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# VA chief orders full review of Illinois hospital

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New problems that have emerged at a troubled VA Medical Center in Marion, Ill., have prompted Veterans Affairs Secretary Eric Shinseki to order a "top-to-bottom" review of the facility, Sen. Dick Durbin said Wednesday.

Durbin and other Illinois lawmakers met with Shinseki on Wednesday after a report this week found ongoing problems at the facility, where nine patients died in surgery in six months ending in March 2007.

That mortality level was more than four times the expected rate. Those problems at Marion surfaced in reporting by the Chicago Tribune, triggering a congressional hearing and changes in top personnel.

Durbin blamed the nine deaths on "medical malpractice" and called the newly disclosed problems "appalling" and "inexcusable."

Durbin said Shinseki promised that a high-level management team would visit Marion and that the VA chief would make the review a personal priority. A report will be concluded in about six weeks, Durbin said.

The Marion VA's interim director, Warren Hill, has been replaced, and more personnel changes may be ahead, the senator said.

The new report identified problems in four areas: quality management; physician credentialing and privileging; medication management; and environment of care, which relates to infection-control standards, cleanliness and safety.

The center serves about 127,000 veterans in Illinois, Indiana and Kentucky. It has 55 hospital beds and eight outpatient clinics.

The 30-page report from the VA's office of inspector general identified problems that emerged in an August assessment. They included:

--A patient with a history of methicillin-resistant Staphylococcus aureus (MRSA) was "inappropriately" put in a room sharing a bathroom with two other patients.

--Two physicians performed procedures for which they lacked privileges. There also was insufficient monitoring to confirm the privilege-specific competency of 20 of a group of 23 physicians.

--Failure to screen deaths within 30 days of surgical procedures. It appears that two deaths after surgeries were not forwarded to quality-management staff.

--Inconsistent reporting of deaths. In April, for example, deaths were reported as five, six or seven in various reports. "Staff were unable to describe the methods used to validate mortality data," the report said.

Sen. Roland Burris, who also met with Shinseki and visited the center in April, said there was reluctance by the hospital to have him out. He urged stronger whistle-blower protections for staff.