The Veterans Administration and Academic Surgery

A Report from the Committee on Issues of the Association for Academic Surgery 1979 Meeting

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The Committee on Issues has, for several reasons, thought it important to examine the relationships between the Veterans Administration (VA) and academic surgery. This topic had been suggested a number of times at previous meetings of the Association for Academic Surgery. Many of the members of the Committee are currently working, or have worked, in the VA system. Finally, a number of ongoing events in the Veterans Administration galvanized our resolve to investigate the interplay between the VA and academic surgery. In order to get a feeling for the current situation, one needs to review some historical antecedents.

Historical aspects. The concept of delivering health care to veterans is not a new one. Thucydides, in his History of the Peloponnesian War, notes "in the same winter, the Athenians gave a funeral at the public cost to those who had first fallen in this war. It was a custom of their ancestors . . . ." George Washington recognized the indebtedness of the United States to its veterans in 1793 when he wrote "it (benefits) was part of their hire . . . it was the price of their blood and of your independency: it is, therefore, more than the common debt, it is the debt of honor. . . ." Every president since 1865 has supported Lincoln's vow, "to care for him who shall have borne the battle, and his widow, and his orphan." In 1924, the Congress provided for hospitalization to veterans of all wars, "without regard to the nature or origin of their disabilities. . . ." Public Law 79-293, signed on January 3, 1946, by President Truman, authorized the establishment of a Department of Medicine and Surgery within the VA with a wide range of missions and authorities. This legislation justified medical education and research as essential to the recruitment of physicians, nurses, and dentists of high caliber to assure quality of care. On January 30, 1946, the VA issued the Bradley-Hawley Policy Memorandum No. 2 which stated the purposes of the relationships between the VA and medical schools. Its charge was, in essence, that reasonable men and women be guided in affiliation so that the VA Hospital staff would be in charge of hospital policy, professional matters, and patient care and that the medical school would be concerned with matters of training and education. It was never intended that either member of equal partnership in affiliation would become predominant. The major concepts of this memorandum are still considered valid by the Veterans Administration Central Office. The VA was interested mainly in improving medical care for veterans, while the goal of the medical schools initially was to expand postgraduate residency training to accommodate the postwar demand for thousands of physicians who had gone into the uniformed services during the war without
There are a number of factors which fostered the growing interdependence between the VA and medical schools. The VA construction policies placed many Veterans Administration Medical Centers near medical schools. The National Institutes of Health Extramural Research and Training Grants resulted in tremendous benefits to medical schools which, in turn, relied upon the VA to support their educational and research programs. In the postwar years there was a crush increase in medical school enrollments. Finally, the growth of third party payments in the ensuing decades have compromised the availability of teaching affiliations in private hospitals. The result is that today 133 VA Medical Centers are participating in "Dean's Committee" affiliation relationships with 103 of the nation's 120 medical schools.

The National Academy of Sciences report. A number of concerns were raised about the VA during and after the Viet Nam War, and these problems were focused on the medical services provided in it. A debate between Congress and the Executive branch of the government developed regarding the resource requirements of the VA Medical Center system. Congressional hearings emphasized the disparity in staff to patient ratios between VA Medical Centers and community hospitals in that the VA Medical Centers were said to be greatly understaffed. In an attempt to examine these issues the Congress directed the Veterans Administration to contract with the National Academy of Sciences (NAS) to study the VA health care system. This report [1] was published in 1977 and is, to say the very least, controversial. It is rather extensive and, for the purposes of this paper, we should focus only on those findings and recommendations pertinent to academic surgery. In general, the report recommended a "phasing in" of the VA Medical Center system into the general health care delivery system in the United States. With regard to surgery, the report suggested: (1) more staff supervision, (2) more outpatient workups, (3) better preadmission surgical screening, (4) elimination of operations in psychiatric hospitals, and (5) a decrease in the number of renal transplant and cardiac surgical centers. It recognized the mutually advantageous interdependence between the VA and the medical schools with resultant improved medical care and education environment. The report suggested a mutual study of these affiliations "as a basis for planning necessary adjustments to realistically meet the needs of both parties." However, the NAS study only looked at the VA dependence on medical schools for staffing and the medical schools' dependence on the VA for student and resident education.

Veterans Administration reply. The reaction engendered in the VA by the NAS report resulted in a rather lengthy rebuttal [2] published three months after the NAS report in 1977. Where these responses are appropriate to the subject, they will be mentioned in the discussion.

METHODS

A questionnaire was sent to all members of the Association for Academic Surgery inquiring about their perceptions of the relationship of the Veterans Administration to academic surgery. This questionnaire was developed by members of the Committee on Issues of the Association for Academic Surgery. The data from returned questionnaires were collated and correlated by computer at the State University of New York Upstate Medical Center in Syracuse. A questionnaire was also sent to the Chairmen of Surgical Departments in the United States and Canada. This was a much shorter version of the original questionnaire. The Committee on Issues invited a panel of four members to the annual meeting held in November of...
1979 at Great Gorge, New Jersey. The panel members were Dr. Saul Farber, Chairman of the Committee on Health Care Resources in the Veterans Administration, which prepared the NAS report; Dr. Herbert Baganz of the VA Central Office who authored the VA response; Dr. Stanley Dudrick, Professor and Chairman of the Department of Surgery, University of Texas Health Science Center at Houston; and Dr. Edward Stemmer, President of the Association of VA Surgeons. Data from the questionnaires are given under Results. Pertinent information from the NAS and VA reports and proceedings of the panel discussion are presented in the Discussion. Unfortunately, we do not have time and space to present all of the data from the questionnaire, all of the information contained in the two reports, and some important interplay between members of the panel at the national meeting. We hope to indicate the importance of the VA to the academic surgeon and vice versa; to examine the degree of satisfaction or dissatisfaction with the role of the academic surgeon in the VA; and to suggest problem areas and concerns that might be addressed in future developments.

### Results

#### Response

Four hundred and forty questionnaires were returned, a response rate of 44% for active members and 14% for the senior members. Of the 130 questionnaires sent to Chairmen, 100 were returned which is a response rate of 77%. This includes responses from six Canadian schools. An affiliation with the VA is quite common. Ninety percent of the membership responding have had some affiliation (medical school, residency, or staff) with the VA in past or present. Thirty-two percent of the membership have a current affiliation which is part-time, 33% serve as consultants or attendants without compensation, and 4% are full-time VA employees.

#### Importance of VA to Departments of Surgery

Eighty-one percent of all program Chairmen and 82% of the responding membership indicated that their department has a VA Medical Center affiliation. A majority of respondents thought that the VA clinical

### Table 1

**The Perceived Value of Veterans Administration to Departments of Surgery and Medical Schools**

<table>
<thead>
<tr>
<th></th>
<th>Chairmen*</th>
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<th>Members*</th>
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<td>E B N D</td>
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<td>Clinical experience for</td>
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<tr>
<td>Faculty</td>
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<tr>
<td>Residents</td>
<td>70 26 4 0</td>
<td>59 34 5 2</td>
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<tr>
<td>Students</td>
<td>53 32 12 3</td>
<td>41 46 12 2</td>
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<td>Teaching of</td>
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<td>Residents</td>
<td>51 38 9 2</td>
<td>25 48 23 4</td>
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<tr>
<td>Students</td>
<td>32 52 14 2</td>
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<td>32 44 24 1</td>
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<tr>
<td>Funding</td>
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<tr>
<td>Salary</td>
<td>24 45 23 8</td>
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* Numbers are percentage of respondents.

* Abbreviations: E, essential; B, beneficial; N, neutral; D, detrimental.
TABLE 2

| INDIVIDUAL PERCEPTIONS OF COMPARATIVE HEALTH CARE DELIVERY IN VETERANS ADMINISTRATION AND UNIVERSITY HOSPITALS |
|-------------------------------------------------|-------------------------------------------------|-------------------------------------------------|
| Closeness of patient contact | No difference | Better at VAMC | Better at univ. hosp. |
| Quality of patient care | 47 | 7 (3) | 46 (39) |
| Ancillary services provided | 18 | 8 | 74 |
| Closeness of resident supervision in OR | 50 | 9 | 41 |
| Closeness of resident supervision on ward | 29 | 7 | 57 |

* Numbers are percentage of respondents to question.

* Numbers in parentheses indicate percentage of respondents to question of similar formulation.

experience was essential or beneficial in clinical experience for the faculty (59% of both Chairman and membership) and residents (96% of Chairmen and 93% of membership, Table 1). Similarly, 89% of the member respondents thought that the VA experience was essential or beneficial for the teaching of residents (Table 1). Based on the Chairman questionnaire, residents gain a significant portion of their senior level operative experience in the VA system. Only 9% of residents had no VA experience, 1% had less than 10% VA experience, and 88% had 10-60% of their senior level experience at VA.

The Importance of the VA to Medical Schools

A majority of respondents (85% Chairmen, 87% membership) indicated the VA provided essential or beneficial clinical training and experience for students. Similarly, 84% of the member respondents thought that the VA offered essential or beneficial student teaching (Table 1). According to Chairmen, the VA was essential or beneficial for research space and facilities (76%), research funding (71%), and salary support (69%, Table 1).

The Importance of Medical Schools to the VA

On the other hand, the Departments of Surgery and the medical schools are important to the VA which has long been recognized by the VA. Perhaps hardest to measure is quality of medical service provided. Almost one-half of individual respondents felt there was no difference in the quality of patient care between the VA Medical Center and the University Hospital despite less complete ancillary services (Table 2). Quality as well as quality is derived from affiliation; 77% of the beds and 81% of the patients are covered by residents. In sum the VA relies upon the medical schools and surgical department for students, residents, and senior attending staff which results in high-quality medical care.

The VA Academic Surgeon

Unfortunately, the VA academic surgeon suffers by comparison to his or her university counterpart in several ways. In what follows it should be noted that most of the responses showed no difference between the VA and non-VA academic surgeons, but there were some important minority opinions. Thirty-nine percent of the respondents and 35% of the Chairmen deemed research opportunities better at the VA, whereas 21% of the respondents and 12% of the Chairmen thought that research opportunities were worse at the VA (Table 3). Only 2% of the respondents felt that VA pay and fringe benefits were better or higher than the University, and 50% indicated that there was lower
pay and fringe benefits at the VA. Seven percent judged patient care better at the VA than at the University (Table 2). Compared to his or her non-VA counterpart, the VA academic surgeon was regarded as superior in overall capability by 2% and as inferior by 34% of respondents (Table 3). Three percent responded that VA surgeons worked harder and 50% thought they worked less hard than non-VA surgeons. Opportunity for advancement was worse according to 41% of the membership in contrast to the 3% who thought it was better in the VA. Only 1% responded that there was more prestige working at a VA Medical Center, and 57% thought there was less prestige.

The degree of affiliation one has with the VA does make a difference in terms of member responses. This may reflect some insight into the actual situation, especially for those who spend more of their time at the VA. One percent of those with no VA affiliation and 0% of those with full-time VA affiliation thought that the pay was more in the VA whereas 61% of the full-time surgeons and 41% of those with no VA affiliation thought that the pay was less in the VA. Two percent of those with no VA affiliation indicated that the quality of the VA academic surgeon was superior to the university academic surgeon as contrasted to 0% of the full-time surgeons and 4% of the Chairmen; 40% of those with no VA affiliation, 1% of those with full-time affiliation, and 19% of the Chairmen felt that the quality of the VA academic surgeon was inferior to that of the university surgeon. Similarly, there was a difference in opinion as to whether the academic surgeon worked harder at the VA than at the University. Zero percent of those with no VA affiliation and 5% of the full-time VA surgeons thought that VA surgeons worked harder than university academicians; 50% of those with no VA affiliation and 22% of full-time VA surgeons affirmed that the VA surgeons worked less hard. The opportunity for advancement was related to the degree of VA affiliation. One percent of those with no VA affiliation, 11% of the full-time VA surgeons, and 4% of the Chairmen described the opportunity for advancement as better in the VA. However, 40% of those with no VA affiliation, 27% of full-time VA surgeons, and 27% of Chairmen thought that the opportunity for advancement was worse in the VA. As to whether the surgeon respondent would accept a job as a Chief at the VA, 0% of those with no VA affiliation, 4% of the part-time staff, and 10% of full-time staff would accept; 32% of those with no VA affiliation and 28% of the part-time staff and 57% of the full-time staff would accept conditionally. Twenty-seven percent of those with no VA affiliation, 36% of the part-time surgeons,

| TABLE 3 |
| Academic VA Surgeon Compared to University Surgeon |
| --- | --- | --- | --- | --- |
| | Chairman | No difference | Members | | |
| | Better | Worse | | | Better | Worse |
| Overall capability | 4 | 19 | 76 | 2 | 34 |
| Clinical experience | 7 | 36 | 57 | | | |
| Research opportunities | 35 | 12 | 54 | 39 | 21 |
| Academic advancement | 4 | 28 | 68 | 3 | 41 |
| Work harder | 3 | 50 | | | |
| Pay and fringe benefits | 2 (8) | 50 (60) | | 34 | |
| No difference in any way | | | | |

* Numbers are percentage of respondents to question.
* Numbers in parentheses indicate percentage of respondents to question of similar formulation.
TABLE 4
THE VALUE OF THE VETERANS ADMINISTRATION TO THE INDIVIDUAL ACADEMIC SURGEON

<table>
<thead>
<tr>
<th></th>
<th>E%</th>
<th>B</th>
<th>N</th>
<th>D</th>
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<tr>
<td>Volume and variety</td>
<td></td>
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<td>clinical opportunities</td>
<td>10</td>
<td>38</td>
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<td>5</td>
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<tr>
<td>Teaching of residents</td>
<td></td>
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<tr>
<td>and students</td>
<td>25</td>
<td>42</td>
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<td>Research facilities and</td>
<td></td>
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<tr>
<td>funding</td>
<td>17</td>
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<td>Providing income</td>
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<td>Time for research and</td>
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<tr>
<td>writing</td>
<td>6</td>
<td>7</td>
<td>63</td>
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</table>

Abbreviations as in Table 1.
Numbers are percent of respondents to question.

and 21% of the full-time surgeons would decline conditionally; and 37% of those with no VA affiliation, 30% of the part-time staff, and 0% of the full-time staff would decline unconditionally.

Most Chairmen felt that overall capability, academic advancement, clinical experience, and research opportunities were the same for a faculty member located at a VA Medical Center compared to one at the University. However, a distressing number felt that the VA surgeon fared worse in overall capability (19%), academic advancement (28%), clinical experience (36%), and research opportunities (12%, Table 3).

Happiness

The VA surgeon then has less money, may have less opportunity for advancement, and is felt to have less prestige. Moreover, he is not as happy. Only 25% of the respondents with a VA affiliation enjoy their job and plan to stay, and 44% were dissatisfied but plan to stay. The VA is of value to the individual academic surgeon chiefly in the volume and variety of clinical opportunities, the teaching of residents and students, and the research facilities and funding (Table 4). Perhaps these considerations outweighed the negative factors for those 44% who were dissatisfied but plan to stay. We asked all respondents to grade their degree of happiness or job satisfaction and we correlated this with median distributions for age, rank, salary, and academic position. Surgeons in the age group 30–34 were, as a median, “reasonably happy” at the rank of Assistant Professor, earning $40–59,000 per year. Surgeons between the ages of 35 and 39 were “reasonably happy” at the Assistant Professor level with an annual salary of $60–79,000. In the 40–44 age group, the academic surgeons were “reasonably happy” at the Associate Professor level, earning a salary of $60–79,000 a year. Between the ages of 45 and 49, academic surgeons were “reasonably happy” at the rank of full Professor, receiving a salary of $80–99,000 per year. When this was broken down by rank, there were 71 Chairmen who were “greatly happy” at a median age of 45–49, making $80–99,000 a year. The 56 respondents at the full Professor level were “reasonably happy” at a median age of 45–49 and a salary of $60–79,000. There were 120 Associate Professors who were “reasonably happy” in the median age of 40–44, earning a median salary of $60–79,000. The 137 Assistant Professors were “reasonably happy” at an age of 35–39 with a median salary of $40–59,000. Contrary to this generally monotonous pattern, happiness was inversely related to the degree of VA involvement! Forty-five percent of those with no VA affiliation, 30% of the part-time VA people, and only 17% of the full-time VA academic surgeons were happy.

Unhappiness is probably due to multiple factors. Part of the unhappiness has to do with the administrative “bog” in the VA. Three of these issues were specifically identified. The first is the administrative use of time cards to keep track of academic surgeons. Only 2% of respondents favored this restriction and 98% opposed it. Ten Chairmen with a VA affiliation did not know of this administrative process. A second problem was that time spent lecturing to affiliated staff or students was not considered VA activity by the timekeeper methodology. Four percent of the respondents thought this
was reasonable, whereas 72% deemed it unreasonable. The fact that part-time staff can be summarily dismissed was thought unfair by 61% of the respondents, but 13% of the respondents thought it was fair.

DISCUSSION

Importance of VA to Departments of Surgery

The VA appears to be quite important for the functioning of the Departments of Surgery. Although only 16% of filled surgical residencies are provided by the VA, this role is a very important one. There has been a shift in third party payments such that most previously indigent patients are now cared for by staff physicians at University and private hospitals. The VA Medical Center remains a place where the resident can be nurtured and grow under the aegis of a staff attending surgeon but with a maximum chance to develop independent thinking and patient care responsibility.

According to the NAS report, residents comprise 63% of the full-time equivalent (FTE) surgeons in the VA, yet perform 79% of all surgical procedures. In affiliated VA hospitals residents perform 88% of the surgery; in 69% of the resident-performed operations, moreover, the operation was not supervised by a staff surgeon (full- or part-time) as first assistant. The NAS recommended 100% supervision of elective cases and 70% supervision of emergency cases. The VA report agreed in principle with these recommendations but stipulated that “supervision” and “meeting of patient care needs” could include multiple levels of involvement depending upon the skill and previous training of the resident. Involvement might be as first assistant or merely present and available in the vicinity of the Operating Room. The NAS survey of professional staff revealed that 15% of full-time physicians, 12% of part-time physicians, and 25% of residents thought that there was too little supervision. Dr. Dudrick commented that staff attendance should be encouraged since it improves resident education; he thought that emergency cases require better judgement and should have more staff involvement than elective cases, just the reverse of that recommended by the NAS. Of course, as he points out, it may be unrealistic to ask a part-time staff physician to staff an emergency operation after he has fulfilled his time obligations to the VA. This is especially true in view of the rigid time constraints imposed on the surgeons by VA medical administration. The whole issue of time commitments including “time cards” is inflammatory and was hotly debated at the meeting (vide infra).

Importance of the VA to Medical Schools

The Veterans Administration makes important contributions to the medical schools regarding teaching, research, and salary support. It is of some interest, however, that 14% of member respondents and 15% of the Chairmen felt that student teaching at the VA was of no importance or detrimental. Whereas most thought the VA essential or beneficial, 27% of member respondents, and 25–28% of the Chairmen declared that the research support (space, facilities, and funding) was of no importance or actually detrimental to the individual. Of department Chairmen, 69% responded that salary support from the VA was beneficial or essential, whereas 31% thought it was either of no importance or detrimental. Of course, these are minority figures, and the majority of members responded that the VA was important for student teaching, research support, and salary.

Importance of Medical Schools to the VA

The VA reaps the benefits of affiliation with improved staffing and quality of patient care. That the quality of health care is improved by affiliation was also pointed out by the National Academy of Sciences as emphasized by Dr. Farber in the panel discussion. According to the NAS report, there
was no difference in the quality of care between non-VA hospitals and VA Medical Centers. Forty-seven percent of our respondents thought there was no difference between the VA and University Hospitals in quality of care. The quality of care was assessed by the NAS on the basis of five criteria: (1) the performance of eight basic tests during the first 3 days of admission; (2) follow-up of abnormal results; (3) appropriate diagnostic tests in follow-up; (4) the degree of patient education and discharge planning; and (5) patient assessment. Only the last is a true outcome measure of the quality of care. It was emphasized by Dr. Farber, however, that an overwhelming majority of patients in the VA are quite satisfied with their care. Furthermore, the NAS found no evidence for excessive rates of mortality or complications in the VA, with a few exceptions. Surgery in psychiatric hospitals had a mortality rate twice that of general hospitals, and the mortality rate for cardiac surgery was excessive in hospitals performing few such operations.

Symbiosis

This symbiotic relationship seems to be important for all parties concerned. It seems obvious that everyone concerned should work to enliven and improve this relationship while allowing changes in response to new needs and conditions. It is in the best interests of the VA to find out how the academic surgeon in the VA feels about all of these issues. But the impetus for this enlightenment is probably going to have to come from the academic surgeons. It is of interest that 42% of the respondents with a VA affiliation and 65% of the respondents without a VA affiliation did not know about the NAS report despite its tremendous import and widespread ramifications. The VA academic surgeon, furthermore, may be ambivalent. On the one hand, he is working in the VA system and, on the other hand, he may be critical of it because of a deeply-felt desire to improve the system, which he may feel is unresponsive to change.

The VA Surgeon

Our results suggest that the VA academic surgeon has lower pay, less prestige, and poorer opportunity for advancement. The NAS survey showed similar results in that the VA was assessed as inferior to a non-VA work setting in professional advancement (by 36% of full-time surgeons, 45% of part-time surgeons, and 35% of clinical service chiefs), research opportunities (by 26% of full-time staff, 24% of part-time staff, and 26% of clinical service chiefs), and salary scale (by 70% of full-time surgeons, 66% of part-time surgeons, and 77% of service chiefs). Salary is the most important source of dissatisfaction in those polled and the reason given most frequently by those physicians leaving the VA system. Changes in salary ceilings are not sufficient to remove salary as a source of concern, and Dr. Baganz claims that VA physicians are salaried at $13,000 per annum less than those of equal training and experience in non-VA academic settings. The maximum salary for a VA surgeon is $50,112. This has to be supplemented by the University to keep most VA surgeons at the VA. The second most common reason given for leaving the VA was blocked professional advancement. Some feel that the VA does not allow academicians to achieve their maximal professional potential.

Happiness

Dr. Stemmer noted difficulties in recruitment and retention of VA surgeons because of the general belief of young, highly qualified academic surgeons that assignment to the affiliated VA hospital indicated that they were considered less qualified than their counterparts who were offered positions in the University Hospital. With all these negative feelings expressed by others, it comes as no surprise that the NAS found low self-
esteem in VA physicians. This finding is of tremendous import in professional development of high quality medical staff as well as in recruiting. Leadership may suffer as a result of these feelings and as reflected in the unwillingness of respondents to our questionnaire to accept a job as Chief of Surgery in the VA.

Despite its length, the VA rebuttal never gets around to addressing the issue of VA physician unhappiness and negative attitudes raised in the NAS report. Unfortunately, these data are submerged in the chapter on hospital staffing which the VA sounds chiefly to expound its theme of understaffing. This is extremely short-sighted. Unless the VA deals with VA physician dissatisfaction, as found in the NAS and our own reports, the problem of understaffing can only be expected to increase. Much of the unhappiness has to do with administrative obstructions. Dr. Baganz pointed out that peer review is being done in the VA by lay people. This has even extended to the institution of a “hotline” by which means anyone can call Central Office with a complaint about anything. He defended the time card system claiming that the VA needed accountability for hours spent and outlined the administrative gobbledegook that covered this issue. Dr. Dudrick responded that this unprofessional approach will inhibit recruitment and development of academic surgeons in the VA.

FUTURE

These data are important as regards the future of academic surgeons in the VA system. Most agree that the relationship between the medical school and the VA is important and mutually beneficial. The VA itself is studying this relationship and has adopted plans to answer the NAS recommendations. It behooves the medical schools to review the details, arrangements, and rules so that plans can be made to meet their needs. Unfortunately, the problems of the VA academic surgeon are not being resolved; the VA academic surgeon has not been given audience in the development of these plans. One of the major problem areas has to do with research support which is one of the chief attractions for an academic surgeon to work at the VA. In particular, Dr. Baganz thinks that future funding in VA research is going to be bleak. What impact this will have on the VA academic surgeon was not discussed but is obviously quite important. The VA needs to identify how many academic surgeons would opt to continue at the VA without research support. The lack of competitive pay, time restrictions, understaffed services, and declining research support will have a negative selective effect. Dr. Baganz thought it was important to continue to foster the relationship between the medical schools and the VA.

Dr. Farber stated that it is the responsibility of the VA academic surgeons to educate both Congress and the VA about their feelings and their perceptions. Since the VA is constrained by existing legislation and appropriations, a number of problem areas may be insoluble. Dr. Baganz feels that the problem with the VA is understaffing which was the original reason for the study by the NAS. As pointed out before, the VA needs to recognize that this problem is inextricably bound to VA physician attitudes, level of research funding, and the relationship with medical schools. Dr. Dudrick suggested that a major problem with the VA is inefficiency; this arises, he feels, because the federal system is intransigent. This is manifested by highly structured, universally applied procedural methods, often irrational and unyielding, particularly for local exigencies and accountability at all levels, often stifling and unproductive. Dr. Farber remarked that VA fiscal support is related to hospital census which may or may not take into account important changes in patient population and distribution. Dr. Dudrick summarized the panel discussion when he said the bottom line is always money, which may not only
be the “root of all evil,” but the root of all problems. All the members of the panel encouraged promulgation of the concerns raised by and the results of our questionnaire. Dr. Dudrick also charged us with the responsibility of making our review more comprehensive and bringing the results to national attention. We feel that this manuscript is but the first step in that process.

REFERENCES
