Approved: March 17, 2009
Date

MINUTES OF THE SENATE JUDICIARY COMMITTEE

The meeting was called to order by Chairman Thomas C. (Tim) Owens at 9:30 a.m. on January 28, 2009, in Room 545-N of the Capitol.

All members were present.

Committee staff present:
Jason Thompson, Office of the Revisor of Statutes
Doug Taylor, Office of the Revisor of Statutes
Athena Andaya, Kansas Legislative Research Department
Karen Clowers, Committee Assistant

Conferees appearing before the committee:
Sandy McCurdy, Clerk of the District Court, Johnson County
Cynthia Smith, Advocacy Council, Sisters of Charity of Leavenworth Health Systems
Debra Stern, Kansas Hospital Association
Dan Morin, Kansas Medical Society
Larry Wall, Kansas Association for Justice
Terry Symonds, Detective, Topeka Police Department
Ed Klumpp, Kansas Peace Officers' Association
Jennifer Roth, Attorney
Kathy Porter, Office of Judicial Administration

Others attending:
See attached list.

Bill Introductions
Dan Murray requested the introduction of a bill which would amend existing statutes pertaining to scrap metal.

The Chairman opened the hearing on **SB 66 - Change of venue in care and treatment cases; transmittal of documents.**

Sandy McCurdy appeared in support stating the bill will simplify and update the process currently in use by court clerks. The change will eliminate the duplication of a time consuming process and assist in the transition to image and electronically filed documents (Attachment 1).

There being no further conferees, the hearing on **SB 66** was closed.

The Chairman opened the hearing on **SB 32 - Evidence in civil actions; expression of apology by health care providers.** Jason Thompson, staff revisor provided an overview of the bill.

Cynthia Smith spoke in support stating the bill is intended to keep lines of communication open between doctors and patients when a medical procedure or treatment does not go as anticipated. Ms. Smith indicated often doctors fail to communicate with families and patients on the advice of their lawyers. Enactment of this bill could result in fewer lawsuits when an expression of compassion is offered. An "apology law" have been enacted in 35 states. (Attachment 2)

Debra Stern appeared in support stating the practice of medicine is both an art and a science and the treatment of patients does not always proceed as anticipated. The current movement towards transparency in communications between doctors and patients is gaining favor and Ms. Stern encouraged the enactment of **SB 32.** (Attachment 3)

Dan Morin testified in support indicating unanticipated, adverse outcomes in health care happen. Allowing physicians and other caregivers to express sympathy or regret will help patients and families better understand the situation concerning the patient. A physician's empathy and concern for the patient who has experienced an adverse outcome should not be a legal tool to be used against them in the event of litigation. (Attachment 4)

Minutes of the Senate Judiciary Committee at 9:30 a.m. on January 28, 2009, in Room 545-N of the Capitol.

Larry Wall testified in opposition stating **SB 32** changes the rules of evidence and creates a special exception for health care providers. Doctors have always been empowered to say "I'm sorry" and Kansas does not need a law to protect them. Mr. Wall indicates **SB 32** raises several concerns including:

- the use of "fault" in Sec.1(a) if interpreted literally would exclude valuable evidence,
- statements of fault could not be entered into evidence while statements demonstrating a patient's liability would be allowed,
- makes an exemption to *res gestae,* and
- may present questions of due process.

Mr. Wall questioned the need for another law to be added to the many laws already in place to protect health care providers, and recommended that **SB 32** not be passed. (Attachment 5)

Written testimony in support of **SB 32** was submitted by:
William Sneed, University of Kansas Hospital Authority (Attachment 6)
Anne M. Kindling, Kansas Association of Defense Counsel (Attachment 7)

There being no further conferees, the hearing on **SB 32** was closed.

The Chairman opened the hearing on **SB 69 - Crime stoppers advisory council; Kansas crime stopper trust fund.** Jason Thompson, staff revisor provided an overview of the bill.

Terry Symonds appeared in support indicating **SB 69** will substantially assist in reducing criminal activity in Kansas through the development and support of community Crimestopper programs. The establishment of an Advisory Council within the Attorney General's Office will work to coordinate and assist local programs across Kansas. Mr. Symonds provided a proposed amendment attached to his testimony. (Attachment 8)

Ed Klumpp appeared as a proponent stating support of the Crimestoppers program. He voiced several concerns the Kansas Peace Officers Association had regarding the bill which have been addressed in suggested amendments offered in Mr. Symonds testimony. (Attachment 9)

Kathy Porter spoke in a neutral capacity stating concerns regarding the mechanics of collection of fees. Ms. Porter provided suggested amendments to address her concerns. (Attachment 10)

Written testimony in support of **SB 69** was submitted by:
K.C. Blodgett, President, Kansas State Lodge of Fraternal Order of Police (Attachment 11)
Dam Gibb, Assistant Attorney General (Attachment 12)

Written testimony in opposition to **SB 69** was submitted by:
Jennifer Roth (Attachment 13)

The next meeting is scheduled for January 29, 2009.

The meeting was adjourned at 10:30 a.m.

PLEASE CONTINUE TO ROUTE TO NEXT GUEST

SENATE JUDICIARY COMMITTEE GUEST LIST

DATE: 1-28-09

NAME	REPRESENTING
TIM VAN ZANDT	Saint Lukes Health System
Neil Buckley	SCLHS
Linda Mosby	St. Francis Health Center
Cynthia Smith	SCL Health System
DEBORAH STERN	KHA
Chip Wheelen	HCSF Bd of Govs
Gina Lambertson	Kansas Health Consumer Coalition
Sonya Garwood	Kansas Farm Bureau
[illegible]	S'G Co Farm Bureau
[illegible]	Sedg. Co. Farm Bureau
[illegible]	Sedg. Co Farm Bureau
[illegible]	Sedg. Co. Farm Bureau
Terry Symonds	KCSA
Ed Klumpp	KAIP & KPOA
Sean Miller	Capitol Strategies
Richard Simmiyo	Kennedy & Associates
JOSEPH Molina	KS Bar Assoc.
Kristy Porter	Judicial Branch

PLEASE CONTINUE TO ROUTE TO NEXT GUEST

SENATE JUDICIARY COMMITTEE GUEST LIST

DATE: 1-28-09

NAME	REPRESENTING
Alice Adams	Judicial Branch
Sandy McCurdy	Judicial Branch
Laurel Klein Searles	KCSDV
Julie Hein	Hein Law Firm
Doug Smith	Pmegar, Smith & Associates
Bill Sneed	UKNA

Phil [illegible]der, President
Ellis County
1204 Fort Street, 3rd Floor
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Hays, KS 67601
785-628-9415

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Ann McNett, President-Elect
Barber County
Barber County Courthouse
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Medicine Lodge, Ks. 67104
620-886-5639

Change of Venue - Care & Treatment Cases

Testimony in Support of Senate Bill 66
By: Sandy McCurdy, Clerk of the District Court
Johnson County - 10th Judicial District

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to appear before you today to speak on behalf of the Kansas Association of District Court Clerks and Administrators in regard to amending two statutes: KSA 59-2971, regarding care and treatment for mentally ill persons, and KSA 59-29b71, regarding care and treatment for persons with an alcohol or substance abuse problem.

Currently, when there is a change of venue ordered prior to trial, the clerk is required under KSA 59-2965 to send by facsimile "all pleadings and orders in the case." When the change of venue occurs after trial, the same statute requires the faxing of several specified documents and then sending the entire file to the receiving court by registered mail no later than 5:00 p.m. of the second full day the transferring court is open for business.

The current procedure of first faxing some documents then sending the entire file, including those documents which have previously been faxed, is time-consuming and results in sending two copies of some documents to the receiving court–once by fax and once by mail. The majority of these files do not contain many, if any, documents beyond those already specified to be faxed.

The proposed amendments would simplify and update the process the clerks of the district court presently use in change of venue cases by allowing documents to be sent by "facsimile or electronic copy." The use of this language will accommodate the courts and parties as we transition into imaged and electronically-filed documents.

In subsections 2(b) of both statutes, the amendments would also delete the requirement of certifying the pleadings and orders sent from the district court changing venue to the district court in the county of residence of the proposed patient if the county of residence is not the receiving county, since the documents are sent from one district court to another. The same process would apply in subsection 2(d) where the certification requirement would be removed when pleadings are sent to the county of residence by the court to which venue is transferred. The authenticity of documents sent by one court to another court can be verified by the fax identification line or the e-mail address of the sending court.

The requested amendments would save the clerks, who are often short-handed, the time now spent on duplicative steps. The Judicial Branch currently has a hiring freeze with no end in sight. These amendments would also save the counties the cost of postage. It is important to look for ideas such as this in difficult economic times.

Thank you for allowing me the opportunity to appear before you today on these issues. We will be glad to answer any questions you may have.

Kathleen Collins
Wyandotte County
710 N. 7th St., Mezzanine
Kansas City, KS 66101
913-573-2946

Tiffany Gillespie, Treasurer
Trego County
216 N. Main
Wakeeney, KS 67672
785-743-2148

Donna Oswald, Immed. Past Pres.
Atchison County
423 N. 5th Street PO Box 408
[illegible]

Senate Judiciary
1-28-09
Attachment 1

Sisters of Charity of Leavenworth Health System

Senate Judiciary Committee
State of Kansas
January 28, 2009

Written Testimony on Senate Bill 32

Expressions of apology, sympathy, compassion or benevolent acts by health care providers not admissible as evidence

The Sisters of Charity of Leavenworth religious community was founded in 1858 by Mother Xavier Ross and the early Sisters responding to a call for health and social services in the ranching and mining communities throughout the Western states. From such humble origins, these committed women built the **Sisters of Charity of Leavenworth Health System**, which is made up of nine hospitals and four stand-alone clinics located in the states of Kansas, California, Colorado, Montana and California.

SCL Health System operates three hospitals in Kansas – **St. Francis Health Center in Topeka, Providence Medical Center in Kansas City, Kansas, and Saint John Hospital in Leavenworth** – as well as three safety net clinics.

The purpose of Senate Bill 32 is for Kansas to adopt public policy that that would allow expressions of apology or compassion and other benevolent acts by health care providers without fear of it being used as evidence of liability when a patient experiences an unanticipated outcome.

The logic of this policy is that when a medical procedure or treatment does not go as anticipated, compassion and benevolence is warranted, regardless of fault. By keeping open the lines of communication between a patient and his or her doctors and hospital during that difficult time, an adversarial relationship and potentially costly lawsuits can be avoided. Doctors won't feel they have to wait for legal counsel to give advice, or for fault to be investigated, for them to be able to freely express compassion to their patients.

Anecdotally, we all know some patients would be understanding when things don't go as anticipated, but sue only because the doctor never said he or she was sorry or even talked to the patient about what happened. Quite likely doctors fail to do that because their lawyers advised them not to say anything. An article in the *New York Times* last May presents some real cases where "sorry" worked.

The bill addresses evidence of admission of liability and admissions against interest.

Yes, this policy limits evidence if a case does end up in court. But if fault is clear, such as a wrong limb being operated on, or something left inside a patient, that evidence isn't even needed. <u>What is gained far outweighs what is lost</u>.

The *New York Times* story reports that even trial lawyers are realizing they like the "sorry works" approach because injured clients are compensated quickly.

While the goal of this legislation is to encourage these acts and conversations, I want you to know that our health system has not waited to take action. The SCL Health System has adopted written policies and implementation guidelines on both (1) Apology and Disclosure, and (2) Financial Response to Serious Adverse Events, and copies are provided. Our Financial Response policy is currently being updated to be ready for new Medicare rules regarding

charges for serious adverse events; we were actually ahead of federal regulators on that issue, acting regardless of payer.

The Mission of SCL Health System is *to improve the health of the individuals and communities we serve*…which is realized through our Vision, including the *unyielding pursuit of clinical excellence.* The foundation of this calling is based upon our Core Values, what we live by on a daily basis. These Core Values encompass not only that we owe excellent service to the people we serve, but also that we treat each and every person with respect and dignity. Because we are people caring for people, situations may occur wherein the patients we serve are harmed or injured while under our care or in our facility. If and when that should occur, it is the foundation of our Core Values that guides our subsequent actions and deeds.

Consistent with our Core Values, in the event where a patient has been injured while under our care, or in our facility, an apology shall be delivered to that person within 24 hours of recognition of the event.

We seek protection from having our policy being turned against us, as well as uniformity of state laws on this issue. As I mentioned, we have hospitals in three other states, and all three states already have law along the lines that we are proposing.

In fact, 35 states already have "apology laws" on the books, and a list is included with our testimony. There is a national movement based on a book called "Sorry Works" by Doug Wojcieszak. Mr. Wojcieszak lost his oldest brother to medical errors, his family was forced to sue the hospital and doctors to get answers, and they obtained a settlement but not a genuine apology. His experiences convinced him there must be a better solution to the medical malpractice crisis, and that solution is disclosure, apology and swift justice after adverse medical events. We agree.

Why should health care providers have an apology law, and not others? Perhaps there are other circumstances where an apology law makes sense, but we don't know about that, we are here to address the relationship between a doctor and his or her patient. What we know is that we are all concerned about rising health care costs and understand the importance of attracting good doctors and other health care workers to Kansas, and this bill moves us in the right direction.

One final point. There has been concern that our pursuing this policy will "open up" tort laws for other changes. We implore with you to try to keep this bill clean and allow this good policy to be adopted. Insist that other interest groups introduce their own bills if they want to make changes to those laws. If this bill is poisoned by amendments we cannot support, amendments that will increase litigation and chase doctors out of Kansas instead, we will of course be forced to abandon it. This is a simple, common sense policy, has no cost to the state, and may actually preserve Health Care Stabilization Fund dollars and reduce health care costs. Please resist unrelated amendments and allow this bill to move cleanly through the legislative process. Because sorry works.

Respectfully submitted,
Cynthia Smith
Advocacy Counsel

Attachments:
List of 35 states with Apology Laws
"Doctors Say 'I'm Sorry' Before 'See You in Court'," The New York Times, May 18, 2008
About SCLHS (system map)
SCLHS Policies on Quality and Compassion, Financial Response to Serious Adverse Events

States with Apology Laws

Arizona A.R.S. 12-2605 (2005)

California Evidence Code 1160 (2000)

Colorado Revised Statute 13-25-135 (2003)

Connecticut Public Act No. 05-275 Sec.9 (2005) amended (2006) Conn. Gen. Stat. Ann. 52-184d

Delaware Del. Code Ann. Tit. 10, 4318 (2006)

Florida Stat 90.4026 (2001)

Georgia Title 24 Code GA Annotated 24-3-37.1 (2005)

Hawaii HRS Sec.626-1 (2006)

Idaho Title 9 Evidence Code Chapter 2 .9-207

Illinois Public Act 094-0677 Sec. 8-1901, 735 ILL. Comp. Stat. 5/8-1901 (2005)

Indiana Ind. Code Ann. 34-43.5-1-1 to 34-43.5-1-5

Iowa HF 2716 (2006)

Louisiana R.S. 13:3715.5 (2005)

Maine MRSA tit. 2908 (2005)

Maryland MD Court & Judicial Proceedings Code Ann. 10-920 (2004)

Massachusetts ALM GL ch.233, 23D (1986)

Missouri Mo. Ann. Stat. 538.229 (2005)

Montana Code Ann.26-1-814 (Mont. 2005)

Nebraska Neb. Laws L.B. 373 (2007)

New Hampshire RSA 507-E:4 (2005)

North Carolina General Stat. 8C-1, Rule 413

North Dakota ND H.B. 1333 (2007)

Ohio ORC Ann 2317.43 (2004)

Oklahoma 63 OKL. St. 1-1708.1H (2004)

Oregon Rev. Stat. 677.082 (2003)

South Carolina Ch.1, Title19 Code of Laws 1976, 19-1-190 (2006)

South Dakota Codified Laws 19-12-14 (2005)

Tennessee Evid Rule 409.1(2003)

Texas Civil Prac and Rem Code 18.061(1999)

Utah Code Ann. 78-14-18 (2006)

Vermont S 198 Sec. 1. 12 V.S.A. 1912 (2006)

Virginia Code of Virginia 8.01-52.1 (2005)

Washington Rev Code Wash 5.66.010 (2002)

West Virginia 55-7-11a (2005)

Wyoming Wyo. Stat. Ann. 1-1-130

The New York Times
nytimes.com

May 18, 2008

Doctors Say 'I'm Sorry' Before 'See You in Court'

By KEVIN SACK

CHICAGO — In 40 years as a highly regarded cancer surgeon, Dr. Tapas K. Das Gupta had never made a mistake like this.

As with any doctor, there had been occasional errors in diagnosis or judgment. But never, he said, had he opened up a patient and removed the wrong sliver of tissue, in this case a segment of the eighth rib instead of the ninth.

Once an X-ray provided proof in black and white, Dr. Das Gupta, the 74-year-old chairman of surgical oncology at the University of Illinois Medical Center at Chicago, did something that normally would make hospital lawyers cringe: he acknowledged his mistake to his patient's face, and told her he was deeply sorry.

"After all these years, I cannot give you any excuse whatsoever," Dr. Das Gupta, now 76, said he told the woman and her husband. "It is just one of those things that occurred. I have to some extent harmed you."

For decades, malpractice lawyers and insurers have counseled doctors and hospitals to "deny and defend." Many still warn clients that any admission of fault, or even expression of regret, is likely to invite litigation and imperil careers.

But with providers choking on malpractice costs and consumers demanding action against medical errors, a handful of prominent academic medical centers, like Johns Hopkins and Stanford, are trying a disarming approach.

By promptly disclosing medical errors and offering earnest apologies and fair compensation, they hope to restore integrity to dealings with patients, make it easier to learn from mistakes and dilute anger that often fuels lawsuits.

Malpractice lawyers say that what often transforms a reasonable patient into an indignant plaintiff is less an error than its concealment, and the victim's concern that it will happen again.

Despite some projections that disclosure would prompt a flood of lawsuits, hospitals are reporting decreases in their caseloads and savings in legal costs. Malpractice premiums have declined in some instances, though market forces may be partly responsible.

At the University of Michigan Health System, one of the first to experiment with full disclosure, existing claims and lawsuits dropped to 83 in August 2007 from 262 in August 2001, said Richard C. Boothman, the medical center's chief risk officer.

"Improving patient safety and patient communication is more likely to cure the malpractice crisis than defensiveness and denial," Mr. Boothman said.

Mr. Boothman emphasized that he could not know whether the decline was due to disclosure or safer medicine, or both. But the hospital's legal defense costs and the money it must set aside to pay claims have each been cut by two-thirds, he said. The time taken to dispose of cases has been halved.

The number of malpractice filings against the University of Illinois has dropped by half since it started its program just over two years ago, said Dr. Timothy B. McDonald, the hospital's chief safety and risk officer. In the 37 cases where the hospital acknowledged a preventable error and apologized, only one patient has filed suit. Only six settlements have exceeded the hospital's medical and related expenses.

In Dr. Das Gupta's case in 2006, the patient retained a lawyer but decided not to sue, and, after a brief negotiation, accepted $74,000 from the hospital, said her lawyer, David J. Pritchard.

"She told me that the doctor was completely candid, completely honest, and so frank that she and her husband — usually the husband wants to pound the guy — that all the anger was gone," Mr. Pritchard said. "His apology helped get the case settled for a lower amount of money."

The patient, a young nurse, declined to be interviewed.

Mr. Pritchard said his client netted about $40,000 after paying medical bills and legal expenses. He said she had the rib removed at another hospital and learned it was not cancerous. "You have no idea what a relief that was," Dr. Das Gupta said.

Some advocates argue that the new disclosure policies may reduce legal claims but bring a greater measure of equity by offering reasonable compensation to every injured patient.

Recent studies have found that one of every 100 hospital patients suffers negligent treatment, and that as many as 98,000 die each year as a result. But studies also show that as few as 30 percent of medical errors are disclosed to patients.

Only a small fraction of injured patients — perhaps 2 percent — press legal claims.

"There is no reason the patient should have to pay the economic consequences for our mistakes," said Dr. Lucian L. Leape, an authority on patient safety at Harvard, which recently adopted disclosure principles at its hospitals. "But we're pushing uphill on this. Most doctors don't really believe that if they're open and honest with patients they won't be sued."

The Joint Commission, which accredits hospitals, and groups like the American Medical Association and the American Hospital Association have adopted standards encouraging disclosure. Guidelines vary, however, and can be vague. While many hospitals have written policies to satisfy accreditation requirements, only a few are pursuing them aggressively, industry officials said.

"We're still learning the most effective way to have these most difficult conversations," said Nancy E. Foster, the hospital association's vice president for quality and patient safety. "It's a time of high stress for the patient and for the physician. It's also a time where information is imperfect."

The policies seem to work best at hospitals that are self-insured and that employ most or all of their staffs, limiting the number of parties at the table. Such is the case at the Veterans Health Administration, which pioneered the practice in the late 1980s at its hospital in Lexington, Ky., and now requires the disclosure of all adverse events, even those that are not obvious.

To give doctors comfort, 34 states have enacted laws making apologies for medical errors inadmissible in court, said Doug Wojcieszak, founder of The Sorry Works! Coalition, a group that advocates for disclosure. Four states have gone further and protected admissions of culpability. Seven require that patients be notified of serious unanticipated outcomes.

Before they became presidential rivals, Senators Hillary Rodham Clinton and Barack Obama, both Democrats, co-sponsored federal legislation in 2005 that would have made apologies inadmissible. The measure died in a committee under Republican control. Mrs. Clinton included the measure in her campaign platform but did not reintroduce it when the Democrats took power in 2007. Her Senate spokesman, Philippe Reines, declined to explain beyond saying that "there are many ways to pursue a proposal."

The Bush administration plans a major crackdown on medical errors in October, when it starts rejecting Medicare claims for the added expense of treating preventable complications. But David M. Studdert, an authority on patient safety in the United States who teaches at the University of Melbourne in Australia, said the focus on disclosure reflected a lack of progress in reducing medical errors.

"If we can't prevent these things, then at least we have to be forthright with people when they occur," Mr. Studdert said.

For the hospitals at the forefront of the disclosure movement, the transition from inerrancy to transparency has meant a profound, if halting, shift in culture.

At the University of Illinois, doctors, nurses and medical students now undergo training in how to respond when things go wrong. A tip line has helped drive a 30 percent increase in staff reporting of irregularities.

Quality improvement committees openly examine cases that once would have vanished into sealed courthouse files. Errors become teaching opportunities rather than badges of shame.

"I think this is the key to patient safety in the country," Dr. McDonald said. "If you do this with a transparent point of view, you're more likely to figure out what's wrong and put processes in place to improve it."

For instance, he said, a sponge left inside an patient led the hospital to start X-raying patients during and after surgery. Eight objects have been found, one of them an electrode that dislodged from a baby's scalp during a Caesarian section in 2006.

The mother, Maria Del Rosario Valdez, said she was not happy that a second operation was required to retrieve the wire but recognized the error had been accidental. She rejected her sister's advice to call a lawyer, saying that she did not want the bother and that her injuries were not that severe.

Ms. Valdez said she was gratified that the hospital quickly acknowledged its mistake, corrected it without charge and later improved procedures for keeping track of electrodes. "They took the time to explain it and to tell me they were sorry," she said. "I felt good that they were taking care of what they had done."

There also has been an attitudinal shift among plaintiff's lawyers who recognize that injured clients benefit when they are compensated quickly, even if for less. That is particularly true now that most states have placed limits on non-economic damages.

In Michigan, trial lawyers have come to understand that Mr. Boothman will offer prompt and fair compensation for real negligence but will give no quarter in defending doctors when the hospital believes that the care was appropriate.

"The filing of a lawsuit at the University of Michigan is now the last option, whereas with other hospitals it tends to be the first and only option," said Norman D. Tucker, a trial lawyer in Southfield, Mich. "We might give cases a

second look before filing because if it's not going to settle quickly, tighten up your cinch. It's probably going to be a long ride."

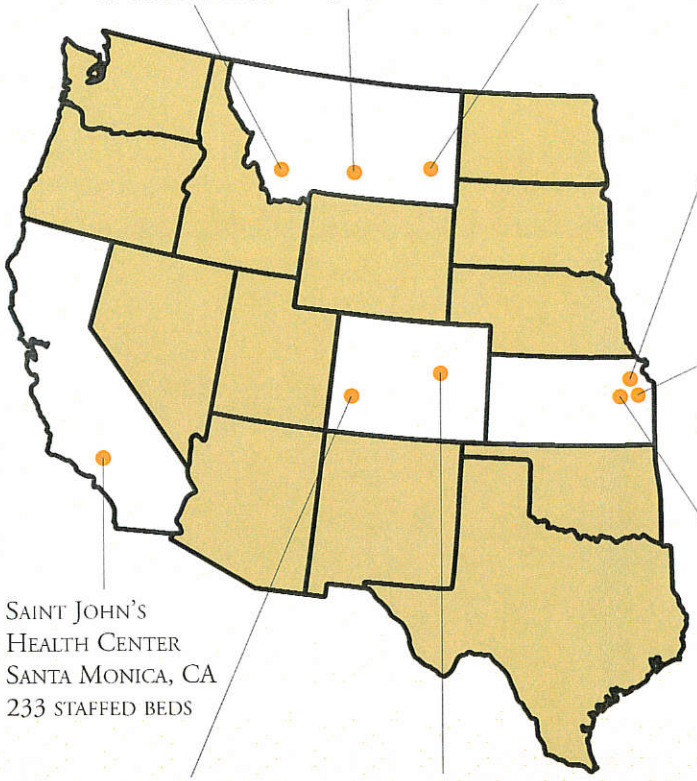
Sisters of Charity of Leavenworth Health System

About SCLHS

The Sisters of Charity of Leavenworth Health System (SCLHS) is a Catholic not-for-profit health system, composed of nine hospitals and four stand alone clinics in California, Colorado, Kansas and Montana. SCLHS is sponsored by the Sisters of Charity of Leavenworth.

SCLHS encompasses nearly 11,000 employees and over 2,000 staffed beds, in communities stretching across the western United States. Our staff are highly trained professionals dedicated to a culture that serves both the patient and the healer. The quality of our leadership, our unyielding pursuit of excellence and dedication to the communities we serve define us as a system.

Where We Serve



St. James Healthcare
Butte, MT
69 staffed beds

St. Vincent Healthcare
Billings, MT
234 staffed beds

Holy Rosary Healthcare
Miles City, MT
138 staffed beds

Saint John Hospital
43 staffed beds
and Saint Vincent Clinic
Leavenworth, KS

Providence Medical Center
257 staffed beds
Providence Place
85 staffed beds
and Duchesne Clinic
Kansas City, KS

St. Francis Health Center
283 staffed beds
and Marian Clinic
Topeka, KS

Saint John's Health Center
Santa Monica, CA
233 staffed beds

St. Mary's Hospital and Medical Center
280 staffed beds
and Marillac Clinic
Grand Junction, CO

Exempla Saint Joseph Hospital
Denver, CO
438 staffed beds

Mission

We will, in the spirit of the Sisters of Charity, reveal God's healing love by improving the health of the individuals and communities we serve, especially those who are poor or vulnerable.

Core Values

Excellence
We offer excellent and compassionate care.

Respect
We recognize the sacred worth and dignity of each person.

Response to Need
The health care we offer is based on community need, with a special concern for the poor.

Stewardship
We are mindful that we hold our resources in trust.

Wholeness
We value the health of the whole person—spiritual, psycho-social, emotional and physical.

Vision

SCLHS will realize its Mission through the unyielding pursuit of clinical excellence, strategic growth, and health care for all.

2-10

Original Date: 10/15/08 Revision Date(s):	Section:	Quality and Patient Safety
	Policy:	Policy of Quality and Compassion
	Cross-Reference:	Mission Integration

POLICY:

The Mission of SCLHS is *to improve the health of the individuals and communities we serve*…which is realized through our Vision, including the *unyielding pursuit of clinical excellence.* Through leadership and professionalism, SCLHS and its Affiliates (collectively the "System") strive to ensure quality patient care. The foundation of this calling is based upon our Core Values, what we live by on a daily basis. These Core Values encompass not only that we owe excellent service to the people we serve, but also that we treat each and every person with respect and dignity. Because we are people caring for people, situations may occur wherein the patients we serve, our employees, or associates are harmed or injured while under our care or in our facility. If and when that should occur, it is the foundation of our Core Values that guides our subsequent actions and deeds.

Consistent with our Core Values, in the event where a patient, employee, or associate has been injured while under our care, or in our facility, an apology shall be delivered to that person within 24 hours of recognition of the event. The apology is a simple "I am sorry for what happened to you" or "for what has taken place." It is a sincere gesture of regret, and compassion, and not because the harm or injury is the fault of anyone involved. The patient and/or family members will likely ask questions regarding the injury and may request additional information. Please refer to the *Apology and Disclosure Implementation Guidelines* for guidance on how to appropriately address these questions.

The person(s) who shall offer the apology may include the CEO of the hospital, the supervisor of the department or unit, the treating physician, the Mission Integration Leader, or others as deemed appropriate depending upon the circumstances of the event and subsequent injury. Please refer to the *Implementation Guidelines* for additional information on this process, as well as the reporting and documentation requirements under certain circumstances.

Original Date: 10/15/08 Revision Date(s):	Section:	Quality and Patient Safety
	Policy:	Policy of Quality and Compassion
	Implementation Guidelines:	*Implementation Guidelines for Policy of Quality and Compassion*
	Cross Reference:	Mission Integration

IMPLEMENTATION GUIDELINES: POLICY OF QUALITY AND COMPASSION

Apology and Disclosure:

Importance and Benefits of Apology and Disclosure

- It is the right thing to do!
- Patients and families want and deserve it.
- It is consistent with the SCLHS Mission, Core Values and Vision.
- It promotes healing for patients, families and caregivers.
- Professional standards require it.
- It may reduce litigation and/or mitigate its outcomes.

What Types of Events Necessitate an Apology and Disclosure? [1]

- Unanticipated outcomes that differ significantly from the anticipated results of a treatment or procedure previously discussed with the patient during the informed consent process.
- Medical errors that result in actual patient harm and are of clinical significance. The following three categories are communicated immediately by phone or pager to the Affiliate Risk Manager:
  1. An event occurred that may have contributed to or resulted in permanent harm to the patient/any other subject and required initial or prolonged hospitalization.
  2. An event occurred that required intervention necessary to sustain life.
  3. An event occurred that may have contributed to or resulted in the patient/any other subject's death.
- Unanticipated safety events that did not cause actual harm but may be of clinical significance in the future.
- Steps that have been or will be taken to prevent similar events in the future.

When Should the Apology and Disclosure Occur?

Communication of the event / outcome should take place as soon as possible after the staff becomes aware of the event / outcome and sufficient facts are known to support

[1] "Disclosure of Unanticipated Medical Outcomes, Guidelines for Health Care Professionals", Advocate Lutheran General Hospital.

the discussion. If an event / outcome is discovered after discharge, the patient / family member should be notified as soon as information and the impact on the patient's health has been determined as well as any actions that need to be taken by the patient / family.

Preparations for Apology and Disclosure

The first priority upon discovery of an unanticipated outcome is to ensure the safety and care of the patient and any others who may be at risk. Only after this initial step is completed will the following take place:

- Report the outcome or event to the next level supervisor immediately regardless of day or time of day.
- Enter the event in the Safety Report Management database.
- Supervisor reviews the outcome or event and then initiates next actions based on severity of the situation.
- At a minimum, the hospital administrator on call will be notified of unanticipated outcomes.
- Hospital administrator on call determines if additional persons should be contacted immediately.

Who Should Communicate with the Patient?

- It is expected that at least one hospital leadership person participate in the disclosure and apology process; but note that when a practitioner has contributed to the unanticipated outcome, Joint Commission standard RI.1.2.2 states: "The licensed independent practitioner, or her/his designee informs the patient, (and when appropriate, the patient's family), about these outcomes of care."
- It is suggested that practitioner and hospital representative meet prior to the meeting with the patient and family.
- In some cases, it may be inappropriate for the practitioner to meet with the patient or he/she may be unwilling or unable to discuss the event. In these circumstances, the administrator on call will notify the chief executive officer for guidance.
- It is suggested the meeting with the patient / family be limited to two individuals; the practitioner and hospital representative or two hospital representatives.

Suggestions for Effective Disclosure and Apology [2] [3]

- Be proactive in preparing for disclosure and apology. Don't wait for the patient or the family to ask or find out from another source.
- Select a private and neutral setting including comfortable chairs for the meeting. Sit down and don't rush. Clear your calendar; turn off pagers and cell phones.

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[2] The Sorry Works Coalition

[3] "Crafting an Effective Apology: What Clinicians Need to Know", Joint Commission International Center for Patient safety.

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- Be prepared for strong emotions. Give individuals ample time to express how they feel without interrupting them. Don't become defensive. Be patient. Don't blame or point fingers at others. Allow venting.
- Begin by stating that the hospital and its staff regret and apologize that event or outcome has occurred. "We are sorry this happened. We feel bad as we are sure you do too."
- Resolve initial problems and concerns such as phone calls, lodging, food and other needs. "What can we do for you at this moment?"
- Use common language, not medical terms.
- If you don't have the answer state: "I'm sorry that I don't have the answer to your question at this time. I will find the answer and get back to you personally as soon as I do"
- The session should provide a clear explanation only of the known facts of the event. Don't admit legal liability if not at fault. Avoid using words such as "wrong", error", "mishap", "incorrect", "inadvertent", "mistake", and "accident". What should be said is "I'm sorry that you (or a family member) had this complication."
- Outline a plan of action to rectify the outcome, if possible.
- Pledge that someone will manage ongoing communication with the patient and family. Ask how the patient would like to be contacted.
- Pledge that a review of the circumstances will take place to prevent similar events from occurring again.
- Provide the patient and family with names and phone numbers of individuals in the hospital or outside the hospital that can provide social, spiritual or emotional support and counseling.
- Factually document in the medical record what has been disclosed.

How to Document the Communication

The health care provider who has the discussion with the patient or patient's representative will document the conversation in the patient's medical record, and include the information set forth below.

- Date, time and place of the discussion.
- Names and relationship to the patient of those present.
- The factual information of the outcome that occurred
- The unanticipated outcome discussed and a concise summary of the discussion (see #2 under "What information should the discussion with the patient include?").
- Any offer of assistance or referrals (including persons or agencies) and the patient, family members or legal guardian's response.
- Questions posed by the patient, family members or legal guardian and the answers provided.

Any follow-up phone calls or conversations with patient/family will be documented utilizing the same content guidelines specified above

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Scripting: *Adverse Events due to Error- Human or System* [4]

"Let me tell you what happened. We gave you a larger dose of your Clozaril than you were supposed to receive. I want to discuss with you what this means for your health, but first I'd like to apologize."

"I'm sorry. This shouldn't have happened. Right now, I don't know exactly how this happened, but I promise you that we're going to find out and do everything we can to make sure that it doesn't happen again. I will share with you what we find as soon as I know, but it may take some time to get to the bottom of it all."

"Now, what does this mean for your health? The dose you received was 250mg. I intended for you to receive 25mg. While 250mg is within accepted dosages for someone who has been on the drug awhile, we typically start at 25mg and gradually increase the dose. I do not anticipate that you will experience any problems, and we have returned the dose to 25mg, but since there is a chance that you may have some decrease in your white blood cells, I am going to monitor this closely for the next month. I would have done this anyway as it is part of the monitoring that should be done for this drug. Do you have any questions?"

Unpreventable Adverse Events

If the event was not caused by an error, or the cause is unknown, the caregiver should express regret but not imply that anyone is at fault. "I am sorry that this happened to you" is appropriate language in these cases. Example:

"Mr. and Mrs. Smith, I know that you are aware that there were risks involved with the procedure Mrs. Smith had. I must tell you that I ran into some difficulty repairing your hernia. This means that you will need to stay in the hospital a few extra days to receive antibiotics. I want to be sure that you are healing and don't have any further complications. I am sorry that you experienced this complication but I expect you to make a full recovery."

Deliver your message very clearly. If you are really not sure what happened, it is better not to speculate. An example of this is after an unexpected cardiac arrest, especially in patients with multiple health problems.

Documentation /Chart Example

June 5, 2006 Met in Mrs. Smith's room at 10:00 a.m. Her daughter was present. Advised Mrs. Smith that too much insulin was given and we will monitor blood sugars hourly for 10 hours. Also advised that there should not be any lasting effect and apologized for discomfort of additional finger sticks. Patient stated understanding. She also stated, "I thought the amount looked bigger but I didn't want to question the nurse." I advised her that it is okay to question a medication if something doesn't look right.

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[4] The Sorry Works Coalition

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Additional References [5]

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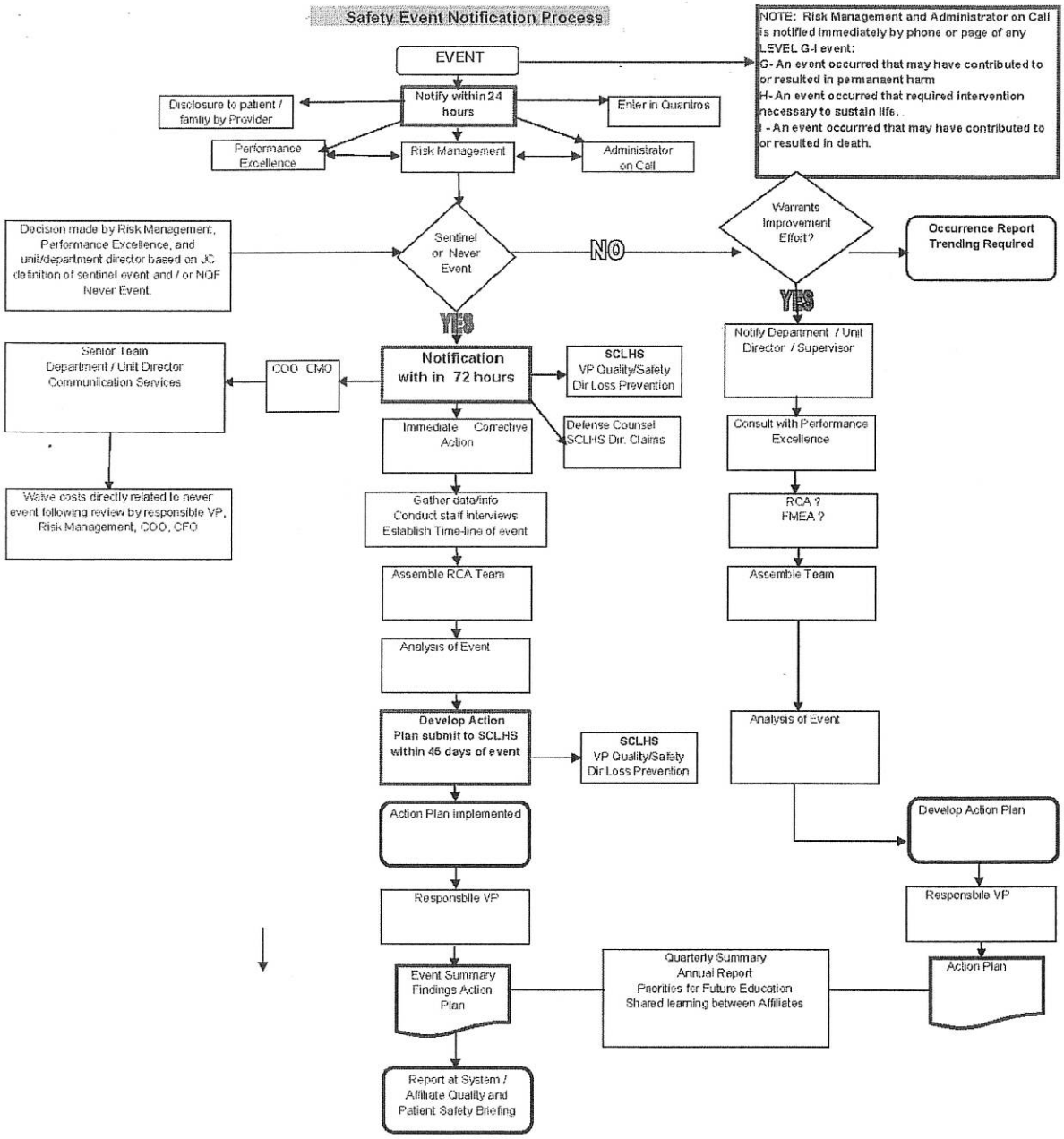
[5] **American Medical Association,** *Code of Medical Ethics* (2000-01 edition), "It is a fundamental ethical requirement that a physician should at all times deal honestly and openly with patients…Concern regarding legal liability which might result following truthful disclosure should not affect the physician's honesty with a patient."
2000 – 2001 Edition
American College of Physicians, *Ethics Manual* (4th edition), "In addition, physicians should disclose to patients information about procedural or judgment errors made in the course of care if such information is material to the patient's well-being. Errors do not necessarily constitute improper, negligent, or unethical behavior, but failure to disclose them may."
American Nurses Association, *Code of Ethics*, "In addition, when errors do occur, nurses are expected to follow institutional guidelines in reporting errors committed or observed to the appropriate supervisory personnel and for assuring responsible disclosure of errors to patients. Under no circumstances should the nurse participate in, or condone through silence, either an attempt to hide an error or a punitive response that serves only to fix blame rather than correct the conditions that led to the error."
JCAHO RI.1.2.2, "At a minimum, the patient, and when appropriate, the patient's family are informed about outcomes that the patient (or family) must be knowledgeable about in order to participate in current and future decisions affecting the patient's care and unanticipated outcomes of that care that relate to sentinel events considered reviewable by the Joint Commission. The licensed independent practitioner, or her/his designee informs the patient, (and when appropriate, the patient's family), about these outcomes of care."
Colorado Revised Statute 13-25-135 (2003) Evidence of admissions - civil proceedings - unanticipated outcomes - medical care. (1) In any civil action brought by an alleged victim of an unanticipated outcome of care, or in any arbitration proceedings related to such civil actions, any and all statements, affirmations, gestures, or conduct expressing apology, fault, sympathy, commiseration, condolence, compassion, or general sense of benevolence which as made by a healthcare provider or an employee of a health care provider to the alleged victim, a relative of the alleged victim, or a representative of the alleged victim and which relate to the discomfort, pain, suffering, injury, or death of the alleged victim as the result of the unanticipated outcome of medical care shall be inadmissible as evidence of an admission of liability or as evidenced of an admission against interest.
Montana Code Ann.26-1-814 (Mont. 2005) (1) A statement, affirmation, gesture, or conduct expressing apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence relating to the pain, suffering, or death of a person that is made to the person, the person's family, or a friend of the person or of the person's family is not admissible for any purpose in a civil action for medical malpractice. (2) As used in this section, the following definitions apply: (a) "Apology" means a communication that expresses regret. (b) "Benevolence" means a communication that conveys a sense of compassion or commiseration emanating from humane impulses. (c) "Communication" means a statement, writing, or gesture. (d) "Family" means the spouse, parent, spouse's parent, grandparent, stepmother, stepfather, child, grandchild, sibling, half-sibling, or adopted children of a parent of an injured party.
California Evidence Code 1160 (2000) (a) The portion of statements, writings, or benevolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering, or death of a person involved in an accident and made to that person or to the family of that person shall be inadmissible as evidence of an admission of liability in a civil action. A statement of fault, however, which is part of, or in addition to, any of the above shall not be inadmissible pursuant to this section.


Safety Event Notification Process
EVENT
NOTE: Risk Management and Administrator on Call is notified immediately by phone or page of any LEVEL G-I event:
G- An event occurred that may have contributed to or resulted in permanent harm
H- An event occurred that required intervention necessary to sustain life.
I - An event occurred that may have contributed to or resulted in death.
Notify within 24 hours
Disclosure to patient / family by Provider
Enter in Quantros
Performance Excellence
Risk Management
Administrator on Call
Decision made by Risk Management, Performance Excellence, and unit/department director based on JC definition of sentinel event and / or NQF Never Event
Sentinel or Never Event
NO
YES
Warrants Improvement Effort?
Occurrence Report Trending Required
Notify Department / Unit Director / Supervisor
Notification with in 72 hours
SCLHS VP Quality/Safety Dir Loss Prevention
Defense Counsel SCLHS Dir. Claims
COO CMO
Senior Team Department / Unit Director Communication Services
Waive costs directly related to never event following review by responsible VP, Risk Management, COO, CFO
Immediate Corrective Action
Gather data/info Conduct staff interviews Establish Time-line of event
Assemble RCA Team
Analysis of Event
Develop Action Plan submit to SCLHS within 45 days of event
SCLHS VP Quality/Safety Dir Loss Prevention
Action Plan implemented
Responsible VP
Consult with Performance Excellence
RCA ? FMEA ?
Assemble Team
Analysis of Event
Develop Action Plan
Responsible VP
Action Plan
Event Summary Findings Action Plan
Quarterly Summary Annual Report Priorities for Future Education Shared learning between Affiliates
Report at System / Affiliate Quality and Patient Safety Briefing

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Approved:

_____

William M. Murray, SCLHS President

Date:

2-18

PROTOCOL - DRAFT Revision 1 (10/14/08)

TITLE: Financial Response to Serious Adverse Events

SCOPE: All SCLHS Hospital Patient Care Staff, Medical Staff, Risk Management, Performance Excellence/Quality, Financial Services, Health Information Management, and Organizational Responsibility Officers.

PURPOSE: To clearly define the circumstances in which (Hospital Name) will not bill a patient or payer for the services due to or which resulted in or created a serious adverse event.

POLICY: SCLHS commits to open disclosure, apology, and the waiver of costs for the hospital based care directly associated with a serious adverse event. Charges not billed may be the total charges or a portion of the charges as deemed appropriate by the Serious Adverse Event Team. Communication with patients and families regarding a serious adverse event will be guided by the SCLHS Policy of Quality and Compassion.

REQUIREMENTS:

1. The first priority upon discovery of a potential serious adverse event is to ensure the safety and care of the patient and any others that may be at risk.
2. SCLHS Patient Care and Medical Staff are to notify Risk Management when they believe a serious adverse event has occurred.
3. Once Risk Management is notified of a potential serious adverse event they will coordinate the following activities:
   a. Secure Attorney-Client Privilege for the investigation and notify the SCLHS Claims Administrator of a Potentially Compensable Event.
   b. Place a hold on the bill by notifying Patient Accounts until the event is evaluated.
   c. Assure that communication occurs with the patient in accordance with SCLHS Policy of Quality and Compassion.
   d. Place a "Potential Serious Adverse Event Alert" form at the beginning of the physician progress notes to alert coding that a potential serious adverse event has been identified. This alert will instruct the coders to proceed with the coding process and inform the coders that Risk Management is aware situation.
   e. If during the coding process, a coder identifies a potential serious adverse event AND a "Potential Serious Adverse Event Alert" form is not present in the progress notes: the coder will immediately notify Risk Management as well as Patient Accounting. This step mitigates the possibility of releasing a bill for payment that may involve a serious adverse event not previously identified.
   f. Within 72 hours of discovery of a potential serious adverse, convene the Event Evaluation Team including representatives from Risk Management,

Performance Excellence/Quality, and the involved department to determine if a serious adverse event has occurred.

4. If the event is determined not to be a serious adverse event the designated team member shall:
   a. Assure that communication of the findings of the Serious Adverse Event Team occurs verbally and/or in writing to the patient/family as appropriate. (ref: SCLHS Policy of Quality and Compassion), and;
   b. Instruct Patient Accounts to release the bill.
   c. Assure that the event is recorded in the Quantros SRM database.
5. If the event is determined to be a serious adverse event:
   a. Convene the Serious Adverse Event Team, including members of the Event Evaluation Team, patient's care providers, and Patient Accounts to complete a needs assessment to determine what additional care is directly associated with the serious adverse event and how the associated charges will be handled.
   b. Refer a list of the charges that will be waived to Patient Accounting to be recorded in Lawson Account # - 41789 Serious Adverse Event Bill Adjustments.
   c. Notify employed physicians and other employed professional providers that they are required to waive costs directly related to a serious adverse event and their billing office shall not seek reimbursement from the patient, guarantor, or a third party provider.
   d. Notify contracted or privileged physicians and professional providers to recommend, as appropriate, that they waive costs directly related to a serious adverse event and not seek reimbursement from the patient, guarantor, or a third party provider.
   e. Communicate findings of the Serious Adverse Event Team verbally and in writing to the patient/family as appropriate. (ref: SCLHS Policy of Quality and Compassion)
   f. Assure that a Root Cause Analysis is completed in accordance with the SCLHS Patient Safety Plan.
   g. Assure that the event is recorded in the Quantros SRM database.

Thomas L. Bell
President

January 28, 2009

TO: Senate Judiciary Committee

FROM: Deborah Stern, Vice President Clinical Services & General Counsel

RE: Senate Bill 32 – Benevolent Acts by Health Care Providers

The Kansas Hospital Association appreciates the opportunity to testify regarding this important proposed legislation. The practice of medicine is both an art and a science and therefore the treatment of patients does not always proceed as planned. KHA strongly believes that voluntary offers of assistance or expressions of benevolence, fault, sympathy, apology, compassion and condolence including the waiver of charges for medical care provided, should be encouraged and should not be considered an admission of liability. Such conduct, statements, or activity should be particularly encouraged between health care providers, health care institutions, and patients experiencing an unintended outcome resulting from their medical care.

The movement to increase transparency is gaining favor as more and more regulatory and accreditation agencies are requiring health care providers and health care institutions to discuss the outcomes of their medical care and treatment with their patients, including unintended outcomes. Studies have shown such discussions foster improved communications and respect between provider and patient, promote quicker recovery by the patient, and reduce the incidence of claims and lawsuits arising out of such unintended outcomes.

For example, The Joint Commission, a national accreditation organization formerly known as the Joint Commission on the Accreditation of Hospitals and Healthcare Organizations, in its 2009 Accreditation Process Guide for Hospitals, Standard RI.01.02.01 asks the following: "Does the hospital inform the patient or surrogate decision-maker about unanticipated outcomes of care, treatment, and services that relate to sentinel events considered reviewable by The Joint Commission?" Sentinel events are defined as an unexpected occurrence involving death, or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function.

The Department of Veterans Affairs, a division of the Veterans Health Administration, issued *VHA Directive - 049* in October 27, 2005 and it reads as follows:

> Disclosure of adverse events to patients or their representatives is consistent with VHA core values of trust, respect, excellence, commitment, and compassion. Providers have an ethical obligation to be honest with their patients. Honestly

> discussing the difficult truth that an adverse event has occurred demonstrates respect for the patient, professionalism, and a commitment to improving care.
>
> Clinicians and organizational leaders must work together to ensure that appropriate disclosure to patients or their representatives is a routine part of the response to a harmful or potentially harmful adverse event.

One change to consider is to replace the words "unanticipated outcome" with the words "unintended outcome". The use of "unanticipated outcome" as defined in section 1 (b) (4) of SB 32 could be problematic as it relates to information provided for purposes of informed consent. For example, under the informed consent process, the physician may indicate to the patient that paralysis is a possibility following back surgery. Therefore, when the physician expresses condolence to her patient who is now paralyzed, counsel seeking to use the "I'm sorry" comment as evidence could argue that paralysis, due to being disclosed in the informed consent process, is not an "unanticipated outcome" and therefore is not restricted from disclosure to the jury.

In keeping with society's expectations that health care providers "do the right thing" and communicate openly and honestly with patients, KHA believes SB 32 should be enacted to promote such conduct, statements, or activity by limiting their admissibility as evidence of an admission of liability or as evidence of an admission against interest.

Thank you for your consideration of our comments.

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To: Senate Judiciary Committee

From: Dan Morin
Director of Government Affairs

Date: January 28, 2009

Subject: SB 32; expressions of sympathy or apology not construed as admission of liability in civil actions

The Kansas Medical Society appreciates the opportunity to appear today as you consider SB 32, which is a so-called "I'm Sorry" bill. The legislation would provide that oral or written statements of apology, fault, sympathy or condolences by a health care provider cannot be used as an admission of liability or as evidence of an admission against interest in a civil action. We support this legislation.

Unanticipated, adverse outcomes in health care happen, even when there has been no departure from the accepted standard of care. Highly trained, competent practitioners, working in excellent health care facilities, occasionally have patient care outcomes that are regrettable, for both patient and practitioner. In those situations, physicians and other health care providers often want to express their concern and sympathy to the patient and his or her family, but are reluctant to do so for fear of having such expressions used against them as an admission of liability in the event of litigation. This fear creates a very real obstacle to effective communication with patients at a time when they need it most.

Allowing physicians and other caregivers to express sympathy or regret over an unanticipated health care outcome will help patients and their families better understand what happened by creating an environment that promotes communication between patients and providers. Studies have shown that when patients and physicians have a relationship built on effective communication, it improves trust and reduces the risk of litigation. This is one concrete way promote better communication, which will be good for patients, and for their relationship with their providers.

Opponents will argue that not allowing a jury at trial to hear of a physician's expression of sympathy will keep critical evidence which proves wrongdoing or liability from them. However, if there is liability and fault due to negligence in the case, that will all be

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apparent from the medical records, testimony of experts, and deposition of providers involved. A physician's empathy and concern for the patient who has experienced an adverse outcome should not be a legal tool to be used against them in the event of any litigation. We should promote such communication because it will help patients deal with the questions and emotions associated with unanticipated health outcomes.

Thank you for the opportunity to provide these comments in support of SB 32. We urge you to report the bill favorably for passage.

Your rights. Our mission.
KANSAS ASSOCIATION FOR JUSTICE

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To: Senator Tim Owens, Chair
Members of the Senate Judiciary Committee

From: Larry Wall, Attorney at Law
Wichita, Kansas

Date: January 28, 2009

Re: SB 32 Admissions of Fault by Health Care Providers—OPPOSE; AMENDMENTS PROPOSED

The Kansas Association for Justice (KsAJ) is a statewide, nonprofit organization of Kansas attorneys. KsAJ appreciates the opportunity to testify on SB 32. Our position on SB 32 as currently drafted is opposed. However, we respectfully propose amendments addressing the bill's flaws for the committee's consideration.

SB 32 changes the rules of evidence, which are procedural rules that apply to all parties during a trial that help juries determine the truth in a dispute. SB 32 creates a special exception to the rules of evidence for health care providers.

The rules of evidence promote truth by spelling out what information may be provided to a jury, when and how it may be provided, and the purpose for which it is provided. The rules of evidence are important because they ensure that each party is given the same opportunity to present their case and that the trier of fact relies on truthful evidence—evidence that demonstrates a provable fact and is not without basis.

Typically, if there is evidence that the defendant admitted fault, the jury can to told about the admission and consider it when determining liability. For example, a statement by a driver who got out of his car and said to the person he collided with, "I didn't see the stop sign," would be admissible on the issue of whether he ran through the stop sign without stopping. If SB 32 passes, this rule would no longer apply to a health care provider who admits to a patient that he/she was at fault for the injuries the patient has suffered.

Policy Question. Would an exception for health care providers in the rules of evidence promote or conceal truth?

When a medical error results in serious injury or death, it would be a rather unusual occurrence if one or more of the health care providers involved did not express

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Attachment 5

sympathy for the loss. It may be expressed as simply as a statement such as "I'm sorry." In some cases the loss is recognized to be so devastating that the provider determines that the patient or his family should not be burdened with a medical bill.

Only the most cynical would chose to believe that a doctor is not being truthful when he or she tells the patient or his family, "I am sorry for your loss. You have my sympathy." However, both of these statements can be misconstrued in a courtroom, which is why such expressions are generally not introduced as evidence. "I'm sorry," may be interpreted to mean either, "I feel sorry for you because I know you are suffering." Or, it could be interpreted to mean, "I'm sorry I caused you harm." The waiver of a bill may be interpreted to be a truly benevolent act, or as an admission that the provider committed a wrong.

But if SB 32 passes as written, the new law may be enforced in such a way that crucial, relevant and truthful evidence is eliminated even though it has nothing to do with an expression of sympathy. At the same time, the jury could hear evidence of self-serving statements not made with true compassion or statements that are intentionally deceptive, which will skew the jury's ability to determine the truth.

- In SB 32, Section 1(a), the word "fault" is included. If interpreted literally, it could mean that the jury could not hear evidence of truthful statements expressing fault. For example, assume a medical provider writes in the medical record that a baby was "administered 750 units per kilogram bolus of heparin," a lethal dose which resulted in the baby's death. Such written statement expresses truth but because it also is a statement of fault, it could potentially be kept from the jury.

- Under SB 32, a health care provider would be allowed to testify that they apologized to the patient, but the patient would not be allowed to introduce this very same evidence.

- Under SB 32, the patient could not introduce into evidence statements of fault made by a highly trained health care provider to demonstrate the provider's liability. However, the health care professional would still be allowed to introduce statements of fault made by the patient, a lay person, that demonstrate the patient's liability.

- SB 32 as drafted protects intentionally deceptive statements. Under SB 32, a health care provider who previously admitted fault to a patient may later deny fault at trial without fear of being confronted. Evidence of the contradictory previous statement could not be given to the jury since it would show liability.

- SB 32 makes an end-run around the long-standing exception to the rule of evidence prohibiting hearsay known as "res gestae." Under res gestae,

statements made in the heat of the moment are admissible and deemed to be credible because they are made spontaneously and without consideration of the speaker's self-interest. However, to the extent that the speaker is not a defendant, SB 32 negates res gestae because apologies or statements of fault which that would have otherwise been admissible as res gestae will no longer be admissible.

- SB 32 may also present questions of due process. Creating an exception in the rules of evidence will do very little to improve the practice of medicine . Instead, SB 32 unfairly and disproportionately deprives plaintiffs' of credible and relevant information on their case. It is important to note that there are few medical malpractice cases in Kansas. According to the Health Care Stabilization Fund's December 2008 report to a legislative oversight committee, there were 34 medical malpractice cases involving 41 Kansas health care providers decided as a result of a jury trial in the fiscal year ending June 30, 2008. Of these 34 cases, only five resulted in damages awarded to plaintiffs and only three resulted in Stabilization Fund obligations. Compensation awarded in those three cases resulted in Stabilization Fund obligations amounting to $1,732,504. Given these statistics, there is very little correlation between changing the rules of evidence and the practice of medicine, except that it will make it harder for patients with legitimate claims to prove their case.

- A final consideration is the vast scope of the current laws that already protect health care providers and whether additional laws are needed. For example, peer review statutes make reviews and critiques of physicians by other physicians completely confidential and not subject to discovery, even by the patient whose case is the subject of review. Even if a peer review process deems that a provider made a mistake or provided less-than-appropriate care, the peer review finding is not revealed and cannot be the basis of a patient's claims.

Committee Options. The following are options for the Committee's consideration.

Option 1. Make no changes to the current rules of evidence and do not pass SB 32. As previously noted, statements of sympathy and apology are not typically introduced into evidence because they can be misconstrued. But when there is evidence of liability in the form of an admission of fault, currently the jury can consider it as part of its determination of truth. The current rules of evidence apply to all disputes, regardless of whether they relate to an auto accident or medical liability or any other type of criminal or civil liability. Currently there are no special exceptions for certain professions or classes of person in the rules of evidence; creating exceptions is unfair, unnecessary, and offensive to justice.

Option 2. Amend the bill to more narrowly tailor its effect. As drafted, SB 32 could potentially eliminate evidence that is truthful, relevant, and crucial to the jury's determination of truth involving a patient and health care provider. It could also encourage intentionally deceptive statements. To assure that the bill is fair and to reduce the likelihood of unintended consequences, SB 32 could be amended as outlined in the attached balloon amendment and below:

- If the rules of evidence are changed to create an exception for health care providers, the exception should not be so broad as to allow relevant and truthful evidence of an admission of fault to be concealed from the jury, or to protect intentionally deceptive statements. We are aware of no other segment of our society that is permitted to hide an admission of fault, and it would be extraordinary to give such a privilege to health care providers. Amendment: delete the word "fault" in line 17.

- Maintaining a level playing field requires making evidence of all expressions of sympathy inadmissible. Fairness is not served if health care providers can introduce evidence showing their benevolence, but patients cannot introduce the same evidence to show liability. If expressions of apology are inadmissible to prove liability, they should be made completely inadmissible for all other reasons, by both the health care provider and the patient. Amendment: beginning in line 22, delete "as evidence of an admission of liability or as evidence of an admission against interest".

- "Unanticipated outcome" is meaningless and perhaps unconstitutional because of its vagueness. Amendment: in line 22, delete "as the result of the unanticipated outcome of medical care", and add "in a civil action for medical negligence" after "admissible in line 22. Delete the definition of "unanticipated outcome" in lines 35 and 36.

- The definition of "relative" includes anyone with a "family-type relationship with a patient." This definition is broad and vague and potentially unconstitutional because it applies to nearly anyone who might hear an admission from a medical provider. Amendment: in line 30, insert a "." after adoption and delete the remaining language through line 31.

Several states have passed laws which preclude true statements of sympathy from being admitted. Attached is a copy of Oklahoma's law as well as a copy of the February 12, 2007, policy adopted by the American Bar Association in support of legislation providing for the inadmissibility of evidence of expressions of sympathy or benevolent acts. These examples demonstrate by comparison the broad and vague language in SB 32.

Option 3. Adopt the bill without amendment. The bill as currently drafted is not sound public policy and is not consistent with the ABA recommendation or similar laws in other states.

Recommendation of the Kansas Association for Justice: Do not pass SB 32, or amend the bill as recommended. The Senate Judiciary Committee must determine if creating a special exception in the rules of evidence for health care providers is consistent with truth and fairness. If SB 32 is passed, it must include amendments to carefully tailor its effect or it is likely that relevant and truthful evidence will be excluded from the consideration of the jury and intentionally deceptive statements will be permitted and encouraged.

To assure fairness to all parties in a medical malpractice dispute, we respectfully request that SB 32 be amended as suggested or not passed. We appreciate the opportunity to provide you with our testimony on SB 32.

Kansas Association for Justice
Proposed Amendments
Senate Judiciary Committee Hearing
January 28, 2009

Session of 2009

SENATE BILL No. 32

By Committee on Public Health and Welfare

1-15

AN ACT concerning evidence in civil actions; expression of apology, sympathy, compassion or benevolent acts by health care providers not admissible as evidence of an admission of liability or as evidence of an admission against interest.

Be it enacted by the Legislature of the State of Kansas:

Section 1. (a) No oral or written statements or notations, affirmations, gestures, conduct or benevolent acts including waiver of charges for medical care provided, expressing apology, ~~fault,~~ sympathy, commiseration, condolence or compassion which are made by a health care provider or an employee of a health care provider to a patient, a relative of the patient or a representative of the patient and which relate to the discomfort, pain, suffering, injury or death of the patient ~~as the result of the unanticipated outcome of medical care~~ shall be admissible ~~as evidence of an admission of liability or as evidence of an admission against interest.~~ *in a civil action for medical negligence.*

(b) As used in this section:

(1) "Health care provider" has the meaning prescribed in K.S.A. 65-4915, and amendments thereto.

(2) "Relative" means a patient's spouse, parent, grandparent, stepfather, stepmother, child, grandchild, brother, sister, half-brother, half-sister or spouse's parents. The term includes such relationships that are created as a result of adoption ~~and any person who has a family-type relationship with a patient~~.

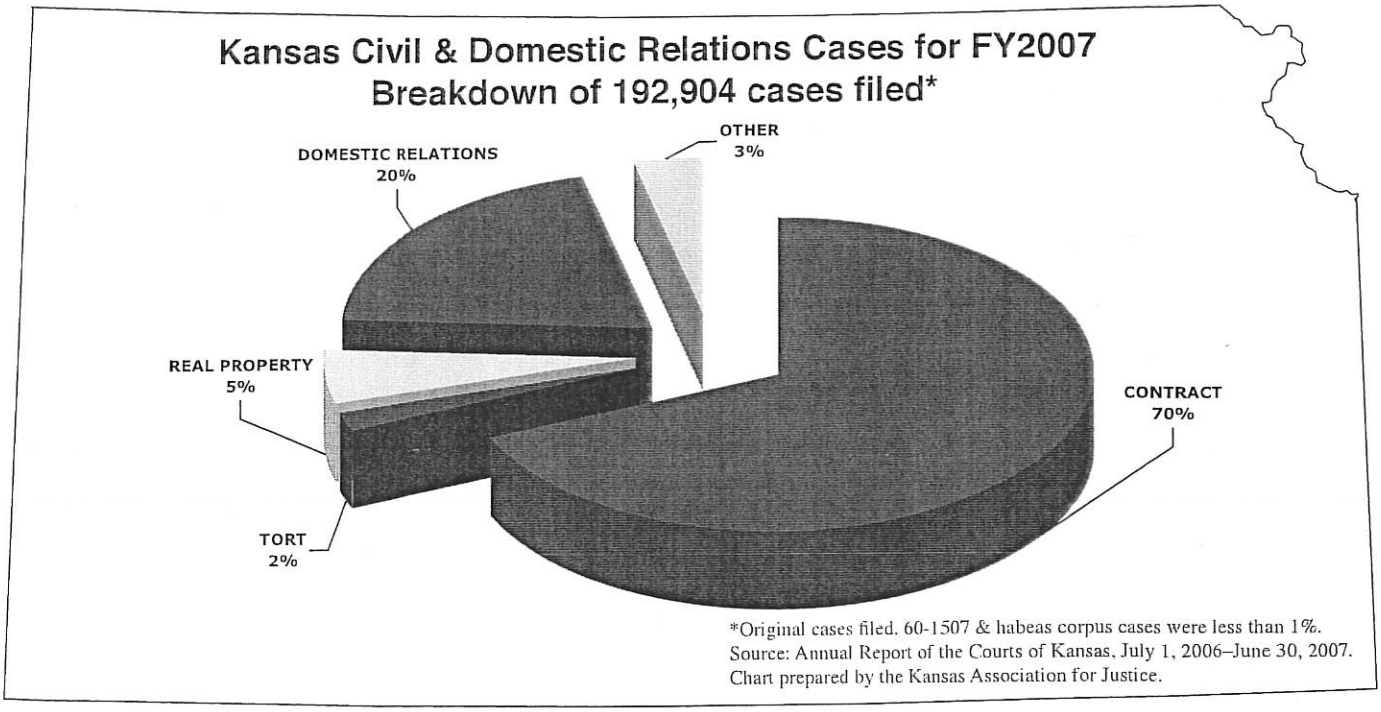
(3) "Representative" means a legal guardian, attorney, person designated to make decisions on behalf of a patient under a medical power of attorney or any person recognized in law or custom as a patient's agent.

~~(4) "Unanticipated outcome" means the outcome that differs from the anticipated outcome of a treatment or procedure.~~

Sec. 2. This act shall take effect and be in force from and after its publication in the statute book.

There is no "litigation crisis" in Kansas

Only 2% of cases filed in Kansas are torts.



*Original cases filed. 60-1507 & habeas corpus cases were less than 1%.
Source: Annual Report of the Courts of Kansas, July 1, 2006–June 30, 2007.
Chart prepared by the Kansas Association for Justice.

By the Numbers...

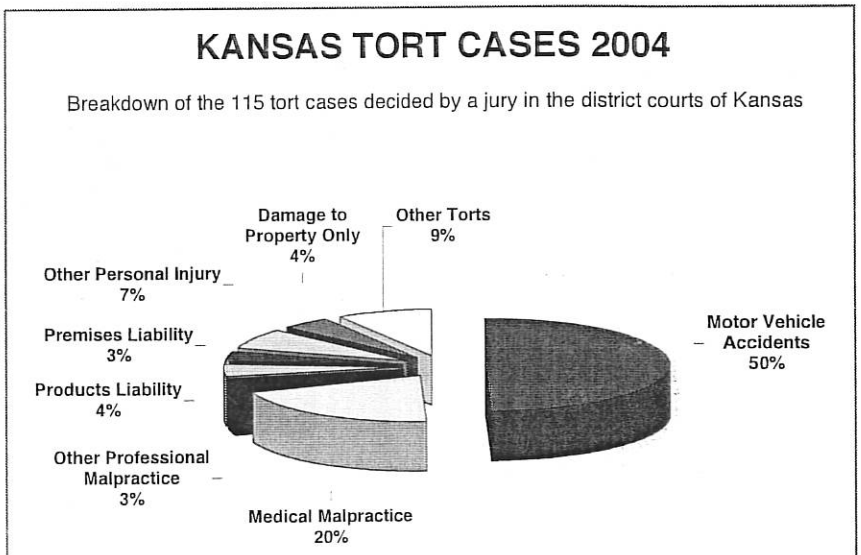
2% of cases filed in FY2005 were torts, or personal injury cases.

115 tort cases were decided by Kansas juries in 2004, down from 135 cases in 2001.

50% of all tort cases decided by juries in 2004 involved auto accidents.

5 cases included punitive damages in 2004.

$18,757 was the median award in 2004 was, down from $23,416 in 2003.



Source: Jury Verdicts in Tort Cases, Jan. 1, 2004–Dec. 31, 2004, Office of Judicial Administration. Chart prepared by the Kansas Associataion for Justice.

Oklahoma

§63-1-1708.1H. Statements, conduct, etc. expressing apology, sympathy, etc. - Admissibility - Definitions.

A. In any medical liability action, any and all statements, affirmations, gestures, or conduct expressing apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence which are made by a health care provider or an employee of a health care provider to the plaintiff, a relative of the plaintiff, or a representative of the plaintiff and which relate solely to discomfort, pain, suffering, injury, or death as the result of the unanticipated outcome of the medical care shall be inadmissible as evidence of an admission of liability or as evidence of an admission against interest.

B. For purposes of this section, unless context otherwise requires, "relative" means a spouse, parent, grandparent, stepfather, child, grandchild, brother, sister, half-brother, half-sister or spouse's parents. The term includes said relationships that are created as a result of adoption. "Representative" means a legal guardian, attorney, person designated to make decisions on behalf of a patient under a durable power of attorney or health care proxy, or any person recognized in law or custom as an agent for the plaintiff.

Added by Laws 2004, c. 368, § 23, eff. Nov. 1, 2004.

Comment [1]: BDERIV

Comment [2]: EDERIV

AMERICAN BAR ASSOCIATION

ADOPTED BY THE HOUSE OF DELEGATES
February 12, 2007

RECOMMENDATION

RESOLVED, That the American Bar Association supports enactment of state and territorial legislation that provides that all statements, affirmations, gestures, or conduct expressing apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence which relate only to the pain, suffering, or death of a person which are made by a medical provider or the staff of a medical provider to that person, that person's family, representative or friend, as the result of the unanticipated outcome of medical care, shall be inadmissible as evidence of an admission of liability or as evidence of an admission against interest for any purpose in a civil action for medical negligence.

Polsinelli

Shalton | Flanigan | Suelthaus PC

Memorandum

TO: THE HONORABLE TIM OWEN, CHAIR
SENATE JUDICIARY COMMITTEE

FROM: WILLIAM W. SNEED, RETAINED COUNSEL
UNIVERSITY OF KANSAS HOSPITAL AUTHORITY

RE: S.B. 32

DATE: JANUARY 28, 2009

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I represent the University of Kansas Hospital Authority. This is the Authority that the Kansas Legislature created to run and operate the hospital commonly referred to as KU Med. We appear here today in support of S.B. 32.

Along with the other specifics offered by the proponents of this bill, we contend that open communication is one of the most essential components between a patient and the health care provider. An upfront apology or expression of sympathy can relieve anger and frustration and reduce the level of emotion.

Finally, by encouraging honest, open communication, bills like S.B. 32 facilitate the continuation of the patient-health care provider relationship following an adverse event.

Based upon the foregoing, we would respectfully request your favorable action on S.B. 32. I would be happy to respond to questions.

Respectfully submitted,

William W. Sneed

WWS:kjb

555 Kansas Avenue, Suite 101
Topeka, K
Telephone: (
Facsimile: (

Senate Judiciary
1-28-09
Attachment 6

KANSAS ASSOCIATION OF DEFENSE COUNSEL
825 S Kansas Avenue - Suite 500, Topeka, KS 66612
Telephone: 785-232-9091 FAX: 785-233-2206 www.kadc.org

MEMORANDUM

TO: **The Honorable Tim Owens**
Senate Judiciary Committee

FROM: **Anne M. Kindling**
Past President, Kansas Association of Defense Counsel

DATE: **January 28, 2009**

RE: SB 32

Chairman Owens and Members of the Committee:

My name is Anne Kindling and I submit this written testimony in support of SB 32 on behalf of the Kansas Association of Defense Counsel. The KADC consists of more than 220 practicing attorneys who devote a substantial portion of their professional time to the defense of civil lawsuits, including the representation of hospitals, physicians, and other health care providers throughout the state.

SB 32 will facilitate communication between health care providers and patients and family members regarding outcomes of care, including unanticipated or adverse outcomes. It may reduce the occurrence of lawsuits, but it will not eliminate a legal remedy for patients injured due to the negligence of a health care provider, as discussed below.

In today's era of medical care, complicated but life-saving procedures are regularly performed for conditions which just a few decades ago meant early death. Prevention, early diagnosis, and intervention are the norm. With advances in medicine, however, expectations for optimal results – indeed, perfect results – are often high. Of course, health care providers are human. They have the same emotions as the rest of us, including sympathy, empathy, and compassion. They care about the patients they treat. They are also not perfect, and they cannot always obtain perfect results. They even sometimes make mistakes. Sometimes less than optimal results are obtained, and unanticipated or adverse outcomes can occur. Such outcomes can occur even in the absence of negligence or fault of the provider.

As an attorney in private practice representing health care providers in medical malpractice lawsuits for over 11 years, and in my current employment in the Risk Management Department of a hospital, I have seen first-hand the value of communication between health care providers and patients/family members. I have attended, and given, numerous presentations addressing why patients sue health care providers, and among the top reasons that lawsuits are filed is a breakdown in communication between the provider and his or her patient about the outcomes of care. Patients want to know why unanticipated outcomes occurred, whether the outcome was avoidable, and what is being done to prevent it in the future. They want an apology when mistakes are made. Adjustment of bills goes hand-in-hand with this. Patients who do not feel they received adequate explanations, or who do not feel the provider has taken responsibility for the outcome, are more likely to file a lawsuit; this often occurs because the patient is angry, even if the outcome was not the result of negligence. Lawsuits are less likely to be filed, on the other hand, when there is a free exchange of information about the care provided, including complications, and expressions of sympathy and compassion.

Certainly, full discussion of outcomes of care is right and ethical. Since 2001, any health care facility that is accredited by The Joint Commission is required to have a policy in place for discussions of unanticipated outcomes. The open discussion of outcomes of care goes beyond unanticipated or adverse outcomes, however. Patients deserv frank conversations about their medical care, regardless of whether the outcome was expected or unexpected.

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Unfortunately, my experience has also shown that sometimes health care providers are hesitant to engage in discussions or expressions of sympathy or compassion for fear of such expressions being construed as an admission of fault or being used against them in a lawsuit. Providers are wary of the ramifications of such expressions in potential litigation, even if they agree that it is the right and ethical thing to do.

SB 32 would facilitate the open discussion of unexpected outcomes by removing the barrier that arises when providers fear such conversations will be used against the provider if a lawsuit is filed. The bill prevents such discussions, or write-off of bills, from being used as admissions against interest or admissions of liability. Providers would be free to show compassion, even apologize, and freely communicate with their patients when the "perfect" result the patient (and provider) expected does not occur. Frank discussions, and apologies where appropriate, helps eliminate anger in patients, can assure patients that the provider has learned from the experience, can help prevent such events from happening again – and may reduce the occurrence of lawsuits.

SB 32 does not stand alone in preventing a potential defendant's actions from being construed as evidence of negligence while facilitating the goals of making reparations and of learning from past events to help avoid future injury. K.S.A. 60-451 prevents subsequent remedial measures from being used to prove negligence. Similarly, K.S.A. 60-452 states that offers to compromise are not admissible to prove liability. The evidentiary protection afforded by SB 32 is no different.

Notably, SB 32 will not eliminate legal remedies for patients who suffer adverse outcomes as a result of the negligence of a heath care provider. SB 32 does not preclude a patient or family from filing suit, and it does not change the elements or type of evidence required to prove such claims or the burden of proof. A provider cannot escape liability and prevent a plaintiff's recovery simply by apologizing. A claim of medical malpractice will proceed just as it always has, with the testimony of qualified expert witnesses to assist the jury in determining negligence or fault.

Frank communication between health care providers and patients improves patient care, improves patient satisfaction, and *may* reduce the occurrence of lawsuits. SB 32 allows providers to be human and show compassion, and it facilitates frank communication with patients without fear of ramifications in a potential lawsuit, while still preserving all of the remedies available to a patient injured due to the negligence of a health care provider.

KADC respectfully urges this Committee to pass SB 32 favorably.

Testimony in Support of SB 69
Senate Judiciary Committee
January 28, 2009
Terry Symonds

Chairman Tim Owens and Members of the Committee,

Crime Stoppers is based on the principal that "Someone other than the criminal has information that can solve a crime" and was created to combat the three major problems faced by law enforcement in generating that information:

Fear of REPRISAL
An attitude of APATHY
Reluctance to get INVOLVED

Crime Stoppers resolves these problems by:

Offering ANONYMITY to people who provide information about crimes.
Paying REWARDS when the information supplied leads to an arrest.

Crime Stoppers is a partnership of the community, the media and law enforcement. Concerned citizens form the non-profit corporation, provide the rewards and oversee the program. The media regularly publicizes the unsolved crimes and citizens are requested to call in anonymous tips which are provided to law enforcement to investigate. If the tip leads to an arrest the caller may be eligible for a cash reward of up to a $1,000. The cooperation and involvement of each partner is crucial for the success of the Crime Stoppers program.

Local Crime Stoppers programs rely on individuals and businesses in their community to donate funds to the program to cover rewards and limited operating costs. There is a volunteer board of directors to oversee the program and the local law enforcement supplies a coordinator who oversees the day-to-day operations and the anonymous tips that are received.

Currently there are approximately 32 local Crime Stoppers programs within the State of Kansas. Crime Stoppers programs in Kansas have recovered over 15 million dollars in drugs and stolen property, paid out one million dollars in rewards, and helped law enforcement clear over 10,000 cases.

In 1987, local Kansas Crime Stoppers programs came together to form the Kansas Crime Stoppers Association, Inc (KCSA). The primary goal of KCSA is to substantially reduce criminal activity in Kansas through the development of community Crime Stoppers programs.

The KCSA is a nonprofit corporation organized to promote and encourage Crime Stoppers programs in the State of Kansas by serving as a functional and constitutive resource to law enforcement and community groups for program development and training. The objectives of the association are:

To provide a vehicle for the communication of information on Crime Stoppers programs, projects and techniques, between participating agencies and groups.

To develop or assist in the development of Crime Stoppers programs and projects that have both statewide and local applicability and impact.

To recommend or provide Crime Stoppers instruction upon request and assist in program implementation and uniformity.

To establish meetings to share information as it relates to Crime Stoppers activities.

To obtain funding to accomplish these goals.

The problems that have developed with the objectives of KCSA in assisting the local programs have been:

Poor communication between the state board and local programs when local volunteer board members change frequently and contacts are lost to the KCSA.

Inability to provide hands on assistance to a community that would like to start a program, and lack of funding to assist in their start up.

Inability to establish a required minimum standard for Crime Stopper programs in Kansas.

Affordability of attending the KCSA annual training conference for the smaller programs.

The goal of SB 69 is to substantially assist in reducing criminal activity in Kansas through the development and support of community Crime Stoppers programs.

I believe that this bill will provide the solutions to the problems that have faced the KCSA and local programs. The intent of SB 69 is to establish an Advisory Council within the Attorney General's Office and create a State Coordinator/Executive Director position to work on their behalf.

The Advisory Council's duties will be:

(1) Set the authority and duties of the State Coordinator/Executive Director position.

(2) Set minimum standards for state certification of Crime Stoppers programs in Kansas.

(3) Create a Crime Stoppers Trust Fund.

(4) Create a method of funding the Crime Stoppers Trust Fund.

(5) Partner with the Attorney General to oversee the following expenses:

(a) Cost of the Coordinator's position

(b) Providing registration-free annual training for local programs

(c)Assisting with the development of new community programs to include $1,000 in start up reward funds, a computer, and access to Crime Stoppers database.

(d) Funds to grant back to the programs that meet the state certification.

(7) Protection Crime Stoppers records concerning reports of criminal acts.

As a 26-year veteran of law enforcement, past President of the KCSA, and the current Coordinator for Crime Stoppers of Topeka, Inc., I would like to respectfully ask that consideration be given to Senate Bill 69.

Recommended change to Section 1 subsection (c)(3) located on page 1, lines 24-25.

(3) meets and maintains certification standards as ~~set forth by the Kansas crime stoppers association, inc.~~ established and approved by the association and by the council.

Associated change to Section 4, subsection (b) on page 2, lines 42-43:

The local crime stoppers program from each county that meets the ~~required certification set forth by the association~~ *requirements of section 1, subsection (a)* may make application to

Recommended change to Section 2 subsection (a) located on page 1, lines 26-29.

Replace the entire subsection (a) with:

(a) There is hereby created within the attorney general's office the crime stoppers advisory council. The council shall be composed of seven members which shall include:

(1) a sheriff to be selected by the attorney general who shall consider, but not be limited to, a list of three nominees submitted therefor by the Kansas sheriffs' association;

(2) a chief of police to be selected by the attorney general who shall consider, but not be limited to, a list of three nominees submitted therefor by the Kansas association of chiefs of police; and

(3) five directors of the Kansas crime stoppers association, of which not more than one may be a law enforcement officer, appointed by the association.

NOTE: The language in (1) and (2) replicates the language in K.S.A. 74-5606 creating the commission on peace officer standards and training.

Kansas Peace Officers' Association

INCORPORATED
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P.O. BOX 2592 • WICHITA, KANSAS 67201

Testimony to the Senate Judiciary Committee
In Support of SB 69
Crime Stoppers Advisory Council and Trust Fund

January 28, 2009

Chairman Owens and Committee members,

The Kansas Peace Officers Association supports the general concept of this bill. We believe the development of a state advisory council and trust fund with the purpose of improving training and assistance to local crime stoppers programs can enhance and expand this proven crime solving tool in Kansas.

Crime Stoppers tips have brought suspects to the forefront of criminal investigations more quickly, helped law enforcement identify suspects not previously known, and saved valuable investigative time by focusing more quickly on productive case leads. It has proved valuable in developing leads in crimes involving gangs, drug trafficking and other crimes where witness intimidation and fear is common.

One area of the bill which we don't have adequate information to evaluate yet is the funding. The source seems to make sense. But we do not have adequate information to form an opinion on the dollar amount at this time.

While we support the bill in concept, we also have several concerns:

1. We believe consideration should be given to provide assurance of including law enforcement representation on the proposed council. We recognize that most, if not all, crime stoppers programs include some minimal law enforcement representation at the local level. The inclusion of law enforcement on the council becomes more important when one considers the proposed authorization to develop regulations and certification standards potentially impacting this investigative lead developing tool. We recognize local crime stoppers programs are independent non-law enforcement entities and we are not suggesting law enforcement should represent the majority of the Council. This can be accomplished by applying similar language to that used in K.S.A. 74-5606 governing the KS-CPOST appointments made by the governor. That language would provide the Attorney General's appointees consist of a Kansas chief of police after considering recommendations from the Kansas Association of

Senate Judiciary
1-28-09
Attachment 9

Chiefs of Police and a Kansas Sheriff after considering recommendations from the Kansas Sheriff's Association.

2. We also believe the number of Council members should be fixed by statute so the number is not later altered by a change in the make up of the executive committee of the Kansas Crime Stoppers Association. This can be accomplished by adding "five members of" after the word "and" in page 1, line 28. The association's current executive committee consists of the five elected officers of the board.
3. We are also concerned that the certification requirements should be set by the Crime Stoppers Advisory Council and not solely by the Kansas Crime Stoppers Association. This can be accomplished by changing the word "association" to "council" on Page 2, line 43. Or in the alternative change the language to reflect approval by both groups.
4. The term "executive board of directors of the association" found on page 1, lines 28 and 29 appears to be ambiguous. The by-laws of the Kansas Crime Stoppers Association uses the term "Executive Committee." Therefore, for the bill to be clear, we suggest adding the words "committee of the" after the word "executive" on page 1, line 28.

We have conferred with the requestors of this bill about our concerns and are working together to address them.

Ed Klumpp
Legislative Committee Chair
eklumpp@cox.net
Phone: (785) 640-1102

State of Kansas

Office of Judicial Administration

Kansas Judicial Center
301 SW 10th
Topeka, Kansas 66612-1507 (785) 296-2256

Senate Judiciary Committee
Wednesday, January 28, 2009

Neutral Testimony Concerning SB 69

Kathy Porter

Senate Bill 69 establishes the Kansas Crime Stopper Advisory Council within the Attorney General's office and would create the Kansas Crime Stopper Trust Fund. Under Section 4, in addition to the fees provided by K.S.A. 21-4610a and 22-2909, each person who is placed on probation, is assigned to a community correctional services program, or enters into a diversion agreement in lieu of further criminal proceedings shall pay a fee of $20. Such fee shall be charged and collected by the clerk of the district court. The clerk of the district court shall remit to the State Treasurer, in accordance with the provisions of K.S.A. 75-4215, the balance of all moneys received by such clerk from such fees. Upon receipt of the remittance, the State Treasurer shall deposit the entire amount in the state treasury and credit it to the Kansas Crime Stopper Trust Fund.

The clerk of each county shall maintain an accounting of the number of fees received pursuant to this section from persons who were placed on probation, were assigned to a community correctional services program, or entered into a diversion agreement in lieu of further criminal proceedings in such county and shall report that number to the council.

If passed, SB 69 will increase the duties of the clerks of the district court as they will be required to charge, collect, and account for the $20 fee, on behalf of and to the credit of the Crime Stoppers Council. Senate Bill 69 also requires that FullCourt, the Judicial Branch case management system, be reprogrammed in order to separately account for the fee. We anticipate the reprogramming cost to be $5,000, at a minimum. If the normal percentage split process used to distribute fines (contained in K.S.A. 2008 Supp. 74-7336, which is included as Attachment A) were used, no reprogramming cost would be incurred and the accounting required by Section 4 of the bill would not be needed. However, we understand that it is difficult to estimate with any degree of certainty how much revenue this bill would generate, and that the bill contemplates that the amount generated by each county be returned to that county. Therefore, the reprogramming and the accounting are needed.

If this bill were enacted, the Office of Judicial Administration would request an amendment regarding the mechanics of the collection process, which is included as a balloon amendment in Attachment B. The amendment would simply amend Section 4(b) to require an accounting of the **amount** collected, rather than the **number** of fees received. The number of

fees received would not appear to be relevant to administration of the fund and reimbursing the counties, particularly given the fact that partial payments frequently occur.

An additional amendment along these lines would appear to be necessary. Section 4 directs payment of the $20 to the clerk of the district court in all instances. However, persons who enter into a diversion agreement pay all fees to the county or district attorney, who then should remit the amount of the docket fee to the clerk of the district court. It would appear best to have the county and district attorneys follow this same model and collect the $20, which they would then remit to the clerk, together with the docket fee, and the clerks of the district court would take care of the rest. A second option would be to have the county or district attorneys remit to the state treasurer the $20 fees they receive and provide a separate accounting. Because a choice is required, no balloon amendment is attached.

Upon review of the Judicial Branch's FY 2008 probation data, a total of 13,794 individuals were placed on probation. If one assumes that each of these individuals paid, in full, the $20 fee proposed in SB 69, Section 4, an estimated $275,880 would be credited to the Council. Please note that these figures include only persons on probation with court services officers, and do not include individuals on probation in community corrections programs, who would also be required to pay the fee under the provisions of this bill.

The Judicial Branch's FY 2008 statistics on diversions indicate that a total of 23,084 persons entered into a diversion agreement. Of those 23,084 people, 19,433 were placed on diversion due to a traffic offense, 2,705 were placed on diversion because of a misdemeanor offense, and 946 persons were placed on diversion due to a felony offense. If one assumes that each of these 23,084 individuals paid, in full, the $20 fee, an estimated $461,680 would be credited to the Council.

Please also note that a majority of the persons required to pay the $20 fee will likely have other items they also need to pay, including restitution, docket fees, and Board of Indigents Defense Services fees. In many criminal cases, payment in full of all of these fees occurs years after conviction, if at all. This will, of course, impact the amount to be collected. Attachment C is a page from the 2008 Kansas Sentencing Commission Journal Entry of Judgment. Section V lists a number of the statutory fines and fees that may be imposed, together with restitution, in criminal cases. Not specifically noted on the form are other expenses that may be paid by criminal defendants, such as the cost of substance abuse treatment, testing, education, and other items.

Thank you for the opportunity to testify, and I would be happy to stand for any questions.

74-7336. Disposition of district court fines, penalties and forfeitures. (a) Of the remittances of fines, penalties and forfeitures received from clerks of the district court, at least monthly, the state treasurer shall credit:

(1) 11.99% to the crime victims compensation fund;

(2) 2.45% to the crime victims assistance fund;

(3) 3.01% to the community alcoholism and intoxication programs fund;

(4) 2.01% to the department of corrections alcohol and drug abuse treatment fund;

(5) 0.17% to the boating fee fund;

(6) 0.12% to the children's advocacy center fund;

(7) 2.50% to the EMS revolving fund;

(8) 2.50% to the trauma fund;

(9) 2.50% to the traffic records enhancement fund; and

(10) the remainder of the remittances to the state general fund.

(b) The county treasurer shall deposit grant moneys as provided in subsection (a), from the crime victims assistance fund, to the credit of a special fund created for use by the county or district attorney in establishing and maintaining programs to aid witnesses and victims of crime.

History: L. 1989, ch. 239, § 31; L. 1995, ch. 243, § 8; L. 2001, ch. 200, § 18; L. 2001, ch. 211, § 17; L. 2004, ch. 125, § 6; L. 2006, ch. 85, § 17; L. 2007, ch. 140, § 17; L. 2007, ch. 195, § 40; July 1.

Revisor's Note:

Section was also amended by L. 2007, ch. 95, § 16, but that version was repealed by L. 2007, ch. 195, § 59.

Session of 2009

SENATE BILL No. 69

By Committee on Judiciary

1-22

AN ACT concerning crime stoppers; establishing an advisory council; imposing certain fees; providing for certain grants; creating the Kansas crime stopper trust fund.

Be it enacted by the Legislature of the State of Kansas:

Section 1. As used in this act:

(a) "Association" means Kansas crime stoppers association, inc.

(b) "Council" means the crime stoppers advisory council.

(c) "Local crime stoppers program" means the acceptance and spending of donations by a private, nonprofit organization for the awarding of rewards to persons who report information concerning criminal activity to the organization if the organization:

(1) Operates less than statewide;

(2) forwards reported information to the appropriate law enforcement agency; and

(3) meets and maintains certification standards as set forth by the Kansas crime stoppers association, inc.

Sec. 2. (a) There is hereby created within the attorney general's office the crime stoppers advisory council. The council shall be composed of two persons appointed by the attorney general and the executive board of directors of the association, as set forth in the by-laws of the association.

(b) At the first meeting of the council, which shall be called by the attorney general, and at the first meeting after the beginning of each new state fiscal year, the council shall elect from among its members a chairperson and such other officers as the council deems necessary.

(c) Members of the council attending meetings of the council, or attending a subcommittee meeting thereof, or performing other official duties of the council, as authorized by the council, shall be paid amounts provided for in subsection (e) of K.S.A. 75-3223, and amendments thereto. The attorney general and the chairperson of the council shall be responsible for approving all expense vouchers of members.

(d) The council shall meet at least once each year and may hold special meetings whenever they are called by the chairperson.

(e) The council, in accordance with K.S.A. 75-4319, and amendments thereto, may recess for a closed or executive session.

Sec. 3. (a) The council may contract with a person to serve as its director with the counsel of the attorney general. The council shall establish the authority and responsibilities of the director. The director shall not hold an elected position in the association.

(b) The council, to the extent resources are available, shall:

(1) Advise and assist in the creation of local crime stoppers programs;

(2) foster the detection of crime and encourage persons to report information about criminal acts;

(3) encourage news and other media to promote local crime stoppers programs and to inform the public of the functions of the council;

(4) assist local crime stoppers programs in forwarding information about criminal acts to the appropriate law enforcement agencies;

(5) help law enforcement agencies detect and combat crime by increasing the flow of information to and between law enforcement agencies;

(6) assess training needs for local crime stoppers programs and provide support and training to crime stoppers programs within the state;

(7) assist local crime stoppers programs in the acquisition of resources needed to keep and report statistical data and to communicate between local programs, law enforcement agencies and other crime stoppers programs and agencies; and

(8) provide other assistance as deemed appropriate to enhance public safety in Kansas.

(c) The council may adopt rules and regulations to carry out its duties under this act.

Sec. 4. (a) In addition to the fees provided by K.S.A. 21-4610a and 22-2909, and amendments thereto, each person who is placed on probation, is assigned to a community correctional services program or enters into a diversion agreement in lieu of further criminal proceedings shall pay a fee of $20. Such fee shall be charged and collected by the clerk of the district court. The clerk of the district court shall remit to the state treasurer, in accordance with the provisions of K.S.A. 75-4215, and amendments thereto, the balance of all moneys received by such clerk from such fees. Upon receipt of the remittance, the state treasurer shall deposit the entire amount in the state treasury and credit it to the Kansas crime stopper trust fund created pursuant to subsection (d).

amount

(b) The clerk of each county shall maintain an accounting of the ~~number~~ of fees received pursuant to this section from persons who were placed on probation, were assigned to a community correctional services program or entered into a diversion agreement in lieu of further criminal proceedings in such county and shall report that number to the council. The local crime stoppers program from each county that meets the required certification set forth by the association may make application to

10-5

the council for a grant for reimbursement of moneys credited to the Kansas crime stopper trust fund which were collected from fees received pursuant to this section from persons who were placed on probation, were assigned to a community correctional services program or entered into a diversion agreement in lieu of further criminal proceedings in such county. The council shall establish the qualifications required to receive such grants. All such reimbursements shall require the approval of the attorney general. The amount of any such grant shall not exceed 50% of the total amount of fees received pursuant to this section from persons who were placed on probation, were assigned to a community correctional services program or entered into a diversion agreement in lieu of further criminal proceedings in the county.

(c) The attorney general shall have the authority to accept, budget and expend for any proper expenses of the crime stoppers advisory council any special source funds made available for the purposes of the crime stoppers program. Any such funds shall be deposited in the state treasury and credited to the Kansas crime stopper trust fund.

(d) (1) There is hereby created in the state treasury the Kansas crime stopper trust fund.

(2) Moneys in the Kansas crime stopper trust fund shall be expended only for the authorized purposes set forth in this act.

(3) All expenditures from the Kansas crime stopper trust fund shall be made in accordance with appropriation acts upon warrants of the director of accounts and reports issued pursuant to vouchers approved by the attorney general for the purposes set forth in this act.

Sec. 5. (a) Council records relating to reports of criminal acts are confidential.

(b) Evidence of a communication between a person submitting a report of a criminal act to the council or a local crime stoppers program and the person who accepted the report on behalf of the council or local crime stoppers program is not admissible in a court or an administrative proceeding whether the evidence is held by the council or a local crime stoppers program or is held by a telecommunications service provider.

(c) Records of the council or a local crime stoppers program concerning a report of a criminal activity and records of a telecommunications service provider relating to a report made to the council or to a local crime stoppers program may not be compelled to be produced before a court or other tribunal except on the motion of a criminal defendant to the court in which the offense is being tried that the records or report contain evidence that is exculpatory to the defendant in the trial of that offense. On motion of a defendant under this subsection, the court may subpoena the record or report. The court shall conduct an in-camera inspection of materials produced under subpoena to determine whether

the materials contain evidence that is exculpatory to the defendant. If the court determines that the materials produced contain evidence that is exculpatory to the defendant, the court shall present the evidence to the defendant in a form that does not disclose the identity of the person who was the source of the evidence, unless the court makes a finding that the state or federal constitution requires the disclosure of that person's identity. The court shall return to the council or to the local crime stoppers program materials that are produced under the section but not disclosed to the defendant. The council or local crime stoppers program shall store the materials until the conclusion of the criminal trial and the expiration of the time for all direct appeals in the case.

Sec. 6. (a) A person who is a member or employee of the council or who accepts a report of a criminal activity on behalf of a local crime stoppers program is guilty of a class A nonperson misdemeanor if the person intentionally or knowingly divulges to a person not employed by the law enforcement agency the content of a report of a criminal act or the identity of the person who made the report without the consent of the person who made the report.

(b) A person convicted of an offense under this section shall not be eligible for state employment during the five-year period following the date that the conviction becomes final.

Sec. 7. (a) A county commission or governing body of a city is authorized to contribute funds to a local crime stoppers program from the general fund of the county or city or any other available source if the local crime stoppers program is established to operate, in whole or in part, within the boundaries of such county or city.

(b) This act shall not be construed to repeal any local ordinance or resolution establishing a crime stoppers program, or affect any crime stoppers program established by a city, county or private entity, or the operation or funding of such program.

Sec. 8. This act shall take effect and be in force from and after its publication in the statute book.

10-7

SECTION IV. DEPARTURE INFORMATION (PAGE 3)

1. **Type of Departure:** (Check all that apply.)

☐ Downward Durational ☐ Upward Durational ☐ Downward Dispositional ☐ Upward Dispositional

☐ Postrelease Supervision (up to 60 months for sexually motivated sex offense) – K.S.A. 2006 Supp. 22-3717(d)(1)(D)(i)

["Sexually motivated" defined in K.S.A. 2006 Supp. 22-3717(d)(2).]

2. **Reasons Cited as Basis for Departure:**

SECTION V. OTHER CONDITIONS

1. **General/Special Conditions of Probation** (COMPLETE AND ATTACH ORDER OF PROBATION TO THIS JOURNAL ENTRY)

2. **Costs Ordered:**

Total Restitution (Please complete #3 below.)	$	Probation Fee	$
Total Court Costs	$	BIDS Attorney Fee	$
Total Fines	$	BIDS Administrative Fee	$
DNA Database Fee (K.S.A. 2006 Supp. 21-2511 & 75-724.)	$	Community Corrections Fee (offenses after 1/4/07)	$
Extradition Costs	$	Booking/Fingerprint Fee	$
Domestic Violence Special Program Fee	$	Reward Reimbursement	$
Apprehension Fee (Escape/Agg. Escape)	$	Children's Advocacy Center Assessment Fee	$
Alcohol and/or Drug Evaluation Fee	$	Medical Costs/Expenses Reimbursement	$
Witness Fee	$	Court-Appointed Attorney Fee	$
KBI Lab Fee	$	Other: _____	$
Other Lab Fee	$	Other: _____	$
		TOTAL COSTS	$

3. **Restitution to be paid as follows:**

Amount	Name and Address
$	
$	
$	
$	
$	
$	

Testimony in Support of SB 69
Senate Judiciary Committee
January 28, 2009

Senator Tim Owens
Chair, Senate Judiciary
536-N
Statehouse
300 SW Tenth Ave
Topeka, KS 66612-1592

Dear Chair:

As the President of the Kansas State Lodge, Fraternal Order of Police which represents more than 3,100 Law Enforcement Officers from across Kansas, we are totally in support of the Senate Bill 69 which deals with Crime Stoppers. I have been informed that your committee will be meeting on this Bill on Wednesday, January 28th, 2008. Unfortunately I will be unable to attend this hearing however wanted to express the full support of this Bill.

The Crime Stoppers Program is extremely beneficial to all Law Enforcement Agencies and another "tool" in which we can fight the Crime War's in Kansas. I would hesitate to think of the number of crimes that would go unsolved were it not for the Crime Stoppers Program.

I would ask you and your committee to provide full support on this important piece of legislation. If you have any questions of me regarding this e-mail please do not hesitate to contact me.

Fraternally,

K. C. Blodgett
President, KS State Lodge
Fraternal Order of Police
kclodgett586@embarqmail.com

Senate Judiciary
1-28-09
Attachment 11

STATE OF KANSAS
OFFICE OF THE ATTORNEY GENERAL

STEVE SIX
ATTORNEY GENERAL

120 SW 10TH AVE., 2ND FLOOR
TOPEKA, KS 66612-1597
(785) 296-2215 • FAX (785) 296-6296
WWW.KSAG.ORG

Senate Judiciary Committee
Senate Bill 69
Assistant Attorney General Dan Gibb
January 28, 2009

Mr. Chairman and members of the committee, thank you for allowing me to submit written testimony regarding Senate Bill 69. The Attorney General's office supports the concept of establishing a Crime Stoppers Advisory Council within the Office of Attorney General, but does not take a position regarding the manner in which this initiative should be funded. Attorney General Steve Six believes Crime Stoppers is a valuable tool for law enforcement and would like to see the program expanded in Kansas.

Attorney General Six does not take a position on the funding mechanism of this legislation. As it stands, SB 69 would create a full time position for an executive director for the council. This FTE would be funded through a $20 fee to any person placed on probation, community corrections, or diversion in the state of Kansas. The revenue from the fee would also be used for grants from the Advisory Council to the local crime stopper programs. AG Six believes that the manner in which this program is funded is best left to the discretion of the Legislature.

Ultimately, the Attorney General would like to see a statewide program implemented that could assist in the creation of additional local crime stoppers programs, provide training and resources to local programs and generally enhance the cooperative efforts between Kansas communities and law enforcement. Thank you for your consideration.

Senate Judiciary
1-28-09
Attachment 12

Senate Judiciary Committee
January 28, 2009
Testimony of Jennifer Roth
Opponent to (parts of) Senate Bill 69

SB 69 would establish within the Attorney General's Office the Crime Stoppers Advisory Council. The Council's primary funding mechanism is found in Section 4: "each person who is placed on probation, is assigned to a community correctional services program or enters into a diversion agreement in lieu of further criminal proceedings shall pay a fee of $20." The Council would award grants to crime stoppers programs in counties where money was collected.

I appear before this Committee in an individual capacity, as a person concerned about indigent defendants. I take issue not with the creation or function of this Council, but with the funding.

While $20 may seem like nothing to many of us (I spend that weekly at various coffee shops), $20 is a lot to poor people. My co-worker has had clients charged with failure to register (a severity level 5 person felony) because they did not have the required $20 photo fee so they did not go in to the sheriff's office on time. My co-workers and I have had countless clients eligible for diversion who need months to come up with the required fees. For example, in Shawnee County, a felony diversion costs a minimum of $250-315 plus court costs/another fee ($182).

When a defendant is sentenced in Kansas for a criminal conviction, the costs may include: court costs ($172 for felonies, $137 for misdemeanors); probation fee ($50 for felonies, $25 for misdemeanors); a fine if required by statute or if the court so determines; a KBI or other lab fee of $400, if applicable; a KBI DNA database fee of $100 (for all felony convictions and some misdemeanors), if applicable; a $100 BIDS administrative fee, if applicable; BIDS or appointed counsel fees, if applicable; and restitution, if applicable. If defendants do not pay, they can be referred to collections and eventually subject to exorbitant interest rates on judgments.

Even if one is not concerned by the financial struggles of defendants, one cannot ignore the current financial struggles of many agencies and organizations. I can think of no example of one entity receiving this large of an amount in this manner where no services were necessarily performed by that entity in a particular case. To my knowledge, not even agencies/organizations responsible for compensating crime victims get an automatic fee with such a broad reach as that proposed in SB 69. I am not saying that the new Council is not a deserving entity; I am simply saying there are lots of criminal-justice-related agencies and organizations in need of funding.

I have one other concern. Because of time constraints, I have not exhaustively researched the implications of Section 5, but Section 5 is arguably at odds with K.S.A. 60-436 (identity of informer) and possibly constitutional requirements. I will try to look into this further.

Thank you very much for your consideration,

Jennifer Roth
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(785) 832-9583 (home)

Senate Judiciary
1-28-09
Attachment 13