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VA infection issues lead to 13,000 veterans' tests

Improper hygiene may have exposed patients to HIV, hepatitis or other blood-borne disease

By **DAN SEWELL**

Associated Press

updated 5/29/2011 1:26:02 PM ET

DAYTON, Ohio— Herman Williams came home safely after fighting in the jungles of Vietnam as a Marine. He was shocked to learn four decades later that his military service had again placed him in jeopardy — this time, because he got a tooth pulled.

Williams is among 13,000 U.S. veterans who have been warned in the last two years that their blood should be tested for potentially fatal infections after possible exposures by improper hygiene practices at five VA hospitals in Ohio, Florida, Georgia, Missouri and Tennessee. This Memorial Day finds the Department of Veterans Affairs under political fire and numerous veterans upset after enduring fear and uncertainty over their health.

"I was scared to death," Williams said.

One afternoon this winter, Williams received a letter warning that he could have been infected during tooth extraction and other procedures in the dental clinic at the Dayton VA Medical Center. A VA investigation found that a dentist who practiced there for decades repeatedly violated safety measures such as failing to

sterilize equipment or change soiled latex gloves, potentially exposing patients to **HIV**, hepatitis, or other blood-borne diseases.

For two anxious weeks, the 60-year-old Springfield, Ohio, man wondered and worried about himself and his family's health.

"HIV ... that's something to be afraid of. AIDS is no joke. If you're positive, then your wife, everybody around you, needs to be tested.

"I didn't know what was going to happen."

As with the vast majority of veterans tested, Williams' results were negative.

Eight patients with HIV, 61 with hepatitis
 So far, VA officials say, tests on nearly 12,000 patients have found eight HIV-positive results and 61 confirmed cases of hepatitis B or C, including three hepatitis cases at Dayton. It's not known how many of the positives resulted from treatment at VA hospitals or from unrelated causes — officials say testing may not be able to determine the origin of the infections.

Infections related to medical treatment are a problem at public and private hospitals nationwide. The VA, as a government entity, must report infections publicly but most public and private hospitals do not.

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The Veterans Affairs system that serves about 6 million vets a year in more than 1,000 medical facilities has been praised by medical authorities for its successful efforts to reduce antibiotic-resistant staph infections from treatment, a common problem in U.S. hospitals. A study published last month in The New England Journal of Medicine reported VA hospitals reduced such infections by 60 percent in intensive care units around the country after three years of emphasizing hygiene education and sanitizer availability in its facilities.

Diane Pinakiewicz, president of the advocacy group National Patient Safety Foundation, agreed that VA health care has done exceptionally well on the problem of health care-associated infections, which the U.S. Centers for Disease Control and Prevention estimates afflict 1.7 million patients nationally, killing 99,000 people and costing up to \$34 billion a year. Many hospitals have balked at pushes for greater transparency about infections, citing issues ranging from inconsistent reporting standards to patient privacy.

"It's not a small problem," she said. "It's something patients should be aware of and very concerned about."

VA officials say their overall record of providing care for veterans is strong, and that critics shouldn't generalize about VA care from the series of hospital infection cases in the last two years. The Disabled American Veterans, which represents some 1.2 million veterans, rallied to the VA's defense as criticism grew.

"VA health care is clearly the best anywhere and has been so deemed by numerous private entities," Wallace Tyson, the group's national

commander, said in a statement late last year.

But subjecting those who had put their lives on the line for their country years ago to such a alarming potential harm infuriates VA critics.

Worried veterans insist on tests

There are stories like those of Tom Sharp, 63, a Vietnam veteran from Springfield.

He wasn't notified for testing — the Dayton VA has contacted only the 535 patients who received invasive procedures such as extractions and root canals from the dentist from 1992 through last July 28. But Sharp has gotten his health and dental treatment at the center for nearly four decades, so he was worried after seeing TV reports of the dental clinic problems.

"I insisted," he said. He came to the hospital and gave five vials of blood for testing. Lab analysis found no infections.

"It tore me up. I was really nervous," Sharp said. "I go all my life, and then this."

"This is abhorrent, that any patient who entered a VA hospital would be placed at such risk," said Rep. Mike Turner, R-Dayton. "Our veterans deserve the quality of care they were promised."

In February, surgeries were halted temporarily at the Cochran VA Medical Center in St. Louis after potentially contaminated surgical equipment was discovered. Last year, improper equipment sterilization at the same center's dental clinics caused the VA to offer testing to 1,800 veterans who may have been exposed to blood-borne infections.

"In my years in public service, this is one of the issues that has made me madder than

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anything I've ever seen," Rep. Russ Carnahan, D-Mo., said after the latest problems.

In 2009, about 10,000 veterans treated at hospitals in Augusta, Ga., Miami and Murfreesboro, Tenn., were informed they could have been exposed to infection during colonoscopies or endoscopic procedures because of improperly cleaned equipment. Surprise inspections at 128 VA facilities afterward found all were following proper procedures, the VA said.

At the Dayton center, whose first patients were Union Army veterans of the Civil War, an employee complaint last July brought VA investigators, who learned that dental instruments weren't properly cleaned between patients and that sterilization of instruments was skipped entirely. One dentist, the employees reported, sometimes left his gloves on between patients, answering his cell phone or **drinking** coffee — routine behavior by him since at least 1992. Employees told investigators a supervisor had been notified but didn't respond. The investigation began in late July and the clinic was closed for nearly a month in August.

"We were horrified and surprised," Dr. John Daigh, an assistant VA inspector general, said in a congressional hearing.

The dentist has denied the allegations, blaming co-workers he said were out to get his boss. The VA won't confirm the dentist's identity, but Dr. Dwight Pemberton, 81, told the Dayton Daily News in an interview this month that he had put no patients at risk and had been falsely blamed. With administrative action against him pending, Pemberton retired this year after more than 30 years with the agency. The hospital's director was reassigned, and the newspaper reported Pemberton's

supervisor was fired.

Has VA been slow to make changes?

Some in Congress say VA officials have been slow to make needed changes at the hospitals to prevent recurrences, and generally were reluctant to share information or cooperate with their fact-finding efforts.

"You neglect the basic issues of communication and accountability," Rep. Bob Filner, D-Calif., told VA officials in a recent Washington hearing.

Sen. Sherrod Brown, D-Ohio, has questioned what he saw as a lack of urgency in responding to the Dayton issues, with six months passing before veterans were notified for testing. Turner and a local independent task force have urged broader testing of the clinic's patients and for reforms in the center's training and openness. The investigations have suggested that a culture of secrecy and fear of retribution contributed to the problems.

Daigh said he considered the Dayton VA dental clinic "an outlier," and not typical of VA operations.

William Montague, a longtime VA hospital executive called out of retirement in March to lead the Dayton hospital, said officials have stepped up efforts to encourage problem reporting, from anonymous employee surveys to confidential face-to-face meetings with him. The clinic adopted a "dental dashboard" system of checks on equipment and procedures and frequent drop-in inspections of the clinic rooms. Montague said this month that two hospital employees have been disciplined recently for not following hygiene procedures, although he declined to give details.



Montague, who last headed the Cleveland VA hospital, has gone out to talk at American Legions, VFW halls and anywhere else he can find veterans to tell that problems in Dayton have been cleaned up.

"We had a situation that was dealt with effectively, but slowly. And because we were slow, we appeared resistant or secretive. For that, I apologize. We should have been quicker. We should have been more transparent," he told The Associated Press.

"I can assure people that dental is completely safe, as is the rest of the hospital," he said. "The Dayton VA is a first-class organization."

Jerry Adams, a Vietnam vet who comes to the Dayton VA for [diabetestreatment](#), said he's generally pleased with the care he receives there, but he's still disquieted by the dental clinic problems.

The Sidney, Ohio, man, age 64, said he will continue relying on his wife's insurance for his dental care elsewhere.

"I had been considering trying a dentist here, but not now," he said. "Not after this."

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