

## **PUBLIC HEALTH AND THE DEPARTMENT OF VETERANS AFFAIRS**

**Kenneth J. Myers, Ph.D., O.D.\***

### **Chapter Summary:**

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 a 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

	Agency Name	Top Officials-Department
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 #1. (1930) Centralization of Veterans Programs***

While the Mayflower Compact was a method to organize benefit programs for members of the first colonies, recognizable public health programs began with services to those who had served in the revolutionary armies, the Civil War and ensuing border and Indian wars. Various agencies were established at the federal and state level to provide for "soldiers' homes", soldiers' pensions and cemeteries. By the end of WWI there was a confusing array of these programs and Congress decided it made sense to place many of these programs for veterans into one federal agency and did this, in 1930, by incorporating them into the existing, but smaller Veterans Administration, which remains located today at

810 Vermont Ave. in Washington, D.C. and is now named the Department of Veterans Affairs (DVA) led by a Secretary appointed by the President on whose cabinet the Secretary sits.

It is widely recognized the United States has the most comprehensive system of benefits of any nation for veterans of its armed services and these range from home mortgages, compensation and pensions to the most advanced forms of medical and surgical treatment.

The genesis of these services, which rapidly expanded after the Civil War, reside in President Lincoln's second inaugural address in 1865 given a short time before the surrender of the Confederate Army and his assassination later that spring. In that speech Lincoln foresaw the need "...to care for him who shall have born the battle and for his widow and orphan...." From that date, bit by bit, our country organized various independent groups caring for veterans and today, DVA operates the world's largest medical care and medical training system in the world as well as administering compensation, pension, cemetery, home loans and other program for veterans such as the new "GI Bill", for the some 27 million living veterans of our country's armed forces. (The Lincoln quote remains chiseled on the wall at the entrance to DVA headquarters.) While some may forget about veterans once a war ends the DVA does not. Not too long ago a one-person office still existed in one of the lower levels in its Headquarters that tracked and provided benefits for veterans and their widows of the Spanish-American War.

### **GROWTH SINCE 1930**

Since 1930, DVA has remained an independent agency and has never been part of the Department of Defense (DoD) which provides health care only to active duty members of the armed forces, their dependents, and retirees. (Although DoD retirees are eligible for DVA care, the majority of DVA beneficiaries are not military retirees since most of those who have served in our armed forces, until recently, have been draftees or volunteers who mustered out once their terms of service expired.) The DVA health care system is open to all veterans, on a prioritized basis, who have served in our armed forces and been discharged in other than dishonorable conditions. Priority of care is given to those treated for service connected conditions which, broadly speaking, are any condition(s) diagnosed during service.

Today, DVA and DoD cooperate and have sharing agreements in place. DVA optometrists and medical staff are civilian federal employees and military optometrists and medical staff are officers in their respective armed service's medical corps. DoD optometry officers usually rotate to several bases during their career whereas DVA optometrists typically remain at one facility unless they request a transfer.

As a result of operating a medical system of 171 hospitals, 350 local community outreach outpatient clinics, 126 Nursing Home Care units, and 35 Domiciliary centers, DVA also administers the world's largest system of educational training programs for health professionals and sponsors national collaborative medical research programs and Centers of Excellence in various disciplines via its Veteran's Health Administration.

DVA is headed by a Secretary of Veterans Affairs, a cabinet level position appointed by the President, with an annual budget of over 110 billion dollars and employs over 200,000 personnel, smaller only than DoD and US Postal Service in workforce.

By definition, DVA is a "bricks and mortar" public health (socialized) program because the government owns (or leases) and operates and maintains its hospitals and clinics and employs its personnel based on federal property. DVA also subsidizes many state operated "veterans homes" via per-capita payments. Since it operates within an annual budget it therefore must, by definition, "ration health care" as do all health care systems whether public, private or charitable that do not have unlimited operating funds (none do). Populists' claims about a future of health care rationing and socialized medicine is misleading since both have existed in this country since the time of the Mayflower Compact.

#### **What Is A Public Health Program**

Before considering the DVA reforms to come, let us examine the public health climate in which the DVA functions and how it evolved.

Essentially any program utilizing public funds (taxes, fees) controlled by a governmental body is a public health program. It is a program citizens, via elected officials, believe should be funded from public coffers and overseen by public officials for the good of the public or a sector of the public such as veterans, active duty military personnel, those over 65 (Medicare) or the poor (Medicaid). Currently, those opposed to such programs term them "socialized medicine" since this has a negative connotation to some Americans. But our federal, county, state and municipal governments have long operated public or "socialized" programs we take for granted such as public highways, police and fire departments, public schools and departments of public health. Our airlines are regulated by the FAA as are trucking companies by the DOT and FCC and our medicines by the FDA. The citizen of a developed nation lives in a "socialized system" having a multiple of "alphabet agencies" ranging from "brick and mortar" ones like DVA to regulatory, oversight ones like the Food and Drug Administration and the meat inspections of the US Department of Agriculture. Many of our farmers receive federal subsidies for not growing crops or are given a guaranteed price on future crops. And most of these programs have counterparts at the state and local level. In the late 1980's the federal government made land grants to start many of the large state universities in the mid-west. As a result, our country has long had "socialized programs" of various

types. We have long been a “socialized” country. The only issue is the degree of socialization compared to other systems; whether these systems infringe upon “freedom” of choice and whether they are fair and efficient. Some are even monopolies such as the agencies regulating public power utilities.

Many opposed to such programs in health care term them “socialized medicine” to imply they believe they do, or will, provide inefficient, slow or rationed services with long waits and rude personnel. Americans bristle at any loss of independence and control over matters that affect them personally and health care is surely personal. But to dismiss all such programs as “socialized medicine” is to ignore the fact they have been with us for a long time and, like all programs, whether public or private, vary from poor to excellent. Each of these “socialized” programs must be evaluated on their own individual merits. To argue against “socialized medicine” without specifying a specific program’s faults is as broad a prejudice as believing only the private sector should deliver public programs.

The ways in which a “socialized medical” system operates can range from one end where the government owns, builds and staffs the health care system and controls the types of services and who receives them to ones like Medicare where the government does not build or staff hospitals or clinics but acts as an insurance plan that provides payment to providers chosen by the recipient or to regulatory ones that, for example, inspect restaurants and packing houses.

The trend towards increased public health care programs in our country is evident. A recent article in *The Wall Street Journal* (“Public Health Tab to Hit Milestone”) notes that... “For the first time ever, government programs next year will account for more than half of all U.S. health-care spending...”. Thus half of all health care costs are now paid or covered by “socialized” public health care programs.

To see this in greater relief, consider that shortly after WWII, support of public health care programs accounted for less than 10% of all health care expenditures and an even smaller portion of the Gross Domestic Product (GDP). In that period clinicians and hospitals billed patients directly and those unable to pay sought the aid of a charitable organization funded by a religious or local agency. Hospitals had charity wards and physicians often varied their fees to fit the patient’s “pocket” or “put the bill on the cuff”. Health care was essentially “cash-and-carry” and not a “right” but a service one bought if one could afford it. If one could not, one did without or sought charitable relief. The author’s great uncle was a country doctor who often was paid in farm goods. Many today do not recall that prior to WWII physicians were not as well paid and most had small, private practices as hospitals had not gained the influence they have today. Physicians of this era had the greatest autonomy and perhaps the greatest respect even though their training was often rudimentary.

But, in only 25 years (1970) public health programs accounted for some 40% of all health care spending and will exceed 50% in 2011. Based upon who is paying the bill, our country now has a 50% socialized (government) health care system. At the same time, the percent of GDP spent on health care has rapidly increased and in 2009 reached 17% of GDP compared to about 9% in 1976.

Coinciding with this rapid growth in expenditures on health by the government came the removal in the late 1970s of bans on advertising by professionals and these factors conjoined to health care becoming truly become “big business” with lay administrators and boards of trustee judging results often by the “bottom line”.

We should temper our common belief we enjoy the best care in the World. Compared to World Health Care Organization criteria, the U.S. has lower quality health care, on average, than many industrialized countries in spite of spending a higher percentage of GDP. It is true that, at its finest, our country meets or exceeds the care offered anywhere, but the question asked by public health officials deals with the quality and accessibility of health care the average American secures and the degree to which poorer citizens may be excluded from medical care.

The goal of public health officials is to recommend, determine, and help improve the standard of care available to the average and the most vulnerable citizens. It is not to ensure that every citizen receives the best, most elaborate care available, but that every citizen can access a level of care society believes all citizens should receive. This is the “public” in public health. It is not, as some claim, the role of public health officials to limit everyone to the same standard of care which is what socialized medicine really means to its critics, i.e., that all are treated the same, there is only the one level of care available and it is mediocre and requires waiting. But without public health initiatives, hospitals would not be required to provide emergency care and stabilize indigents at emergency rooms for example.

Of the 17.3% of US GDP spent on health care in 2009, government programs accounted for 8.4% of the expenditures and, while Medicare and Medicaid represented the bulk of this government spending, other government bodies, the DVA, military hospitals and Indian Health System addressed the health needs of subsets of citizens and other less known government bodies benefited the public’s health such as the Centers for Disease Control, the National Institutes of Health and countless local departments of public health. Often not thought of as public health agencies because they are taken for granted are municipal, town and village sanitary systems and water departments. In fact, civil engineers have long been hidden heroes of public health via construction of systems which accounted for a large part of the improved health of Americans. These systems only become visible after an earthquake, hurricane or other major natural disaster or war.

Let us now examine how DVA reacted to calls for reform after its reformation and expansion in 1930.

### **Reform #2 (1946)**

The growth and changes within the VA medical system (as it was then known) following 1946 illustrate the interactions between a public health provider and its officials with those it serves, congressional oversight committees, special interest groups and trade associations. The “iron triangle”, is the name given a model of these forces as consisting of a public agency, its congressional oversight committees and lobbying groups, represent the three primary forces shaping federal policy and expenditures. There may be a fourth corner, forming a rectangle, if there is an employee within an agency who believes something needs improvement and appeals to the other three corners for assistance.

From 1930 to 1945 the VA medical system operated a modest collection of out-dated facilities often inherited from the military or from state sanitariums and “soldiers homes”. VA physicians and dentists were federal civil servants recruited from US civil service rolls and tended to be older and/or close to retirement and poorly paid. They often saw the VA as a form of sinecure and worked part time in semi-retirement. Many in the VA saw its role as being responsible for offering a form of “care taking” and domiciliary care to elderly veterans.

VA hospitals were not affiliated with medical and dental schools and its medical staff were not affiliated with medical schools and externs and interns or residents did not train at VA hospitals. Those seeking VA care generally lacked the means to secure private health care and most Americans did not have health insurance. Despite those shortcomings, a person without means was more fortunate if he or she was a veteran. Still standing today, next to the Washington, DC DVA hospital is the Old Soldiers and Sailors home President Lincoln often visited by riding, often without guards, up 16<sup>th</sup> street from the White House to seek solitude.

Organized medicine and medical schools had long deplored the VA as offering “socialized medicine” and had no interest in VA facilities. Their criticism was valid but they made no suggestions how VA care could be improved save closing them. Rather than criticizing the VA for offering incomplete and less than excellent medical care it dismissed it as “socialized” medicine instead of helping.

### **Wake up Call in 1946:**

As WWII wound down and millions of men and women in the armed forces were returning to civilian life, it became clear large numbers of them would require continuing medical care which military hospitals do not provide once a wounded soldier is discharged unless they are retired careerists which most veterans were not. The overwhelming numbers of WWII combatants were civilians in “for the

duration” and not careerists, who would soon access the VA system and, since they also suffered the majority of injuries, who was to care for them? Health insurance plans were rare in those days and many veterans needed care not widely available. Thousands were returning legally blind, missing limbs and needing continued care for which there were few civilian institutions capable of offering that care. And neither was the VA which had, for example, no blind rehabilitation centers and very few, and outmoded, prosthetic services still issuing WWI era devices.

President Truman decided action was needed and asked three-star General Omar Bradley to leave the army and administer the reforms he knew were needed at the VA. Bradley brought with him Dr. Paul Hawley who had retired as the two-star General commanding the US Army Medical Corps in the European Theater of Operations. Shortly after that, Paul Magnuson, an energetic orthopedic surgeon from Chicago with no prior bureaucratic experience but a burning desire to do the right thing for returning GIs and an interest in rehabilitation medicine was brought to Washington by Dr. Hawley and given the formidable task of enlisting the help of medical and dental schools.

Dr. Hawley became the first Chief Medical Director once the reforms took place with the formation of the Department of Medicine and Surgery and was followed in that position by Dr. Magnuson. The autobiographies of General Bradley, “A Soldiers Story” and Dr. Magnuson “Ring the Night Bell”, give compelling histories of their struggles to modernize the VA beginning in 1946.

Articles in the Washington Post during this era were vivid in their description of the struggles between the President, Congress, Civil Service Commission and organized medicine over how to modernize the VA hospital system. Although it was to later become a major beneficiary of VA modernization, the medical schools and organized medicine had no interest in the crisis and did not engage in the public debate save for urging the VA system be closed because it was socialized medicine. The AMA and the medical schools were not stepping forward to aid the VA, only to criticize it.

A major VA construction project was organized to build modern hospitals and with the support of the President (against political and bureaucratic resistance and especially the US Civil Service Commission) Congress passed legislation to remove VA physicians and dentists from the Civil Service, to create a new, independent, VA “Department of Medicine and Surgery” with a personnel department offering competitive salaries and to recruit higher quality medical and dental staff. As important was the mandate to convert VA hospitals into teaching hospitals by affiliating with medical and dental schools and creating Deans Committees to oversee and recommended medical staff appointments affiliated VA hospitals. But how was this to be done?

This was the seemingly impossible task given Dr. Magnuson when no medical school was affiliated with a VA hospital and most did not want to become part of “socialized medicine” which, in those days, was seen as the next thing to Communism. In addition, congress created a Special Medical Advisory Group (SMAG) composed of leaders in medical, dental and nursing education that met regularly in VA Central Office and reported directly to the top medical administrator but its formation was also facing stiff opposition from medical schools who saw those physicians joining it as going over to the “enemy”.

All of these changes to regulations and new statutory authorities were placed in an amended 38USC, the collection of federal rules and regulations, governing the VA and its many programs in 1946. But it next took a number of years and millions of dollars to modernize the VA and overcome the resistance of the medical schools.

Medicine is, properly, a conservative profession and Dr. Magnuson had to make the rounds of leading schools to encourage them to affiliate by pointing out how their training programs and VA patients would both benefit from affiliation and to appeal to their patriotism. It was a hard sell, but slowly, the leading, more progressive medical schools began to affiliate and to rotate externs, interns and residents and take part in nominating candidates to attend at VA hospitals via the Deans Committees. New VA hospitals were constructed in the immediate neighborhood of medical schools and by 1950 schools began to compete with each other to affiliate with the VA since fiscal support and access to new patients began to change their minds. Today, few medical schools remain un-affiliated and the VA is the largest supporter and operator of medical education in this country. Medical schools are now very possessive of “their” VA and, on average, half of all medical students and residents train at a VA facility during their education. This change in attitude led some to view non-teaching DVA facilities as “backwater” facilities and encouraged them to also seek teaching affiliations.

### ***The Era of Expansion, 1945-1972:***

It took many years to modernize the VA after WWII. The next 25 years saw the VA rapidly grow and cement strong, enduring affiliations with all health training programs (save optometry and podiatry) to the point almost all medical, dental or nursing schools were VA affiliated and it became common for the VA to arbitrate disputes between medical schools over which could secure a VA affiliation. Socialized medicine began to look appealing to the medical schools when they saw it could benefit their training programs.

The VA liked to use the model that it and the medical and dental schools both had the same goals but in reverse order. For the VA these were patient care and then education and for the schools it was education and then patient care. Thus these affiliations flourished.

Their appeal stemmed from the VA offering a large, diverse population of patients having acute and chronic health conditions and paying stipends of the VA trainees and the salaries of their VA supervisors who often also held faculty positions at the affiliated medical school and from the VA constructing and maintaining the VA hospitals. As a result VA hospitals came to be viewed as valuable resources for medical schools and it became the norm for physicians to have joint appointments at their medical school and “their” VA hospital with interns and residents rotating at both. It also allowed the VA to transfer complex cases to the teaching hospital.

The new Department of Medicine and Surgery (DM&S) was itself organized as a hospital with a Chief of Professional Services to whom each specialty reported via a Director which paralleled the hospital system of a Chief of Staff supervising their Chiefs of Services. To be a Director of a service during this era was to enjoy great authority as each was in charge of a specialty and possessed considerable resources. Overseeing the entire program was the Chief Medical Director who reported to the Administrator of the VA.

For example, the Director of Surgical Services in DM&S controlled these elements:

- National budget for surgical personnel
- National budget for surgical research
- Appointment and promotion of surgeons
- National budget for stipends paid surgical residents
- National budget for surgical equipment.

Service directors in DM&S were able to put their stamp on their specialty during their tenure and the role of the Chief of Professional Services was to allocate the total VA medical budget among them much as a mother hen feeding her chicks. The role of the chief of staff at each VA hospital was then to ensure the quality of care and maintain productive relationships with the affiliated schools so neither dominated while overseeing the resources allocated it by DM&S. Without a strong VA Chief of Staff the affiliated medical school dean and service chiefs could tend to turn “their” VA into a mirror of their own teaching hospital as medical schools now embraced the VA system so there was a built in tension between the VA Chiefs of Staff and the deans of the medical schools.

Medical schools had eventually rushed to affiliate with a new VA hospital since this opened the door to a large, interesting patient population and fiscal support for their training programs. But, even today, some major population centers lack a VA hospital because during this period of expansion their medical societies viewed the VA as the “enemy” (or competition) and refused to support a VA hospital and missed the boat. An example is Columbus, Ohio which only gained a VA outpatient clinic in the 1970s and still lacks a hospital although Cleveland, Chillicothe (35 miles away), Dayton and Cincinnati have long had VA teaching

hospitals showing that local medical politics can cast political shadows far into the future.

### ***Reform #3 Era of Decentralization and Mission Shift, 1972 to 2000***

The most recent global reform of the DVA health care was triggered by new theories of administration referred to now as creating a “flat organization” via decentralization and by changes in the health care demographics of veterans due to the aging of WWII veterans and the influx of veterans from the Vietnam conflict and Gulf Wars coupled with new treatment techniques not requiring hospitalization. During this period each new Chief Medical Director and then Undersecretary for Health often introduced a new management concept such as Management by Objectives or Zero Based Budgeting and Diagnostic Related Groups (DRGs) came and went as a means of setting work units. Like most large agencies much of the day-to-day work was routine and even self inflicted such as seemingly endless meetings and meeting the requirements placed on it by other agencies.

Whether from bureaucratic power struggles or outside pressures, the strong centralized roles of service directors in the Department of Medicine and Surgery were curtailed by 1973 and they lost control of national budgets for staff, residents, equipment and research within their specialty with new VA departments in Central Office controlling them. Residents was split away to the Office of Academic Affairs, research funds were assigned to another office and the Regional Directors gained increased control over budgets for staff, space and equipment. This weakened the power of the Directors who were now in advisory staff positions without operational or budget control and Regional Directors gained power but were not clinicians and controlled staff and budgets.

Rather than doled out to each hospital by each Director of a specialty, VA hospitals were now given separate “ceilings” for operating funds, numbers of personnel, residents, and research and equipment funds by other offices in Central Office and each hospital then decided how these funds and staff were to be allotted. Since greater authority had been transferred to each VA hospital, their affiliated medical schools also gained greater influence by their linkage via the Deans Committees. To some observers it appeared medical schools that once viewed the VA as the enemy were now increasing their influence over VA operations and gaining the upper hand because a single Service Director in Central Office no longer allocated funds, staff, equipment and research monies for each specialty. Frequently budget requests by local VA hospitals were driven by the “needs” of their affiliated schools. In the first of ironies to be noted, this led in 1975 to an investigation by the General Accounting Office upon the request of Senator Proxmire that later, upon the request of Senator Cranston, was expanded into looking into whether the VA was offering sufficient eye care (last case study). One reason for Senator Cranston’s concern was that while the VA employed large numbers of audiologists along with ENT physicians, it employed

few optometrists and relied on ophthalmologists to provide all aspects of eye care.

Then, in the 1980's, the VA began to realize its mission would have to shift due to changes in veteran demographics and trends in treatment. For example, a shift from inpatient to outpatient treatment of many conditions once requiring long term or extended care was becoming evident and the VA had to adjust not just to these new treatment modalities but to changes in its patient demographics as large numbers of WWII veterans began to be replaced with Korean and Vietnam veterans having different medical conditions.

A major reorganization took place in 1989 when VA became the DVA, a Cabinet Level agency, and decentralization was accelerated during 1994-99 under the direction of Kenneth W Kizer, MD, MPH who had previously been a chief public health official in California. An activist, he spearheaded the need to further decentralize, close long term care wards, and rapidly added small, community outreach or neighborhood clinics. It had also been no secret that many DVA hospitals organized their clinics and residency training programs to mirror those of their affiliated medical schools (one reason for the above GAO report) and their teaching hospitals even though this was not necessarily the best alignment of services for veterans having different morbidity demographics.

In recognition of these different patient demographics Dr. Kizer began to take firmer control of DVA teaching programs and to adjust the numbers of residents it supported in each specialty to better reflect the needs of veterans. In addition, DVA began, or increased, residencies in geriatrics and other specialties germane to the rapidly changing and aging veteran population.

By this process the DVA made three major mission shifts after becoming a cabinet level agency with new administrative titles and flow charts.

- Moved from long or extended stay to shorter term care
- Moved from hospital-based care to large numbers of small outpatient clinics
- Adjusted residency training programs to better reflect the needs of veteran patients rather than the general population served by civilian teaching hospitals

The very close scrutiny given the last item by medical schools and medical specialties reflected how important DVA affiliations had become to them.

More recently the DVA has had to address the issue of veterans returning from the two Gulf Wars and the Afghanistan deployment and to improve coordination of medical care and benefits with the Department of Defense and its budget has been significantly augmented after suffering from belt tightening in the prior decade.

These three reforms now discussed, all addressed how the entire DVA health care system was reformed and better adapted to the needs of those it served. Optometry played no role in reforms 1 and 2 because its schools and colleges were not part of the VA affiliations with medical and dental schools and all eye care was provided by the ophthalmology departments affiliated with the DVA. But there also had been no interest expressed by the optometry schools in DVA affiliations as they continued to train their students in campus or neighborhood clinics removed from medical education and hospital settings.

But at the time of reform #3 the VA had integrated optometry and podiatry care into its clinical programs and they were integral parts of that reform process and played significant roles because they were suited to deliver ambulatory primary and secondary patient care and were being increasingly sited at the expanding community outreach clinics. How this came about now follows.

#### ***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 (see references). 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 4<sup>th</sup> 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 581<sup>st</sup> law passed by the 94<sup>th</sup> 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 by 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 4<sup>th</sup> 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.

### **End Notes To Those Interested In Public Health**

As former President Carter once said, "Life is unfair". The making of public health policy is messy and frequently inefficient but so is democracy and the higher one is placed in any bureaucracy the more politics become visible since agency heads and their staff are political appointees or elected officials. Things are seldom done by a committee of "wise men" who see their recommendations efficiently carried out without protest groups forming because there is no issue that will not have groups offering different opinions of which some are evidence-based or honest differences of opinion while some are scare tactics not based in fact.

Unfortunately, special interest groups or trade associations know they can secure additional members (and funds) if they have an "enemy" around which to rally in addition to providing member services and conventions. Thus a public health proposal may find itself beset by lobbying groups portraying it as the work of the devil despite the facts. The National Rifle Association sponsors many fine programs but also opposes almost any restriction on firearms including assault rifles for hunting. Public health officials proposing to lower homicide and suicides by limiting access to firearms face formidable opponents capable of harsh marketing campaigns.

The currently famous "death panels" some opponents of health care reform invented to scare Americans is an example of how far antagonists may go. As recently as 1994, CEO's of major tobacco companies testified before Congress nicotine was not addictive and even questioned smoking as a risk for lung cancer. People tend to fear or deny what they do not understand (but have usually not taken the time to understand) or have taken the word of others there is something (or nothing) to fear. Public health workers must be prepared to handle these emotional movements in a professional manner just as climatologists must deal with those who deny global warming is connected to human habitation while traffic and coal-fired power plants continue to spill their exhausts into the air.

A recent survey claimed 3% percent of Americans believe they have been taken aboard an alien space vessel and returned to Earth. (If you attend a sporting event with 100,000 people it's likely there are 3,000 of these "astronauts" there with you.) Only around 61% of Americans believe humans are the result of millions of years of evolution and many believe Earth is a few thousands years

old despite overwhelming evidence from scientific dating methods. And the same science which leads to life saving vaccines, medicines, and other therapies are quickly embraced by the same people who deny the concept of genetic change or grow pale at the thought of stem cell research. How much would the reader desire to be a public health official addressing whether abortions or “morning after pills” should be available at a clinic or free needles given addicts or marijuana prescribed for treatment of glaucoma.

Even with the billions of neurons within our brains, we are not capable of understanding all there is to know about even a single subject yet alone all those affecting our lives. Thus we all have “opinions” based on incomplete knowledge even the great scientists. Sir Isaac Newton, the greatest mathematical physicist, lost a fortune betting on the London Stock Market, from backing his wrong opinions with money.

Reformers often suffer even when correct. Engineers at the company building the Challenger Space Shuttle solid rocket boosters were “shut up” by company officials who insisted to NASA it was safe to launch in freezing weather for the first time. The executive warning Enron CEO Kenneth Lay company financials were unsound has received as much criticism as praise. Health officials may need to titrate personal ambitions and career concerns in the knowledge they may be placed in difficult positions where mere facts are not sufficient to ensure their viewpoints will prevail and to always carefully consider whether their opinion might be wrong.

Consider these DVA examples. Some years ago the then Secretary of Veterans Affairs testified before a congressional budget committee that next fiscal year’s DVA budget was fine. Despite ample evidence DVA needed additional funds to address the needs of returning gulf war veterans he stated the budget proposed by the administration was in good order and remained a ‘team player” by supporting the President’s proposed budget. Was he correct to do this? What if, as is always the case, the President would have had to cut funds supporting another good program to provide more DVA funds?

Even more relevant, the current DVA Secretary was earlier the Army Chief of Staff “encouraged” to retire by the Secretary of Defense for not agreeing to the latter’s belief relatively few numbers of troops were sufficient to conduct the second Gulf War and he had, instead, stated a larger number would be needed to defeat Iraqi armed forces and then maintain order.

To adopt contra positions one must carefully weigh the facts and be prepared to take the consequences even if later shown to be correct. In fact, despite a flurry of “whistle blower” legislation in the past decade, it continues to be true their careers usually suffer. Thus every public health officer above the rank of “bean counter” can be placed in difficult positions.

## Past and Present Observations about Public Health and Costs

Health care costs and how to deliver it have long been “hot buttons” in the US. Consider these excerpts from Time magazine describing an AMA meeting in New York City.

“The country may well suffer from...”a massive crisis” in public health”. “At the AMA’s semi-annual meeting last week... , the members came equipped with the usual bag of proposals to block “socialized medicine”. Still remembered are the association’s relentless fights of yesteryear against Medicare and Medicaid...and its efforts to limit medical school enrollment. Thus the AMA...is blamed, somewhat unfairly, for the soaring cost of medical care, which is *rising at a rate of more than double that of the cost of living.*”

While these statements sound familiar, they appeared in the July 25, 1969 issue of Time magazine, 41 years ago, the week Astronauts Armstrong and Aldrin walked on the moon and before most readers were born. By the 1970’s many schools of public health and even schools of business were conducting courses in health care management in which considerable time was devoted to containing rising costs and rationing coverage. These enduring themes of cost and availability were foreshadowed in this 1969 Time magazine article in these other excerpts.

- “Just after the predominantly white, middle-aged doctors had joined in a 30 minute tribute to the flag, a strident group of young medical students, doctors and nurses burst into the hall, chanting “Hip, hip Hippocrates, up with services, down with fees!””.
- “Later the delegates wound up endorsing the concept medical care “...is a basic right of every citizen. In the past, such care had been called “a privilege””.

Health care issues are not just complex, longstanding and laden with emotional values but frequently discussed after assuming its costs must be reduced, or at least not allowed to increase, as a percentage of the GDP. It now hovers around 14%. But is this an unreasonable percentage of GDP? Most observers, with thought, agree good health is vital not just to the individual but to society and our financial prosperity. Americans signal what they value by how they spend money... so how does spending on health care compare to spending on cars, travel, clothes, entertainment and the latest in cell phones, cable and satellite fees, all of which are transient, perishable items compared to health. Perhaps we should spend 20% of GDP on health and less on other things?

How responsible are we, individually, for the rise in health care costs? Newspaper articles continue to point out Americans increasingly gain weight, smoke, fail to exercise, eat fast foods and miss sleep while we relentlessly pursue income to support non-health-care activities while consuming more

energy sources per capita than other industrial countries. Even the food we buy in grocery stores is highly processed and laden with agents not fully understood nor desirable as witnessed by the sudden rise in type diabetes II many attribute to not just overeating and lack of exercise but prevalent use of high fructose corn syrup.

This is not to say other countries' citizens are more virtuous since the American form of "lifestyle" has slowly but surely spread across the world since WWII because humans tend to be susceptible to the same temptations as they gain affluence. Perhaps "human nature" then is responsible for continually rising health care costs?

The March, 2010 issue of Fortune magazine interviewed Dr. Delos M Cosgrove who directs the Cleveland Clinic. It, along with the Mayo Clinic, are recognized for their excellence of care and cost efficiency suggested as possible models for national health care programs. The answers he gave are revealing.

- Fortune: "America has the world's highest medical costs by a mile, but we have only mediocre health compared with other developed countries. What's the problem?"
- Dr. Delos: "We do not have a system of health-care delivery in the U.S. It's a series of mom-and-pop shops all over the country, and it has not been systematized. In addition, I think we get a bad rap in terms of not having health-care quality comparable to that of other developed countries. When you have a high murder rate and a high traffic accident rate, those all skew the data. Nonetheless, we're not as good as we should be."
- Fortune: "But why are the costs so extremely high?"
- Dr. Delos: "There's a dirty little secret, and I might as well tell you to start with. The secret is that regardless of what happens with health-care reform legislation, the costs are going to go up. We have more elderly people, and we can do more for them. So regardless of what happens, we can really only try to contain the rate of inflation. The costs are going to go up with time."
- Fortune: "...why?"
- Dr. Delos: "Look at the other side--suffering has gone down, diseases have gone down. Deaths from heart disease in the past 15 years have gone down by 30%. That's tremendous progress. Health care is the second leading employer in the US after restaurants and the food industry. It does a tremendous amount of research. It makes products. It exports. So it is an economic stimulus at the same time it's a cost."

The challenges faced by public health planners are daunting and perhaps outside the full control of any agency, collection of agencies or a national government. Perhaps the best we can hope for is to “muddle through”. But, before despairing, remember the average citizen today lives longer, with less discomfort, and has available far higher quality health care than those living before us when even Kings and Presidents suffered from what we now know was poor, or as in the case of George Washington<sup>1</sup>, harmful forms of health care.

If you are seeking a complex, relevant and intellectually challenging profession you could do worse than to elect public health.

\*The author served as founding director (emeritus) of the DVA optometry service, 1974-1989 and is incorporator of the American Board of Certification in Medical Optometry.

1. The dying President Washington was “bled” by physicians who believed in the then current therapy of removing “bad” blood to aid recovery although there were no blood tests available to determine if blood was “bad”.

### Information Sources

1. Current information about the DVA Optometry Service is available at [www.va.gov/optometry](http://www.va.gov/optometry), and the website of the National Association of VA Optometrists [www.navo.org](http://www.navo.org). Information on board certification of optometrists in medical optometry is at [www.abcmo.org](http://www.abcmo.org). and about ACMO at [www.nbeo.org](http://www.nbeo.org).

2. Series of federal laws (sections of) affecting DVA optometry care resulting from AOA lobbying efforts.

PL 85-96 (1957) Authority to employ optometrists

PL 85-464 (1958) Required optometrists be state licensed

PL 85-857 (1958) Accepted DC licensure for employment

PL 86-598 (1960) Optometry care defined as a medical service. A key change for when a veteran is ruled eligible for VA “medical services” these included optometry care.

PI 93-82 (1973) Created Director of Optometry position but without budget or position description.

PL 94-581 (1976) Created Optometry Service, a Director of, placed ODs in

---

<sup>1</sup> In the last days of his life, Washington was bled- a common form of treatment to get the “bad blood” out of the body and hopefully restore health.

Physician-dentist personnel system, created SMAG, called for ODs to be appointed and affiliations created with optometry schools to “produce more comprehensive and cost-effective eye care”. The equivalent of the 1946 reforms for physicians and dentists.

### 3. Congressional and Agency Reports and Recommendations

Veterans’ Omnibus Health Care Act of 1976. Report of the Committee on Veteran’s Affairs, United States Senate, to accompany PL 94-581

VA Policy Memorandum (1977) Established independence of VA optometrists forming them as a section of surgical service reporting to Chief of Surgery or to Chiefs of Staff in absence of a surgical service.

AMA Resolution #115 (1978) Called for repeal of PL 94-581 sections pertaining to optometry and required VA optometrists be supervised by ophthalmology. VA Chief Medical Director Dr. Donald Custis appeared at the AMA meeting in Chicago to oppose the resolution which was withdrawn.

Report in 1978 by Comptroller General of the United States, General Accounting Office (GAO), “Role and Use of Optometry in the Veterans Administration Need Improvement”. Cited inadequate VA optometry care.

Department of Housing and Urban Development-Independent Agencies, Appropriation Bill, 1980. Language supporting utilization of optometrists to offer more cost-effective VA eye care.

Report to the Committee on the Budget, Senate Committee on Veteran’s Affairs, Budget for Fiscal Year 1981.

Joint report by the AOA and the Association of Schools and Optometry. 1978. Recommendations for implementation of PL 94-581 and creation of optometry teaching affiliations.

### 4. Bibliography

“History of the VA Department of Medicine and Surgery” Available from VA Headquarters library, 810 Vermont Ave. N.W., Washington D.C., 20420. A good history of the factors leading to the 1946 VA reforms by a former VA official.

“Ring the Night Bell: The Autobiography of a Surgeon” by Paul B Magnuson, MD. 1960. Dr. Magnuson, second VA Chief Medical Director, devotes a significant portion to detail his experiences struggling with Washington bureaucracy. This struggle eventually led him to not seek reappointment which some groups were

opposing after which he returned to Chicago and resumed leadership of the rehabilitative institute he founded.

“A Soldier’s Story, Autobiography of General Omar N Bradley”, 1951. Picked by President Truman to oversee the VA transformation, it contains chapters giving his view of the VA reform process and pitfalls of being a reformer within a Washington bureaucracy for which his Army career had well prepared him. He returned to military service, retiring as a five star general.

Archives of “The Washington Post”, 1945-8. Interesting contemporary descriptions of the political, medical and bureaucratic turf wars waged during the creation of the VA Department of Medicine and Surgery and the effect of support from President Truman against the opposition of organized medicine, US Civil Service Commission and other opponents. Although there was wide spread public support for improving the care of returning servicemen, the bureaucracies came close to killing the proposed law. Stories in the Washington post (and regional papers and Time magazine) about inadequate VA care were a powerful aid to those pushing for reform.