Shifting Boundaries in Health Care

Scope of practice is at the center of the discussion.

At least since 1859, when Florence Nightingale first published *Notes on Nursing: What It Is and What It Is Not*, nurses have struggled to describe the ways that nursing differs from medicine. But factors like rapid advances in medical therapies and technology, demographic shifts, an aging population (some healthier than ever, some sicker), and a global sensibility regarding the need for better health care delivery systems are making those differences even harder to identify. In fact, boundaries between the health professions are becoming *more* permeable, not less.

Task shifting. Although the concept of task shifting should be familiar to nurses, who've taught skills and delegated work to nursing assistants for decades, the term has come to have a broader, more formal meaning and a more official standing worldwide, as organizations attempt to address health care issues in resource-poor settings with grave shortages of health care providers, particularly nurses and physicians. The Global Health Council describes task shifting as the process of "realistically and responsibly shifting tasks to health care workers or others who are trained to deliver a specific set of services."

In the United States, nurses are slowly but surely expanding into primary care practice, which had previously been the bastion of physicians; an estimated 158,000 advanced practice nurses (APNs) were practicing in the United States as of 2008, and 84% of them had a master's degree, according to the 2008 National Sample Survey of Registered Nurses (read the final report at http://bit.ly/t8T0oN). By 2010, about 152,000 APNs had "national provider identifier" numbers (an acquisition that simplifies the process of direct billing of health insurers). This trend has been boosted in part by economic challenges, U.S. health care reform, and the recommendations in the Institute of Medicine's 2010 report, *The Future of Nursing: Leading Change, Advancing Health*.

The task shifting trend is reaching not only upward and downward but sideways, sparking enthusiasm in some cases and turf wars in others. In some states, for example, certified nursing assistants are working with school nurses. And in most states pharmacists can administer certain medicines, such as vaccines. In some hospitals, pharmacists are making rounds to explain medications to patients.

Anne Robinson, BSN, RN (left), observes as Kevin Creek, a community paramedic with the Western Eagle County Ambulance District in Eagle, Colorado, assesses a patient in her home. Photo courtesy of seanfboggs.com.

The Community Paramedic Program. Pilot paramedic programs are springing up in rural areas nationwide. Part of the Community Paramedic Program, developed by the North Central EMS Institute in St. Cloud, Minnesota, these pilot programs involve paramedics visiting patients in their homes. The goal is to provide better access to health care and reduce visits to the ED. Not everyone in nursing is happy with this trend, yet as far back as 2006 even the National Council of State Boards of Nursing (NCSBN) acknowledged that "overlapping scopes of practice are a reality in a rapidly changing health care environment." That report, *Changes in Healthcare Professions' Scope of Practice: Legislative Considerations*, also declared, "No one profession actually owns a skill or activity in and of itself." The document was the outcome of a collaboration of six health care regulatory organizations: nursing, medicine, occupational therapy, pharmacy, physical therapy, and social work.

Scope-of-practice concerns. Scope of practice is a very real issue worldwide. The International Council of Nursing says that, "unless planned with

nurses, task shifting and adding new cadres of assistive personnel may result in fragmented, unsafe and inefficient service." And scope-of-practice concerns was the first topic in 2006 testimony given by Linda Hamilton, BSN, RN, then president of the Minnesota Nurses Association, opposing the way a bill regarding the Community Paramedic Program in her state had been phrased. "How is the role of a community paramedic NOT public health nursing without a nursing license?" she asked. (Despite her arguably valid question, the bill passed in the Minnesota legislature and was signed into law on April 6, 2011.) According to the NCSBN, the only valid criterion for determining scopes of practice is whether a health care professional is qualified to perform functions safely without the risk of harm to the public.

And doing what's best for the patient is exactly what Community Paramedic programs are all about, according to Anne Robinson, BSN, RN, who was recently the public health nurse manager in Eagle County, Colorado, where a new Community Paramedic pilot program began last June in collaboration with the Western Eagle County Ambulance District. When *AJN* asked Robinson what she thinks about scope-of-practice issues between nurses and paramedics, she said the relationship is "not competitive but supportive." She explained: public health nurses in Eagle County, and in much of rural Colorado, have to travel fairly long distances between patients. "It takes six to nine months to replace one public health nurse," she said, and having paramedics available to help with home visits can "free nurses up to assess and identify health needs in the community and push larger policy issues."

COLLABORATIVE CARE VS. AUTONOMY

It may be asked whether collaborative care and autonomy are mutually exclusive. Probably not, says at least one study published in a supplement to the December 2001 issue of *Quality in Health Care* by Rafferty and colleagues. The researchers found that the nurses whose jobs involved more teamwork also had greater autonomy and were also more involved in decision making. The authors couldn't determine definitively which factor—teamwork or autonomy—was the reason for the positive findings, and they surmised that there is a synergistic interaction between the two.

Some physicians are also beginning to see the value of other professionals in primary care. Towle and colleagues recently concluded, in a report in the September 2011 *Journal of Oncology Practice*, that the presence of nonphysician practitioners (NPPs, defined as NPs and physician assistants [PAs]) in a collaborative practice model contributed to high patient, physician, and NPP satisfaction, as well as to a 19% improvement in productivity, which strongly supported the use of NPPs in oncology practices. And in the October 2011 issue of *Pediatrics*, Freed and colleagues reported on a survey of almost 500 U.S. pediatricians and found that 25% planned to increase the use of NPs in their practices over the next five years.

Cautious optimism. Disasters are just one of the arenas in which different health care providers may be called upon to use a variety of skills in less-than-ideal circumstances, but some are leery. As the American Nurses Association's 2008 report *Adapting Standards of Care Under Extreme Conditions* cautioned, "A dentist does not become a surgeon, a nurse does not become a pharmacist, a physician does not become a radiation technologist." Robinson counters that it helps to understand exactly what emergency medical technicians (EMTs) and paramedics do within their scope of practice. She suggests that others who take issue with Community Paramedic programs go on a "ride-along" to better understand. Those who can't or who still don't trust may find it comforting to know that EMTs and paramedics in all 50 states require licensure to practice and that in most states, certification by the National Registry of Emergency Medical Technicians is required; also, some states have separate certification requirements, much like the state board licensure variations in nursing.

WHERE ARE WE HEADED?

Nurses now have support to deliver health care fully within their scope of practice, while acquiring skills that once had been the purview only of physicians. Likewise, says Robinson, paramedics are striving to deliver care within *their* scope of practice, "just in a different setting." Even the 2006 NCSBN report leaned toward less rigid boundaries among the professions: "It is no longer reasonable to expect each profession to have a completely unique scope of practice, exclusive of all others." The report also pointed out that what often gets lost in debates on scope of practice is consideration of whether changes designed to improve access to health care services also protect the public.

Even Nightingale might have agreed that those historically firm boundaries between the health care professions seem destined for oblivion. It just may be that, in today's dynamic health care environment, there's little room for hierarchies of any kind. Robinson thinks that nurses can be role models, demonstrating what can be accomplished as we take in the big picture in health care. "What's really important is breaking down barriers," she says, which will help us, ultimately, "to determine what's best for the patient."—*Gail M. Pfeifer, MA, RN, news director* ▼