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FOR IMMEDIATE RELEASE

American Legion outraged by latest VA negligence in St. Louis

WASHINGTON (July 1, 2010) -- The American Legion expressed outrage today over revelations that a VA medical center may have exposed veterans to serious infections through improperly cleaned dental equipment. Because cleaning protocols were not followed by workers at the John Cochran VA Medical Center in St. Louis, more than 1,800 veterans may have been exposed to HIV and hepatitis viruses. Those veterans recently received letters from the VA center, warning them of possible exposure to the diseases and offering screening and support.

"This is an extremely serious problem that has happened before and will happen again unless VA ensures strict adherence to proper sanitation and sterilization protocol," American Legion National Commander Clarence Hill said. "We're talking about people who have risked their lives, who have lost arms and legs and who are suffering mentally and emotionally because they served their country honorably. They should have no misgivings about getting treatment at VA facilities, and they wouldn't if VA ensured that its staff were following the medical protocols already in place. It's management's responsibility to make sure the protocols are followed. This is a failing on the part of management that should not be excused."

Last year, veterans were notified by VA that they may have been exposed to infectious diseases via improperly cleaned endoscopic equipment at several of its medical facilities. On Sept. 18, 2009, a report from VA's Office of Inspector General indicated the problem had been eliminated.

Mark Seavey, director of new media for The American Legion, has been monitoring blogsite entries made by veterans who are angered over VA's latest failure to keep its medical instruments clean.

"Veterans are rightly angered by what they see as another failure by VA to safeguard their health," Seavey said. "Many of the veterans online are openly questioning whether it is worth the hassles and potential problems to continue using VA as their main provider of health services."

Just last month at a congressional hearing, The American Legion raised concerns about VA training standards and its high turnover in personnel. Barry Searle, The American Legion's director of Veterans Affairs and Rehabilitation, testified at a June 2 hearing before a House subcommittee on health. "VA needs to do a better job in training its people more quickly and effectively – making sure they understand the correct protocols that have already been established, such as the proper cleaning of dental equipment," Searle testified.

Each year, American Legion staff members visit VA medical centers nationwide, evaluating the quality of health care being provided for veterans and their families. They report their findings to VA and Congress.

"After all the assurances made by VA Secretary Shinseki and others to The American Legion – after past incidents like this one – we are very disappointed to see this happen once again" said Peter Gaytan, executive director of The American Legion's Washington office.

Gaytan said that VA should be commended for the care it has taken to create thorough protocols for the cleaning of medical equipment. "The failure was by the staff in not following those protocols. VA facility administrators must do a better job of enforcing proper actions by staff who are responsible for cleaning equipment. The lives of our veterans depend on their performance."

According to a fact sheet released yesterday by VA, the "failure to clean dental handpieces according to manufacturer instructions and VA standard operating procedures" was discovered at the St. Louis facility in March by inspectors from the National Infectious Diseases Program Office.

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