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One More Comment on Expanding the Scope of Practice for VA Advanced Practice Nurses

You may have heard that the VA has proposed to amend its regulations to permit advanced practice registered nurses (APRNs) to wield full practice authority. For several years, there have been rumors of the change, but there also was uncertainty until Under Secretary for Health David J. Shulkin, MD, announced the proposed rule May 29, 2016.¹ When the commentary period ended July 25, 2016, an incredible 212,242 people had commented on the proposed rule.

The function of the regulatory process during this period of open comment in the *Federal Register* is to inform the drafting of the final rule, meaning that this proposal is a long way from becoming law.² If nothing else, it will take months for the VA to take stock of the responses. That makes this an optimal time to figure out why the issues involved have generated such intense controversy and to invite you, our readers, to share your thoughtful opinions.

The rule is written in the usual bureaucratic language, but the plain meaning is APRNs would be able to practice without physician supervision. If you're not familiar with how much advanced practice nursing has grown, this ruling can come as a pleasant surprise or an unpleasant shock, depending on your perspective. And although advanced practice nursing may be a new development in

the VA, it is in no way a novel one for American health care. Clearly, APRNs will play a greater role in health care at the VA, but the nature of that role remains contentious, and, it cannot be emphasized enough, undecided.

Advanced practice registered nurses who provide health care with full practice authority already are the standard in other branches of federal service, including the DoD and IHS. Many veterans are therefore used to having a nurse practitioner (NP) as their primary care provider and seeing other types of APRNs in specialty care in the clinic and the hospital. As of 2015, 18 states and the District of Columbia granted APRNs full scope of practice. The other states have various and variable forms of reduced and restricted practice that in some manner involve physician supervision, reflecting the debate that now engages the VA.³

I read many of the comments on the proposed rule. A majority of the responses are formulaic comments promoted by organizations on each side of the issue. The opinions of those for and against the proposal express genuine and principled concerns about patient safety and access, while less admirable postings reflect vainglory and turf battles.⁴ Prestigious organizations came down on each side of the debate and along relatively predictable discipline lines: The American Medical Association (AMA) took the con stance on the

specific proposal, and the Institute of Medicine took the pro position on the more general issues of APRNs having full scope of practice as early as 2011.^{5,6}

Many of the objections to the rule are focused on one of the 4 recognized APRN roles: the certified registered nurse anesthetist (CRNA). The volume and vehemence of the comments along with other considerations persuaded Dr. Shulkin and his advisors to exclude CRNAs from the current policy change. For that reason and my lack of expertise in the area, I will not discuss CRNAs and instead focus my discussion on the other 3 roles that will be granted full authority: certified NPs, certified nurse specialists, and certified nurse midwives.

We are all familiar with continuing education presentations beginning with a conflict of interest statement, so here is mine: I am a board-certified physician (MD) and educator of medical students and medical residents. But I also have trained and supervised—when the latter was required—APRNs in the VA. What I have learned from these experiences is not revelatory but is relevant. There are good doctors and bad, just as there are outstanding and poor APRNs. For both, the distinction between those who competently provide safe, high-quality, compassionate care and those who do not is based not on a degree, but on the ability to recognize one's

limitations and seek outside consultation when necessary.

After decades in clinical education, only 2 types of trainees (of any profession) worry me—the ones who don't know that they don't know and the ones who won't ask for help. It is sheer hubris to think APRNs will not need the consultation of physicians and, even in some cases, their supervision, or that they can “replace doctors” especially given the VA population of older patients with more mental health comorbidities and a higher prevalence of medical illnesses.⁷ Equally arrogant is to not recognize that superior physicians also routinely need to consult their colleagues, specialists, and other experts in order to provide the best care to patients. The scientific and informatics base on which clinical medicine must rest in the 21st century does not give any practitioner the luxury of self-sufficient knowledge.

We also must keep in mind that the proposed rule will increase the authority of the APRN and his or her accountability. Like physicians and other VA-licensed independent practitioners (LIPs), APRNs will be subject to the same rigorous credentialing and privileging that includes scrutiny of education and training, qualifications, and licensure before being granted full scope of practice. Where final responsibility for decisions once stopped with the physician, APRNs could now be the captain of the ship in many circumstances, sharing with physicians and other LIPs the discipline of peer review and the risk of tort claims.

In my July editorial, I talked about the physician shortage in the VA, a microcosm of national patient demand exceeding doctor supply. Two

of the biggest lacunae are in the most critical areas for the VA cohort: primary care and mental health.⁸ The empirical work supporting the model of the National Council of State Boards of Nursing Consensus strongly suggests that APRNs can improve access and wait times while upholding the quality of patient-centered care.⁹ To deny this evidence exists or is solid research, as some opponents have, brings more heat than light to the debate. But it does not answer what the relationship between physicians and APRNs in the VA will or should be, hence, the thousands upon thousands of comments on the proposal.

The AMA and other physician professional societies have many valid points expressed in a plethora of recent articles in print and on the Internet. As they rightly point out, health care is best delivered in teams, teams that physicians are often, but not always, in the optimal position to lead. Both physicians and APRNs are educated and trained, but that professional identity formation is different. Those differences should be seen as complementary skill sets. Any attempt in this brief space to characterize those differences and their relationship would risk my being perceived as invidious. What is clear is that the logical corollary of approving the proposed rule is to pass a similar regulation that provides greater incentives for physicians, especially those in family medicine, general internal medicine, and psychiatry, to work at the VA. Then and only then will veterans have the best of both health care worlds. ●

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Disclaimer

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