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Why the VA matters: Resident education, research and patient care

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ABSTRACT

The Veterans' Health Administration (VHA) has had a long and storied relationship with academic medicine and particularly academic surgery throughout its history. Since the initial inception of the Veterans' Health Administration in 1946 there have been relationships between medical schools and the VHA to provide care to our veterans as well as provide a fertile training environment for the residents that will enhance their overall training experience and prepare them to the provide health care for the nation as a whole. At this point in our history that relationship is in jeopardy. The problems facing the Veterans' Health Administration are well known and seemingly are proving to be an insurmountable obstacle for continuation of this relationship.

It is my intention in this lecture honoring Dr. Organ, who was committed to surgical education as well as the surgical care of our veterans to demonstrate why the Veterans' Health Administration is more important than ever to the well-being of our residents and graduate medical education as a whole.

1. Introduction

Before I begin my talk I would like to take the opportunity to thank Dr. Burlew and the other members of the Southwestern Surgical Congress for bestowing on me the honor of giving this lecture honoring Dr. Organ.

I was lucky enough to know Dr. Organ as I grew up in Omaha where Dr. Organ had begun his career at Creighton University. To call Dr. Organ a giant in surgery would not do him justice. He was a pioneer, a visionary, an educator and most of all a courageous man who faced more difficulties than any of us will ever know as he forged a path for other African-American surgeons to follow. It is truly an honor to be giving this lecture in his name to all of you today.

2. History

Providing health care to those who have sacrificed so much for our liberty is embedded in our culture. The United States has the most comprehensive system of assistance for veterans of any nation in the world. President Lincoln's admonition in his second inaugural address " Let us strive on to finish the work we are in, to bind up our nations wounds, to care for him who has borne the battle, and for his widow and his orphan" rings in our collective conscience. Roots of this care can be traced to the Pilgrims who passed laws providing care to the soldiers who were injured fighting with the indigenous tribes. Throughout our history at various times laws were passed to provide assistance to disabled veterans as well as their dependents.

Following World War I, there was significant expansion of benefits housed in a variety of agencies and managed through separate departments. In 1921 these were consolidated in the Veterans Bureau and an ambitious construction program of new hospitals was carried out. Over the ensuing 10 years more and more benefits were added to the assistance program. In 1930 President Hoover consolidated all of the services again elevating the Veterans Benefits to a federal administration.

At the end of WW II there was a massive influx of servicemen requiring assistance. General Omar Bradley took over the reins of the VA in 1945. He appointed General Paul Hawley as the first director of the Veterans Healthcare Administration. Dr. Hawley was the first to recognize the extraordinary relationship that needed to be created between the VA and the nation's academic medical institutions. He saw the resident work force as the necessary ingredient to provide the much needed labor to care for the returning soldiers as well as establish the environment for an unequaled educational experience. In addition he also recognized the pool of specialized care that would be accessible through this relationship housed in the medical schools across the country. General Hawley was instrumental in guiding the construction of new VA hospitals in proximity to these medical schools and university hospitals for

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these reasons. This dynamic persists to this day.

3. Benefits and eligibility

I think most health care providers; even those in the VA system have minimal understanding of who qualifies for VHA healthcare and the costs. First you must be a veteran. A veteran is an individual who has served in the active military naval, coast guard or air services and was discharged or released under conditions other than dishonorable. All veterans are eligible for care and benefits extended to all. No cost coverage is available for many pending their service connected disability and family income. The VA has had a long standing policy to provide world class care to all of those veterans who otherwise could not pay for their care. There are currently approximately 9.2 million veterans enrolled to receive their healthcare through the VA and that number continues to grow daily.[1]

We are all aware of the problems the VA has experienced the last few years. The scandal that rocked the foundation of the VA with the exposure of the delays in care at multiple sites to this vulnerable population was hard to understand and even more difficult to explain. It is not clear if all allegations are founded on hard truths, but what is in the debate is that the way the VA goes about its prime mission of providing care to the veterans and their dependents must be analyzed, modified and improved. It is our moral duty. Solutions to the situation are legion, one of which is to dissolve the VA. The purpose of this lecture is to convince all of you who are participants in the enterprise of graduate medical education and providing this care that dissolution is not a viable option.

4. Mission

The Veterans Healthcare Administration has 3 foundational missions.[2] The first and foremost of these missions is to provide high quality and readily available healthcare to all veterans eligible for that care. The second is to provide broad based education to multiple learners. The largest but not necessarily the most important of those groups is the medical education/graduate medical education (GME) group. The VA currently educates over 120,000 trainees annually.[3] In addition to GME, the VA also provides education opportunities to a large group of nursing students, advanced fellowships in many disciplines including but not limited to dietetics, physical therapy, dentistry, patient safety and a multitude of other learners. The third is in research with research funding that is broad based and accessible to essentially all providers within system. I would like to explore these areas in more detail with emphasis on the benefits that are derived by our academic affiliates.

5. Research

The mission of VA research is to discover knowledge and create innovations that advance the health and care of veterans and the nation. This is accomplished through a four-fold approach. Veteran's health and well-being is improved through basic, translational, clinical health services and rehabilitative research. Scientific knowledge is applied to develop effective individualized care solutions for Veterans. The VHA attracts trains and retains the highest caliber investigators and nurtures their development as leaders and it assures a culture of professionalism, collaboration, accountability and the highest regard for research volunteer's safety and privacy. The Office of Research and Development in the VA has been in existence for over 90 years. The current breadth of VA research encompasses some 2000 active projects at more than 100 sites. This is being supported by a budget in the FY 2016 of 1.8 billion dollars. This figure does include both direct VA support and research funding from outside entities such as the National Institute of Health, other federal agencies and non-profit and private organizations. To be eligible for an award you must have a staff position with at least 5/8 of clinical time based on a 40 hour week dedicated to the VA facility for which you are aligned. Clinicians are expected to have 2/8 clinical time but this can be reduced with the approval of the service chief and the chief of staff. Awards are available to all providers including physicians, Ph.D.'s, pharmacists, nurses and Pharm D's. An important exclusion for the academic affiliate is that contract physicians are excluded from eligibility. Approximately 20% of all grant submissions are accepted. In addition to the benefits afforded to the principal investigator in these studies, individuals who participate in other areas of research leadership within the VA also are afforded protected time. The clear benefit of this bench to bedside structure to the affiliated academic institution is the ability to offer to faculty the opportunity to participate in a broad range of projects from basic science to outcome based research within an academic community with protected time that they might not otherwise have available to them in the sponsoring medical center with other funding mechanisms. For the individual VHA institution the benefit is the ability to attract and retain top tier physicians, educators and researchers to achieve the goal of providing the highest quality care possible to the veteran. In a recent survey of VHA investigators 78% felt that it was important or very important reason for them to come to the VHA and 98% felt that it was the reason they stayed at the VHA.[4] In addition there are other awards, specifically career development awards which offer 75% protected time over 6 years with a guaranteed position within the sponsoring service at the VA at the end of that time. VA cooperative studies have provided invaluable information to the surgical literature and remain a tool readily available to the industrious researcher particularly those interested in examining large clinical populations (see Fig. 1).

6. Education

The Veterans Health Administration conducts the largest and most inclusive educational enterprise in the nation. Over 120,000 learners participate annually within education programs within the VA. Nearly 70,000 of those are medical students or residents from allopathic or osteopathic programs.[5] 133 of 144 allopathic medical schools and 30 of 33 osteopathic medical schools have affiliation agreements with Veterans Health Administration medical facilities (Fig. 2).[3]

The ACGME in their “Next Accreditation System” has laid out for surgical educators a model of resident trajectory from novitiate to expert over the span of the training period. Milestone evaluations within the accreditation system are an attempt to objectify this trajectory in a more definable model so that learners who are struggling can be identified and ostensibly assisted to remediate. The problem is the perception within many of the supervisors and residents of those training programs is that our residents are not reaching the perceived level of proficiency that will qualify for the designation of competence within the field of surgery by the end of their prescribed training.[6] Studies analyzing this phenomenon have identified a lack of autonomy as a commonality amongst responders. Residents in surveys have identified a lack of autonomy in the operating room as area in need of improvement.[7] Current continuous direct supervision in the OR mandated by hospital bylaws and other oversight bodies lends itself to development of technically skilled residents, but one who lacks the confidence of independent decision making when they no longer have the participation of the more senior surgeon. This lack of confidence can result in a perception of incompleteness at the end of the

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