The Veteran Betrayed

How Long Will the Veterans' Administration Continue to Give Third-Rate Medical Care to First-Rate Men?

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NO SOLDIERS on earth receive better medical care than our own. From Guadalcanal to Coral Gables, from Normandy to Mitchel Field, I have seen with a proud heart how endless resources and priceless skill have been combined to give our sick and wounded the best that modern medicine can provide.

But I have been shocked and shamed to discover that these same service men, after they have received a veteran's honorable discharge, are suffering needlessly and, all too often, dying needlessly in our Veterans' Hospitals.

Our disabled veterans are being betrayed by the incompetence, bureaucracy and callousness of the Veterans' Administration, the agency set up over 20 years ago to insure the finest medical care for them.

We have never stinted the Veterans' Administration. We have given it over a quarter of a billion dollars for nearly a hundred great hospitals. Recently Congress appropriated over $105,900,000 just to run these hospitals. But conditions in these beautiful buildings are far worse than cold statistics can indicate.

In every one of these hospitals that I have visited — from Minnesota to Massachusetts — I have found disgraceful and needless overcrowding.

I have found doctors overloaded and hog-tied by administrative restrictions. One man could give his average patient *only seven minutes'* attention a week. Many of the doctors were incompetent men who could hold no position in any well-run hospital; cynical men who joked about their patients' miseries.

I have found nurses so negligent that they did not bother to wash their hands after examining one patient with a contagious disease before turning to another.

I have seen desperately sick veterans served food that would be rejected in the worst Bowery flophouse. And I have seen these same veterans exploited by concessionaires.

Then I have gone to many state and county hospitals, just as tied down by government restrictions and labor shortages. Here I've found real doctors practicing real medicine. Here there are lower death rates and higher cure rates. That is why I know that there is no excuse for the Veterans' Administration's third-rate

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treatment of first-rate men — no excuse except incompetence and complacency.

I have seen such incompetence in Veterans' Hospitals of all types: the mental institutions, the general hospitals and the tuberculosis hospitals. But because no single article can tell the whole grim story, I shall concentrate on the last of these three groups.

Last June Harold Schweibert wrote a letter from the bed he had occupied for almost a year in the Veterans' Facility at Dayton, Ohio. An overseas veteran of World War II, Schweibert had been treated for tuberculosis in Army hospitals in England and, later, in the United States. Then, discharged, he was turned over to the Veterans' Administration for further treatment.

For a year he endured that "treatment." Finally, in despair, he wrote to Dr. H. H. Brueckner, Superintendent of the District Tuberculosis Hospital of Lima, Ohio, begging to be admitted to that institution. Here is his description of the Veterans' Hospital treatment:

"I have lost all belief of recovering in this place. I was admitted June 23, 1943. I was only aspirated twice, in July when 1500 cc. of fluid were removed and in August when 1000 cc. were removed. Haven't been examined since February 1944. I had a flare-up about three weeks ago and being sent up to be fluoroscoped by our ward surgeon, the pneumo doctor refused to do the fluoroscoping and sent back a sarcastic note to our ward surgeon. I have made up my mind to leave here and the sooner the better for my own good."

Dr. Brueckner sent Schweibert's letter to Dr. Louis Dublin, vice-president of the Metropolitan Life Insurance Company and at that time member of the Veterans' Administration Medical Advisory Council. Dublin had been fighting for improvements in the Veterans' Tuberculosis Hospitals. But two weeks later, Dr. Brueckner wrote another letter. It read: "Harold Schweibert will not have a chance of coming to this hospital for removal of his pleural effusion. He died July 2 of apparently cardiac failure and cardiac embarrassment probably because of severe mediastinal shift caused by effusion."

In simple English, that means that Harold Schweibert died because the wall separating the right and left lung was forced against his heart by the fluid that gathered in his lung cavities — *the fluid that Schweibert begged to have removed.*

An isolated case? I have records of many cases of shocking neglect. But let's see what the Veterans' Administration itself says.

Its last published annual report showed that more than ten thousand men were treated for tuberculosis and discharged from the hospitals during the fiscal year. But *only 233 were discharged as arrested cases* — less than one "arrest" achieved out of every 43!

New York State T.B. hospitals, excluding, for the sake of fairness, Ray Brook Sanatorium, which takes mostly early or minimal cases, achieved an arrested condition in 25.6 percent of all the patients they discharged — *a record more than 11 times as good as that of the Veterans' Administration!* Even in cases classified as "far advanced" when admitted, more than 15 percent were dis-

charged as "arrested" — *still six and a half times as many as the Veterans' Hospitals attain for all cases, including minimal.*

Let us make another comparison. Of all the veterans treated for tuberculosis, only 3.67 percent are discharged as "quiescent," "apparently arrested" or "arrested." But New York State's hospitals (Ray Brook again excluded) discharge 48.1 percent in these favorable classifications.

What about the death rate in these so-called hospitals for our veterans? During the last recorded fiscal year, 1117 patients — exclusive of the "runaways," whose hospitalization was incomplete, and those whose condition is not stated — were discharged alive. In the same period, 1922 veterans died in these hospitals.

This is no war-created situation. The Veterans' Administration has been "achieving" this desperately poor record for two decades. And it has been publishing figures in its annual reports which, though technically correct, are actually deceptive.

The trick is simple. The reports do not figure the death rates as a percentage of the total number who complete treatment. Instead, they figure it as a percentage of the *total number discharged. And that total includes more than 58 percent who never complete treatment at all* — the men who run away "Against Medical Advice" or "AWOL" because they see how few are cured and how many die; the men who prefer to go elsewhere for treatment, or to suffer and die quietly at home. Those who die outside — usually after leaving a Veterans' Hospital in disgust — are just as dead, but they don't clutter up the statistics!

By such juggling with figures the Veterans' Administration manages to make it seem that the death rate in its tuberculosis hospitals is only 18.96 percent. Even so, that rate is 50 percent higher than the average death rate of all the 92 T.B. hospitals approved for "residencies" by the American Medical Association.

One reason for this appalling result is that the Veterans' Hospitals are desperately overcrowded — despite official evasion of this fact. At Castle Point, N. Y., for instance, there were 582 patients on October 3, 1944. Yet Castle Point was built for 479 patients. I asked Colonel Carleton Bates, Manager of the Facility, how this miracle was accomplished.

"Oh," the Colonel replied, "we've actually raised our capacity to 625. We do it by the *more economical use of space.*"

By robbing patients of day rooms, diet kitchens and toilet facilities, by crowding beds, the Veterans' Administration has "stretched" the same facilities to serve 30 percent more men than they were built to serve.

Another reason for the high death rate and the sky-high number of "runaways" is that the veterans' doctors are overworked. The excuse is "the war." Yet in the county and state hospitals I have visited, hit just as hard by the Army's call for doctors, physicians carry nothing like the burden of cases heaped upon some veterans' M.D.'s.

The county sanatorium in Minneapolis, Glen Lake, had 451 patients on September 19, 1944. It had 11 physicians — one to 41 patients. But in the same county on the same day, the Veterans' Facility could spare

only three doctors for 179 patients in the T.B. Pavilion — one doctor to 59 patients. The third doctor had just arrived. During the previous six months there were only two doctors for an average of 150 patients.

The record of the Facility was bad. Out of 125 discharges in the first seven months of 1944, 28 left the hospital in coffins. Seventy went out "Against Medical Advice." Only 27 achieved "maximum hospital benefit." *Seventy-eight percent of the men treated for T.B. achieved no benefit.*

At Glen Lake Sanatorium, three quarters of all discharged patients achieve a rating of "improved" or better.

If the overloaded veterans' doctors were at least first-class T.B. specialists, the patients might have less cause for complaint. But here again, the Veterans' Administration has a shocking record.

The Assistant Medical Director of the Veterans' Administration in charge of all tuberculosis hospitals told me that he has "more tuberculosis specialists than any other outfit in the United States."

"How do you select these specialists?" I asked.

"Well, they come to us as general practitioners," he answered. "All we require is an M.D. and one year of internship. Then we give them a four months' orientation course at one of our Facilities."

Four months makes a "specialist" in the eyes of the head of all the Veterans' T.B. Hospitals! Not a single Veterans' Hospital has been approved by the American Medical Association for residencies in chest surgery or tuberculosis. The reason? Residencies cannot be offered unless the American Medical Association judges a hospital to be "in a position to furnish acceptable training." Obviously, synthetic specialists who qualify by a four months' orientation course cannot give "acceptable training" to anybody. No wonder Dr. Dublin has written: "M.D.'s of good repute just will not stay."

There are exceptions, but the majority of the physicians I have interviewed have been tired or cynical men, whose goal seemed to be to finish the day's work and get home.

Under such physicians — and under the kind of administration that sets such standards — the treatment of tuberculosis cases cannot but be far below average.

Consider now the matter of chest surgery. During the last 20 years physicians have developed a dozen operations to collapse the infected parts of the lungs so that they rest. Sixty percent of discharged patients at Glen Lake Sanatorium receive collapse therapy. In New York State's T.B. hospitals, the 2239 patients treated in a single year received 560 pneumothoraxes (the simplest type of collapse therapy) and 907 had more complex operations. At the Minnesota State Sanatorium, 58 percent of the patients receive pneumothorax or other surgical treatment. But in the Veterans' Hospitals, only 1968 chest surgery operations were performed in a year for 10,718 tuberculosis patients treated. Only 18.4 percent of the patients received any chest surgery whatever.

Nor is that the worst of the story. At some Veterans' Hospitals, chest surgery is practically unobtainable.

Even at Washington, D. C., under the very nose of the Veterans' Administration Central Office, 190 T.B. patients received a grand total of eight operations, all induced pneumothoraxes. Yet this Veterans' Hospital is listed as a *Chest Surgery Center*.

Poor treatment, backward treatment and "no treatment at all" are not all the tuberculous veteran has to complain of. At every Veterans' Hospital I have visited, a private concessionaire has been allowed to run a "canteen." Invariably the patients complained about these "licensed profiteers."

At Castle Point last year, petitions signed by hundreds of patients complained that the dishes in which food was served to contagious T.B. cases were afterward used — without sterilizing — to serve other patients and visitors. They also complained about high prices.

One patient told me of being charged 35 cents to cash a $20 Government check. Whereupon the man in the next bed became highly indignant. *He* had been charged 65 cents!

After six months of repeated protests, this concessionaire was finally removed — only to have another private check-casher installed. For cashing Government checks at no risk, this individual now nets over a hundred dollars' profit in a single morning's work.

A universal complaint of the patients concerns the food. Last September, at Castle Point, 400 patients signed a petition begging for better food. *Three weeks later*, this is what I found being served as the day's main meal: one small pot of cold tea, two thin slices of white bread, a tiny pat of butter, a few thin slices of stewed peaches and — the main course — a beef stew containing six or seven tiny chunks of greasy meat swimming in fast-congealing gravy. All cold as the grave.

Nor is Castle Point unique among Veterans' Hospitals in its bad food. My records show complaints about the food from almost every patient interviewed in every Veterans' Hospital I have visited. And this in the treatment of tuberculosis, where good food — and plenty of it — is considered an essential for successful treatment.

One might expect that this combination of skimped food, skimped service and skimped medicine would at least not cost the taxpayers too much money. The cost at Glen Lake Sanatorium, Minneapolis, is $3.85 a day per patient. At the Minnesota State Sanatorium it is $2.71. But the cost of caring for a T.B. case in a Veterans' Facility is $5.80 per day — a first-class price for third-class medicine!

In the face of all this evidence one might well wonder, "Can reform help? Can anything be done — now — to insure decent treatment, a fighting chance for a cure, for the thousands of veterans now herded into these excuses-for-hospitals?"

Men such as Dr. Louis Dublin have fought for reforms for many years. But all such protests have been in vain. Indeed, many prominent physicians have considered the task of reform a hopeless one.

The root of this cancer is in the Central Office in Washington, among the men who have long been aware of this mess and have failed miserably

to clean it up. The cure must start there, with drastic changes in both personnel and policies. Here are specific things the Veterans' Administrator could do, right now, to effect a cleanup:

He could bring in new blood, starting with a new medical head of all the Veterans' Hospitals — a man with an outstanding record both as a doctor and a hospital administrator. This "new broom" could rid the hospitals of the worst of their present personnel. He could give the rest a chance to practice real medicine, by freeing them from paper work and from the rain of restrictive orders that now beat even the better men into a self-protective policy of "playing it safe" and "standing pat." He could make the hospitals *teaching hospitals*, keeping the older doctors on their toes by making them train young interns and residents.

He could eliminate overcrowding immediately by using the same device the Army and Navy have used — leasing resort hotels until new hospitals can be built. But most of all, he could restore simple, common humanity to the Veterans' Hospitals. The individual veteran would cease to be a "case" or a "number" or a "compensable." He would be recognized for what the country and Congress meant him to be: an honored citizen entitled to the very best his country can provide.

All these things *could* be done — right now. Whether they *will* be done is up to the Administrator of Veterans' Affairs — and up to the American people, who hire him, pay him and who can give him his orders.

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Doctor's Dilemma

A THIRD-YEAR medical student was delivering unaided his first baby in one of the poorer sections of South Boston. As is the case in "home deliveries," most of the family were present.

As soon as the infant was born, the nervous student held it up for the customary spank. To his horror, the baby slipped through his fingers, falling harmlessly onto a pile of blankets on the floor. The grandmother, who throughout the entire procedure had been sitting calmly by the kitchen stove, began to hurl a stream of abuse at the frightened young medico. Quickly recovering his wits, he said professionally, "He'll be all right, madam. Sometimes we have to drop 'em three times before they start breathing." — Contributed by Dr. L. E. Hackworth

Lieutenant General Vandegrift of the Marines tells this one:

A patient came to one of our field hospitals with the complaint that he was unable to sleep at night, and the doctor advised him to eat something before going to bed.

"But, doctor," the patient reminded him, "two months ago you told me never to eat anything before going to bed."

The good doctor blinked and then with professional dignity replied: "My boy, that was two months ago. Science has made enormous strides since then."

— AP