Oral Testimony
House Veterans Affairs Subcommittee
O & I Hearing
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Good morning. It is once again an honor and a privilege to be asked to testify before a committee of the US House of Representatives that focuses on the lives of our precious Veterans. The title of this hearing refers to “Kerfuffle”, a funny-sounding word whose meaning—“to throw into disorder”—should not be underestimated. What I have witnessed in the primary care service at the G.V. (Sonny) Montgomery VA Medical Center in Jackson, Mississippi is a sad, serious, and self-perpetuating state of ugly chaos.

The VA’s own investigative team report on my Office of Special Counsel Whistleblower Complaint substantiated that “the Medical Center does not have enough physicians, and nurse practitioners (NPs) have not had appropriate supervision and collaboration with Physician Collaborators.” It states “NPs were also erroneously declared as Licensed Independent Practitioners (LIP), and the required monitoring of their practice did not consistently occur resulting in NPs practicing outside the scope of their licensure.” It is crucial to understand that in *all* the years that NPs have

existed at the Jackson VAMC, there was *no* oversight or review of their clinical care. Physicians had ongoing quality assurance and peer reviews done on their work—the NPs had *no oversight.* Dorothy Taylor-White oversaw this set-up through her power over "patient care services", but Dr. Kent Kirchner, Chief of Staff, enabled and agreed to this illegal operation. And these unsupervised NPs outnumbered the physicians in primary care by a ratio of 3:1, and sometimes 4:1.

This same cavalier attitude and laxity by the Medical Center and VISN (Veterans Integrated Service Network) leadership towards safe and proper medical care for the Veterans empowered the NPs to prescribe narcotics—*without physician supervision*—without individual DEA registration numbers, in flagrant violation of Federal and individual state laws and VA Handbook regulations. A practitioner who *never* obtained an NP license was the entire Women's Health Clinic for two decades, writing narcotics and seeing patients independently. "A clinical care review" of records where NPs prescribed controlled substances "outside of the authority granted by their licenses" was called for in the report.

Scheduling of Veterans in a "ghost" or "vesting" clinic when no provider was assigned to that clinic, overbooking /double-booking, and inadequate capacity for walk-in visits were all found, and *all* these issues threaten the care of the Veteran. Both administrative and medical leadership were continuously informed.

In view of what has happened at Jackson, it is a blessing that this hearing comes as proposed changes to the VA Nursing Handbook have come out. The plan is to make *all* NPs in the nationwide VA system operate as fully independent and unsupervised, *without regard to state licensure requirements or scope of practice*—not as part of a physician-led Veteran's care team. My current work in the Compensation and Pension Service allows me to see care from all clinics in the Jackson system. And this is what I often see from unsupervised NPs (exacerbated by clinician turnover and discontinuity of care):

1.) Diagnoses not made when they should have been. Common stellar examples are heart disease, diabetes, and asthma. Symptoms aren't addressed or recognized and proper tests/treatments are delayed.

2.) Even when diagnoses are made, diseases are not monitored or treated appropriately. Diabetes leads to chronic kidney disease; and then the kidney disease is not noted until far advanced.

3.) A bizarre progress note template used for office visits, different from what physicians use. The NP does not take an adequate history for the Veteran's current complaints; the same history and physical is cut and pasted into perpetuity, as is the chronic problem list—including the diagnosis and billing code for "URI"—the common cold.

The most compelling case is a Veteran who had white blood cell changes showing the onset and insidious march of chronic lymphocytic leukemia for ten years, and was only diagnosed when a mass causing severe abdominal pain was biopsied. When I saw him in C &P he was dying—and he and his wife told me they remembered the shocked look on the face of the blood specialist when he reviewed the Veteran's records.

Veterans suffer needlessly even when they don't die. Think of the Veteran whose "fatigue" is not just due to his chronic medical conditions but because of a *new* cardiac arrhythmia; when the subtlety of that diagnosis is missed by an NP the

Veteran goes home and dies. When the symptom is acknowledged and an EKG is done as it should be, a pacemaker can buy a few more human life years. Quoting from the classic opening pages of *Harrison's Textbook of Medicine,* a seminal part of medical school education, "disease often tells itself in a casual parenthesis… skill in diagnosis reflects a way of thinking more than doing…The content of the record…reflects the true quality of the care provided." My written testimony documents the vast differences in training and approach to the patient between nurse practitioners and physicians; as Americans become sicker and sicker, younger and younger, and on more and more medicines the VA proposal shortchanges the Veterans. The care of human beings is too sacred to change a policy for either monetary or nursing lobby reasons.

The Center Director, Joe Battle, is fond of reminding us that "when you're at the VA, you're on the reservation"; this translates into Federal Supremacy means "we don't have to follow the laws". It also means that medical and ethical boundaries are boldly breached. In this case, standing up to the "Federal Specialness" claim, and "going off the reservation", is a sign of sanity and professionalism. Duty calls us now—as it called the Veterans.