

DR. HENRY BUTLER III
Letter to Eileen P. Keenan, Investigator, DoD Inspector General

12 December 2003

Dear Mrs. Keenan:

Thank you. The issue I had in mind was not error, but the apparent 'corporate culture' (1999-2003) of cover-up of error and the failure (refusal) for political reasons to identify and correct it: Captain Ranck, to the best of my knowledge, did nothing. If he did anything, he never informed me and to my knowledge informed none of the other doctors who reported the matter to him. I was, and probably remain, the second most senior physician in this hospital (M.D. Columbia University 1969). It is ironic that I have been censured after trying to improve safety for patients, much as has been reported in the press last month in both civilian and federal medicine (see www.semmelweissociety.net).

To the best of my knowledge, he also did not inform his superior, Captain Thomas Cullison, then hospital commander, because 8 months later when the illegal order not to testify on behalf of Dr. Gluck in Groton was transmitted to me by Captain Ranck (~August 23, 2000), Captain Cullison said he had heard nothing of the matter of the nurse, Mr. Farrish, who refused to inform any of four physicians present in our clinic of the fact that a diabetic employee was in distress and had become a patient (approximately 10:30 A.M. on 17 Dec 1999). In fact, Mr. Farrish spoke both to me and to one other physician without reporting the deteriorating condition of Mr. P-----, the diabetic former Navy corpsman whose blood sugar another nurse, Commander Carrol, allegedly had measured at 26 mg% before Mr. Farrish became involved. When I asked her why she had not called any of 4 nearby physicians, she said, "I know how to treat seizures; you give Valium." Neither nurse holds a medical license, and therefore both were apparently guilty of practicing medicine without a license by refusing to call any of 4 physicians within approximately fifteen to fifty feet of the stricken employee-turned-patient. He could have died. Glucose (sugar) is the treatment for hypoglycemia, not Valium. I do not know how long they delayed when they should have notified us as soon as the patient declared his confusion or when they measured his sugar. I do not know whether they gave Valium. When I asked Mr. Farrish why he had not called for help, he said, "I didn't need your Harvard brains. I needed someone with muscle." Is withholding care a violation of North Carolina law--assault, battery, or neither?--such as the Nursing Act? Or, are only Army and Air Force officers required to obey state law? Commander Carrol asked me whether I knew her boss, Commander Janakowski. When I said I did not, she said, "You will." I took that to be a threat!

I believe Commander Janakowski, then head nurse, may have sat on the committee which then controlled the selective disbursement of funds for continuing medical education, a committee possibly chaired by Captain Sidney Ranck. My impression was that education was not then considered a matter of responsibility and of duty to the patient, but a reward, a favor, an extra. I obtained this impression from Commander, now Captain, K. Delahanty, who said as much. He is the gentleman who informed me that I was not a 'team player' when he explained that I had not been funded to attend the annual national surgery meeting while a colleague, who had also reported on the diabetic patient by writing a letter to Captain Ranck, was fully funded to attend said meeting. I took Commander Delahanty's statement as confirmation of reprisal.

I served 12 years in the Army. In the Army we referred to the 5 stages of a project. They were:

1. Enthusiasm
2. Disenchantment
3. Search for the guilty
4. Punish the innocent
5. Reward the uninvolved.

The Navy is much the same: In this case, Mr. Farrish left the Navy for civilian nursing and Mrs. Carrol became the head nurse in our emergency room, while Commander Janakowski was promoted before retirement and Captain Ranck retired. Here is an article (Feb. 2001 Letter to the Editor, www.usmedicine.com) which merits review by anyone in government:

February 2001

Letters To The Editor -

Military Physicians Leave For A Plethora Of Reasons

I have been reading several of the articles in your publication concerning military physician retention. I have recent experience with military medicine and find much of what has been written very accurate. I do wish to add some things:

During my four year stint in the military I did not witness one single physician with the rank of O-4 or below remain in the military beyond their initial obligation for HPSP or USUHS. Thus, from what I have seen, military physician retention at the rank of O-4 and below is zero. This goes for all specialties across the board. The only physicians I have seen stay are those in ranks of O-5 and above who seem "stuck" in the system for whatever reason. But, they are certainly in the minority and are mostly in administrative non-clinical jobs. This all combines to produce a practicing military medical corps that is consistently youthful and relatively inexperienced. Why this severe military physician retention problem? Obviously, the military is not a good place to practice medicine. Here are some contributing factors:

1. Low Pay and Difficult Working Conditions. Why continue to work for the federal government, [which] is consistently demanding more and more from physicians, when one can go to the private sector and still work as hard but be much better compensated for it? This is true for all specialties and is a "no-brainer."

2. Inadequate Retirement Plan. The retirement plan is not a good deal for physicians. This is because it is based upon "base pay" only, and is not based upon the total income.

3. Too much Managed Care. The military now seems to have a love affair with managed care, and has forced it upon its physicians. Unless one shares this passion for managed care, practicing medicine in the military, especially as a "PCM," is demanding, difficult and frustrating. This is mainly because one does not have the autonomy to limit the amount of HMO patients in his or her practice. Military medicine (in the MTF) is now 100 per cent HMO. One primary care physician who recently left the military described the experience as "hellish" because of this. This leads to the next reason.

4. Lack of Autonomy. All physicians place a high degree of value upon this, whether they are willing to admit it or not. Most, if not all, physicians are strong-willed, independent people or they would not have the "right stuff" to get into and through the rigors of medical school and residency. (If the military allowed them a residency-which is a whole other problem.) Military physicians, simply because of the organization they are in, have less autonomy than any others. Granted, this is given up when one chooses to "sign on the dotted line" and accept money from the government for medical education. But as soon as freedom can be regained, most take advantage of the opportunity. However just because one "belongs" to the military does not mean that there needs to be as much micromanagement of military medical practice that there now seems to be. This micromanagement is a direct result of total "managed care."

5. Loss of Traditional, "Old-Fashioned" Medical Values. Military medicine now seems to be concerned more with numbers such as "metrics" and "productivity." Whatever happened to the patient? The patient seems to have become lost in all this. In fact, the patient no longer exists at all; this is evidenced by the fact that the patient has become a "customer." Pardon me, but a "customer" is someone who buys a hamburger from McDonald's. A "patient" is someone who seeks the help of a physician. But wait, the physician has been lost also, the physician no longer exists either but is now a "provider." So, we have "customers" "accessing"" providers." This doesn't sound like medicine at all. Sounds more like business doesn't it? So, there we have it folks, military medicine is now all about business. What is business all about? MONEY. So, what is military medicine all about now? MONEY. Yes, private practice is about earning money also, but it is not the prime focus. Believe it or not, most physicians I know did go to medical school because they wanted to help people. People are what is most important in their lives, not making money. On the other hand, the prime focus of military healthcare as a whole now seems to be centered around money. What does this have to do with physician retention? Practicing medicine in such an overly cost-conscious environment is often very difficult and frustrating because of the limitations that are imposed in an effort to preserve that which is valued the most: money. What limitations? Limited pharmacy formularies, strict referral criteria, and the

many other limitations imposed by managed care.

6. Career Progression Leads Out of Clinical Medicine. In the military, achieving higher rank (and thus higher pay), almost certainly means leaving the practice of medicine for a "desk job." This is a good thing for physicians who don't want to practice medicine anymore, for whatever reason. But for most who want to continue the full time practice of medicine AND experience career progression, there is only one direction to go: out.

7. Promotion Dependent upon Unnecessary Non-Applicable Professional Military Education. In the military, physicians cannot be promoted beyond the rank of O-4 without "Professional Military Education." This "PME" is not geared toward medical officers in any way shape or form, but rather is totally oriented toward line officers. For a physician who wants to become a line officer, this is probably a necessary thing, but how many of those are there? Furthermore, I doubt we will ever see a medical officer in command of a line organization.

8. Little or No Professional Development. The military continues to deny medical school graduates the opportunity to obtain a seamless medical education from medical school through residency before entering practice. The military has come under congressional heat for this and deserves every bit of it. Hopefully, Congress will keep the pressure on to put an end to this archaic practice. No need is so great as to justify this. All too often, these unfortunate physicians must serve out their entire time with incomplete medical training, because the military then refuses to provide them with the additional education they need and ask for, or they are so disillusioned and disappointed with their military medical experience (after what has happened to them) that they just want to get it behind them. This goes for GMOs and GMO-flight surgeons.

Speaking of GMO-flight surgeons, isn't it baffling that its pilots-among the military's most valuable human assets-are being cared for by its least trained physicians? Go figure. This list is by no means exhaustive. I could go on and on, but I think most would agree that I have hit the big ones. Will anything be done to correct all this and thus the physician retention problems? It's anybody's guess. But, I wouldn't hold my breath. -NAME WITHELD The only item I would add is that federal physicians are too frequently punished for trying to uphold medical standards. In some cases they have been fired (Dr. Shaller, Veterans Administration) or incarcerated on military psychiatry wards (Dr. Stephen W. Smith, Army; Dr. Victoria Voге, Navy).

Sincerely,

Henry E. Butler III, M.D., FACS

Dr. Butler,

In order to complete our preliminary inquiry, we require the following additional information.

During your interview with us in June, you stated that, in December 1999, you met with CAPT Sidney Ranck concerning alleged improper medical care of a diabetic staff member at Naval Hospital Camp Lejeune.

Did CAPT Ranck take any action in response to your report -- for example, an investigation or informal inquiry? If so, what were the results?

Sincerely,

Eileen P. Keenan
Investigator
DoD Inspector General