

Profiles in Medical Courage: Of Mice, Maggots and Steve Klotz

“I never did give them hell. I just told the truth, and they thought it was hell.”

-Harry S. Truman



Mice and maggots bring to mind visions of filth and decay with an accompanying sense of sickening revulsion-hardly the impression you want associated with a hospital. However, an infestation of mice and maggots did occur in a hospital- not in medieval Europe as you might expect, but in 1998 at the Kansas City Veterans Administration (VA) Hospital. Although the mice and maggots are the attention grabbers, the story is worth repeating because it illustrates how dysfunctional modern hospitals can become and how Steve Klotz tried to affect change by speaking against the management that allowed the situation to occur.

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To understand the story, we need to go back to 1995, ancient history to our fellows, residents and medical students but not so ancient to lots of us. Many Veterans Affairs (VA) hospitals were called Dean's hospitals and had a special relationship with a local medical school (1). Each of these hospitals had a Dean's committee, made up of officials from the VA and the local medical school. This committee approved physician hires and had a voice in most major decisions affecting the medical school faculty at the VA. The rationale for such an arrangement was the VA would not be able to hire high-quality faculty unless associated with a medical school where the faculty had an appointment. Overall this arrangement had served the VA well since shortly after World War II. The VA did get first rate faculty resulting in a level of care that could not be provided to Veterans by less qualified practioners.

However, not everyone was happy with the arrangement, particularly the hospital administrators. At that time, the administrators were in charge of the Medical Administration Service (MAS). This service supervised the business functions of the hospital (fiscal, human resources, purchasing, etc.) and several of the non-medical services (food preparation, janitorial services, security, etc.). The medical functions were headed by the chief of staff. The hospital director and the chief of staff had a shared and equal partnership between the hospital director and the chief of staff.

The administrators argued that the arrangement was disadvantageous to the VA in several ways. First, it gave the medical school, and therefore, the physicians too much voice in hospital operations. Second, physicians were often hired to fill

medical school needs rather than VA needs. Third, the physician hires were often subspecialist and there was a move at the VA to emphasize primary care. Fourth, split responsibilities sometimes resulted in conflicts that were not easily resolved. Dr. Ken Kizer, then Under Secretary for Veterans Health Affairs in charge of all VA hospitals, was persuaded to dissolve the partnership and make the hospital director the ultimate authority at the hospitals in his Prescription for Change (2).

Against this background, Dr. Steve Klotz, an infectious disease specialist was consulted on two patients in the Kansas City VA ICU with nasal myiasis (3). The first case occurred in July, 1998. The myiasis was thought to be due to flies having direct access to the hospital through open windows during construction. However, after the second case in September, 1998, Klotz called his brother, John Klotz, an entomologist at the University of California, Riverside. He advised sending some of the flies and maggots to Nancy Hinkle, an entomologist with expertise on flies. She identified the flies and maggots as the green blowfly and explained to Klotz that these flies prefer to lay their eggs in mice carcasses. She suggested that the presence of green blowfly maggots suggested that the hospital had a mouse infestation.

In agreement with Dr. Hinkle's speculation, the Kansas City VA was known to have a mouse problem preceding and coincident with the two cases of myiasis (3). In response to this problem, warfarin-based mouse bait had been scattered throughout the hospital by a pest control contractor. However, this approach was largely unsuccessful. Numerous mice were observed during the daylight hours on all hospital floors. In some patient wards mice were being cared for as pets by the nursing personnel. Mice were so common in the building that they scampered over the feet of the associate hospital director during administrative morning report in the hospital director's suite.

On learning of the egg-laying preferences of the blowfly, the warfarin baits and traps were replaced with live traps. The results of mouse captures showed the mice to be centered on the fourth floor of the hospital where the canteen was located (3). During an infection control inspection of the canteen and hospital canteen, inspectors discovered mouse carcasses in food storage rooms adjacent to the canteen on glue boards, mouse nests behind boxes on food shelves in the canteen, live mice trapped in a large wastebasket, and mouse droppings covering the floor of the canteen work room.

However, the above did not explain why there was a mouse problem. All VA hospitals have canteens, many are in older buildings, and most do not have a mouse problem. It was apparent from the results of the live trappings and the canteen inspection that the mice seemed centered around the canteen (3). However, the real clue to the cause came when Klotz asked the janitors (S. Klotz, personal communication). They pointed out that a computer program had been purchased to indicate when rooms would be cleaned. The head of

housekeeping was removed during downsizing along with the night time janitor who cleaned the canteen. However, the canteen and its storage rooms were not on the cleaning schedule. The janitors pointed out that these rooms had not been cleaned by housekeeping personnel for at least a year and every canteen employee was aware of the magnitude of the mouse problem (3).

Given that this was an interesting chain of epidemiological events, Klotz published the results of his investigations on March 25, 2002 (3). Action by VA Central Office was swift. Anthony Principi, Secretary of Veterans Affairs removed the regional network director, Patricia Crosetti, and ordered a full investigation. Principi would likely have removed the acting hospital director, Kent Hill, except that he was just hired. Hill had replaced the previous hospital director, Hugh Doran, who resigned after being filmed soliciting prostitution on "John TV".

Even prior to publication of the article, Klotz had phone calls from Hill and was told "not to talk to anyone" (4). The VISN headquarters in Kansas City closed a research lab with six employees that Klotz had formerly supervised. The employees were keyed out of the lab. Crosetti, the VISN director who had been removed, was heard to say "Klotz ain't gonna work for the VA anymore" (4).

The publicity caused Congress to be involved and a field hearing was held at the Kansas City VA in June, 2002 (4). Klotz appeared as a witness and went first. Although he discussed the mice and maggot problem, he focused on five major root causes which he thought led to the incident:

- “1. The addition of an 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 the 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.”

To support his claims he showed that the number of doctors and nurses caring for the patients decreased in the VA while the number of support personnel increased (Table 1).

Table 1. Employment at the Department of Veterans Affairs

Year	Total FTEs	Physicians	Dentists	RNs	LPN/LV N/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)

Yet the number of patients and expenditures had increased (Table 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

When all of this was occurring, it appeared as if the possession of real credentials for a job position was grounds for immediate disqualification at the Kansas City VA according to Klotz (4). For example, “an engineer was given authority over pharmacy and housekeeping, disciplines for which he was untrained and had only superficial knowledge. Internists were placed in direct charge of subspecialty surgeons whose specific requirements often went unmet. A nonphysician was placed in charge of pathology and radiology”. The chief of pulmonary was asked to set a broken arm. When he refused, he was asked “You’re a doctor, aren’t you?” The position of Chief of Staff was eliminated because it was “obsolete”.

Testimony was given by a representative from the office of inspector general (IG). He stated that most of the environmental problems identified during the April, 2002 inspection ordered by Principi fell into one of several categories: 1. An overall lack of cleanliness; 2 Failure to maintain equipment, furniture, utilities, hospital services; and 3. Inadequate pest control (4). Not mentioned is that 10 months prior to this report the IG had visited the Kansas City VA on a routine visit (5). Although rodent problems were identified by the employees, the IG’s recommended action was to remove the rodent traps from patient areas and the canteen.

Officials from the VA management testified next. Although there were multiple administrators that testified, particularly revealing were the testimonies of Doran, the former director of the Kansas City VA, and Robert Roswell, then Under Secretary of Veterans Health Affairs.

Doran went first. He stated that, "The unfortunate incident involving the maggots was handled expeditiously and appropriately by our staff." This was the last time he mentioned any of his staff in a positive light. He went on to say that his first priority had been patient care and that he had initiated a number of construction projects towards this end. According to Doran, the problems arose from the Kansas City VA being an older building with an inadequate budget. Attacking Klotz he said, "There is absolutely no evidence to establish a relationship between the two nasal myiasis cases and the alleged mouse problem. You have an obviously disgruntled former employee's opinion who managed to get the article published." Doran went on to tout his accomplishments at the Kansas City VA, particularly noting his Joint Commission on Healthcare Organization (JCAHO) scores. He noted that the JCAHO had recently inspected the hospital and found no problems. However, he failed to acknowledge the nurses, doctors and support personnel who were responsible for the success.

The ranking minority member, Dr. Bob Filner (D, CA) was unconvinced. By background, Dr. Filner is a former academic from the University of San Diego whose PhD is in the history of science. After some intense questioning, Filner chastised Doran saying, "The vocabulary used and the tone you use to defend yourself makes your testimony suspect in my eyes and it is contradictory to everything that we have heard over the years about problems here [Kansas City VA]. So I will tell you if you had to have me vote on who I was going to believe here, I would vote for the employees on the first line and I would have to say, you, sir, are the weakest link."

Doran responded by attacking Dr. Filner. Saying that Filner's personal attack was "unprofessional and totally uncalled for" and only done to embarrass him. He further accused Filner of "grandstanding for the cameras".

Roswell, who had been confirmed as the Under Secretary for Veterans Healthcare Affairs only a few months earlier, went next. Like Doran, he also attacked Klotz noting that, "Despite the author's assertions of a relationship between the rodents and the flies, there was (and is) no conclusive evidence that such a relationship existed". Again like Doran, Roswell went on to blame the age of the facility but did acknowledge the "lack of effective supervision and leadership in the housekeeping department...Due to the lack of knowledgeable leadership and supervision, the infrastructure within the housekeeping department eroded".

Representative Dr. Filner was again skeptical. He asked Roswell, "What is it about a system that requires a publication of a significant problem to direct the resources where they need to go?" Roswell responded, "I think what we are dealing with is a situation where there were competing priorities, limited resources, ineffectual communication between various levels of management, and less than ideal monitoring." Filner asked Roswell to assure him that the VA would not be retaliate against Klotz and was assured that the VA would not.

With that, the hearing and the controversy surrounding the cleanliness at the Kansas City VA ended. The Kansas City VA did receive a multi-million dollar facelift, but no changes occurred affecting the management problems that according to Klotz led to the incident. Central office management became more concerned about employees publically speaking even through scientific publications. A mandate was issued that all scientific manuscripts needed to be submitted to the local Research and Development Committee for review prior to publication (6).

In the aftermath of the controversy Patricia Crosetti was proven right-Klotz does not work for the VA anymore. After receiving poor reviews on his Merit Review grant which he held for nearly 20 years, he left the VA to become a full time university professor. He is currently Chief of Infectious Disease at the University of Arizona. Ken Kizer left the VA when it became apparent his appointment would not be renewed by Congress. Roswell resigned from the VA a couple of years after these events in a controversy about a failed computer system. Patricia Crossett, the VA regional director, was subsequently dismissed. Kent Hill became the permanent director of the Kansas City VA where he is today. Dr. Filner remains on the Veterans Affairs Committee and Hugh Doran remains retired.

Although Klotz's 5 root causes of the mice and maggots incident have yet to result in substantial change, we should remember Klotz for his courage in speaking up and identifying the managerial problems that led to the infestation of mice and maggots.

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