Senator Sherrod Brown

Opening Remarks of Senator Sherrod Brown
Senate Veterans' Affairs Committee Field Hearing Regarding the Dayton Dental Clinic
Tuesday, April 26, 2011, Dayton VA Medial Center, Dayton, Ohio

Thank you for joining us today. This official hearing of the United States Senate Committee on Veterans' Affairs has now come to order.

Chairman Patty Murray of the State of Washington has a continued interest in the Dayton VA Medical Center and for all of Ohio's veterans.

I thank her for encouraging this hearing – and thank you to Ryan Pettit of her staff, who is here today, for his work in helping to organize it.

Thank you also to John McDonald who is also here.

The investigation of the Dayton VA Dental Clinic has affected so many local veterans and their families that it simply makes sense to hold the hearing here, rather than in Washington.

However, Chairman Murray, Secretary of the VA Eric Shinseki, and I have had many discussions about what happened, and this hearing is result of that work.

It will operate with the authority of any other hearing in the U.S. Senate in Washington, DC.

We'll be hearing from The Office of the Inspector General of VA and members of the VA leadership on what happened at the Dayton VA Dental Clinic.

I'll be asking tough questions on how we got here and how we move forward.

To any audience members who would like to submit testimony for the official record, please contact Doug Babcock or Rachel Miller of my staff.

But before we start I'd like to ask all the veterans who are here today to please stand or raise your hand.

Thank you for your service.

And thank you to everyone here today and the veterans you support.

A special thank you to the leaders of Ohio's Veteran's Service Organziations – Tom Burke of the Buckeye State Council President for Vietnam Veterans and Dave Kenyon, State Service Officer for AMVETS.

For nearly 150 years, Ohio has been a leader in providing veterans' services.

Ohio founded one of the nation's first chapters of the Veterans of Foreign Wars (VFW).

Ohio has the nation's best county veteran service officers and organization.

And the Dayton VA Medical Center was one of the nation's first VA Hospitals, providing continuous service to Veterans for over 140 years.

As a member of the Senate Veterans' Affairs Committee – it's not only an honor to serve our nation's veterans, it's a sacred responsibility.

We shouldn't have to be here. This hearing shouldn't have to take place.

I would much rather have a hearing on the future of the VA in Dayton – how we can help the community leverage federal resources to ensure that the hospital and the campus meet the needs of our veterans.

I would much rather be talking about our strong bid for the VA Archives – a distinction clearly earned and deserved by Ohio veterans.

But one of the most important duties of representing Ohio's veterans on the Committee is providing oversight of the VA.

That means understanding what works at VA – and making it better. It means finding out what's not working – and fixing it.

And in the process, it means recognizing that serving our veterans is a nonpartisan responsibility of our government – Our veterans deserve nothing less.

That is why we are here today.

Most of us are aware of the inexcusable facts and unconscionable consequences behind what happened at the Dayton VA Dental Clinic.

Over the course of 18 years, the Clinic failed in its duty to serve our veterans.

A dentist disregarded basic sterilization practices.

Nurses and assistants were ignored when they reported substandard care.

Reports of employees punished for reporting unsafe practices.

Petty, mean spirited, inter-personnel dysfunction led to verbal and physical confrontations.

Dental students allegedly provided care well beyond that for which they were qualified, based on VA regulations and standard practices.

Management at the dental clinic and Medical Center studiously ignored problem after problem – a symptom of general management chaos.

Those are the irrefutable, inexcusable facts.

More than 500 patients at the Dayton VA dental clinic have been told to be tested for blood borne pathogens as a result of the care they received at the facility.

Other experts are saying thousands more should be tested.

As many as nine patients have tested positive for Hepatitis. Perhaps there are more.

Veterans received life-threatening blood borne pathogens instead of high quality health care. It's an outrage.

The patients at the clinic are our nation's veterans and their families.

They served our nation when called upon.

High quality health care is a benefit they have earned and they deserve.

And in most cases that's what the VA Medical System does – ensure a high standard of care to veterans who have earned it.

I often tell people that nowhere in the world will you find better care than when you step into a VA medical facility.

During the debate on health insurance reform — the VA Health System was an example to emulate.

So this hearing isn't a trial or a witch hunt on the entire VA Medical System.

We want to restore the public's confidence in the system. We want to ensure accountability for those responsible for horrific wrongs.

We want to instill transparency moving forward – to ensure no veteran is ever treated with such blatant disregard.

We want transparency, we want accountability and, and we want to learn from the clinic's mistakes so that those mistakes are never repeated.

This hearing is grounded in those goals.

We'll explore specific questions about what happened over the last 18 years.

Why was the clinic allowed to operate in this fashion for more than a decade?

Why did it take so long to close the clinic?

Has every person exposed to contagions from unsafe medical practices been notified, tested, and treated?

What is being done to hold those accountable including those that knew and sat idly by and those who should have known?

We'll explore where we are today.

Is the Dayton dental clinic now safe for patients who expect the world class care VA prides itself on?

Are systems in place for this to never happen again?

What is VA doing to make those exposed whole?

What is VA doing to reassure every veteran that VA care is the best care anywhere?

And we'll explore how to restore the public's confidence in the system.

I have heard from hundreds of veterans about the Dayton VA. Most are angry; many are disappointed.

I wanted to share two with you.

One veteran from Huber Heights told me:

"I desperately need dental care but not at the expense of my health."

And a veteran in Minster in Auglaize County wrote:

"I am one of the veterans that was potentially exposed by the Dentist in question. I have been tested, now I have to wait in limbo, being treated as if I am positive, until said test results come back. No offense Senator, but the testing is being done by the same agency that ignored the problem for 18 years, and put me in jeopardy to begin with. Am I to trust the VA will get it right?"

I'm not happy with the pace of the administrative process regarding the disciplining of those involved.

I understand there are legal and procedural hurdles and for that matter criminal processes that need to be followed.

But people must be held accountable.

Transparency, accountability, and making sure this crisis in care and in confidence is an anomaly, that it never happens again.

That's what today is about. I'll start the hearing by asking Congressman Mike Turner to offer his testimony.