HB 2376 Testimony - Proponent

Nancy Clarkson, Arkansas City, Ks.

Most of the legislators or representatives of medical or legal groups I have visited with concerning HB 2376 are aware of past proposed apology bills and have referred to this one as an apology bill. HB 2376 is *not* an apology bill. This bill is for the required disclosure of unanticipated medical outcomes and medical errors. Section 4 of this bill does exclude apologies from being used as evidence in court, but please understand that this is a patient-centered bill, not a doctor-centered bill.

Much has been said about apologies. Our bill does not require anyone to apologize. Our bill requires disclosure. The language in our bill says that patients and families should be offered "an apology when appropriate". There are many cases in which an apology may be inappropriate, particularly when there is no negligence.

It is critical to understand the difference between disclosure, apology, and statements of sympathy.

- A **disclosure** is an honest and complete account of an incident and the reasons for the incident, to the best of the care team's knowledge. This includes an acknowledgement of any errors and harm.
- An **apology** has three parts: (1) a disclosure, (2) an expression that one believes they were at fault for the harm, or that the healthcare team or institution is collectively at fault for the harm, and (3) an expression of remorse for the incident causing harm. Notice that the disclosure is a statement of facts. The second two are about the emotional state of the speaker. It is nonsensical to require someone to have a particular emotional state, so our bill requires only disclosure.
- A statement of **sympathy** is an expression that one recognizes the physical or emotional pain of another. Sometimes a statement of sympathy is included in an apology, but sympathy can be expressed by anyone aware of someone else's pain.

There are many times apologies make sense, and when conscientious healthcare providers give apologies they can be tremendously beneficial to patients, as well as providers. But be aware that when an "apology" is delivered under false pretenses, perhaps for the purpose of trying to win favor with a patient or avoid accountability, is worse than no apology at all.

But our bill is not about apologies. Our bill makes clear that patients have a right to know what has (or has not) happened to their bodies and why, and it is about the responsibility of healthcare workers to deliver that information.

My daughter, Melissa Clarkson, and I put a great deal of work and research into writing this bill. It is not something we dreamed up or pulled out of thin air. It was written using current, recommended best practices. In addition, the justification for this bill comes from four principals that we believe capture the rights of patients and responsibilities of medical institutions when something has gone wrong in a patient's care. Too often these rights and responsibilities have been disregarded in the traditional model of healthcare. Thus, this legislation is needed.

1) Patients have the right to know about unanticipated outcomes of their care and medical errors that have occurred during their care.

Our bill is not simply about disclosing medical errors, it is about keeping patients informed when things go wrong during their care. Many of the things that go wrong are not the result of errors. Our bill requires that patients be informed of both unanticipated outcomes and medical errors.

We recognize that some unanticipated outcomes and medical errors are very minor and do not have the potential to harm patients. These are excluded from requirements for disclosure (section 3(j)). An example of a minor error would be if a nurse gives a medication to a patient at too low of a dose, realizes the error a short time later, and then gives the rest of the medication to the patient. Because this error had no potential for harm, our bill would not require this minor medical error to be communicated to the patient. Our bill concerns unanticipated outcomes and medical errors that result in harm.

The right of patients to know about harm is explicitly stated in the American Medical Association Code of Ethics. However, this code of ethics does not have the force of law, and many harmful errors remain hidden from patients. This violates the integrity of the patient-provider relationship and compromises the ability of patients to make decisions about future healthcare. Hiding errors is unfortunately common. I have attached an article by Dr. Lucian L. Leape titled "Full Disclosure and Apology---An Idea Whose time has Come" and I also ask you to read online an article titled "Disclosure of Medical Error: Facts and Fallacies" which was published in the fall 2001 *Journal of Healthcare Risk Management*.

2) Health care workers and administrators of health care institutions have the responsibility to have timely and authentic conversations with patients (and their families or representative, as appropriate) about unanticipated outcomes and medical errors.

In best practice, disclosure is not a one-time event. It is a series of conversations that occur as the medical team learns more about an incident. Our bill promotes quick communication, because any unanticipated outcome must be disclosed, whether or not an error was involved.

Disclosure should not be optional. It must be a standard part of healthcare. But it is not. I have attached a narrative from Dr. Neil Calman, published in the January 12, 2014 journal *Health Affairs*. This describes his personal experience with entering the world of medical secrecy as well as his observations for what needs to change.

We realize that one barrier to disclosure is physicians' fear that their words could be used against them in court. Apology bills were introduced in the 2009, 2010 and 2011 Kansas legislative sessions, but did not pass. The language in our bill is based in part on the 2011 draft. It prohibits use of oral or written expressions of apology, sympathy, or fault from being used as evidence in court (section 4(a)). This is because any evidence used in court to establish negligence or harm should pertain to the incident itself, not to the communication of the incident to the patient and family.

3) Patients who have been harmed due to medical errors have the right to be treated fairly and compensated appropriately.

Some states and hospitals are trying new approaches to work *with* patients who have been harmed, rather than *against* them in a courtroom. This can be a good solution for both parties and should be

encouraged. However, there is a danger that patients will be persuaded to settle for an amount of compensation far less than necessary to cover future medical expenses, replace lost income, and compensate for pain and suffering. Therefore, this bill creates a six month waiting period between the offer of a settlement and acceptance of that settlement if a patient chooses not to consult an attorney (Section 3(m)). Short-term compensation (such as child care expenses, rent or mortgage payments for patients unable to immediately return to the job, or funeral expenses for a deceased patient) are not subject to the six-month waiting period.

4) Health care institutions have the responsibility to establish procedures for disclosure of unanticipated outcomes and medical errors to patients and their families.

Unanticipated outcomes and medical errors will occur in even the best of medical care facilities. Therefore, it is to the benefit of both patients and medical care facilities that procedures for disclosure are established so that the responsibilities of health care providers, expectations of administrators of the medical facility, and timelines for action are clear.

The ideas in our bill are not new. As I mentioned earlier, we did not dream them up. They are drawn from the research of scholars in the fields of medicine, law, bioethics, and public health and published in the attached paper titled "The Flaws in State 'Apology' and 'Disclosure' Laws Dilute Their Intended Impact on Malpractice Suits," published in the September 2010 issue of *Health Affairs*. The five authors examined apology and disclosure laws of all fifty states and the District of Columbia. At that time, 34 states and the District of Columbia had apology laws and 9 states had disclosure laws. Of all those states, 6 had both apology and disclosure laws. Kansas was among the 13 states that had neither law. They found that most of the laws had "major shortcomings." To address the flaws they found in these simple laws, the authors proposed a set of best practice recommendations for state disclosure and apology laws. We incorporated the recommendations from this study into our bill. That is why our bill appears complex.

When drafting this bill, we never considered it perfect and recognized that changes might need to be made to improve it. We have been very open about what we have proposed and even asked for comments and suggestions from all the different groups who have testified on apology bills in the past, both pro and con. As a result, there is one amendment we propose be added to the definitions in HB 2376. There also needs to be a change in the date for implementing disclosure policies because this bill was introduced during the last legislative session.

Add to Sec. 2: (k) "harm" means any physical or psychological injury or damage to the health of a person, including both temporary or permanent injury, as well as injury resulting in death.

Date change in Section 3 (e): July 1, 2015.

I am aware that passage of this bill will cause some people in the medical profession to feel uncomfortable. After all, it calls for a new way of thinking in which the needs of patients must come before the needs of healthcare providers and institutions. But responding to the needs of patients is simply being professional.

There are many benefits to having disclosure policies in place and having real, authentic conversations with patients and their families. Perhaps the most important benefit would be the healing of the strained relationship between the medical facilities and professionals who make errors and the patients and their families who suffer as a result of the errors.

I ask you to study the information and carefully consider this bill keeping in mind the rights of patients and the responsibilities of medical institutions and professionals.

Thank you.

Attachments:

Lucian L. Leape, "Full Disclosure and Apology--An Idea Whose Time has Come," *The Physician Executive*, (Mar.-April 2006): 16-18. [Permission to reproduce granted by Bill Steiger on Feb. 4, 2014.]

Neil S. Calman, "No One Needs To Know," *Health Affairs*, 20, no. 2 (2001): 243-249. [Permission to reproduce only photocopies granted by Glenda Koby on Feb. 5, 2014.]

Anna C. Mastroianni et al., "The Flaws in State 'Apology' and 'Disclosure' Laws Dilute Their Intended Impact on Malpractice Suits," *Health Affairs* 29, no. 9 (2010): 1611-1619. [Permission to reproduce only photocopies granted by Glenda Koby on Feb. 5, 2014.]

Online article that can be accessed by typing the title into a search engine:

"Disclosure of Medical Error: Facts and Fallacies" by Grena G. Porto, RN, MS, CPHRM, DFASHRM.

Full Disclosure and Apology—An Idea Whose Time has Come

By Lucian L. Leape, MD

IN THIS ARTICLE...

Examine some persuasive arguments that support full disclosure and apologies for medical errors and learn the key steps hospitals need to take.

One of the groundbreaking trends set in motion by the famous Institute of Medicine reports of 2000 and 2001[1,2] and promoted by a growing number of patient advocacy groups is increasing transparency in all aspects of health care.

Perhaps the most important manifestation is the call for full disclosure following an adverse event. While both the Joint Commission on Accreditation of Healthcare Organizations and the American Medical Association call for informing the patient when complications occur, what takes place in practice is often less than "full" disclosure. Why is this, and what do hospitals need to do?

What hospitals need to do is develop and implement policies that ensure that all patients who are harmed by their treatment receive timely, open, complete information on the causes and circumstances that led to their injury, delivered in a compassionate manner by the responsible caregiver. When the injury results from an error or system breakdown, the response should include an apology and restitution.

The arguments for such an approach are both theoretical and practical. The theoretical argument has two pillars: ethical and therapeutic.

The ethical case is straightforward and rarely challenged: the patient has a right to know what happened. Conversely, hospitals and physicians or nurses have no right, morally or legally, to withhold information from patients.

Just as patients are entitled to know all the results of laboratory tests, opinions from consultants, risks of treatment and alternative therapeutic options, they are entitled to know what the causes of the breakdown are when things go wrong. It is also what each of us would want for ourselves. We want to know what went wrong, why, and what will be done to prevent it from happening again.

Full disclosure is the right thing to do. It is not an option; it is an ethical imperative.

The therapeutic argument is also simple and straightforward: full disclosure is essential for healing.

Curiously, for the healing professions, this aspect of disclosure is frequently overlooked in the obsession with liability. But the evidence is clear that a serious preventable injury causes severe emotional trauma. The patient was wounded by those he or she trusted for care.

Unfortunately, on the surface, in the absence of other information, for the patient the accident may appear to have resulted from lack of caring, from not being careful.

The incident damages the patient's trust—in the physician and in the institution. If it is not openly and honestly dealt with, trust is irrevocably destroyed and the patient will be psychologically scarred for life.

The doctor-patient relationship also suffers, for it is based on trust. Trust is based on truth. If there is silence, or dissembling, or incomplete information (partial "truths"), trust crumbles, both in the physician and in the institution.

The only treatment, the only way trust can be restored and the patient begin to heal, is for the caregiver to acknowledge the error, take responsibility—and apologize.

Apology vs disclosure

The case for apology is very different from that for disclosure. Apology is not an ethical right, but a therapeutic necessity. Apology makes it possible for the patient to recognize our humanity, our fallibility, our remorse at having caused harm. It "levels the playing field." It makes it possible for the patient to forgive us.

Apology is necessary for healing, for "getting over it." It doesn't always work. Sometimes the patient's anger is too great for forgiveness. But healing cannot occur without it. To be effective, it must be a true apology, in which the caregiver takes responsibility for the event and shows remorse and a desire to make amends.

"I'm sorry this happened to you," is no substitute, for it lacks responsibility and remorse. Making amends should include reimbursement for expenses as well compensation for long-term disability.

Apologizing is also necessary for healing of the doctor or nurse who made the error. They, too, are emotionally traumatized. They are the "second victims," devastated by having been the unwitting instrument that seriously harmed another. They feel shame and guilt that sometimes can be overwhelming.

Apologizing, expressing their remorse and desire to make amends, can lead to forgiveness and healing for them as well. So apology is a balm for both the patient and the caregiver. It heals their psychological wounds.

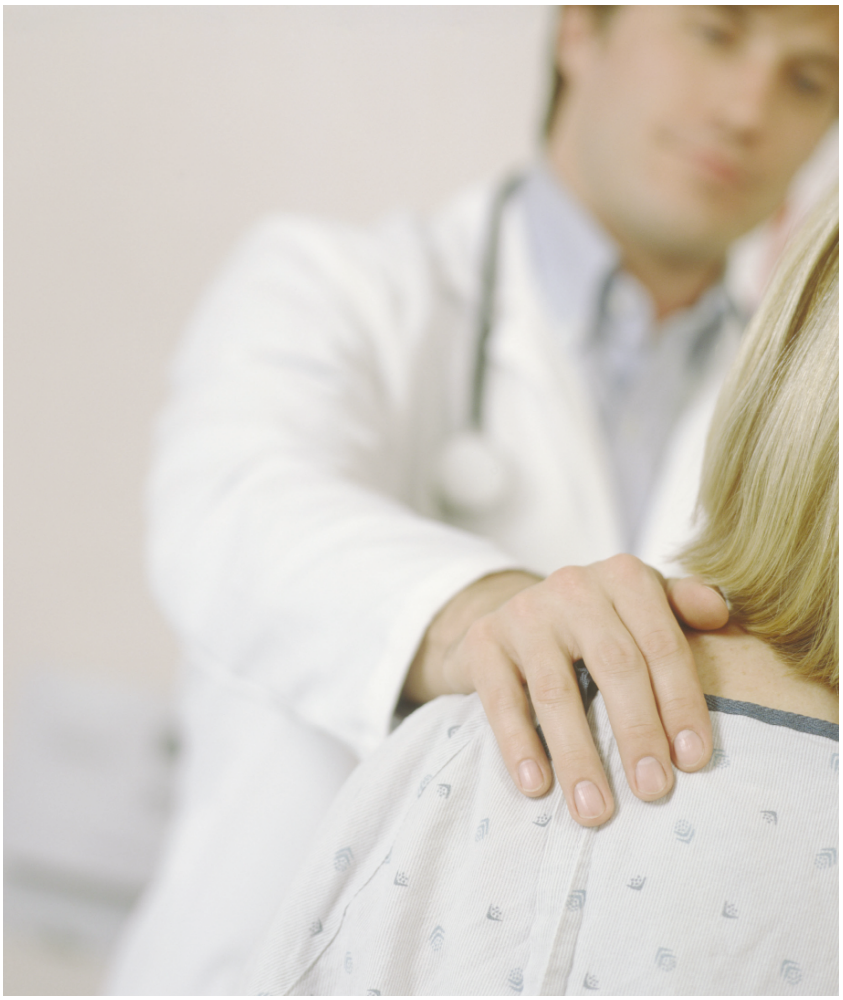
Can we afford it?

The practical arguments for open and complete communication, with apology and restitution, are that it is effective treatment for patient and doctor and that it is less costly for all parties.

For decades, lawyers and risk managers have claimed that admitting responsibility and apologizing will increase the likelihood of the patient filing a malpractice suit and be used against the doctor in court if they do sue.

However, this assertion, which on the surface seems reasonable, has no basis in fact. There is to my knowledge not a shred of evidence to support it. It is a myth.

The reality, in fact, appears to be just the reverse. Patients are much more likely to sue when they feel you have not been honest with them. There now are several experiments under way—the Veterans Administration, University of Michigan, COPIC in Colorado—where full disclosure and small early settlements have resulted in dramatic reductions in suits and in payouts. These need to be expanded and replicated in other locations.



Apology makes it possible for the patient to recognize our humanity, our fallibility, our remorse at having caused harm.

Again, the ethical argument is clear: patients should not have to bear expenses caused by our mistakes. From a practical standpoint, the figures are encouraging.

In the 1990 Harvard Medical Practice Study in New York state, it was found that compensating all patients with disabling injuries for their out-of-pocket expenses would cost less than liability insurance premiums paid by doctors and hospitals.[3]

A no-fault compensation system was recommended. While this has yet to happen, the experience at the VA, Michigan, and COPIC provides further evidence of its feasibility.

Barriers to disclosure

Why does full disclosure so often not occur? Why do so many patients fail to receive a full and truthful explanation of what went wrong and hear their caregiver accept responsibility and apologize? The reasons are many and complex, but several stand out.

First, apologizing is hard to do—for anyone. As we all know, it is difficult in non-medical situations, even when the "injury" is merely a slight or an insult. But a medical apology is much more difficult.

The harm we have caused is physical and may even be disabling or fatal. The more serious the injury, the more difficult it is to apologize. Showing sympathy ("I'm sorry you were hurt.") is much easier, but lacks the essence of true apology, which is to take responsibility for the harm and express true remorse.

In fact, because it seems to specifically communicate no responsibility or remorse, some believe it can be, paradoxically, more harmful than no expression of concern.

Second, the injury was not intentional. The doctor or nurse didn't harm the patient on purpose. It was an accident, due to an error, not a deliberate act. Even though the caregiver may feel bad for the patient, and chagrined, it was an "honest mistake."

Third, many physicians lack the skills, which are considerable, to present bad news well. We haven't been trained to control our own emotions while we try to handle patients' anger, frustration and disappointment.

But probably the most important reason caregivers don't readily admit errors and apologize is shame and fear. Shame at failing to live up to our own and the patient's expectations of perfection. Fear of the consequences: loss of the patient's trust, loss of respect of colleagues, the risk of being sued.

These rational fears have been fed and amplified by bad legal advice that ignores the emotional consequences of injury for both patient and caregiver. Indeed, hospital lawyers and insurance companies sometimes demand that doctors and nurses not admit responsibility or apologize following a preventable adverse event. Fortunately, that is changing.

Moving ahead

What should hospitals do? It is time to take our focus off self-protection and put it on our mission, which is patient care.

Leaders have an obligation to their patients and to their staff to help heal the emotional trauma that follows a serious adverse event. The core is to establish effective methods for disclosure, apology and support. To do this, leaders have to set expectations, provide training, and provide support systems for patients and personnel.

First, set expectations. Hospital policy should be clear and unequivocal (and in writing): patients are entitled to a full and compassionate explanation when things go wrong. Usually, this will be the responsibility of the patient's physician, although nurses, pharmacists and others should be involved when appropriate. The policy also should include providing apology when indicated.

Second, doctors and nurses, as well as risk managers and other support personnel, need training in communicating with patients after adverse events. They also need training on how to support colleagues when they are "second victims."

Third, support systems need to be developed for all parties. Patients need help after an event, including after discharge from the hospital. We also need to provide support and "just-in-time training" to help the physician communicate with the patient following the event. And we need to help these second victims deal with their emotional trauma. Professional and peer support systems must be developed.

Finally—and this is the tough part—after enlisting full support of the boards of trustees, hospital leaders need to insist that liability carriers provide early settlements for injured patients.

Making amends, financial or otherwise, is intrinsic to a meaningful apology. No patient should have to sue to receive a just settlement. The amounts required are often surprisingly small. But they should be sufficient to meet the actual expenses, and should be given freely, not grudgingly, as true reparations.

The new world of transparency can be daunting, requiring substantial changes in many of our practices and ways of thinking. The benefits for our patients, and for ourselves, can be tremendous.

Lucian L. Leape, MD, *is a professor of health policy at Harvard University and a long-time advocate of the non-punitive systems approach to the prevention of medical errors. He can be reached at leape@hsph.harvard.edu*

References

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