Honoring Our Nation's Veterans

Today is Armistice Day, renamed Veterans Day in 1954, to honor our Nation's Veterans. In Washington the rhetoric from both the political right and left supports our Veterans. My cynical side reminds me that this might have something to do with Veterans voting in a higher percentage than the population as a whole, but let me give the politicians this one. Serving our Country in the military is something that deserves to be honored. I was proud to serve our Veterans over 30 years at four Department of Veterans Affairs (VA) hospitals.

However, the VA has had a very bad year. First, in Washington there were the resignations of the Secretary of Veterans Affairs, Eric Shinseki; the undersecretary for the Veterans Health Administration, Robert Petzel; and the undersecretary for the Veterans Benefits Administration, Allison Hickey. Locally, in the light of the VA wait scandal there were the firing of the Phoenix VA Medical Centers director, Sharon Helman, and her deputies along with the retirement of her boss, Susan Bowers. Furthermore, there seem to be a never-ending string of scandals ranging from the mundane of greed-driven fraud to the more exotic of accusing a VA whistleblower of engaging in sexual threesomes. Despite a healthy increase in funding, there was the threat by VA administrators of closing VA hospitals to meet a VA budget shortfall. This resulted in Congress knuckling under to allow the use of emergency funds. Veterans groups are using billboards to accuse the VA of lying (Figure 1).

Figure 1. Billboard across from the VA October 12, 2015.

I could go on and on. However, the real question is not so much of what dirty deeds are being done, but how the VA administrators get away with it.

There has been both a lack of oversight and lack of accountability. Robert McDonald, who replaced Shinseki, has promised to punish the evil doers but has replaced action with the mantra "all is well" and *has done nothing*. In several instances wrong-doing has apparently been rewarded, such as Bowers replacement having lied to Congress (1). If the VA cannot police itself-and it apparently cannot-there are a multitude of regulatory agencies that have shirked their oversight responsibilities. I thought it was time to mention a few.

First, there are both the Veterans Integrated Service Networks, the regional VA offices, and VA Central Office itself in Washington. Both these organizations have been caught in the scandals and ***have done nothing***. Second, there is Congress. The House Veterans Affairs Committee has seemed to make a sincere effort to identify some of the problems but Secretary McDonald and his cadre of 11,000 in Central Office has repeatedly stone-walled any investigation and Congress ***has done nothing***. Third, there is the White House. The Obama Administration has seemed more interested in declaring the problem fixed than actually fixing the problem and ***has done nothing***.

Those are the obvious but there are some less obvious regulatory failures. First, there are the multiple hospital inspectors. Within the VA is the Office of Inspector General (IG) who is charged with investigating wrong-doing within the VA. Locally they had been called to Phoenix multiple times including for the wait time scandal but ***have done nothing***. The poor performance resulted in the resignation of the acting VA IG, Richard Griffin, under pressure. Second, there is the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO). The Phoenix VA Medical Center managed to go from a "top performer" in 2011 to noncompliant "with U.S. standards for safety, patient care and management" in 2014. Only the naive would believe that a hospital can transition that much in 3 years. There is also the Arizona Board of Medical Examiners and Nursing. Both doctors and nurses were involved in the cover-up of the wait scandal but these boards ***have done nothing***. The VA is the largest system for training future physicians and nurses, and it seems that the future doctors and nurses might not be learning the highest professional and ethical standards. Nonetheless, the Accreditation Council for Graduate Medical Education (ACGME) and American Association of Colleges of Nursing ***have done nothing***.

However, my personal disgust is highest for the Department of Justice (DOJ). It is known that seventy percent of the hospitals were fudging their wait data. The administrators, not the doctors or nurses, received bonuses for short wait times. None of the administrators have gone to jail or even been charged with fraud. None have even had to repay their bonuses. The DOJ ***has done nothing***. If 70% of the doctors were caught faking data to received bonuses, I have every confidence that the legal eagles at DOJ would gleefully put each and every one on trial.

So what can be done? There appears to be no oversight. This was clearly illustrated in the report from the recent Human Resources (HR) team from Central Office sent to Phoenix to help with what can be kindly described as a dysfunctional department. They

were essentially shown the door by the acting director, Glen Grippen, saying that he "calls the shots" (2).

The solution is that Mr. Grippen and others of his ilk should no longer call the shots. They have shown a consistent arrogance and disregard for our Nation's Veterans and those that serve them. He and others need oversight, not by a far-off committee in Washington as President Obama has proposed which will likely fare no better than Congress. Oversight could be best provided by local physicians and nurses who have interest in Veteran care but are not employed by the VA. This used to occur in many VA hospitals and was called the Dean's Committee. The dean of the local medical school along with the chairman of the departments of medicine, surgery, pathology, radiology, and others formed a committee that oversaw care at the VA. The committee had interests in the patient care of Veterans but also in the physicians who were faculty at the local medical school and the medical students, residents and fellows who were under their supervision. This committee was a victim of Ken Kizer's "prescription for change" in the 1990s. Now, this old system might be an antidote for Kizer's prescription which has seemed to turn poison.

The VA is pushing to hire more personnel to deal with wait times and lack of patient care. However, it is unclear how many of the new hires are doctors and nurses contributing to patient care and how many are administrators and bureaucrats. My experiences and conversations with my colleagues convinces me that not all hospitals are as badly managed as those in the Southwest. Those considering a career at the VA need to carefully investigate each hospital to see if it is the type of place that the leadership will provide the resources to care for the Veterans, which is after all, the definition of leadership.

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References

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