Congressional panel to analyze VA hospital mishaps

May 31 2009, By BILL POOVEY , Associated Press Writer

(AP) -- A congressional panel will question Department of Veterans Affairs officials about mistakes that put patients at risk of possible exposure to HIV and other infectious body fluids at three VA hospitals.

The VA recommended more than 10,000 former VA patients in Miami, Murfreesboro, Tenn., and Augusta, Ga., get follow-up blood checks. Five have tested positive for HIV and 43 have tested positive for hepatitis, according to an update on the VA Web site Friday.

The U.S. House Committee on Veterans' Affairs oversight and investigations subcommittee has set a June 16 hearing in Washington to look into what caused the problems and what the VA has done to fix them. The VA's inspector general is currently investigating.

The subcommittee chairman, U.S. Rep. Harry Mitchell D-Arizona, said Thursday in a phone interview that veterans who are testing positive for HIV and hepatitis, "whether it came from these improper procedures or not, the VA has a responsibility to take care of these patients."

A top VA doctor has said no one will ever know if the positive tests were caused by exposure to improperly operated or cleaned endoscopic equipment used in colonoscopies at Murfreesboro and Miami and to treat patients at the VA's ear, nose and throat clinic in Augusta. The VA has not denied the mistakes.

U.S. Rep. Phil Roe, R-Tenn., was among those in Congress who asked

for an immediate investigation.

"As a physician and a veteran, this is disturbing to me on so many levels and immediate action must be taken to ensure that all medical equipment is clean and safe," Roe said in a statement.

The VA's initial December discovery of an equipment mistake at Murfreesboro led to a nationwide safety "step-up" at its 153 medical centers. Since then, the problems have been discussed with staff at all VA hospitals and with representatives of the equipment manufacturer, Olympus American. The VA has said problems discovered at more than a dozen other of its medical facilities, which officials declined to identify, did not require follow-up blood tests for patients.

In Murfreesboro, the equipment - an incorrect valve - may have allowed body fluid residue to transfer from patient to patient. VA officials have said they don't know if that happened just one day or for more than five years since the equipment was installed in 2003.

In Miami, a tube that was supposed to be cleaned after each colonoscopy was instead cleaned at the end of each day, affecting patients between May 2004 and March 2009. And in Augusta, the ENT scopes used for looking into the nose and throat weren't properly cleaned, affecting patients between January 2008 and November 2008.

The follow-up blood tests are continuing. As of May 18, VA records show about 8,000 of the 10,483 possibly affected patients have been notified of their follow-up blood test results.

Democratic U.S. Rep. Bart Gordon, whose Tennessee district includes the VA hospital at Murfreesboro, said in a statement that he hopes the House subcommittee can "get to the bottom of how this unfolded and make certain it doesn't happen again."

One veteran who had a colonoscopy at Murfreesboro in 2007 and has since tested negative for infections said he has VA officials have tried to assure him that he can trust the hospitals' quality of care. He said he plans to return there for future treatment, but wants an explanation.

Gary Simpson, 57, of Spring City, said that despite the follow-up blood tests, his marriage has suffered because he and his wife have worried since the VA first notified him about the mistake in February.

"They've apologized for it," Simpson said. "I'm not after money. They've helped me a lot in the past. But it still continues to be upsetting."