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Defining the Scope of Nursing Practice: Actors, Criteria and Economic Implications

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To Subscribers:

A portion of Professor Hershey's article was misprinted when it originally appeared (Vol. 1, No. 7, August-September 1980). The entire article is correctly printed here in a 4-page supplement which may be inserted or pasted in the proper issue. The editors apologize for any inconvenience caused by the error.

This article provides a framework for consideration of two questions: who should decide the scope of professional nursing? and what criteria should be employed in determining the scope of professional nursing? It is my view that professional as well as practical considerations must be reconciled in determining the answers to these questions.

The Role of Legislation

Licensure legislation determines who is a professional nurse as far as the law is concerned, and it does that quite well. The legislation also defines the scope of professional nursing practice for certain purposes, and it does that rather imprecisely. It does not define the scope of professional nursing practice so that practitioners of the profession, practitioners of other health professions, administrators of health services organizations, and the public at large, can easily agree on an answer when specific practice questions are raised. But is it reasonable to expect that a group of legislators sitting in Boston, or Harrisburg, or some other state capitol can do so? They recognize that the nature and scope of nursing practice will change over time and that each modification in practice for professional nurses need not be controlled by specific legislation.

Legislators function subject to many constraints and limitations. Because of the interaction of many organizations and individuals which seek to affect the definitions of practice in licensing legislation for their own benefit, the process of writing a definition is laden with political difficulties. Various professions and occupations struggle to protect their turfs from incursions by other competing professions and occupations and, at the same time, to expand their areas of practice onto the turfs of their competitors.

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This is the way things are, and part of the answer to the question of who should decide the scope of professional nursing practice is that it can not be the profession of nursing alone, even if one believes that nursing could speak with one voice. When one accepts the fact that legislation itself is not decisive on many issues with regard to the scope of professional nursing practice, the question becomes: who should participate in the ongoing process of refining and redefining the scope of professional nursing in a changing environment?

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The Role of State Agencies, Officials, and Associations

Historically, several legal processes have been employed in defining the scope of professional nursing practice. The courts have done so in disposing of litigation concerning alleged malpractice on the part of professional nurses. They have also done so by their decisions concerning whether nurses have violated the medical practice act, or some other licensing legislation in the state, as well as in determining whether persons not licensed as professional nurses have violated the nursing practice act by engaging in activities reserved by mandatory legislation to professional nurses.

State associations, implementing the concept of joint practice determinations, have also provided clarifications or refinements of legislative definitions of professional nursing in dealing with specific activities and functions. The attorneys-general of many states have also participated in the definition of professional nursing through their responses to questions submitted by legislators, state boards, and various other state agencies. State nursing boards, acting separately as well as in conjunction with other state licensing boards, particularly state boards of medicine, have engaged in this definition process.

In 1964 I authored a short monograph entitled *Toward Better Definition of Nursing*, in which I urged that nursing and medical boards together resolve issues of whether nurses could engage in activities ostensibly on the border of, or within, the definition of medicine, and not necessarily encompassed by the legislative definition of professional nursing. I was strongly influenced by the naive view that the medical and nursing boards, as organs of the state, were the most appropriate bodies to make these decisions. I felt that they would or could have the authority to stimulate experiments that would demonstrate the safety and efficacy of nurses performing activities which raised scope of practice questions under strict interpretation of legislative language, and to evaluate their results. Service on the state medical board in Pennsylvania for approximately five years has left me less than enchanted with my proposal. I have seen scope of practice issues handled by the state nursing board and the state medical board in Pennsylvania in a fashion that strongly suggests the inability of the members of the state boards to provide answers to these questions. Not all the difficulty derives from motivation to protect professional turf or enhance a profession's stature. Much of it stems from lack of understanding of the relevant factors or criteria for making such decisions. As a nonphysician member of the medical board, I felt that while I was less aware of the detail of determining whether a nonphysician would be qualified to carry out specific functions, as a "public" person, I could add the dimension of the public's interest in the deliberations.

The presence of public members on licensing boards is an increasing national trend. It is likely that the quality

of responses to scope of practice issues will be enhanced when persons who are not in the regulated professions participate more heavily in the activities of the state licensing boards.

Criteria for Decision

No matter who will decide scope of practice questions, it is vital that the criteria used be understood. As an illustration, consider a question actually submitted to state boards with regard to the appropriate scope of professional nursing practice. A teaching hospital seeks to determine whether professional nurses, trained in the procedure, could remove bone marrow for biopsy purposes. The reason that the hospital desires to have nurses perform the procedure is that there are insufficient physicians, either on the regular staff or in training, to perform all of these procedures which are required. The hospital seeks to make better use of personnel and also to reduce costs since the cost of the service might well be less if it were performed by a professional nurse rather than by a physician. Assume that there are professional nurses employed at the hospital who are willing to undertake preparation so that they can perform this procedure, and that some, if not all, of these nurses are sufficiently competent and qualified to master the procedure so that they will perform it at least as well as the physicians who currently are performing the procedure. Are there any reasons to determine that this procedure should not be recognized as legally within the scope of professional nursing, with the understanding that not all nurses will automatically be qualified to carry out the procedure merely because the procedure is now to be defined as within the scope of professional nursing practice?

The first criterion is **the public interest**. If the procedure can be performed by professional nurses at a level of skill equivalent to that of physicians, particularly if the cost to the health system will be no greater and perhaps less, it would appear from the public interest perspective that a redefinition or interpretation of the state licensing laws to permit nurses to carry out such a procedure is warranted. Some physicians will recognize that to so expand the scope of nursing practice might ultimately decrease employment opportunities for physicians, and will argue against expanding nursing practice.

Some nursing boards would say the question is, "Is the procedure professional nursing?" and answer "No, it is medicine." They would go on to say that since it is the practice of medicine, there is nothing further for the boards to do about the subject. These nurses may believe that recognition by them that nurses could, let alone should, perform such procedures will destroy or adversely affect an aspect of professional autonomy. The very process of seeking medical board concurrence or agreement on the subject may mean to them that the nursing profession is accepting the idea that the medical profession, to some extent, may define the scope of professional nursing. Their position may be simply that nurses should not enter upon areas recognized within the practice of medicine, and that their role is to define or expand professional nursing in its independent or autonomous areas only, not in the area of the diagnostic and therapeutic activities that physicians order. But a second criterion, **the economic position of nurses**, must be considered.

On a purely pragmatic economic basis, expanding the procedures nurses may legally perform can only enhance the opportunities for better compensation. In an ideal sense, perhaps, this shouldn't be the case. But the world we all live and work in is far from ideal. More importantly, if professional nurses are barred from performing bone marrow aspiration, and physicians are not sufficiently available to perform the procedure in the necessary volume, then, as has been the case time and time again, a technician or therapist will emerge as the delegate of the physician to perform the procedure, and also to do some traditional nursing as well for the patient, and nursing will be powerless to interfere. Note that nothing prevents individual nurses from making personal decisions not to perform traditionally medical tasks.

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Some nurses may believe that if nurses expand their technical tasks they will be neglecting the planning, counseling and other pure nursing functions. However, technical tasks and support and counseling of patients are inextricably intertwined. Consider bone marrow aspiration once more. Is it not to the advantage of the patient to have the practitioner who performs the procedure be also one who can and is willing to speak with understanding and compassion about the procedure and the condition that requires the procedure to be performed, and who can assist the patient in dealing with his fears?

Thus, expansion of the scope of nursing practice to include some aspects of medical practice can serve the public interest and can serve the economic interests of nurses as well. Are there countervailing factors?

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Autonomy vs. Economic Realities

Currently there are pressures for some nurses to expand their practice to encompass ordering of medication for patients, including even the writing of prescriptions. This is the result, in part, of the development and legal recognition of nurse practitioners. An expanded role is now countenanced by much of the medical profession for nurse practitioners. In Oregon, the state medical board will grant prescribing authority to nurse practitioners who meet certain standards, for medications included within a formulary developed jointly by a council on which nurses, physicians and pharmacists sit. Is this nursing? Perhaps not, because the state medical board has the statutory authority to suspend or revoke the prescribing privileges if abused. On the other hand, if nurses can possess such authority, what once was exclusively medicine has become a shared or joint function. If it is safe for patients, we should applaud the development, although it does depart from the ideal of nursing autonomy as some conceive it. In this illustration the legislature, medicine, nursing and pharmacy all participate in creating the expanded role for nurse practitioners.

A recent court decision[1] has raised a tricky issue regarding nurses following PRN orders, which has implications for the expansion of the scope of professional nursing practice into traditional medical practice areas. The California court has held that the nurse, in deciding whether to administer the medication, is held not to the standard of a member of the medical profession but to that of nurses. To the extent this suggests a "lower" standard of care, the result may be to discourage this type of delegation to nurses. Many lawyers in the health field take the view that a nurse should be held to the standard of

the medical profession in carrying out any functions or duties that are generally recognized as within medical practice. The rationale for this position is that, assuming the medical standard to be higher, the public interest is not served by acceptance in any form of the notion that an appropriate utilization of nurses is to lower the quality of service patients are entitled to receive. *This would appear to be the view nursing should adopt.*

There have been a host of statements pointing to the shortage of professional nurses in many parts of the United States. In some communities, such as Pittsburgh, a number of hospitals are relying upon agencies and registries to provide professional nurses, because the hospitals are unable to hire adequate numbers of qualified persons to meet their stated complement of professional nurses. Use of agency nurses is not a very healthy development because it appears that a good many nurses who work through the agencies lack the appropriate degree of commitment to the patients at the institutions where they provide services. Agency nurses move from one institution to another frequently and they often fail to develop the necessary rapport with, and interest in the patients that they serve; continuity of nursing care is lost.

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Why is it that the shortage of licensed professional nurses is so severe? It was reported in HOSPITALS,[2] a publication of the American Hospital Association, that although more than 2,000,000 persons in the United States have received nursing licenses, the total number of nurses providing direct patient care is between 350,000 and 400,000, and many of these hold supervisory positions. This state of affairs may be a reflection of the inadequate compensation provided to many professional nurses who work in health institutions, and the conditions in which they work. The environment in which many hospital nurses work cannot be radically changed, particularly in an era of cost containment. But nurses should be sensitive to the economics and the practical elements of the environment. As a short term step, nursing needs to consolidate the position of professional nurses within health organizations, because the alleged nursing shortage may well be the result of nurses deciding that there are greener pastures than long term employment as professional nurses in hospitals. The education and experience of a professional nurse can be used, at least as a strong base, for work other than service to patients.

The relationship of these realities to scope of practice decisions is: if nurses *are not willing and able to assume responsibilities* and perform tasks that arguably fall within the definition of medicine, even though a legitimate case can be made to encompass them within professional nursing, reorganization of services within hospitals will accelerate. The results of the reorganization will be to emphasize the roles of a plethora of technicians and therapists, and diminish further the status of professional nurses and the need for them. Increased utilization of licensed practical nurses and nurse aides and orderlies will accompany this.

No one can state with certainty whether such a development would be good or bad for professional nursing, but it is my impression that professional nursing is likely to suffer if that development takes place. In that context professional nurses will be performing almost exclusively the independent, autonomous duties of professional nurses, as recognized in the basic definitions of nursing in the nursing practice acts. But there may be an element of delusion because, as autonomous and independent as some professional nurses may see themselves because of some statutory definitions, as salaried employees in almost every work setting professional nurses lack the kind of autonomy that marks some other professions. What makes a profession autonomous is not how the profession is defined in the law or within a larger societal context, but how well the individual professionals within the profession can control their access to clients, on one hand, and the money for the services rendered on the other. This is not to deride the quest for autonomy by professional nurses; it is only to suggest that it is not the only goal for which nurses should strive.

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There are many categories of technicians, therapists and technologists in health institutions who earn more than staff nurses, although they have no more, and often less, post-secondary school education. And for most of them, weekend, evening and night shifts are rarely, if ever, necessary. For example, at a hospital with which I am familiar the entry salary for nurses with a B.S. degree in nursing is $12,600 per year. A radiologic technologist's entry salary at this hospital is $14,019, and a registered physical therapist enters at $16,300. *The radiologic technologist* has less post-secondary education than the baccalureate nurse, the registered physical therapist has the same amount as the nurse. The professional nurses at this hospital who are relatively well compensated are those who are qualified to perform extra corporeal technology — perfusion techniques — which suggests that, whether it is just or unjust, "doctor's work" pays better than "nurse's work," even when it is performed by nurses.

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In this context the comparable work theory of job evaluation should be mentioned. Very briefly, the theory is that women have been relegated by employers to lower paying jobs, and that a dual wage structure (paying men more than women for work of comparable value to the employer) constitutes sex based discrimination under Title VII of the Civil Rights Act of 1964. Increasing the overlap of professional nursing with medicine in terms of functions and tasks, given the great disparity between physician and nurse compensation paid by health services providers, might be useful in establishing that nursing (female) jobs have been consistently underevaluated compared to physician (male) jobs. Court tests of the theory have been few so far, and mostly unsuccessful,[3] and the impact of licensure of many health professions, with different statutory definitions, is unclear. Nevertheless, the effect of the articulation of the theory upon the health services industry could still be substantial, by influencing the evaluation of nursing services and wage structures of health services providers.

Consider again the criteria for answering the scope of practice question. Will it usually be difficult to determine whether professional nurses can become qualified to perform particular tasks and procedures at an acceptable level in terms of public protection? Past experience suggests it usually will not.

The reason is that before such a question is raised for consideration at the state level, there has already been a fairly substantial number of the procedures performed by nurses or other non-physicians. Thus, there is already a working hypothesis that professional nurses can be prepared to perform the procedures. Almost any time such a question is submitted to a state board by a legitimate provider institution or organization, one might assume that the objective answer with respect to the public interest criteria — safety and efficiency — is yes. However, that does not guarantee that the public interest criterion will be given serious attention. The board, or boards, may be dilatory in responding, or answer in the negative, because their agenda is different. A state nursing board deliberating on a scope of practice issue should, if the board is not going to restrict itself to the public interest criterion, at least not adopt a negative position regarding expansion of nursing into medicine, with the belief that its position is good for professional nurses working on the firing line. The state medical board, if it is participating, and the attorney-general, if consulted, can usually be relied upon for a negative view.

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One additional comment concerns the exercise of discretion by nursing boards in carrying out their disciplinary functions. There appears to be a willingness on the part of some nursing boards to pursue disciplinary action against professional nurses in situations when the facts, ascertainable by a thorough investigation, would indicate such action was unwarranted. In *Tuma v. Board of Nursing*,[4] the nurse had been charged with interfering with the physician-patient relationship by discussing alternative treatments with the patient, and thus engaging in unprofessional conduct. Although the Idaho Supreme Court decision in favor of the nurse was based on a strictly legal issue, there is a hint in the court's opinion that the court did not believe the nurse had done anything warranting disciplinary action. A Pennsylvania court[5] found, upon review of the evidence, that a nurse, reprimanded by the state nursing board for slapping a patient's hand, was justified because the patient had failed to release his grip on the nurse's arm after the nurse had both asked him to let go and attempted, unsuccessfully, to pry his fingers loose. The question may well be asked: do some nurses, when serving on nursing boards, lose the ability to understand what comprises the real world of nursing?

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Conclusion

In articles by nurses, and statements at conferences about nursing by nurses, the remark is often made that "nursing is its own worst enemy." You don't see or hear that remark about medicine or law by these professions as frequently. Perhaps it is because the leadership of these professions have taken the view that their members could do everything they claimed they could, or at least didn't seek to circumscribe role development. How many times has a medical practitioner of modest, or even declining skills become the chief executive or medical director of a hospital, because a physician can do almost anything? How many attorneys have served as executives in both the private and public sectors without any preparation apart from law study and practice? A physician once asked me — his question was tinged with venom — why it seemed that only an attorney could ever serve as Secretary of Health, Education and Welfare, particularly since attorneys knew little about any of the three?

An article with the engaging title, *The False Professionalism: Professionalism in Nursing*, emanating from an aggregation of nurses called the Boston Nursing Group contains this statement:

> As nurses, we have the goals of better patient care and better working conditions. We decided to look beyond nursing, at the rest of the hospital. Who else shares our problems, and our goals? And why are these goals so difficult to achieve?[6]

All nurses probably share these goals, and most would like to know the answers to the questions. When a scope of practice question arises respecting whether nurses can provide services generally viewed as medicine, the answer should be viewed (if these goals are those of nurses) in the light of these goals. Generally, expanding the scope of nursing will be consistent with these goals. Assuming any flexibility in the statutory definitions, the actions of nursing as a profession should be to make certain that nurses, willing to provide the services, are given the opportunity to do so and are assisted to attain such additional education or training as is necessary. Nurses should leave the raising of legal and other impediments to others; there are enough of those folks around already.

References

1. *Fraijo v. Hartland Hospital*, 160 Cal. Rptr. 246 (1979).
2. HOSPITALS 54(1):18 (January 1, 1980).
3. *IEU v. Westinghouse Electric Corp.*, 19 FEP Cases 450 (1979) (unsuccessful); *Gunther v. County of Washington*, 20 FEP Cases 792 (1979) (successful); *Lemons v. City and County of Denver*, 10th Cir., No. 78-1499 Apr. 21, 1980 (unsuccessful).
4. 593 P.2d 711 (1979).
5. *Leukhardt v. Commonwealth of Pennsylvania*, 403 A.2d 645 (1979).
6. SCIENCE FOR THE PEOPLE, p. 23, May-June 1978.