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Negligence Suits Likely Over VA Procedures

Written On August 24, 2009 By Bob Kraft

As reported today in the Washington Post, the Department of Veterans Affairs is facing the possibility of a series of negligence lawsuits over contaminated medical equipment used in colonoscopy and endoscopy procedures. Here are excerpts:

Army veteran Juan Rivera reported to the veterans hospital in Miami for a routine colonoscopy in May 2008. Almost a year later, the 55-year-old father of two learned that the Department of Veterans Affairs had not properly sterilized the equipment used for the procedure.

A test then revealed that he had been infected with HIV. “The VA has issued me a death sentence,” Rivera said, according to his attorney.

A problem with sterilization practices at a VA facility in Tennessee was discovered in December, and the department has notified more than 11,000 veterans who had endoscopic procedures at three of its facilities that they may have been exposed to cross-contamination. VA has advised them to return for testing.

As of Aug. 3, eight of those patients have tested positive for HIV, 12 for hepatitis B and 37 for hepatitis C, according to VA.

Rivera, who served in the Army for 13 years and drives a truck for the U.S. Postal Service, filed notice last month of his intent to sue VA. The administrative claim, filed with VA under the Federal Torts Claim Act,

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says his infection was caused by the department's failure to clean its equipment and to follow proper procedure.

VA, while promising full care for those infected, has said that no link has been established between the patients' conditions and the endoscopy procedures.

The department referred a request for comment to its Web site, http://www.va.gov, where it provides updates on patient testing. "VA will continue to notify, inform, and treat all potentially impacted veterans, regardless of risk, cause, or harm," says a posted statement.

The sterilization problem came to light when officials at the VA Medical Center in Murfreesboro, Tenn., learned that workers were sanitizing endoscopy equipment at the end of the day instead of after each procedure. The manufacturer of the equipment recommends a cleaning after each use.

All VA facilities were subsequently instructed to review their procedures and identify problems.

Based on the review, VA announced that patients who underwent endoscopic procedures in Murfreesboro from April 2003 to December 2008; in Augusta, Ga., from January 2008 to November 2008; and in Miami from May 2004 to March of this year may have been exposed to cross-contamination.

But the problems could extend beyond those locations. In April, the VA inspector general sent investigators on unannounced inspections at 42 of the department's medical facilities. Its report, released in June, concluded that only 43 percent were in compliance.

"Facilities have not complied with management directives to ensure compliance with reprocessing of endoscopes, resulting in a risk of infectious disease to veterans," the report said. "The failure of medical facilities to comply on such a large scale with repeated alerts and directives suggests fundamental defects in organizational structure."

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