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24 HOURS PRIOR TO THE SCHEDULED MEETING

Bill # SB 96

Date of testimony 1/26/2016

Print Contact Name (and/or person who will be testifying):

Rachelle Colombo

Agency represented Kansas Medical Society

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Please check type and category applicable:

Type: Oral Testimony: _____ or Written Only: X

Category: Proponent: ____ Opponent: X Neutral:____

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KANSAS MEDICAL SOCIETY
Established 1859

To: Senate Judiciary Committee

From: Rachelle Colombo
Director of Government Affairs

Date: January 26, 2016

Subject: SB 96; the Kansas disclosure of unanticipated medical outcomes and medical errors act

The Kansas Medical Society appreciates the opportunity to appear today as you consider SB 96, the Kansas disclosure of unanticipated medical outcomes and medical errors act. This bill imposes a duty on health care providers to make mandatory disclosures to patients and licensing agencies of any unanticipated outcomes and medical errors. Failure to disclose such events is punishable by a $10,000 fine per event. It also requires hospitals to develop and implement disclosure policies, and mandates meetings and discussions between patients and providers about these events. It also mandates disclosure of unanticipated outcomes or medical errors to past patients if they weren't previously informed of the event. It also prohibits confidential settlements in medical liability claims which arise from unanticipated outcomes or medical errors.

Although we support the development of communication-and-resolution programs which create an environment in which health care providers can engage patients and their families in candid discussions about any unanticipated or adverse outcomes associated with their care in order to answer questions, and to perhaps resolve misunderstandings and disputes expeditiously, we cannot support this bill. While well intended, the main part of the bill which deals with mandatory disclosures of adverse events, and mandatory meetings and discussions with patients, is overly regulatory and unnecessarily complex.

It is our belief that programs for disclosing adverse outcomes and errors, offering expedited compensation in appropriate cases, and learning from those events are strategies that hospitals and other health care providers are already implementing voluntarily, without the need for complicating legislation or regulations imposed by legislatures or licensing agencies. The goal of these programs is to identify adverse outcomes or errors promptly, tell patients and their families what happened, make things right, and use lessons learned to improve patient safety for the future.

Our concern is that this bill is so complex, and so prescriptive, that it will complicate an already overly adversarial, legalistic dispute resolution system in health care, which is the opposite direction in which we ought to be headed. Additionally, much of medical care is often delivered in settings and circumstances that includes care and interventions by several clinicians, either at the same time, or throughout the course of one episode of treatment. It may be very difficult to

readily ascertain who, if anyone, is responsible for an adverse event, unanticipated event or medical error, particularly in emergencies, care involving traumatic injuries, or patients with very complex medical conditions. For many clinical situations, it will be very difficult to know if there was an outcome or error that required reporting, and it may often be that a clinician won't know that they breached their duty to report and are subject to a $10,000 fine until well after the care has been delivered.

The bill also mandates that providers and patients have the required disclosures and discussions, whether the patient desires them or not. Even the content of the discussions between provider and patient is mandated by the bill. The bill also requires the mandated disclosure of unanticipated outcomes or medical errors in the case of past patients who suspect they were the victim of an unanticipated outcome or medical error, but were not informed of such event. That provision is so broad, without limits, and impractical, as to render it impossible to comply with in many cases.

These are just a few of the problems we see with the disclosure and reporting part of the bill, which we believe will have the unintended consequence of discouraging the very discussions it was designed to promote. Unless it became part of a comprehensive, confidential, legally-protected, and non-punitive disclosure and reporting structure, this proposal just adds more complexity, cost and uncertainty to the already complex intersection of law and medicine.

Unfortunately, although well-intended, this legislation will not promote or achieve that which it is designed to do – encourage better, more timely communication and understanding between providers and patients, especially about adverse or unanticipated events. The legislation is just too complex and prescriptive. The establishment of communication and resolution programs by hospitals and health care providers at the local level should certainly be encouraged. We do not believe, however, that the best way to do that is to design and impose such programs by state law.

Thank you for the opportunity to provide these comments on SB 96.