Hearing to air VA mistakes with hospital equipment

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(AP) -- A congressional panel is pressing the Department of Veterans Affairs to disclose on Tuesday whether non-sterile equipment that may have exposed 10,000 veterans to HIV and other infections was isolated to three Southeast hospitals or is part of a wider problem.

"Somebody is going to have to take responsibility," said U.S. Rep. Phil Roe of Tennessee, the ranking Republican on the House Committee on Veterans' Affairs' oversight and investigation subcommittee.

The subcommittee scheduled Tuesday's hearing in Washington to discuss mistakes involving endoscopic equipment used for colonoscopies and other procedures at its hospitals in Miami, Murfreesboro, Tenn., and Augusta, Ga. with top agency officials and to receive a yet-unreleased report by the VA's inspector general.

Roe said he had not yet seen the report but was told in a briefing Friday that the VA's inspector general conducted a random check on 42 VA locations.

VA officials have said problems discovered at more than a dozen other VA facilities did

not warrant follow-up blood tests for patients. Roe, who is a private physician, has questions about whether the problems were isolated to three hospitals or were more widespread.

"I think this was an institutional breakdown," Roe said.

The VA since February has been warning about 10,000 former patients, some who had colonoscopies as long ago as 2003, to get blood tests for HIV and hepatitis.

The VA's chief patient safety officer, Dr. Jim Bagian, has said no one will ever know if the patients with HIV and hepatitis were infected because of 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. Bagian has also said all the mistakes were human error.

As of Friday, the VA reported that six veterans taking the follow-up blood checks tested positive for HIV, 34 tested positive for hepatitis C and 13 tested positive for hepatitis B. All but 724 affected patients have been notified of test results.

VA spokeswoman Katie Roberts did not respond to repeated requests for comment Thursday and Friday.

The initial discovery of an equipment mistake at Murfreesboro led to a nationwide safety "step-up" by the VA at its 153 medical centers. Since then, the VA says the problems have been discussed with staff at all VA hospitals and with representatives of the equipment manufacturer, Olympus American.

Roe said he believes the VA has been open and trying to keep former patients and the public informed since discovering the mistakes in December. "These people did not intentionally do anything wrong," he said.

That is not always the case when private-sector hospitals discover

mistakes, according to Barbara Rudolph, director of The Leapfrog Group, which promotes quality health care.

She said private hospitals also have spread infectious diseases with non-sterile equipment, but requirements on reporting such problems vary by state and there's no national regulation requiring disclosure.

"Some hospitals have become very open and have made a commitment to be transparent about things like that," she said. "There are a number of hospitals who would not have gone as far as the VA has gone."

Michael Sheppard, a Nashville lawyer who represents dozens of veterans among the affected VA patients, wrote in a June 3 letter to the committee that it was "hard to describe the upheaval and injury this has caused innocent veterans."

"Some no longer trust or have confidence in the VA medical facilities and feel betrayed, misled and ill-informed," Sheppard wrote, adding others may avoid colonoscopies for fear of HIV or other infections.

A spokesman for the American Society for Gastrointestinal Endoscopy, Dr. David A. Greenwald, said in a telephone interview from the Montefiore Medical Center in New York that although the VA patients recently tested positive, they could have had the viruses for years - and before the VA treated them - without showing symptoms.

Greenwald said the positive tests for HIV and hepatitis C reported by the VA are far below the frequency of positive tests reported from studies of other groups of veterans. He said the same is likely true of the hepatitis B cases.

"Probably all of the infections that are being reported are infections people already had," Greenwald said.

Megan Longenderfer, a spokeswoman for Olympus America, said from the equipment maker's vantage point the VA "has been diligent and transparent in its investigation and corrective action."