

July 29, 2021

The Honorable Denis McDonough
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue NW, Room 1063B
Washington, DC 20420

Dear Secretary McDonough:

The undersigned physician organizations have recently learned of the Department of Veterans Affairs (VA) Supremacy Project. We are writing to express our serious concerns with the VA's efforts to develop National Standards of Practice for physicians and other health professionals that supersede state scope of practice and licensure laws. In particular, we are dismayed that the VA has not provided a transparent process by which public stakeholders are provided an adequate opportunity to review and provide meaningful input into the standards of practice. Furthermore, based on what we have learned about the VA's approach to developing the standards of practice for 48 categories of health professionals, we believe the VA has failed to consider that these health professionals do not operate in isolation but rather as a team. Yet, the VA is creating and moving standards forward independent of one another. In order to provide the best care for our Veterans, the VA must engage in a systematic examination of how all these standards will fit together and affect the health professional team. The policies the VA is seeking to overhaul will have implications for standards of care beyond the VA. It is therefore vitally important that the VA initiate a meaningful process for the collection, dissemination, and inclusion of stakeholder input as early into the process as possible.

As physicians, we want to ensure that our nation's Veterans receive the best medical care possible, including care from physician-led teams which research has shown results in the highest quality of care for patients.¹ **We therefore urge the VA to reconsider its implementation of the National Standards of Practice.** It is essential that, before the VA moves forward, there needs to be a meaningful opportunity for stakeholders to provide feedback that is incorporated into the National Standards of Practice for all occupations, especially since the Interim Final Rule (IFR) did not provide a significant opportunity for public comment.

Creating one standard for all physicians is impractical and not consistent with the practice of medicine.

Our physician groups are concerned about the feasibility of developing a single set of practice standards for all VA-employed physicians. There are 40 specialties and 87 subspecialties for physicians.² Physicians spend years in residency learning their chosen specialties and subspecialties and this depth of knowledge enhances care teams and ultimately leads to better

¹ 38 U.S.C. [7306](#), [7401](#), [7405](#), [7406](#), or [7408](#).

² <https://www.abms.org/board-certification/abms-board-certification-report/>.

patient outcomes. To adequately reflect these different specialties and subspecialties the Accreditation Council for Graduate Medical Education, residency programs, state licensing boards, and countless other entities have spent years developing and implementing education requisites, practice standards, and licensing requirements to ensure the proper oversight of the practice of medicine. These governing entities take into consideration the different requirements for each specialty and subspecialty and set their standards accordingly.

Given this complexity, it would be nearly impossible for the VA to adequately capture the overall breadth of the practice of medicine and nuances among each physician specialty and subspecialty in one standard of practice, especially within the course of a few months.

The VA must allow meaningful input into the National Standards of Practice of non-physicians by the physician community.

Our organizations are deeply concerned with the VA National Standards of Practice being developed for non-physician occupations and the lack of a systemic procedure for meaningful input and review early in the process by all stakeholders, not just the occupations to which the standards would apply. This early input and review are especially critical since we have learned that the VA intends to modify other existing VHA policies to align with the National Standards of Practice. We are concerned that important current patient safety policies could be eliminated or comprised because of this policy alignment. External stakeholders, such as the American Medical Association (AMA) and other national physician specialty societies, can provide meaningful insight into the development of standards for all health care team members. As the leaders of the health care team, physicians are uniquely qualified to understand the roles of the various team members. We believe the VA risks lowering the standard of care for our nation's Veterans without sufficient input from the physician community.

We are concerned that the National Standards of Practice drafted for non-physician providers (NPPs) may not accurately reflect the skills acquired through the education and training of such occupations and may allow non-physicians to provide services and perform procedures that are outside the scope of their knowledge and licensure. While we greatly value the contribution of all non-physicians, no other health care professionals come close to the four years of medical school, three-to-seven-years of residency training, and 10,000-16,000 hours of clinical training that is required of physicians.

In developing National Standards of Practice, we urge the VA to consider patient sentiment and support for physician-led teams. Based on a series of nationwide surveys, patients overwhelmingly want physicians leading their health care team. Four out of five patients want a physician leading their health care team and 95 percent believe it is important for physicians to be involved in their medical diagnoses and treatment decisions (68 percent said it is very important). Moreover, 94 percent of patients said it was important to have physicians involved in specific treatments such as anesthesia, surgery, and other invasive procedures. Patients understand the value that physicians bring to the healthcare team and expect to have access to a physician to ensure that their care is of the highest quality. Developing National Standards of

Practice that expand the scope of practice for NPPs and supersede state laws goes against what patients want, which will decrease patient confidence and the effectiveness of the VA.

The VA's Federal Supremacy Project does not consider the importance of state licensing boards and the negative consequences of inadequate oversight of NPPs.

State licensing boards play a leading role in ensuring that medical care is properly administered and that providers are disciplined when malpractice is committed. Such laws are often the result of extensive debate by state legislatures sometimes spanning several years and involving negotiations among all stakeholders. However, the VA's decision to circumvent state scope of practice laws and regulations through the Federal Supremacy Project will make it impossible for state boards to oversee physicians and NPPs employed by the VA, leading to unintended consequences³. Moreover, unlike physicians who are supposed to have their licenses reviewed every two years, registered nurses and other NPPs within the VA are appointed for an indefinite period.

According to multiple Government Accountability Office audits, the VA is already doing an inadequate job of supervising and disciplining its NPPs. Over the past few years, the VA Office of Inspector General has reported multiple cases of quality and safety concerns regarding VA providers.⁴ The issues reported range from providers lacking appropriate qualifications, to poor performance, and provider misconduct.⁵ Unfortunately, the VA has been deficient in putting an end to this subpar care, in part due to poor VA reporting and oversight.^{6,7} If the National Standards of Practice is implemented the oversight that these NPPs have will be lowered even more, leading to an increased lack of accountability for Veteran's care. Moreover, it will make it extremely difficult for state boards to oversee the practitioners that they license and make it all but impossible to discipline VA-employed NPPs that inadequately care for Veterans. This lack of oversight means that patients' safety could easily be jeopardized especially if the national standard for a particular provider-type differs from a state's scope of practice and licensing requirements. In these cases, it would be unclear whether the VA provider would have the necessary training, as dictated by the state licensing or medical board, to appropriately treat a patient and could potentially lead to Veterans receiving subpar care with little to no repercussions for the provider.

³The vast majority of states support physician-led teams. For example, 38 states plus DC require physician supervision of physician assistants (PAs) and 11 states require PAs to practice pursuant to a collaboration agreement with a physician. Similarly, 20 states require physician involvement for nurse practitioners to diagnose, treat or prescribe and 14 more states require physician involvement for a certain number of hours or years of practice.

⁴ <https://www.gao.gov/assets/710/702090.pdf>.

⁵ <https://www.gao.gov/assets/710/702090.pdf>.

⁶ <https://www.gao.gov/assets/710/702090.pdf>.

⁷ <https://www.gao.gov/assets/710/702090.pdf>.

The IFR violated the Administrative Procedure Act and did not meet the standards set out in Executive Order 13132.

The IFR was unlawful rulemaking because no good cause existed for the VA's failure to comply with the notice and comment requirements. The Administrative Procedure Act (APA) authorizes an agency to issue a rule without prior notice and opportunity for public comment when the agency for good cause finds that those procedures are "impracticable, unnecessary, or contrary to the public interest."⁸ The VA stated, as one of its rationales, that COVID-19 necessitated the quick shifting of health care professionals across the country. However, since the public health emergency began the VA hired over 12,000 new employees to supplement surge capacity.⁹ Moreover, the VA did not explain why these expanded scope provisions would be needed permanently rather than just during the public health emergency (PHE), with a built-in sunset clause, as is the case for most of the other state and federal based PHE plans. Moreover, the IFR preempts state law by asserting that state and local scope of practice laws relating to NPPs that are employed by the VA "will have no force or effect," and that state and local governments "have no legal authority to enforce them." However, the requirements to preempt state law, set forth in Executive Order 13132, have not been met.¹⁰ The VA did not "provide all affected State and local officials notice and an opportunity for appropriate participation in the proceedings."¹¹ This can be seen by the fact that the VA did not provide any time for comments and instead published the IFR on the same day the rule took effect, which gave no opportunity for any stakeholders to meaningfully participate in the proceedings.¹² As such, the VA did not follow the guidelines set out in Executive Order 13132 and "act only with the greatest caution," nor did the VA possess good cause when it bypassed the APA and acted arbitrarily and capriciously by failing to adequately consider the rights of the states and the long-term safety of our nations' Veterans.

Our nation's Veterans deserve to be provided with the best possible medical care. As such, the undersigned organizations urge the VA to put the health of the nation's Veterans first and to reconsider its implementation of the National Standards of Practice. If you have any questions, please contact Margaret Garikes, Vice President for Federal Affairs, at margaret.garikes@ama-assn.org, or by calling 202-789-7409.

Sincerely,

American Medical Association
Academy of Consultation-Liaison Psychiatry
American Academy of Allergy, Asthma and Immunology
American Academy of Cosmetic Surgery
American Academy of Dermatology Association

⁸ 5 U.S.C. §§ 553(b),706(2).

⁹ https://www.va.gov/HEALTH/docs/VHA_COVID-19_Response_Report.pdf.

¹⁰ <https://www.govinfo.gov/content/pkg/FR-1999-08-10/pdf/99-20729.pdf>.

¹¹ *Id.*

¹² *Id.*

American Academy of Emergency Medicine
American Academy of Family Physicians
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngology – Head & Neck Surgery
American Academy of Physical Medicine and Rehabilitation
American Academy of Sleep Medicine
American Association for Hand Surgery
American Association of Child and Adolescent Psychiatry
American Association of Clinical Urologists
American Association of Neurological Surgeons
American Association of Neuromuscular & Electrodiagnostic Medicine
American Association of Orthopaedic Surgeons
American College of Emergency Physicians
American College of Osteopathic Internists
American College of Osteopathic Surgeons
American College of Physicians
American College of Radiology
American College of Surgeons
American Gastroenterological Association
American Medical Women’s Association
American Osteopathic Association
American Psychiatric Association
American Society for Dermatologic Surgery Association
American Society for Gastrointestinal Endoscopy
American Society for Laser Medicine and Surgery
American Society for Surgery of the Hand
American Society of Anesthesiologists
American Society of Cataract & Refractive Surgery
American Society of Dermatopathology
American Society of Interventional Pain Physicians
American Society of Neuroradiology
American Society of Plastic Surgeons
American Society of Regional Anesthesia and Pain Medicine
American Urological Association
American Vein & Lymphatic Society
College of American Pathologists
Congress of Neurological Surgeons
Heart Rhythm Society
International Society for the Advancement of Spine Surgery
International Society of Hair Restoration Surgery
National Association of Medical Examiners
Renal Physicians Association
Society for Pediatric Dermatology

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Society for Vascular Surgery

Society of American Gastrointestinal and Endoscopic Surgeons

Society of Cardiovascular Computed Tomography

Spine Intervention Society

The Aesthetic Society

Medical Association of the State of Alabama

Alaska State Medical Association

Arizona Medical Association

Arkansas Medical Society

California Medical Association

Colorado Medical Society

Connecticut State Medical Society

Medical Society of Delaware

Medical Society of the District of Columbia

Florida Medical Association Inc

Medical Association of Georgia

Idaho Medical Association

Illinois State Medical Society

Indiana State Medical Association

Iowa Medical Society

Kansas Medical Society

Kentucky Medical Association

Louisiana State Medical Society

Maine Medical Association

MedChi, The Maryland State Medical Society

Massachusetts Medical Society

Michigan State Medical Society

Minnesota Medical Association

Mississippi State Medical Association

Missouri State Medical Association

Montana Medical Association

Nebraska Medical Association

Nevada State Medical Association

New Hampshire Medical Society

Medical Society of New Jersey

New Mexico Medical Society

Medical Society of the State of New York

North Dakota Medical Association

Ohio State Medical Association

Oklahoma State Medical Association

Pennsylvania Medical Society

Rhode Island Medical Society

South Carolina Medical Association

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South Dakota State Medical Association

Tennessee Medical Association

Texas Medical Association

Utah Medical Association

Vermont Medical Society

Medical Society of Virginia

Washington State Medical Association

West Virginia State Medical Association

Wisconsin Medical Society

Wyoming Medical Society