Testimony of Dr. Stephen Klotz

I am pleased to be here this morning to testify before this committee. The issue of the mice and maggots as reported in a recent article is a matter of public record. It is accurate and I hope we will not waste time rehashing the contents of the publication. I was led to believe that this committee wanted to address weightier problems, for example, what events or decisions brought about such a dismal state of affairs. Hence, my interest in appearing.

All of my adult life has been spent in Federal service, first as Battery Commander in the Army Artillery with nuclear weapons, later as a physician with the Indian Health Service and now as an Infectious Disease physician with Veterans Affairs (VA) for the past 17 years. I mention this to point out that I have experienced a variety of bureaucratic organizations.

There was a cataclysmic change in the managerial structure in this organization, now half a decade ago, that has entirely changed the landscape of patient care, with the unfortunate result that there has been a loss of focus on the veteran patient. Some of the decisions and their consequences were not self evident at the time of change. Important knowledge on how to run an effective and safe hospital was sacrificed in no small degree at that juncture. Difficulties are only apparent now as we gaze at beleaguered VA hospitals with increasing numbers of patients, fewer doctors and nurses, an increasing need for expensive and effective medications, and timely consultations and operations.

The structural changes that occurred brought a measure of fiscal responsibility to the VA, which is good thing. However, I would like to focus our attention on some matters that still require change to bring about more improvement.

I have limited time in this statement and so will restrict myself to brief mention of five major ongoing problems in the VA system, most a consequence of the change in management style some years ago. What I have to say is applicable to all VAs. It is exceedingly difficult to uncover where trouble begins in an organization of this size but I believe I can disclose some areas where changes were made leading to major deficiencies, eventually impacting on patient care.

The five major problems are as follows:

1. **The addition of entire cadre of middle managers who embrace a business model of management. These managers have fiscal oversight in the clinical side of the organization and are neither sufficiently knowledgeable nor trained in areas they supervise.**
2. **The hospital Director has more real power than the Chief of Staff: there is no equal partnership.**
3. **A sundering of any meaningful relationship with local medical schools.**
4. **Individuals in the organization with direct patient care, for example, physicians and nurses, have no meaningful influence in the organization of patient care.**
5. **Supervisory positions are all too frequently held until retirement.**

Let us look in detail at problem 1, that is, the insertion of a business style of middle management and how this relates to current problems. Former departmental structures were eliminated in 1996 and entirely new positions were created with

supervisory and fiscal control. I direct your attention to Table 1. The real numbers of physicians, dentists, RNs, LPNs, and Nurses Aids have declined since 1995. You will not be surprised to hear me tell you that the numbers of support personnel has actually risen during the same time frame. Contrast the data in Table 1 with Table 2 where it is evident the number of patients, visits and expenditures by the VA have all risen from 1995 to present. When all of this was occurring, it appeared as if the possession of real credentials for any job position was grounds for immediate disqualification. For example, we had the unenviable experience at the Kansas City VA of witnessing the promotion of a very fine engineer to direct line authority over the pharmacy and housekeeping—disciplines of which he had only superficial knowledge. Internists were placed in direct charge of subspecialty surgeons whose specific requirements often went unmet. Similarly, another fine man, in this case not a physician, was placed in charge of pathology and radiology, disciplines that even trained specialists in these fields struggle to direct in the VA. We were told that the position of Chief of Staff was obsolete and the individual in the position was summarily dismissed, only to have the position reinvented months later. If fiscal responsibility were the desired goal, it would have been cheaper to hire accountants.

The entire personnel structure of hospitals was reformed around a business model with the primary emphasis on fiscal soundness, something we have learned to our regret doesn't always perform well even in the private sector, much less in the VA. In the VA system the changes like those described before translate into more "process", i.e., paperwork and meetings, than into any actual doing, that is taking care of patients. The end result following all of these changes, it was still left to nurses and physicians to figure out how to deliver care in spite of all the managerial impediments.

Problem 2 deals with the accumulation of power, real or perceived, in the Hospital Director's office and is separate from the middle management problem. Prior to recent changes, the Chief of Staff (representing the clinical arm of each hospital) had meaningful supervisory control of the professionals and influence on the use of fiscal and real resources. In bureaucracies, there is always a tendency to seize more power in order to influence one's own agenda. In an organization such as the VA, established to provide professional services to patients, this can be disastrous when the equation is tilted toward non-clinical management. In the present setup, the Chief of Staff is veritably in the pocket of the Director—he or she is incapable of instituting the best system of medical care composed of nurses and physicians representing the needed disciplines in order to meet hospital needs. Hence, we see a system embracing Primary Care at the expense of all else. There is disdain for specialists at the very time HMOs are realizing the hazards of such an approach. Specialty consultations can not be met in a timely fashion, and many subspecialties are inadequately represented in the system.

Problem 3. A sundering of any meaningful relationship with local medical schools. The VA is an important partner in the training of physicians, pharmacists, psychologists and nurses in the United States. One of the major reasons many professionals join the VA is to participate in a collegial fashion with the local university medical school. Individuals may enjoy regular faculty status with their respective schools because of their own accomplishments. In these Dean's Committee VAs the control of education establishing who would teach trainees was exercised, rightfully, by the universities. This productive working relationship is no longer extant.

The medical schools are in fiscal distress and the VA has the money to spend on cheap workers (the resident and intern trainees) and a willingness to employ them. The power in this equation is enjoyed solely by VISN headquarters throughout the country. According to the new rules, residents and interns will perform direct patient services when at the VA regardless of the increasing number of patient encounter scheduled or the quality of the interactions. Individuals supervising such trainees are not necessarily established as competent or even interested in medical education.

Problem 4. Individuals in the organization with direct patient care, for example, physicians and nurses, have no meaningful influence on the conduct of patient care. Diminished in numbers and treating an increasing number of patients, the professional employees (physicians, dentists, pharmacists and nurses) are increasingly unhappy and unfulfilled. It is alarming when one hears the best of physicians stating: "I can't always do what is right for the patient" or "My time is spent doing computer entry". Caretakers in this organization are trapped behind computers entering data of little or no immediate clinical relevance that consumes half of the patient encounter time. Consultations, depending upon the service requested, are often not performed in a timely fashion—patients are forced to utilize the private sector to obtain these services only to return to the VA for their medications which cost them less in the federal system. Contemplate the following scenario, which is VA's idea of a meaningful patient encounter. Following clinic visits patients were asked questions (mandated by VA Central Office) such as: "Did your doctor smile?" "Did your doctor look you in the eye?" "Are you happy with your care?" All cosmesis, no substance. There is no process by which to determine if your doctor is even competent in the VA which is an important question since there is no meaningful professional development for physicians in the VA and the distancing from the medical schools contributes in no small way to a deterioration of the faculty. I suspect the demoralization of the professional staff will be the ultimate undoing of this organization.

Problem 5. Supervisory positions are all too frequently held for a professional lifetime. This statement is self explanatory. The genius of the democratic system is not that we can vote in whom we want but more importantly, that we can vote out individuals whom we do not want. Such is not the case in the VA.

In conclusion, changes are needed now but they are not necessarily large ones—all of the foregoing, the good and the bad, was accomplished by the appointment of one individual with the authority and mandate to affect change. Laws are not required but the re-establishment and embracing of a professional culture of sound clinical practice is required.

Table 1. Employment at the Department of Veterans Affairs

Year	**Total FTEs**	**Physicians**	**Dentists**	**RNs**	**LPN/LVN/NA**	**Support + Other**
1995	200,448	12,053 (6.0)	930 (0.5)	37, 731 (18.8)	23,196 (11.6)	29,769 (14.9)
1996	195,193	11,891 (6.1)	906 (0.5)	34,187 (19.1)	22,033 (11.3)	28,878 (14.9)
1997	186,185	11,507 (6.2)	867 (0.5)	35,190 (18.9)	20,184 (10.8)	27,853 (14.8)
1998	184,768	11,258 (6.1)	826 (0.4)	34,397 (18.6)	19,448 (10.5)	29,976 (15.0)
1999	182,661	11,241 (6.2)	814 (0.4)	34,071 (18.7)	18,646 (10.2)	31,167 (16.2)

Table 2. Veteran population, treatments and costs.

Year	**Patients**	**Inpatients Av. daily**	**Acute care Av. daily**	**Outpatient visits (X1000)**	**Expenditures (X1000)**
1995	2,858,582	81,071	16,028	26,501	$15,981,948
1996	2,937,000	74,764	13,948	29,850	$16,372,856
1997	3,142,065	67,353	10,461	31,919	$17,149,463
1998	3,431,393	63,969	9,030	34,972	$17,441,079
1999	3,610,030	60,036	8,371	36,928	$17,875,584