

Scope of Practice and the Nurse Practitioner: Regulation, Competency, Expansion, and Evolution

Tracy A. Klein, MS, WHCNP, FNP

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Nurse Practitioners: Defining Scope of Practice

Nurse practitioners (NPs) are one of the few healthcare providers mandated by their role and practice to carry what amounts to 2 licenses to practice. All NPs must first be trained and recognized by their state of practice with the registered nurse (RN) license. They are then additionally state- and/or nationally certified in their advanced practice specialty and role. As an NP, your scope depends upon basic education as a nurse combined with additional specialized training. This entitles you to practice in areas beyond the scope of the RN, such as diagnosing and prescribing.

An NP may be held to many standards, and therein lies the confusion. Who do you turn to when you have a question regarding your scope of practice: your employer, professional association, collaborating physician, nurse practice act, Medicare provider, or insurance carrier? All can and do play a role in defining the scope of healthcare in terms of permitting what you *may* do. But what about what you are able to do, or what your patient *wants* you to do? How each state handles scope-of-practice questions varies, although general principles cross all lines of practice.

The purpose of this article is to evaluate current mechanisms for credentialing and recognizing scope of practice for NPs. Each NP, whether governed by state regulations providing for independent, supervised, collaborative, or other practice requirements, is independently responsible for his/her patient care. This article will help you sort out some of the ethical and practical questions you should ask yourself when faced with a scope-of-practice decision.

What Influences Scope of Practice?

What is scope of practice? Scope can be defined as the activities that an individual healthcare practitioner is permitted to perform within a specific profession. However, as noted by the Federation of State Medical Boards, even the wide scope of the physician is pressured by "factors including: fluctuations in the health care workforce and specific health care specialties; geographic and economic disparities in access to health care services; economic incentives for physician and non-physician providers, and consumer demand."^[1]

The Institute of Medicine (IOM), in its report titled *Health Professions Education: A Bridge to Quality*,^[2] calls for competency-based education and interdisciplinary practice models for the future. Some advanced practice nursing specialties, such as midwifery and nurse anesthesia, have decades-long histories of uniform accreditation and competency-based education. Physician assistant education has also developed under a single accrediting body, core curriculum, and board certification mechanism since the 1970s. The NP role, however, evolved in a more fragmented fashion, and curriculum standardization and accreditation standards followed, rather than directed, education.

The development in 2002-2004 of the National Organization of Nurse Practitioner Faculties core competencies for several NP specialties offers a framework for specialty education as an adult, family, gerontological, pediatric, women's health, or psychiatric mental health NP. All NPs should be familiar with these important documents. However, these competencies, although they are useful, address the entry-level NP. What about the evolution of practice as the NP expands his or her competency within his or her scope? Experience and environment can and will stretch the NP's knowledge and competency beyond that of the basic education level.

Scope of Practice: Why NPs Should Be Concerned

Scope of practice determines who you can see, who you can treat, and under what circumstance or guidance you can provide this care. Scope of practice also determines the limits and privileges of your licensure and certification as an advanced practice nurse. In the United States, scope of practice determines your ability to bill and be paid for what you do, as well as your ability to be covered by malpractice insurance. Significant liability issues are created when NPs practice outside of their scope.

According to Nurses Service Organization (NSO) claims data in 2004,^[3] practicing beyond scope accounted for 6% of all claims filed. Scope also determines the "minimum standard" of competency for a provider with like knowledge and training in a given specialty; 32% of NSO claims in the same report pertained to "failure to meet minimum standards." If you are the only NP practicing in cardiology in your state, you may have some opportunity, by virtue of your unique status, to shape the minimum standard for your specialty. More concerning, however, is the potential for physicians and physician-controlled groups to set the standards for your practice. At best, these standards may mandate physician supervision to assure and determine your competency and credentialing

to practice. At worst, lacking a defined body of specialized knowledge, board certification, or other credentialing mechanism to measure the NP in their specialty, the standard of your practice could be determined to be the same as that of the cardiologist!

Although initially envisioned as a primary care role, the increasing opportunities for NPs to practice in acute-care and subspecialty settings are generating more questions in the area of credentialing. Conversely, NPs who begin their professional career in a more narrowly defined practice arena, rather than establishing broad training and competencies, may limit their scope to the degree that mobility is difficult. This has led many NPs to pursue post-Master's degrees and dual specialty certifications as a mechanism to expand practice. While academically supervised clinical and didactic training is an established route to expand scope and the competencies within a scope, the increase in training to expand scope (with its plethora of letters signifying various certifications and licenses) has served to increase rather than decrease barriers to uniform credentialing processes.

Regulatory Structure

Nursing practice is defined and regulated, first and foremost, by the Nurse Practice Act in each state. Although multistate practice privileges for RNs are now a reality in states that have adopted the Nurse Licensure Compact (19 so far as of July 2004),^[4] only Utah has approved the compact for NPs. Until this process of allowing your home state license to carry across state lines (much as a drivers' license does) is more widespread, NPs must hold an individual certificate or license to practice in each state where they see patients. Each state, in turn, has something to say about your scope of practice.

State-by-state certification or licensure creates unique issues in practice confusion. As an example: NPs in Oregon can independently prescribe Schedule II-V narcotic medications with their own DEA number and without a collaborative agreement. Between August 2001 and July 2005, NPs could prescribe Schedule II-IV drugs in Washington only if they had a mandatory joint practice agreement (JPA) with a physician. The JPA was required to be approved by the state's nursing commission. This change in the law came only after more than a decade of lobbying despite the fact that since 1979 NPs had been prescribing controlled substances independently in the bordering state of Oregon. A law passed in 2005 eliminated the JPA requirement and allows Washington NPs to prescribe all controlled substances independently as of July 24, 2005.

This begs the question: "Is mandatory collaboration a predictor of safety, or should collaboration and accountability instead be the professional standard upon which nurses (and physicians) help develop and expand their scope and competencies?" I would argue that collaboration, in itself, does not define the NP's unique scope.

Independent, Collaboration, Supervision: How is Your Scope Regulated?

Recently, NSO stated that 14 states permit NPs to practice independently, while 23 states require some type of collaborative agreement as a condition for practice, and 13 states still use supervisory language in their practice act.^[3] All practice models require that the provider know, be accountable for, and function within their scope of practice. The umbrella of supervision, collaboration, or delegation can never be used to replace scope and individual responsibility.

The terms "independent," "collaboration," and "supervision" vary widely in interpretation and regulatory definition. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) defines an LIP, or Licensed Independent Provider, as "any individual permitted by law and by the organization to provide care and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges."^[5] Recent acknowledgement by JCAHO in their Medical Staff Handbook of the LIP role of the NP offers support for hospital privileges based upon the NP's individual credentials, training, competency, and scope, rather than using the proxy of supervision as the primary eligibility requirement.

Credentialing. The American Nurses Association recently began an examination of the credentialing process for nurses. This includes analysis of the use of standardized forms and any barriers these forms may create in the development of assessment models for advanced nursing that focus on nursing rather than medical models of training and competency.

Collaboration. The Federation of State Medical Boards^[1] confirms that the "American Medical Association does not have an official definition of collaboration." In 1994, the American Nurses Association endorsed the statement that collaboration involves physicians and nurses working "together as colleagues, working interdependently within the boundaries of their scope of practice."^[1] Collaboration is regulated as a mandatory relationship between 2 providers, generally a physician and an NP in many states, though the structure of this regulatory relationship varies greatly. Collaboration is still the most common model of regulatory requirement for NPs practicing in the United States as of this writing.

Delegation. Delegation is still used to define NP practice in a few states. Delegation typically allows a licensed provider who practices independently to permit certain functions to be performed under his or her supervision by another person who does not have them expressively provided for in their own practice act. This is a model used to identify the legal relationship between physicians and medical assistants or other unlicensed persons. While delegation may still be the legal requirement in your state, the training and competencies inherent in your degree of education will hold you to a higher standard than a subordinate employee. The practice of delegation also does not permit you to practice in areas that are outside of your scope.

According to the Federation of State Medical Boards: "Delegated services must be ones that a reasonable and prudent physician using sound medical judgment would find appropriate to delegate and *must be within the defined scope of practice both of the physician and the non-physician practitioner* [emphasis mine]."^[1]

It would seem then, that whether your state requires you to practice under supervision, delegation, collaboration, or as an independent practitioner, you are always responsible to practice within your scope. Having a physician supervise, cosign, or otherwise endorse a practice or task that is not within your legal and professional scope does not make it within your realm of practice. This is principle number one in defining your scope of practice as an NP.

Principle 1: Scope is uniquely defined by the congruence between law and appropriate practice.

Models of Practice: Existing Scope Models

A survey of 7 state Boards of Nursing who use a Scope of Practice decision tree model to help define parameters for practice was done. States selected were Washington, Kentucky, Georgia, Maine, Louisiana, Oklahoma, and Nevada, and were accessed through their Web sites at <http://www.ncsbn.org>. These decision tree models were then compared with 2 other scope-of-practice documents from other professions: the Ontario Professional Foresters Association's Policies and Guidelines: Scope of Practice^[6] and the American Dietetics Association's The Scope of Dietetics Practice Framework.^[7] Four of the states specifically identified advanced practice in their decision tree as differentiated from the basic RN level.

Common factors were identified in all scope-of-practice decision trees. The 2 factors common to all documents were:

- Clinical competence/skill
- Knowledge/training

The second highest-ranking qualities in these models were:

- Acceptance of responsibility/consequences
- Organizational policies and procedures
- Professional standards

The third ranked mechanism offered was the option of seeking an advisory opinion from the Board or organization to clarify areas of confusion or precedence.

Despite the focus on evidence-based research and practice safety by the IOM and other national advisory groups, only 4 of the decision trees referred to the use of research to support a scope determination, usually in connection with the request for an advisory opinion. Nonetheless, as pointed out by the IOM report, *Crossing the Quality Chasm: A New Health System for the 20th Century*,

All health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics.^[8]

NPs can anticipate that expanding practice and scope will be expected to have support from evidence-based research, such as pilot studies and federal waiver demonstration projects. Data addressing areas of practice ambiguity can also be gained from experience in other healthcare systems such as that in the United Kingdom, which uses nurses in an expanded role to provide many services.^[9]

"Supervision" was the lowest ranking mechanism stated to define individual scope of practice in the decision tree models. It was present in only 1 practice decision tree, referencing the basic level of nursing practice. This leads us to the second principle regarding scope of practice:

Principle 2: Supervision does not, in itself, define scope of practice for the professional in fields that have a specialized body of knowledge, skill, and competency.

Boards of Nursing are charged with protecting the safety of the public through the promotion of safe practice. Professional standards and associations help further define the ethics and application of practice in the appropriate setting. An ability to accept responsibility for the patient through establishment of a client/patient relationship, documentation, and follow-up is a cornerstone of practice within your scope.

Principle 3: Ethics guide scope through individual ability to accept and manage consequences, in accordance with safe standards of practice.

Scope of Practice: Models of Application

The scope of practice for the advanced practitioner does not well lend itself to the typical decision tree model. However, several principles combined with indicators already identified in the decision tree model can be used to offer a framework of questions that can help shape the unique scope of practice for the NP.

The more specific the question and the less defined the area of practice, the more likely it is that an advisory or other formal opinion should be sought from your licensing authority. Ill-defined areas of practice also offer opportunities to engage in supporting research that may clarify areas of overlapping scope or serve to define new fields of opportunity.

Lack of competency in any one of the following domains (see [Table](#)) excludes the practice from your scope by definition. Several sample questions will be answered at the end of this paper to illustrate the application of this guided self-inquiry.

Scope of Practice: Common NP Questions and Answers

The following questions represent a cross-section of issues that face NPs in today's practice environment. Several are taken from actual questions submitted to Medscape. Despite the differing practice regulations from state to state, the framework of self-inquiry using principles discussed in this article can be applied to each situation.

I am a family NP (FNP) and am wondering if I can work as a non-advanced practice RN at a local nursing home? I plan to function as any other RN. Would I be held to higher liability standards?

From a regulatory standpoint, you are always legally entitled to work under your RN license, as long as it is current and you meet all RN requirements. However, insurers agree that someone with advanced practice training and certification needs to be insured at the higher level, regardless of position. See the NSO newsletter answering this topic at: <http://www.nso.com/newsletters/advisor/2000/np/npra5.php#qa>.

Role validation is a large component of scope. If you take such a job, you will need to ensure that the role validation of the RN, rather than that of the NP, is the face you hold out to the public. The setting where you are employed can also help match your role validation, by keeping your job title, job description, duties, and activities crystal clear. The most conservative advice would be to avoid working in areas that *share* the specialty of your advanced practice focus (such as a nurse midwife working as a labor and delivery nurse). Taking such a position is asking for role confusion, and that, in turn, affects your ability to practice appropriately with your patients.

Should an NP who is educationally prepared as an acute care NP work in an adult primary care setting?

The answer is no. The acute care NP program prepares graduates for a specialty focus in acute, episodic, and critical conditions that are primarily managed in a hospital-based setting. The program of study does not contain adequate clinical and didactic content to support the ACNP for a broader role in outpatient primary care diagnosis, treatment, and follow-up. Diagnosis and outpatient management of stable and unstable chronic illness, as well as directing health maintenance of a wide range of conditions, is a required competency for practice in the primary care role.

Additionally, professional licensure and certification will reflect validation that the provider has met criteria for practice in a focused, rather than broad, scope of practice. Finally, the environment of primary care is not congruent with the acute care secondary or tertiary care training focus. A lack of congruence between the practice environment and level of expertise results in a decreased level of safety for the patient and increased risk of liability for the NP.

Is it within the scope for an FNP to diagnose and treat uncomplicated mental health conditions like depression, anxiety, and ADHD?

The answer is yes, in the context of primary care, and at the level of competency and skill expected for the FNP standard of practice. The context of primary care means that you are seeing this patient for health needs and the depression or anxiety is clearly diagnosed to be situational, acute, and/or potentially responsive to medications. The competency and skill preparing the FNP for practice does not include differential diagnosis of complexities such as unipolar vs bipolar depression, or anxiety related to underlying psychiatric conditions as an example. If you are prescribing medications for a condition that you cannot clearly diagnose (or support the established diagnosis with documentation), treat, follow, and monitor to a level of stabilization and beyond, you are practicing outside of your scope. Atypical or off-label prescribing for a mental health condition would be considered a subspecialty role requiring greater expertise and competencies.

Most practice acts provide for *time-limited* stabilization of a patient or continuation of psychiatric medications that a patient has been taking for a diagnosed condition. Initiating diagnosis of a complex condition that has consequences for schooling, job, and military records, such as ADHD, is out of the scope of training and competency for the typically educated FNP. Collaboratively arriving at a diagnosis and treatment plan with a mental health provider trained and licensed to diagnose mental health conditions may be one possibility for initial diagnosis and for periodic management.

I am a psychiatric mental health NP (PMHNP), working in a VA health system. My patients wait a long time to see their primary care provider. Can I treat a rash that I see and prescribe hydrocortisone? Does it make a difference if this medication is over the counter?

The answer is a qualified perhaps. Do you have clinical and didactic training in your preparation, including physical assessment, to evaluate the differential diagnosis of the rash? Are you familiar with all of the medications the patient is taking as well as other health conditions such as liver disease? What type of follow-up visit and examination can you offer this patient if the rash is not getting better? Is the rash secondary to a condition that you are treating such as a reaction to medications you have prescribed? If so, treatment may be appropriate in the context of your care of the patient. However, since you are not available or designated as this person's provider for their other medical conditions, it would be difficult to identify on what basis you have chosen to treat (and feel yourself qualified to treat) some conditions and not others.

There have been several licensing disciplinary cases related to both FNPs treating mental health conditions and PMHNPs treating primary care conditions. In the case of the FNPs, many were not licensed or clinically trained to differentially diagnose beyond the very basic self-limited mental health conditions, yet had prescribed medications such as antipsychotics or had mistakenly given selective serotonin reuptake inhibitors to patients with mood disorders who they thought had simple self-limited depression. Lack of access to mental health providers (or primary providers) may be an issue, but it does not change the requirement to get your patient to the most appropriate provider to coordinate their care. For the PMHNP, coordinating or initiating treatment for primary care conditions without the knowledge of a primary care provider can be a significant area of risk to the patient and to your license.

I practice in a specialty area of surgical oncology and benign breast disease, and have teenage patients referred to me. Since this is a specialty area of practice, can I see patients under the age of 18 years as an adult NP?

The answer varies depending upon which state you practice in. If you had no clinical and didactic training in patients under the age of 18 years, it may be difficult to identify how you developed expertise in the presentation and management of illness in this age group. However, many programs include an adolescent practicum, and many states support practice scope for adolescents based upon this. It would also be important to be able to support how you developed expertise in differential diagnosis of breast conditions in this age group, since hormonal and physiological variations are in stark contrast to the older female patient. Your level of expertise and safety in treating the specific condition (such as fibrocystic breast disease) may enable you to be a consultant to the patient's primary care provider regarding patient management, regardless of whether the patient is 18 years or 35 years of age.

I would like to set up a practice reading x-rays. Does my license permit this?

The answer is no, unless you have additional licensure and training that qualifies you as a specialist. The NP scope of practice generally provides for ordering and evaluating laboratory results. Again, however, this is in the context of *provision of care for that patient in the specialty in which you are trained and licensed*. Specific functions, such as reading x-rays to screen for gross abnormalities, are different from the level of expertise required to read x-rays for a diagnostic outcome on a focused and ongoing basis. This would demand additional training and validation of competency. Currently, the standard of practice in this field is established by the training and competencies of the radiologist. Meeting this standard would be extremely challenging, given the basic preparation for primary care and lack of supervised preceptorships, internships, or other specialized training mechanisms. Holding oneself out to the public as an expert in reading x-rays without a mechanism to meet the competencies for practice validation is poor clinical practice.

I am an adult NP working in a collaborative practice in allergy. The collaborating physician sees children under 13 years of age. Can I provide follow-up care or write prescriptions for these children?

The answer is no. Again, you have a certain degree of expertise in the condition and treatment of the disease specialty. However, an adult NP clearly has no academic training that would support seeing children below the age of adolescence, regardless of the presence of a collaborating or supervising physician. A physician, as per the Federation of State Medical Boards, also has no foundation to delegate care for a condition that he or she knows is not in the scope of practice for the NP. If the collaborating physician is collaborating to the extent that they are making the determination or taking the responsibility for the diagnosis, then that physician should be seeing that patient.

We would like to hire a geriatric NP to work in the ER. What is the problem if she sees a 25-year-old patient with hypertension, since she has expertise in treating this disorder?

The scope-of-practice issue in this question concerns differential diagnosis. The symptom of hypertension in an 80-year-old vs a 25-year-old signifies an entirely different list of possible etiologies and treatments. Without the foundational clinical and didactic training in this population, an NP with geriatric training cannot demonstrate validated competency and skill in safely determining what is

causing this potentially worrisome symptom in a young person. Scope for the geriatric NP, based upon licensure, national certification, and standards of practice, clearly excludes this population for treatment and care regardless of setting.

I am a pediatric NP who has expertise in congenital cardiac conditions. Many of these patients are now in their 20s, seeing internists who may not be familiar with their condition. Can I still see these patients?

The answer is a qualified yes. A pediatric NP who has expertise in diagnosis and treatment of a condition that presented in a pediatric patient and for which he or she has an established relationship, should be able at minimum to serve a consultative role for that patient's medical condition in adulthood. However, managing this patient in the absence of any primary care or internal medicine provider would be clearly out of your scope of practice. If you practice in a state that bases scope of practice strictly on national guidelines that have a defined age limit for practice, you will need to discuss this issue further with your state Board. NAPNAP has supported the existence of specialty circumstances that allow for possible treatment of patients older than 21 years, through their scope and standards statements.

Expansion and Evolution of Scope

Expansion and evolution of scope is inevitable in all professions. The RN working at the entry level now performs many of the specialized procedures and patient care activities previously reserved for physicians. As the RN role evolved into more specialized nursing practice, the advanced practice nursing role expanded as a way to provide greater access to primary and preventive care. Now, opportunities continue to open up for advanced practice in acute and specialized care, including mental health. Will NPs be able to demonstrate that such training is within their scope, and will they be able to obtain what they need to expand their competencies within their scope as their expertise evolves?

The American Association of Colleges of Nursing has declared its support of the clinical doctorate as the entry standard for NP education.^[10] This expanded model acknowledges the need to include a possible internship within the educational framework. Increasing scope by adding specialty certifications and post-Master's training is one mechanism, but it can be ultimately burdensome in terms of number of credits and time spent for nondegree study. Other developments on the horizon include the potential for multistate licensure and practice, and recognition of the NP training and role in other countries. All of these forces will serve to drive increasing examination of scope and core competencies.

These changes will not make some of the questions NPs face any easier. A practitioner can expect more, rather than less, questioning from credentialers, consumers, and employers as they try to incorporate new degrees and new roles. The basic principles of safe and ethical practice, however, should remain a constant, whether an NP practices independently, collaboratively, or in a rural or an urban area. Self-examination and reflective practice, through examination of the scope domains listed in this article, should help guide NPs throughout their career and in any setting in which they practice.

Links for More Practice Information

Information regarding individual Boards of Nursing and their practice acts can be found at Medscape Nurses (see Related Links) or through the [National Council of State Board of Nursing Web site](#). The [DEA](#) also has information on NP prescriptive authority from state to state for controlled substances, as does Medscape's map of NP prescriptive authority (see Related Links).

Related Links

External Links

- [Institute of Medicine](#)
- [National Organization of Nurse Practitioner Faculty \(NONPF\)](#)
- [Joint Commission on Accreditation of Healthcare Organizations](#)
- [Nurses Service Organization](#)

Library/reference resources

- US Nurse Practitioner Prescribing Law: A State-by-State Summary
<http://www.medscape.com/viewarticle/440315>
- Boards of Nursing in the United States: State-by-State Web Links
<http://www.medscape.com/viewarticle/482270>

Resource Centers

APN Business and Law
<http://www.medscape.com/pages/editorial/resourcecenters/public/apn/rc-apn.ov>

Tables

Table. Scope of Practice: Domains and Questions

Domain: Knowledge

- Did I complete a program that prepared me to see this population (family, adult, pediatric) of patients?
- Did this program include supervised clinical and didactic training focusing on this population?
- Did I complete a program that prepared me for subspecialization (acute care, geriatric, neonatal)? If so, is the patient in question in that category?
- Do I have the knowledge to differentially diagnose and manage the conditions for which I am seeing this patient?

Domain: Role Validation

- Am I licensed to practice in this role?
- Is additional licensure or certification required to do this skill on an ongoing or specialized basis?
- Do professional organizations define this role through specialty scope statements and criteria or standards of practice?
- Do professional standards support or validate what I am doing?
- How do I "hold myself out" (define my role) with the public? Do my qualifications, training, and licensure match this?
- Is the information regarding my training easily accessible and can it be validated to the public, healthcare credentialing staff, facilities, and other interested parties?

Domain: Competence and Skill

- What are the clinical competence/skills required to treat this condition?
- Have I been trained to differentially diagnosis this type of patient?
- Did this training include clinical and didactic training?
- How have I achieved and demonstrated competence?
- How have I maintained competence?
- What is the standard of a practitioner in this field and do I meet it? Do I meet these standards on a limited or broad basis?
- Have I completed a specialty preceptorship, fellowship, or internship that qualifies me beyond my basic educational training?

Domain: Environment

- Does the environment that I work in support this scope or practice through structures such as staffing, consultation, policies and procedures, protocols, and community standards?
- Am I an expert, novice, or midlevel provider in this field? Do my credentialing to the public and my consultative network match this?
- Is access to care an issue? Will I be facilitating or impeding access to the best trained professional?

Domain: Ethics

- What are the potential consequences of accepting treatment responsibility for this patient?
- Am I prepared to accept and manage the consequences of my diagnosis and treatment, or do I have a formally established relationship with a provider who is so trained and immediately available?
- If I am not the primary care provider, will my provision of care be shared with this person?
- Is the safety of the patient at acute risk if I do not act?
- Will the safety of the patient be compromised if I do act?
- Is there a personal or formal relationship with this patient that would potentially affect my ability to provide or to deny care?

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Author

Tracy A. Klein, MS, WHCNP, FNP

Tracy A. Klein, MS, WHCNP, FNP, Adjunct Faculty, School of Medicine & Nursing, Oregon Health Services University, Portland, Oregon; Nurse Practitioner, Kartini Clinic, Portland, Oregon; Advanced Practice Consultant, Oregon State Board of Nursing; Public Policy Chair, American College of Nurse Practitioners

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Editor

Susan Yox, RN, EdD

Site Editor/Program Director, Medscape Nursing, Medscape

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