

U.S. Rep. Harry Mitchell gave the following statement at today's Department of Veterans' Affairs Subcommittee on Oversight and Investigations hearing entitled "Enforcement of VA's Brachytherapy Program Safety Standards." Mitchell serves as Chairman of the Oversight and Investigations Subcommittee.

I would like to thank everyone for attending today's Oversight and Investigations Subcommittee hearing entitled, *Enforcement of U.S. Department of Veterans Affairs Brachytherapy Safety Standards*. Thank you especially to our witnesses for testifying today.

All the Members of this Subcommittee take particular interest in this issue as well as the care of our nation's veterans; however, I would like to especially thank Congressman John Adler of New Jersey for being such a passionate advocate of this issue.

Reports of botched prostate cancer procedures, a lack of quality and standard controls in the VA healthcare system and egregious errors in the brachytherapy treatment at the Philadelphia VA Medical Center are unacceptable and wrong.

Brachytherapy is a form of radiotherapy, often used to treat prostate cancer, in which radioactive seeds are placed inside or next to a patient's malignancy. Failure to accurately place the radioactive seeds can cause serious harm.

To say that it is disturbing to learn that veterans received bungled procedures and that safety protocols failed to safeguard against such mistreatment would be an understatement.

As a result, we are here today to examine the system-wide safety standards for these procedures to ensure that our veterans are receiving the best and safest care available.

In 2003 and 2005, the Nuclear Regulatory Commission (NRC) received reports of botched placement of radioactive seeds and inconsistent dosage at the Philadelphia VA Medical Center. After careful review, it was determined that no NRC protocols were violated.

In May of last year, the NRC received a notification of potential under dosing at the Philadelphia VA Medical Center. This led to a VA National Health Physics Program Inspection (NHPP), evaluating all 116 brachytherapy treatments that took place since the creation of the program in 2002.

The New York Times reported last month that investigators for the Nuclear Regulatory Commission and VA officials found that 92 of the 116 men treated at the VA Medical Center in Philadelphia's brachytherapy program received incorrect doses of the radiation seeds, often because they landed in nearby organs or surrounding tissue, rather than the prostate. Dr. Gary Kao, who is here today at this hearing, performed the majority of the procedures under a VA contract with the University of Pennsylvania, where he was on staff. Out of the four suspended brachytherapy programs, we know that Philadelphia was by the far the worst.

On top of this, in March of this year, the NRC issued a detailed inspection report citing the Philadelphia VA Medical Center with six violations of NRC regulations.

This is downright unacceptable. While we are disturbed that, perhaps, there was a lack of proper local quality controls and management of these brachytherapy programs, our main concern is that the problems marring the program in Philadelphia could be happening at the other nine facilities still doing these procedures. As such, we have asked the VA Office of Inspector General to review and assess the VA's brachytherapy programs and, although the complete NRC inspection report on the Philadelphia program, along with the other VA facilities using brachytherapy treatments, as well as the NHPP performance is not complete, we look forward to reading that report when it becomes available.

Though it is commendable that VA's leadership took swift action once these issues were reported, it is still troubling that it took almost six years for these events to actually be reported. Even more troubling is just last month we were here discussing quality control and lack of proper procedures and oversight of endoscopy procedures being conducted by the VA, yet we are here again, questioning the quality of care our veterans receive.

The VA health care system relies upon a complementary system of accountability to identify quality control problems throughout the entire system and at individual levels. Failure to ensure consistent oversight and safe treatment is unacceptable and wrong. I am anxious to hear VA assurances not only to this Subcommittee, but to all the veterans they serve, that the issues identified, once a thorough review has been conducted, is not occurring at any of the remaining brachytherapy programs across the country, and that the four suspended program may be continue to deliver this important treatment to our veterans. Lastly, I am equally interested in hearing from one of our witnesses, Dr. Kao, regarding allegations of erratic seed placements, as well as experts we have invited to provide their thoughts on the safety and effectiveness of the treatment.

Thank you again to all of our witnesses for testifying today and we look forward to your testimony.