

## Development of Medical Optometry within the VA

Pages 1-5 and 16-28 from [Public Health and the Department of Veterans Affairs](#)

This narrative describes the complex dynamics that produced four notable reforms in the Department of Veterans Affairs (DVA) health care programs for eligible veterans beginning in 1930 when various veterans “agencies” were added to its charter. It discusses the factors that led to these reforms and the interplay between DVA health care policy makers and external “stake holders” that included recipients of its health care, DVA congressional oversight committees, fraternal organizations of veterans, trade associations of those delivering DVA health care and public opinion which is often the spark leading to reform.

Adding to the complexity of reforms within such a large agency are those individuals within them who may see no need for reform, have been appointed to their positions by individuals who see no need for reform, head programs threatened by reform or have been party to previous ones and have had enough of reforms. The latter attitude is common within agencies that have had frequent turnovers in leadership as political tides swept to and fro. The tasks of a public health official thus are often complex, not susceptible to simple solutions, usually contentious, not subject to analytical study and may proceed at a snail's pace.

These narratives emphasize that changes in a public health agency's mission, and how that mission is carried out, are difficult to achieve, may take years, and put public health officials within the agency into positions of internal and external conflict. Public health is a difficult field of study compared to physics and mathematics. Despite Newton's laws fully describing how gravity affects the motion of bodies being known for centuries, even the advent of Cray super computers has not made it possible to fully predict the motions of more than two bodies interacting via gravitational forces. Nor has the problem of containing nuclear fusion been solved after over 60 years of work although these forces are also well understood.

So imagine then the complexity, and uncertainty, of identifying and measuring forces generated by unpredictable human beings, and groups of human beings having a multitude of motivations. This “messy”, roiling and changing environment is the milieu in which public health officials work and is far from the neat, sterile setting of the laboratory. To be a public health official in a policy shaping position is to be a political operative dealing with human emotions, bias and incomplete knowledge.

But, despite these attendant problems, these four narratives describe how DVA transformed itself overall (cases 1, 2 and 3) and tactically (case 4) since 1930 to produce clearly significant improvements to the availability and quality of the medical care provided eligible veterans. The common tools used in all four reforms were:

- Improvements in salary structure to recruit better qualified medical staff.
- Appointments and promotions based upon the “rank-in-the-man” on an peer-reviewed basis rather than number of subordinates as in Civil Service positions or lists of “approved personnel”.
- Affiliation with schools and colleges training medical practitioners.
- Hiring needed medical staff using these reforms.

Just as the success of a football team or army is derived from the quality of its front-line staff so is that of a medical program. Certainly skilled leadership is important but no amount of it can overcome poor quality personnel which then may eventually produce a similar quality of leadership and a status quo difficult to overcome after being entrenched.

This is why reforms happen infrequently, are difficult to predict and depend upon a confluence of factors and cadre of determined reformers. Used as backdrop to these DVA case studies in reform are the changing attitudes and politics of public health since 1930 and the increasing role played by federal, state and local governments and insurers in defining and paying for health care. From a “cash- and-carry” system of health care in 1930, government entities now pay for one-half of all US health care and define its services and this percentage continues to increase. Also discussed is the faulty perception many Americans have of what constitutes “socialized medicine”.

## Introduction

In a democracy, public health officials face a variety of opinions from clients, organizations and individuals attempting to influence policy decisions. Most external forces stem from special interest trade groups and those seeking to maintain or gain benefits. It is the responsibility of those representing the public to see these conflicting opinions blended into policy that benefits the greatest number of clients in a cost-effective manner without favoritism. This goal is seldom completely reached.

The resultant quality of the health care produced depends upon how adroitly public health policy makers deal with these political and economic realities while attempting to put public interest first. (Sadly, some public health officials have other goals.)

Unfortunately, a common tactic is to offer a “pork barrel” solution with something for everyone which usually weakens the product and dilutes the services provided. When there are several strong but opposing external viewpoints it is essential policy makers secure powerful patrons that support rational and evidence-based reform and stick to their guns themselves if they believe their policy offers the best chance to produce useful results.

The four Department of Veterans Affairs (DVA) case studies presented demonstrate that for a sound product to result it is necessary for supporters of reform to take a strong, consistent stand on principle and marshal facts and public opinion to buttress their position. Cases 1, 2 and 3 describe agency-wide reforms of DVA health care beginning in 1930 and Case 4 describes the reform of a specific DVA program overlooked by the reforms of cases 1 and 2.

**History and structure of the Department of Veterans Affairs**

	<b>Agency Name</b>	<b>Top Officials-Department</b>
Circa 1700 to 1929	Diverse agencies including VA providing health care to veterans, widows, orphans and “old soldiers homes” including cemetery plots and pensions	State, local, and federal officials. Department of Veterans Affairs with appointed Administrator.
1930 to 1945	Many of above groups incorporated into expanded Veterans Administration (VA)	VA an Independent Agency with appointed Administrator, Civil Service personnel
1946 to 1989	Veterans Administration (VA)  Era of expansion	Appointed VA Administrator Chief Medical Director Department of Medicine and Surgery. Physicians and dentists removed from Civil Service. VA Central Office.
After 1989	Department of Veterans Affairs (DVA)	Secretary of DVA- A Cabinet Position Undersecretary for Health who heads Veterans Health Administration (VHA). DVA Headquarters

The first reform occurred in 1930 when groups of government and some state and local programs for veterans were assimilated into an expanded federal Veterans Administration. Some military and state facilities were transferred to the VA. All VA employees became civil servants. The driving force was the complexity and the lack of a central administration to coordinate and integrate this complex group of agencies serving veterans, widows and dependents.

In the second reform, in 1946, it was President Truman, Retired General Omar Bradley of the US Army, retired Maj. General Paul Hawley, M.D. of the US Army Medical Corps, Paul Maguson, M.D., and members of Congress who, propelled by common sense, editorials in the Washington Post and veterans' organizations, led reforms needed to properly care for returning WWII servicemen. More recently a similar outcry arose over the care of Gulf War 2 servicemen treated by military hospitals and coordination of their benefits once discharged and cared for by DVA.

The third reform began as the VA and then DVA decentralized its administration and shifted from inpatient to outpatient care delivered through small clinics. While not discussed in detail, it began in the 1980s and led to rapid decentralization and mission change sparked by a dynamic Under Secretary of Health, Kenneth W Kizer, M.D., M.P.H. (1994-1999).

The fourth reform describes reform of a specific component of the then VA; optometry care, which was driven by Congress, some veterans groups and the American Optometric Association and Association of Schools and Colleges of Optometry that led to legislative reform in 1973 and 1976. Then a critical General Accounting Office (GAO) report followed by a congressional hearing were needed to begin implementation of this reform.

Today, there is ample evidence these reforms greatly improved the medical care given veterans by the VA-DVA as well as strengthening and supporting the education of physicians, dentists, optometrists and podiatrists. The role of physicians and dentists were reformed in 1946 and optometry and podiatry in 1976 utilizing the same principles of reform. All four reforms were entangled in political disputes and vigorous contending forces within and external to the agency demonstrating the difficulty of managing reform in public agencies answering to a wide range of constituents and regulators.

Reform is usually a messy process since a council of "wise men" issuing policy then smoothly implemented seldom occurs without public hearings, petitioning, lobbying groups and public debates. In these DVA case studies a narrative style is used to capture the "messy" human process by which a public health system adapts to change and criticism. In all four cases many DVA careerists opposed what are now considered sound policies and did so often from sincere beliefs. Human nature being what it is, new policies are often not accepted as the norm until those opposing them retire or die even in scientific arenas yet alone in the complex world of health care policy where there is greater inexactitude of results.

These four reforms occurred within this time line:

- 1.The major expansion of responsibilities of the VA in 1930.
- 2.The transformation of VA medical hospitals in 1946 via teaching affiliations, and an independent personnel system for physicians and dentists and construction of additional hospitals.
- 3.The 1980's-2000 decentralization and mission shift to outpatient care.
- 4.The inclusion of optometrists, optometry teaching affiliations and residencies and removal of optometrists from Civil Service in 1976.

## **Role of Optometry at Other Federal Agencies**

First, let us look at how other federal agencies utilized optometry before the DVA, belatedly, began to do so. The Department of Defense (DoD) was the first federal program to systematically employ clinical optometrists. In WWII ODs served as technical sergeants and in the early 1950's optometrists began to enter the uniform services as officers in the medical corps or an equivalent and today provide the majority of eye care to active duty servicemen, dependents and retirees. This was a contentious process pushed from within by an outspoken Army optometrist "Billy" Greene who rose to the rank of Colonel and from without by continued calls for reform from the American Optometric Association over many years. Issues of the Journal of the AOA during this era show process was slow and eventually required legislative reform similar to those of 1973 and 1976 to improve DVA optometry care.

Sizable numbers of optometrists also serve in other federal and state agencies as well as the U.S. Public Health Service, FDA and Institutes of Health. For example, the Indian Health Care Service (IHS) appoints optometrists as commissioned officers and began to increase utilization of optometrists about the same time as the VA, also the result of congressional intervention. The growing utilization of optometrists in the 1970's within DVA and IHS was triggered by the increased role they played in providing primary eye care in the uniformed services and HMOs which usually had ratios of 3 optometrists for every eye physician and the frequent deployment of optometrists to outpatient and outreach clinics adopted by a growing number of community health care agencies that also sprang up in the 1970's.

It was the fact these other federal agencies and HMOs utilized optometry staff to provide eye care that added support to the drive for the DVA to do likewise rather than rely solely upon eye physicians, that was central to the language within the Senate Report that accompanied the bills that led to reform of DVA optometry.

## **Reform #4: How DVA Reformed Optometry Care and Transformed Optometry Education**

In the 1946 reform, VA physicians and dentists gained statutory independence from civil service and their duties and salary became controlled by the VA which allowed VA to offer competitive salaries and VA hospitals to offer the same level of sophistication in staff, equipment and treatments as teaching hospitals by becoming teaching hospitals themselves.

While the VA could refer distant veteran patients to civilian physicians and dentists and pay for their treatment and travel, it could not legally refer to, or employ optometrists. No school of optometry had asked (or thought to ask) to rotate students. Eye care, when available, was rendered by an ophthalmologist or resident rotating from the medical school or, at distant hospitals, by a local ophthalmologist, or the patient was bused to a VA having an ophthalmologist or resident. This reflected the fact VA hospitals were patterned after teaching hospitals and optometry had no role at them.

Even at public universities having medical and optometry schools (Ohio State and Indiana University), there were no joint programs or shared eye clinics on campus, and they viewed each other as hostile camps. While once shunning VA hospitals, medical schools and their departments of ophthalmology now viewed VA hospitals as "their" preserve and optometry (or podiatry) was not welcome there either.

There was no statutory authority under 38USC to authorize VA to employ optometrists or refer patients to them in the community. As far as the VA was concerned optometry did not exist despite the fact military hospitals had begun to recruit and appoint them as commissioned officers by 1950 and by the 1960s there were more DoD optometrists than ophthalmologists since the majority of eye care needs fell within the abilities of optometrists and HMOs were also deploying large numbers of optometrists.

Optometry did not view itself as part of the medical community and had insisted when state optometry laws were created early in the 1900's that optometrists were *not* physicians, did *not* practice medicine and that "A Lens Is Not a Pill". It was those optometrists writing the first optometry laws who insisted they not utilize medications for any purpose. This only began to change in the 1950s as optometry schools broadened and lengthened their training programs and began to emphasize use of the ophthalmoscope to visualize the fundus.

Then, in the 1960s the American Optometric Association tried in each session of Congress to introduce legislation to authorize VA to employ optometrists. The first change to 38USC authorized VA to refer patients to civilian optometrists for care. Then, to hire optometrists at VA hospitals as Civil Service employees. But the VA then did not emphasize outpatient care and few, if any, referrals were made and the few hospitals that hired an optometrist via Civil Service offered noncompetitive salaries and utilized them as refractionists. As late as 1972 there were but 9 optometrists among 182 VA hospitals and hundreds of outpatient clinics of which most were within a VA hospital.

In the late 1960s a movement also began (the LaGuardia meeting) led by some educators and state optometry associations to seek modernization of state optometry laws and introduce greater medical diagnosis and treatment content into training programs which now generally required a baccalaureate degree before admission to four years of optometry school. Additional optometry schools opened in this period and the curriculum continued to broaden and to emphasize medical aspects of eye care. Many older optometrists deplored these educational reforms and insisted optometry not change. In fact until this time many of the university affiliated optometry schools granted the bachelor's degree in optometry whereas independent schools granted the OD degree.

This was an activist era among all segments of society and soon state practice acts were amended, against strong medical opposition, to include topical use of pharmaceuticals for diagnosis and then topical medications for treatment. It was during the heat of these "turf battles" between optometry and ophthalmology that efforts began to integrate optometry care and training programs into the VA system. The goal was to duplicate, for optometry, what had occurred for medicine and dentistry in the 1946 VA reforms since it was clear that reform had benefited both VA patients and the medical and dental schools.

The first shoe dropped in 1972 when Henry B. Peters, O.D., M.A., founding dean at the new (1968) University of Alabama at Birmingham (UAB) School of Optometry, secured Central Office funds from its office of Academic Affairs carrying a directive to open an optometry teaching clinic at the Birmingham VA hospital. Dr. Peters had been the first dean to organize an optometry school at a medical center with its students attending the same basic courses as medical students and he saw no reason optometry students should not rotate through the VA hospital around the corner along with medical and dental students. Dean Peters was a WWII Navy veteran with a strong clinical background that began with working in his father's practice and then as director of clinics at the U of California at Berkeley school of optometry. He had published epidemiological studies and was also given a faculty appointment at the UAB school of public health. A tall, robust man, he considered himself an "educational entrepreneur" and cast an imposing figure, often clamping a pipe in his teeth

This "radical" step (and it was) became so strongly opposed by the UAB department of ophthalmology that rather than creating an interdisciplinary eye clinic, as dean Peters and VA Central Office envisioned, a separate optometry clinic was created in the basement of the VA hospital which required duplication of equipment, scheduling and clerical systems. This came at the behest of the local VA administration to ensure optometry staff and externs did not work with ophthalmology staff and residents. A version of the "separate but equal" doctrine then a common compromise solution to race problems. While this separation was also the case at some DoD hospitals, there it was more logically, since DoD optometry clinics were busy entry and triage points and required space closer to hospital entrances. Also, when present, they were administered by the ophthalmology clinic rather than being separate.

The local Birmingham VA hospital administrators were, against their wishes, placed in the OD-MD crossfire and tasked with “making peace” and utilizing optometry despite threats from the ophthalmology department it would leave if optometry began a teaching clinic. This threat would later be echoed by other departments of ophthalmology but never honored because it would have damaged the ophthalmology residency programs which relied upon the VA for large numbers of patients and access to VA staffed and equipped ORs. Traditionally, medical department training heads referred to this as a need for “teaching material”.

While seldom remembered today, local VA hospital administrators and their chiefs of staff effectively worked out solutions to these disputes over the intervening years and many ophthalmology departments elected to endorse the establishment of optometry services and the cooperation between optometry and ophthalmology within DVA is now on par with that at military and USPH hospitals and HMOs. In one case, the affiliated chairman of ophthalmology divided his large, one-room VA eye clinic into 4 smaller exam rooms and agreed to accept two optometry 4th year externs who were told to “make themselves useful” which led, over the years, to a large optometry program covering that and other hospitals and clinics over a 50 mile radius and turning the ophthalmology clinic into a large referral center with a large surgical program. But, at first, it was pressure and funds from Central Office and the lobbying of dean Peters that led to the first optometry teaching program at an American teaching hospital in 1973.

Then, in response to AOA lobbying efforts within the House and Senate VA Committees, language was added to the bill that became PL 93-82 in 1973. Part of it established a position “Director of Optometry” in VA Central Office. The title was originally “Director, Optometry Service” but, during markup, “mysteriously” became “Director of Optometry”, a unique designation since all Directors in Headquarters were Directors of a Service. To this day, optometry is one of the few medical programs to be designated by law as a Service with a Central Office Director.

In 1974 this position was filled but, lacking a “Service” to direct, the Director did not have a budget, office or staff and was relegated to the prosthetics department to oversee the VA eyeglass contract. Meanwhile, the Civil Service decided the optometrist in charge of the optometry clinic at Birmingham had been appointed at too high a grade and significantly reduced his grade and salary to the point Dean Peters had to subsidize it. To put this in perspective, the approved Civil Service optometry salary was GS (Government Service) Grade 11 but DVA optometry salaries now start at the equivalent of GS-11 and range to the equivalent of GS-15, the grade of a DVA hospital director or senior DVA physician or dentist.

After little progress was made by the “Director of Optometry” the AOA renewed its lobbying and pointed out to congress that military hospitals and HMOs employed large numbers of optometrists and there was a large unmet need for optometry care within the VA. In 1976, ***against the recommendations of the VA in testimony before Congress***, Congress added language to the bill that became PL 94-581 that included a mandate for a VA Optometry Service and removed VA optometrists from Civil Service, placed them into the physician and dentist pay and personnel system and also directed the VA to appoint optometrists and create teaching affiliations with schools of optometry. This was a blockbuster provision some saw as long overdue and others saw as a threat to the quality of VA care.

### **It's 1946 for VA Optometry**

This 1976 Veterans Omnibus Bill did for VA optometry care what the 1946 law did for VA medical and dental care. It moved optometry staff from the noncompetitive civil service salary system into the VA physician-dentist personnel and salary system, mandated VA to appoint optometrists to the medical staff and, importantly, to establish optometry teaching programs and affiliate with schools of optometry.

But progress remained slow. There is a Washington saying that Congress may legislate but agencies implement and can stall, defer or kill a congressional mandate. Later, in the early spring of 1977, a joint AOA-ASCO report was presented to the VA offering detailed recommendations for implementation of PL 94-581 and, for the first time, the

schools added their support for integration of optometry care and teaching programs into the VA system. Dean Peters, understandably, was one of its chief authors.

Progress still continued so slowly that after Senator Proxmire, Chairman of the Senate Subcommittee on HUD-Independent Agencies, asked the General Accounting Office (GAO) to investigate the extent to which medical schools influenced appointments at VA hospitals (noted earlier), Senator Cranston, Chairman of the Senate VA Committee, asked him to include a GAO report on whether the VA was implementing the optometry portions of PL 94-581 (the 581st law passed by the 94th session of congress).

That is the irony. While once medical schools had refused to affiliate with VA hospitals in 1946; now affiliated, they fought against including optometry in 1972, and were being investigated for allegedly exerting undue influence in VA staff appointments and it was an investigation into this accusation that was broadened at the request of Senator Cranston to investigate why the VA was not affiliating with optometry schools and appointing optometry staff.

In 1978, a year later, GAO issued its report titled, "Role and Utilization of Optometry in the VA Need Improvement", making its findings clear. While one chapter documented resistance from ophthalmology, it was also clear VA Central Office had not been making serious attempts to implement the creation of an optometry service.

But, yet again, little progress resulted despite these findings and a congressional hearing convened and VA officials asked to appear. At this hearing Congress again made it plain it expected optometry to be fully integrated into the VA and this led, later in 1978, for funds to appoint optometrists and support teaching affiliations. {In fairness to the VA it must be noted that congress, while mandating the VA build an optometry service, had not appropriated the funds to do this. An all too frequent habit of Congress... to give an agency a mandate to carry out but no funding. To "mandate but not fund" and then... criticize the agency for not acting.}

But, in a rear guard action the VA, with the support of the US Civil Service, now argued that while VA optometrists would, by law, be transferred into the DM&S independent salary system for physicians and dentists, they would still receive the same compensation as they had under Civil Service at the very low GS-11 Grade. This position was taken despite the fact language in PL94-581 explicitly stated that salary was too low and VA should offer competitive salaries.

Meanwhile, some behind-the-scenes progress had been made in 1975, when one VA in Kansas City requested funding to begin an optometry residency which was approved by Central Office officials (not realizing none existed) which became the first residency program in optometry, another was added in 1976 and several small student rotations began without any support from CO using local funds and staff.

But clear sledding was still far in the future.

The Alabama VA teaching program and then the residency at Kansas City in 1975 and the debate over how to implement PL94-581 created such concern within medicine an AMA committee drafted a resolution in 1978 (#155) opposing employment and training of optometrists at VA hospitals and asking for repeal of those sections of PL 94-581 authorizing them. The AMA viewed this nascent VA optometry action as an "incursion" within the VA and a breach in their historical justification for not recognizing or cooperating with optometry... optometry had no medical or hospital training or experience.

This resolution might have passed if VA Chief Medical Director Dr. Donald Custis had not appeared at the AMA Congress in Chicago to argue against its adoption. He did so both because he was under a congressional mandate

and, perhaps as importantly, had earlier been the Navy Surgeons General and knew of the wide use of optometrists in military medical systems.

Even after resolution #115 was pulled, the entry of optometry and an optometry residency training programs into VA hospitals continued to be controversial, and the American Academy of Ophthalmology demanded Central Office send an official to appear and defend these programs before a hostile audience.

The situation was not helped by the appearance of the periodical PEN (Physicians Education Network), a journal distributed by MDs opposed to optometrists being employed by the VA or being authorized pharmaceutical use, and revised state optometry laws. The PEN elicited waves of angry letters to VA Central Office and these only increased when it issued a circular stating VA optometrists would not be supervised by ophthalmology but by chiefs of surgery or chiefs of staff. PEN considered this a grievous error because ophthalmology had always assumed that if optometrists did manage to enter the VA system, they would be under the direct supervision of ophthalmologists and this Circular salted their wounds.

Ironically once again, it was the actions of the AMA committee, the American Academy of Ophthalmology, and PEN that convinced Central Office it had to insure the independence of optometry as a service via this Circular on a "separate but equal footing" because young optometrists would insist upon professional autonomy and ophthalmology supervision would not allow optometry to thrive. And it was at this time that VA Central Office, while still using much of the appointment qualification language insisted upon by the Civil Service, tacitly agreed internally to offer competitive salaries up to and including the equivalent of GS-15. Thus by 1978 the way was clear, in theory, to construct an optometry service but no funding to do so was given by Congress.

As mentioned, this was an era during which states were changing optometry practice laws and few optometrists and ophthalmologists worked together, and it was rare for an optometry student to examine any but fellow students at school clinics. University medical and optometry schools did not talk to each other and the establishment of the optometry clinic at the Birmingham VA was seen as an invasion of sacrosanct training ground at "their" hospitals, and deeply resented. In 1974 the VA Director of Optometry had been physically given the "bum's rush" at a VA hospital by the chairman of the affiliated department of ophthalmology who told him to "get out of my eye clinic" while pulling him out the door. (An event noted in the GAO report.)

The slow progress in initially building the DVA optometry service only began to rapidly accelerate as a result of Reform #3 which emphasized the need to provide community outreach eye care and began to mandate treatment regimes for diseases such as diabetes calling for annual eye examinations. This shift to ambulatory treatment centers and growing emphasis on the value of eye examinations led to building upon the early progress made during 1976-1990 and an exponential enhancement of optometry staff and programs. Existing optometry programs were expanded and spread to surrounding new outreach clinics and new hospital optometry programs began which also spread to outreach clinics.

### **Medical Controversies Not Unusual**

The fact these disputes and jealousies were eventually overcome speaks to the positive role played by DVA officials charged with delivering eye care to veterans and changes in policy that began to set criteria on care. Rather than reacting to the medical needs presented by patients the DVA became proactive, and established screening programs and optimal treatment regimes specific to the needs of veterans.

But public health officials often have to listen to competing claims and arbitrate "turf battles", to separate the self interests of those competing to be a part of a health care system from what is in the best interests of those the system serves, and to attempt to educate a public which surveys show increasingly lacks basic understanding of the



scientific process and distrusts authority. These are not easy positions to fill and those holding the positions need thick skins. The subsequent rapid growth of DVA optometry programs occurred because they were ideally suited to the new, proactive positions on health care taken by Dr. Kizer during Reform #3 after only growing slowly from 1976 to 1994.

But controversies will always exist in health care like those that occurred in the past. There was once a bitter battle in Grand Rapids, Michigan about fluoridating the city drinking water and some saw it as an evil plot to corrupt children. Recently there have been battles over the value of vaccination against swine and other types of flu and a now-discredited paper was published in the respected journal *The Lancet* linking vaccination with autism. How about claims power lines or cell phones cause cancer? Struggles to educate or advise the public are not helped either when dishonest behavior clouds the picture. There have been cases of FDA advisors receiving subsidies while they made recommendations on an applicant's new drug. There were long contentious debates over "Agent Orange" and more recently concerns about depleted uranium bullets used in the Gulf wars. It is into these debates that public health officials are often called upon for clarification and during which they may find themselves caught between their personal beliefs and those of their agency superiors.

In fact, while non-physicians may view medicine as a monolithic profession it also has just as contentious debates and turf battles between its specialties. Plastic surgeons vie with cosmetic surgeons and battles occur over the oral cavity between oral surgeons, maxillary-facial surgeons and ENT specialists not counting oral surgery dentists from outside the fold. Orthopedic surgeons and podiatrists have had a longstanding skirmish over the demarcation between the foot and supporting leg and thus far seem to have reached a stalemate somewhere below the knee. Orthopedic surgeons and neural surgeons both claim the spinal column. But the ophthalmology-optometry disputes have been among the worst because both treat the same organ but have different training regimes and cultures.

Thus public health officials or officers associated with medical facilities soon become accustomed to these various forms of turf battles and they will continue to occur in health care just as diplomats will continue to face strife and war between countries.

## **DVA Optometry Today**

There is an exact parallel between the effects the 1946 reform produced on VA medical and dental patient care and training programs and the reform to VA optometry care and optometry training programs from 1976 changes in law... because the tools of reform were the same:

1. Competitive salaries to recruitment highly qualified staff
2. Independent personnel system to allow appointments and promotions based on "rank in the man" rather than number of staff supervised and use of personal, selective recruitment rather than "lists" of the "qualified".
3. Teaching affiliations to ensure modern standards and techniques, lower costs per patient treated and create a pool from which to recruit qualified future staff.

In 1972 there were no VA optometry teaching affiliations, no students rotated, no residency training programs existed and 9 poorly paid optometrists with limited privileges manned the VA's 172 hospitals and 120 outpatient clinics.

Today DVA is the largest employer of optometrists after originating hospital rotations of optometry student externs and pioneering postgraduate optometry residency training. DVA optometrists are the largest source of published clinical papers and CE lectures and every optometry school is affiliated with the DVA and rotates students and cooperates with residencies at one or more VA hospitals or clinics. This resulted because Reform #4 created the

tools to build an optometry service and, while it was slow to progress, Reform #3 established policy around which to expand those optometry services needed to meet the new, proactive policies on how DVA delivered health care.

### **Reform #4 Results 35 Years Later**

**DVA Residency Training Programs:** DVA supports 161 one-year residency positions with each resident full-time and supported by a stipend and fringe benefits. Annual DVA support of optometry residencies exceeds four million dollars. In addition DVA underwrites the costs incurred by the Accreditation Council on Optometric Education to support their accreditation by paying annual fees. The schools followed the DVA lead and later developed residency programs at their sites but over one-half of residencies remain based at DVA facilities. There are three DVA optometry research Fellowships.

**DVA Extern Training Programs:** DVA provides rotations for 4th year optometry externs and currently 900 serve a DVA rotation. Thus 70% of optometry students receive training at a DVA medical facility prior to receiving their degree.

**DVA Optometry Manpower:** Instead of the 9 of 1972, today over 600 optometrists are on the medical staffs of DVA facilities of which 420 are full-time. Of these, 60% hold faculty appointments at a school of optometry and 10% hold faculty appointments at a school of medicine. They are independent, prescribing members of the medical staff holding written therapeutic privileges.

**DVA Optometry Patient Care:** Recent data show DVA had 2.3 million eye care annual patients of which 1.3 million were cared for by optometry staff. This underlines statements made in 1976 and 1978 by congressional committees, the GAO, AOA and optometry schools that DVA then had an unmet demand for eye care.

**DVA Blind and Low Vision Care:** In 1972 there were three blind rehabilitation centers (Palo Alto, Chicago, West Haven) serving about 450 blinded veterans per year and since then additional BRCs have opened. A 1976 study by the Directors of Blind Rehabilitation, Optometry and Social Work Services determined that while additional BRCs were needed, DVA did not have programs for the larger number of veterans who had uncorrectable visual loss interfering with shopping, driving, preparing meals, reading and taking medicine. A year later funds were provided to open a pilot low vision plan at the Kansas City hospital staffed by ophthalmology, optometry, low vision therapists and social workers. It was overbooked and over the years additional low-vision centers have opened (The KC program received the AOA's Apollo Award). At these centers optometrists provide 90% of the care. More recently, to ensure greater access to low vision care without referral to a low vision center, the VA added 58 full-time optometrists with specialized training in low vision and eventually low vision services will become available at every VA having an eye clinic.

### **Implications of PL 94-581**

Clearly, the actions of DVA to create a national Optometry Service following the established 1946 model reforming utilization of medical and dental schools had a great positive impact on the care of DVA patients and the optometry schools, their training programs and students. While formerly denied access to hospitals for training students (the goal of AMA Resolution #115), DVA now offered access to a national system of hospitals and encouraged optometry schools to affiliate and rotate students. In addition DVA created a hitherto absent type of training, residencies, for graduates of optometry schools from which future DAV and optometry school staff and faculty are recruited.

Significantly, the opening of hospital-based training for optometrists coincided with, and often preceded the efforts to expand state optometry acts to include diagnostic and therapeutic medications.

These improvements in DVA eye care should be viewed against a 1975 VA medical advisory committee that concluded all patients needing eye care were receiving it and recommended DVA not recruit optometry staff. That recommendation was the result of politics, “turf” protection and the fact medical schools considered hospitals, and the VA in particular, their private preserve. That recommendation added fuel to the fire that led to PL 94-581 by making it clear to congress DVA believed its eye care programs were providing all the care needed.

### **Better Professional Cooperation**

A goal during the development of the VA Optometry Service was to create team eye clinics in which optometrists and physicians and their students and residents would work as colleagues so eye care would be more widely available, efficient and “turf” battles moderate. To a large degree that has not happened, but DVA optometrists and ophthalmologists today seldom have political skirmishes. Often their clinics are close together but usually under different administration divisions (outpatient care vs. surgery), referrals between them are two-way and easily accomplished. A large part of the additional optometry staff in the past 15 years have been placed at the rapidly expanding community based outreach clinics, ideal locations for them as they are trained to render first-line care, diagnosis, treatment and triage and to refer to the medical center eye clinics as needed. The relationship is therefore akin to that at military hospitals by being separated but harmonious except DVA optometrists have greater administrative autonomy.

Also aiding harmonious relations is the fact both can now concentrate on their respective strengths — primary eye care or surgical eye care — are salaried and have ample patient backlogs. When only one is present at a facility it will usually push to have the other established since they complement each other so well.

Since over half of DVA eye care is rendered by DVA optometrists today while the number of eligible veterans has declined and the size of DVA ophthalmology programs and staff have remained essentially constant, DVA did have a large unmet need for eye care in 1975. This means DVA ophthalmology programs did not suffer from the addition of optometry programs but were enhanced by receiving increased surgical and secondary medical referrals and by reducing their need to provide general medical and follow up eye care. Adding optometry staff has turned larger DVA hospitals into high volume ophthalmology specialty referral centers.

### **Recent Developments in DVA Optometry Since 2005**

In 2002, DVA optometrists began work with the National Board of Examiners in Optometry to develop a written examination to test the advanced competence gained by optometrists completing DVA residencies in medical optometry. The resulting Advanced Competence in Medical Optometry (ACMO) written examination became available in 2005 to quantitatively test advanced competence in medical eye care and, in 2010, ACMO was opened to residents completing an ACOE accredited medical optometry residency rather than just DVA optometry residents. This parallels the growth of the Optometry Residency Matching Program (ORMS) that began by only matching applicants to DVA optometry residency positions but as non-DVA residency programs began, expanded to include matches for all residency programs on a national basis.

Completing the maturation of optometry residency training, in 2009, the nonprofit American Board of Certification in Medical Optometry (ABCMO) was incorporated to offer certification in the specialty of medical optometry utilizing the traditional criteria leading to certification of medical, osteopathic, dental and podiatry specialists; residency and passage of a written specialty examination to become eligible for certification in that specialty.

Now, 35 years after they began, through the final process of establishing ACMO and ABCMO, optometry residents in medical optometry have a creditable, national certification process using criteria recognized by the credentialing committees at JCAHO accredited health care facilities.

## Conclusions

To counter those who claim public or “socialized” health systems must be sub par I ask them to consider the DVA hospital system since 1946. Over the years national external studies have found DVA delivers excellent care at a lower cost per treatment episode than in the private sector and DVA health care facilities meet the same accreditation standards of the Joint Commission on the Accreditation of Health Care Organizations (JCAHO), the national gold standard, required of civilian US hospitals and clinics. In the past 10 years the DVA has led the way towards digital record keeping to insure the medical records, scans, and lab reports of any veteran entering any DVA facility are immediately accessible by the attending clinician at their desk top and DVA continues to have a very low malpractice claim rate compared to civilian hospitals.

A less noted positive feature of a system such as the DVA is that their medical staffs, including optometrists, are subject to far more oversight than their counterparts in private practice. Not only are all relevant credentials verified upon appointment but all undergo regularly scheduled peer reviews and annual proficiency evaluations and searches of the National Practitioner Data Bank and the DVA digitized patient record system provides reminders and checks for essential tests and procedures customized for each patient's list medical diagnosis and treatment. Similar systems are used to monitor prescription interactions which are not entered in handwriting but from the prescriber's computer to improve legibility and years before DVA has begun to utilize unit dosage.

The revolution in DVA medical, dental and nursing care in 1946 and then VA optometry and podiatry care in 1976, took place because public health officials, congressional committees, veterans groups and special interests made their concerns known and were eventually able to progress against the strong and well organized resistance of vested interests. The process was contentious and some VA officials were placed in the middle of disputes while others were part of the disputes. But results show that, in the end, DVA officials did what was in the best interests of its patients.

Validation also lies in the fact that once these four reforms began, VA hospital chiefs of staffs looked at the results and insisted their hospitals join in and did so by expending their own budgets rather than waiting for Central Office to fund them. Later, the criteria used to evaluate DVA administrators began to include the goals first stated in these four reforms of which teaching affiliations still remain key.

Because DVA has had to adapt to local health care issues and differing local political climates since its inception, there is a time honored saying among its staff that: “If you've seen one DVA hospital you've seen one DVA hospital”. The shift towards greater decentralization and outreach clinics that began in the 1990's has only made this maxim truer. So, far from being a cookie cutter health care system, in which every community has identical DVA facilities and services, each DVA is empowered to adjust to the demands of the environment in which it finds itself while maintaining the goals and standards set by DVA Headquarters by exercising a high degree of flexibility and autonomy.

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