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News Release

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This morning, Dr. Robert Petzel, Under Secretary of Health at the Department of Veterans Affairs, made the following statement after testifying at a House Committee on Veterans Affairs hearing in Pittsburgh, Pa.

First and foremost, I offer my sincerest condolences to the families here today. As I said earlier, the testimonies given by the first panel are powerful. I am deeply saddened by the stories I have heard. My written testimony discussed in detail what we know, and have done about the events in Atlanta, Buffalo, Dallas, Jackson, and Pittsburgh.

When patient safety incidents occur at VHA, we are committed to identifying, mitigating and preventing additional patient safety risks within the VA health care system. We conduct a prompt review to understand what happened, hold those responsible accountable and prevent similar accidents in the future. If employee misconduct or failure to meet performance standards is found to have been a factor, VA will take appropriate action immediately. We work hard to incorporate lessons learned so that future incidents can be avoided or mitigated throughout the entire health care network, and VA is in industry leader in changing practices and standards that both private and public sector hospitals employ.

VA is committed to consistently providing the high quality care our Veterans have earned and deserve. VA operates the largest integrated health care delivery system in the country, with over 1,700 sites of care. Each year, over 200,000 Veterans Health Administration leaders and health care employees provide exceptional care to approximately 6.3 million Veterans and other beneficiaries.

The VA health care system is consistently recognized by The Joint Commission and numerous other external reviews as a top performer on key health care quality measures. We operate with unmatched transparency in public and private sector healthcare, fostering a culture that reports and evaluates errors in order to avoid repeating them in the future.

I'd like to reiterate a few points I made in my testimony. In Jackson, the facility and VISN are responding to all of the findings set forth in VA's reports to the Office of Special Counsel. We have new management at the facility, and they are making significant improvements. In Buffalo, our own staff discovered an inappropriate use of insulin pens. The practice was stopped immediately and was investigated in a systematic way. Those findings triggered a national change in how our system manages the use of insulin pens, ultimately positively impacting our over 1,700 sites of care. In Atlanta, we have responded to all of the recommendations made by VA's inspector general, and are extensively monitoring the contracts, the contractors, and our mental health services. The new Director has taken this challenge head on and is committed to restoring trust with the Veterans of Atlanta. For Dallas, we have not yet received the task force report that we commissioned as a result of Congresswoman Johnson's concerns, and therefore, I will reserve comment until the report is reviewed. Lessons learned from Pittsburgh are now being used to ensure water safety at all VA medical centers throughout the nation, and we continue to work with federal, state and local partners to keep all informed of the situation.

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