New Mexico: An Expansion of Scope of Practice Model

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I. INTRODUCTION

Healthcare reform exacerbates primary care shortage problems in the United States, continuing the tug-of-war between physicians and nurse practitioners (NPs) over who will provide primary care services. This tug-of-war is especially problematic with the thirty-million expected newly insured Americans come 2014. The existing shortage is highlighted by the sixty-five million Americans already living in regions without adequate primary care. In order to shrink the gap, between the care needed and the

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1. A nurse practitioner is a registered nurse with at least a master’s degree in nursing and advanced education in primary care of particular groups of clients in; nurse practitioners are capable of independent practice in a variety of settings. State laws regulate their scope of practice and degree of autonomy. *Steidman’s Medical Dictionary* (27th ed. 2000).


4. *States in Action Archive: State and Federal Efforts to Enhance Access to Basic Health Care*, THE COMMONWEALTH FUND (March/April 2010), http://www.commonwealthfund.org/Newsletters/States-in-Action/2010/Mar/March-April-2010/Feature/Feature.aspx; Doctors and clinicians have continued to migrate away from primary care to specialty fields that offer higher pay and better hours. Ann Sanner, *Newly Insured to Deepen Primary Care Doctor Gap*, THE ADVOCATE (June 29, 2013), http://theadvocate.com/news/business/6323359-123/newly-insured-to-deepen-primary.The doctors entering the field aren’t expected to keep pace with the demand – about 25,000 primary care physicians work in America now. *Id*. The Association of Medical Colleges projects that the shortage will reach 30,000 in two years, and 66,000 in 10 years. *Id*. 
care available, there must be an increase in primary care providers.⁵ One proposed solution by state legislatures is to increase the number of primary care providers by expanding scope of practice laws for mid-level practitioners.⁶ Scope of practice expansion for mid-level practitioners will have a greater immediate impact on the supply of primary care providers than practice redesign or a restructuring of medical education.⁷

Scope of practice laws are state specific.⁸ The dichotomous relation between laws in New Mexico and Texas exemplifies the possible range of scope of practice laws. While Texas requires collaborative agreement and tight supervision, New Mexico allows NPs to be independent providers.⁹ Loosening restrictions on scope of practice laws would allow for greater access to primary care.¹⁰ Expanding scope of practice is supported by availability, lower cost, and the quality of services that NPs provide.¹¹ In addition, allowing NPs to function independently will reduce physician liability concerns.¹²

This article asserts that states should follow New Mexico’s model by expanding NP scope of practice laws and removing physician supervision. In Part I, this argument will be developed by examining the dichotomous

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⁵ For example, by changing the structure or funding of Medical education, making primary care more appealing and financially rewarding, or encouraging a team based medicine approach. Sarah Klein, Quality Matters: Strengthening the Primary Care Workforce to Meet Population Needs, THE COMMONWEALTH FUND (May 2011), http://www.commonwealthfund.org/Newsletters/Quality-Matters/2011/April-May-2011/In-Focus.aspx.
⁶ Id., See Vestal, supra note 3.
⁷ Practice redesign would be a change in medical care delivery through a team-based approach. The restructuring of medical education would involve changes to the education and funding structure of medical schools in an effort to incentivize student to go into primary care by making it more financially rewarding. See Klein, supra note 5.
⁸ The future of Nursing: Focus on Scope of Practice, INST. OF MED. (October 2010) http://www.iom.edu/~/media/Files/Report%20Files/2010/The-Future-of Nursing/Nursing%20Scope%20of%20Practice%202010%20Brief.pdf.
⁹ See Pettypiece, supra note 3.
¹⁰ See infra Part II.
¹¹ See infra Parts II-III.
¹² See infra Part IV.
positions between New Mexico and Texas scope of practice laws and their impact on access to care. Part II will present arguments in support of scope of practice expansion for NPs by examining the availability and cost of employing NPs to the healthcare system. Then, Part III will evaluate the necessity of scope of practice expansion per New Mexico’s model by countering opponents against NP quality of care arguments. Finally, Part IV will discuss how physician liability concerns are effectively handled by the New Mexico model functions and support for expanding scope of practice laws.

II. Nurse Practitioner Scope of Practice Expansion: Availability & Cost

The nursing profession makes up the largest percentage of the United States’ healthcare workforce at over three million. The number of NPs is rapidly growing while the number of physicians entering general internal medicine or primary care is decreasing. Only about two percent of medical school students are preparing for primary care. In fact, between the years 1995-2009, the number of NPs per primary care physician doubled. The supply of NPs, because of the shorter training time in comparison to physicians, can be used to increase workforce supply in less time than medical schools can turn out physicians. This discrepancy in the supply of NPs and physicians will continue given that the new federal healthcare law provides more funding for nursing education and nurse-

15. Id.
16. Id.
17. Id.
managed clinics, allowing for more positions in nursing schools and job opportunities.

In addition to the higher numbers of NPs available to the primary care field, NPs have a lower labor cost than physicians, and they are able to provide basic clinical services at lower costs. This discrepancy may be due to the lower cost of educating NPs over physicians, which costs four to five times less and can be completed in a shorter time frame. Over all, greater utilization of NPs results in greater cost savings for the healthcare system. These lower costs have been demonstrated by retail health clinics (RCs), which are staffed primarily by NPs and follow state scope of practice and prescription authority laws.


23. Battaglia, supra note 21 at 1142.


cost less than treatment provided in physician offices and demonstrates no obvious adverse effects on quality of care.\textsuperscript{26} The cost of RC services is low and usually ranges from $30-$60 without insurance coverage.\textsuperscript{27}

A recent estimate projects that underutilization of nurse practitioners costs the nation nearly nine billion dollars annually due to practice restrictions in state laws.\textsuperscript{28} Increasing the current NP work force can be done more quickly and cheaply than other professions.\textsuperscript{29} Services in NP-run clinics are cheaper for patients and are comparable to physician care.\textsuperscript{30} These facts demonstrate that expanding scope of practice laws for NPs is a fiscally responsible decision, given that greater utilization of NPs overall would mean more cost savings for the healthcare system as a whole.\textsuperscript{31}

### III. Nurse Practitioner Scope of Practice Expansion: Quality of Care

Over the past forty years, the healthcare system has expanded and the education and roles being carried out by NPs have evolved.\textsuperscript{32} NPs work throughout the entire healthcare spectrum, from health promotion and disease prevention to early detection.\textsuperscript{33} Generally, NPs enter the healthcare system trained to do more than many states allow them to.\textsuperscript{34} Depending on state specific restrictions, NPs may be prohibited from admitting patients to hospitals, assessing patient condition, or ordering tests, which could restrict

\textsuperscript{26} Id.
\textsuperscript{27} Id.
\textsuperscript{28} AM. ASS’N OF COLL. OF NURSING, supra note 22
\textsuperscript{29} Id.; Battaglia, supra note 21 at 1142; INST. OF MED., supra note 14.
\textsuperscript{30} See Nelson, supra note 25; Battaglia, supra note 21 at 1160.
\textsuperscript{31} AM. ASS’N OF COLL. OF NURSING, supra note 22
\textsuperscript{32} Ritter, supra note 19 at 22.
\textsuperscript{33} INST. OF MED., supra note 8.
\textsuperscript{34} Most states recognize national certification requirements, however scope of practice law may be restricted based more on political decision with in the states where NPs work rather than being restricted based on ability or training. Id.
a patient’s access to care. NPs, when allowed by scope of practice laws, are capable of providing many services that people associate with physicians, such as assessing conditions, evaluating tests, and a full range of other services.

Evidence shows that NPs provide quality care to patients, including preventing medical errors, reducing infections, and helping with home transitions. A number of studies demonstrate that quality of care would be upheld by adding NPs to the primary care market. In 1986, the Office of Technology Assessment of the United States Congress (OTA) reported that studies comparing NPs and physicians found that the quality of care demonstrated by NPs, when performing the same tasks within their training and expertise, was just as good as or better than their physician counterparts. The OTA report also remarked that NPs were better than physicians in assisting ambulatory care patients with chronic problems, and communicating with, counseling, and interviewing patients. NPs incorporate a range of disciplines, including social work, nutrition and physical therapy, in both training and practice. NPs advise their patients holistically, emphasizing patient treatment in the context of the patient’s total well-being and encouraging patient education. This care is the nursing model of care. In 2000, the Journal of the American Medical Association found that in ambulatory care settings where NPs had the same responsibilities and patient population as a physician, patient outcomes

35. Id.
36. Id.
37. Id.
38. Ritter, supra note 19 at 22.
39. Id.
40. INST. OF MED., supra note 14.
41. Hansen-Turton, supra note 18 at 1243.
42. Id.; INST. OF MED., supra note 14.
between NPs’ and physicians’ care were comparable. A 2004 study confirmed these conclusions. A 2002 study found that patients that received care from NPs at nurse-managed health centers were given cost effective generic medications at higher rates and had lower rates of hospitalization, than patients of like providers.

This evidence contradicts physician and AMA arguments that scope of practice laws should not be expanded because of quality of care and safety concerns. Study findings that quality of care is comparable between NPs and physicians carrying out the same tasks, supports expanding scope of practice laws. Arguments by a variety of stakeholders, from state legislators to the Centers for Medicare and Medicaid Services, support expansion of scope of practice laws and argue that NPs should be allowed to practice to the full extent of their education and training. The growing shortage in primary care is negatively impacting the access Americans have to affordable health care. The only way NPs can reduce the primary care shortage is if they are allowed to perform to the full extent of their training under the state scope of practice law.

In Texas, where the scope of practice laws are restrictive, NPs that are capable of independently providing primary care are barred from doing so. NPs in Texas are required to have a physician under contract to sign off on ten percent of medical charts and spend at least one in ten days in the

43. Hansen-Turton, supra note 18 at 1243; INST. OF MED., supra note 14.
44. Id.
45. Id.
47. See THE COMMONWEALTH FUND, supra note 4; Sanner, supra note 4.
48. See Pettypiece, supra note 3.
49. Id.
These requirements result in medical clinics sitting empty for lack of a supervising physician and a waitlist of patients. If these clinics are not able to cover a physician’s asking price to sign such a contract or collaborative agreement, the clinic will remain closed. The law makes it harder to access care in the communities where these clinics are needed.

Unlike Texas, New Mexico does not require physician supervision, and qualified independent NPs have full authority to diagnose, order tests, and prescribe medications to their patients. This allows clinics to stay open and provide needed and affordable healthcare to patients. Based on quality of care and the shortage of primary care, states should follow in New Mexico’s expanded scope of practice footsteps and loosen the restriction on NPs to allow them to more independently offer primary care services.

IV. Nurse Practitioner Scope of Practice Expansion: Medical Liability

Physicians are concerned that expanding scope of practice for NPs would negatively impact their own liability. This concern is likely a result of the cyclical return of medical malpractice crises and the fear of getting

50. Id.
51. Id.
52. Id.
53. Id.
54. Id.
55. Id.
56. See Christine Vestal, In Many Communities Nurse Practitioners Fill an Important Void, KAISER HEALTH NEWS (Dec 06, 2012), http://www.kaiserhealthnews.org/stories/2012/de/december/06/nur/age-practitioners-rural-health-care.aspx. (Illustrating how Virginia’s new law requiring NPS to be part of doctor-led patient care teams, which have a volunteer supervising physician asking his lawyer to review what his own liability as a volunteer team leader would be under the new law when collaborating with two NPs and their outreach in to communities that lack access to healthcare).
57. Medical malpractice cases are negligence actions where the plaintiff, i.e. the patient, alleges an injury that resulted from a breach of accepted medical standards of care. David N. Hoffman, The Medical Malpractice Insurance Crisis, Again, 35 HASTINGS CTR. REP. 15
It may also be one reason physicians are arguing against expansion of NP scope of practice. Physicians would face less liability risk if scope of practice laws for NPs were expanded to mirror New Mexico’s model allowing independent practice. Physicians actually face greater liability risk, with team based models or collaborative agreements, where physicians are the head of a collaborative team of medical providers that include NPs. As part of a team, NPs would be under the physician’s employment or supervision. In New Mexico, NPs can function independently and run clinics or NPs can continue to be supervised by physicians. In cases where a NP is supervised or employed by a physician and does not function independently, a physician could still be held liable for the NPs actions under New Mexico law through vicarious liability laws like respondeat superior.


59. Id.

60. See Battaglia, supra note 21 at 1142-43.

61. “The majority of states require a nurse practitioner to have a collaborative agreement with a local physician in order to provide professional care. Although there is not one definition or understanding of a collaborative practice, Medicare law defined collaboration as a process in which a nurse practitioner... works with a physician to deliver health care services within the scope of the practitioner’s professional expertise, with [physician] medical direction and appropriate supervision... as defined by the law of the State in which the services are performed.” Hansen-Turton, supra note 18 at 1245.


63. Id.


65. Liability can be shifted onto a physician by vicarious liability. Vicarious liability is a legal doctrine whereby liability for an injury is assigned to a party that did not cause the injury, but that has a particular legal relationship with the party that did. Gallegos, supra note 6. The basic agency theory of respondeat superior shifts liability from employee to employer or from servant to master for negligent acts which arise in the scope of the employee’s service, such as NPs under the supervision of a physician in a physician’s practice. This theory shifts liability to the physician if the physician has the right to direct or control the NPs practice. Mary Beck, Improving America’s Healthcare: Authorizing Independent
A malpractice scenario where NPs are not functioning independently requires the investigation of their supervising physician. A NPs employment contract or physician supervision requirement extends the physician’s constructive knowledge and liability based on a NPs actions. The physician has responsibility over the NP as an extension of his practice, and the physician would be more likely to be held liable in both New Mexico and Texas models.

Scope of practice expansion creates a shift where independent NPs will be providing care without a supervising physician, like NP-run clinics in New Mexico. The physician would not have the requisite level of control over the independent NP needed to establish vicarious liability. Texas, with increased supervision, puts physicians in more control of NPs through the use of collaborative agreements, which opens physicians to greater liability for NP actions. The scope of practice and liability law in New Mexico addresses both physician delegation and supervision as well as a NPs independent practice. New Mexico still uses respondeat superior in cases where the principal actor, the NP, functions completely under the scope of a physician’s agency. Where an independent NP provides

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Prescriptive Privileges for Advanced Practice Nurses, 29 U.S.F. L. Rev. 951, 963 (1995). Supervising physician and physician’s leading a collaborative team, already have a level of control over what a NP following their direction does. See Battaglia, supra note 21 at 1142-43.


67. Id. at 38
68. See Battaglia, supra note 21 at 1142-1143
69. See Id.
71. Id.
72. New Mexico’s model includes exceptions for nursing in its state’s Medical Practice Act (the Act) stating that it will not affect or apply to nursing licensing laws. N.M. Stat. Ann. § 61-6-17 (West, WestlawNext through Ch. 228 (end) of the First Regular Session of the 51st Legislature 2013); UJI 13-402 (Westlaw); UJI 13-1114 (Westlaw).
73. UJI 13-402 (Westlaw)
primary care, the NP is solely responsible for the treatment of a patient. 74 A physician that is not involved in the treatment of a patient cannot not be trapped by vicarious liability laws. 75 New Mexico law mitigates physician liability in relation to NPs. 76

Texas allows physicians greater supervision and control over NPs and the delegation of certain medical acts. 77 The wording of the delegation segment of Texas law is vague and leaves a physician’s liability open to interpretation. 78 The law outlines that physicians can delegate to a person acting under the physician’s supervision any medical act they find reasonable to delegate. 79 Texas law also outlines that a delegating physician will remain responsible for the medical acts they delegate. 80 Texas gives total discretion to delegate the performance of medical acts to the delegating physician. 81

Physicians, from the structuring of the laws in Texas, are open to more liability based on the actions of the NPs they supervise, and physician liability is directly related to how NP scope of practice is limited. 82 The New Mexico model allows for a separation of physician liability from NP liability when a physician is only tangentially related and not in charge of

74. UJI 13-1114 (Westlaw)
75. Id.
76. See Id.; Baker, supra note 70 at 349.
77. V.T.C.A., Occupations Code § 157.001 (West, WestlawNext through the end of the 2013 Third Called Session of the 83rd Legislature).
78. See Id.
79. Id.
80. Id.
81. This interpretation is supported by Texas’ use of several liability, where parties are proportionally liable for breaches in care to a patient based on percent of fault, unless the percentage of responsibility attributed to the defendant with respect to a cause of action is greater than 50 percent. Medical Liability/ Medical Malpractice Laws, NAT’L CONF. OF STATE LEG. (last updated August 15, 2011) http://www.ncsl.org/research/financial-services-and-commerce/medical-liability-medical-malpractice-laws.aspx#TX.
82. See V.T.C.A., Occupations Code, supra note 79.
patient care, thereby lowering physician liability concerns. 83 This separation affords physicians less liability concerns when NPs practice independently. 84

V. CONCLUSION

In an effort to deal with the primary care shortage, which is an ever-increasing problem in today’s healthcare system, expanding scope of practice is a viable option. 85 Expanding scope of practice for NPs would allow the large, increasing and underutilized NP population to practice to the full scope of their abilities and provide care affordably to patients and to areas which currently struggle or do not have access to primary care. 86 New Mexico’s scope of practice laws allowing for independent NPs that can open and run clinics are an avenue that more states should follow. 87 The AMA and other physician organizations have enumerated concerns against scope of practice expansion relating to issues of quality of services and liability. 88 There is no evidence to say that a NP allowed to give primary care to the full scope of their training, practice and experience is a reduction in the quality of services a patient would receive. 89 In fact a number of studies and evidence show in measures like readmission rates, affordability of prescriptions and patient satisfaction, NPs provide care comparable if not better than some of their physician counterparts. 90 Physician groups may be rebelling against scope of practice expansion partly because of their own

85. See supra Part I Introduction.
86. See supra Part II - III.
87. See supra Part I Introduction.
88. See supra Part II.
89. See supra Part III.
90. See supra Part III.
liability concerns. The New Mexico scope of practice laws allow the independent functioning of NPs under their nursing licenses and reduces physician liability concerns. Physicians appear to be more protected in New Mexico from liability than they are in Texas. Physicians may have their concerns about expanding scope of practice for NPs, but those concerns are not supported when it comes to the availability, cost, quality of primary care services NPs provide and concerns about physician vicarious liability.

91. See supra Part IV.
92. See supra Part IIIV.
93. See supra Part IV.
94. See supra Parts II-IV.