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Jarrett Nathaniel Brunny

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# Failures in the Veterans Administration and New Strategies for Leadership

Jarrett Nathaniel Brunny, BA

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## ABSTRACT

*World news organizations have criticized the United States Department of Veterans Affairs for endangering patient safety through negligence. Several VA medical centers - including prominent centers operating in Florida - failed to sterilize endoscopy and colonoscopy equipment. Through improper sterilization, a pathway for infection is created resulting in potential disease exposures to patients. In response, the Department of Veterans Affairs Office of Inspector General investigated the reports and found that facilities did not adhere to protocol concerning reusable medical equipment (RME) problems during the practice of performing endoscopies and colonoscopies. The Office of Inspector General noted that the incidents reflected flaws in the fundamental organizational structure of the VA. Such a statement is consistent with the fact that other VA medical centers have been implicated for endangering patient safety in medical hygiene cases unrelated to the endoscopy and colonoscopy scandal. The top-down organizational structure of the VA requires leadership to take responsibility for operational problems. Goleman's theory of emotional intelligence in leadership provides a basic framework for the VA to overcome what is essentially a values problem on an institutional level.*

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## Background

The vision statement of the VA includes providing the highest quality of care to veterans through the values of compassion, commitment, excellence, professionalism, integrity, accountability, and stewardship (United States Department of Veterans Affairs, 2010a). The Veterans Health Administration (VHA) includes 23 Veterans Integrated Service Networks (VISN's) on American soil. These integrated networks comprise over 134 medical centers, 22 health care systems, 142 outpatient clinics, 638 community based outpatient clinics, 252 veteran centers, 1 integrated clinical facility, 1 independent outpatient clinic, and 3 domiciliary facilities (United States Department of Veterans Affairs, 2010b). VA medical centers function as regional hospitals, often providing emergency, family, and life-long healthcare to veterans. Such facilities have the capacity for diagnostic and surgical procedures.

Recent reports of negligent practices within several VA medical centers (Bixler, Cohen, & Rice, 2009), and verified by the Department of Veterans Affairs Office of Inspector General (2009), indicate that endoscopy and colonoscopy procedures were performed in a way that endangered patient safety. Consistent with such facts, a study on the health-related quality of life in patients served by the VA found that - compared to civilian populations - VA patients scored poorly on all health-related measures used in the study, and "VA outpatients have substantially worse health status than non-VA populations" (Kazis et al., 1998, p. 626).

## Significance of the Problem

Former representative Harry Mitchell (D - AZ) (Committee on Veterans Affairs U.S. House of Representatives, 2009) states:

"Sadly we have been there before. Time and again we have seen the VA violate the trust of those who have bravely served this country. These endoscopy errors are yet another reason for veterans to lose confidence in a system they rely on for the care we owe them. Most infuriating is the irony that these veterans were undergoing routine medical evaluations to keep them safe and to prevent illness, but ultimately, they may be in more danger now than before the procedure" (p.1).

The alarming aspect of this scenario is that negligent hygienic procedures impacted over ten thousand individuals in multiple states - including prominent centers in Florida. The following table displays VA records of test results for Hepatitis B, Hepatitis C, and HIV among those veterans that were determined to have been exposed to negligent practices. These data are by no means complete. The VA could not reach all veterans selected for testing; the VA chose not to notify all veterans with exposure risks; some veterans selected for testing chose not to participate in testing; and harmful practices continued in VA medical centers even after the initial data collection event (Committee on Veterans Affairs U.S. House of Representatives, 2009, p. 11).

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Although VA administrators have debated absolute causation for these cases and have downplayed the risks, Congressman Timothy J. Walz (DFL - MN) (Committee on Veterans Affairs U.S. House of Representatives, 2009) has emphasized the humanity of the victims by stating: "Going in for a routine colonoscopy and being contacted later that you are HIV positive or have Hepatitis C is not just an adverse event...that is absolutely catastrophic" (p. 6).

### Factors Related to or Affecting the Problem

In a report by the Department of Veterans Affairs Office of Inspector General following the endoscopy and colonoscopy scandal (2009), it was noted that "facilities have not complied with management directives to ensure compliance with reprocessing of endoscopes, resulting in a risk of infectious diseases to veterans" (p. 31). Thus, even after the initial reports of negligence, several VA medical centers continued to endanger patient safety. The Office of Inspector General goes on to note that "fundamental defects in organizational structure" are responsible for a continued lack of compliance.

In a top-down organizational culture, the focus and blame of the problem is often shifted downwards through the chain of command towards staff at the lowest level. The VA has responded in this manner by focusing on training, accountability, and enforcement of hygienic practice for those in direct contact with RME endoscopy equipment. Such a response - although arguably part of the solution - also serves to shift blame away from leadership. Whereas improving operational protocol is an important part of correcting the mistakes, it is shameful that the VA has not addressed leadership issues that are the driving force behind chronic lapses in care.

### Implications for Leadership

Repeated failures by the VA leadership to adequately respond to the endoscopy scandal are unfit for an organization dedicated to providing a high level of care to United States veterans. New strategies for leadership are needed. To this end, a framework for establishing resonance in leadership could help improve the operational integrity of the VA.

Resonance refers to the theory of emotional intelligence in management (Goleman, Boyatzis, & Mckee, 2002). Simply put: the values, ideals, and goals of a leader must resonate with employees and become practiced throughout the organization. Social awareness and the development of professional relationships are the means by which an emotionally resonant leader channels desirable characteristics to their staff and peers in a process

known as mirroring. Concepts of primal and resonant leadership suggest that the individual capacity for sustaining resonance is the most fundamental of tasks (Goleman, Boyatzis, & Mckee, 2002). In times of crisis - when an organization's values and capacity to uphold such values are tested - it is the burden of the leader to model the response of the organization. Thus when the VA leadership inadequately responds to crisis, the entire organization receives cues on how to act through negative top-down signals.

The positive capacity for inspiring an organization is referred to as primal leadership through resonance, or emotional intelligence. It is the capacity to lead in a way which encourages role modeling and emulation. In Goleman's (2002) words: "Great leaders move us" (p. 3). Such a capacity is built upon a foundation of skills and attitudes. These include self awareness, self management, social awareness, and relationship management. Leaders must also recognize that mood is contagious. It is not enough to list an organization's mission and value statements. Rather, these principles should be evident through observation and reputation. Whereas Goleman's strategy for leadership may seem ambiguous and thus difficult for such a bureaucratic organization like the federal government to implement, it is in actuality quite a basic principle. An organization that evaluates leaders based on emotional intelligence must focus first on positive individual characteristics, human empathy, and team dynamics. Only after these are resolved can specific strategies related to the mission of the organization become ready for implementation.

Simply continuing with "business as usual" and focusing on endoscopy RME problems at the ground level rather than the over-arching systemic issues burdening the VA will further erode the values of excellence, integrity, stewardship, professionalism, commitment, compassion, and accountability upon which the organization is founded. A resonating and values-driven leadership paradigm must become a reality in the Veterans Administration. In practice, and beyond any one framework for change, this essentially requires replacing top-level positions with emotionally intelligent and natural leaders. Unfortunately, it is unlikely that current VA leadership will respond to crisis by sacking themselves. Fixing the VA's incompetence in such matters requires re-structuring in a manner that can be accomplished only at the highest level of government. Voters must make high-quality healthcare for our veterans a priority on Election Day. In the words of Congressman Paul C. Broun (R - GA) (Committee on Veterans Affairs U.S. House of Representatives, 2009): "As Americans, we all owe a debt of gratitude to the men and women who

throughout our Nation's history have served so bravely in defense of liberty" (p. 8).

**Table 1. Disease-specific Cases among VA Patients Tested After Negligent Endoscopy Exposures**

Disease	Number of cases
Hepatitis B	13
Hepatitis C	34
HIV	6
Total	53

Source: Committee on Veterans Affairs U.S. House of Representatives, 2009, p. 55.

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Jarrett Brunny ([jbrunny@health.usf.edu](mailto:jbrunny@health.usf.edu)) wrote this paper while an MPH student, Department of Community and Family Health, University of South Florida College of Public Health, Tampa, FL. This paper was submitted to the *FPHR* on February 13, 2011, revised and resubmitted, and accepted for publication on June 17, 2011. Copyright 2011 by the *Florida Public Health Review*.