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Scope of practice regulation in medicine: balancing patient safety, access to care and professional autonomy

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ABSTRACT

Scope of practice regulation in medicine is crucial for ensuring patient safety, access to care and professional autonomy. This paper explores the impact of scope of practice regulation on healthcare delivery, professional responsibilities and patient outcomes. It discusses the variability in standards for safe practice, the challenges in defining boundaries between medical specialties and the recent controversies in cosmetic surgery practice. The paper also examines the potential benefits and drawbacks of rigorous scope of practice regulations, including their impact on clinical innovation, flexibility and access to care. Furthermore, it delves into the implications of defensive medicine and the consequences of restrictive regulations on patient care. The author proposes implementing a proactive, national, artificial intelligence-powered, real-time outcome monitoring system to address these challenges. This system aims to cover every patient undergoing a surgical procedure and could be gradually extended to non-surgical conditions, benefiting all key stakeholders in the health system. The paper emphasises the need for a balanced approach to scope of practice regulation to avoid stifling clinical innovation and professional autonomy, while ensuring patient safety and professional accountability.

Keywords: health law, health policy, hospitals, litigation, medical negligence, performance and evaluation, professional autonomy, quality and safety.

Scope of practice regulation for medical practitioners plays a pivotal role in ensuring the delivery of safe and effective healthcare. Scope of practice can be defined at the group level for a discipline and at the level of the individual doctor. For all interventional procedures, the question of which specific training and skill level is required before a procedure can be safely performed by an individual doctor without supervision is somewhat arbitrary. Therefore, it is unsurprising that the standards for minimally safe practice vary widely between health systems.

Likewise, the boundaries between specialties are often not clear-cut. A good example is the recent controversy in the USA about where the scope of a dental surgeon ends and where it encroaches into the scope of practice of maxillo-facial surgeons.[1]

In Australia, the scope of practice for cosmetic surgery recently hit the national headlines. After investigative journalists from the Australian Broadcasting Corporation *Four Corners* television program unearthed unethical behaviours and unsafe practices in the clinics of celebrity cosmetic surgeon Dr Daniel Lanzer,[2] the Medical Board of Australia issued long-overdue practice guidelines for cosmetic surgery. This includes a new registration standard for cosmetic surgery[3] and a much-needed restriction on who can call themselves a 'surgeon.' After an amendment to the Health Practitioner Regulation National Law, the title 'surgeon' is now restricted to medical practitioners holding specialist registration in surgery, obstetrics and gynaecology, or ophthalmology.[4] Previously, any doctor with general registration, including general practitioners, could call themselves a 'cosmetic surgeon' and perform complex surgical procedures without adequate training or approved qualifications. The only limits were their conscience and the fear of litigation.

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Scope of practice regulation aims to establish the boundaries within which doctors can operate, outlining their responsibilities, required competencies and limitations.

While such regulation offers obvious benefits regarding patient safety, quality assurance, standardisation and professional accountability, it also comes with certain disadvantages that can impact clinical innovation, flexibility, access to care and professional autonomy.

Rigorous scope of practice regulations may hinder surgical innovation by limiting the ability of surgeons to explore new techniques or procedures. Overly restrictive regulations may discourage creativity and slow the adoption of cutting-edge technologies, potentially impeding advancements in surgical care. Arias suggested that doctors' resistance to implementing innovative medical procedures is partly due to a perceived liability risk.[5] In my experience as a practising neurologist in both the public and private sectors, doctors in Australia are acutely aware of the risks of medical negligence litigation, and most of us practice defensive medicine.

A rigid scope of practice leads to reduced flexibility and access to care issues. It can limit a doctor's ability to adapt to evolving healthcare needs. Surgeons may find it challenging to diversify their skill sets or take on new roles in response to changing patient demographics, emerging technologies or healthcare delivery models. This lack of flexibility can impede professional growth and adaptation to evolving circumstances.

Access to care issues arise when doctors are reluctant to operate on a high-risk patient because they fear the potential medicolegal consequences. These can range from medical negligence litigation and coronial investigations to disciplinary proceedings and manslaughter trials. Consequently, patients are not offered treatment according to the standard patient risk versus patient benefit balance but instead to a doctor risk versus patient benefit balance. Theoretically, this should be less of an issue in countries with no-fault compensation systems, such as New Zealand, Sweden or Denmark.[6] However, I am not aware of any evidence supporting this hypothesis.

The consequences of defensive medicine for patients with life-threatening diseases can be dramatic and result in access to care issues and potentially suboptimal care. The best example is that of an advanced cancer patient who might still benefit from the removal of the tumour but who also has a high risk of surgery-related death or morbidity. This question was at the centre of the recent scope of practice scandal concerning celebrity neurosurgeon Dr Charlie Teo, which is the topic of the case study by Walsh *et al.* in this issue of the *Australian Health Review*.[7] Dr Teo was famous for operating on brain tumour cases deemed inoperable by other neurosurgeons. Despite undisputed technical excellence as a surgeon, he tripped over pushing the boundaries of patient selection too far, at least for the taste of the New South Wales Professional Standards Committee.

Scope of practice regulation brings benefits and disadvantages to the healthcare system. While it undoubtedly contributes to patient safety, professional accountability and quality assurance, regulation must strike a delicate balance to avoid stifling clinical innovation, limiting flexibility and inadvertently producing access to care issues and suboptimal care.

As a step forward, I propose a proactive, national, artificial intelligence-powered, real-time outcome monitoring system that uses electronic health record (EHR) data. This system would cover every patient undergoing a surgical procedure, gradually extending to non-surgical conditions. While the EHR rollout in Australia is still inconsistent, this should not hinder the development of a monitoring system for health services already using EHR. The feasibility of this approach has been demonstrated in various health systems,[8,9] including in Australia.[10]

As shown in the German external quality assurance model,[11] the focus should be on early detection of negative outliers, confidential investigation through peer review and rapid remedial action rather than public naming and shaming. This needs to be flanked by other regulatory measures promoting a just healthcare culture, as outlined in the Doctors' Association UK's 'Learn Not Blame' campaign.[12]

Such a system would benefit all key stakeholders in the health system – patients, doctors, hospitals, health insurance companies, Medicare and ultimately taxpayers.

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