bound, professional behemoth).

103 Christensen, *supra* note 99, at 104.

104 *Id.* at 105.

105 *Id.*

106 *Id.* at 106.

107 *Id.*

108 *Id.*

If such innovations can produce high quality care in more efficient and convenient ways, why aren't they more widely embraced? "Unfortunately, the people and institutions whose livelihoods they threaten often resist them."[109]

> Take nurse practitioners . . . . [M]any states have regulations that prevent nurse practitioners from diagnosing diseases or from prescribing treatment that they are fully capable of handling. The flawed rationale behind such policies is that because nurse practitioners are not as highly trained as physicians, they are not capable of providing care of comparable quality. This is the same logic that minicomputer makers used to discredit the personal computer. When a physician diagnoses a simple infectious disease, the patient uses only that fraction of the physician's training that relates to simple infectious diseases. Studies have shown that nurse practitioners with comparable training in simple infectious diseases can provide care of comparable quality . . . even though they lack training in more complex disorders.[110]
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> Some nearsighted advocates of patients' rights assert that nurse practitioners might not have the judgment to recognize when a disorder is beyond their expertise. But family practice doctors recognize when they can treat a disorder and when it merits referral to a specialist. Surely nurse practitioners . . . can . . . do the same thing. The real reason for blocking such disruption, we suspect, is the predictable desire of physicians to preserve their traditional market hegemony.[111]

In one final observation particularly salient for our purposes, the authors pointedly note the difficulty in overcoming the inertia of regulation:

> Attempts to use regulation to stave off disruptive attacks are quite common . . . . Unfortunately, regulators are inclined to be even more protective of the entrenched professions and institutions in health care . . . . The links between those institutions, federal and state regulators, and insurance companies are strong; they are wielded to preserve the status quo. (Nothing else could explain why nurse practitioners are forbidden from diagnosing simple illnesses in so many states.)[112]

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109 *Id.*
110 *Id.* at 108.
111 *Id.*
112 *Id.* at 112.

Although it may be somewhat unorthodox to quote so extensively from another article, I have done so because the authors of *Disruptive Innovations* have beautifully captured the essence of the obstacles to meaningful policy reform in the scope-of-practice context. It is my hope that, by acquainting policymakers with the historical foundations of the current regulatory framework and its shortcomings, and by offering some principles and models upon which they might usefully rely in designing the needed reforms, this essay will help to illuminate the way forward.