Chairman Daniel K. Akaka

Good morning. I welcome Committee Members and witnesses to this important hearing on VA quality management. This weekend, the press reported that the VA medical center in Philadelphia failed to oversee the care being provided to prostate cancer patients. Last year, we learned of patients who died following surgical procedures at the Marion VA medical center in Illinois. And certain facilities have failed to clean endoscopes properly over a period of years, putting veterans at risk for infectious diseases, including H.I.V.

Each of these instances are breaches of our promise to provide the highest quality of care to our veterans. How is it that some have declared VA as the best care anywhere, yet we continue to learn about shocking missteps in care that endanger patients?

We know that mistakes happen. We know that medicine is not an exact science. And that is why hospitals have quality management programs. Through these programs, physicians are required to review the work of their peers and hospitals are required to track patient outcomes.

Oversight is a challenge in a system consisting of more than 150 hospitals. Many decisions are made locally. But it is clear in the wake of these and other complaints that VA has become too decentralized. Oversight has been ceded to individual VA hospitals, with little to no direct oversight by VA's central office.

This Committee's Members have long shared a strong commitment to providing high quality health care for our nation's veterans. I will be working with the new Administration to ensure that VA has the tools and structure it needs to fulfill its commitment to veterans.

The Department must learn from its mistakes, and see how it can avoid similar problems in the future. We must ensure that those in leadership roles in the Veterans Health Administration know what is happening at the local level and are confident that when corrective action is called for, it will be taken.

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