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January 14, 2013

Hon. Eric Shinseki
Secretary
Department of Veterans Affairs
810 Vermont Ave. NW
Washington D.C. 20420

Dear Secretary Shinseki,

The news that over 700 individuals treated at the Buffalo VA Medical Center may have been exposed to the Hepatitis A virus, Hepatitis B virus or the Human Immunodeficiency Virus (HIV) due to an extended period of medical errors is both disgraceful and appalling.

Beyond the fact that the error occurred at all, most concerning was the length of time it took the Buffalo VA to catch the error – over 2 years, as well as the three month delay in informing patients who may have been exposed. Please explain why it took two years to discover this error and what new checks and balances are being implemented to prevent future medical errors hospital-wide. Also detail why affected patients weren't notified immediately.

The Veterans Administration acknowledged the situation in which medical equipment intended for individual use was being utilized on multiple patients at the Buffalo VA, representing a serious cross contamination danger. Why weren't medical guidelines followed for administration of the drug? Was this standard practice hospital-wide among all administering this drug or was it isolated to specific health care providers? What steps are being implemented to coordinate better direction between patient health care professionals and pharmacists to see that adequate dispensing of medication is taking place?

In initial responses to our office from your office, the Veterans Administration illustrated the VA National Center for Patient Safety (NCPS) was notified and a request was made to review information pertaining to the proper use of the insulin pens and to prepare a national patient safety alert on this topic for all VA facilities. Is this situation isolated to the VA Medical Center in Buffalo or is it reflective of a systemic problem in patient labeling that has endangered veterans throughout the VA healthcare system?

We understand that at this point no disciplinary action has been taken against any individuals or groups in connection with this incident. The potential exposure of our veterans and their families to harmful pathogens without their knowledge demands action and greater accountability from the Veterans Administration.

I cannot even begin to express my utter disappointment with this entire situation including the prolonged lax administration and mishandling of medicine and the deferred notification of patients. Facilities that care for the men and women who served this nation should be held to a much higher standard. Please provide an immediate and detailed response on the steps being taken to see that our veterans are never subject to these failures again.

Sincerely,

A handwritten signature in blue ink that reads "Brian Higgins". The signature is stylized and includes a horizontal line extending to the right.

BRIAN HIGGINS
Member of Congress