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VETERANS WILL BE HARMED BY H.R. 1215: THE "PROTECTING ACCESS TO [UN]SAFE CARE ACT OF 2017"

H.R. 1215 limits the legal rights of all patients harmed by health care received through a "federal program, subsidy, or tax benefit." That includes veterans receiving care through the Department of Veterans Affairs (VA), which operates one of the largest and continuously dysfunctional health care systems in the nation.[1]

More specifically, H.R. 1215 would restrict the legal rights of sick and injured veterans who receive negligent care while also weakening the government's accountability for the increasingly dangerous situation of unsafe VA hospitals.

Below are recent examples of negligent or substandard care given veterans in VA hospitals:

- An April 12, 2017, interim report by the U.S. Department of Veterans Affairs' Office of Inspector General (VA OIG) identified 194 instances during the past three years where hospital practices compromised patient safety.[2] The VA OIG also found that the following hazardous situations occurred in March and April 2017 – the "operating room at the hospital ran out of vascular patches to seal blood vessels and ultrasound probes used to map blood flow. The facility had to borrow bone material for knee replacement surgeries. And at one point, the hospital ran out of tubes needed for kidney dialysis, so staff had to go to a private-sector hospital and ask for some."[3] Two weeks later, "the dialysis unit ran out of dialyzer bloodlines and 15 gauge fistula needles, both of which are essential for dialysis treatments."[4]

- A May 30, 2016, *New York Daily News* analysis of Treasury Department data uncovered multiple examples of missed diagnosis, botched procedures and other avoidable errors.[5]

    - Among the cases cited: an "army veteran who died from internal bleeding in Cleveland after complications from a routine gallbladder removal surgery;" a "Gulf War tanker in Atlanta suffering from serious depression who suffocated to death following an electro shock therapy session that went awry"; and "a Vietnam veteran in St. Petersburg, Fla. who died from colon cancer after his doctor ignored red flags on an annual medical test for three years."

    - Veteran advocates say this situation "reflects years of substandard care at the 152 federal hospitals at a time when additional troops who served in Iraq and Afghanistan returned from combat tours."

- A July 2015 GAO report found that medical errors in the VA system had increased by 7 percent from fiscal year 2010 to fiscal year 2014, "a jump that roughly coincided with 14 percent growth in the number of veterans getting medical care through VA's system."[6]

- According to an *Associated Press* review of VA internal documents, inspector general reports and interviews, "Nationwide, nearly one in four VA hospitals does not have a fulltime gynecologist on staff."[7]

- "In the decade after 9/11, the U.S. Department of Veterans Affairs paid compensation to nearly 1,000 families in wrongful death cases," with victims "ranging from decorated Iraq War veterans who shot or hanged themselves after being turned away from mental health treatment, to Vietnam veterans whose cancerous tumors were identified but allowed to grow, to missed diagnoses, botched surgeries and fatal neglect of elderly veterans."[8]

NOTES

[1] *See*, *e.g.*, U.S. Department of Veterans Affairs, *Interim Summary Report - Healthcare Inspection - Patient Safety Concerns at the Washington DC VA Medical Center, Washington, DC,* April 12, 2017, https://www.va.gov/oig/pubs/VAOIG-17-02644-202.pdf; Suzanne Gordon, "Why privatizing the VA health care system is a bad idea," *Boston Globe*, February 17, 2016, https://www.bostonglobe.com/magazine/2016/02/17/why-privatizing-health-care-system-bad-idea/2PyB5Dz36pdahjwVFr3p3M/story.html; "Cleaning up the VA," *60 Minutes*, June 28, 2015, http://www.cbsnews.com/news/secretary-robert-mcdonald-on-cleaning-up-veteran-affairs/; U.S. Department of Veterans Affairs, "Veterans Health Administration," http://www.va.gov/health/; U.S. Department of Veterans Affairs, "About VA," http://www.va.gov/about_va/vahistory.asp

[2] U.S. Department of Veterans Affairs, Office of Inspector General, *Interim Summary Report - Healthcare Inspection - Patient Safety Concerns at the Washington DC VA Medical Center, Washington, DC,* April 12, 2017, https://www.va.gov/oig/pubs/VAOIG-17-02644-202.pdf

[3] Donovan Slack, "Veteran patients in imminent danger at VA hospital in D.C., investigation finds," *USA Today,* April 12, 2017, https://www.usatoday.com/story/news/politics/2017/04/12/veterans-danger-va-hospital-washington-dc-investigation-finds/100376124/, discussing U.S. Department of Veterans Affairs, *Interim Summary Report - Healthcare Inspection - Patient Safety Concerns at the Washington DC VA Medical Center, Washington, DC,* April 12, 2017, https://www.va.gov/oig/pubs/VAOIG-17-02644-202.pdf

[4] U.S. Department of Veterans Affairs, *Interim Summary Report - Healthcare Inspection - Patient Safety Concerns at the Washington DC VA Medical Center, Washington, DC,* April 12, 2017, https://www.va.gov/oig/pubs/VAOIG-17-02644-202.pdf

[5] Creela Bell Howard and Reuven Blau, "Legal settlements at Veterans Affairs more than tripled since 2011, many due to medical malpractices," *New York Daily News*, May 20, 2016, http://www.nydailynews.com/news/national/legal-settlements-veterans-affairs-triple-article-1.2654179

[6] Lisa Rein, "Medical errors are up at VA hospitals, but they're actually doing less to figure out why," *Washington Post*, August 31, 2015, https://www.washingtonpost.com/news/federal-eye/wp/2015/08/31/medical-errors-are-up-at-va-hospitals-but-theyre-actually-doing-less-to-figure-out-why/; U.S. Government Accountability Office, *VA Health Care: Actions Needed to Assess Decrease in Root Cause Analyses of Adverse Events* (July 2015), http://www.gao.gov/assets/680/671748.pdf

[7] Garance Burke, "Veterans Affairs Falls Short On Commitment To Women's Medical Issues," *Associated Press*, June 22, 2014, http://www.huffingtonpost.com/2014/06/22/veterans-affairs-womens-health_n_5519796.html

[8] Aaron Glantz, "VA pays out $200 million for nearly 1,000 veterans' wrongful deaths," *Center for Investigative Reporting*, April 3, 2014, http://cironline.org/reports/va-pays-out-200-million-nearly-1000-veterans%E2%80%99-wrongful-deaths-6236. *See also*, U.S. Senator Tom Coburn, *Friendly Fire: Death, Delay & Dismay at the VA*, June 24, 2014, https://www.hsdl.org/?view&did=755200