

ETHICAL PATIENT CARE FOR VETERANS ACT OF 2016

NOVEMBER 14, 2016.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. MILLER of Florida, from the Committee on Veterans' Affairs, submitted the following

R E P O R T

[To accompany H.R. 5399]

[Including cost estimate of the Congressional Budget Office]

The Committee on Veterans' Affairs, to whom was referred the bill (H.R. 5399) to amend title 38, United States Code, to ensure that physicians of the Department of Veterans Affairs fulfill the ethical duty to report to State licensing authorities impaired, incompetent, and unethical health care activities, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

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PURPOSE AND SUMMARY

H.R. 5399, the “Ethical Patient Care for Veterans Act of 2016,” was introduced by Representative David P. Roe of Tennessee on June 7, 2016. H.R. 5399 would require the Department of Veterans Affairs (VA) to ensure that each VA physician is informed of his/her duty to report directly to the applicable state licensing authority any covered activity committed by another physician that the physician witnesses or otherwise discovers.

BACKGROUND AND NEED FOR LEGISLATION

It is a well-established obligation within the medical community that physicians must report other physicians that engage in incompetent, unsafe, or unethical behavior that may put patients at risk to the applicable state licensing body (SLB) so that appropriate disciplinary action can be taken. In this regard, the American Medical Association (AMA) Code of Medical Ethics subchapter 9.4.2, Reporting Incompetent or Unethical Behaviors by Colleagues, states that, “[t]he obligation to report incompetent or unethical conduct that may put patients at risk is recognized in both the ethical standards of the profession and in law and physicians should be able to report such conduct without fear or loss of favor.”¹

Under VA regulations found at 38 C.F.R. Part 47, “[i]t is the policy of VA to report to [SLBs] any currently employed licensed health care professional or separated licensed health care professional whose clinical practice during VA employment so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients.” Several examples of actions that meet the criteria include patient neglect or abandonment; physical or mental impairment; substance abuse; falsification of credentials, medical records, or prescriptions; inappropriate dispensing of drugs; mental, physical, sexual, or verbal abuse of a patient; or unethical or moral turpitude. Veterans Health Administration (VHA) Handbook 1100.18, Reporting and Responding to State Licensing Boards, contains the requirements for health care facilities’ procedures regarding reporting and responding to SLBs.² The Handbook calls for multiple levels of review at the local, regional, and national level. The problem is that this process can cause delays of months or even years that put patients at unacceptable risk.

For example, VA’s policies, procedures, and practices with regard to reporting inappropriate behavior to SLBs have come under scrutiny in response to an incident at the Tomah, Wisconsin VA Medical Center. The VA Office of the Inspector General (IG) conducted a review of alleged inappropriate prescription of controlled substances and alleged abuse of authority in response to a number of allegations made throughout 2011. According to media reports, veterans commonly referred to the Tomah VA Medical Center as “Candy Land” and to the then-Chief of Staff—Dr. David Houlihan—as the “Candy Man” due of the high number of opioid prescriptions that were routinely made available to veteran pa-

¹American Medical Association Code of Medical Ethics, Chapter 9: Opinions on Professional Self-Regulation, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>

²VHA Handbook 1100.18 Reporting and Responding to State Licensing Boards

tients at that facility.³ The IG administratively closed its investigation in 2014 after finding that the amounts of opioids prescribed by Dr. Houlihan and select other providers were “at considerable variance” compared to the amounts of opioids prescribed by other VA medical facilities in the same region and substantiating that there were, “widely held beliefs and concerns among pharmacy staff and among some other staff,” of abuse of authority, intimidation, and retaliation on the part of the Chief of Staff when controlled substance prescription practices were questioned.⁴ An internal VA investigation into these issues was initiated in January 2015 after the IG’s review was made public. That internal investigation substantiated unsafe clinical practices in areas such as pain management and psychiatric care and found that, “an apparent culture of fear at the [Tomah VA Medical Center] compromised patient care and impacted staff satisfaction and morale.”⁵ Dr. Houlihan was eventually terminated by VA for failure to provide appropriate medical care to some patients in his care. However, VA did not notify the Wisconsin Medical Examining Board of the instances of inadequate care that Dr. Houlihan had provided so that the Board could take licensing action against him until after he had resumed private practice.

The Committee believes that VA’s existing policies regarding reporting inappropriate behavior to SLBs or other relevant bodies must allow for direct reporting by physicians to SLBs for impaired, incompetent, or unethical medical care that puts patients at risk. As such, Section 2 of the bill would require VA to ensure that each VA physician is informed of his/her duty to report directly to the applicable state licensing authority any covered activity committed by another physician that the physician witnesses or otherwise discovers within five days. A “covered activity” is defined as any activity occurring in a VA medical facility that consists of or causes the provision of impaired, incompetent, or unethical health care that requires direct reporting under the AMA Code of Medical Ethics.

HEARINGS

There were no Full Committee or Subcommittee hearings held on H.R. 5399.

SUBCOMMITTEE CONSIDERATION

There was no Subcommittee markup of H.R. 5399.

COMMITTEE CONSIDERATION

On September 21, 2016, the Full Committee met in open markup session, a quorum being present, and ordered H.R. 5399 reported favorably to the House of Representatives by voice vote. A motion by Representative Mark Takano of California to report H.R. 5399

³ Chicago Tribune, “Veterans: VA hospital nicknamed ‘Candy Land’ because painkillers given out freely,” January 9, 2015. <http://www.chicagotribune.com/news/ct-tomah-va-hospital-nw-20150109-story.html>

⁴ VA Office of the Inspector General, “Administrative Closure—Alleged Inappropriate Prescribing of Controlled Substances and Alleged Abuse of Authority, Tomah VA Medical Center, Tomah, WI.” <http://www.va.gov/oig/pubs/VAOIG-11-04212-127.pdf>

⁵ Summary of Phase One Clinical Review Findings, Tomah, WI, March 10, 2015, [http://www.va.gov/opa/docs/](http://www.va.gov/opa/docs/MEMO_Summary_of_Phase_One_Clinical_Review_Findings_Tomah_WI.pdf)
MEMO_Summary_of_Phase_One_Clinical_Review_Findings_Tomah_WI.pdf

favorably to the House of Representatives was agreed to by voice vote.

COMMITTEE VOTES

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, there were no recorded votes taken on amendments or in connection with ordering H.R. 5399 reported to the House.

COMMITTEE OVERSIGHT FINDINGS

In compliance with clause 3(c)(1) of rule XIII and clause (2)(b)(1) of rule X of the Rules of the House of Representatives, the Committee's oversight findings and recommendations are reflected in the descriptive portions of this report.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

In accordance with clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee's performance goals and objectives are to ensure the Secretary of Veterans Affairs clarifies that VA physicians have a duty to report impaired, incompetent, or unethical behavior committed by another physician to applicable State licensing authorities.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee adopts as its own the estimate of new budget authority, entitlement authority, or tax expenditures or revenues contained in the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

EARMARKS AND TAX AND TARIFF BENEFITS

H.R. 5399 does not contain any Congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9 of rule XXI of the Rules of the House of Representatives.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate on H.R. 5399 prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the following is the cost estimate for H.R. 5399 provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 13, 2016.

Hon. JEFF MILLER,
*Chairman, Committee on Veterans' Affairs,
House of Representatives, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 5399, the Ethical Patient Care for Veterans Act of 2016.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Ann E. Futrell.

Sincerely,

KEITH HALL.

Enclosure.

H.R. 5399—Ethical Patient Care for Veterans Act of 2016

H.R. 5399 would require physicians employed by the Department of Veterans Affairs (VA) to report unethical health care practices that take place at VA medical facilities to the appropriate state licensing authority within five days of occurrence. The bill also would require VA to inform physicians of that responsibility.

Under current law, VA monitors and evaluates the quality of health care through its quality-assurance program. Under that program, physicians may confidentially submit reports of unethical practices that they witness. CBO expects that VA would distribute information about the new reporting requirement through electronic correspondence. As a result, CBO estimates that implementing H.R. 5399 would have insignificant costs for administrative activities over the 2017–2021 period; that spending would be subject to the availability of appropriated funds.

Enacting the legislation would not affect direct spending or revenues; therefore, pay-as-you-go procedures do not apply.

CBO estimates that enacting H.R. 5399 would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2027.

H.R. 5399 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act and would impose no costs on state, local, or tribal governments.

The CBO staff contact for this estimate is Ann E. Futrell. The estimate was approved by H. Samuel Papenfuss, Deputy Assistant Director for Budget Analysis.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates regarding H.R. 5399 prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act would be created by H.R. 5399.

STATEMENT OF CONSTITUTIONAL AUTHORITY

Pursuant to Article I, section 8 of the United States Constitution, H.R. 5399 is authorized by Congress' power to "provide for the common Defense and general Welfare of the United States."

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that H.R. 5399 does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

STATEMENT ON DUPLICATION OF FEDERAL PROGRAMS

Pursuant to section 3(g) of H. Res. 5, 114th Cong. (2015), the Committee finds that no provision of H.R. 5399 establishes or reauthorizes a program of the Federal Government known to be duplicative of another Federal program, a program that was included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111-139, or a program related to a program identified in the most recent Catalog of Federal Domestic Assistance.

DISCLOSURE OF DIRECTED RULEMAKING

Pursuant to section 3(i) of H. Res. 5, 114th Cong. (2015), the Committee estimates that H.R. 5399 contains no directed rule making that would require the Secretary to prescribe regulations.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Short title

Section 1 of the bill would provide the short title for H.R. 5399, as the "Ethical Patient Care for Veterans Act of 2016."

Section 2. Duty to report impaired, incompetent, and unethical health care activities

Section 2(a) of the bill would amend Subchapter II of chapter 74 of title 38, U.S.C., by adding a new section, "7330B. Duty to report impaired, incompetent, and unethical health care activities." 7330B(a) would require VA to ensure that each VA physician is informed of the duty to directly report to the applicable licensing authority any "covered" activity in which that physician witnesses another VA physician committing or otherwise directly discovers. 7330B(b) would require each VA physician to make a direct report to the State licensing authority no later than five days after witnessing or otherwise directly discovering a covered activity. 7330B(c) would define a "covered activity" to mean any activity occurring in a VA medical facility that consists of or causes the provision of impaired, incompetent, or unethical health care that requires direct reporting under opinion number 9.031 of the Code of Medical Ethics of the American Medical Association, and the term "physician" to include any contractor who is a physician at a VA medical facility.

Section 2(b) of the bill would amend the table of contents at the beginning of chapter 74 by inserting "7330B. Duty to report im-

paired, incompetent, and unethical health care activities.” after 7330A.

Section 2(c) of the bill would amend section 7462(a)(1)(A) of title 38 U.S.C. by inserting “, including pursuant to section 7330B(c) of this title” before the semicolon.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (new matter is printed in italic and existing law in which no change is proposed is shown in roman):

TITLE 38, UNITED STATES CODE

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PART V—BOARDS, ADMINISTRATIONS, AND SERVICES

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CHAPTER 74—VETERANS HEALTH ADMINISTRATION - PERSONNEL

SUBCHAPTER I—APPOINTMENTS

Sec.

7401. Appointments in Veterans Health Administration.

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SUBCHAPTER II—COLLECTIVE BARGAINING AND PERSONNEL ADMINISTRATION

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7330B. *Duty to report impaired, incompetent, and unethical health care activities.*

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SUBCHAPTER II—COLLECTIVE BARGAINING AND PERSONNEL ADMINISTRATION

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§ 7330B. *Duty to report impaired, incompetent, and unethical health care activities*

(a) *REPORTING TO STATE LICENSING AUTHORITY.—In addition to confidential reporting under the quality-assurance program pursuant to section 7311(b)(4) of this title and any other reporting authorized or required by the Secretary, the Secretary shall ensure that each physician of the Department is informed of the duty of the phy-*

physician to report directly any covered activity committed by another physician that the physician witnesses or otherwise directly discovers to the applicable licensing authority of each State in which the physician who is the subject of the report is licensed to practice medicine.

(b) *TIMING OF REPORTING.*—Each physician of the Department shall make a direct report to the State licensing authority of a covered activity under subsection (a) not later than five days after the date on which the physician witnesses or otherwise directly discovers the covered activity.

(c) *DEFINITIONS.*—In this section:

(1) The term “covered activity” means any activity occurring in a medical facility of the Department that consists of or causes the provision of impaired, incompetent, or unethical health care that requires direct reporting under opinion number 9.031 of the Code of Medical Ethics of the American Medical Association.

(2) The term “physician of the Department” includes any contractor who is a physician at a medical facility of the Department.

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SUBCHAPTER V—DISCIPLINARY AND GRIEVANCE PROCEDURES

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§ 7462. Major adverse actions involving professional conduct or competence

(a)(1) Disciplinary Appeals Boards appointed under section 7464 of this title shall have exclusive jurisdiction to review any case—

(A) which arises out of (or which includes) a question of professional conduct or competence of a section 7401(1) employee, including pursuant to section 7330B(c) of this title; and

(B) in which a major adverse action was taken.

(2) The board shall include in its record of decision in any mixed case a statement of the board’s exclusive jurisdiction under this subsection and the basis for such exclusive jurisdiction.

(3) For purposes of paragraph (2), a mixed case is a case that includes both a major adverse action arising out of a question of professional conduct or competence and an adverse action which is not a major adverse action or which does not arise out of a question of professional conduct or competence.

(b)(1) In any case in which charges are brought against a section 7401(1) employee which arises out of, or includes, a question of professional conduct or competence which could result in a major adverse action, the employee is entitled to the following:

(A) At least 30 days advance written notice from the Under Secretary for Health or other charging official specifically stating the basis for each charge, the adverse actions that could be taken if the charges are sustained, and a statement of any specific law, regulation, policy, procedure, practice, or other specific instruction that has been violated with respect to each charge, except that the requirement for notification in advance may be waived if there is reasonable cause to believe that the

employee has committed a crime for which the employee may be imprisoned.

(B) A reasonable time, but not less than seven days, to present an answer orally and in writing to the Under Secretary for Health or other deciding official, who shall be an official higher in rank than the charging official, and to submit affidavits and other documentary evidence in support of the answer.

(2) In any case described in paragraph (1), the employee is entitled to be represented by an attorney or other representative of the employee's choice at all stages of the case.

(3)(A) If a proposed adverse action covered by this section is not withdrawn, the deciding official shall render a decision in writing within 21 days of receipt by the deciding official of the employee's answer. The decision shall include a statement of the specific reasons for the decision with respect to each charge. If a major adverse action is imposed, the decision shall state whether any of the charges sustained arose out of a question of professional conduct or competence. If any of the charges are sustained, the notice of the decision to the employee shall include notice of the employee's rights of appeal.

(B) Notwithstanding the 21-day period specified in subparagraph (A), a proposed adverse action may be held in abeyance if the employee requests, and the deciding official agrees, that the employee shall seek counseling or treatment for a condition covered under the Rehabilitation Act of 1973. Any such abeyance of a proposed action may not extend for more than one year.

(4)(A) The Secretary may require that any answer and submission under paragraph (1)(B) be submitted so as to be received within 30 days of the date of the written notice of the charges, except that the Secretary shall allow the granting of extensions for good cause shown.

(B) The Secretary shall require that any appeal to a Disciplinary Appeals Board from a decision to impose a major adverse action shall be received within 30 days after the date of service of the written decision on the employee.

(c)(1) When a Disciplinary Appeals Board convenes to consider an appeal in a case under this section, the board, before proceeding to consider the merits of the appeal, shall determine whether the case is properly before it.

(2) Upon hearing such an appeal, the board shall, with respect to each charge appealed to the board, sustain the charge, dismiss the charge, or sustain the charge in part and dismiss the charge in part. If the deciding official is sustained (in whole or in part) with respect to any such charge, the board shall—

(A) approve the action as imposed;

(B) approve the action with modification, reduction, or exception; or

(C) reverse the action.

(3) A board shall afford an employee appealing an adverse action under this section an opportunity for an oral hearing. If such a hearing is held, the board shall provide the employee with a transcript of the hearing.

(4) The board shall render a decision in any case within 45 days of completion of the hearing, if there is a hearing, and in any event no later than 120 days after the appeal commenced.

(d)(1) After resolving any question as to whether a matter involves professional conduct or competence, the Secretary shall cause to be executed the decision of the Disciplinary Appeals Board in a timely manner and in any event in not more than 90 days after the decision of the Board is received by the Secretary. Pursuant to the board's decision, the Secretary may order reinstatement, award back pay, and provide such other remedies as the board found appropriate relating directly to the proposed action, including expungement of records relating to the action.

(2) If the Secretary finds a decision of the board to be clearly contrary to the evidence or unlawful, the Secretary may—

(A) reverse the decision of the board, or

(B) vacate the decision of the board and remand the matter to the Board for further consideration.

(3) If the Secretary finds the decision of the board (while not clearly contrary to the evidence or unlawful) to be not justified by the nature of the charges, the Secretary may mitigate the adverse action imposed.

(4) The Secretary's execution of a board's decision shall be the final administrative action in the case.

(e) The Secretary may designate an employee of the Department to represent management in any case before a Disciplinary Appeals Board.

(f)(1) A section 7401(1) employee adversely affected by a final order or decision of a Disciplinary Appeals Board (as reviewed by the Secretary) may obtain judicial review of the order or decision.

(2) In any case in which judicial review is sought under this subsection, the court shall review the record and hold unlawful and set aside any agency action, finding, or conclusion found to be—

(A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;

(B) obtained without procedures required by law, rule, or regulation having been followed; or

(C) unsupported by substantial evidence.

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