

By Bill Theobald

[USA Today](#)

WASHINGTON - House lawmakers blasted Veterans Affairs officials on Tuesday after hearing testimony that the agency still wasn't following procedures for handling endoscopes, months after discovering that the improperly cleaned instruments may have exposed veterans to hepatitis and HIV.

"I'm outraged that any of our nation's heroes were potentially infected or that they even have to worry about the possibility," said Rep. Harry Mitchell, D-Ariz., who is chairman of the House's Veterans' Affairs subcommittee on oversight and investigations.

VIDEO: [Lawmakers grill VA officials over botched colonoscopies](#)

Endoscopes are used for checking areas such as the colon, nose and throat.

Investigators with the inspector general's office at the VA testified Tuesday that fewer than half of the VA facilities using endoscopes had posted proper cleaning guidelines for the equipment as well as documents showing that the staff is trained in such procedures.

That finding was based on surprise inspections of 42 VA facilities in May.

The investigation came after the VA discovered in December 2008 and January of this year that endoscopes at VA facilities in Murfreesboro, Tenn.; Miami; and Augusta, Ga., were not maintained properly, possibly exposing veterans to the fluids of other patients.

More than 10,000 veterans were notified. Forty-seven were found to be infected with hepatitis, and six were found to be carrying HIV, although it's impossible to prove the mishandled devices caused the infections.

Howard McIntyre, commander at one of two Disabled American Veterans chapters in Augusta, Ga., called the findings "disturbing."

"As soon as it was caught, the training should have been stepped up instantly," the 67-year-old

Testimony: VA medical gear still being mishandled

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Navy veteran said. Medical care for veterans, he said, "shouldn't be any less than perfect, because these are lives we're talking about."

Rep. Bart Gordon, D-Tenn., and others testified that they hope the VA will pay the entire cost of treatment for the infected veterans.

William Duncan of the Veterans Health Administration testified that all VA facilities are being ordered to follow procedures for maintaining medical devices. VA health officials plan to conduct unannounced inspections of every facility by July 31.

The VA has acknowledged that the mistakes were caused by human error.

In Murfreesboro, VA officials said, use of an incorrect valve may have allowed body fluid residue to transfer from patient to patient.

In Miami, a tube that was supposed to be cleaned after each colonoscopy was instead cleaned at the end of each day, affecting patients between May 2004 and March 2009. And in Augusta, scopes used for looking into the nose and throat weren't properly cleaned, affecting patients between January 2008 and November 2008.

Mitchell and ranking subcommittee Republican Rep. Phil Roe of Tennessee said they plan to ask the VA's inspector general to conduct surprise inspections again within 90 days.