

St. Louis, MO - Today Congressman Todd Akin (R-MO), ranking member of the House Armed Services Sea Power Committee, released the following opening statement for the Committee on Veteran's Affairs' hearing on patient safety issues in St. Louis, Missouri:

"Mr. Chairman, thank you for coming to St. Louis to hold this hearing on an issue of vital importance to our veterans and to our nation.

"Just over two weeks ago, the VA notified Congress of its findings of a significant failure to clean dental instruments sufficiently at the St. Louis VA Medical Center – John Cochran that may have exposed over 1,800 veterans to hepatitis or HIV. Although the risk to each exposed veteran may be minimal, the fact that VA staff may not have been cleaning their equipment properly is appalling. Cleanliness and sterilization are foundational to modern medicine, and if equipment was not being cleaned properly it would be the result of more than a failure of a few employees. If these allegations are true it would be a leadership failure at the St. Louis facility and a cultural failure of the Veterans Health Administration as a whole. If the finding of the VA is accurate, VA healthcare professionals, and their bureaucratic supervisors failed our veterans and their families significantly.

"Unfortunately, this is not the first issue we have seen at the St. Louis VA Medical Center. As recently as April of this year, the VA Inspector General confirmed allegations of endoscopy reprocessing issues at this facility. Additionally, veterans who are supposed to be "served" by the staff at John Cochran have instead faced an environment where truly serving and caring for veterans seems to be an afterthought at best. Veterans have told me and my staff about maddening bureaucratic roadblocks, doctors ignoring test results, privacy being violated and more. While there may be some great staff at the facility, it seems that the overall climate is closer to a poorly run DMV than a world class health facility.

"To make matters worse, this is not the first case like this across the VA health system. In late 2008, the VA discovered that a number of VA medical facilities were not cleaning endoscopy equipment properly. The VA's response to that incident was supposed to prevent future incidents like this one here in St. Louis. Clearly, the VA has not done enough to ensure that medical equipment is properly cleaned. If the VA as a whole cannot figure out how to ensure clean medical equipment, how are veterans supposed to trust the VA for more complicated things like diagnosing and treating medical issues?

“America owes our veterans a great deal. These heroes put their lives on the line to keep us safe. In return, they are facing a VA medical system that often seems less helpful than the IRS. This is atrocious and must be corrected.

“In conclusion, I have a number of questions for our witnesses today. Some of these questions I already raised in a letter I sent to Secretary Shinseki that I would like to insert for the record. While I will have a number of detailed questions later on, they will largely revolve around four key issues:

1. Given the VA’s recent attempt to increase emphasis on cleaning equipment, why is it that we have this finding of serious lapses in protocol?
2. What is being done to care for veterans who may have been affected?
3. Who has and will be held responsible for such lapses?
4. What needs to be done to address the leadership and cultural failure of VA medical care both here in St. Louis and nationwide?

“Thank you, Mr. Chairman. I yield back.”

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