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## The Hospital on the Hill

**A mean-spirited VA medical center director has patient care playing distant second to the bottom line**

BY WYATT OLSON

From a distance, the West Palm Beach Veterans Administration Medical Center sits there like a castle on a hill. Just west of I-95 on Blue Heron Road, the veterans hospital perches atop a man-made knoll anchored by a cavernous parking garage. A single, narrow drive curls up to the hospital's entrance, a bottleneck for patients being pushed in wheelchairs or perambulating slowly with crutches or walkers.

The surrounding grounds are a labyrinth of parking lots, one-way loops, and footpaths. So busy is the medical center that parked cars swell onto the grassy swales on the periphery.

As impressive as the hospital looks from a distance, the ten-story building's design was virtually obsolete upon completion ten years ago. By then, medical cost-cutting had moved away from admitting patients into hospitals in favor of treating them on an outpatient basis. It was like building a high-rise hotel and then turning it into a fast-food restaurant: wasted vertical space and an obstructively narrow entry. On any given weekday morning, hundreds of visitors - - many aged veterans of World War II and the Korean War -- trudge toward the hospital entrance on high. The less hearty wait at various pickup points to ride shuttles.

By the time they get to the striking, sunlit atrium that serves as the hospital's anteroom, they can start tracking their waiting time on a giant clock hanging there. Uniformed nurses, technicians, and doctors zip through the space and scuttle down the tangle of hallways stretching into the vast medical complex.

With a budget of about \$220 million this year, the West Palm Beach VA Medical Center treats about 2,000 veterans a day as outpatients. It's the fastest-growing veterans hospital in the state, serving the counties of Palm Beach, St. Lucie, Martin, Okeechobee, Indian River, Hendry, and Glades. As aging veterans have migrated from the chilly north to the Sun Belt -- along with a good share of younger vets -- this medical center has become crucial in caring for those who served in America's military. The veteran medical system is part of the nation's social contract with former draftees and volunteers of the military: Give your time, your health, your limbs for the defense

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of the country and our country will care for you. With the ongoing battles in Afghanistan and Iraq, hospitals like this will be all the more indispensable.

But some employees of the hospital -- many of whom are veterans -- describe it as a workplace rent with nepotism, favoritism, retaliation, and self-dealing. They claim, with considerable support from the VA Inspector General's Office, an investigative arm of the federal agency, that the institution's management is more concerned about manufacturing rosy budget numbers in order to receive bonuses and pay incentives than it is in solving problems and serving veterans.

"It's pounded into us: Do what's right for the veteran, do what's right for the veteran," one long-time employee says. "And there are a lot of good workers who do that. But that has now become a sarcastic comment for those of us who've been here a long time. 'Do what's right for the veteran,' from the top down, is nothing but a lot of bullshit from management. Doing what's right from the management's standpoint is: Do what's right for me to get my bonus. Screw the veteran."

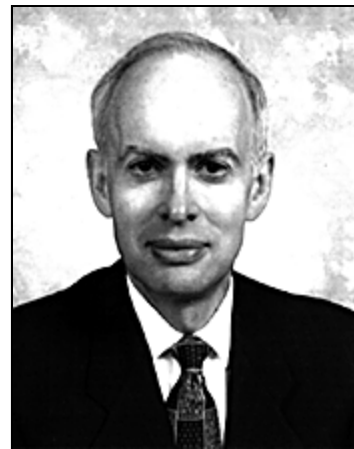
The past years have brought about a bevy of complaints to the union and the VA Inspector General's Office. But the grievances, even when they were substantiated, have led to little in the way of reform. In fact, whistle-blowing often leads only to retaliation.

"What I learned," says one employee who decried favoritism by management and felt the wrath of his superiors, "is that they all gang up on you with the hope that you'll give in and say, 'I'm tired of this crap.'" (He asked not to be identified to avoid further retaliation.) He adds: "Anyone who has a title in this administration thinks the rules are there to punish the rest of us but that none of that stuff applies to them."

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Such an atmosphere of reprisal can't occur in a vacuum, and many employees blame the man in charge of the hospital, Edward H. Seiler, for fostering it. Director since 1998, Seiler is a Teflon chief, protected by what critics describe as a good ol' boy mentality that permeates the Veterans Administration. Insulated from the public by handpicked staff and an on-site federal police force, Seiler is obsessively parsimonious, sometimes petty, and at all times in control. Divorced last year, he lives in a modest, two-bedroom home adjacent to the hospital, but the medical center is the castle he calls home.

His leadership has demoralized many employees and, ultimately, lessened the quality of care, critics say. "In the face of a punitive



**Director Edward Seiler has created a culture of fear at the West Palm Beach veterans hospital, some who work there say.**

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leader -- who hires managers who are afraid of him -- you don't get much creativity," one long-time doctor at the medical center says.

Stories abound among patients and staff about lapses in care and service. For example, in June, Clifford Hoskin, an old World War II Navy man, received hearing aids from the medical center. When he got home, however, he discovered they didn't work properly. When his daughter, Sandra Gay, called to make an appointment to get him back in for an adjustment, she was told it would be two months. "We couldn't wait two months!" she declares. "He couldn't hear a thing." He showed up at the clinic, saying he'd wait a few hours if he could just get in for a few minutes, but he was told the clinic didn't take walk-ins. He made an appeal to the administrative office, but it fell on deaf ears. The only way he finally got the adjustment was by contacting Dan Liftman, an aide to Rep. Alcee Hastings, whose district covers much of the area served by the medical center. Liftman then accompanied him to the hospital.



The Blinded American Veterans Foundation has documented lengthy waits -- often more than a year to get an appointment scheduled -- at the hospital's blind-rehab center; it also found that employees at the rehab center have been subject to harsh discipline and retaliation, which is why the unit is now being investigated by the VA's Inspector General's Office.

The existence of a link between Seiler's management style and lapses in services is not a given, critics acknowledge. But it is safe to assume that content, well-managed employees will be more conscientious in their work, that all their energies will go into providing care for veterans, not protecting themselves.

"He [Seiler] is a holy terror," Liftman offers. "He's created a climate of fear, and I don't have a problem saying that based on all the staff I've talked to."

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The WPB VA Medical Center experienced rocky times from the day it opened in 1995. Designing the hospital began in the 1980s, before the notion of cost-cutting through managed care had found traction. The plans called for 450 medical/surgical beds and 120 nursing home beds. By the time it opened, however, managed care was king. Gone were the days when patients with torn ligaments or even a hernia were kept overnight. Those hundreds of rooms were simply wasted space. And access to outpatient services through a single front entry has simply led to a logjam. By 1998, the average number of inpatients a day, including nursing home patients, was 172. The most recent figures, for 2001, show 186 patients -- a usage rate of less than 50 percent.

But the anachronistic design wasn't the only problem, according to a 1999 analysis by the VA Inspector General's Office. The hospital "essentially created its own organizational structure, which was unique within the VA," the IG report stated. The man responsible for this freewheeling style was Richard Isaac, who had overseen construction and then stayed on as the hospital's first director. Like any top hospital administrator, Isaac was responsible for implementing medical care with the roughly \$100 million annual budget. Hoping to circumvent the bureaucracy and foster innovation, Isaac -- who had never run a VA hospital before -- chose a cadre of physicians with no prior VA experience

to manage the clinical departments. In 1996, Isaac hired a new chief of staff who had little experience in such a position.

In 1997, Isaac -- a schmoozer with a penchant for micromanaging, according to people who worked with him -- attempted to restructure the organization, but "the effort was not well received or understood by the clinical staff and was not successful," the IG report stated. Late that year, Isaac resigned.

The next director, Edward Seiler, looked like a good choice on paper. He began his career in 1968 as a personnel management specialist at the VA Medical Center in Baltimore. During the ensuing years, Seiler worked his way up the ladder and in 1987 became director of the VA Medical Center in Providence, Rhode Island, where he earned a reputation as a man who could cut costs. While at the helm of the Providence hospital, he was forced to deal with a \$1.5 million budget shortfall in 1996. He saved money by cutting staff and restricting the number of patients accepted.

Then Seiler came and imposed his own reorganization in West Palm, a system of harsh disincentives designed to keep costs down no matter what the consequences, critics say.

"The clinicians felt that too many decisions were being made by administrators," a psychologist at the medical center recalls. "It was a very punitive environment. If they didn't do what they were told, they were chastised."

By the end of 1998, Liftman, who works out of an office in West Palm Beach, had been bombarded with complaints by employees of a hostile work environment. At Hastings' behest, the VA Inspector General's Office looked into the allegations, finding a dysfunctional medical center in which the director had surrounded himself with top managers who broached no input from doctors and other medical professionals. The chief of acute care medicine told investigators that Seiler's chief of staff "lacks leadership skills" and "runs a feudal system that does not promote teamwork." Another former chief asserted that the chief of staff "uses intimidation to get his way, creating an atmosphere of mistrust and vindictiveness."

At the same time, Seiler "does not appear to want to talk with staff directly," a former chief of psychology told investigators.

The director, however, had solid support from Robert Roswell, another career VA man with a stern, long face who had become director of a network of six VA hospitals in Florida and Puerto Rico in 1995. An Oklahoma native who previously served as chief of staff at VA hospitals in Birmingham and Oklahoma City, Roswell insisted that Seiler and company were, in fact, "on the right track." Seiler would receive solid backing in the years to come from Roswell, until his benefactor himself crashed and burned earlier this year under allegations of mismanagement.

Coddling shaky administrators in the VA has been well-documented by congressional committees that oversee the VA medical system. Terry Everett, a square-jawed Republican representative from Alabama who chaired hearings about VA management in 1999, told members that "there is without question a good-old-boy network within the VA" that tolerates "favoritism, cronyism, harassment, and reprisal." He decried numerous examples "of where higher-ups have been given no discipline whatsoever for the actions they have taken." Retaliation against whistle blowers was also common, he said.

*New Times* asked for an interview with Seiler, a request denied by Phil Kaplan, the medical center's director of communications. Initially, Kaplan offered to answer questions, but he retreated quickly when the IG's Office was mentioned.

"You're getting into allegations that were made; they were looked at, and they were found to be baseless," Kaplan interjected testily. "It's already been looked at by the inspector general and other people and found to be baseless or unfounded. That's all I'm going to say about those."

*New Times* hadn't even asked a question yet, so what was he referring to?

"Any allegations," he snapped. "I know where you're going."

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The hospital union office is a cramped den on the bustling first floor, not far down a hall from the busy atrium. At various times during the week, Paula Lang, president of the local chapter of the American Federation of Government Employees, holes up here to manage the affairs of a union made up of doctors, nurses, technicians, housekeepers, and many other positions. Lang possesses a wide, motherly smile and soothing voice, both undoubtedly helpful in her job as a clinical psychologist. Despite the easy-going manner, however, Lang became one of the hospital administration's most persistent and vocal gadflies.

"I started to do this because I was so worried about what was happening here and how badly people were being treated," she explains. "I'd never seen anything like it, how punitive it was."

Regardless of how employees were being treated, statistically, the medical center appeared to be doing an outstanding job of keeping workplace injuries low; the number of worker's compensation claims filed were far fewer than at other VA hospitals in Florida. In fact, Seiler had managed to cut costs related to the program by 10 percent in 1999 compared to 1998. He crowed about the savings in his annual performance self-appraisal that year. And why not, since that statistic is one of the many indicators by which he receives annual bonus money? Roswell even gave Seiler a special award in May 1999 for his achievements in the worker's comp realm.

But workers were telling a different story. In 1999, two employees complained that medical center managers had mishandled their claims, but Roswell dismissed the complaints as unfounded.

There were other cases. In the winter of 2000, Lang, then a union steward, says she discovered that the hospital's policy violated some provisions of the Federal Employees' Compensation Act. Specifically, in some cases, injured employees had not been informed of their right to choose a physician and were improperly compelled to use leave time. In other cases, claims had not even been processed.

"I had an employee come to me because he was injured on the job," she says. "He felt like he was getting the runaround. So I pulled up the law on the Internet and pulled up the local policy, and I saw that there was a difference. In the law, if you're injured on the job, you're entitled to have your doctor paid for, entitled to 45 days off. If there's impairment, you need to get another job and get retrained. Workers have those entitlements." Many employees are veterans themselves, sometimes partially disabled in some way. Work often involves repetitive motion, heavy lifting, and sharp instruments. Injuries are not rare.

One nurse's aide, for example, injured her back on the job, which required surgery and a lengthy recuperation, Lang says. "She told me that the documents she submitted [to management] didn't go to the Department of Labor, so the DOL assumed that she'd not done what was required of her and stopped benefits," Lang says. The aide fell behind in her bills and ended up losing her car. Lang filed a union grievance on her behalf and had her benefits reinstated.

David Green, who was serving as both chief of human resources and acting associate director, assured the union that any specific cases would be reviewed and corrected, according to the minutes from a meeting with union representatives.

Though Seiler wasn't at the meeting, he no doubt had learned about the complaints by the time that, a few months later, a team from the VA Inspector General's Office launched a new probe into allegations by employees that management had violated federal law and VA rules for worker's comp claims.

"Everyone said they didn't know anything about it," Lang says of management. "But everything I'd told them was right there in the minutes of that meeting, and Seiler is supposed to review the minutes."

The wheels of the IG's Office turn slowly, but the agency's findings, released a year later, were a bombshell. Investigators concluded that Seiler and other managers routinely withheld information from injured employees about their rights under the worker's comp program. Up until Seiler became director, injured workers had been given an information packet that outlined those rights, but that was discontinued under Seiler's tenure. One former employee who had been responsible for the program told investigators that management discouraged him from providing information about workers' rights.

In another example cited by the report, after a worker's comp specialist informed an injured employee of his right to file a claim within three years -- and the importance of doing so if necessary -- the specialist was chastised by the medical center's safety and occupational health management officer. The manager, whose name was blotted out from the heavily redacted report, became alarmed when he learned of that helpful assistance. He wrote a note to someone high in the hospital administration, saying that sharing such information was "giving away the show."

The IG report again called for Roswell to take "appropriate administrative action" against Seiler.

Investigators also found that management had violated federal regulations by underreporting many of the 166 workplace injuries during 18 months in 1999 and 2000. If the medical center had followed proper procedure, it would have submitted medical bills for those employees to the U.S. Department of Labor, which in turn would reimburse the medical center for costs related to worker's comp claims. In other words, the hospital forfeited those reimbursements, which ultimately could have been used to fund treatment of veterans at the cash-strapped hospital.

Seiler told investigators that the reporting requirements, to his knowledge, were being met. But another manager, whose name was also redacted, testified that he, Seiler, and a third manager decided not to bill the labor department because "it would reflect unfavorably on the facility's occupational safety statistical measures." While investigators couldn't conclusively determine Seiler's role in these decisions, the report concluded: "It was his responsibility as the director to know what the medical center's practices were and take steps to correct them, if necessary." The report again

called for Roswell to take action against Seiler.

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Roswell never took any disciplinary action against Seiler. Lang says she was dumbfounded when union members continued to complain about the same problems. She filed a complaint with the IG's Office in October 2001, and not until January 2003 did the agency inform her that the investigation was complete. Her request for a copy through the Freedom of Information Act was denied by the agency, which said the report wouldn't be closed until the Veterans Health Administration "provides actions to implement the recommendations." Lang's further inquiries were eventually met with the response that, inexplicably, no such report existed. "It vaporized," she sighs.

A likely assumption is that no actions could be agreed upon between the IG's Office and VA management. (*New Times* filed a Freedom of Information Act request to the agency asking for copies of all investigations and audits of the West Palm hospital. There was no reference to this report among those we received.)

Bent but not broken, Lang filed yet *another* complaint to the IG's Office in March 2003, offering new examples of mishandled worker's comp claims. As it turned out, Liftman had also submitted two cases, as had the office of U.S. Sen. Bill Nelson. This time, a team arrived not from the IG's Office but from the Florida regional headquarters in St. Petersburg. Roswell was no longer in charge there since his March 2002 promotion to undersecretary for health for the Department of Veterans Affairs in Washington, D.C., but he still remained in the chain of authority over Florida's VA hospitals. The Administrative Investigation Board found that the medical center had correctly handled only three of the 11 cases involved. But the final report was more an exercise in *Dilbertian* futility than a rigorous call for rectification. Lang finally received the undated report this June, and, like a road map to nowhere, it contained absolutely no recommendations.

Seiler remains close-mouthed about the problems. "Whenever I tell him about these things, he denies it," Lang says. "When I confront him with a problem, he denies it."

Liftman hasn't had much luck with the director either. Asked if he ever gets face-to-face time with Seiler to discuss problems at the medical center, Liftman laughs raucously. "That's a good one!" he hoots.

*New Times* tried to meet Seiler by showing up unannounced at a gathering of employees at the hospital in late August. Seiler appeared in the small meeting room a few minutes before noon. He wore a light-tan suit over his small frame. His skin was ghostly pale.

Several minutes later, a plainclothes investigator with the hospital's police department marched *New Times* out of the meeting room and off hospital property.

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Seiler and his underlings seem to have no qualms about disregarding VA policy and federal regulations when it comes to favors for friends and family. In some cases, veterans end up getting the short end of the stick because of cronyism.

For example, the IG's Office blasted Seiler for improperly promoting Diana Dilkes, an administrative

assistant in his office, to the position of equal employment opportunity (EEO) program specialist. Many employees were disturbed by the promotion, which had not been competitively posted, because the EEO complaint process is one of the few avenues available to workers who believe they've been treated unfairly. Some feared that Dilkes would be too beholden to Seiler to act as a gatekeeper for such complaints. As a result of the IG report, the position was reposted. In the end, Dilkes was still given the job.

One long-time pharmacy employee explains how the administration has become adept at following the letter of the law for posting jobs while circumventing the spirit in order to promote the favored.

"When a new position is open, it's supposed to be open to everybody," he explains in the world-weary tone of a man who knows his future holds no job advancement at the VA. "The name of the game with these guys is that they post it for a day, take it off, and no one's aware of it. After it closes, then they say, 'Hey did you know there was a position open that's a grade higher? Oh, it just closed yesterday.' Then someone ends up getting the position who's a friend of [upper management] or Seiler."

Seiler received a fat Bronx cheer from the Blinded American Veterans Association (BAVA) in October 2000 for cronyism in hiring -- all the more remarkable because Seiler is also blind. The association took Seiler to task on its website for playing the "pre-selection game" in hiring a nonveteran to direct the hospital's new blind-rehabilitation program.

"Blinded veterans who applied were not given an opportunity to compete for the position," according to a column written by BAVA President John Fales under his pen name of Sgt. Shaft, a crusty alter ego who operates as a consumer advocate for blinded vets. "Their paperwork was conveniently lost, and the most qualified blinded veteran was not even on the list to be interviewed. And guess who got the chief's position: Seiler's nonveteran friend."

In 2001, the IG's Office probe also found that Seiler and his top managers knowingly stiffed eight rehab specialists out of relocation reimbursements for moving to West Palm Beach from VA positions around the country. Under federal law and VA policy, Seiler was required to fully reimburse those expenses. Seiler told investigators that he withheld reimbursements because it was a "prudent budgetary decision."

Once again, Roswell was advised to take administrative action against Seiler. Roswell's hard-hitting response was to employ the entire affair as a "lesson learned" for other hospital directors.

Seiler isn't beneath a bit of nepotism either, critics say -- even if it means making rank-and-file veterans wait a bit longer in line. Just ask Veronica Pledger, a 44-year-old single mother who has processed veterans claims at the hospital for the past 15 months. Pledger resides in a modest apartment in west ern Palm Beach County, which is liberally decorated with knickknacks and family photos, a youngish woman whose sad eyes mist up easily when she speaks about her job.

She works on the medical center's first floor, behind a windowless security door, where she and a handful of others process veterans' claims each day. Technically, they're employees of the Veteran's Benefits Administration, and its headquarters is in St. Petersburg, but they work closely with hospital personnel. Veterans wishing to receive medical or disability benefits file paperwork with this VBA minicenter, created to speed processing by keeping it local.

Pledger moved here last year from Cleveland, where she worked with a special unit that expedited VA claims for aging -- and quickly passing away -- World War II veterans. It was a vibrant team, empowered, she says, by management that always encouraged creative thinking if it would help veterans. The atmosphere in Florida, however, was a world away from that in Ohio. "They shuffle things," she says of the Florida hospital's current administration. "We have this report to do, so let's quick-shuffle this over to here so this report looks good. And when we need this report to look good, we'll shuffle over there. It's all about numbers."

In December 2003, Pledger returned from a break and saw her boss, Mike Richland, in his office talking to another man. "We're behind locked doors," Pledger explains, sounding as if she's gritting her teeth at times. "Nobody's supposed to be in our office, according to my supervisor, unless they're employees."

Richland then brought the man over to one of Pledger's co-workers and rearranged her desk to make room for paperwork. He then told her to fill out an application and process this veteran's claim as he stood there. Everyone in the office soon realized why this veteran was getting special treatment: He was Bruce Seiler, the director's brother.

"My boss, because it furthers his career," Pledger sputters, "broke the rules and allowed this vet to come in, made her stop the work she was doing on the files of four other veterans, fill out this guy's paperwork, and *then*, she was told to expedite the claim. I'm a vet, and at the time that happened, *my* claim was pending in Atlanta. And *it* was not getting any expedited treatment." In fact, Pledger says no veteran had ever been in the office before; Bruce Seiler's appearance was unique.

"The only time we're supposed to expedite is if the vet is homeless, has financial hardship, or is terminally ill. That's the only time we're supposed to put them to the top of the list." Bruce Seiler was none of the above, she says, but Richland continued to hover over the file like a hen over eggs.

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Some employees are guardedly optimistic that a recent debacle at regional headquarters could lead to sweeping changes in management throughout the Sunshine State. In April, Roswell resigned as VA undersecretary because of his role in the disastrous implementation of a computer system at Bay Pines VA Medical Center in St. Petersburg. The half-billion-dollar project, of which \$249 million had already been paid to BearingPoint, was supposed to track and control finances. Instead, the outsourcing scheme brought operations to a halt at times, leading to canceled surgeries and backlogs of patients. Two other top administrators in Florida also fell on their swords, including Seiler's direct boss, Elwood Headley. Sen. Bill Nelson has prompted the U.S. Justice Department to investigate whether there was criminal wrongdoing by VA officials.

An IG's Office report found that management problems had existed under Roswell but that they had not been reported. Pledger says that no one should be surprised that mismanagement comes from the top down. "It's a perpetual thing," she offers. "They choose the people who think like them. Even when you remove this person, you're promoting someone who's been groomed to be just like him. You're perpetuating the same kind of thinking."