SENATOR RICHARD BURR, RANKING MEMBER

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SENATE COMMITTEE ON VETERANS'AFFAIRS

Oversight Hearing on Hiring Practices and Quality Control in VA Medical Facilities

November 6, 2007

Chairman Akaka, I appreciate you calling this hearing today to look at a very important issue - Hiring Practices and Quality Control in VA Medical Facilities.

We owe our veterans not only the very best medical care but also the highest quality professionals to deliver that care. One way to show our commitment to our veterans is to ensure that the VA's hiring practices conform to the highest of standards. However, recent allegations of substandard care at the Marion VA Medical Center have called into question the VA's current system for credentialing and privileging health care professionals.

Everyone in the veterans community -- including those who care for veterans professionally, concerned family members, and veterans themselves -- was alarmed when they learned of the sharp rise in the number of deaths at Marion. These deaths have raised many questions about whether substandard care and poor hiring practices are to blame.

Mr. Chairman, as you know, the VA Inspector General is in the midst of an investigation into the deaths at the Marion VA Medical Center, which is why he declined to testify at today's hearing. I have spoken with the Inspector General, although not directly about this case, and I am confident that he and his team will be successful in getting to the bottom of this case.

Once the Marion investigation is complete, the IG has indicated that he intends to conduct a national audit of the VA's policies, procedures, and practices on credentialing and privileging. This is critical information we must have before we can truly address any hiring or healthcare delivery problems that may exist within the VA system.

Mr. Chairman, I would like to suggest that rather than jump to conclusions about what did or did not happen in Marion, or what may or may not be wrong with VA credentialing, that we wait for the IG to do his job. Let him investigate these issues and report back his findings. At that time, we will better be able to answer questions such as:

Was the VA credentialing or privileging process itself at fault?
Was the Marion facility negligent in following the established VA process? and
What exactly happened at Marion and who is responsible?

Mr. Chairman, we owe it to the surviving families to get to the bottom of the Marion case. We also owe it to our veterans to find out whether the rise in deaths at Marion is a warning sign of a system-wide credentialing and privileging problem within the VA.

I know we both share a desire to see that these issues are thoroughly investigated. Once the IG's work is complete, I hope you will call a hearing-one where we can call all the appropriate witnesses, look at all the facts, and ask the hard questions. I look forward to that hearing, and I look forward to working with you to address these very important issues, again, in the near future.