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Trouble at VA went beyond 1 dentist

A VA investigation shows the dental office was poorly managed and understaffed.

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DAYTON — Problems at the Dayton VA Medical Center's dental clinic went far beyond Dr. Dwight Pemberton, the dentist whose poor infection control practices may have exposed 535 patients to such diseases as hepatitis and HIV from January 1992 to July 2010.

In sworn testimony given during a Veterans Affairs investigation, workers describe a poorly run, understaffed clinic, where supervisors tolerated inappropriate activities and cut corners, and workers were paralyzed by fear.

According to a post-investigation report, another of the clinic's eight dentists allegedly broke teeth during extractions and performed unnecessary procedures. Working with that dentist, whose name hasn't been obtained by the Dayton Daily News, "was just like watching a child be abused," one worker told investigators.

Clinic dentists even took credit for being primary providers of dental work done by unlicensed students, who were permitted to practice without the required level of supervision, according to the report.

A former patient of Pemberton's said he received substandard care at the clinic during a visit five years ago. Thomas Woodson of Harrison Twp. told the Dayton Daily News Pemberton enthusiastically introduced him to his fellow dentists after Woodson told him he is a descendant of Thomas Jefferson and slave Sally Hemings. While Pemberton took keen interest in Woodson's roots, Woodson went home with ill-fitting dentures that he soon quit wearing.

VA Secretary Eric Shinseki acknowledged a "failure of leadership" in Dayton during a federal budget hearing earlier this month, during which he was asked why VA Medical Center Director Guy Richardson had received an $11,874 bonus at the end of federal fiscal 2010.

"I'm not going to try to describe why a bonus was sensible," Shinseki said. "This went on for an extended period of time when it wasn't brought to the attention of leadership, and I again fault that to a failure in leadership."

Soon after, Richardson was reassigned to a VA regional headquarters job in Cincinnati, described by VA officials as a "lateral move" without a change in pay. Richardson received $167,328 in fiscal 2010.

The VA initially said nine veterans had tested newly positive in preliminary tests for hepatitis B or hepatitis C antibody, but on Friday cut that number to five.

Members of Congress have been unimpressed by the VA's response to the scandal so far.

"These practices are so shocking and outrageous that you would expect the VA to have a very strong and open response to this," U.S. Rep. Mike Turner, R-Centerville, said Thursday. Instead, he said, the

agency “clearly appears to be in cover-up mode.”

Sen. Sherrod Brown, D-Ohio, called the response “slow” but said transparency is improving.

The VA has defended its response, pointing to a recent New England Journal of Medicine article that singles out the VA’s disclosure policy for adverse events to patients. The policy, according to the article, “endorses transparency.”

VA officials didn’t defend Pemberton’s actions, but noted not all of the complaints about the second dentist were deemed valid. Dr. Bill Germann, the Dayton VA’s acting chief of staff, said that dentist will likely begin practicing again at the Dayton VA.

Germann also said there was appropriate oversight of fourth-year dental students, and dentists appropriately documented work done by those students.

“Based on my knowledge, the comments in the (investigative) report were not totally appropriate,” Germann said.

The dental clinic scandal in Dayton calls into question how accountable people are held throughout VA, said Ronald Hamowy, a fellow with the Cato Institute and the Independent Institute, both libertarian groups. Hamowy authored “Failure to Provide,” a March 2010 report on the VA.

Hamowy prefers the government stop providing medical care directly to veterans and instead contract for that care to be provided in civilian medical facilities under a Medicare-type program.

Though Medicare itself has been abused by clinicians, “there’s less opportunity for waste and corruption,” Hamowy said.

But Brown said the dental clinic scandal reflects long-standing issues specific to the Dayton VA that merit a hospital-wide organizational review, not systemic issues across VA nationwide.

“It’s a very good health care delivery system,” Brown said of the VA. “It’s a cultural issue in that VA (in Dayton). It doesn’t extend beyond that VA, but it’s been endemic there for some time.”

Underperformers at understaffed clinic

Dental clinic workers told investigators the clinic was woefully understaffed. The director of the facility’s residency program said the ratio of dental assistants to dentists was too low to support four resident slots and put patients at risk.

“We were critically short dental assistants, not only to run a residency, but to run a dental service,” he told investigators.

One assistant was hired in response to his concerns, but the staffing levels remained unacceptably low, the director said.

The shortage of dental assistants also may have had implications for infection control. Prior to 1992, investigators said Pemberton regularly had at his side a dental assistant, who would prod him to follow hygiene protocols. But in 1992, Pemberton began working alone, and the VA report concluded “it was when he worked alone that (he) presented a clear danger to patients since he would often fail to adhere to established infection control protocols.”

Supervisors for years had been told about Pemberton’s failure to change gloves and sterilize dental instruments, but he was not disciplined and continued to receive raises up until dental clinic workers alerted an outside team of VA inspectors to the infection control issues in July.

“I’ve seen him literally walk from his room with this patient’s denture in one hand, go across to another room, open this patient’s mouth with this denture of the opposite patient in his hand,” one dental assistant testified. “I’ve seen him use the same instruments, the same handpiece, the same burs all day long on every patient. I’ve seen him go out of the clinic and push the button on the elevators with dirty gloves on. I’ve seen him open lab doors with dirty gloves on; I’ve seen him go in the lunchroom and use the microwave with dirty gloves on.”

Over the years, Pemberton had been counseled about infection control practices. At times, he showed improvement, but eventually lapsed back into old habits, witnesses said.

A former dental clinic supervisor blamed intervention by the NAACP for foiling his efforts in the early 1990s to remove Pemberton, who is black.

A subsequent dental service chief often changed Pemberton’s instruments so Pemberton wouldn’t continue to use dirty instruments on patient after patient, according to the report.

One dental clinic worker said she saw supervisors clean Pemberton’s room at times “because they (knew) what (was) going on, and to cover their — I mean since things have been brought up to them — to cover their own butt.”

Pemberton, 81, of Centerville “repudiated” the claims against him, according to the report. He retired Feb. 11, and thus is no longer subject to possible disciplinary action by the VA. He declined comment for this article.

The Dayton Daily News confirmed Pemberton’s name independently, but was unable to do so for other dental clinic employees whose names were also edited from the investigative report.

While some claimed the clinic was chronically understaffed, other testimony suggested some workers weren’t pulling their weight.

The dental service chief, for example, admitted under oath that he saw patients only two days a week, despite the dental clinic’s shortage of dentists.

Pemberton, who was paid $165,878 annually before retiring Feb. 11, obsessed over genealogy. He spent “countless hours conducting genealogy research on work computers” when he should have been working on patients, the report claimed. In the report, a VA investigator said patients complained about Pemberton asking questions about their family background and doing genealogy research.

One former dental assistant even told VA investigators she suspected Pemberton scheduled follow-up appointments with patients based on his genealogy interests rather than on medical necessity.

“Sometimes he would want me to get a patient back in even though I didn’t feel like there was enough time to do the patient,” the dental assistant told VA investigators.

“And the reason you believe he wanted that was because of the genealogy?”

“It’s possible,” she said.

Another coworker testified Pemberton spent a great deal of his clinical time doing genealogical research and was not productive.

“Was that (lack of productivity) a good thing?” an investigator asked.

“Yes,” the coworker replied. “Very good thing.”

VA hospitals subject to enough oversight?

VA hospitals like Dayton's are subject to both independent and internal oversight.

The Veterans Health Administration monitors the hospitals to identify patient care or systems-related issues. For example, Dayton VA dental clinic employees alerted a VA official to Pemberton's infection control issues during a System-wide Ongoing Assessment and Review Strategy (SOARS) review at the hospital in late July.

The VA's facilities also are independently monitored by The Joint Commission, an independent nonprofit that accredits and certifies more than 18,000 U.S. health care organizations and programs.

In November, a Joint Commission team conducted an unannounced, triennial review of the Dayton hospital. During that review, one surveyor reviewed infection control practices and other aspects of the dental clinic. No adverse findings were reported, the VA said.

The Dayton Daily News on March 16 requested recent Joint Commission inspection reports at the Dayton VA from the VA and the Joint Commission. The Joint Commission declined, and the VA has not yet responded.

The Dayton clinic is not the VA's only troubled dental clinic. At a VA medical center in St. Louis, improper cleaning and sterilization of reusable dental equipment posed an infection risk to patients between February 2009 and March 2010. The VA notified 1,812 patients, four of whom tested positive for hepatitis C or hepatitis B, a VA spokesman said.

In a prepared statement, the VA said its medical centers have been "increasingly vigilant" in monitoring and investigating any infection control issues. When VA's central office learns of actual or potential adverse events, a clinical review board is formed to see if evidence indicates any patient risk and if disclosure of those adverse events to patients and their families "is in the best interest of their health and well-being," the statement reads.

After Dayton's dental clinic scandal became public, VA added a dental component to its SOARS review.

"If I go down, everybody's going down"

The VA report faulted the clinic's dental service chief not only for failing to take action against Pemberton, but for his "wholly insufficient" professional practice evaluations of staff members. Staff members told investigators the dental service chief stuck his head in the door of operatories where dentists were working on patients, but couldn't actually see how dentists were doing their work. Only the top of the patient's head was visible from the doorway.

The dental service chief had been hired at the clinic as a dentist to be groomed for the chief role. But one unidentified witness told investigators that he/she wouldn't have endorsed the dental service chief for the job, though he/she wasn't asked.

"He was always — for want of a better term — lurking, standing around doorways, and at corners and whatnot, attempting to overhear conversations," the witness said. "And he didn't do much dentistry; he didn't have very good rapport with the dental residents. Didn't have very good rapport with anyone, for that matter, in the dental service, except for a couple of the staff dentists. But he was just not, in my mind, a leader that would be able to move the dental service forward in any particular constructive way."

Following revelations of Pemberton's poor infection control practices, the dental clinic closed Aug. 19 for staff training and a thorough cleaning.

At the same time, a VA administrative investigation board began calling witnesses to provide sworn testimony about the dental clinic's problems. Two people testified that they felt intimidated by the dental service chief.

"I heard they made you come in at 6:45 in the morning," the dental chief told one witness while she was lunching outside the VA hospital one day with another witness.

"No, they didn't make us," she replied. "We volunteered."

"Well, I'm still the dental chief and I will be back," the other witness recalled the dental chief saying. "And if I go down, everybody's going down."

Turner said he'll continue to push for a congressional investigation in the wake of the scandal.

"As a member of the House armed services committee, I have never dealt with a federal agency that has been so secretive as the VA," Turner said. "I think they know that there's more to the story than they're telling us, and that there's a lot wrong here."

But Jack Hetrick, director of the VA network that includes Ohio's VA medical centers, said he believes the VA is serious about becoming perceived as a high-quality and responsible institution in the public eye, and that officials are taking steps to "make certain our beliefs are reaffirmed by actual practice."

"I feel confident in reassuring your readers that everything that's going on at the Dayton VA Medical Center right now is being done with veterans in mind," Hetrick said.

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