

United States Senate

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June 22, 2009

The Honorable Eric Shinseki
Secretary
Department of Veterans Affairs
810 Vermont Ave, NW
Washington, DC 20420

Dear Secretary Shinseki:

I write to request a thorough review of the brachytherapy program at the Philadelphia VA Medical Center. According to a June 21, 2009 *New York Times* article, the prostate cancer unit at the hospital "botched 92 of 116 cancer treatments over a span of more than six years—and then kept quiet about it."

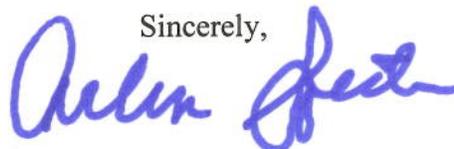
The article alleges that "The 92 implant errors resulted from a systemwide failure in which none of the safeguards that were supposed to protect veterans from poor medical care worked." For example, "From December 2006 to November 2007... 16 patients received seed implants in Philadelphia even though computer interface problems prevented medical personnel from determining whether these treatments had been successful. The VA's radiation officials knew of the problem but took no action, the [Nuclear Regulatory Commission] charges."

The allegations made by the *Times* are very serious and deserve a full and prompt review by the VA. Specifically, what allowed such chronic failures to occur? How have these substandard brachytherapy procedures affected individual veterans? Following the closure of the brachytherapy program at the Philadelphia VA Medical Center last June, where have local veterans gone for brachytherapy treatment? Finally, what steps has the VA taken to improve its internal review process to ensure that such problems do not occur at other VA hospitals?

I will be speaking with Chairman Akaka to discuss holding a field hearing in Philadelphia to examine this issue further.

Thank you for your attention to this important matter.

Sincerely,



Arlen Specter