The Veterans Administration and Family Practice: Time for a Change

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The Veterans Administration (VA) has an immense organization with wide responsibilities for patient care and medical education. The VA and organized family practice have in common a mandate to provide comprehensive care to millions of Americans and a strong commitment to a full range of ambulatory care, including home health care, geriatrics, alcoholism treatment, and preventive care. Remarkably, there has been minimal interaction between the two despite these similar goals. Recently, however, at least two family medicine departments have expanded their roles with their affiliated VA hospitals. The VA is well aware of the increasing interest in primary care education, and it is important for the VA to demonstrate its resolve to help the nation meet its health manpower needs.

CURRENT VA RESOURCES

An immense organization, the VA has 220,000 employees and administers 134 hospitals affiliated with 101 medical schools. There are over 9,600 full-time medical staff positions. The VA's budget for its Department of Medicine and Surgery is about $9 billion—almost twice that of the National Institutes of Health and greater than any other budgeted item in the federal government except the Department of Defense. Over one half of all medical students receive some of their training in VA facilities. There are 7,800 housestaff positions (approximately 10 percent of the US total), which are filled yearly by 28,000 residents (more than one resident rotates through most positions). The VA has 18 million outpatient visits per year by over 3 million veterans; and the number of outpatient visits are increasing rapidly!

Family practice currently plays a miniscule part in the VA's day-to-day delivery of health care. There are 68 family practice full–time-equivalent housestaff positions as of 1985, down from 75 in 1984. This amount represents 0.9 percent of the total VA resident positions. The VA does employ a few family physicians, but the author is not aware of any full-time family physician educators at a VA facility.

Unfortunately, relatively few family physicians have been interested in working with the VA, perhaps because the VA does not take care of families. Their patients are predominately men (98 percent), who are older (average age 56 years), poor, minority, single, and often afflicted with chronic or psychiatric diseases. This demography probably does not reflect the kind of wide spectrum of practice that most FP residency graduates wish to do. Second, most VA outpatient facilities use an internal medicine clinic model that tends to be episodic, with patients going to different specialty clinics at each visit. First-line care may be done by rotating specialty residents, often backed up by subspecialty internists. The VA has tried a "case manager," or continuity of care, approach at a few facilities, but so far without widespread adoption.

THE CHALLENGE TO FAMILY MEDICINE

Despite these discouraging circumstances, the time has come for family physicians—both educators and clinicians—to give serious consideration

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to more collaboration. One principal reason is the need to expand family medicine's training base and residency programs. The growth in the number of family practice residencies has slowed to a trickle; but the training of more family physicians will require additional resources and patients as well as increased financial support at a time when such support is growing increasingly scarce. If the number of current graduates decreases, even more students will be discouraged from becoming family physicians.

Although fully VA-based FP residencies would be unlikely and unwise, expanded rotations through affiliated VA inpatient medicine and surgery services, as well as incorporation of a full range of ambulatory experiences, could serve not only to increase the residents' clinical base (and thus the numbers of residents) but also to increase the VA's ability to deliver high-quality primary care. Many residency programs have not fully and carefully investigated linkages with nearby VA facilities.

In many ways, the Veterans Administration is an exciting setting for family physicians—it offers a singular opportunity to develop a comprehensive, and potentially less expensive way of delivering care to millions of people. Moreover, the chance to be associated with a medical school and to engage in teaching and research has made positions in the VA attractive to many physicians. The VA has considerable intramural research funds, and it is interested in the same types of education and research projects as are most family practice faculty: geriatrics, patient education, home care, family-based care for alcoholism and stress disorders, and health services research.

It is important that the VA be responsive to current national health policy issues, including the need for increased training in primary care and for cost-effective health care delivery. The key word is *responsive:* the VA is not going to change just because it makes sense to family physicians for the agency to do so. First, family practice program directors and university faculty should give strong consideration to what kinds of interactions make sense. They should fully explore possible modes of collaboration in patient care, education, and research. However, if the VA system is going to make substantial changes toward working with family practice, family practice will need to work with national veterans' organizations and the US Congress—the political forces to whom the VA is responsive. It is time to begin a constructive dialogue.