COMMITTEE ON SCIENCE, SPACE, AND TECHNOLOGY
CHAIRMAN LAMAR SMITH

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Statement of Oversight Subcommittee Chairman Paul Broun (R-Ga.)
Hearing on Technology for Patient Safety at Veterans Hospitals

Chairman Broun: Thank you, Chairman Bucshon, and thank you to all of our witnesses for being here today. I am looking forward to hearing from you all on this very important matter.

As both a medical doctor and a U.S. Marine, it is deeply troubling to hear reports of poor care given to veterans in my home state of Georgia as well as across this country. In January, I returned to Augusta for an oversight visit of the Charlie Norwood VA Medical Center with some of my colleagues. During the trip, I was extremely saddened to see the cavalier attitude expressed by the VA, and the potential implication for hospital-associated-infections—or HAIs--and preventable deaths. A recent Wall Street Journal article on VA hospitals cited specifically that, "at Augusta, the in-hospital death rate was 120% above that of the best facilities." This kind of negligence is intolerable.

The principle function of our federal government under the Constitution is to provide for our national defense and take care of the men and women who have so bravely served our country with dignity and pride. We have made promises, and we must fulfill those promises for those who have sacrificed for us. Our veterans should receive the best care – there is no question about it.

The Centers for Disease Control and Prevention states that "approximately 1.7 million HAIs occur in U.S. hospitals each year, resulting in up to 99,000 deaths and an estimated $20 billion in healthcare costs." Contributing to these numbers is the wide variation in medical care at VA hospitals with substantially more HAIs and preventable deaths at certain VA hospitals. However, since the VA does not publicly disclose comprehensive details on each of their facilities, it is hard for veterans to receive fair warning that they are walking into a potentially life-threatening situation when requesting medical care. What is additionally astounding is that the infection rates at some VA hospitals exceed the rates at private sector hospitals by ten times or more.

On top of that, the Wall Street Journal article I mentioned earlier notes that, "VA senior management suspended a long-standing program that had sent teams of doctors and monitors to its worst-performing hospitals to try to improve them." As the Chairman of the Oversight Subcommittee, I consider this lack of oversight, accountability, and due-diligence to be inexcusable.

The treatment of veterans is not only a moral issue, but a national security issue as well. If the federal government fails to fulfill the promises it has made to our veterans, how are we going to recruit the finest men and women to come into the military and stay to be senior NCOs, senior officers, or flag officers? It won't happen!

I look forward to hearing from our witnesses about technologies that can save veterans from preventable infections and deaths. I also encourage everyone at the VA listening to this hearing today to renew their

commitment to our veterans by doing everything in their power, as soon as possible, to ensure our nation's heroes are given the care that they deserve and have earned.

Thank you again Chairman Bucshon for holding this very important hearing, and I yield back the balance of my time.

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