

United States Senate

WASHINGTON, DC 20510

July 1, 2009

The Honorable Eric K. Shinseki
Secretary of Veterans Affairs
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, D.C. 20420

Dear Secretary Shinseki:

The Senate Veterans Affairs Committee held a hearing in Philadelphia on June 29 concerning allegations that inappropriate brachytherapy treatments were performed at the Philadelphia VA Medical Center by a contracted doctor, Dr. Gary Kao, from the University of Pennsylvania hospital. A number of matters require the attention of your Department.

When Dr. Kao was questioned about performing brachytherapy, which involves the injection of radioactive pellets into the prostate, Dr. Kao admitted that some of the pellets missed their mark and some went into the bladder and rectum. When asked if he advised the patient, he responded in the negative.

Dr. Kao further testified that he used excessive radiation treatments. Again, when asked if he notified the patient, he responded in the negative.

At a minimum, the rules should be explicit on the obligation of the performing doctor to report such mishaps to his supervisors and in turn those mishaps should be reported to the patients so they can be aware of what happened and decide for themselves what additional steps ought to be taken as a result of those mishaps.

Dr. Kao further testified that there was no precise definition of "medical event" which would require notification to hospital authorities. If that is so, there certainly ought to be such a definition which is widely circulated so that doctors like Dr. Kao would know what to report.

The hearing further disclosed that there was no outside oversight by any independent agency as to the efficacy of the procedures employed by Dr. Kao. Obviously, there should be an established procedure for such independent review and analysis.

The mishaps occurred in a timeframe going back to 2002 and were not discovered until May 2008 and even then patients such as Reverend Ricardo Flippin, who was treated for prostate cancer at the VA hospital testified, were not advised as to what had happened to them.

There is an additional question as to what obligations there are on the part of the Hospital of the University of Pennsylvania to oversee activities of their medical personnel on contract with the VA, especially in the context of the errors committed by Dr. Kao.

I thought you would want to know of these preliminary findings at an early date so you could consider what corrective action should be taken as promptly as possible.

I want to express my personal appreciation to Dr. Gerald M. Cross who altered his plans to attend the hearing on short notice.

Again my thanks to you for undertaking the important assignment as Secretary of Veterans Affairs. I look forward to working with you in the future.

My best.

Sincerely,

A handwritten signature in cursive script, appearing to read "Arlen Specter".

Arlen Specter

Cc: Dr. Gerald Cross