Ranking Member Richard Burr

WASHINGTON, D.C. – Good morning, Mr. Chairman. I thank you for honoring my request from early May and calling this important hearing about VA's improper cleaning of its medical equipment. Welcome to our witnesses today.

There is a human element to this issue that must not be forgotten or overlooked. Those affected are all veterans who served their country with honor.

These are people like Michael Priest, a Navy veteran who had a colonoscopy performed at the Murfreesboro VAMC in June 2007.

The VA notified Mr. Priest by telephone that he had tested positive for Hepatitis B and HIV. After he came in for more extensive tests and treatment, they notified him by phone a week later that the first round of tests were inaccurate: he was not infected.

The lack of sensitivity displayed by VA officials in Mr. Priest's case is troubling, to say the least. There was no formal apology issued to him, no phone call from a higher up from the hospital explaining why there was a mix-up, just a single phone call saying, "We got it wrong," as if the detail was trivial and not life-impacting. There was this and clinicians informing his wife, who accompanied him for the second test and was also presumed to be infected, that she was on her own when looking for treatment, that VA would not help her.

Simply put, this is not an acceptable way to treat our veterans or their families. Unlike Mr. Priest, who was ultimately found to be negative for these diseases, 52 of his fellow veterans have tested positive. While it is still unclear if the procedures at VA facilities are responsible for infection, what is clear is that VA's practices opened the door to exposure.

Mr. Priest has abandoned the VA health system and is now seeing a private provider. When veterans have lost confidence in VA, then we have all failed in our mission to care for those who fought for us.

Although the VA has been working to restore confidence in their services, veterans are still hesitant, and who can blame them? The more I learn about this issue, the more it seems to be a case of extreme negligence.

With multiple past incidents, multiple warning signs, multiple patient safety alerts, multiple internal VA directives, widespread media attention, an ongoing Inspector General investigation, and pending hearings on this issue, there is no possible justification as to why this still has not been corrected.

I'm going to run through a brief timeline here.

March 2003: Patient Safety Advisory issued, stating that auxiliary water channels on endoscopes must be cleaned after each use. Despite this warning, this was not followed in at least 18 facilities, including Murfreesboro and Miami.

February 2004: Another alert, this time about using the correct connectors. Despite this warning, incorrect connectors were used in Murfreesboro.

Are you noticing a pattern? Since this February 2004 alert, there have been eleven additional Patient Safety Alerts on the topic of medical device and equipment reprocessing.

I continue.

April 2006: Over 500 Maine veterans are tested due to improper disinfection of biopsy needles. 17 facilities in 11 states are later found to have the same problem.

March 2008: 714 veterans at an Illinois facility put at risk because of improper cleaning of biopsy valves. VA put out a Patient Safety Alert in response.

July 2008: 159 veterans at a North Dakota facility put at risk because of improper cleaning of ENT endoscopes, strikingly similar to the problem we saw at the Augusta medical center.

As you can see, despite 6 years of warnings about improper cleaning of medical devices, we now arrive at the current problem that has all of our attention.

December 2008: In the wake of improper reprocessing at Murfreesboro, another Patient Safety Alert was issued. Again, not new issues, but issues first brought out in 2003 and 2004.

February 2009: VA issues another directive, detailing the proper procedures for the maintenance of the equipment. The IG report shows this was ignored at many facilities.

March 2009: VA conducts a "Step-Up Week," in which, according to a VA press release, VA would focus on "retraining, accountability, and training on standard operating procedures." The IG report shows this was also ignored at many facilities.

Mr. Chairman, it is one thing for the VA to discover problems at its facilities and disclose them. But that's only one side of the equation. The other side is learning from mistakes so they aren't repeated. That didn't happen here.

The IG conducted unannounced visits to a random sample of hospitals on May 13 and 14, and in these visits, less than 50% of the facilities were able to prove they are doing this right. Still. After all that has happened to shed light on the proper way to do this, they are still not doing it right.

In the wake of Murfreesboro, we were told that all facilities were looking at their procedures and fixing any problems they had.

The VHA directive on February 9 was supposed to have codified the procedures. The Step-Up Week in early March was supposed to have engaged senior hospital management in personally assuring that the procedures were being done right. And then came the IG's findings.

Mr. Chairman, the warning signs were there. But the decision not to focus on them and take corrective action is what we cannot tolerate. That is the culture that must change.

I look forward to hearing VA's testimony. I am not satisfied that the larger problem of patient safety is being adequately addressed. I hope to be convinced today. Not for my sake, but the safety of our veterans who depend on this system.

Mr. Chairman, I yield back.

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