MINUTES

SPECIAL COMMITTEE ON JUDICIARY

October 25, 2010
Room 548-S—Statehouse

Members Present

Senator Thomas C. (Tim) Owens, Chairperson
Representative Lance Kinzer, Vice-chairperson
Senator David Haley
Senator Dwayne Umbarger
Representative Sydney Carlin
Representative David Crum
Representative Melody McCray-Miller

Members Absent

Representative Aaron Jack
Representative Scott Schwab

Staff Present

Athena Andaya, Kansas Legislative Research Department
Lauren Douglass, Kansas Legislative Research Department
Iraida Orr, Kansas Legislative Research Department
Laura Younker, Kansas Legislative Research Department
Jason Thompson, Office of the Revisor of Statutes
Doug Taylor, Office of the Revisor of Statutes
Sean Ostrow, Office of the Revisor of Statutes
Matt Sterling, Office of the Revisor of Statutes
Karen Clowers, Committee Assistant

Others Attending

See attached list.

Morning Session

The meeting was called to order by Chairperson Owens at 10:10 a.m.

The hearing on 2010 SB 374 and 2010 Sub. for SB 374 was opened.

Chairperson Owens called on Lauren Douglass, Kansas Legislative Research Department, to brief the Committee on 2010 SB 374 and 2010 Sub. for SB 374 (Attachment 1). Ms. Douglass also provided an article addressing flaws in state apology and disclosure laws (Attachment 2).

Nick Badgerow testified on behalf of the Judicial Council Civil Code Advisory Committee in support of 2010 SB 374, as introduced, and reviewed the development of SB 374 following a request to study the issue by the Legislature. He advised the Committee that the Judicial Council Civil Code Advisory Committee is comprised of plaintiff and defense attorneys who practice in the field, trial judges, appellate judges, and law professors. He further stated that the Judicial Council has no client in this issue. Mr. Badgerow indicated he had two specific concerns regarding Sub. for SB 374. The first would exclude, among other things, statements of mistake or error. The second concern is Sub. for SB 374 limits the exclusion to statements or actions by a "health care provider, employee or agent of a health care provider." It is the opinion of the Advisory Committee that the original SB 374 is a superior approach to an apology statute in Kansas by fairly meeting the objective of creating an apology law without limiting the immunity to health care providers or extending it to admission of fault (Attachment 3).

Gary White testified on behalf of the Kansas Association for Justice in support of SB 374, as introduced in 2010. Mr. White indicated the Association does not oppose changing the rules of evidence relating to apologies as long as such changes are fair and equitable to all parties. Sub. for SB 375 skews the results of evidence, favors one party, permits concealment of truthful evidence, or allows negligent or intentional acts to be hidden from a jury (Attachment 4).

Mitzi McFatrich, Executive Director, Kansas Advocates for Better Care, testified in support of 2010 SB 374, as introduced. Ms. McFatrich represents the people in long-term care who, often times, do not have an abundance of financial resources. Ms. McFatrich stated it is unfair to deprive a person of the opportunity to seek redress through the courts because an apology has been offered, including one that contains fault. Allowing a health care provider to be shielded from a lawsuit because of an apology is an over protection of health care workers (Attachment 5).

Joseph Molina testified on behalf of the Kansas Bar Association (KBA) indicating the KBA supports 2010 SB 374, as introduced. Mr. Molina indicted the KBA Legislative Committee conducted a detailed review of both SB 374 and Sub. for SB 374, and determined the recommendations forwarded by the Kansas Judicial Council should be supported (Attachment 6).

Ed Barker testified on behalf of the Sisters of Charity of Leavenworth Health System, detailing the request for an apology law in Kansas, and the subsequent alternate version which became Sub. for SB 374. The intention of Sub. for SB 374 is to codify public policy allowing expressions of apology or compassion without fear of it being used as evidence of liability when a patient experiences an adverse medical outcome. He argued that SB 374, as introduced had a chilling effect on speech because there is no protection upon which doctors can rely. Doctors will not need to wait for legal counsel to advise them before they can freely express compassion to their patients. Sub. for SB 374 is a simple, common sense tort reform policy which would reduce health care costs by lowering litigation (Attachment 7).

Douglas Wojcieszak, a disclosure training consultant for Sorry Works, appeared in support of Sub. for SB 374 stating disclosure can be an alternative solution to the medical malpractice crisis. Mr. Wojcieszak said apologies for medical errors reduce anger in patients and families which leads to a reduction in medical malpractice lawsuits and associated litigation expenses. In response to questioning by a Committee member, Mr. Wojcieszak stated legislation is not necessary to effectuate a policy to make a person feel whole and to focus on customer service (Attachment 8).

Dr. Barry Solomon, citizen, testified in support of Sub. for SB 374, stating that for health care professionals, the standard procedure is to never talk to anyone without representation and to call their insurer or their attorney first. Sub. for SB 374 would go a long way to changing that mindset (No written testimony provided).

Shelly Koltnow, Vice-president of Corporate Responsibility, Via Christi, spoke in favor of Sub. for SB 374 stating it would encourage open and honest dialogue between physicians, other health care providers, and their patients when an adverse event occurs. Medical mistakes do happen and an expression of apology, sympathy, compassion, or a benevolent act should not be used as evidence of negligence or wrongdoing in a subsequent malpractice claim. Sub. for SB 374 would be one way to address the rising costs of healthcare by lowering civil malpractice and could go a long way in facilitating transparency between patients and providers (Attachment 9).

Dan Morin, Kansas Medical Society, testified in support of Sub. for SB 374, stating unanticipated, adverse medical outcomes happen. As a result, healthcare providers are reluctant to express concern or sympathy for fear such statements will be used against them later in a civil suit. Sub. for SB 374 would foster better communication between healthcare providers and patients while reducing the number of medical liability claims files (Attachment 10).

The Committee recessed for lunch and reconvened at 1:15 p.m.

Afternoon Session

Gregory Dennis, Executive Vice-president, Kansas Veterinary Medical Association, appeared requesting that the Committee consider adding veterinarians to the apology bill. Mr. Dennis indicated veterinarians would benefit from the same protection (Attachment 11).

Bob Harvey spoke on behalf of the American Association of Retired Persons (AARP), indicating AARP is not opposed to SB 374, but is opposed to Sub. for SB 374. Any efforts to address medical malpractice concerns should begin with a patient-centered focus on reducing errors and promoting fair compensation (Attachment 12).

Written testimony in support of Sub. for SB 374 was submitted by:

William Sneed (Attachment 13); and
Deborah Stern, Kansas Hospital Association (Attachment 14).

Chairperson Owens closed the hearing on SB 374 and Sub. for SB 374.

Melody McCray-Miller moved, Senator Haley seconded, to recommend the Kansas Judicial Council approach to an apology law, 2010 SB 374, as introduced, be adopted.

Following further discussion, Representative Kinzer requested copies of the South Carolina statute be distributed to the Committee (<u>Attachment 15</u>).

Following further discussion, Senator Umbarger called the question. <u>*Motion carried.*</u>

Chairperson Owens called on Athena Andaya, Kansas Legislative Research Department, to review the Committee's hearing on criminal background checks for potential employees of adult care homes.

Following discussion, the Committee recommended, by consensus, to request the Senate Public Health and Welfare Committee provide a status report during the Legislative Session to a joint meeting of the House and Senate Judiciary Committees on the newly enacted legislation (2010 HB 2323) to determine if additional recommendations are needed relating to criminal background checks on individuals and entities associated with adult care home facilities.

Chairperson Owens reopened the discussion regarding recommendations on the Kansas Open Records Act exemptions.

Representative Kinzer moved, and Representative Crum seconded, to recommend introduction of a house bill on the renewal of all of the Kansas Open Records Act exceptions scheduled for expiration in 2011, with the additional recommendation that the language in KSA 12-5611 needs to clarify what types of agency actions are covered and should look at penalty provisions for breach of confidentially in KSA 44-1132, 75-457, and 75-723. <u>*Motion carried.*</u>

Chairperson Owens announced the final report and minutes of the Special Committee on Judiciary will be submitted electronically for approval.

Representative Carlin moved, and Representative Crum seconded, to approve the Committee minutes of September 13, 2010. <u>*Motion carried.*</u>

The meeting adjourned at 4:02 p.m.

This is the last scheduled meeting of the 2010 Special Committee on Judiciary.

Prepared by Karen Clowers
Edited by Athena Andaya

Approved by Committee on:

<u>December 6, 2010</u>
(Date)

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PLEASE CONTINUE TO ROUTE TO NEXT GUEST

SPECIAL COMMITTEE ON JUDICIARY
GUEST LIST

DATE: October 25, 2010

NAME	REPRESENTING
Jeff Bottenberg	KU Hospital Authority
Matt Casey	KADC
Doug Smith	KAPA
Berend Koops	Hein Law Firm/HCAA
EDWARD BARKER	SCLHS
Cynthia Smith	SCLHS
Daryl Wyciskalla	Sorry Larks!
Callie Jill Denton	KS Assn for Justice
[illegible] White	" " " "
Brad K. Dempsey	SRS
DEBORAH STERN	KS. HOSP. ASSN.
Dorothy Tenney	KDHE
Tara Roseberry	Intern KNASW
RJ Wilson	KSAJ
[illegible]	Health Care Stabilization Fund
Erin DeKoster	KU law student
Patrick Vogelsberg	Kearney and Assoc.
BARRY Solomon MD	SCLHS

(over)

Whitney Damron	KS Bar Assn.
Joseph Molina	KS Bar Assn.
Mitzi E. McFatrich	KS Advocates for Better Care
Dodie Wellshear	KS Academy of Family Physicians
Sean Miller	Capitol Strategies
Gregory M. Dennis	Kansas Veterinary Medical Association
Marla Rhoden	KDHE
Jennifer Crow	KSAJ
Martha Cooper	KDHE

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October 22, 2010

To: Special Committee on Judiciary

From: Lauren S. Douglass, Research Analyst

Re: 2010 SB 374 – The "Apology Bill"

According to the National Conference of State Legislatures, "apology laws" have been adopted by 34 states, the District of Columbia, and Guam. Additionally, in 2010, 12 states considered legislation on the issue, including Kansas. Lists of these states are attached. This Committee was charged with the task of reviewing the legislation considered in Kansas during the 2010 Legislative Session, SB 374.

Background

In 2009, at the request of the Sisters of Charity of Leavenworth Health System (Sisters of Charity), Senator Jim Barnett introduced SB 32, which was based on a Colorado statute. The bill would have prohibited a court in civil actions from admitting oral or written statements or notations, affirmations, gestures, conduct, or benevolent acts expressing apology, fault, sympathy, or condolence made by a health care provider relating to the unanticipated outcome of medical care as evidence of an admission of liability. Included in this prohibition were waivers of charges for medical care. The bill had a hearing in the Senate Judiciary Committee and subsequently was referred to the Judicial Council for study.

The Judicial Council's Advisory Committee (Advisory Committee) considered similar laws from other states, relevant academic and law review articles, and the testimony submitted to the Senate Judiciary Committee and found it did not support the approach taken by SB 32. Specifically, the Advisory Committee agreed that the statements or expressions of fault should not be excluded and the law should apply more broadly than just to health care providers. Further, the Advisory Committee discussed the approaches taken by other states to determine whether a mixed statement of apology and liability is inadmissible, and adopted Hawaii's stance. Its statute provides that exclusion is not required when an apology or other statement acknowledging or implying fault is part of a statement or gesture that is inadmissible. (Haw. Rev. Stat. § 626-1, Rule 409.5.) This provision gives trial court judges discretion on that issue.

In the 2010 Legislative Session, SB 374, which was based on the Hawaii statute, was introduced as recommended by the Advisory Committee. It would have provided that evidence of statements or gestures that express apology, sympathy, commiseration, or condolence concerning the consequences of an event in which the declarant was a participant is not admissible to prove liability for any claim growing out of the event. The language described above, giving judges discretion to determine the admissibility of mixed statements, was also included in the bill. In the

Senate Judiciary Committee. Sisters of Charity proposed alternative language based on a South Carolina law, S.C. Code Ann. § 19-1-190, which was ultimately adopted.

The substitute bill would have created the Kansas Adverse Medical Outcome Transparency Act, making inadmissible, in any claim or civil action brought by or on behalf of a patient alleging an adverse outcome of medical care, any and all statements, activities, waivers of charges for medical care, or other conduct expressing benevolence, regret, mistake, error, sympathy, apology, commiseration, condolence, compassion, or a general sense of benevolence made by a health care provider or a provider's employee or agent. Further, pursuant to the substitute, such statements or conduct would not constitute an admission of liability or an admission against interest. Finally, the substitute would have allowed a defendant in a medical malpractice action to waive, in writing, the inadmissibility of such statements. The Senate Committee of the Whole rereferred the substitute bill to the Judiciary Committee, where no further action was taken.

Comparison of SB 374 and Sub. for SB 374
(Text in bold appears in all versions)

	SB 32	SB 374	Sub. for SB 374
Applies to	Oral and written **statements** or notations, affirmations, gestures, conduct, or benevolent acts, including waiver of charges for medical care provided	**Statements** or gestures	**Statements**, activities, waivers of charges for medical care provided, or other conduct
Expressing	**Apology,** fault, **sympathy, commiseration, condolence,** or compassion, related to the discomfort, pain, suffering, injury, or death of the patient resulting from the unanticipated outcome of medical care	**Apology, sympathy, commiseration, or condolence** concerning the consequences of an event in which the declarant was a participant	Benevolence, regret, mistake, error, **sympathy, apology, commiseration, condolence,** compassion, or a general sense of benevolence
Made by	A health care provider or an employee of a health care provider	Not addressed	A health care provider, or an employee or agent of a health care provider
Made to	Patients, relatives of a patient, or representatives of a patient	Not addressed	Not addressed

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	SB 32	SB 374	Sub. for SB 374
Not admissible	As an admission of liability or as evidence of admission against interest	To provide [sic] liability for any claim growing out of the event	As evidence in any civil action brought by or on behalf of a patient allegedly experiencing an adverse outcome of medical care; does not constitute an admission of liability or a statement against interest
Mixed statements	Not addressed	Exclusion not required for apologies or other statements or gestures that acknowledge or imply fault, even though contained in, or part of, any statement or gesture excludable under this section	Not addressed
Waiver	Not addressed	Not addressed	In medical malpractice action, defendant may waive inadmissibility by expressly stating, in writing, the intent to make such a waiver
Based on	Colo. Rev. Stat. Ann. § 13-25-135	Haw. Rev. Stat. § 626-1, Rule 409.5	S.C. Code Ann. § 19-1-190(D)

States that Considered Apology Legislation in 2010

Currently Have Apology Law

1. **Georgia 2010 HB 24** would have made minor amendments to an existing apology law as part of a recodification of the state's evidence laws.

2. **Illinois HB 6844** would have reenacted those statutes declared unconstitutional as not severable in *Lebron v. Gottlieb Memorial Hosp.*, including 735 Ill. Comp. Stat. Ann. § 5/8-1901, the state's apology law. 930 N.E.2d 895 (Ill. 2010) (holding that statute capping noneconomic damages in medical malpractice actions was unconstitutional).

3. **Maryland SB 374** would have repealed an exception to the state's apology law.

4. **Massachusetts** considered several bills that would have amended or supplemented the state's existing apology law: **HB 1332, HB 4720, HB 4862, SB 561, and SB 574.**

5. **Utah H.J.R. 34** amended the Utah Rules of Evidence to make expressions of apology, sympathy, condolences, and the like inadmissible against the health care provider. This amendment supplements an already existing medical malpractice statute with similar provisions.

6. **Virginia HB 87** would have amended an existing apology law to comply with changes to the state's malpractice laws.

Do Not Currently Have an Apology Law

7. **Kansas SB 374** (discussed above)

8. **Michigan HB 6073** would have prohibited the introduction of evidence of an expression of sympathy as an admission of liability in a civil action.

9. **New York SB 7519** would have made apologetic statements inadmissible. **AB 9488 and SB 6321** would have established the "Sorry Works" demonstration program to test whether participating health care providers experience reduced malpractice verdicts, settlements, and litigation costs, when they promptly acknowledge mistakes in unanticipated outcome cases.

10. **Pennsylvania HB 1804, HB 1843, SB 208, and SB 206** would have made benevolent gestures or expressions of empathy inadmissible.

11. **Rhode Island HB 7320 and SB 2562** would have provided that expressions of sympathy and other statements by a health care provider regarding the outcome of such patient's medical care and treatment are inadmissible.

12. **Wisconsin AB 710** would have provided that a statement, a gesture, or conduct of a health care provider that expresses apology, condolence, compassion, benevolence, or sympathy is not admissible or subject to discovery in any civil action or administrative hearing regarding the health care provider as evidence of liability or as an admission against interest.

LSD/jl

Attachments

1-5

SENATE BILL No. 32

By Committee on Public Health and Welfare

1-15

9 AN ACT concerning evidence in civil actions; expression of apology, sym-
10 pathy, compassion or benevolent acts by health care providers not ad-
11 missible as evidence of an admission of liability or as evidence of an
12 admission against interest.
13
14 *Be it enacted by the Legislature of the State of Kansas:*
15 Section 1. (a) No oral or written statements or notations, affirma-
16 tions, gestures, conduct or benevolent acts including waiver of charges
17 for medical care provided, expressing apology, fault, sympathy, commis-
18 eration, condolence or compassion which are made by a health care pro-
19 vider or an employee of a health care provider to a patient, a relative of
20 the patient or a representative of the patient and which relate to the
21 discomfort, pain, suffering, injury or death of the patient as the result of
22 the unanticipated outcome of medical care shall be admissible as evidence
23 of an admission of liability or as evidence of an admission against interest.
24 (b) As used in this section:
25 (1) "Health care provider" has the meaning prescribed in K.S.A. 65-
26 4915, and amendments thereto.
27 (2) "Relative" means a patient's spouse, parent, grandparent, step-
28 father, stepmother, child, grandchild, brother, sister, half-brother, half-
29 sister or spouse's parents. The term includes such relationships that are
30 created as a result of adoption and any person who has a family-type
31 relationship with a patient.
32 (3) "Representative" means a legal guardian, attorney, person des-
33 ignated to make decisions on behalf of a patient under a medical power
34 of attorney or any person recognized in law or custom as a patient's agent.
35 (4) "Unanticipated outcome" means the outcome that differs from
36 the anticipated outcome of a treatment or procedure.
37 Sec. 2. This act shall take effect and be in force from and after its
38 publication in the statute book.

Approved by the Judicial Council December 4, 2009

REPORT OF THE JUDICIAL COUNCIL CIVIL CODE ADVISORY COMMITTEE ON 2009 SB 32

DECEMBER 4, 2009

BACKGROUND

In March, 2009 Senator Tim Owens requested that the Judicial Council review and make recommendations on 2009 Senate Bill 32, which concerns admissibility of expressions of apology by health care providers. At its June 4, 2009 meeting, the Judicial Council assigned the study to the Civil Code Advisory Committee. The Committee considered the bill at its September 25, 2009 meeting.

COMMITTEE MEMBERSHIP

The members of the Judicial Council Civil Code Advisory Committee are:

J. Nick Badgerow, Chairman, practicing attorney in Overland Park and member of the Kansas Judicial Council

Hon. Terry L. Bullock, Retired District Court Judge, Topeka

Prof. Robert C. Casad, Distinguished Professor of Law Emeritus at The University of Kansas School of Law, Lawrence

Prof. James M. Concannon, Distinguished Professor of Law at Washburn University School of Law

Hon. Jerry G. Elliott, Kansas Court of Appeals Judge, Topeka

Hon. Bruce T. Gatterman, Chief Judge in 24th Judicial District, Larned

John L. Hampton, practicing attorney in Lawrence

Joseph W. Jeter, practicing attorney in Hays and member of the Kansas Judicial Council

Hon. Marla L. Luckert, Kansas Supreme Court, Topeka

Hon. Kevin P. Moriarty, District Court Judge in 10th Judicial District, Olathe

Thomas A. Valentine, practicing attorney, Topeka

Donald W. Vasos, practicing attorney, Fairway

INTRODUCTION

SB 32 was introduced on January 15, 2009 by Sen. Jim Barnett at the request of the Sisters of Charity of Leavenworth Health System and contains what is commonly known as an "apology law." SB 32 excludes a health care provider's apology or admission of fault under certain circumstances from admissibility "as evidence of an admission of liability or as evidence of an admission against interest" in a trial relating to an "unanticipated outcome of medical care." The bill was first referred to the Public Health and Welfare Committee, but was then withdrawn and referred on January 20, 2009 to the Judiciary Committee. Hearings were held on January 28, 2009 and the bill was subsequently referred to the Judicial Council for study.

BACKGROUND

The first apology law was passed in Massachusetts in 1986. The daughter of a Massachusetts state senator was killed in the 1970's when she was struck by a car while riding her bike. The senator was angry that the driver never apologized, and he was told that the driver dared not do so because the apology could constitute an admission in the trial over the girl's death. Following his retirement, the senator and his successor presented a bill designed to offer some protection to apologizers. Lee Taft, *Apology Subverted: The Commodification of Apology*, 109 Yale L.J. 1135, 1151 (2000).

The Massachusetts statute provides in part that "[s]tatements, 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 such person or to the family of such person shall be inadmissible as evidence of liability in a civil action." Mass. Gen. Laws Ann. ch 233, § 23D. It was the only statute of its kind in the country for many years. Texas then passed an apology law in 1999, and by 2007 apology laws had been enacted in 35 states.

In general, apology laws are based on the theory that apologies are healing for both sides and should not be discouraged by the fear of legal ramifications. Debate has raged over the last decade concerning the relationship of apology and the law. See, *e.g.*, the extensive list of articles cited in Runnels, *Apologies All Around: Advocating Federal Protection For the Full Apology in Civil Cases*, 46 San Diego L. Rev. 137, FN 13 (Winter 2009). While all apology laws exclude for purposes of

proving liability at least some expression of apology or sympathy, there are many variations. Although the Massachusetts statute refers to "an accident," approximately two-thirds of states opted to restrict the exclusion of apologies to cases involving health care providers. The vast majority of states do not extend the exclusion to admissions of fault. There are four states that explicitly include statements of responsibility or liability (Arizona, Colorado, Connecticut, and Washington) and a few others that may, but it is not as clearly stated (Georgia, Indiana, South Carolina, and Vermont).

DISCUSSION

In its consideration of HB 32, the Committee reviewed apology laws from other states, academic and law review articles on the topic, and the written testimony submitted to the Senate Judiciary Committee.

HB 32 applies only to health care providers and does explicitly exclude from admissibility expressions of fault. The text of the bill is as follows:

> (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.
>
> (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.

At the outset, the Committee was in agreement with the underlying premise that public policy favors apologies, and that it would be consistent with public policy to exclude for purposes of proving liability an apology or expression of sympathy.

In spite of that common ground, the Committee did not agree with the approach taken in HB 32. The Committee was unanimous in its determination that statements or expressions of fault should not be the subject of an evidentiary exclusion. Further, although the primary proponent of HB 32 operates hospitals and clinics and drafted the bill to apply solely to health care providers, the Committee was unanimously opposed to that limitation.

After reaching unanimous agreement that it would not support HB 32 as written, the Committee did a comprehensive review of apology laws passed in other states. The Committee noted that most states had reached the same conclusion as the Committee had regarding the issue of extending the exclusion to admissions of fault. The Committee also noted that under many apology laws, it was unclear whether a mixed statement of apology and liability would be deemed inadmissible under the law.

Some states have opted to answer that question by specifically providing that statements of fault that are part of, or in addition to, an apology that would be inadmissible under the applicable apology provision would not likewise be deemed inadmissible. Hawaii has taken a different approach, providing that the apology rule "does not require the exclusion of an apology or other statement that acknowledges or implies fault even though contained in, or part of, any statement or gesture excludable under this rule." Haw. Rev. Stat. § 626-1, Rule 409.5 (2007). This provision directly responds to concerns that uncertainty about whether the words "I'm sorry" are an apology or an admission of fault make it impossible for physicians to believe they can rely on an apology law unless expressions of fault or liability are specifically covered by the statute. Hawaii's approach leaves that decision squarely in the capable hands of the trial judge, allowing the court to weigh the probative value against the risk of undue prejudice as it routinely does on questions of admissibility.

The Committee agreed to propose an alternative to SB 32 that is based on the Hawaii apology law.

COMMITTEE'S CONCLUSIONS

The Committee is unanimously opposed to SB 32. While it supports an apology law for Kansas, the Committee does not support legislation limited to health care providers and specifically rejects extending the immunity to admissions of fault.

COMMITTEE RECOMMENDATION

The Committee proposes an alternative to SB 32 that is based on Hawaii's apology law. The provision is not limited to health care providers. In addition, the provision deals with mixed expressions of apology and fault by rendering them neither specifically included nor excluded from the immunity granted, instead leaving the decision on such expressions to the court. Finally, this proposed statute is consistent with the Kansas approach to offers of compromise that include express admissions of facts. See K.S.A. 60-452.

The Judicial Council Civil Advisory Committee proposes that the following statute be presented to the legislature:

> **Admissibility of expression of apology, sympathy, commiseration, or condolence.** Evidence of statements or gestures that express apology, sympathy, commiseration, or condolence concerning the consequences of an event in which the declarant was a participant is not admissible to prove liability for any claim growing out of the event. This section does not require the exclusion of any apology or other statement or gesture that acknowledges or implies fault even though contained in, or part of, any statement or gesture excludable under this section.

SENATE BILL No. 374

By Committee on Judiciary

1-14

9 AN ACT concerning evidence in civil actions; expression of apology, sym-
10 pathy, commiseration or condolence not admissible as evidence of an
11 admission of liability or as evidence of an admission against interest.
12
13 *Be it enacted by the Legislature of the State of Kansas:*
14 Section 1. Evidence of statements or gestures that express apology,
15 sympathy, commiseration or condolence concerning the consequences of
16 an event in which the declarant was a participant is not admissible to
17 provide liability for any claim growing out of the event. This section does
18 not require the exclusion of any apology or other statement or gesture
19 that acknowledges or implies fault even though contained in, or part of,
20 any statement or gesture excludable under this section.
21 Sec. 2. This act shall take effect and be in force from and after its
22 publication in the statute book.

Substitute for SENATE BILL No. 374

By Committee on Judiciary

2-16

9 AN ACT enacting the Kansas adverse medical outcome transparency act;
10 concerning evidence in civil actions; expression of apology, sympathy,
11 compassion or benevolent acts by health care providers not admissible
12 as evidence of an admission of liability or as evidence of an admission
13 against interest.
14
15 *Be it enacted by the Legislature of the State of Kansas:*
16 Section 1. (a) This section may be cited as the "Kansas adverse med-
17 ical outcome transparency act."
18 (b) In any claim or civil action brought by or on behalf of a patient
19 allegedly experiencing an adverse outcome of medical care, any and all
20 statements, activities, waivers of charges for medical care provided or
21 other conduct expressing benevolence, regret, mistake, error, sympathy,
22 apology, commiseration, condolence, compassion or a general sense of
23 benevolence which are made by a health care provider, an employee or
24 agent of a health care provider, shall be inadmissible as evidence and shall
25 not constitute an admission of liability or an admission against interest.
26 (c) A defendant in a medical malpractice action may waive the in-
27 admissibility of statements defined in subsection (b) that are attributable
28 to such defendant by expressly stating, in writing, the intent to make such
29 a waiver.
30 (d) As used in this section:
31 (1) "Health care provider" has the meaning prescribed in K.S.A. 65-
32 4915, and amendments thereto.
33 (2) "Adverse outcome" means the outcome of a medical treatment
34 or procedure, whether or not resulting from an intentional act, that differs
35 from an intended result of such medical treatment or procedure.
36 Sec. 2. This act shall take effect and be in force from and after its
37 publication in the statute book.

SESSION OF 2010

SUPPLEMENTAL NOTE ON SUBSTITUTE FOR SENATE BILL NO. 374

As Recommended by Senate Committee on Judiciary

Brief*

Sub. for SB 374 would create the Kansas Adverse Medical Outcome Transparency Act. The bill would make inadmissible, in any claim or civil action brought by or on behalf of a patient alleging an adverse outcome of medical care, any and all statements, activities, waivers of charges for medical care, or other conduct expressing benevolence, regret, mistake, error, sympathy, apology, commiseration, condolence, compassion, or a general sense of benevolence made by a health care provider, employee, or agent. Such statements or conduct would not constitute an admission of liability or an admission against interest.

A defendant in a medical malpractice action may expressly waive, in writing, the inadmissibility of statements made expressing benevolence, regret, mistake, error, sympathy, apology, commiseration, condolence, compassion, or a general sense of benevolence.

Background

2009 SB 32 was a bill introduced by the Sisters of Charity of Leavenworth Health System to conform Kansas law with "apology laws" in other states. It was modeled after the Colorado apology law. It would have prohibited a court from admitting statements, gestures, conduct, or benevolent acts, including a waiver of charges for medical care, expressing

*Supplemental notes are prepared by the Legislative Research Department and do not express legislative intent. The supplemental note and fiscal note for this bill may be accessed on the Internet at http://www.kslegislature.org

apology, fault, sympathy, or condolence, which are made by a health care provider relating to the unanticipated outcome of medical care, as evidence of an admission of liability in civil actions. 2009 SB 32 was sent to the Kansas Judicial Council (KJC) for study during the 2009 Interim.

The KJC reviewed the apology statutes enacted in 35 other states and found that there has not been uniformity in the approaches taken. The KJC drafted a bill modeled after Hawaii's apology law. That bill, SB 374, as introduced, would have provided that the evidence of statements or gestures that express apology, sympathy, commiseration, or condolence concerning the consequences of an event in which the declarant was a participant is not admissible to prove liability for any claim growing out of the event.

The proponents of SB 374, as introduced, who presented testimony in the Senate Committee hearing were representatives of the KJC, the Kansas Association for Justice, the Kansas Medical Society, and the University of Kansas Hospital Authority.

Although listed as proponents of SB 374, as introduced, representatives of the Sisters of Charity of Leavenworth Health Systems and the Kansas Hospital Association advocated adoption of language modeled after South Carolina's law rather than Hawaii's law. The proposed substitute would create the Kansas Adverse Medical Outcome Transparency Act. A copy of a proposed substitute was attached to the written testimony of the Sisters of Charity of Leavenworth Health Systems.

There were no opponents of the bill who presented testimony in the Senate Committee hearing.

On final action on the bill in the Senate Committee, the proposed substitute by the Sisters of Charity of Leavenworth Health Systems was adopted.

The fiscal note provided on this bill, as introduced, states the judicial branch does not anticipate any fiscal effect to result from the passage of the bill.

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The Flaws In State 'Apology' And 'Disclosure' Laws Dilute Their Intended Impact On Malpractice Suits

ABSTRACT **Apologies are rare in the medical world, where health care providers fear that admissions of guilt or expressions of regret could be used by plaintiffs in malpractice lawsuits. Nevertheless, some states are moving toward giving health care providers legal protection so that they feel free to apologize to patients for a medical mistake. Advocates believe that these laws are beneficial for patients and providers. However, our analysis of "apology" and "disclosure" laws in thirty-four states and the District of Columbia finds that most of the laws have major shortcomings. These may actually discourage comprehensive disclosures and apologies and weaken the laws' impact on malpractice suits. Many could be resolved by improved statutory design and communication of new legal requirements and protections.**

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Patients justifiably expect that they will be told about mistakes or errors—sometimes known in the medical industry as "unanticipated outcomes"—in their care.[1,2] This expectation is increasingly being codified into state laws, accreditation requirements for health care facilities, and medical society consensus statements.[3–5] However, a sizable gap exists between current practice and the expectation that patients will be notified of a medical error.[6–8] The failure of health care providers to communicate information about unanticipated outcomes may impair patients' decision making, increase their distress, and heighten their desire to seek legal redress.[9–12]

A key barrier to more-open communication between health care providers and patients is the concern that such conversations might precipitate lawsuits, especially when an adverse health outcome may have been preventable.[1,13–15] In response, many states have recently passed laws encouraging health care providers to discuss unanticipated outcomes with patients.[16–17]

One approach uses what are called "apology laws" to protect aspects of a provider's conversation with a patient from use as evidence of liability in a lawsuit.[18] A second approach, using "disclosure laws," typically mandates disclosure of certain unanticipated outcomes to patients and may protect the communication from being used in a legal or administrative action. Both types of laws are intended to encourage providers to share more information about unanticipated outcomes with patients by reducing liability exposure and shaping standard practices.

Although these laws are motivated by noble intentions, it is unclear whether they will achieve their goals. It is too early for a rigorous empirical evaluation of these initiatives, and key data on disclosures and malpractice litigation costs are not systematically collected outside of individual institutions. Predicting the effect of these laws is further hampered by the scarcity of research exploring the impact of specific communication strategies on patients' intent to sue.[19]

Notwithstanding this lack of evidence, both state and federal policy makers remain intensely interested in disclosure and apology approaches. For example, the U.S. Department of Health and Human Services (HHS) has committed $23 mil

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Attachment 2

lion to funding pilot projects of innovative medical liability reforms, including several institutional programs that provide for disclosure, apology, and rapid offers of compensation.[20]

Because such programs generally do not bar patients from filing suit, the scope of legal protection in existing state laws is important. State disclosure and apology laws may also influence what is communicated to patients through these programs, and in what form.

In this article we contribute preliminary findings to inform these policy deliberations, based on an analysis of existing statutes (Appendix Exhibit 1).[21] We then address three policy questions. First, are the existing laws likely to foster transparency around medical injuries and reduce malpractice litigation? Second, do the strengths and weaknesses of disclosure and apology laws suggest best practices for designing future laws? Finally, on balance, are these laws worth adopting, or can their goals be more effectively achieved through alternative public or private initiatives such as disclosure and settlement offer programs?

Background

DISCLOSURE AND APOLOGY Disclosure and apology are conceptualized differently in the medical literature than they are in state statutes. In the medical literature, the term "disclosure" refers to informing the patient that an unanticipated outcome has occurred and providing some explanation for it.[1] Specifically, studies have shown that the information that patients desire following an unanticipated outcome includes an explanation of what happened, whether the outcome was caused by an error, how it happened, and plans for preventing recurrences.[22,23] The term "apology" refers at a minimum to an expression of sympathy, although some commentators suggest that a "full" apology for an unanticipated outcome caused by an error also includes providing an explanation, accepting responsibility, and making amends.[24-26]

CONVERSATION ABOUT UNANTICIPATED OUTCOMES In contrast, state laws recognize three distinct components of conversations with patients about unanticipated outcomes: "expression of sympathy," "explanation," and "admission of fault." The first two are roughly equivalent to the concepts of apology and disclosure. However, "admission of fault" does not have a close analogue in current disclosure guidelines promulgated by the medical profession, such as those from the National Quality Forum.[27]

The growing interest in communication between health care providers and patients about unanticipated outcomes has been stimulated in part by research suggesting that such communication might improve outcomes, including a reduction in litigation, amounts awarded, and greater patient satisfaction.[28-30] Nonetheless, health care workers and the institutions where they work still identify fear of malpractice suits as a major barrier to disclosure conversations.[31]

LEGAL RAMIFICATIONS Lawyers and insurance carriers have traditionally advised clients to avoid expressions of sympathy, explanations, and admissions of fault to patients out of concern that such statements could be used in litigation.[32-34] Worries about stimulating rather than ameliorating litigation persist. One group of scholars recently described disclosure as "an improbable risk management strategy."[29]

Study Data And Methods

We identified and reviewed statutes, regulations, judicial cases, and legislative histories of the fifty states and the District of Columbia that concerned the use in litigation and other legal proceedings of health care providers' statements of apology and disclosure to patients following unanticipated outcomes. The review is current through June 18, 2010.

We used online legal databases (LexisNexis and Westlaw) and annotated compilations of state laws. We then analyzed the laws for common themes (Appendix Exhibit 1),[21] categorizing them through a rigorous classification scheme. In states that have adopted both an apology law that is specific to the medical context and a more general apology statute that applies to other kinds of accidents, we analyzed only the law that would apply to medical malpractice litigation. (Appendix Exhibit 2 provides legal citations by state.)[21]

Study Results

PREVALENCE OF LAWS Thirty-four states and the District of Columbia have adopted an apology law, and nine states have adopted a disclosure law.[35] Six states have both types of laws, and thirteen have neither.[36] Among the states with apology laws, eleven have laws of general applicability,[37] and twenty-five have laws specific to the medical context. One state, Washington, has both a general apology law and an apology law specific to the medical context.

Sixteen states do not currently have any apology law. In these states, sympathetic statements by a provider could be used by a plaintiff as evidence of provider liability.

VARIATIONS IN FEATURES OF APOLOGY LAWS The vast majority of the apology laws—found

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in twenty-five states and the District of Columbia—are sympathy-only laws, which protect only the expression of sympathy made after an unanticipated outcome (Exhibit 1). Although some experts assert that a meaningful apology includes an explanation for the injury and an acceptance of responsibility,[38] the legal protection provided by sympathy-only laws does not inherently extend to statements of explanation or fault. Indeed, more than half of the sympathy-only laws explicitly indicate that expressions of fault made in conjunction with an expression of sympathy are admissible in litigation.[39]

These laws suggest that portions of a statement that explain or acknowledge responsibility—such as, "I'm sorry *I hurt you*," or, "I'm sorry *I made a mistake when I administered the wrong medication*"—could be used in litigation.

In the remaining sympathy-only laws, the statutes are less clear about whether a statement of fault embedded in a statement of sympathy would be admissible in litigation. In states with those laws, any expression of fault or liability would be likely to be admissible, as other evidence rules generally permit plaintiffs to use such statements against defendants.

Three states have sympathy and explanation-apology laws. These laws protect expressions of sympathy as well as the description of the event, such as, "I'm sorry you had an unexpected reaction to the medication." Like the sympathy-only laws, they do not explicitly protect expressions of fault. Therefore, the portions of statements that identify the responsible party—for example, "I'm sorry you were hurt *when I prescribed the wrong dose of medication*"—may be admissible in litigation.

Six states have laws that protect both a provider's expression of sympathy and any admission of responsibility or fault. We assumed in our

EXHIBIT 1

Characteristics Of State Apology Laws

Provision	Number
CONTENT OF COMMUNICATION RECEIVING LEGAL PROTECTION	
Statement of sympathy, explanation, and fault	0
Statement of sympathy and fault	6
Statement of sympathy and explanation	3
Statement of sympathy	26
COVERED PARTIES	
Not restricted to health care providers	9
Institutional and individual health care providers	25
Institutional health care providers only	1
TRIGGERING EVENT	
All accidents[a]	6
Unanticipated outcomes of medical care[a]	25
Serious unanticipated outcomes of medical care	0
Medical errors/alleged negligence	4
TIMING OF COMMUNICATION	
No time frame specified	33
Communication must be made within X days of discovery	2[b]
FORM OF COMMUNICATION	
May be oral, written, or by conduct	34
May be oral or written	0
Must be written	0
Must be oral	1
Must be both oral and written	0
RECIPIENT OF COMMUNICATION	
Not limited to certain recipients	7
Recipient must be injured patient, family, representative, or friend	3
Recipient must be injured patient, family, or representative	23
Recipient must be injured patient	1
Recipient must be family (wrongful death cases only)	1

SOURCE Authors' analysis of LexisNexis and Westlaw searches of state statutes, regulations, and case law, last updated June 18, 2010. **NOTES** $N = 35$, which includes thirty-four states and the District of Columbia. [a]The category "all accidents" includes statutes that do not specify a triggering event, if the statute is not limited to incidents involving health care providers. The category "unanticipated outcomes of medical care" includes statutes that do not specify a triggering event, if the statute is limited to health care providers. [b]30 days (VT, WA).

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classification scheme that the protection for admissions of fault would be construed to cover any accompanying explanation of the event, and therefore that these sympathy-and-fault statutes provide the most expansive legal protection for providers.

In most jurisdictions, the protected communication may be verbal or nonverbal. For example, oral and written "statements," "affirmations," "gestures," "activities," or "conduct" are forms of protected communication. One state, Vermont, protects only oral communications. Two states encourage timely disclosure by protecting statements made within a defined time period. Although nearly all of the laws apply to apologies for unanticipated medical outcomes, four statutes apply more narrowly to medical errors or allegedly negligent care.

VARIATIONS IN FEATURES OF DISCLOSURE LAWS Since 2002, seven states have passed mandatory disclosure laws, and two have passed discretionary disclosure statutes (Exhibit 2). Mandatory disclosure laws require health care facilities to notify patients or their families, or both, of unanticipated outcomes of medical care. The discretionary disclosure law in Washington allows health care facilities to determine when disclosure of unanticipated outcomes to patients is appropriate. Oregon's discretionary law allows hospitals to voluntarily participate in the state's patient safety program, which mandates patient disclosures of serious unanticipated outcomes.

Six of the nine states with mandatory or discretionary disclosure laws provide legal protection for the communication in subsequent litigation. In five of those states, the protected communication is limited to a statement that an unanticipated outcome occurred, such as, "During the operation, your ureter was injured." Only one state, Washington, also protects explanations and expressions of sympathy such as, "I'm sorry your ureter was injured during the surgery." All six of the states whose disclosure laws provide legal protection also have separate apology laws that may be relevant.[40] The remaining three states offer no protection.

Among the nine states with mandatory or discretionary disclosure laws, Washington's approach is unique, offering the most comprehensive protection of disclosure conversations for health care providers. It adopted what reads like a combination disclosure-and-apology law. The statute explicitly provides protection for an explanation of the event and an expression of sympathy offered as part of a voluntary disclosure conversation with the patient, such as, "I'm sorry your ureter was injured when a surgical tool malfunctioned during the operation." Washington also has a separate apology law that could extend protection to an admission of fault.

Except in Florida, state disclosure laws apply to health care facilities only, not to individual providers. Although most apology laws apply to all unanticipated outcomes, disclosure laws typically apply only to events that have caused serious harm. Only two states—Oregon and Pennsylvania—require that the notification be in writing. For these two states, oral communications are permitted but not sufficient. Four states' disclosure laws require that the communication be made within a specified time frame.

All nine state disclosure statutes require institutions to inform patients that an unanticipated outcome occurred, but none requires disclosure of specific information. One state requires disclosure of the patient's legal rights in certain situations. None requires or even suggests that the institution explain what happened, what impact it will have on the patient's health, or how institutions will follow up on the incident. Thus, an institution could adhere to the letter of the law simply by telling a patient, "The outcome of your surgery was unanticipated."

Discussion

Our research revealed that more than two-thirds of states have apology laws. The majority of such laws protect only the provider's voluntary expression of sympathy to the patient from use by a patient in malpractice litigation. A small number of states also protect explanations of the event or expressions of fault, or both. The definitions and scope of coverage vary in other ways, including requirements for timely communication in two state laws.

Nine states have disclosure laws, most of which require health care facilities to notify patients of events that have caused serious harm. States vary on whether the disclosure receives protection from subsequent use by a plaintiff in malpractice litigation. For the most part, states provide limited, if any, procedural guidance; some states require written—versus oral—communication or timely communication.

LIKELY EFFECTIVENESS OF EXISTING LAWS Our analysis reveals that most of these laws have structural weaknesses that may discourage comprehensive disclosures and apologies and weaken the laws' impact on malpractice suits. Disclosure laws do not require, and most apology laws do not protect, the key information that patients want communicated to them following an unanticipated outcome. Patients view the apology and disclosure processes as inextricably intertwined, seeking not only an expression of sympathy but also information about the

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EXHIBIT 2

Characteristics Of State Disclosure Laws

Provision	Number
CONTENT OF COMMUNICATION RECEIVING LEGAL PROTECTION	
Statement of sympathy, explanation, and fault	0
Statement of sympathy and fault	0
Statement of sympathy and explanation	1
Statement of sympathy	0
Statement that an unanticipated outcome occurred	5
None	3[a]
COVERED PARTIES	
Not restricted to health care providers	0
Institutional and individual health care providers	1
Institutional health care providers only	8
TRIGGERING EVENT	
Unanticipated outcomes of medical care	1
Serious unanticipated outcomes of medical care	7
Preventable serious adverse outcomes of medical care	1[b]
Medical errors	0
TIMING OF COMMUNICATION	
No time frame specified	5
Communication must be made within X days of discovery	4[c]
FORM OF COMMUNICATION	
May be oral, written, or by conduct	0
May be oral or written (not specified)	6
Must be written	2
Must be oral (if patient is available)	1
Must be both oral and written	0
RECIPIENT OF COMMUNICATION	
Not limited to certain recipients	0
Recipient must be injured patient, family, or representative	9
VOLUNTARINESS	
Communication is mandatory	7
Communication is discretionary	2
INFORMATION REQUIRED TO BE CONVEYED	
Statement that unanticipated outcome occurred	9
Explanation of facts, context of unanticipated outcome	0
Acknowledgment of harm	0
Explanation of impact on treatment plans or health status, or both	0
Explanation of investigation or follow-up done or to be done	0
Explanation of cause of unanticipated outcome	0
Offer of support services	0
Statement of accountability or responsibility	0
Statement of patient's legal rights	1

SOURCE Authors' analysis of LexisNexis and Westlaw searches of state statutes, regulations, and case law, last updated June 18, 2010. **NOTE** $N = 9$. [a]One state (TN) has no explicit statutory protection for patient notification but does provide explicit liability protection for hospitals reporting the same event to the state. [b]This state (NJ) also requires disclosure of adverse events arising from allergic reactions. [c]Range: 24 hours to 7 days (NJ, CA, NV, PA).

nature of the event and why it happened, and how recurrences will be prevented.[1,2,41]

Yet disclosure laws require only a bare-bones statement that an unanticipated outcome occurred. And most apology statutes protect only an expression of sympathy, failing to appreciate the importance of providing additional information to patients.[16]

A related problem is that some disclosure laws do not appear to extend protection to communications about events that occur outside the narrow context specified in the law. Pennsylvania has no apology law. However, the state does protect certain communications under a mandatory disclosure law that requires a health care facility to provide written notification to patients affected by a "serious event."[42] A reasonable interpretation of this law is that a clinician who

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orally apologizes to a patient risks having that communication used by a plaintiff as evidence of fault. Physicians may be unaware of such limitations and may mistakenly assume that an entire disclosure conversation is legally protected.

Where legal protections are unclear or perceived to be inadequate, health care workers and facilities might not provide all of the information that patients want about unanticipated outcomes. Merely expressing sympathy without sharing information about an injury's cause and prevention or accepting responsibility may strike patients as insincere,[43] provoking rather than appeasing a potential plaintiff.

Similarly, laws that protect only expressions of sympathy and explanation may make for awkward communications, as it may be difficult to explain an error without discussing the different but closely related issues of responsibility or fault. For these reasons, narrowly crafted disclosure and apology laws might not achieve their objectives of fostering transparency and deterring lawsuits.

Because apology and disclosure statutes are fairly new, it is unclear how they will be interpreted and implemented in practice. For example, in a sympathy-only state, the legal system will have to determine exactly what language constitutes a protected expression of sympathy and what constitutes an unprotected explanation or admission of fault.

Lastly, the impact of mandatory disclosure laws may be limited by the difficulty of enforcing them.[28] To our knowledge, none of the states with disclosure laws has plans to monitor the occurrence or quality of disclosures.

Many of these problems could be resolved by improved statutory design and communication of new legal requirements and protections. But even well-designed laws might not dampen some patients' propensity to file malpractice claims and indeed could stimulate claims.[29] Although a provider's words to a patient may be legally protected, the communication can still alert the patient to a potential legal claim. The legal discovery process can then be used to obtain independent evidence to prove malpractice.

Even a sincere apology might not dissuade some patients from suing, particularly if the injury entails large economic losses and there is no offer of compensation. These considerations do not mean that providing legal protections for disclosures and apologies is valueless, but they should militate against unqualified optimism about the impact of improvements in transparency on malpractice claims.

Determining the effectiveness of these laws will ultimately hinge on future research. As institutions, insurers, and states begin tracking the disclosure and apology process, research projects can assess the real-world impact of different communication and compensation strategies on patient trust and satisfaction, on provider distress and burnout, and on malpractice claims and malpractice insurance premiums.[44–48]

BEST PRACTICES FOR DISCLOSURE AND APOLOGY LAWS Research into patients' needs surrounding unanticipated outcomes of care, the National Quality Forum's recommendations on disclosure, and analysis of existing disclosure and apology laws suggest some recommendations for future statutory design (Exhibit 3).[27,49] Several principles should inform design choices: Disclosure requirements should acknowledge both patients' needs and providers' anxieties about legal risk; disclosure and apology should be considered as an integrated process; and legal protection should be broad, in order to encourage comprehensive disclosures and willingness to accept responsibility for error.

These principles suggest that apology and disclosure laws should be drafted in more expansive terms than most existing statutes. Legal protections should apply to individual as well as institutional health care providers; to both oral and written communications; and to statements of explanation and fault as well as sympathy.

The principles also point toward greater specificity in disclosure laws. Such laws should require the disclosure of all serious unanticipated outcomes and articulate a minimum set of information to be disclosed, beyond a simple statement that an unexpected event occurred. Legislatures should delegate responsibility for specifying the information set to a state agency, so that modifications can be implemented in response to evolving knowledge about best practices without legislative amendment.

Based on current research about patients' needs, disclosures should include what is known about the event's cause, plans for prevention, and available patient support services. Disclosure laws should also provide mechanisms for monitoring disclosures to ensure compliance with the law, such as reporting and audit provisions.

What accounts for the gap between current laws and best practices in provider-patient communication? The language on the books probably reflects political compromises in the legislative process. Some legislatures have been motivated to pass apology laws because of the potential emotional benefit to providers and patients of more-open communication.

The most common rationale, though, has been that apologies could decrease medical malpractice litigation and related costs. State trial law-

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EXHIBIT 3

Best-Practice Recommendations For State Disclosure And Apology Laws

Provision	Recommended practice
Protected content	Disclosure and apology laws should be drafted broadly to protect statements that an unanticipated outcome occurred and statements of sympathy, explanation, and fault
Covered parties	Disclosure and apology laws should cover individual and institutional health care providers
Triggering event	Apology laws should apply to statements made in response to any unanticipated outcome; disclosure laws should require disclosure of all unanticipated outcomes
Timing of communication	Apology laws should not limit protection to a specific time frame; disclosure laws should specify a time frame in which communications must be made The time frame should encourage prompt initial disclosures that an unanticipated outcome occurred but should permit additional investigation time before an explanation of the outcome is required
Form of communication	Apology laws should protect oral statements, written statements, and conduct; disclosure laws should require both oral and written notification for serious unanticipated outcomes, but should permit oral communications to suffice for less serious events The statute should provide a definition of a serious unanticipated outcome
Recipient of communication	Disclosure and apology laws should apply only to communications made to the injured patient, his or her family, representative, or friend
Voluntariness[a]	Disclosure laws should mandate communications following unanticipated outcomes
Required content	Disclosure laws should require that the communication include a statement that an unanticipated outcome occurred, an explanation of the facts or context of the event, an acknowledgment of harm, an explanation of the impact on the patient's treatment plans and health status, an explanation of the investigation or follow-up done or to be done, and an offer of support services, where available

SOURCE Authors' analysis. [a]Applicable to disclosure laws only.

yers' associations do not share that goal and have often opposed apology laws, concerned that evidentiary exclusions make it more difficult to bring successful malpractice claims. The limited scope of protection in the laws eventually passed may have been an attempt to accommodate such concerns.

Disclosure laws, on the other hand, have typically been enacted as part of patient safety reform efforts and are frequently paired with provisions that mandate state reporting. We can only speculate, but the lack of specificity about disclosure content may be a response to health care providers' concerns about liability exposure for explanations of the cause of an injury, particularly in states where apology protection is limited or absent.

ALTERNATIVE MECHANISMS FOR ENCOURAGING DISCLOSURE Are apology and disclosure laws a desirable means of fostering transparency in health care? On balance, the answer is yes.

Some experts have argued that the aims of apology and disclosure laws can be more effectively pursued through private initiatives. In particular, health care institutions can implement their own disclosure policies, accompanied by early settlement programs.[50] Although none of the existing institutional programs has yet been studied by external evaluators, program administrators report success in fostering transparency around medical injuries and reducing malpractice litigation costs.[28,48]

These programs show promise, but they are best viewed as complements, rather than alternatives, to apology and disclosure laws. They now exist at only a handful of institutions, and widespread change beyond these early adopters is unlikely in the current legal environment without substantial legislative encouragement. Further, although some programs appear to be flourishing even in the absence of a law, others have benefited from having such legal structures in place.[28] Colorado's comprehensive apology law, for example, has been credited with contributing to the success of the program implemented by COPIC Insurance, which reimburses patients up to $30,000 for "loss of time" and out-of-pocket expenses associated with adverse events, without regard to whether the standard of care was met.[51]

Particularly in programs like COPIC's that extend beyond the walls of a single institution, the legal environment in a state may greatly influence providers' willingness to participate in disclosure, although insurers could promote disclosure by making it a condition of having

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an incident covered by malpractice insurance. In contrast, in closed systems such as self-insured academic medical centers, the institution can exert greater leverage over its physicians, and the legal regime may play a secondary role in shaping practices.

States should recognize that advances in disclosure and apology are likely to continue at individual institutions and support institutions committed to transparency. Legislators can also collaborate with other state agencies to support institutional disclosure and apology programs. COPIC, for example, believes that its program's success is linked not only to the state's apology law and tort reforms, but also to close ties with key stakeholders, including the state board of medicine and the state insurance commissioner's office.[51]

Conclusion

Honest communication with patients is a moral imperative.[52] States are to be commended for confronting the serious deficiencies in how patients are currently informed about unanticipated outcomes. Substantial conceptual and practical problems, however, are likely to diminish the effectiveness of existing apology and disclosure laws.

Legislation can be ineffective or even counterproductive if it is drafted too narrowly, if health care providers overestimate the protection it offers, or if the resulting disclosures or apologies are interpreted by patients as insincere. Policy makers and health care providers need to have realistic expectations about what these laws will accomplish. They should not rely on laws as the primary means of changing the culture of communication with patients following unanticipated outcomes. Such culture change is likely to be most effective when it originates from within institutions that develop systems to support health care workers in conducting these difficult conversations.[5]

Practical policy options do exist for state legislators to increase transparency with patients. By understanding the relationship between disclosure and apology; ensuring that broad legal protections for disclosed information are in place; and collaborating with all key stakeholders, including health care institutions, states can support the development, evaluation, and dissemination of effective disclosure and apology programs. ■

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**JUDICIAL COUNCIL TESTIMONY
ON 2010 SB 374 RELATING TO THE ADMISSIBILITY OF
EXPRESSIONS OF APOLOGY TO PROVE LIABILITY**

SB 374 (2010) was drafted by the Judicial Council Civil Code Advisory Committee, which had been asked to study and make recommendations on SB 32 (2009).

SB 32 was introduced on January 15, 2009 by Sen. Jim Barnett at the request of the Sisters of Charity of Leavenworth Health System and is what is commonly known as an "apology law." SB 32 would have excluded from evidence a health care provider's apology or admission of fault under certain circumstances from admissibility "as evidence of an admission of liability or as evidence of an admission against interest" in a trial relating to an "unanticipated outcome of medical care." After referral to the Public Health and Welfare Committee, and then to the Judiciary Committee, hearings were held on January 28, 2009, and the bill was subsequently referred by Judiciary Chair Owens to the Judicial Council for study. The Judicial Council assigned the study to the Civil Code Advisory Committee. A list of the then-current Committee members is included with this testimony.

In its consideration of HB 32, the Committee reviewed the written testimony submitted to the Senate Judiciary Committee, academic and law review articles on the topic, and apology laws from other states. The Committee unanimously concluded:

(a) public policy favors apologies,

(b) it would be consistent with public policy to exclude for purposes of proving liability an *apology or expression of sympathy*, but

(c) statements or expressions of *fault* should not be excluded from evidence;[1] and

(d) the exclusion of apologies should not be limited to health care providers.[2]

Viewed against the public policy which approves the cathartic and potentially healing effect of apologies is the long-standing and well-based reasoning for holding admissions of fault to be admissible.

> Admissions against interest made by a party are the strongest kind of evidence and override other factors. (*Hiniger v. Judy,* 194 Kan. 155, 165, 398 P.2d 305; *Reeder v. Guaranteed Foods, Inc.,* 194 Kan. 386, 393, 399 P.2d 822; and see *Green v. Higbee,* 176 Kan. 596, 272 P.2d 1084; *Stewart v. Gas Service Company,* 252 F.Supp. 385 (D.Kan.1966); and K.S.A. 60-460(g) and (h).)[3]

[1] Substitute Senate Bill 374 would exclude, inter alia, statements of "mistake" or "error."

[2] Substitute Senate Bill 374 would limit the exclusion to statements or actions by a "health care provider, an employee or agent of a health care provider."

[3] *Kraisinger v. C. O. Mammel Food Stores*, 203 Kan. 976, 986, 457 P.2d 678 (1969).

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The Committee reviewed apology statutes enacted in 35 other states and found that there has not been uniformity in the approach taken. The Committee selected Hawaii's law as the model in drafting SB 374, approving of both the statute's substance and its simplicity. Haw. Rev. Stat. §626-1, Rule 409.5 (2007).

SB 374 is simple and straightforward and meets the Committee's primary objectives:

- The evidentiary exclusion created by the bill does not extend to outright admissions of fault.[4] This is consistent with the vast majority of apology statutes studied, only four of which explicitly include statements of responsibility or liability.
- Like the original apology statute enacted in Massachusetts and many others, the evidentiary exclusion created by the bill is not limited to health care providers.
- The bill deals with mixed expressions of apology and fault by rendering them neither specifically included nor excluded from the immunity granted, instead leaving the decision on such expressions to the court.
- The proposed statute is consistent with the Kansas approach to offers of compromise that include express admissions of facts. See K.S.A. 60-452.

While the proponent of Substitute Senate Bill 374 touts the success of apologies reported by a study at the University of Michigan, that success says nothing about whether admissions of liability or statements of fault should be excluded from evidence at trial. Indeed, under Michigan law, any admissions or statements against interest *are still admissible*. Rule 804, Michigan Rules of Evidence, states:

> *Statement against interest.* A statement which was at the time of its making so far contrary to the declarant's pecuniary or proprietary interest, or so far tended to subject the declarant to civil or criminal liability, or to render invalid a claim by the declarant against another, that a reasonable person in the declarant's position would not have made the statement unless believing it to be true.

See, e.g. *People v. Washington*, 650 N.W.2d 708 (Mich. App. 2002). Thus, the University of Michigan experiment is a brave one, and any benefits to making an apology have been derived not only without an apology law, but in spite of the *absence* of an apology law.

It is the opinion of the Committee and the Judicial Council that SB 374 is a superior approach to an apology statute in Kansas. SB 374 fairly meets the objective of codifying the public policy favoring apologies without limiting the immunity to health care providers or extending it to admission of fault.

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[4] See, e.g. K.S.A. 60-460(g), (h) and (i) (hearsay is admissible if it represents an admission by a party or its representative, an authorized or adopted admission, or a vicarious admission). *Pape v. Kansas Power and Light Co.*, 231 Kan. 441, 647 P.2d 320 (1982); *State v. Stano*, 284 Kan. 126, 159 P.3d 931 (2007).

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JUDICIAL COUNCIL CIVIL CODE ADVISORY COMMITTEE

The members of the Judicial Council Civil Code Advisory Committee who participated in the study of SB 32 and the draft of SB 374 are:

J. Nick Badgerow, Chairman, practicing attorney in Overland Park and member of the Kansas Judicial Council

Hon. Terry L. Bullock, Retired District Court Judge, Topeka

Prof. Robert C. Casad, Distinguished Professor of Law Emeritus at The University of Kansas School of Law, Lawrence

Prof. James M. Concannon, Distinguished Professor of Law at Washburn University School of Law

Hon. Jerry G. Elliott, Kansas Court of Appeals Judge, Topeka

Hon. Bruce T. Gatterman, Chief Judge in 24th Judicial District, Larned

John L. Hampton, practicing attorney, Lawrence

Joseph W. Jeter, practicing attorney in Hays and member of the Kansas Judicial Council

Hon. Marla L. Luckert, Kansas Supreme Court Justice, Topeka

Hon. Kevin P. Moriarty, District Court Judge in 10th Judicial District, Olathe

Thomas A. Valentine, practicing attorney, Topeka

Donald W. Vasos, practicing attorney, Fairway

OP 427285.1

KANSAS ASSOCIATION FOR JUSTICE

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Your rights. Our mission.

To: Senator Thomas "Tim" Owens, Chair
Representative Lance Kinzer, Vice Chair
Members of the Interim Judiciary Committee

From: Gary D. White
Palmer, Leatherman, White & Dalton, LLP, Topeka

Date: October 25, 2010

Re: **SB 374 and Sub for SB 374: Rules of evidence; Exceptions for apologies in certain circumstances**

On behalf of the Kansas Association for Justice (KsAJ), thank you for the opportunity to comment on the policy of creating exceptions to the rules of evidence for apologies.

KsAJ supports SB 374 as introduced, which was drafted and recommended by the Kansas Judicial Council Civil Code Committee. In general, KsAJ does not oppose changing the rules of evidence relating to apologies, as long as such changes are fair to all parties and do not permit concealment of wrongdoing.

The law in Kansas is that a doctor is presumed to have skillfully treated his patient. There is no presumption of negligence, even if the patient has an injury or adverse result. (*Tatro v. Lueken*, 212 Kan. 606, 611, 512 P.2d 529.) However, encouraging genuine expressions of compassion and sympathy between patient and provider makes sense, and public policy favors apologies. Improved communication resolves disputes, expedites settlements, and is in the best interests all parties.

At the same time, KsAJ urges caution. Apology legislation that skews the rules of evidence, favors one party, permits concealment of truthful evidence, or allows negligent or intentional acts to be hidden from a jury is poor public policy. KsAJ believes Sub for SB 374 would bear these consequences, and would harm Kansas patients. KsAJ opposes Sub for SB 374.

<u>Overview: **Rules of Evidence**</u>. Both SB 374 and Sub for SB 374 change the rules of evidence. The rules of evidence are procedural rules that apply to all parties during a trial and help juries determine the truth in a dispute. The rules spell out what information is provided to a jury, when and how it is provided, and the purpose for which it is provided. It is important that the rules of evidence are balanced and fair to all parties so that no side is advantaged—or disadvantaged—at trial.

Promoting empathetic, and better, communication is in the interests of patients and their families. But haphazardly changing the rules of evidence can compromise patients' interests: apology legislation that is too broad can be used to conceal gross or intentional negligence from the consideration a jury, making the rules of evidence one-sided and unfair.

<u>**If the Interim Judiciary Committee recommends changes to the rules of evidence creating an exception for apologies, KsAJ strongly recommends that such changes be carefully and narrowly tailored.**</u>

<u>**SB 374: Judicial Council Bill.**</u> KsAJ believes that SB 374, drafted by the Kansas Judicial Council Civil Code Committee, is a fair and balanced approach for the following reasons:

- **SB 374 was recommended and drafted by the Kansas Judicial Council, the appropriate expert body to make neutral policy recommendations regarding the rules of evidence.** After exhaustive research of previous Kansas bills, academic and law review articles, and apology laws enacted in 35 other states, the Council's Civil Code Advisory Committee recommended SB 374.

- **The rules of evidence relating to apologies should apply to anyone that apologizes. There should not be a special rule of evidence for health care providers.** An apology rule that applies only to health care providers and not to patients, or to anyone else that might want to say "I'm sorry," is not fair.

- **SB 374 does not allow concealment of evidence that shows gross or intentional negligence and is consistent with other states' apology laws.** The vast majority of states do not exclude from the jury admissions of fault as evidence of liability or admission against interest. SB 374 is fair to patients because it cannot be used to conceal gross or intentional negligence from a jury.

Sub for SB 374. KsAJ cannot support Sub for SB 374. Sub for SB 374 goes well beyond the scope of protecting sincere apologies and promoting open communication.

- **Sub for SB 374 conflicts with the Judicial Council Civil Code Committee policy recommendations.** The Judicial Council is charged with reviewing the judicial system and recommending policy that assures the fair administration of justice to all parties to a dispute. The Judicial Council's recommendations regarding changes to the rules of evidence should, appropriately, carry significant weight.

- **Evidence of mistakes or errors is concealed.** Under Sub for SB 374, evidence demonstrating a health care provider's mistakes or errors can be withheld from a jury, even if the evidence shows that a mistake or error caused a patient to die or be permanently injured.

- **Settlements are discouraged, not encouraged.** Since juries cannot consider evidence of mistakes or errors in determining liability, there is little incentive for health care providers that cause injury to patients to settle quickly or at all

- **The public policy favoring apologies is totally defeated.** Sub for SB 374 is based on South Carolina's apology law, but Sub for SB 374 is missing some very important patient protections. In South Carolina, in order for the protection of the rules of evidence to apply, the apology must be made to the patient, the patient's relative, or a patient's representative. In addition, the South Carolina law protects only apologies made during a designated meeting called by the health care provider to discuss an unanticipated outcome. Neither of these patient protections is required in Sub for SB 374.

  In Sub for SB 374, "apologies" regarding an adverse outcome are protected by the rules of evidence regardless of whether or not the apology is actually communicated to the patient or the patient's representative. Statements about mistakes or errors, made to anyone, in any place, at any time, can be kept from the jury. Sub for SB 374 is so overbroad that it can be interpreted to include written statements in medical records that show evidence of mistakes or errors.

  The result is that a patient may never be given any information at all about an adverse outcome, mistake or error. Nevertheless, under Sub for SB 374, evidence of negligent care, even if it causes permanent injury or death, could be withheld from a jury's consideration.

If the Interim Judiciary Committee recommends changes to the rules of evidence relating to apologies to the 2011 Legislature, the Kansas Association for Justice respectfully requests that it recommend legislation mirroring SB 374, as introduced, which was drafted and recommended by the Kansas Judicial Council.

Thank you for the opportunity to provide you with our perspective.

"Advocating for Quality Long-Term Care" since 1975

Kansas Advocates for Better Care

October 20, 2010

To Members of the Special Committee on Judiciary
From Kansas Advocates for Better Care, a non-profit organization speaking up for frail elders and vulnerable adults in Kansas for 35 years.

Dear Chairman Owens and Committee Members,

On behalf of the members, volunteers and Board of Directors of Kansas Advocates for Better Care I am submitting testimony regarding SB 374 "Apology Bill" and the substitute bill that was introduced in the 2010 regular session. Kansas Advocates is a state-wide citizen group made up of members (including nursing home residents) and volunteers whose mission is to advocate for frail elders and vulnerable adults and the public policies that will improve health and safety for those who receive long-term care in nursing homes, assisted living and their own homes.

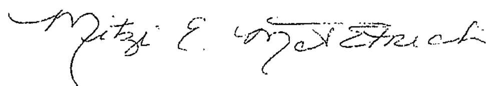
We strongly support SB 374 and encourage you to recommend passage of this legislation with its current provisions. We oppose the substitute legislation introduced as Proposed Substitute for SB 374.

Adults living in long-term care settings rely on legislators and legislation; regulators and regulation to vigorously protect their health and safety. Many vulnerable adults do not possess the mental capacity or physical ability to advocate for their needs with health care providers, or other service providers. Many do not have family to advocate for them. For those who do have family, members are often consumed by providing care for a loved one or they live out of state, and they too rely on legislators to safeguard the interests of loved ones.

Reports of poor care, abuse, neglect and exploitation were confirmed in 132 adult care homes in the past twelve months. Earlier this year I received a call from a family member whose aunt had passed in an adult care home after being sexually abused by a worker whose job it was to care for her. The resident was mentally challenged and unable to speak. Providing an apology is an important step in the healing process for persons who have suffered abuse or inadequate care, but it should not be exculpation for the person whose occupation it is to provide that care. A significant percentage of elders who are victimized by fraud or abuse die within 18 months. Depriving a person the opportunity to seek redress through the courts because an apology has been offered, including one that contains a statement of fault, is a further exposure of the vulnerabilities of frail adults. For a health care provider to be shielded from a lawsuit because s/he has offered an apology for error or wrong-doing is an over protection of health care workers at the expense of someone already harmed.

Kansas Advocates for Better Care asks that you offer frail elders and disabled adults the protection that SB 374 provides and that they deserve.

Thank you,



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Special Committee on Judiciary
10-25-10
Attachment 5

KANSAS BAR ASSOCIATION

TO: **The Honorable Tim Owens**
And members of the Special Committee on Judiciary

FROM: **Joseph N. Molina**
On Behalf of the Kansas Bar Association

RE: ***2010 Senate Bill No. 374 - The Apology Bill***

DATE: **October 25, 2010**

Good morning Senator Owens and Members of the Special Committee on Judiciary. I am Joseph N. Molina and I appear on behalf of the Kansas Bar Association in support of SB 374 as introduced by the Kansas Judicial Council. The apology statute was first considered in 2009 by the Senate Judiciary Committee when SB 32 was introduced. After extensive testimony the Senate Judiciary Committee referred the issue to the Kansas Judicial Council for further study. The Kansas Judicial Council opposed SB 32 as written, although they did support the concept for an apology law. As a result of their review, the Judicial Council Civil Code Advisory Committee crafted SB 374.

The Kansas Bar Association was neutral in 2009 when SB 32 was introduced and had no position on SB 374 prior to February 16 when a substitute bill was advanced out of committee. The KBA Legislative Committee reviewed both SB 374 as introduced and the substitute bill. The KBA has determined that the recommendations forwarded by the Kansas Judicial Council should be supported. The Judicial Council review process is a highly effective approach that considers various points of view. For instance, the Civil Code Advisory Committee of the judicial Council assigned to study SB 32 is comprised of plaintiff and defense bar members, law professors and judges from the appellate and district court levels. We believe that this evaluation and recommendation in the form of SB 374, as introduced, should be given the support of this Special Committee.

On behalf of the Kansas Bar Association, I thank you for your time this morning and would be available to respond to questions.

About the Kansas Bar Association:

The Kansas Bar Association (KBA) was founded in 1882 as a voluntary association for dedicated legal professionals and has more than 6,900 members, including lawyers, judges, law students, and paralegals. www.ksbar.org

Special Committee on Judiciary
10-25-10
Attachment 6

Sisters of Charity of Leavenworth Health System

2010 Special Committee on Judiciary
State of Kansas
October 25, 2010

Written Testimony on Senate Bill 374/Substitute for Senate Bill 374

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 (SCLHS), which is made up of eleven hospitals and four stand-alone clinics located in the states of Kansas, Colorado, Montana and California.

SCLHS 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.

In 2009, the Sisters of Charity of Leavenworth Health System requested a bill to establish an apology law in Kansas. Per our request, Senate Bill 32 was introduced and referred to the Judiciary Committee. The Judiciary Committee held a hearing on Senate Bill 32 on January 23, 2009, and ultimately referred it to the Kansas Judicial Council for study. The Judicial Council adopted a report on Senate Bill 32 in December 2009, and requested Senate Bill 374, an alternate version of an apology law. SCLHS asserted the Judicial Council's logic was flawed and, joined by other Kansas hospital systems, asked for a substitute version of the bill. Substitute Senate Bill 374 was adopted and passed favorably out of the Senate Judiciary Committee, but was returned and referred to interim study.

The Mission of Sisters of Charity of Leavenworth 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.* Our 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.

SCLHS has spearheaded the effort for Kansas to codify public policy which 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 adverse medical outcome.

The logic of this public policy is that, when there is an adverse outcome of a medical procedure or treatment, 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 will not need to wait for legal counsel to advise them, or for fault to be investigated, before they can freely express compassion to their patients.

This policy limits evidence if a case goes to trial. If fault is clear – such as a wrong limb being operated on, or something left inside a patient – we assert that evidence of an apology statement isn't needed and ***what is gained far outweighs what is lost.***

Anecdotally, we all know some patients would be understanding when things do not 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 counsel them not to say anything. An article in the *New York Times* in 2008 discusses cases where "sorry" worked to avoid costly litigation. **The *New York Times* investigator reports that even trial lawyers are realizing they like the "sorry works" approach because injured clients are compensated quickly.**

Thirty-four states have apology laws in statute. Much has been written about the success of these laws, and studies have confirmed their effectiveness for patients and health care providers. **The University of Michigan Health System reduced malpractice claims by 55 percent between 1999 and 2006, and reduced average litigation costs by greater than 50 percent. Average claims processing time dropped from 20 months to about 8 months.** Reports on their experience are provided.

An empirical study on *"The Impact of Apology Laws on Medical Malpractice"* by economists Benjamin Ho PhD of Cornell University and Elaine Liu PhD of University of Houston was released in December 2009, with follow-up in 2010. They found:

> When doctors apologize for adverse medical outcomes, patients are less likely to litigate. However, doctors are socialized to avoid apologies because apologies admit guilt and invite lawsuits. **Apology laws specify that a physician's apology is inadmissible in court, in order to encourage apologies and reduce litigation.** Using a difference-in-differences estimation, **we find that State-level apology laws expedite time to resolution and increase the closed claim frequency by 15% at the State level. Using individual level data, we also find such laws have reduced malpractice payments in cases with the most severe outcome by nearly 20%.** Such analysis allows us to quantify the effect of apologies in medical malpractice litigation.

Background on Apology Bill in Kansas

When the Senate Judiciary Committee referred the apology bill to the Kansas Judicial Council for study in 2009, Cynthia Smith, SCLHS Advocacy Counsel, communicated with the Judicial Council and offered our expertise. We suggested they consider the language of the South Carolina law on adverse medical outcomes, which we determined was a better model than the Colorado model used in Senate Bill 32 in 2009.

Instead, the Judicial Council advisory committee decided the Hawaii law was preferred. **We respectfully disagreed with the conclusion of the Judicial Council.**

First, Hawaii law is not limited to health care providers. Perhaps there are other circumstances where an apology law would be good public policy. We cannot supply evidence supporting that, but are here to address the relationship between a doctor and his or her patient, and how apologies are proven to work in the health care setting. 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. **In fact, apology laws are held up by Republicans in Congress as a desirable model of medical liability reform.**

Second, the Hawaii law offers no assurance that an apology will be excluded from evidence. Instead, the statute commentary states "Whether a challenged utterance amounts to an expression of sympathy or an acknowledgment of fault will be entrusted to the *sound discretion of the trial court*...In making this determination, the court could consider factors such as the declarant's language, the declarant's physical and emotional condition, and the context and circumstances in which the utterance was made." (emphasis added)

In other words, the Hawaii law and SB 374 *as introduced* demanded that whether an apology will be excluded from evidence must be – in each case, after the fact – decided in court.

In hearings before the Senate Judiciary Committee during the 2010 legislative session, SCLHS -- joined by Via Christi Health System, Saint Luke's Health System, and Shawnee Mission Medical Center -- asserted that, under S. 374 as introduced, health care providers would not be able to rely on protection under the law. **Doctors would instead follow their lawyers' advice not to communicate with patients or acknowledge an adverse event, and the law will be useless in opening lines of communications and do nothing to reduce costly medical liability litigation.**

The 2010 Senate Judiciary Committee voted to substitute the South Carolina-based language suggested by SCLHS and referred Substitute for Senate Bill 374 to the full Senate favorably for passage. We were disappointed when the bill was later returned to the committee despite widespread support. The bill was referred to interim study.

Fault

The primary question raised about the apology bill is whether statements of "mistake" or "error" or "fault" should be excluded from evidence. Substitute Senate Bill 374 would exclude such statements from evidence.

We assert again that a bill that carves these statements out of an apology law would render it impotent. **When a doctor says "I'm sorry," is that a statement of mistake or error (fault), or not?** We envision each apology statement would have to examined by a judge to determine whether it was an admissible statement of fault, after the fact.

> Best case: statements of apology will occur, but be so carefully scripted as to be unsatisfactory to either the patient or the doctor.
>
> Worst case: lawyers will find the protections under the law unreliable, and continue to advise silence.

If there is mistake or error involved in an adverse event, and statements of mistakes or errors (fault) are not excluded from evidence, those will be the exact circumstances in which a sincere apology may not happen. That would be an unfortunate result.

Law vs. Policy

The University of Michigan Health System was able to achieve success with a policy which demanded disclosure and apology. SCLHS also has such a policy, which we have provided.

An important difference is that the doctors and other care providers at the Michigan health system are employees of the University. Most doctors serving patients in hospitals are not hospital employees. We still intend for them to follow our policies. **In reality, if a patient experiences an adverse medical outcome, the doctors involved will follow their lawyers' advice to ignore the policy and not conduct the disclosure and apology we demanded of them.**

An apology law is necessary because not only do we want doctors to know they can apologize, but also to make their lawyers comfortable with their clients communicating with the patient and apologizing. A policy is not enough, we need new law.

This is a simple, common sense tort reform policy which would reduce health care costs, has no cost to the state and would likely preserve Health Care Stabilization Fund dollars. We urge the Special Committee to support adoption of Substitute for Senate Bill 374.

Respectfully submitted,
Edward L. Barker, Esq.
Sr. Vice President / General Counsel

Attachments:

- List of 34 state apology laws, www.sorryworks.net.
- Benjamin Ho, PhD, and Elaine Liu, PhD, The Impact of Apology Laws on Medical Malpractice, Cornell University and University of Houston, September 2010.
- Honesty and apology after medical errors result in 55 percent reduction in malpractice claims, *Premier SafetyShare*, September 2009.
- Boothman RC, et al., A better approach to medical malpractice claims? The University of Michigan experience, *J. of Health and Life Sciences Law* 2:2, January 2009.
- SCLHS disclosure policies
- Editorial coverage of apology bill in Kansas, 2010
- Sack, Kevin, "Doctors Say 'I'm Sorry' Before 'See You in Court'," *The New York Times*, May 18, 2008
- Goodman, David M., Apologizing for medical mistakes, saying `sorry' is paying off for doctors at U. of Michigan, Associated Press, July 2009

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
- 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, Title 19 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

http://www.sorryworks.net/default/resource-center/states-with-apology-laws

What's an Apology Worth?

Estimating the Effects of Apology Laws in Medical Malpractice *

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September 2010

ABSTRACT

When doctors apologize for adverse medical outcomes, patients are less likely to litigate. However, doctors are socialized to avoid apologies because apologies admit guilt and invite lawsuits. Apology laws specify that a physician's apology is inadmissible in court, in order to encourage apologies and reduce litigation. Using a difference-in-differences estimation, we find that State-level apology laws expedite time to resolution and increase the closed claim frequency by 15% at the State level. Using individual level data, we also find such laws have reduced malpractice payments in cases with the most severe outcome by nearly 20%. Such analysis allows us to quantify the effect of apologies in medical malpractice litigation.

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Recent trends in medical malpractice claims have long been of public concern in the United States. In response, lawmakers in various States have passed legislation attempting a number of reforms, including jury award caps, insurance premium price caps, State medical malpractice funds and information disclosure requirements. In this paper, we focus on a more recent medical malpractice reform—the so called "apology law". While the details of apology laws may differ across States, most declare that a statement of apology made by a medical practitioner to a patient is inadmissible as evidence of liability in court. The apology laws are based on the premise that physicians would like to apologize to their patients in the case of adverse complications, but are stymied by their fear of inviting lawsuits (Lamb et al., 2003; Novack et al., 1989; Pinkus, 2000); on the other hand, patients often sue their doctors out of anger, though their anger would have been assuaged by a physician's apology (Hickson et al., 1992; May & Stengel, 1990; Vincent & Young, 1994). These two stylized facts lead to a vicious cycle, which breaks down the communication between patients and doctors leading to unnecessary malpractice litigation (Cohen, 2003; Robbennolt, 2006). Apology laws are designed to reduce unnecessary litigation. Analysis of these laws also serves as a useful instrument to quantify the value of apology in medical malpractice. By quantifying the impact of the laws on the frequency of malpractice claims and the claim severity, we are able to obtain a measure on the extent to which apologies influence claims of medical malpractice.

As of January 2009, 36 States (including Washington D.C.) have enacted various forms of apology laws. Despite this wide-spread adoption, there has been very little empirical economic analysis examining the laws' effectiveness. Studies by Liebman & Hyman (2004 2005) and Kraman & Hamm (1999), examining the effectiveness of apology programs at individual hospitals, both find that programs that encourage effective apologies and disclosure of

mistakes can dramatically reduce malpractice payments. Most notably, the apology and disclosure program at University of Michigan Health Service has been deemed as a role model for its peers since Boothman et al. (2009) reported a dramatic decrease of 47% in compensation payments and a drop in settlement time from 20 months to 6 months, after its implementation in 2001. While the findings for hospital-level apology programs are promising, it is not clear whether the impact of State-level apology laws would be as remarkable. For example, these aforementioned hospitals could be under the management of reforming administrators, or may have other concurrent programs (e.g. full information disclosure program at University of Michigan Health Services); therefore, the reduction in claim frequency or payout could be attributed to factors besides the apology program. In other words, the true effect of apologies on medical malpractice litigation could be overestimated.

From a legal aspect, a study by Robbennolt (2003, 2006) provides an overview of why and how apologies could be effective in reducing patient's likelihood to litigate based on existing psychological theories. Several studies give subjects hypothetical situations report that apologies may reduce the subjects' likelihood to litigate (Gallagher et al, 2003; Witman et al., 1996; Mazor et al. 2004; Wu, 1999; Wu et al., 2009). Conversely, the critics of apology laws argue that the laws may be counter-effective. Especially given that the majority of patients in the adverse medical event are unaware of medical errors, unsolicited apologies could possibly induce more malpractice claim (Studdert et al., 2007). Wei (2008) also examines the social norm of apology in medicine, and she concludes that the norm and habit among medical professionals could be a major barrier to the effectiveness of the apology law. Mastroianni et al. (2010) suggest that most of the State-level apology laws only protect statement of sympathy, and it may actually discourage apologies and weaken the laws' impact on malpractice suits. Therefore, the true

impact of the State-level apology laws remains an open empirical question. To date, this is the first empirical paper to investigate the impact of State-level apology legislation on claim frequency and claim severity.[2]

The plan of the paper is as follows: Section 2 provides a background of the apology laws. In Section 3, we provide an economic argument for how apologies could affect malpractice liability claims and lawsuits. Section 4 describes the dataset in detail and presents summary statistics. Section 5 presents the empirical results, and Section 6 concludes.

2. Background of Apology Law

As of January 2009, apology laws have been enacted in 36 States, all of which were enacted between 1999 and 2008 (except for Massachusetts, whose law dates to 1986). Table 1 lists all of the State legal codes pertaining to medical apologies.[3]

[Insert Table 1 About Here]

Most State apology laws have similar templates, but only a slight variation in the types of statements that are protected. Protected statements typically include a combination of apology, fault, sympathy, commiseration, condolence, compassion, and admissions of mistakes, errors, and liability. Connecticut's apology law is a typical example. The Connecticut law States that:

> In any civil action brought by an alleged victim of an unanticipated outcome of medical care, or in any arbitration proceeding related to such civil action, any and

[2] This paper focuses on the positive economics, not the normative aspect of the apology laws. For an overview of the debate of the appropriateness of the apology law see Taft (2005).

[3] California, Massachusetts, Florida, Tennessee, Texas, and Washington have general apology statutes that apply across all industries while the other 30 States have specific laws that only protect the statements of apology made by health care providers. The States can be first divided into two types depending on the applicability of these laws: general versus health practitioners only. We perform an F-test checking whether we can group the general versus health-care only laws together, the F-test fails to reject the null hypotheses that these two types of apology laws have the same impact. Therefore, for the remainder of the paper, we are not going to differentiate between general and health-care only apology laws.

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> all statements, affirmations, gestures or conduct expressing **apology, fault, sympathy, commiseration, condolence, compassion or a general sense of benevolence** that are made by a health care 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 that relate to the discomfort, pain, suffering, injury or death of the alleged victim as a 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. (emphasis added)

In the legal literature examining apology laws, some studies divide the apology laws into full versus partial apology laws. The key difference is that full apology laws protect against all statements including fault, mistakes, errors, and liability, whereas partial apology laws only protect against statements of sympathy only. However, throughout our discussion and analysis, we do not differentiate between full and partial apology laws for two reasons: First, the divisions between full and partial apology laws are imprecisely defined. A paper by McDonnell and Guenther (2008) reports eight States as having full apology laws, whereas an article by Morse (2009) reports only five States as having full apology laws. Second, we conduct a statistical test checking whether these full and partial apology laws have differential impact on claim severity and claim frequency, and we fails to reject the null hypotheses that full and partial apology laws have the same impact.[4]

3. Economic Framework

In this section, we consider the economics of how apology laws affect physician and patient behaviors as well as the outcomes of the judicial process. A more mathematically formal representation of this section can be found in the Appendix. We assume that patients have two main motivations for seeking litigation, 1) the monetary incentive and 2) and psychic value of their relationship with the doctor. Similarly, suppose doctors have two main motivations when

[4] One possible explanation for this somewhat surprising finding could be due to the fact that all of the full apology laws have only been passed after 2003. Given that the full apology States are a small sample with very short elapsed time, there may not be enough statistical power to differentiate the impact of the two. However, it is not the same as stating that the partial and full apology laws have the same impact.

deciding whether to apologize, 1) their own monetary costs of litigation and 2) their psychic value of their relationship with their patients. Patients decide to litigate by weighing the monetary benefits from litigation with the psychic costs of suing their doctor. We assume that patients find it more costly to sue their doctor when there is more communication between the two. Doctors decide to apologize or not by weighing the monetary costs of the increased costs of litigation with the benefits of strengthening the relationship with their patients. The third major player will be the Courts who decide the size of the settlement award in case of litigation. Here, we assume that *ceteris paribus* the expected settlement award is larger when plaintiffs have the options to use apologies as evidence, than when laws prohibit their usage. For simplicity, we will assume lawyers simply faithfully represent the interests of their clients and we also assume that since most cases settle, settlement sizes are on average proportional to the expected judgment size.

In our model, apology laws work by reducing the expected damage award that doctors face if the case goes to court. The reduced expected damage award leads to a lower expected settlement payment, which leads to a lower monetary costs faced by doctors if they decide to apologize. Therefore the law makes it more likely for doctors to apologize. The frequency and severity of malpractice claims are reduced then through two channels. Patients are less likely to sue both because their likelihood of winning a lawsuit is reduced, and because the increased likelihood that a doctor apologized improves the relationship between patient and doctor.

Economic models of bargaining largely find that if agents care only about money, settlements occur immediately. Thus it is reasonable to also assume that it is the emotional relationship between patient and doctor rather than pecuniary concerns that accounts for delays

in settlement. Therefore, we would expect that the passage of apology laws would improve the relationship between patient and doctor and therefore would increase the speed of settlements.

The model also demonstrates that these laws may also have unintended consequences. For example, if doctors are shortsighted in their apologies, then more apologies by doctors could increase the awareness of mistakes by patients and thus lead to more lawsuits (see also Studdert et al (2007)). Similarly if patients become aware that the consequences of an apology are reduced, then the law would effectively devalue all apologies made by doctors, and potentially worsen patient-doctor relationships on average (Cohen, 2003; Ho, 2007). Finally, if apologies are successful at reducing the consequences of malpractice errors, then we may expect to see an increase in medical errors as well.

Our empirical analysis finds little evidence for these unintended consequences, but it is important to be aware that such effects may have attenuated the full value of apologies which we are estimating.

4. Data

In order to analyze the impact of State-level apology laws on claims severity and claim frequency, we need a dataset which contains detailed information on compensation and timing of adverse events in all States. Due to the federal Health Care Quality Improvement Act (HCQIA), all malpractice payments—either as part of a settlement or as part of a court judgment—made by or on behalf of a licensed health care provider must be reported to National Practitioner's Data Bank (NPDB) within 30 days since 1991. The NPDB contains the universe of all malpractice cases with non-zero payments, and it provides information regarding the year the incident occurred, the nature of the allegation (e.g., diagnosis related, anesthesia related, surgery related, etc.), the outcome of the incident (e.g., emotional injury, minor temporary injury, major

permanent injury, death, etc.),[6] the practitioner's work and licensing State, and whether the payment was for a judgment or a settlement. Due to its comprehensive and universal nature, NPDB is the most frequently used dataset in medical malpractice by economists despite some caveats with this dataset (see Baicker & Chandra, 2005; Durrance, 2009; Matsa, 2007).[7]

We restrict our analysis to the reports in which adverse events occurred after 1991 due to the incomplete reporting in the earlier years. Table 2 provides summary statistics at the individual level. There are a total of 225,319 payment reports in our sample. Note that the average time to settlement was 3.86 years with a standard deviation of 2.15. Longer settlement times are associated with cases that involve more severe injuries. This variability in settlement time will be crucial for understanding our results. In Figure 1 we present a histogram of resolution times for cases that occurred in 1992 so that we can be reasonably certain that this represents a fairly complete distribution of cases.

[Insert Figure 1 About Here]

[Insert Table 2 About Here]

In Figure 2 we present, by the year the event occurred, the number of resolved cases and the average number of years taken to reach a resolution.[8] Since the NPDB only receives information about an offense/omission when the payment is made, the dataset is truncated for offenses/omissions which occurred more recently but have yet to be resolved. For example, as

[6] The outcome variable only became mandatory for recording in 2004. The categories of injuries are reported by the entities that make payments to the patients.
[7] The NPDB dataset is not free of problems. It has been criticized because of a "corporate shield" loophole, through which settlement payments made on behalf of a practitioner end up excising the practitioner's name from the settlement data in the NPDB. Chandra, Nundy, and Seabury (2005) compare data from the NPDB with other sources of malpractice information and while they find approximately 20% underreporting, they find that underreporting is not systematically different across States. Therefore, for our analysis, which is extracting information at the State level, there is no obvious reason why the corporate shield loophole would bias the effects of the apology legislation. It is also important to note that the NPDB dataset has been used for most recent influential studies of medical malpractice reform (Currie & MacLeod, 2008)
[8] Figure 1 includes both those cases settled out of court and those cases resolved in court.

evident in Figure 2, fewer than 1,000 offenses that occurred in 2007 are included in our data since most of the offense that occurred in 2007 would have yet to be resolved. Therefore, the interpretation of regression results requires extra caution, which will be addressed in the analysis section.

[Insert Figure 2 About Here]

[Insert Table 3 About Here]

Besides the individual-level data, the NPDB was used to generate an aggregate dataset where an observation is at the State-year level. We establish two measures at the State level. With 51 States (including the District of Columbia) reporting over a 17 year period (1991-2007), there are 867 observations in the State-level dataset.[9] The first key variable, claim frequency, is defined as the number of claims made against a given practitioner working in a given State for an offense committed in a given year.[10] The second key variable is the total compensation made by medical practitioners in a given State for an offense committed in a given year.[11] These two variables are presented in Table 3 along with other State level characteristics. In 2000, the median claim frequency per State was 184 cases and the median total value of compensation was $35.7 million.

5. Empirical Strategy

[9] We have excluded all cases that occurred in 2008 since only less than 100 cases which occurred in 2008 had been settled by 2009.

[10] Another way to construct the State-level dataset is by the total number of settlements made in a given year. Our goal is to analyze the impact of apology laws, which intend to encourage practitioners to apologize and communicate more openly with their patients. The impact on the settlement is hinged upon the apology. While the model in Section 2 cannot distinguish the timing of the apology, the apology is likely to be most effective soon after the incident occurs, not a few years later. Therefore, we aggregate it by the year of incident instead of the year of settlement.

[11] We adjust the settlement by CPI. Therefore, all payments are in Y2000 dollars.

7-15

To examine the impact of the laws on malpractice claims, our analysis is conducted at two levels: State and individual level. First, at the State level, we use the difference-in-difference method to compare the change in claim frequency in States with apology laws compared to the States without the laws before and after the enactment of the laws. More specifically, we first employ OLS to estimate the following:

$$\log Y_{st} = \lambda controls_{st} + \beta\, apology_{st} + \sum_{t} \delta_t Year_t + \sum_{s} \delta_s State_s + \varepsilon_{st} \quad --Eq(1)$$

where Y_{st} is one of the two key outcome variable variables (claim frequency or total compensation payout) in State s during year t and *apology* is a dummy variable which is one if an apology law was in effect in State s during year t and otherwise is zero. Our main coefficient of interest is β, which represents the percentage change in claim frequency or percentage change in total compensation due to the adoption of the apology law. The results are presented in Table 4. Columns 1 and 4 are presented without controls while Columns 2 and 5 add a set of tort reform changes (i.e. the existence of a noneconomic cap, a punitive cap, joint and several liabilities and collateral source rule, and a law on full information disclosure). Columns 3 and 6 include a set of time-varying State demographics including the number of physicians in the State, racial compositions, population, and percentage of population that are 65 or above. The results in Table 4 show a consistent 14−15% increase in the closed claim after the apology law is adopted. The results for total compensation also show an increase of 20−27%.[12] The fact that the percentage increase shown in columns 4-6 is larger than those in columns 1-3, suggests that the claim severity per case increases after the law is enacted.

[12] The high R^2 is mostly due to the State and year fixed effects. In regression without any other covariates, the R^2 is about 0.96 for specification in columns 1-3. This is pretty natural as the number of cases resolved is mostly related to the year in which the case occurred.

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The result may seem surprising especially since the intents of the apology laws are to reduce malpractice costs rather than increase them. There are two possible explanations that could explain the positive coefficients in Columns 1 to 3. One is that there are increasing numbers of malpractice claims filed after the law is enacted in a State, either because doctors exerted less effort or patients now are better informed about the medical errors because of the improved communication. The second is that cases are resolved more quickly after States have enacted the apology laws. If there is such a distributional shift in the duration of malpractice cases (as illustrated in Figure 3), given that our dataset only includes resolved cases, we would temporarily observe an increase in the number of resolved cases.[13]

[Insert Table 4 About Here]

To understand which of these possibilities explains the increase in closed claims, we further break down the analysis by the severity of medical injury. The dependent variable is the natural log of claim frequency in each medical injury category (e.g., insignificant injury, "somewhat" significant injury, and major permanent injury/death).[15] Since only the cases that occurred after 2002 contains information about medical injury, we further restrict our sample.[16] Table 5 indicates that the overall increase in claim frequency observed is due entirely to the increase of claims for major/permanent injury and death. For insignificant injuries, which normally settle quickly enough to see the apology laws' full effect, we see a net reduction of 16.7−18.5% in the number of cases.

Again, to think about which hypothesis explains this result, suppose that doctors are exerting less effort after the apology laws are implemented, it is difficult to explain why there is

[13] In other words, if our dataset include all open claims data, then we would not be able to find this increase. This is artifact of data structure.

[15] There are nine categories of injuries in the NPDB, which we group into three categories for the ease of analysis and presentation (see Table 3 for subcategories).

[16] The severity of injuries is only available for cases reported after 2002. For a similar analysis grouped by the size of payment, see Table A2 in the Appendix.

7-17

such a pattern based on case severity. Furthermore, if the increase in closed claims in States with apology laws are driven by otherwise uninformed patients, why would the increase be solely driven by the increased frequency in major permanent injury/death cases, given that the death and severe cases are less likely to be neglected compared to the insignificant cases. The results in Table 5 suggest that after passing the law, there is a short-term increase in the number of cases that normally take years to resolve,[17] but an overall decrease in the number of cases involving the least significant injuries. This is consistent with Figure 3 in which the apology laws cause a shift of case settlement distribution to the left.

[Insert Table 5 About Here]

[Insert Figure 3 About Here]

We conduct a number of additional specifications to ensure the results are robust.[18] Also for all the States that have adopted apology laws, we subtract three years from the year of adoption and perform the same analysis to capture any possible spurious effect attributable to properties of the States in question rather than to the laws themselves. The coefficients in these specifications remain insignificant.

Lastly, as we intend to interpret the result as a causal interpretation, we need to check to see if the increase in settlements came after the adoption of the apology laws. Therefore, we include in our differences-in-differences specification a series of lead dummy variables, which specifies whether apology laws will be adopted in that State 1 year, 2 years, 3 years, 4 years, or 5 years into the future. We find that all coefficients on the lead dummies are not statistically

[17] From this dataset we can observe that it is true that cases involving more severely injured patients usually take longer to resolve than insignificant injury cases.

[18] The same analysis has also been performed on settlements excluding all cases that result in judgments and the results are similar. It could be worrisome if the effect of the States is spurious to the structure of the data or the time period upon which we estimate the data. Therefore, we perform various robustness checks. First, we randomly assign half of the States as having adopted the law between 2000 and 2005 and estimate the same difference-in-difference regression. The results are presented in columns 1-3 of Table A1 in the Appendix.

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different from zero, suggesting that the effects that we find do not predate the passing of the apology laws. Now, knowing that the results are robust and not due to spurious effect, we need to find the hypotheses that could explain the seemingly surprising results.

In Table 6, we consider the impact the law has on the claim severity of payments using a difference-in-difference model. We find that after the law is adopted, claim severity is reduced by approximately $17,000–27,000 (~17%) per case for somewhat severe cases and $55,000–73,000 (~20%) per case for those with the most severe outcome.[19]

[Insert Table 6 About Here]

Even though our qualitative analysis does not directly offer predictions as to which specialties should be most impacted by the adoption of apology laws, nevertheless it is still interesting to examine whether there is a differential impact on different subgroups. There is no data in the NPDB on the physicians' specialties, but the NPDB does divide the nature of the allegations into 11 categories: diagnosis related, anesthesia related, surgery related, medication related, IV and blood product, obstetrics related, treatment related, monitoring related, equipment/product related, other miscellaneous, and behavioral health related. In Table 7, we interact the allegation categories with the apology law dummy, controlling for medical outcome, gender, patient age, physician experience, and timing of other tort reform. The results suggest that relative to the diagnosis-related cases, anesthesia-, surgery-, and obstetrics-related cases would experience a greater reduction in claim severity. In regression results not reported in the current paper, we perform the same analysis controlling for the same set of covariates, but with our main coefficients of interest being the health practitioner's age. In this case, we find that

[19] Regressing the same specification on different payment size quantiles finds that the law has the largest effects on the 3rd quantile and no effect on the 1st and 4th quantile. The lack of effect on 4th quantile payments could be due to the fact that apologies are likely to be less important in cases worth millions of dollars, or that the largest cases take many years to resolve and thus cases of this size have yet to be resolved in most States where apology laws have been passed.

compared to younger health practitioners, those who are between 31 and 59 years of age experience a $25,000−30,000 compensation reduction per case due to the adoption of apology laws.

[Insert Table 7 About Here]

6. Conclusion

In this paper, we perform both quantitative and qualitative analysis of the effects of apology laws on medical malpractice claim frequency and claim severity and get some insight into the value of an apology. We find evidence that the apology law would increase the claim frequency in the short run. We also find that the compensation for those cases with permanent injuries/death would drop by nearly 20% after the law is passed. While having an insignificant impact on the claim severity for cases involving minor injuries, the apology laws do reduce the total claim frequency of such cases. While the short term increase in malpractice settlements could be a surprise to policymakers and advocates of apology laws, we believe this is an artifact of data limitations. Our findings suggest that apology laws reduce the amount of time it takes to reach a settlement in what would normally be protracted lawsuits, leading to more resolved cases in the short run. In the long run, the evidence suggests there could be fewer cases overall.

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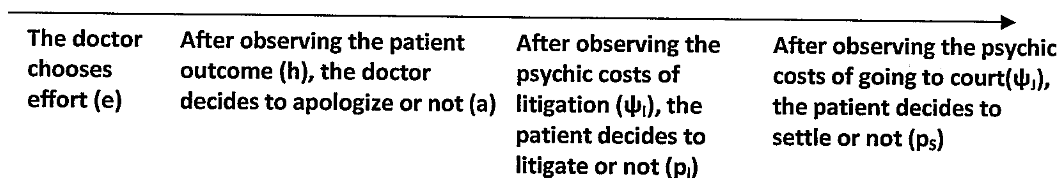
Appendix

To illustrate the mechanisms that we are analyzing, consider first the simplest possible model of how doctors decide to apologize and how patients decide to litigate and settle. Previous models of apologies (Ho, 2009) and litigation (Daughety & Reinganum, 1993, 2000; Farber & White, 1994; Spier, 2005) have focused on asymmetric private information, but these assumptions introduce considerable complications to the analysis that we will return to at the end of this section.

Consider a situation in which there are two players: a patient/plaintiff (P) and a doctor/defendant (D) who play a game of healthcare provision, apology, and litigation with the following timeline:



The patient's health outcome, $h(e, \varepsilon)$,[20] depends on the doctor's effort, e, which can be thought of as whether the doctor adhered to the standard of care, $e = \bar{e}$), but also depends on the patient's circumstances, which are represented by a noise term, $\varepsilon \sim F(\varepsilon)$, and are unobserved by the doctor when deciding effort. We will assume for now that the doctor always adheres to the standard of care ($e = \bar{e}$), but later we will consider the possibility that the doctor's efforts may depend on the incentives created by

[20] Higher h indicates better health. It is increasing with e, the doctor's effort. See for example, Gaynor and Gertler (1993).

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the threat of malpractice payments. The doctor then decides whether to apologize ($a = 1$) or not apologize ($a = 0$).[21]

The cost of an apology for the doctor is that the apology can be used as evidence against him/her in court. If litigation occurs, since the court cannot observe the doctor's effort, we assume that the expected judgment, $J(h, a)$,[22] is exogenously decreasing with better health outcomes and exogenously increasing with the doctor's apology (Sloan & Hsieh, 1990) since the apology can be used as evidence (Rehm & Beatty, 1996). We consider the implications of endogenizing the judgment size in Section 3.

The benefit of an apology to the doctor is that it increases the psychic cost of litigation. Numerous case studies suggest that anger is a main motivator for litigation that can overcome the patient's aversion to litigate (Hickson et al., 1992; May & Stengal, 1990; Vincent et al., 1994). Studies also find that apologies reduce patient anger, increase communication, and reduce the patient's motivation to litigate (Liebman & Hyman, 2004, 2005; Ohbuchi, Kameda, & Agarie, 1989; Sloan & Hsieh, 1995). We capture these psychological factors by saying there is a psychic disutility of initiating litigation, $\psi_l(a)$, and a psychic disutility for going to court, $\psi_J(a)$. Both disutilities would increase if the doctor apologizes. These psychic costs are modeled as random valued functions of whether a doctor apologizes where ψ_i (1) first order stochastically dominates ψ_i (0) for $i \in \{l, j\}$. For now we assume that apologies exogenously increase the patient's psychic disutility to litigate, but in Section 3 we discuss alternatives for which apologies serve as signals.

After the doctor apologizes (or not), the patient observes the realization of his psychic disutility of litigating. It is now the patient's turn to decide whether to litigate or settle. We define p_s as the probability the patient decides to settle, p_l as the probability the patient decides to litigate, and c_p as the economic cost of going to court.

[21] In this model, even though doctors adhere to the standard care procedure, since the court cannot observe the level of care, they might still want to apologize if apology helps reduce the probability of litigation. Patients could still sue the doctors as long as the utility from litigation is higher than the disutility from litigation.

[22] This is the amount that the patient receives and the doctor is required to pay after accounting for the probability that the patient wins.

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Solving then by backward induction, the patient decides to settle if the benefit of settling, $S(h,a)$, is greater than the benefit of going to trial, $J(h,a) - c_P - \psi_J(a)$. How the settlement is determined relative to the judgment size typically depends on a bargaining game that we will abstract away from the current paper. For this paper will we simply say that the settlement, $S(h,a)$, is some fraction of the judgment size, $S(h,a) = \lambda J(h,a)$ where $\lambda \in [0,1]$.

If the patient decides to litigate, then the probability of settling is:

$$p_s = \Pr\left[S(h,a) > [J(h,a) - c_P - \psi_J(a)]\right]. \quad (1)$$

From here, we can take a step back and compute the expected malpractice payment to be equal to the expected value from settling plus the expected value from a judgment minus the costs (both psychic and economic) of going to court:

$$E\left[p_s S(h,a) + (1-p_s)\left(J(h,a) - c_P - \psi_J(a)\right)\right]. \quad (2)$$

The patient's probability of litigating, p_l, is then given by the probability that the expected malpractice payment is greater than the psychic disutility of litigating:

$$p_l = \Pr\left[E\left[p_s S(h,a) + (1-p_s)\left(J(h,a) - c_p - \psi_J(a)\right)\right] > \psi_l(a)\right]. \quad (3)$$

Consistent with the empirical evidence found by Sloan and Hsieh (1995), equation (3) predicts that patients are more likely to litigate given more serious health outcomes.

To summarize, patient utility depends on the patient's health plus expected malpractice payments net of litigation and psychic costs, while doctor utility depends on the doctor's cost of effort minus expected malpractice payments and the economic costs of litigation (c_D):

$$U_P(l,s) = h(e,\varepsilon) + p_l\left[p_s S(h,a) + (1-p_s)\left(J(h,a) - c_P - \psi_J(a)\right) - \psi_l(a)\right] \quad (4)$$

$$U_D(e,a) = -e - p_l[p_s S(h,a) + (1-p_s)(J(h,a) + c_D)].$$

Doctors will apologize if and only if $U_D(\bar{e},1) \geq U_D(\bar{e},0)$. Note that a rational doctor will only apologize if the apology reduces his expected costs from litigation. Therefore, it follows that the probability that the

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patient litigates, p_l, must go down in the event of an apology.[23] The impact of an apology on the probability of the patient obtaining a settlement is ambiguous since apologies increase the patient's psychic cost of going to trial, but by providing the patient with more evidence to use against the doctor, apologies also increase the potential judgment that would be awarded.

Introducing Apology Laws

Now suppose that the legislature passes a law excluding apologies as evidence in court. Assume that the law has no effect on how apologies affect psychic costs and that the only effect of an apology is to reduce judgments such that the new expected judgment function, $\hat{J}$, treats all cases as if no apology was ever tendered: $\hat{J}(h,1) = \hat{J}(h,0) = J(h,0)$. We will examine how introducing asymmetric information changes both of these assumptions later in this section.

Continuing with the symmetric information case, the law has no effect on the doctor's payoff when he does not apologize, but when he does apologize, the patient is unambiguously more likely to settle and less likely to litigate, thus reducing the size of the expected medical malpractice payment. Consider the expression for p_S. Rearranging terms, a patient chooses to settle if the cost of seeking a court judgment outweighs the benefit of seeking a court judgment:

$$p_s = \Pr\left[c_p + \psi_J(a) > J(h,a) - S(h,a)\right]. \quad (5)$$

After substituting $S(h,a)$ with $\lambda J(h,a)$, we can rewrite equation (5) as:

$$p_s = \Pr\left[c_p + \psi_J(a) > (1-\lambda)J(h,a)\right]. \quad (6)$$

Equation (6) shows that a patient settles if the cost of going to court is greater than the incremental benefit of seeking a judgment. Apology laws reduce the benefit of seeking a judgment, without affecting the costs; thus patients settle more often. Furthermore, going back to equation (3), a patient decides to initiate litigation if the expected benefit from litigation outweighs the costs of litigation.

[23] A doctor only apologizes if the size of his expected malpractice costs, $p_l[\, p_s[S(h,a)] + (1-p_s)(J(h,a) + c_D)\,]$, is decreasing in apologies. Assume for the sake of contradiction that p_l increased with a , then that would imply that expected payments also increased, because the apology made the psychic cost of litigation increase so that the patient would only litigate if expected payments increased. However, if that were the case, then the doctor would never apologize. Therefore, p_l must be decreasing in apologies.

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Apology laws reduce judgment sizes and increase settlements, both of which decrease the benefits of litigation; and thus, the probability that the patient litigates decreases as well.

Moreover, given symmetric information and risk neutral parties, the welfare implication of the law is unambiguous: since for now we assume that doctor effort is unaffected, litigation results only in transfers from the defendant to the plaintiff and the deadweight loss of the cost of litigation $(c_P + c_D)$. Thus the reduced likelihood of litigation means that the law must increase welfare.

If we make additional assumptions about the distribution of psychic costs, then we can say more. Assuming the psychic costs are uniformly distributed, the model predicts that the apology law would increase the probability of settlements relative to going to trial more for those cases with higher expected malpractice payments and for the cases in which patients have relatively less pretrial bargaining power,[24] which might occur when the patient has less evidence of wrongdoing and needs a trial to substantiate it. Similarly, these same conditions that lead to a larger increase in the probability of settlements also lead to a corresponding decrease in the probability of litigation.

With an overall decrease in the number of lawsuits, and an increase in the number of settlements (relative to going to court), the cases that make it to a court judgment should on average be more severe. However, when considering two cases with the same characteristics before and after the passage of an apology law, it becomes clear that the apology law reduces the amount of evidence available to the plaintiff and thus should reduce the size of the expected judgment payment.

Introducing Private Information

The preceding analysis presumes that there is no private information between players. Much of the past theoretical literature on malpractice litigation has focused on asymmetric information, and thus,

[24] If we assume that ψ takes on the uniform distribution that is shifted by α in the case of an apology such that $\psi \sim [\underline{\psi}, \bar{\psi}]$ if there was no apology and such that $\psi \sim [\underline{\psi} + \alpha , \bar{\psi} + \alpha]$ if there was an apology. Since we know from the patient's utility function that he will settle if $\text{p}_s = \Pr [c_p + \psi_J > (1-\lambda)J(h,a)]$, then we can say that $p_S(a=1) - p_S(a=0) = -[(1-\lambda)[J(h,1) - J(h,0)] - \alpha]$. Introducing the law means that apologies no longer affect judgment sizes $\hat{J}(h,1) = \hat{J}(h,0)$, so the first term goes away and we are left with $p_S(a=1) - p_S(a=0) = \alpha$. Thus the change in the probability of settlements is given by : $(1-\lambda)[J(h,1) - J(h,0)]$

introducing private information is important for increasing the validity of the model. Unfortunately, private information also makes most of the model's predictions indeterminate.

The obvious place to introduce private information is to introduce moral hazard into the doctor's effort. The doctor knows whether she adhered to the standard of care (i.e., the doctor's effort), but the patient and the courts cannot directly observe the doctor's standard of care. To ensure a range of efforts are provided, the model needs heterogeneous doctor types so that different doctor types have different marginal costs of effort. The consequences of such moral hazard on the effects of the apology law are numerous.

One consequence is that the welfare effects become ambiguous, because as noted by Polinsky and Rubinfeld (1988), malpractice litigation is an important deterrent to moral hazard. By reducing the expected malpractice payments a doctor faces, apology laws could reduce doctor effort. This increase in moral hazard is echoed by Cohen (2002) who worries that the predicted decrease in lawsuits filed will have a detrimental impact on the natural process of remediation. Already, very few cases of medical malpractice come to trial (Huycke & Huycke, 1994). One could argue that since these lawsuits are essential for restorative justice and efficient monitoring, patient welfare would be enhanced if there were more lawsuits, not fewer.

A second possible consequence, in a world in which patients are imperfectly informed about their own health and doctors have private information about the health outcomes, is that an apology could lead to the disclosure of health information that informs the patient about his chance of winning a lawsuit. However, a rational doctor would only apologize if the apology reduced his expected medical malpractice payment, and thus the law should still reduce malpractice payments.

However, if the law leads to a potential devaluation of the apology, then it could have ambiguous effects on malpractice payments. Ho (2009) analyzes a more general model of apologies and shows that the impact of an apology is increasing in the cost of tendering it.[25] By reducing an apology's potential

[25] Ho (2009) also predicts when apologies would be most prevalent, and therefore, when one might expect the apology laws to have the greatest impact. For example, Ho's theory predicts that apologies are more prevalent when

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consequences, the apology laws make apologies less effective, thereby potentially increasing lawsuits and decreasing patient welfare. Such concerns are echoed on legal and ethical grounds by Taft (2002) who argues that apology laws reduce the moral weight of apologies. Consider the following scenario that illustrates this counterintuitive result. In the event of a medical error in a State in which there is no apology law, an apology could possibly satisfy the patient and removed his desire to litigate. But if an apology law were in effect, a lawyer might tell the patient that the doctor only apologized because she was protected by the apology law, thus prompting the patient to litigate anyway. Furthermore, in States where apology laws have made apologies easier to tender, the lack of an apology could become even more offensive to a patient since the doctor no longer has a potential lawsuit as an excuse for not apologizing.

The impact on the likelihood of settlement and the time to settlement are also affected by private information. The impact on the likelihood of settlement depends critically on the assumptions about the negotiation and settlement process (Bebchuk, 1984; Spier 1992). Settlement offers could both serve to screen or to signal (Daughety & Reinganum, 1994; Spier, 1994). These models tend to predict that more asymmetric information reduces settlements and increases bargaining time (Spier, 2004). If the law does increase information disclosure to the patient, then States which implement apology laws could be expected to experience more settlements and faster resolution of malpractice cases.[26]

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the patient has greater uncertainty about the doctor's abilities. Thus one might look at specialties in which the doctor's effect on the outcome is more difficult to observe. The theory also suggests that apologies are more important when reputations are less well established, and thus, one would expect younger doctors to apologize more frequently. Also, the differential importance of reputation means that apologies potentially play a bigger role in specialties such as obstetrics/gynecology (OB/GYN), for which patients shop around more for their doctors, as opposed to specialties such as emergency medicine, for which circumstances typically dictate which doctor the patient sees. Apologies are more important in longer term relationships with repeated doctor-patient interaction. Thus, one would expect larger effects in oncology, which has a long course of treatment, than in anesthesiology, which has little doctor-patient interaction. The theory predicts that conditional on there being a mistake; competent doctors apologize more than incompetent doctors. One would expect that doctors with fewer prior offenses or State licensing actions are more likely to apologize than doctors with more prior offenses. Finally, the theory predicts that apologies are more effective when outcomes are less severe, thus apologies are more effective for emotional injuries or minor temporary injuries rather than cases of major permanent injury or death.

[26] A decrease in bargaining time and an increase in settlements would reduce the uncertainties involved in litigation, which would cause risk-averse patients to litigate more frequently.

Thus, while the theory presented here offers some guidance on the effects to expect, the net effect of apology laws on whether they increase or decrease medical malpractice litigation and whether the laws increase or decreases malpractice settlements becomes an empirical question that this paper intends to resolve. To connect between the theory and the empirical analysis, we would ideally like to analyze at the individual level the probability of settlements for all for open claims. At the aggregate level, assuming that the total incidents of malpractice should not be affected by apology laws, we would like to conduct our analysis on the total number of malpractice claims ever filed (including both open and closed claims). Unfortunately, to our knowledge, there does not exist any comprehensive and public data available on all open claims that have yet to be resolved.

Figure 1: Cases Resolved By Year of Incidents

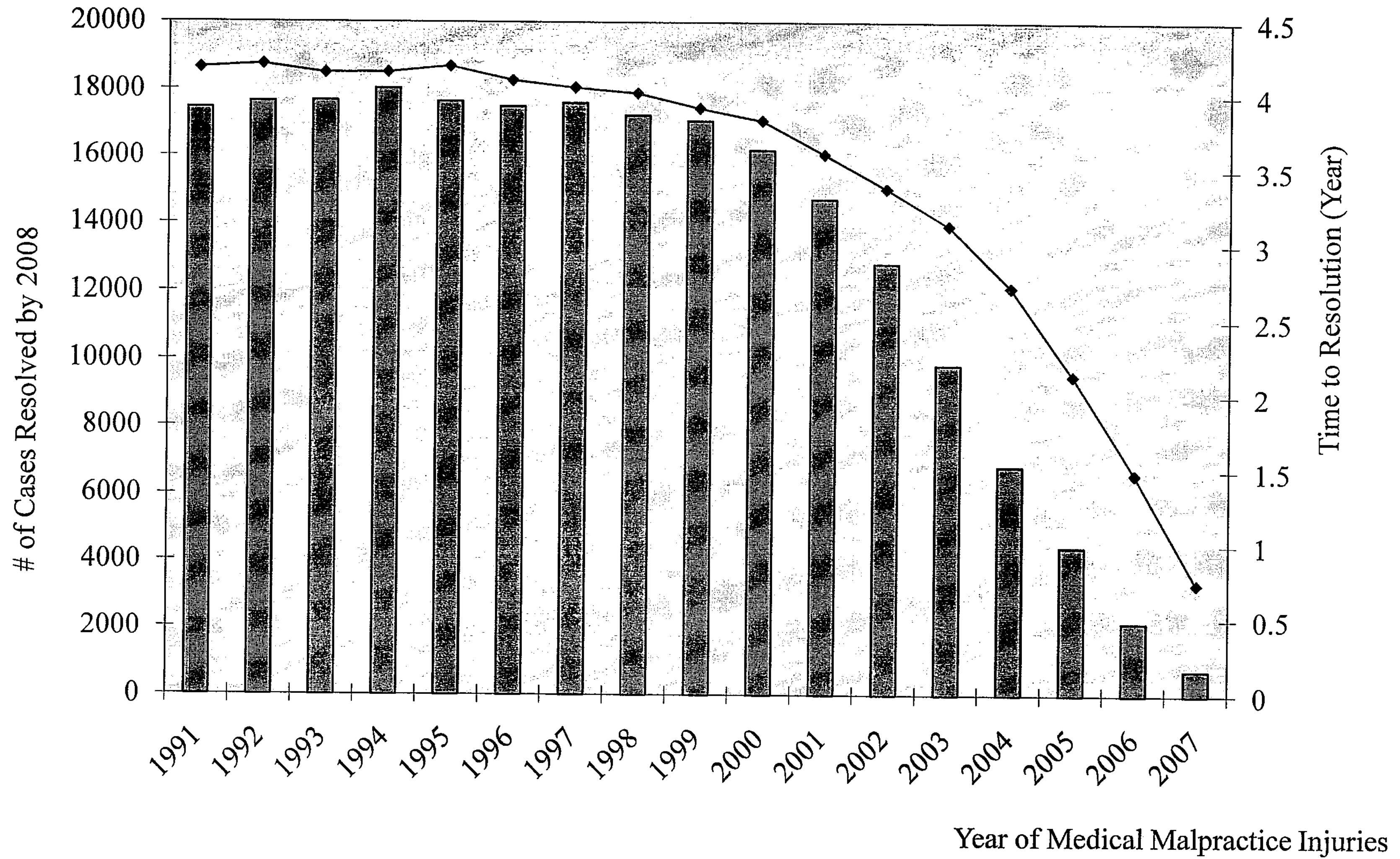

Figure 2: Histogram of Claims By Time to Resolution

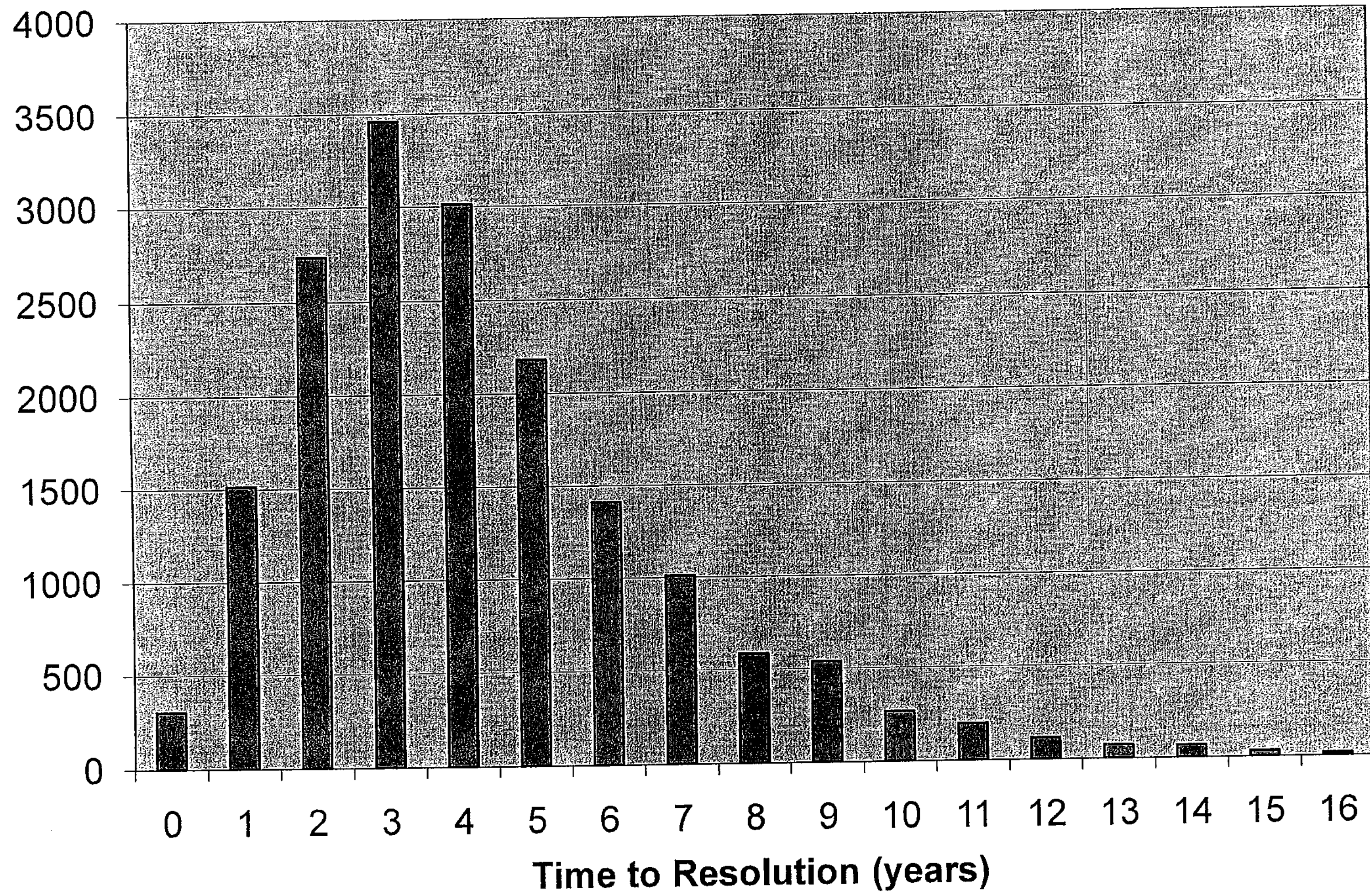

Figure 3: Two Scenarios of Shifting of Distribution

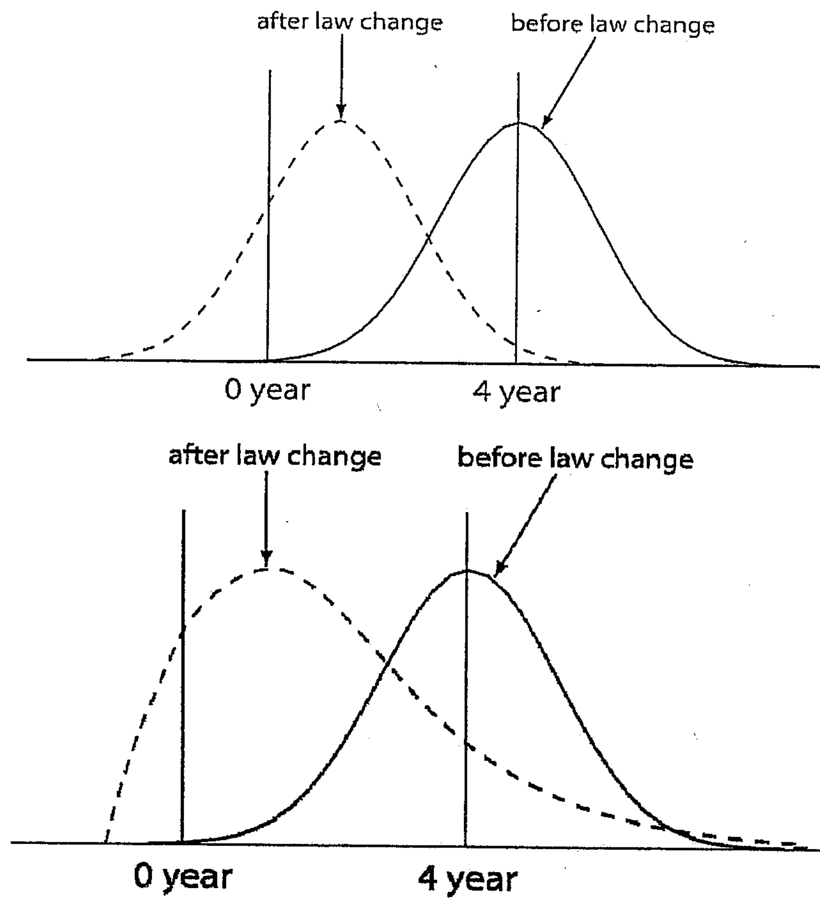

Table 1. State with Statutes Pertaining to Apology Law

State	Year Law Passed	Full Versus Partial	Statutes
Massachusetts	1986	Partial	ALM GL ch. 233, § 23D (1986)
Texas	1999	Partial	Tex Civ Prac & Rem Code Ann 18.061 (1999).
California	2000	Partial	Cal Evid Code 1160 (2000).
Florida	2001	Partial	Fla Stat Ann Ch 90.4026 (2004).
Washington	2002	Partial	Rev. Code Wash. §5.66.010(2002)
Tennessee	2003	Partial	Tenn. Evid. Rule §409.1
Colorado	2003	Full	Colo Rev Stat Sec 13-25-135 (2003)
Oregon	2003	Partial	Oreg Rev Stat Sec 677.082 (2003).
Maryland	2004	Partial	Md. COURTS AND JUDICIAL PROCEEDINGS Code Ann. § 10-920
North Carolina	2004	Partial	N.C. Gen. Stat. § 8C-1, Rule 413 (2004)
Ohio	2004	Partial	ORC Ann. 2317.43 (2006)
Oklahoma	2004	Partial	(63 Okl. St. § 1-1708.1H
Wyoming	2004	Partial	Wyo Stat. § 1-1-130
Connecticut	2005	Full	Conn. Gen. Stat. § 52-184d (2005)
Louisiana	2005	Partial	La. R.S. 13:3715.5 (2005)
Maine	2005	Partial	24 M.R.S. § 2907 (2005)
Missouri	2005	Partial	Mo.Rev.Stat §538.229 (2005)
New Hampshire	2005	Partial	N.H.Rev. Stat. Ann. § 507-E:4 (2005)
South Dakota	2005	Partial	S.D. Codified Laws § 19-12-14 (2005)
Virginia	2005	Partial	Va. Code Ann. §8.01-581.20:1 (2005)
Arizona	2005	Full	A.R.S. § 12-2605
Georgia	2005	Full	O.C.G.A. § 24-3-37.1
Illinois	2005	Partial	735 ILCS 5/8-1901 (2005)
Montana	2005	Partial	Mont. Code Anno., § 26-1-814 (2005)
West Virginia	2005	Partial	W. Va. Code § 55-7-11a (2005)
Delaware	2006	Partial	Delaware Del. Code Ann. Tit. 10, 4318 (2006)
Idaho	2006	Partial	Ida. ALS 204; 2006 Idaho Sess. Laws 204;
Indiana	2006	Partial	Ind. HEA 1112
Iowa	2006	Partial	Iowa HF 2716 (2006)
South Carolina	2006	Full	South Carolina Ch.1, Title19 Code of Laws 1976, 19-1-190 (2006)
Utah	2006	Partial	2006 Ut. SB 41
Vermont	2006	Partial	Vermont S 198 Sec. 1. 12 V.S.A. 1912 (2006)
Hawaii	2006	Partial	HRS section 626-1, Hawaii Rules of Evidence Rule 409.5
Nebraska	2007	Partial	Nebraska Neb. Laws L.B. 373 (2007)
North Dakota	2007	Partial	North Dakota ND H.B. 1333 (2007)
District of Columbia	2007	Partial	D.C. Code 16-2841 (2007)

Table 2. Summary Statistics--Individual Level

Individual Level		
Number of Observation		224,904
Average Claim Severity		$200,120
(standard deviation)		(378,986)
Average Years to Resolution		3.86
(standard deviation)		(2.15)
Practitioners' License Field (%)		
Physicians and Physician Intern		72.9
Osteopatic and Osteopatic Intern		4.81
Dentist and Dentist Intern		13.13
Others (RN, Pharmacist, Chriopractor)		9.16
Outcomes (Available If Reported After 2004) (%)		
Emotional Injury Only	Insignificant injury	2.09
Insignificant Injury		3.04
Minor Temporary Injury		14.89
Major Temporary Injury	"Somewhat" Sign. injury	9.36
Minor Permanent Injury		13.77
Signifant Permanent Injury		13.94
Major Permanent Injury	Significant Injury	9.17
Quadriplegic		4.32
Death		27.68
Cannot be Determined		1.76
Payment Type (%)		
Settlement		90.28
Judgment		2.54
Unknown		7.18

Table 3: Summary Statistics--State Level

State Level	Mean	SD	Median
Claim Frequency in 2000	317	445	155
Total Claim Compensation in 2000	$71,332,844	$105,560,095	$28,030,700
Physicians in 2000	13,892	16,724	8,581
Population in 2000	5,532,783	6,184,308	5,532,783
Noneconomic Damage Cap	51%	-	
Punitive Damage Cap	33%	-	
Collateral Source Rule	53%	-	
Joint & Several Liablity	61%	-	
Law on Information Disclosure	12%	-	
Apology Law	63%	-	

Note: All laws are tabulated in 2007.

Table 4. The Impact of Apology Law on Medical Malpractice Settlements (% Change)

Dependant Variable	*Claim Frequency*			*Claim Compensation*		
	(1)	(2)	(3)	(4)	(5)	(6)
Apology Law Change	0.142 (0.086)	0.153 (0.083)*	0.147 (0.095)	0.279 (0.163)*	0.276 (0.163)*	0.202 (0.181)
Other Law Change[a]		X	X		X	X
Other Covariates[b]			X			X
State Fixed Effects	X	X	X	X	X	X
Year Fixed Effects	X	X	X	X	X	X
N	867	867	867	867	867	867
R-squared	0.97	0.97	0.97	0.97	0.97	0.97

Note: Each column shows the results from a separate Diff-in-Diff regressions. Standard errors are clustesed at the state level. The dependent variables are either Log (Number of Cases) in a state-year or Log (Total amount of Settlement) in a state-year.

a. Other law change includes non-economic damage cap, punitive damage cap, law on medical malpractice disclosure, csr_tort and jsl_tort.

b. Covariates include population, % Black, % White, % of population that are 65 or above, and # of Physicians.

Table 5. The Impact of Apology Law on Medical Malpractice Claim Frequency by Severity of Outcomes (% Change)

	Insignificant Injury			*"Somewhat" Significant Injury*			*Major Permanent Injury/Death*		
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Apology Law Change	-0.167 (0.099)*	-0.182 (0.104)*	-0.194 (0.101)*	0.118 (0.124)	0.091 (0.124)	0.047 (0.121)	0.27 (0.129)**	0.265 (0.133)*	0.217 (0.141)
Other Law Change[a]		X	X		X	X		X	X
Other Covariates[b]			X			X			X
State Fixed Effects	X	X	X	X	X	X	X	X	X
Year Fixed Effects	X	X	X	X	X	X	X	X	X
N	255	255	255	255	255	255	255	255	255
R-squared	0.91	0.91	0.92	0.93	0.93	0.93	0.93	0.93	0.94

Note: Each column shows the results from a separate Diff-in-Diff regressions. Standard errors are clustered at the state level. The dependent variables are Log (Claim frequency by severity of outcome) in a state-year

a. Other law change includes non-economic damage cap, punitive damage cap, law on medical malpractice disclosure, csr and jsl tort

b. Covariates include Population, % Black, % White, % of population that are 65 or above, and # of Physicians,

Table 6. The Impact of Apology Law on Compensation By Severity of Medical Outcome

	Insignificant Injury Baseline Mean $45,019			*"Somewhat" Significant Injury Baseline Mean $155,070*			*Major Permanent Injury/Death Baseline Mean $342,869*		
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Apology Law Change	-431 (4,236)	632 (4,132)	3,132 (3,894)	-24,017 (13,432)*	-27,264 (13,564)**	-16,990 (9,538)*	-73,097 (17,334)***	-67,645 (21,188)***	-55,248 (18,022)***
Other Law Change[a]		X	X		X	X		X	X
Other Covariates[b]			X			X			X
State Fixed Effects	X	X	X	X	X	X	X	X	X
Year Fixed Effects	X	X	X	X	X	X	X	X	X
N	13317	13317	11618	24156	24156	22780	26561	26561	25273

Note: Numbers reported above are payments in Y2000 dollar. Each column shows the results from a separate OLS regression. The dependent variable is the claim compensation.

a. Other law change includes non-economic damage cap, punitive damage cap, csr_tort, jsl_tort & law on information closure

b. Other covariates include allegation nature, patient gender, patient age, experience of physician and square of experience

Table 7. Change in Compensation By Allegation Nature

	Value of Payment
Anesthesia	-65,066
	(29,004)**
Surgery	-19,218
	(9,146)**
Medication	-18,751
	(18,718)
IV & Blood Product	35,064
	(48,473)
Obstetrics	-88,968
	(45,384)*
Treatment Related	8,456
	(13,864)
Monitoring Related	-25,346
	(20,158)
Equipment/Product Related	8,950
	(26,086)
Other Miscellaneous	-1,275
	(16,157)
Behavioral Health Related	38,893
	(49,429)
Other Law Change[a]	X
Other Covariates[b]	X
State-Year Fixed Effects	X
N	63640
R-squared	0.2

Note: The default category is diagnose related cases.
a. Other law change includes non-economic damage cap, punitive damage cap, csr_tort, jsl_tort & law on information closure
b. Other covariates include allegation nature, patient gender, patient age, experience of physician and square of experience

Appendix Table A1. Threat to Validity (% Change)

Dependant Variable	*Randomly Assign Law Year*			*Earlier Law Year*		
	(1)	(2)	(3)	(4)	(5)	(6)
Apology Law Change	0.044 (0.032)	0.041 (0.032)	0.046 (0.032)	0.044 (0.032)	0.041 (0.032)	0.046 (0.032)
Other Law Change[a]		X	X		X	X
Other Covariates[b]			X			X
State Fixed Effects	X	X	X	X	X	X
Year Fixed Effects	X	X	X	X	X	X
N	867	867	859	867	867	859
R-squared	0.97	0.97	0.97	0.97	0.97	0.97

Note: Columns 1-3: Randomly assigned half of the states with year of law change between 2000 and 2005.
Columns 4-6: Reassign law adoption years as 3 years prior to the actual adoption
The dependent variables are either Log (Number of Cases) in a state-year
a. Other law change includes non-economic damage cap, punitive damage cap, law on medical malpractice disclosure.
b. Covariates include Population, % age 65 or above, % Black, % White, and # of Physicians.

Appendix Table A2. The Impact of Apology Law on Claim Frequency by Size of Payments (% Change)

	1st Quantile ($775-$22,500)		*2nd Quantile ($22,500~$84,322)*		*3rd Quantile ($84,322~$229,288)*		*4th Quantile (>$229,288)*	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Apology Law	0.032 (0.084)	0.075 (0.056)	0.186 (0.096)*	0.27 (0.104)**	0.369 (0.122)***	0.392 (0.129)***	0.008 (0.142)	0.152 (0.145)
Other Law Change[a]	X	X	X	X	X	X	X	X
Other Covariates[b]		X		X		X		X
State Fixed Effects	X	X	X	X	X	X	X	X
Year Fixed Effects	X	X	X	X	X	X	X	X
N	867	867	867	867	867	867	867	867
R-squared	0.94	0.94	0.93	0.94	0.93	0.94	0.92	0.93

Note: Each column shows the results from a separate Diff-in-Diff regressions. Standard errors are clustered at the state level. The dependent variables are Log (Number of Cases by severity of outcome) in a state-year.
a. Other law change includes non-economic damage cap, punitive damage cap, law on medical malpractice disclosure, csr and jsl tort
b. Covariates include Population, % Black, % White, and # of Physicians

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PREMIER

SafetyShare™

Transforming Healthcare Together

September 2009

Honesty and apology after medical errors result in 55 percent reduction in malpractice claims

Open communication and honesty with patients about medical errors, including an apology, were found to be the key to reducing malpractice claims by as much as 55 percent.

The evidence appears to support the position that patients file malpractice lawsuits because they get so angry when communication, honesty, accountability, and literally good customer service are lacking after a perceived error. A lawsuit is often the only way to find out what actually happened to a loved one. This position was addressed in a recent commentary in the British Medical Journal (BMJ) referencing decades of evidence published by "Sorry Works!," a coalition led by Doug Wojcieszak.

The University of Michigan Health System (UMHS) has adopted many of these strategies, including an apology after a medical error that resulted in a greater than 50 percent reduction in average litigation costs and reduced malpractice claims by 55 percent between 1999 and 2006. UMHS published its effective strategy for reducing litigation and malpractice claims. The article notes that a principled accounting of what occurred is best not only for patients and their families and the institution, but also for the healthcare providers involved in the event, future patients and even the lawyers. In addition to the policy of owning up to responsibility for adverse events, apologizing, and compensation to the patient and family as the core of the program, UMHS has a comprehensive patient safety initiative that includes other structural and cultural changes.

Other organization's disclosure programs UMHS isn't the only organization to implement a comprehensive disclosure program. The Department of Veterans Affairs, the University of Illinois at Chicago (UIC) Medical Center, and Kaiser Permanente also have well-developed programs of apology and disclosure. As originally developed by UMHC and enhanced by the UIC, principles of "full disclosure" include the following elements:

- Provide effective and honest communication to patients and families following adverse patient events;
- Apologize and compensate quickly and fairly when inappropriate medical care causes injury;
- Defend medically appropriate care vigorously; and
- Reduce patient injuries and claims by learning from past experience.

Downloads and links

- You can say sorry. Feinmann BMJ 2009;
- Sorry works! Editorial Wojcieszak
- Journal of Health & Life Sciences Law-Boothman, January 2009
- Premier Inc. Web conference on "Disclosure, Apology and Early Resolution" http://www.premierinc.com/risk/education-newsletters/websessions/may27/
- Patient Safety Share - January 2009: "Recent rise in "apology" laws in 36 states protect physicians from malpractice."
- Joint Commission White Paper: "Healthcare at the crossroads: Strategies for improving the medical liability system and preventing patient injury."

J Health Life Sci Law. 2009 Jan;2(2):125-59

A better approach to medical malpractice claims? The University of Michigan experience

Boothman RC, Blackwell AC, Campbell DA Jr, Commiskey E, Anderson S

Abstract:

The root causes of medical malpractice claims are deeper and closer to home than most in the medical community care to admit. The University of Michigan Health System's experience suggests that a response by the medical community more directly aimed at what drives patients to call lawyers would more effectively reduce claims, without compromising meritorious defenses. More importantly, honest assessments of medical care give rise to clinical improvements that reduce patient injuries. Using a true case example, this article compares the traditional approach to claims with what is being done at the University of Michigan. The case example illustrates how an honest, principle-driven approach to claims is better for all those involved-the patient, the healthcare providers, the institution, future patients, and even the lawyers.

The Michigan way to reduce malpractice claims

University of Michigan Health System, which employs 18,000 workers and has a $1.5 billion annual budget, has reaped national fame and the admiration for its success in reducing litigation and malpractice claims. The architects of the renowned program spell out how they do it in the January 2009 issue of **Journal of Health & Life Sciences Law**.

First, the results. The number of new claims against the health system has dropped steadily from 136 in 1999 to 88 in 2002 to 61 in 2006. The number of open claims has also dropped steadily from 262 in 2001 to 114 in 2005 to 83 in 2007.

"Over that same time span (August 2001 through August 2007), the average claims processing time dropped from 20.3 months to about 8 months. Total insurance reserves dropped by more than two-thirds. Average litigation costs have been more than halved," report Richard Boothman, J.D., chief risk officer for the University of Michigan Health System, and colleagues.

Although Michigan's success is often summed up by the phrase "sorry works," offering apologies for medical errors explains only a small part of the health system's success. The university's well-funded risk department works closely with excellent clinicians and, throughout, there is a focus on improving patient safety.

In addition to rapid response teams, a large hospitalist service, provision of pulse oximetry for adult and pediatric inpatients, and purchase of portable "vein sensors" to reduce complications,

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the health system also has a "patient safety contingency fund" that allows the chief of staff to pay for needed clinical improvements without going through a ponderous institutional capital process.

The health system also benefits from the fact that its **physicians are employees** of the university and faculty members of its medical school. "UMHS has been self-insured since the mid-1980s, which allowed for consistency and alignment of ethical and financial motivation between the hospital, care providers, and insurer. Alignment of these components remains an important advantage," the authors write.

The health system is known for its willingness to compensate patients quickly if they were harmed by unreasonable care. "The key challenge is distinguishing between reasonable and unreasonable care. This determination is pivotal – it provides direction for the institutional response – and it is critical to get it right," they say.

UMHS developed the expertise to accomplish the detailed investigation and expert assessments necessary to know the difference between reasonable and unreasonable care. It revamped its risk management department and staffed it with experienced nurses "based on the reasoning that it would be easier to teach claims handling to caregivers than to acquaint claims handlers with complex medical issues."

Using experienced caregivers to review claims also helps the health system achieve one of its central objectives, i.e. learning from patients' experiences to reduce patient injuries. "Every risk management consultant at UMHS is assigned specific clinical services. It is the consultant's task to understand how care is delivered, counsel the department chair or division chief, and continually look for ways to improve patient safety and decrease the risks of injury and mistake," the authors write.

In a wide-ranging essay, the authors also emphasize the value of informed consent, when done properly. "In this approach, addressing the root causes of litigation begins before an injury occurs. The informed consent process is an under appreciated opportunity to establish rapport with the patient and create realistic expectations," they say.

Building on that important first step, the Michigan health system takes pains to follow through. "If the patient's experience reasonably mirrors expectations, if the patient's need for information is met readily, if the patient is assisted in processing the information, and if the patient believes that the system has responded to his or her experience with improvements, the likelihood that the patient will feel the need for an advocate or seek satisfaction through the legal system diminishes significantly," they conclude.

[Emphasis added]

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 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.

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

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.
- 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.

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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.

- 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

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."

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[4] The Sorry Works Coalition

"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."

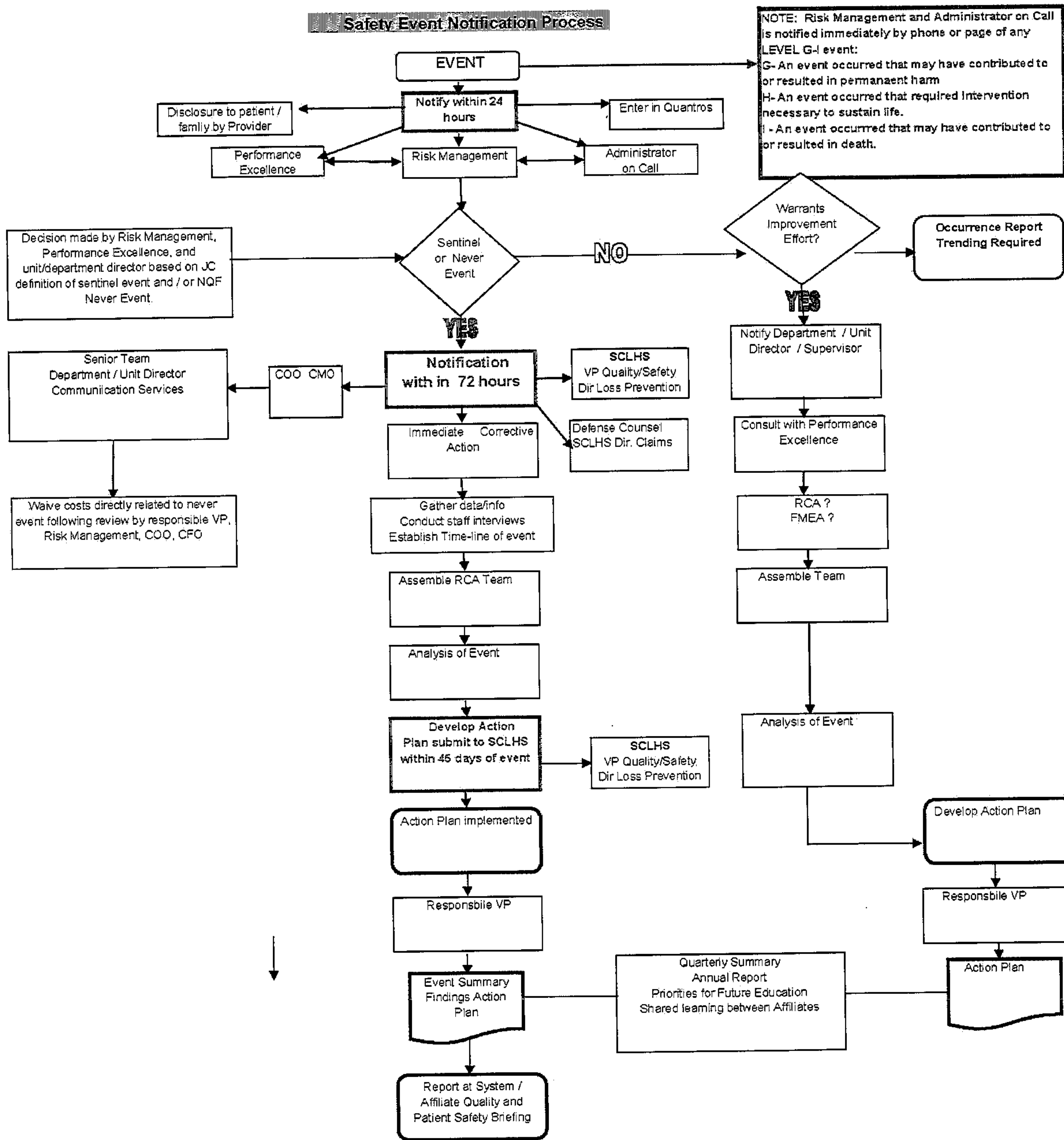
Deliver your message very clearly. If you are really not sure what happened, it is better not to speculate. An example of this is after an unexpected cardiac arrest, especially in patients with multiple health problems.

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.

Additional References [5]

[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.



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2010 Editorials and media reports in Kansas

Patients are less likely to sue when doctors apologize for errors

By The Editorial Board, stltoday.com (St. Louis)
Posted: Wednesday, September 1, 2010 9:00 pm

As many as 98,000 Americans die each year as a result of preventable medical errors. Thousands more suffer serious injuries.

Many of them ultimately will end up in court. In 1994, a London psychologist named Charles Vincent set out to answer a deceptively simple question about those litigious patients: Why do they sue?

One reason, obviously, is to replace lost income or recover out-of-pocket costs of treatment. But most patients are looking for "more than compensation," Mr. Vincent concluded.

They're looking for answers about what went wrong in their care and how that problem has been addressed. They want an acknowledgement and an apology, the kind of things you'd do without thinking if you bumped into a stranger on the sidewalk.

This raises an interesting question: What would happen if patients got an advocate, an apology and a swift offer of reasonable compensation?

Many never would file suit in the first place.

In 2002, the University of Michigan Health System adopted new policies about medical errors.

It would investigate all "adverse events" — incidents in which an error caused potential or actual harm to a patient.

Where appropriate, the health system would apologize, share the findings of its internal investigations with injured patients and their families and quickly offer compensation.

In the years since, the Michigan health system has cut in half the amount it spends on litigation. The number of new claims fell by 40 percent. Also dramatically reduced: the time it takes to resolve outstanding claims and the proportion of suits that end with an award to the plaintiff. When claims do go to trial, juries are told about the hospitals' apologies and offers to settle.

The university hospital system trumpeted those results in a study published last month in the *Annals of Internal Medicine*. It's the latest addition to a large and growing body of evidence that shows that when doctors openly acknowledge their errors, patients are less likely to look for a lawyer.

So why don't doctors just apologize when they make a mistake?

One reason is that many lawyers hired to represent doctors and hospitals in malpractice cases advise against it. They worry that an apology could be used in court as an admission of guilt, or that a frank discussion with patients' families could invite claims that otherwise never would be filed.

Yet at least 35 states, including Missouri and Illinois, have laws that prevent a doctor's apology or expression of remorse from being used against him or her in court.

Even the best physicians and hospitals make mistakes. Health care is an inherently complex undertaking; errors are inevitable.

But the culture of secrecy about medical errors is at odds with the movement toward greater transparency about health care quality and costs. Secrecy is bad for patients, and it's bad for doctors.

The thrust of "malpractice reform" in recent years has been to punish the victims of those errors instead of compensating them fairly and preventing future mistakes.

But we don't have to choose between fairly compensating injured patients and protecting good doctors. The key to reducing malpractice claims dramatically lies with doctors and hospital administrators.

They can say two difficult, but very meaningful words: "I'm sorry." Or they can listen to four frightening words: "See you in court."

Lawmakers consider bill that would guarantee an apology couldn't earn doctors extra punishments
'I'm sorry' bill may help reduce lawsuits

February 1, 2010 *LAWRENCE JOURNAL WORLD*

Topeka — A simple apology can go a long way toward reducing lawsuits, health care officials said Monday.

But the so-called "I'm sorry" bill came under strong questioning before the Senate Judiciary Committee.

Under Senate Bill 374, a doctor could express sorrow or concern over an event, such as an operation not turning out well, without that expression being admitted as evidence of liability for any civil claim.

Some 35 states have similar laws, and evidence is mounting that those statutes are reducing the number of malpractice claims and lawsuits.

But under SB 374, an admission of fault will remain admissible in a lawsuit.

That prompted a lot of questioning from Judiciary Committee members, who asked if an expression of regret also implied that a mistake was made.

"The only safe way for a defendant is to never say anything," said state Sen. John Vratil, R-Leawood.

Cynthia Smith, a representative of the Sisters of Charity of Leavenworth, which runs several hospitals, urged the committee to amend the bill to ensure that expressions of regret couldn't be admissible as evidence. She called the measure as it's written now the "hugs" bill because doctors would be afraid to say anything.

But Gary White Jr., a plaintiff's attorney, said that under the bill a doctor could apologize for an operation not going right without fear of that statement being used against him or her. But, he said, if the doctor said the operation went wrong because certain procedures weren't followed, then that statement should be admitted during a trial to determine whether that was the truth.

The committee took no action on the bill.

Originally published at: http://www2.ljworld.com/news/2010/feb/01/lawmakers-consider-bill-would-guarantee-apology-co/

Show of compassion

Physicians should be able to express sorrow without having it used against them in court.

Journal -World Editorials

February 3, 2010

Apparently, there's a fine line between compassion and self-incrimination. Kansas legislators are trying to help the state's physicians negotiate that line with a measure that is being referred to as the "I'm sorry" bill. The goal of the legislation is to allow a physician to show simple compassion by expressing sorrow to a patient or family without that expression being used in court as some admission of wrongdoing.

Similar measures have been passed in about 35 other states, and there is come indication the laws are having the desirable effect of reducing the number of malpractice claims and lawsuits in those states. Having a doctor show concern or compassion — simply say "I'm sorry" — apparently makes some patients and families less inclined to seek retribution.

Of course, there's a difference between a doctor saying "I'm sorry this treatment wasn't as successful as we had hoped," and one saying "Because we failed to follow proper procedure, we operated on the wrong foot. Gee, I'm sorry." One simply conveys sympathy and concern while the other clearly conveys an admission. The Kansas bill is seeking to draw a line between the two, protecting doctors' right to show compassion while allowing incriminating statements to be used in court.

Kansas doctors surely will appreciate any assistance lawmakers can offer in this area. Most of them wouldn't be in the profession they're in if they didn't have a sense of compassion that they naturally want to share with patients and their families. Yet, the fear that even a simple "I'm sorry" legally can be construed to assign blame forces them into a stilted, unemotional style of communication.

From a practical standpoint, reducing the number of malpractice claims and lawsuits is a benefit for the society as a whole. Such claims, even if they are unfounded, drive up health care costs and may drive a certain number of doctors to drop all or part of their practice as a defensive move.

Saying "I'm sorry" shouldn't protect a physician whose negligence has harmed a patient, but neither should an honest show of sorrow or compassion be automatically construed as an admission of guilt.

It's a sad commentary that doctors must be legally protected in order to show the kind of honest compassion that should be a natural part of practicing medicine. Nonetheless, a bill that would help facilitate that kind of communication is a step in the right direction.

Senators hear 'sorry' bill

By Barbara Hollingsworth, *Topeka Capital-Journal*
February 2, 2010

Lawmakers on Monday grappled with the challenge of putting apologies into statute.

The Senate Judiciary Committee heard details of a bill that would allow people to apologize without fear of having their "I'm sorry" be used against them in court. Any statement accompanying the apology that acknowledged fault could still be used in litigation under the bill (SB 374).

Although the bill would apply to a broad range of people who might want to apologize, it was prompted to address concerns of physicians and others in the medical community.

Dan Morin, director of government affairs for the Kansas Medical Society, said in testimony that physicians can find themselves reluctant to offer concern or sympathy for patients and their families out of worries that their words will be turned against them in court.

"Oftentimes plaintiff attorneys will misinterpret the statement and mischaracterize what was said," Morin testified. "This fear creates a very real obstacle to effective communication with patients at a time when they need it most."

One hope is that litigation costs could be lowered as a result.

"An upfront apology or expression of sympathy can relieve anger and frustration and reduce the level of emotion," said William Sneed, who represents The University of Kansas Hospital Authority.

Apology laws have expanded in use in recent years and were found in 35 states by 2007, according to the Kansas Judicial Council, which worked on the bill currently under consideration after reviewing a bill proposed last year.

"In general, apology laws are based on the theory that apologies are healing for both sides and should not be discouraged by the fear of legal ramifications," the council said in a report. "Debate has raged over the last decade concerning the relationship of apology and the law."

Indeed, some lawmakers questioned what it would mean if the bill became law and if physicians could safely offer an apology under the statute. There didn't appear to be much leeway.

"So," asked Sen. John Vratil, R-Leawood, "about the only thing you could say safely under this bill is I apologize?"

Cynthia Smith, advocacy counsel for Sisters of Charity of Leavenworth Health System which operates St. Frances Health Center, said a more effective bill is needed. As is, she said the bill would provide unreliable protections for physicians who want to apologize or offer sympathy. She said doctors will then "follow their lawyers' advice not to communicate with patients or acknowledge an adverse event, and the law will be useless in opening lines of communications and do nothing to reduce costly medical liability litigation."

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."

Apologizing for medical mistakes, saying `sorry' is paying off for doctors at U. of Michigan

By: DAVID N. GOODMAN
Associated Press
07/20/09 10:40 PM EDT

DETROIT — When a treatment goes wrong at a U.S. hospital, fear of a lawsuit usually means "never daring to say you're sorry."
That's not the way it works at the University of Michigan Health System, where lawyers and doctors say admitting mistakes up front and offering compensation before being sued have brought about remarkable savings in money, time and feelings.
"What we are doing is common decency," said Richard Boothman, a veteran malpractice defense lawyer and chief risk officer for a health system with 18,000 employees and a $1.5 billion annual budget.
The estimated $5.8 billion annual cost of malpractice claims nationwide has drawn scrutiny as President Barack Obama and Congress plot an overhaul of the nation's $2.4 trillion health care system. So far, Obama has spoken in broad terms about shielding doctors from unwarranted lawsuits without capping damage awards, but medical malpractice is an issue that deeply divides. Doctors, hospitals, trial lawyers and patient advocates disagree not only on the solution but the problem itself.
Is it the high price of malpractice insurance? The difficulty for victims of medical errors getting justice? The cost of unneeded tests ordered by lawsuit-wary doctors? The "burying" of medical errors that kill tens of thousands of Americans yearly?
Officials at the University of Michigan say their approach addresses doctor, patient and public concerns.
The willingness to admit mistakes goes well beyond decency and has proven a shrewd business strategy, according to a 2009 article in the "Journal of Health & Life Sciences Law" by Boothman and four colleagues at the Ann Arbor school.
According to Boothman, malpractice claims against his health system fell from 121 in 2001 to 61 in 2006, while the backlog of open claims went from 262 in 2001 to 106 in 2006 and 83 in 2007. Between 2001 and 2007, the average time to process a claim fell from about 20 months to about eight months, costs per claim were halved and insurance reserves dropped by two-thirds.
Boothman said the health system learns of possible medical errors from doctors themselves, as well as from patients or their lawyers. In any case, the university conducts a peer review to see if there was an error and if changes are needed to prevent a recurrence.
Equally important, health system doctors and officials offer to meet with patients and their families, sometimes to explain that treatment was appropriate and sometimes to admit a mistake.
"I do believe caregivers want to do this," said Boothman, whose second-floor office looks out on the University Hospital at the heart of the sprawling medical center, 35 miles west of Detroit. "It's not a hard sell at all, as long as you can reassure them it's OK."
Malpractice lawyer Norman Tucker has several active cases against the University of Michigan and said the school is fair, though not an easy mark. Lawyers say because

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Michigan admits mistakes in some cases, it can signal a tough fight ahead in those cases where it denies error.
"You should follow Mark Twain's advice: `When in doubt, tell the truth,'" Tucker said.
According to Harvard Medical School Dean Dr. Joan Reede, patients and their families can find great relief and comfort when a doctor promptly admits an error. She learned this personally when her mother nearly died from a medical error in 1998.
Tommye Reede of Hull, Mass., spent eight weeks in a hospital after hip surgery when doctors at first failed to spot a severe allergic reaction despite warnings from her medically trained daughter.
"There was an apology from the surgeon," Joan Reede said. "There was an acknowledgment that `I did not pay attention.' ... At no point did I feel abandoned."
"When you get what you consider to be a sincere apology, you always feel better," said her mother, now 79, who didn't sue.
Mother and daughter talked about the experience in a 2006 doctor training DVD "When Things Go Wrong" by Dr. Tom Delbanco of the Harvard Medical School. They declined to name the hospital, saying they didn't want to single it out for attention.
The openness approach is catching on at places from Boston Medical Center to the University of Illinois to California's Stanford University hospital.
"Apologies for medical errors, along with upfront compensation, (reduces) anger of patients and families, which leads to a reduction in medical malpractice lawsuits and associated defense litigation expenses," according to Doug Wojieszak, spokesman for The Sorry Works! Coalition. The group includes doctors, lawyers, insurers and patient advocates.
The "saying sorry" movement has its skeptics, even among those who agree it's the right thing to do.
The right of injured patients to sue health care providers and force them to open up their internal records is a crucial part of reducing medical mistakes and improving care, said Matthew Gaier, co-chairman of the New York State Trial Lawyers Association's medical malpractice committee.
Harvard University public health associate professor David Studdert says a review of published studies shows about 181,000 people are severely hurt each year as a result of mistakes at U.S. hospitals but only about 30,000 file legal claims.
Many people don't sue because they don't discover they're victims of malpractice, Studdert and colleagues wrote in a 2007 article in the journal "Health Affairs." The spread of disclosure, the article said, could cause malpractice costs to rise from $5.8 billion now to between $7 billion and $11.3 billion a year.
For "saying sorry" to work, doctors need protection from having their own honesty used against them in court, said Jim Copland, director of the Manhattan Institute's Center for Legal Policy and an advocate of curbs on damage suits. Protection could take the form of a shield law that would exclude an apology from admission as evidence in a malpractice suit. A number of states have or are considering such laws.
"If you go out and say, `Oh, we messed up, are you going to lose the lawsuit? You need to give them some protection," Copland said.

Douglas B. Wojcieszak

The Sorry Works! Coalition
Founder

Phone: 618.559.8168
email: doug@sorryworks.net

Doug Wojcieszak is a disclosure training consultant who has had several personal and professional experiences with tort reform and medical malpractice issues. He lost his oldest brother to medical errors in 1998 and his family successfully sued the hospital and doctors with the case settling in 2000. The hospital attorneys – not the doctors – apologized to Wojcieszak's family, but only after the case was settled and money exchanged hands, and they never admitted fault for the incident.

Around the same time his brother's case was concluding, Mr. Wojcieszak became the Executive Director of Illinois Lawsuit Abuse Watch (I-LAW), a grass-roots, pro-tort reform group. He was able to place over 200 positive stories about lawsuit abuse and capping lawsuit damages with TV, radio, and print media throughout Illinois. During his time with I-LAW, Mr. Wojcieszak also first read and studied full-disclosure methods for medical errors as a way to lower malpractice lawsuits and liability costs as well as reduce medical errors.

Mr. Wojcieszak left I-LAW in 2001 and shortly thereafter founded a consulting firm. The firm had several clients, including a pro-plaintiffs group, Victims and Families United (VAFU). He served as the group's spokesperson in 2004 and touted traditional plaintiffs/anti-tort reform messages such as insurance reform and increased doctor discipline. However, while representing VAFU, Mr. Wojcieszak revisited full-disclosure methods and created a marketing term - "Sorry Works!" - to successfully promote apologies for medical errors as the solution to the medical malpractice crisis.

Mr. Wojcieszak was able to place over 50 stories about Sorry Works! during 2004 with numerous media outlets, including the Chicago Tribune, St. Louis Post Dispatch, CNBC, and a worldwide story through the Associated Press. He noticed that Sorry Works!, while agreeable to many trial lawyers, also attracted the interest and support of many doctors and insurers. These observations led Wojcieszak to create a new, separate group – The Sorry Works! Coalition – in February 2005 solely dedicated to promoting Sorry Works! and full-disclosure methods as a middle ground solution to the malpractice crisis.

The Sorry Works! Coalition has grown quickly to over 3,500 members nationwide, the website has received over 4 million hits, and the group has been publicized in countless popular and trade publications, including Time Magazine, National Review, National Law Journal, and American Medical Association News.

In partnership with Stevens & Lee, a legal and risk management firm, Sorry Works! has become the nation's leading disclosure training organization. Mr. Wojcieszak has trained and consulted thousands of healthcare, insurance, and legal professionals on disclosure and apology through his live presentations as well as his weekly newsletters, best-selling Sorry Works! Book, and webinars.

To schedule a presentation or training, contact Doug at 618.559.8168 or doug@sorryworks.net.

List o[illegible]losure Presentations by Doug Wojcieszak

Greater New York Hospital Association
Advocate Health Care, Grand Rounds, Chicago
South Carolina Senate, Medical Malpractice Subcommittee
Loyola University Health Law Seminar
Chicago Healthcare Risk Management Society Meeting
Chicago NW CPCU Society
University of Maryland Health & Law Seminar
APMC Insurance Services
American Association of Orthopaedic Surgeon State Strategies Meeting
South Carolina Hospital Association
American College of Obstetricians and Gynecologists
Annual Congressional Leadership Conference
Central Illinois CPCU Society
American Society of Cataract and Refractive Surgery
California Medical Board
Michigan Hospital Association
Virginia Medical Society Tort Reform Summit
Tennessee House of Representatives
MacNeal Hospital (Chicago, IL)
Indiana Association for Healthcare Quality
Washington Orthopaedic Surgeons
Crittenden's Insurance Meeting
Texas Medical Board
Federation of State Medical Boards
Australian Society of Cataract and Refractive Surgery
New Jersey Medical Liability Task Force
New York State Neurological Society
Placentia Linda Hospital, Placentia, CA
PhRMA Medical Liability Conference
West Virginia Hospital Association
McLeod Health, Florence, South Carolina
Carson City Hospital (Carson City, MI)
Utah Orthopaedic Surgeons
Arizona/Western Orthopaedic Surgeons
New Jersey Council of Teaching Hospitals
Wisconsin Society of Healthcare Risk Management
Baylor University Medical Center
ExecuSummit Insurance Conference (twice)
Physicians Reciprocal Insurers
Colorado Patient Safety Coalition Meeting
Advocate Health Care, Chicago, IL
Holy Name Hospital, Teaneck, NJ
Texas Tech Univ. Health Science Center, El Paso, TX
Pro Mutual Insurance Company
Health Care For All, Boston, MA
CNA Insurance
RM&PSI – Las Vegas National Seminar
PLICO Insurance (two CME-approved seminars)
Missouri Center for Patient Safety
Tennessee ASHRM Chapter
JUA/Marsh Insurance
Adventist Hospitals in Chicago (three separate hospitals)
The Reading Hospital and Medical Center (two engagements)
Southern California Society of Healthcare Risk Managers
CHS Hospital Risk Managers
North Carolina Association for Healthcare Quality
Canadian Ombudsman Association
JCAHO/JCR Disclosure & Apology Conference
Meadowbrook/Star Insurance Conference
Compliance Online webinars
Sun Rise Hospital, Las Vegas, NV (three engagements)
Alegent Hospital Network
Illinois Risk Management Services 23rd annual meeting
Iowa Chapter of the Society for Healthcare Consumer Advocacy
Highmark Health Care, Pittsburgh, PA
Kentucky Society for Healthcare Risk Managers
Womack Army Medical Center
Community Medical Centers, Fresno, CA
Delaware Association for Healthcare Quality
University of Texas Law School Symposium
Bayfront Medical Center, Florida
Chicago Patient Safety Forum Annual Meeting
American Academy of Physician Assistants (two engagements)
Good Samaritan Hospital, Los Angeles, CA
Northern New England ASHRM
Kansas Risk Managers
Loyola Medical School & Hospital
Northwestern Hospital
Indiana Hospital Association
MD Advantage Insurance (two engagements)
Jane Phillips Medical Center, Bartlesville, OK
Indian Health Services
Colorado Hospital Association
Arizona Hospital Association
Southwestern Ohio CLMA
Pinnacle Partners in Medicine, Dallas, TX
ECRI Institute Risk Management Conference
Connecticut Hospital Association
Guy Carpenter Insurance Meeting
Mercy Medical Center (Iowa)
Hospital Association of Southern California
Kirby Pines Retirement Corporation
Tri-State Medical Group, Fort Wayne, IN
Arkansas Hospital Association
Ohio State Medical Association litigation committee
California Association for Healthcare Quality
Case Western Reserve Law School
Philadelphia College of Osteopathic Medicine
American College of Nurse Mid-Wives
Illinois Society of Healthcare Risk Management
Oklahoma Hospital Association
Clinical Laboratory Management Association (two engagements)
Cigna Healthcare, Arizona
Tampa General Hospital

Date:	**October 25, 2010**
To:	**Senator Tim Owens, Chair** **Members of the Special Committee on Judiciary**
From:	**Shelley Koltnow** **VP, Corporate Responsibility** **Via Christi Health**
Re:	**Substitute for SB 374**

Testimony on Substitute for Senate Bill 374

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

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Via Christi Health supports Substitute SB 374 and urges the Committee to recommend its passage. SB 374 would establish the "Kansas Adverse Medical Outcome Transparency Act" that would encourage open and honest dialogue between physicians and other healthcare providers and their patients when an adverse event occurs.

The premise of an "apology law" is that medical mistakes do happen and a healthcare provider's expression of apology, sympathy, compassion or benevolent act should not be used as evidence of negligence or wrongdoing in a subsequent civil malpractice claim. However, SB 374 does allow a healthcare provider who is a defendant in a malpractice claim the option to surrender the inadmissibility of such statements if request is made in writing.

SB 374 offers physicians and other healthcare providers some assurance that if they do express a statement of sympathy, it will not equate to an admission of wrongdoing. Human gestures such as saying, "I'm Sorry", reinforce the fact that healthcare providers are fallible. Having this reassurance will help foster trust between the two parties.

Studies have shown that many patients pursue legal remedies to an adverse outcome simply because they want to know what happened. Knowing they can ask questions of a provider with the expectation of receiving a response, helps many patients achieve closure. Some legal experts even suggest that those healthcare providers who offer patients a simple "I'm sorry",

make a more sympathetic defendant in any subsequent malpractice lawsuit than those who say absolutely nothing.

Proponents of apology laws maintain that having a state apology law is one way to address the high cost of medical malpractice claims which contribute to the rising cost of healthcare in the United States. In fact, the "Patient Protections and Affordable Care Act of 2010 (ACA) offers grants to states to develop alternative approaches to settle disputes between providers and patients other than through civil litigation. Having a state apology law could contribute to such an effort in Kansas.

Opponents of apology laws point to the lack of evidence showing such laws actually help reduce the number of civil lawsuits against healthcare providers or that they help reduce the cost of settlements. But in 2001, the University of Michigan Health Service conducted a study following their adoption of an apology and disclosure program and found that their payments for each case dropped by 47% while the time involved in their settlements also dropped from 20 months to 6 months.[1]

Via Christi Health encourages its healthcare providers to communicate openly with patients and we urge passage of SB 374. Doing so would not harm either providers or patients but could go a long way in facilitating transparency.

Via Christi Health's rich history of serving the people of Kansas and the surrounding region dates back more than 100 years to the healing ministries of our founding congregations. Today, Via Christi Health is the largest provider of healthcare services in Kansas. We serve Kansas and northeast Oklahoma through our 10-owned or co-owned medical centers, 12 senior services villages and programs, and our retail (home-based) and outpatient services.
In FY 2010, Via Christi Health provided $78 million in benefit to the communities we serve. This included more than $39 million in charity care and more than $18 million in unpaid costs of Medicaid services provided. Via Christi Health employed more than 7,800 and generated $989 million in revenue in 2009. We are affiliated with the Marian Health System and Ascension Health.

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[1] Boothman, M., A. Blackwell, D. Campbell, E. Commiskey and S. Anderson (2009): "A better approach to medical malpractice claims? The University of Michigan experience.," *Journal of Health Life Science Law*, Jan(2), 125-59.

To: Special Committee on Judiciary

From: Dan Morin, Director of Government Affairs

Date: October 25, 2010

Subject: SB 374; expressions of sympathy or apology not construed as admission of liability in civil actions

The Kansas Medical Society appreciates the opportunity to provide written comments today as you consider SB 374 and Substitute for SB 374, which is commonly referred to as, "I'm Sorry" legislation. The substitute bill would provide that statements or gestures that express apology, sympathy, commiseration or condolence concerning the consequences of an event would not be admissible as evidence of liability for any civil claim arising from such event. It also allows the defendant to waive the inadmissibility of such statements. SB 374, as introduced, does not require exclusion under certain circumstances.

The Kansas Medical Society supports the goal of this legislation, which is to reduce the incidence of medical liability claims. According to the American Medical Association, more than 30 states have laws offering some kind of legal protection for physicians who express regret or empathy to patients who experience an adverse event. The type of expressions covered by such laws and their levels of protection vary among the states, including varying the level of protections afforded to the communication.

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. Apologies can ward off lawsuits; however, there then is a need to ensure that a physician's words are not twisted into admissions of guilt. Many statements can be, and have been, misinterpreted and subsequently mischaracterized during the process of a liability action. This fear creates a very real obstacle to effective communication with patients at a time when they need it most.

The Kansas Medical Society supports apology legislation should it foster even better communication between healthcare providers and patients, as well as reduce the number of medical liability claims being filed. Thank you for your time and attention to our comments.

623 SW 10th Avenue • Topeka, Kansas 6661

February 6, 2010

Senator Thomas Owens
Room 559-S, State Capitol
300 S.W. 10th Street
Topeka, Kansas 66612-1504

Representative Lance Kinzer
Room 165-W, State Capitol
300 S.W. 10th Street
Topeka, Kansas 66612-1504

Re: **S.B. 374 (2010)**: *An Acting concerning evidence in civil actions; expression of apology, sympathy, commiseration or condolence not admissible in evidence of an admission of liability or as evidence of an admission against interest*

Dear Senator Owens & Representative Kinzer:

The Kansas Veterinary Medical Association ("KVMA") joins the Kansas Medical Society and The University of Kansas Hospital Authority in supporting **S.B. 374 (2010)** as presently drafted.

The KVMA was formed well over a hundred years ago, in 1904 and was incorporated in 1926. It is a not-for-profit corporation. The KVMA represents the Kansas veterinary profession through legislative, regulatory, education, information and public awareness programs. The KVMA has more than 600 members in Kansas and almost 400 members in all other states.

Kansas has a long-history of acknowledging the importance of *veterinary* medicine to this state, as reflected by the College of Veterinary Medicine at Kansas State University, which can be traced back to at least 1905. KSU-CVM, without doubt, is an institution of world-wide renown.

Regarding the Senate Committee on Judiciary hearing on **S.B. 374** (Monday, February 1, 2010), the KVMA concurs with the following comments made to the Committee, which are likewise applicable to *veterinary* medicine.

- "Oftentimes plaintiff attorneys will misinterpret the [apology] statement and mischaracterize what was said." "This fear creates a very real obstacle to effective communication with patients [veterinary clients[1]] at a time when they need it most." **Dan Morin, Director of Government Affairs, Kansas Medical Society.**

- "An upfront apology or expression of sympathy can relieve and frustration and reduce the level of emotion." **William Sneed, The University of Kansas Hospital Authority.**

- "In general, apology laws are based on the theory that apologies are healing for both sides

Special Committee on Judiciary
10-25-10
Attachment 11

and should not be discourage by the fear of legal ramifications." **Kansas Judicial Council.**

Additionally, as Kathleen Bonvicini, Ed. D, Associate Director, Institute for Healthcare Communication, noted at the January 2008 American Veterinary Medical Association Leadership Conference:

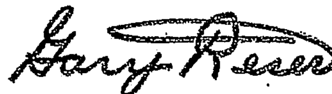
> "Being open and honest with clients about medical errors can help rebuild trust, preserve professional integrity, and reduce malpractice lawsuits." Journal of the American Veterinary Medical Association News, *Veterinary Leaders Synergize at AVMA Conference* (March 1, 2008).[2]

Succinctly, such a law: "favors expressions of sympathy as embodying desirable social interactions and contributing to civil settlements, and the evidentiary exclusion recognizes that the law should 'facilitate or, at least, not hinder the possibility of this healing ritual.'" Hawaii Rules of Evidence 409.5,[3] *Commentary* citing Robbennolt, *Apologies and Legal Settlement: An Empirical Examination,* 102 Michigan Law Review 460, 474 (2003).

The KVMA would be glad to respond promptly to any request for information.

Sincerely

KANSAS VETERINARY MEDICAL ASSOCIATION



Gary L. Reser, Executive Vice-President

GLR/gd

cc: D. Morin, Kansas Medical Society
W. Sneed, The University of Kansas Hospital Authority
Kansas Judicial Council

Footnote

[1]K.S.A. 47-816(*n*) "Veterinary-*client*-patient relationship" means:

(1) The veterinarian has assumed the responsibility for making medical judgments regarding the health of the animal or animals and the need for medical treatment, and the *client*, owner or other caretaker has agreed to follow the instruction of the veterinarian;

(2) there is sufficient knowledge of the animal or animals by the veterinarian to initiate at least a general or preliminary diagnosis of the medical condition of the animal or animals. This means that the veterinarian has recently seen or is personally acquainted with the keeping and care of the animal or animals by virtue of an examination of the animal or animals, or by medically appropriate and timely visits to the premises where the animal or animals are kept, or both; and

(3) the practicing veterinarian is readily available for follow-up in case of adverse reactions or failure of the regimen of therapy. (Italics supplied.)

[2] www.avma.org/onlnews/javma/mar08/080301a.asp

[3] **Hawaii Rule of Evidence 409.5:** *Admissibility of expressions of sympathy and condolence.* Evidence of statements or gestures that express sympathy, commiseration, or condolence concerning the consequences of an event in which the declarant was a participant is not admissible to prove liability for any claim growing out of the event. This rule does not require the exclusion of an apology or other statement that acknowledges or implies fault even though contained in, or part of, any statement or gesture excludable under this rule.

I'm Sorry Laws: Summary of State Laws

Compiled by *American Medical Association Advocacy Resource Center* (February 2008)

At least thirty states have enacted an "I'm Sorry" law for health care providers, including **Arizona, Colorado, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Missouri, Montana, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming,** and the **District of Columbia**. Generally these laws protect health care providers who express sympathy to a patient for an unanticipated outcome from having such statement used against the physician in a subsequent lawsuit.

One of the criticisms of the current litigation system is that it stymies a provider from expressing any sort of apology for an unanticipated outcome because of the fear of being sued. The purpose of an "I'm sorry" or "apology" law is to encourage open communication between patients and physicians without fear of reprisal. The type of expressions covered by the law and their level of protection, however, vary among the states. Following is a summary of state I'm sorry laws.

The laws in **Arizona, Colorado, Connecticut, Georgia, Idaho, Indiana, Iowa, Maine, Montana, Nebraska, North Dakota, Ohio, Oklahoma, South Carolina, Utah, Washington** and **Wyoming** are virtually identical and apply to any statements, gestures, or expressions of apology, benevolence, sympathy, or commiseration made by a health care provider to an alleged victim of an unanticipated outcome or the victim's relative or representative. Specifically the statement, gesture or expression must be related to the discomfort, pain, suffering, injury or death of the alleged victim in all of the laws except for the **North Dakota** and **Utah** laws. **Colorado**'s law also specifically applies to statements of fault. Employees of health care providers are also afforded protection under the law. The laws in **Delaware, Missouri, New Hampshire**, and **Virginia** are slightly different and cover any statements, writings, or benevolent gestures expressing sympathy or a general sense of benevolence relating to pain, suffering, or death of a person and made to that person or the person's family. **Maryland** and **Oregon**'s laws apply to any expression of regret or apology made orally, in writing, or by conduct. **Hawaii**'s statute applies to evidence of written or oral apologies and evidence of benevolent gestures made in connection with such apologies. **Vermont**'s law only applies to oral expressions of regret or apology. The **North Carolina** and **South Dakota** laws address statements made by a health care provider apologizing for an adverse outcome, offers to provide corrective or remedial treatment, and gratuitous acts to help affected persons. **Illinois'** law is limited to expressions of grief, apology or explanation made within 72 hours of when the provider knew or should have known of the potential cause of such outcome. The **District of Columbia** ordinance applies to the use of expressions of sympathy or regret made in writing, orally, or by conduct to the injured patient, the patient's family, or anyone who claims damages through the victim.

States also vary in the level of protection afforded to the communication. For example, the laws in **Arizona**, **Colorado**, **Connecticut**, **Georgia**, **Maine**, **Nebraska**, **North Dakota**, **Ohio**, **Oklahoma**, **South Carolina**, **Utah**, and **Wyoming** provide that the communication is inadmissible as an admission of liability or an admission against interest, while **Oregon**, **Montana**, and the **District of Columbia** specify that the communication does not constitute an admission of liability for any purpose. The **Delaware** law states that the communication is inadmissible in a civil action that is brought against a health care provider. **North Carolina**'s law states that the communication is inadmissible to prove negligence or culpable conduct. **Louisiana**'s law provides that the communication is inadmissible as an admission of liability, admission against interest, or for any other purpose, including impeachment. The **Vermont** law states that the statement shall not constitute a legal admission of liability and shall be inadmissible in any civil or administrative proceeding. The **Washington**, **Hawaii**, and **Iowa** laws state that such communication shall not be admissible as evidence. Still, nine states, including, **Idaho**, **Indiana**, **Louisiana**, **Maine**, **Maryland**, **Missouri**, **New Hampshire**, **South Dakota**, and **Virginia** specify that a statement of fault is not inadmissible as evidence.

Admissibility of Sympathetic Gestures Related to an Accident

At least five states, **California**, **Florida**, **Massachusetts**, **Texas**, and **Washington** have broader laws protecting sympathetic statements made to a person involved in an accident. Specifically these laws protect statements, writings, or benevolent gestures made to a victim of an accident or the victims' family, that express sympathy or a general sense of benevolence and relate to the pain, suffering, or death of a person involved in an accident. Such expressions shall be inadmissible as evidence in a civil action. With the exception of **Massachusetts**, these laws specify that a statement of fault shall not be inadmissible as evidence.

Formerly cited as HI R REV Rule 409.5
West's Hawai'i Revised Statutes Annotated Currentness
Division 4. Courts and Judicial Proceedings
Title 33. **Evidence**
Chapter 626. Hawaii Rules of **Evidence**(Refs & Annos)
Hawaii Rules of **Evidence**
Article IV. Relevancy and Its Limits
→**[Rule 409.5].** ***Admissibility of expressions of sympathy and condolence***

Evidence of statements or gestures that express sympathy, commiseration, or condolence concerning the consequences of an event in which the declarant was a participant is not admissible to prove liability for any claim growing out of the event. This rule does not require the exclusion of an apology or other statement that acknowledges or implies fault even though contained in, or part of, any statement or gesture excludable under this rule.

CREDIT(S): Laws 2007, ch. 88, § 1, eff. May 23, 2007.

RULE 409.5 COMMENTARY: This rule, shielding expressions of "sympathy, commiseration, or condolence," resembles measures recently adopted in several sister states. *See, e.g.*, CA Evid. Code § 1160, excluding expressions of "sympathy or a general sense of benevolence." The rule favors expressions of sympathy as embodying desirable social interactions and contributing to civil settlements, and the evidentiary exclusion recognizes that the law should "facilitate or, at least, not hinder the possibility of this healing ritual." Robbennolt, Apologies and Legal Settlement: An Empirical Examination, 102 Mich. L. Rev. 460, 474 (2003). The Hawaii legislature also stated: "Your committee finds it appropriate to allow individuals and entities to express sympathy and condolence without the expression being used...to establish civil liability". Senate Standing Committee Report No. 1131, March 21, 2007.

Whether a challenged utterance amounts to an expression of sympathy or an acknowledgment of fault will be entrusted to the sound discretion of the trial court under rule 104(a). In making this determination, the court could consider factors such as the declarant's language, the declarant's physical and emotional condition, and the context and circumstances in which the utterance was made.
H R S § 626-1, Rule 409.5, HI ST § 626-1, Rule 409.5

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Session of 2010

Substitute for SENATE BILL NO. 374

By Committee on Judiciary

2-16

9 AN ACT enacting the Kansas adverse medical outcome transparency act; concerning evidence in
10 civil actions; express of apology, sympathy, comparison or benevolent act by health care
11 providers **and veterinarians** are not admissible as evidence of an admission of liability or
12 as evidence of an admission against interest.
13
14 *Be it enacted by the Legislature of the State of Kansas*:
15 Section 1. (a) This section may be cited as the "Kansas adverse medical outcome
16 transparency act."
17 (b) In any claim or civil action brought by or on behalf of a patient **or an animal**
18 **owner** allegedly experiencing an adverse outcome of medical **or veterinary** care, any and all
19 statements, activities, waiver of charges for medical **or veterinary** care, provided or other
20 conduct expressing benevolence, regret, mistake, error, sympathy, apology, commiseration,
21 condolence, compassion or a general sense of benevolence which are made by a health care
22 provider **or a veterinarian**, an employee or agent of a health care provider **or a veterinarian**,
23 shall be inadmissible as evidence and shall not constitute an admission of liability or an
24 admission against interest.
25 (c) A defendant in a medical **or veterinary** malpractice action may waiver the
26 inadmissibility of statements defined in subsection (b) that are attributable to such defendant by
27 expressly stating, in writing, the intent to make such a waiver.
28 (d) As used in this section:
29 (1) "Health care provider" has the meaning prescribed in K.S.A. 65-4915, and
30 amendments thereto.
31 (2) "Adverse outcome" means the outcome of a medical **or veterinary** treatment or
32 procedure, whether or not resulting from an intentional act, that differs from an intended result of
33 such medical **or veterinary** treatment of procedure.
34 **(3) "Veterinarian" has the meaning prescribed in K.S.A. 47-816, and**
35 **amendments thereto.**
36 **(4) "Animal" has the meaning prescribed in K.S.A. 47-816, and amendments**
37 **thereto.**
38 Section 2. This act shall take effect and be in force from and after its publication in
39 the statue book.

11-7

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October 25, 2010

The Honorable Tim Owens, Chair
Special Committee on Judiciary

SB 374 and Sub SB 374: Apology Bill

Good morning Chairman Owens, Co-Chairman Kinzer and members of the Special Committee on Judiciary. My name is Bob Harvey and I volunteer for AARP Kansas. I have served as a member of the AARP National Policy Council, a volunteer body which recommends national policy to the AARP Board of Directors. I am also an attorney and retired judge.

AARP has more than 337,000 members living in Kansas. We are dedicated to enhancing quality of life for all as we age. Thank you for this opportunity to express our opposition to Sub SB 374.

While we do not have policy that explicitly supports Senate Bill 374, we do have policy to support our opposition to Sub Senate Bill 374, called the apology bill.

AARP agrees that our current malpractice system must be improved – it must go beyond the doctors-versus-lawyers debate and instead focus on consumers. Last year, before passage of the Health Care Reform Act, we supported the "Fair and Reliable Medical Justice Act" sponsored by Senators Enzi and Baucus, which would promote state testing of tort alternatives to see if they could provide fair compensation and help to reduce errors.

The new health care law (Sec. 10607) has provisions for grants to states to test malpractice alternatives (not sure these have been funded yet). This provision may allow states to apply for funding to "test" for five years.

AARP believes that any efforts to address medical malpractice concerns should begin with a patient-centered focus on reducing errors and promoting fair compensation. AARP does not support malpractice reform proposals that do not reduce errors or that would impair the right of injured patients to full and just compensation for injuries resulting from inappropriate medical care.

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Our principles for malpractice reform include:

- People with legitimate injuries should get fair, prompt compensation.
- Providers should be required to report errors so we can study them and learn to prevent them.

We believe that the current tort system serves most consumers poorly:

- It provides no compensation to most people harmed by medical errors – especially older individuals who are usually not eligible for much in economic damages.
- It disproportionately impacts AARP members and other 50-plus-aged Kansans.
- It also encourages providers to hide mistakes in order to avoid lawsuits.

That is why we support testing alternatives to the current tort system for medical injuries, as suggested by the Institute of Medicine. AARP endorses the Institute of Medicine's (IOM) IOMN recommendations for exploring alternatives to the tort system, and specifically supports:

- Reforms that would promote access to the courts for all legitimate claims, including smaller malpractice claims, and accelerated resolution of cases;
- Further exploration of alternative dispute resolution systems for medical malpractice cases that could serve injured patients better than the current system does;
- The development and evaluation of demonstration projects for other promising systems of compensation for preventable medical injuries, such as the comprehensive patient-centered, safety-focused, nonjudicial injury compensation system proposed by the IOM – such projects should be conducted under government auspices, with strong oversight, adequate funding and staffing, and rigorous evaluation, and should apply schedules of damages that do not result in unreasonably low awards to older, nonworking patients; and
- Malpractice insurance rates that fairly and accurately reflect claims experience.

We believe that, from a patient perspective, the most important purposes of the medical malpractice system are to compensate negligently injured patients and deter unsafe health care practices that lead to injury. Sub SB 374 will not provide those patient protections. We believe that under Sub SB 374 health care providers that make mistakes--or intentionally harm patients--can apologize and then have the evidence of their negligent or intentional bad acts kept from a jury. Therefore, we would respectfully request that you not support Sub Senate Bill 374.

Thank you for this opportunity.

Polsinelli Shughart PC

Memorandum

TO:	The Honorable Tim Owens, Chairman 2010 Special Committee on Judiciary
FROM:	William W. Sneed, Retained Counsel University of Kansas Hospital Authority
SUBJECT:	2010 Substitute for S.B. 374
DATE:	October 25, 2010

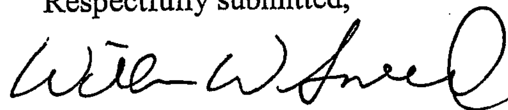
Mr. Chairman, Members of the Committee: My name is Bill Sneed and I represent the University of Kansas Hospital Authority. This is the Authority that the Kansas Legislature created to run and operate the hospital commonly referred to as KU Med. We appear here today in support of the concepts found in 2010 Substitute for S.B. 374.

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. Open communication is important in our commitment to patient safety and can improve teamwork.

Finally, by encouraging honest, open communication, bills like 2010 Substitute for S.B. 374 facilitate the continuation of the patient-health care provider relationship following an adverse event.

I would be happy to respond to questions.

Respectfully submitted,



William W. Sneed

WWS:kjb

555 South Kansas Avenue, Suite 101

Tele

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Thomas L. Bell
President and CEO

October 25, 2010

TO: Special Committee on Judiciary

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

RE: Substitute for Senate Bill 374

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 along with over 30 states strongly believes that a health care provider, an employee or an agent of a health care provider should be able to express benevolence, regret, mistake, error, sympathy, apology, commiseration, compassion and condolence and waive charges for medical care provided, without these expressions or actions being admissible as evidence, considered an admission of liability, or an admission against interest. Such conduct, statements, or activity should be encouraged between health care providers, health care institutions, and patients experiencing an adverse event resulting from their medical care.

The movement to increase transparency is welcomed by patients and by more and more regulatory and accreditation agencies that are requiring health care providers and health care institutions to discuss the outcomes of their medical care and treatment with their patients, including adverse events. 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 events. KHA supports the amendments offered by The Sisters of Charity.

In keeping with society's expectations that health care providers "do the right thing" and communicate openly and honestly with patients regarding adverse events, KHA urges the Committee to support the Substitute for Senate Bill 374 as proposed by the Sisters of Charity of Leavenworth.

Thank you for your consideration of our comments.

Kansas Hospital Association
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South Carolina Unanticipated Medical Outcome Reconciliation Act

Code 1976 § 19-1-190

Code of Laws of South Carolina 1976 Annotated Currentness
Title 19. Evidence (Refs & Annos)
Chapter 1. General Provisions
§ 19-1-190. South Carolina Unanticipated Medical Outcome Reconciliation Act; legislative purpose; definitions; inadmissibility of certain statements; waiver of inadmissibility; impact of South Carolina Rules of Evidence.

(A) This section may be cited as the "South Carolina Unanticipated Medical Outcome Reconciliation Act".

(B) The General Assembly finds that conduct, statements, or activity constituting voluntary offers of assistance or expressions of benevolence, regret, mistake, error, sympathy, or apology between or among parties or potential parties to a civil action should be encouraged and should not be considered an admission of liability. The General Assembly further finds that such conduct, statements, or activity should be particularly encouraged between health care providers, health care institutions, and patients experiencing an unanticipated outcome resulting from their medical care. Regulatory and accreditation agencies are in some instances requiring health care providers and health care institutions to discuss the outcomes of their medical care and treatment with their patients, including unanticipated outcomes, and 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 unanticipated outcomes. The General Assembly, therefore, concludes certain steps should be taken to promote such conduct, statements, or activity by limiting their admissibility in civil actions.

(C) As used in this section, the term:

(1) "Ambulatory surgical facility" means a licensed, distinct, freestanding, self-contained entity that is organized, administered, equipped, and operated exclusively for the purpose of performing surgical procedures or related care, treatment, procedures, and/or services, by licensed health care providers or health care institutions, for which patients are scheduled to arrive, receive surgery or related care, treatment, procedures, and/or services, and be discharged on the same day. This term does not include abortion clinics.

(2) "Designated meeting" means any meeting scheduled by the health care provider, representative or agent of a health care provider, or representative or agent of a health care institution:

(a) to discuss the outcome including any unanticipated outcome of the provider or institution's medical care and treatment with the patient, patient's relative or representative; or

(b) to offer an expression of benevolence, regret, mistake, error, sympathy, or apology between or among parties or potential parties to a civil action.

(3) "Health care institution" means an ambulatory surgical facility, a hospital, an institutional general infirmary, a nursing home, or a renal dialysis facility.

(4) "Health care provider" means a physician, surgeon, osteopath, nurse, oral surgeon, dentist, pharmacist, chiropractor, optometrist, podiatrist, or similar category of licensed

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health care provider, including a health care practice, association, partnership, or other legal entity.

(5) "Hospital" means a licensed facility with an organized medical staff to maintain and operate organized facilities and services to accommodate two or more nonrelated persons for the diagnosis, treatment, and care of such persons over a period exceeding twenty-four hours and provides medical and surgical care of acute illness, injury, or infirmity and may provide obstetrical care, and in which all diagnoses, treatment, or care are administered by or performed under the direction of persons currently licensed to practice medicine and surgery in the State of South Carolina. This term includes a hospital that provides specialized service for one type of care, such as tuberculosis, maternity, or orthopedics.

(6) "Institutional general infirmary" means a licensed facility which is established within the jurisdiction of a larger nonmedical institution and which maintains and operates organized facilities and services to accommodate two or more nonrelated students, residents, or inmates with illness, injury, or infirmity for a period exceeding twenty-four hours for the diagnosis, treatment, and care of such persons and which provides medical, surgical, and professional nursing care, and in which all diagnoses, treatment, or care are administered by or performed under the direction of persons currently licensed to practice medicine and surgery in the State of South Carolina.

(7) "Nursing home" means a licensed facility with an organized nursing staff to maintain and operate organized facilities and services to accommodate two or more unrelated persons over a period exceeding twenty-four hours which is operated either in connection with a hospital or as a freestanding facility for the express or implied purpose of providing skilled nursing services for persons who are not in need of hospital care. This term does not include assisted living, independent living, or community residential care facilities that do not provide skilled nursing services.

(8) "Renal dialysis facility" means an outpatient facility which offers staff assisted dialysis or training and supported services for self-dialysis to end-stage renal disease patients.

(9) "Skilled nursing services" means services that:

(a) are ordered by a physician;

(b) require the skills of technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and

(c) are furnished directly by or under the supervision of such personnel.

(10) "Unanticipated outcome" means the outcome of a medical treatment or procedure, whether or not resulting from an intentional act, that differs from an expected or intended result of such medical treatment or procedure.

(D) In any claim or civil action brought by or on behalf of a patient allegedly experiencing an unanticipated outcome of medical care, any and all statements, affirmations, gestures, activities, or conduct expressing benevolence, regret, apology, sympathy, commiseration, condolence, compassion, mistake, error, or a general sense of benevolence which are made by a health care provider, an employee or agent of a health care provider, or by a health care institution ***to the patient, a relative of the patient, or a representative of the patient and which are made during a designated meeting to discuss the unanticipated outcome*** shall be inadmissible as evidence and shall not constitute an admission of liability or an admission against interest.

(E) The defendant in a medical malpractice action may waive the inadmissibility of the statements defined in subsection (D) of this section.