

Charles Sherwood, M.D., oral statement  
Subcommittee on Oversight and Investigations  
House Veterans Affairs Committee  
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Thank you, Mr. Chairman and members for this opportunity to testify today. My name is Charles Sherwood. I am a recently retired ophthalmologist with all of my 31 years of service at the Jackson VAMC. The VA has a long and sordid history of intimidation and retaliation against employees who dare to object to poor patient care. Congressional hearings on this subject going back more than twenty years are cited in my written testimony. I am dismayed to report to you today that the leadership culture of the VA is unchanged with the exception of the improved sophistication with which it intimidates its employees.

There was a federal trial. I was a witness at that trial. The evidence presented there is the basis for my Office of Special Counsel complaint and my complaint to the Mississippi State Board of Medical Licensure, to expose the fact that this erosion of ethical boundaries is a systemic problem for the VA. The federal civil suit by three female radiologists was brought for three issues: discrimination based on race, gender and national origin; a hostile, intimidating work environment; and retaliation against the three physicians. The jury unanimously found for the three female plaintiffs. Key revelations from trial include the following:

1. The entire VA chain of command, including the then Undersecretary for Health, Michael Kussman, was aware of the 52 injured or dead patients there. These losses were the result of "intentional medical negligence".
2. Only two patients received a disclosure of their adverse event from the VA. The other 50 patients and their families remain unaware of their adverse events in violation of the VA's own policy on disclosure.
3. The "intentional medical negligence", a turn of phrase endorsed by his supervisor and co-defendant as an appropriate description of his professional misconduct, was caused by a single radiologist, Dr. Majid Khan, who admitted he did not read all the images of every diagnostic study. Dr. Khan was financially rewarded and protected by VA management for his unrealistic productivity, which was the result of his deliberate failure to read all images of every imaging study he interpreted.
4. Dr. Michael Kussman, Undersecretary for Health Affairs issued a "gag order" memorandum to silence Dr. Margaret Hatten. She was the radiologist who sent him the list of the 52 patient victims.
5. In addition, Dr. Hatten's direct supervisor admitted at trial that he had lied about a specific case involving Dr. Hatten in order to protect Dr. Khan, and to damage her reputation and credibility among her peers on the medical staff.

6. The VA conducted five so called reviews of Dr. Khan's work and professional conduct. These were either hopelessly statistically invalid, were tainted by either blatant bias, lies, or both, or were simply incomplete. Dr. Kent Kirchner, the Chief of Staff, who organized these reviews and who was editor of a medical journal, and medical researcher himself, knew these reviews by their design would not find Dr. Khan's work substandard.

7. A final Professional Standards Board (PSB) was for the avowed purpose of determining two issues: Should the VA report Dr. Khan's professional conduct to his state licensing board, and should the VA do an extensive and more statistically valid review of the imaging studies that he has interpreted?

This PSB was uncharacteristically composed of service chiefs only, each beholden to the director and chief of staff for their positions. Each member had received the email from Dr. Hatten's supervisor that lied about her to shield Dr. Khan. The only radiologist on the PSB was forced to recuse herself. The PSB chairman admitted that the PSB understood that a finding against Dr. Khan would expose the VA to a flood of lawsuits.

8. No management official has to date suffered any adverse career impact as a consequence of the trial outcome and the facts of official misconduct.

The trial was concluded in August of 2010. Since then the VA has resisted all attempts by the Mississippi State Board of Medical Licensure to investigate Dr. Khan. Hiding behind privacy laws, the VA has defied complying with a subpoena to produce the medical records of the 50 plus veterans. In addition, the chief of radiology position has been vacant since 2008 but advertised two or three times. Dr. Brigid McIntire and Dr. Hatten, plaintiffs in the trial, have served with distinction as the acting chief for the past five years. Although both have applied each time for the chief's job and are qualified, neither has been offered the position. This is a form of "chronic retaliation".

In response to my OSC complaint, the VA said the 52 misreads could be within the normal standard of error, and left whether to make institutional disclosures to the 50 patients to the discretion of the management of the Jackson VAMC.

I will also testify about a union sponsored and physician led internal survey of all physicians of the medical staff of the JVAMC. The VA's own core values of **TRUST**, **RESPECT**, **EXCELLENCE**, **COMPASSION**, and **COMMITMENT** were used to evaluate physician confidence in the hospital leadership. The results indicated a critical loss of confidence in the hospital leadership. Sadly, the published results garnered scant interest from the VA, veterans service organizations, or the media.

I look forward to answering the questions you may have.