Approved: 3/2/11
Date

MINUTES OF THE HOUSE JUDICIARY COMMITTEE

The meeting was called to order by Chairman Lance Kinzer at 3:30 p.m. on February 9, 2011, in Room 346-S of the Capitol.

All members were present except:
Representative Colloton
Representative Alford

Committee staff present:
Jill Wolters, Office of the Revisor of Statutes
Matt Sterling, Office of the Revisor of Statutes
Tamera Lawrence, Office of the Revisor of Statutes
Lauren Douglass, Kansas Legislative Research Department
Robert Allison-Gallimore, Kansas Legislative Research Department
Sue VonFeldt, Committee Assistant

Conferees appearing before the Committee:
Representative Mast, Seventy-Sixth District, Emporia
Steve Graber, Attorney, Manhattan, Kansas
Kirk Sours, Concerned Citizen
Cynthia Smith, JD Advocacy Counsel, Sisters of Charity of Leavenworth Health System
Chad Austin, Vice President of Government Operations, Kansas Hospital Association
Bob Williams, Executive Director of the Kansas Association of Osteopathic Medicine,Topeka
Gary Reser, Kansas Veterinary Medical Association (KVMA)
Mitsi McFatrich, on behalf of Kansas Advocates for Better Care
Whitney Damron, on behalf of the Kansas Bar Association
Callie Denton, Kansas Association for Justice
Robert Harvey, AARP Kansas Volunteer

Others Attending:
See attached list.

The Hearing on **HB 2087 - Concerning the protection of rights granted under the constitution** was opened.

Matt Sterling, Staff Revisor, provided the committee with an overview of the bill. (Attachment 1)

Representative Mast, Seventy-Sixth District, Emporia, addressed the committee in support of this bill, stating Article 6 of the U.S. Constitution contains the Supremacy clause, and that clause is of vital importance today as we see an international desire to merge into a global form of governance that defies the basic values we place on human life in the United States. She added many parts of the world are in conflict over what legal system should be recognized by other cultures and it is time we define which one must be recognized by the court systems in Kansas. (Attachment 2)

Steve Graber, Attorney, Manhattan, Kansas appeared before the committee as a proponent, and shared with them some examples of the growing global reality which necessitates this bill. He stated if this bill, is enacted and applied, it would preempt any expectation of any immigrant from any nation that they can come to Kansas and yet live as if they were not here jurisprudentially but remained in their home land. (Attachment 3)

Kirk Sours, a concerned citizen of Kansas, spoke before the committee, also encouraged passage of this bill, and stated there is a real storm coming regarding social issues within this country. He stated this bill would remind and direct the Courts within the State of Kansas to avoid referral to, consultation with, and permission of any Foreign or Cultural Law when deciding or hearing cases in Kansas and simply codifies the Constitution. (Attachment 4)

The following Proponents provided written testimony:
Currie Myers, Retired Sheriff of Johnson County (Attachment 5)
Christopher Holton. Vice President, Center for Security Policy (Attachment 6)

There were no opponents.

After much discussion the hearing on **HB 2087** was closed.

Minutes of the House Judiciary Committee at 3:30 p.m. on February 9, 2011 in Room 346-S.

Chairman Kinzer announced that **HB 2069** and **HB 2123** will be heard simultaneously because they are very similar.

The hearing on **HB 2069 - Enacting the Kansas adverse medical outcome transparency act** and on **HB 2123 - Enacting the Kansas adverse medical outcome transparency act** was opened.

Tamera Lawrence, Assistant Revisor of Statutes, provided an overview of the bill, advising the committee that **HB 2069** is identical to 2010 substitute for **SB 374**, and it is similar to **HB 2123**, but does have some differences, including additional types of apologetic expressions and allowing the defendant to waive the inadmissibility of such statements so the apology could be introduced as evidence. Both **HB 2069** and **HB 2123** would prevent apologies and similar statements made by healthcare providers from being admitted in civil actions. Current law allows apologies and other similar statements to be admitted as evidence in civil actions under the admissions exception to the Kansas hearsay rules. (Attachment 7)

Cynthia Smith, JD, Advocacy Counsel, Sisters of Charity of Leavenworth Health System, addressed the committee as a proponent and provided some history behind this bill. She stated by keeping open the lines of communication between a patient and his or her doctors and hospital, when there is an adverse outcome of a medical procedure or treatment, an adversarial relationship and potentially costly lawsuits can be avoided. She also stated thirty-four states have an apology law in statute and much has been written about the success of these laws. She also provided additional documentation from various resources. (Attachment 8)

Cynthia Smith also presented testimony on behalf of Thomas Theis, Attorney, Foulston Siefkin, LLP, Topeka, Kansas. Mr. Theis was originally scheduled to present oral testimony as a proponent, but due to the snow storm and subsequent rescheduling of the Hearing of **HB 2069**, he was unable to appear due to a conflicting court case schedule. She said Mr. Theis has defended well over a thousand cases alleging medical malpractice during his career and what the system has consistently overlooked is the emotional impact of these cases on the parties involved, both plaintiffs and defendants. Mr. Theis strongly supports this bill and believes it would likely play an important role in reducing non-meritorious litigation. (Attachment 9)

Bill Sneed, Legislative Counsel, The University of Kansas Hospital Authority, was scheduled to present oral testimony but was delayed due to presenting testimony before another committee, and therefore Chairman Kinzer advised the committee to give consideration to his written testimony. (Attachment 10)

Chad Austin, Vice President of Government Operations, Kansas Hospital Association (KHA), appeared as a proponent and stated the practice of medicine is both an art and a science and therefore the treatment of patients does not always proceed as planned. He stated 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. He also stated 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. (Attachment 11)

Bob Williams, Executive Director of the Kansas Association of Osteopathic Medicine,Topeka, addressed the committee as a strong proponent and stated it is rather sad that our legal system has evolved to a point whereby we need a law passed to allow Doctors to express their condolences to patients and their families. He also stated many Osteopathic doctors practice in a family practice setting and frequently in rural communities and in many cases have been providing care to a family over generations and are therefore very connected to the family and when an "adverse outcome" occurs, the natural human response is to provide condolences, be it an apology or an expression of sympathy. He believes this bill will allow health care providers, their patients, and families to obtain closure. (Attachment 12)

Gary Reser, Kansas Veterinary Medical Association (KVMA), spoke to the committee in support of the bill and urging them to add veterinarians to this bill. He quoted Kathleen Bonvicini, an associate director of the Institute for Healthcare, speaking to the American Veterinary Medical Association, as saying: "Being open and honest with clients about medical errors can help rebuild trust, preserve professional integrity, and reduce malpractice lawsuits." (Attachment 13)

Representative Sloan was unable to attend the Hearing, however, he submitted written testimony

Minutes of the House Judiciary Committee at 3:30 p.m. on February 9, 2011 in Room 346-S.
in support of bill **HB 2123.** (Attachment 14)

The following proponents provided written testimony:
Dan Morin, Director of Government Affairs, Kansas Medical Society (Attachment 15)
Shelly Koltnow, JD, VP-Corporate Responsibility, VIA Christi Health (Attachment 16)
Tim Van Zandt, RN, MPA, Director of Public Affairs, Saint Luke's Health System (Attachment 17)

Mitsi McFatrich, on behalf of Kansas Advocates for Better Care, appeared before the committee as an opponent, stating that for a health care provider to be shielded from a lawsuit because he or she has offered an apology for error or wrong-doing is an over protection of health care workers at the expense of someone already harmed. (Attachment 18)

Whitney Damron, appeared an an opponent on behalf of the Kansas Bar Association (KBA). He provided the committee with some background information stating the legislature first considered similar legislation in the 2009 session as **SB 32**, and the Committee on Judiciary requested a review of the proposal by the Kansas Judicial Council, and the bill died in committee, at conclusion of the 2010 session. In 2009, the Civil Code Advisory Committee of the Judicial Council reviewed apology statutes enacted in 35 other states before drafting their own version of the apology bill, which was presented to legislature in 2010 as **SB 374**. He stated the KBA did not take a position on **SB 374** as originally introduced, however a substitute bill was adopted by the Senate Committee on Judiciary and advanced out of committee. The KBA and others expressed strong concerns with the amended bill before it was scheduled for floor debate and it was eventually returned to Committee, where it died at the conclusion of the 2010 session. Following the 2010 session, the proponents of the bill before you today sought a review of their proposal in the form of an interim study. The Special committee on Judiciary heard from a number of conferees during the 2010 interim hearing process, and recommended the Judicial Council version from the 2010 session be adopted (2010 **SB 374**) as introduced, and has been introduced in the 2011 session as **SB 142**. In conclusion, he stated the KBA supports the work product of the Judicial Council, and if this committee believes legislation is necessary, they request adopting the language contained in **SB 374** as originally introduced in 2010. (Attachment 19)

Callie Denton, JD, Director of Public Policy, Kansas Association for Justice (KsAJ), presented testimony in opposition, on behalf of Gary D. White, KsAJ, stating if the committee chooses to adopt changes to the rules of evidence, KsJA recommends the Committee support the language of the bill recommended by the Kansas Judicial Council(**SB 142**). She stated they believe the Judicial Council is the appropriate expert body to make neutral policy recommendations regarding rules of evidence. (Attachment 20)

Robert Harvey, AARP Kansas Volunteer, a retired Judge and attorney, and a Kansas resident, addressed the committee as an opponent. He stated 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 and **HB 2069** and **HB 2123** will not provide those patient protections. (Attachment 21)

The hearing on **HB 2069 and HB 2123** was closed.

The next meeting is scheduled for February 10, 2011.

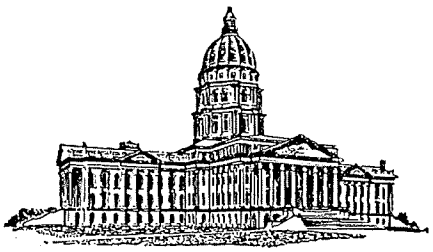
The meeting was adjourned at 5:42 p.m.

JUDICIARY COMMITTEE GUEST LIST

DATE: February 9, 2011

NAME	REPRESENTING
Cynthia Smith	SCL Health System
Chad Austin	KHA
Whitney Damron	KS Bar Assn.
Joe Molina	KS Bar Assn
Steve Fabert	~~Legislator~~ Self
Kirk Jones	Self
Mitzi McCormick	KABC
Bob Harvey	AARP Kansas
Catherine Bender	Washburn University
Nancy Thouse	Judicial Council
Jim Clark	Health Care Stabilization Fund
Callie Jill Denton	KS Assn for Justice

MARY ANN TORRENCE, ATTORNEY
REVISOR OF STATUTES
JAMES A. WILSON III, ATTORNEY
FIRST ASSISTANT REVISOR
GORDON L. SELF, ATTORNEY
FIRST ASSISTANT REVISOR



OFFICE OF REVISOR OF STATUTES
KANSAS LEGISLATURE

Legal Consultation—
Legislative Committees and Legislators
Legislative Bill Drafting
Legislative Committee Staff
Secretary—
Legislative Coordinating Council
Kansas Commission on
Interstate Cooperation
Kansas Statutes Annotated
Editing and Publication
Legislative Information System

MEMORANDUM

To: Chairman Kinzer and members of the House Judiciary Committee

From: Matt Sterling, Assistant Revisor of Statutes

Date: February 9, 2011

Subject: House Bill 2087

HB 2087 provides that any court, tribunal or administrative agency ruling or decision and any contract or contractual provision providing for choice of law or jurisdiction that is based in whole or in part on any law, legal code or system that would not grant the affected parties the same rights and privileges granted under the U.S. or Kansas Constitutions would be void and unenforceable.

If a resident of Kansas that is subject to personal jurisdiction in this state seeks to maintain litigation, arbitration, agency or similarly binding proceedings in Kansas and the court finds that granting a claim of forum non conveniens would likely violate the rights and privileges granted under the U.S. and Kansas constitutions of the nonclaimant in the foreign forum then the claim shall be denied.

The bill defines, "foreign law," "legal code" or "system" as any law, legal code or system of a jurisdiction outside of any state or territory of the United States, including, but not limited to, international organizations and tribunals and applied by that jurisdiction's courts, administrative bodies or other formal or informal tribunals.

House Judiciary
Date 2-9-11
Attachment # 1

300 SW TENTH AVE - STE 010-E, Statehouse—TOPEKA, KANSAS 66612-1592
PHONE (785) 296-2321 FAX (785) 296-6668 E-mail: Revisor'sOffice@rs.state.ks.us

Testimony on HB 2087

February 9, 2011

A few years ago I would have never thought it necessary to have the need to stand before you today and defend a critical part of our U.S. Constitution and the Constitution of the State of Kansas. I am speaking about Article 6 of the U.S. Constitution that contains the Supremacy clause. That clause is of vital importance today as we see an international desire to merge into a global form of governance that defies the basic values we place on human life in the United State of America.

Article 6 makes a clear definition that the U.S. Constitution is the supreme law of the land and yet there are cultures in our midst that declare they follow other laws that are supreme and should be followed strictly no matter how much their loyalty to that law conflicts with ours. Their laws do not grant equal protection to women. These foreign laws still allow for slavery and cast systems.

In our diverse society, we are already seeing some judges choosing to give credence to those foreign laws and so far it would seem the judgment has been overruled by a higher court. We are all familiar of a young girl who fled her parents because she could no longer feel safe in the home environment because she feared their perceived responsibility for "honor killing" because of her choice to leave their law and come under the protection of ours right here in the United States of America.

Kansas is not alone in recognizing the need for such legislation. There are three states that have already passed laws and many others who are in the process. I beg you to not set us back in this endeavor. You will hear others testify about the need for the legislation and you have testimony of some who have survived the peril of those other existing laws that want to usurp ours. Many parts of the world today are in conflict over what legal system should be recognized by other cultures. It is time we define which one must be recognized by the court systems in Kansas.

Thanks for allowing me the opportunity to appear before you today. I stand for questions.

Respectfully submitted by

Representative Peggy Mast

House Judiciary
Date 2-9-11
Attachment # 2

THE NEED FOR HOUSE BILL NO. 2087

I. INTRODUCTION:

WHILE THERE ARE MANY JURISPRUDENTIAL ISSUES ADDRESSED BY HOUSE BILL 2087, THIS OUTLINE ADDRESSES TWO JURISPRUDENTIAL ASPECTS OF OUR GROWING GLOBAL REALITY WHICH NECESSITATES HOUSE BILL 2087.

ASPECT ONE: When Kansas citizens expatriate to another country or obtain dual citizenship by adding another country to their American citizenship, a jurisprudential issue often arises.

A. That issue which this legislation resolves is the extent to which a judgment by a court in the other country is to be enforced in a Kansas Court.

B. The X Family example (a true example still ongoing after 10 years): As is often the case, the need for judicial intervention often arises in the context of family issues which an order or orders have been rendered in another country.

X Family Case facts:

- Apparent luring by one spouse to the other country for the purposes of being able to use that other country's family law for divorce, support and maintenance economics;
- Legal malpractice in the other country confirming jurisdiction over the Kansas resident irremedial;
- Judgments are awarded and "enforcement" rulings made by courts in the other country that resulted in **economic consequences that violate the law and public policy of Kansas and could not have been awarded in a Kansas Court;**
- **Multiple court and administrative costs in other country and in Kansas for legal and administrative actions that are both redundant and errant (for example, SRS, on December 23, 2010 confiscated all the funds of the Kansas resident...over $300,000.00...from the resident's accounts on the false notion that an order in the case was defective. After a change of minute moment, the funds were restored but hours of cost and unnecessary Kansas administrative work were lost and of no effect);**
- Because of the total confusion of the jurisprudence and lack of due process and judicial integrity in the multinational arrangement, the parties have spent over $1million dollars in attorney fees and costs and the case is yet to be resolved.

C. House bill 2087 would provide clear guidance and resolution to this ASPECT ONE as reference to Kansas law and public policy would give

knowable direction and this matter could have been resolved years ago. House Bill 2087 would have identified the aspects of the other country's order that could have been awarded in Kansas and affirmed those elements. Many states have taken this step and address such foreign judgments accordingly. There is a greater degree of certainty and no violation of the Uniform Enforcement Laws results.

II. ASPECT TWO: The immigration of citizens of another country to Kansas, which country has a vastly different jurisprudential reality than our Kansas jurisprudential reality, can surface many issues if the immigrants do not fully agree and understand that while we are glad to have them here; their talents and skills, this is America, this is Kansas and we expect them to leave their old country jurisprudential realities, as much as they are in contradiction with ours, in the old country. With the great transition of people, especially the huge numbers coming to America, there has been inadequate attention paid to making clear this jurisprudential reality. House Bill 2087 goes a long way to bring that clarity.

A. FOR EXAMPLE, one of the most far reaching, current and ongoing, internationally confusing jurisprudential environmental issues is the immigration of individuals from countries with partial or full Shariah Law jurisprudence. While only Saudi Arabia and Iran claim to have full Shariah jurisprudence, many other countries claim such and practice such.

SHARIAH LAW

INTRODUCTION:

Shariah law is the law that governs all aspects of Islamic life and, therefore, in a nation looking to accommodate its tenants, all citizens are affected by its implementation. It behooves the legal community serving the body politic to come to understand and deal honestly with the nature of any proposed jurisprudence that impacts on the foundational precepts of that body's jurisprudence.

From the underlying philosophical basis to the express written substantive and procedural details, all must be reviewed in light of what is enforced as the current governing legal fabric of the society. Should the existing legal community fail in this responsibility and allow the assimilation of unknown, untried, untested and not understood. Indeed! Currently forbidden jurisprudential principles would be the highest breach of fiduciary duty to the body politic which cannot and should not be prevailed upon to carry such a high duty and heavy burden!

It is to this end and responsibility this paper and this effort is directed as a point of inquiry and determination. This is a beginning; an initial effort to stimulate the investigation that will lead to the understanding and evaluation of Shariah Law that will allow our legal community to provide honest and clear counsel and advice to those we

serve. We dare not listen and rely on the proponents of the positive values of this or any other corpus juris without fully acquitting ourselves of our duty to be the keepers of the public trust. In a word, this will mean that we must be able to say of our own conscious, based on our own investigation and to our best knowledge, "This is the impact of Shariah Law generally and this tenet of such law specifically as it regards you my constituent."

I would speak a word about honest inquiry. During the ongoing research of this matter (now exceeding 9,000 pages) it is frequent to encounter "agendites" or promoters of Shariah jurisprudence who resort to attempting to demonize those making honest inquiry. Clamoring like "Islamic phobia" and "Hate slandering" are found in the writings of those who would claim tolerance and peaceful acceptance of Western Civilization and our jurisprudence. If such intimidation is allowed to truncate, moderate or even influence execution of our duty to act in the public trust we took oath to fulfill, we are not deserving of the privilege of our title. Let me illustrate.

Honor Killings are a point of inquiry and confusion and in this research at this time are placed in the category of debated tenants of Shariah Law. No conclusion is drawn in this paper at this time. The research goes forward. BUT, there are clear warnings. Our jurisprudence has never tolerated a man beheading his wife for ANY REASON! Whether or not these practices are permissible under tenants of Shariah Law is a point of debate and yet to be resolved. What is NOT UP FOR DEBATE is that these killings are given far different treatment in nations embracing Shariah Law than in our jurisprudence. SO, it is totally unacceptable and impermissible to neglect the resolve of this issue or to be sidetracked to focus on Shariah Financing Law and fail to resolve all aspects of Shariah jurisprudence for, **indeed, by the proclamation of all proponents of such law, every tenant of Shariah is rooted in the same world view and assumptions. The ONLY DIFFERENTIAL is the degree of application. There is NO DIFFERENCE in a jurisprudence that would permit and encourage a man to beat his wife and one which allows him to decide to killer her for any reason! The clamoring of "Muslim phobia" notwithstanding the ruse is intellectually dishonest and represents some false, covert, or inappropriate value.** Welcome to the inquiry! What do you really know? We begin here.

A. The existing and current presence of Shariah in American jurisprudence and public policy making forums compels this inquiry.
B. Active ongoing promotion of Shariah

Professionals are promoting: International Law Journal
Law Professors: Washburn University Law School; Harvard
Governmental Agencies promoters: U.S. Dept of Treasury
Practitioners are promoting Shariah: Wills and Estates
Domestic issues
Parental rights issues
Constitutional Law issues
Religious freedom

Freedom of Association

Areas of active debate of the clarity of:
Honor Killings: The Hassan case.

C. So, WHAT IS SHARIA LAW? Multiple of spellings Sharia, Shari', etc.

D. Historical perspective: Whatever else is debatable, it is clear there is no known credible reference to Shariah Law as a definitive jurisprudence prior to the Koran.

E. The sources of Shariah Law according to the scholars of Sharia are agreed.

1. Shariah law is defined by all concerned whether academics of Shariah institutions, Shariah scholars, the U.S. Department of Treasury, legal practitioners or those who have research such but are not of that jurisprudential persuasion as:

THE LAW THAT GOVERNS ALL ASPECTS OF ISLAMIC LIFE BEING THE RULES AND PRINCIPLES THAT ARE ACTUALLY APPLIED IN THE REGULATION OF HUMAN EXISTENCE. The sources for such law are as follows: the Quran; the Hadith (sayings of Muhammad) the Sunnah (the interpretive conduct of Muhammad) with interpretation by Scholars, Imams and Consensus.

2. With a definition so comprehensive in scope, there is an obvious need to clarify with all immigrants that come from Shariah law countries that there may be significant variances with the jurisprudence of their understanding but the resolve of those variances will be the application of U.S. and Kansas law. Welcome they are to be a part of us governed by our laws and jurisprudence. House Bill 2087 provides the basis for that jurisprudential underpinning. Notice is sufficient in our law.

3. The UK has chartered a "separate but equal" course which we in Kansas, of all places, know does not work.

4. Canada began to follow the British lead but soon saw its impossible compatibility and in 2009 terminated that course.

5. Australia has been in chaos since 2005 dealing with this issue in a reactionary way.

B. It would be totally unwise for Kansas to fail to address the issues surfacing in other countries addressing the Shariah law matter.

1. The costs of multijurisdictional administration in a time of shrinking budgets is untenable even if there was evidence the sociological infrastructure resulting from the separate but equal status would be compatible.

2. The multijurisdictional jurisprudential system is not working in the UK.

3. There is abandonment of the Shariah law jurisprudential environment by those formerly adherent and it is accelerating.

4. Those that have lived under and promoted Shariah law and dominance and have abandoned that reality are numerically significant had energetically outspoken being clear in the details of the difference between our system and the Shariah system.

   Sharia for Dummies: Nonie Darwish

   The sheer costs of judicial administration in the hiring and training and enforcing of polar opposite jurisprudential systems is staggering to contemplate.

5. It is not just the voices of those who have abandoned the life of Shariah jurisprudence dominance that call to us the gravity of the need for House Bill 2087. The proponents and participants in Shariah driven jurisprudence are expressive and clear in their agendas. Indeed! Some of these voices emanate from the points of interest in our country using our own jurisprudence of free speech to make demands for recognition of Shariah jurisprudential rights.

We understand that a Turkish delegation has an interest in Kansas as expressed by their coming to Kansas and escorting Kansas legislators on exchange visits to Turkey. We understand them coming here as there is research that over 6 million Shariah adherents are leaving that environment each year and have been since 2006. What we are not sure of is ultimate purpose of the Turkish interest in Kansas. We do know from the purpose statement of the Turkish delegation to Germany that the purpose as stated to the Germans would not be acceptable to Kansans: I quote:

As the Turkish journalists said: **Modern Day Trojan Horse, Sam Solomon, Page 51.**

6. American think tanks have provided much work that supports the need to clarify as House Bill 2087 would do. **McCormick Foundation.**

7. The voices of those who have left Shariah jurisprudential environments have identified its presence already being exhibited in our country. **Blood of the Lambs, Kamal Saleem p. 71.**

III. There is much a stir in the globalization process. Some see financial and economic venues as the equalizers of jurisprudential differences.

A. Such analysis is errant. The research is conclusive that economic incentives will not regulate character and philosophical conduct and are not a successful motivation source for such. **John Gato.**

B. To substitute the components of Shariah jurisprudence for our Kansas system (and the other 28 states now involved in this very process with this or similar legislation) even in part will be intolerably unacceptable to those who have lived generations in our system.

C. The only possible solution for the implementation of a totalitarian jurisprudence as is defined by the Shariah proponents is the elimination of any variance. That has been attempted many times in history and never once successful. It fails because it is jurisprudentially flawed.

The chilling thought is that there are those advocating that it is appropriate to try.

CONCLUSION

House Bill 2087 if enacted and applied, would preempt any expectation of any immigrant from any nation that they can come to Kansas and yet live as if they were not here jurisprudentially but remained in their home land. They need to understand from the beginning that they cannot enjoy the benefits of our, albeit imperfect, society and its jurisprudential values and conduct themselves as if they were somewhere else. If they cannot make the required transition to our jurisprudence then they should remove to their homeland and we will do what we can from here to see that the benefits of liberty they forfeit by such removal become the jurisprudential values of that country. WE ARE FULLY AWARE THAT OUR LIBERTIES AND FREEDOMS ARE NOT GLOBALLY THE NORM.

WE ONLY NEED TO LOOK AT THE GREEN CARD LINES IN IRAN AND SAUDI ARABIA AND COMPARE THEM TO THOSE IN THE USA TO SEE THAT THERE IS A GREAT DEAL OF DIFFERENCE.

PEOPLE WANT TO COME HERE TO LIVE BECAUSE OF THE LIFE THERE IS HERE TO LIVE.

HOUSE BILL 2087 WOULD PROVIDE A BASIS FOR USE TO PRESERVE THAT LIFE.

Respectfully submitted,

Steven Graber, Attorney
Manhattan, KS

3-7

Hearing before the Kansas House of Representatives
Committee on the Judiciary
Written Testimony in Support of House Bill 2087
Wednesday, February 9, 2011

Thank you Mr. Chairman, Committee Members, Ladies and Gentlemen.

It is indeed an honor to speak with you today concerning a matter that is of great importance to each one here, as well as every Kansas citizen. That matter is the preservation of the integrity of our laws in the State of Kansas as well as those of the United States, specifically the Constitutions of the United States and the State of Kansas, both of which are compatible and complimentary. There have recently been court decisions handed down which refer to, and give authority in American courts, to foreign law and cultural law that may be ***incompatible*** with the Kansas Constitution and the US Constitution. This particular Bill, **HB 2087**, will remind and direct the Courts within the State of Kansas to avoid referral to, consultation with, and permission of any Foreign or Cultural Law when deciding or hearing cases in Kansas. It simply codifies the Constitution, nothing more.

Lance Corporal Jesse T. Sours, United States Marine Corps, Reserve, is my 21 year old son. When he told his mother and me he had joined it did not surprise me, nor did I ask him why. I knew why. It was the way we raised him. "Why the Marines?" some would ask. I never had to ask him. It was the greatest challenge. Neither was I surprised when I recently learned he has put his name on the deployment list to go wherever his country needs him. Yes, I am proud of my son.

I recently asked him what oath he took when he enlisted. The oath was "...support and defend the Constitution of the United States against all enemies, foreign and domestic..."

Each person in this room who is here by election of the people of Kansas took an oath to "uphold and protect the Constitution of the United States and of the State of Kansas". Then you signed your name to that oath. It probably won't cost you much to keep that oath. It could cost my son everything to keep his oath. The Marine's core values of "Honor, Courage, and Commitment" are what drives my son to keep his oath. I think our elected officials in Kansas and every State would be well served to take that set of values to the floor of our Congress's and fulfill their oaths.

We are at a crossroads in this country. We see our traditional values under attack on many fronts. Our laws and institutions are being challenged by some activist judges who seem to legislate from the bench, bypassing the people's house for the sake of a political agenda; and by activist groups and cultures that do not have the best interests of America or her citizens in mind.

Kansas was forged from the spirit of freedom loving people who desired to see ***all people*** free and buckets of blood are soaked into our soil for that reason. They died with Honor, their Courage was commendable, and their Commitment to liberty has never been questioned. They wanted to bring Kansas into the Union, under the Constitution, as a "Free State". Kansas has never shied away from the challenge, and has been a proven, committed leader for the cause of human rights. Some think our

House Judiciary
Date 2-9-11
Attachment # 4

State silly for taking such costly stands. I hope you would agree that it was worth it. Well, now it's our turn.

Ladies and Gentlemen, If we don't draw a line in our good Kansas soil now, today, by supporting HB 2087, a bill that underscores your very oath to support and defend the Constitution, then when? The time is now. Thank you!

Respectfully submitted,

Kirk Sours

Hearing before the Kansas House of Representatives
Committee on the Judiciary
Written Testimony in Support of House Bill #2087
Wednesday, February 9, 2011

Mr. Chairman and members of the Committee:

Thank you for allowing me the opportunity to provide written testimony in support of House Bill No. 2087. It was my hope to testify in person on this most important piece of legislation, but due to a conflict could not attend in person.

Today's hearing involves, among other things, the interplay between international law and domestic law. These issues are crucial in today's age of globalization for they relate to sovereignty and ultimately our theories and concepts underlying international law and democratic government.

We do not have the same moral and legal framework as the rest of the world, and never have. If you told the framers of the Constitution that we're from now on to use foreign law in our judicial decisions they would have been appalled. And if you read the Federalist Papers, it's full of statements that make very clear our framers didn't have a whole lot of respect for many of the rules in European countries. Madison, for example, says -- speaks contemptuously of the countries on continental Europe, "who are afraid to let their people bear arms."

Justice Scalia indicated in a debate on the use of foreign law in 2005 the following: "Why is it that foreign law would be relevant to what an American judge does when he interprets" -- interprets, not writes -- I mean, the Founders used a lot of foreign law. If you read the Federalist Papers, it's full of discussions of the Swiss system, German system, etc. It's full of that. It is very useful in devising a constitution. But why is it useful in interpreting one? Scalia further states, "Now, my theory of what I do when I interpret the American Constitution is I try to understand what it meant, what was understood by the society to mean when it was adopted. And it hasn't changed since it was written. *Source: **Transcript of Scalia-Breyer debate on foreign law**, American University, Jan. 13, 2005*

Federalist John Jay wrote in the Federalist Paper #2 that, "This country and this people seem to have been made for each as if it was the design of Providence, that an inheritance so proper and convenient for a band of brethren, united to each other by the strongest ties, should never be split into a number of unsocial, jealous, and alien sovereignties. Source: Federalist #2 **Concerning Dangers from Foreign Force and Influence**, Author: **John Jay**

Today, we see a number of countries using foreign law or in some cases allowing foreign law in parallel to their own court systems. For instance in Britain there is the headquarters of the Islamic Sharia Council which oversees the growing number of Muslim (Sharia) courts operating in Britain.

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Sharia has been operating in parallel to the British legal system, since 1982. Work includes issuing fatwas, which are religious rulings through an Islamic court. The Islamic Sharia Counc also rules on individual cases, primarily in matters of Muslim personal or civil law: divorce, marriage, inheritance and settlement of dowry payments are the most common.

Until last year in Britain, Sharia courts were permitted to rule only in civil cases, such as divor and financial disputes. But now, due to a clause in the Arbitration Act 1996 that was recently interpreted, Sharia is now enforceable by county and high courts and have begun to tackle cri by bypassing police and the British court system altogether. Source: UK Dailymail, July 2009

The use of international law in Britain has developed into an accepted practice and has spread other countries. It's a perilous tightrope we tread - the line between multicultural tolerance and protecting the rights of the individual. Kansas must take steps to curtail the use of international or "foreign law," "legal codes" or "systems" in order to protect the sovereignty of our nation, great state and our citizens. Therefore I request that you pass HB-2087.

Respectfully submitted,

Currie

Sheriff (Ret) Currie Myers, PhD, MBA
Public Safety/Defense Consultant

Sheriff of Johnson County, Kansas 2003-2005
Special Agent, KBI 1990-2003
State Trooper, KHP 1985-1990

TESTIMONY SUBMITTED TO THE KANSAS STATE LEGISLATURE

9 FEBRUARY 2011

By Christopher Holton
Vice President
Center for Security Policy

Some 235 years ago, America's forefathers gathered in Philadelphia to debate and write a unique document. That single-page document announced the formation of a new country—one that would no longer find itself in the clutches of a foreign power. That document was the Declaration of Independence. Eleven years later, many of those same men gathered again to lay the foundation for how the United States of America was to be governed: The US Constitution, a form of government like no other *by the people, of the people and for the people.*

For more than two centuries, hundreds of thousands of courageous men and women have given their lives to protect America's sovereignty and freedom.

American constitutional rights must be preserved in order to preserve unique American values of liberty and freedom.

State legislatures have a role to play in preserving constitutional rights and American values of liberty and freedom. If States did not have such a role to play, why then do states have constitutions which often mirror, echo and reinforce the US constitution?

• America has unique values of liberty which do not exist in foreign legal systems, particularly Shariah Law. Included among, but not limited to, those values and rights are:

- Freedom of Religion
- Freedom of Speech
- Freedom of the Press
- Due Process
- Right to Privacy
- Right to Keep and Bear Arms

Civil and Criminal Law Serve as the Bedrock for American Values: We are a nation of laws. Unfortunately, increasingly, foreign laws and legal doctrines—including and especially Shariah law--are finding their way into US court cases.

Invoking Shariah law, especially in family law cases, is a means of imposing an agenda on the American people while circumventing the US and state constitutions by using foreign laws which do not recognize our constitutional rights and liberties in US courts.

The potential impact of using foreign and international laws and legal doctrines in US courts on the liberty of ordinary American citizens are as profound as they are despairing. The embrace of foreign legal systems such as Shariah law, which is inherently hostile to our constitutional liberties, is a violation of the principles on which our nation was founded.

The threat of the infiltration of shariah into American law is real and immediate. On many occasions litigants have demanded that American courts apply shariah.

American courts on occasion must decide whether to apply shariah, or recognize decisions rendered under shariah, when addressing whether foreign judgments should be recognized, whether forum selection or choice of law clauses in contracts should be enforced, what jurisdiction's law to apply, and whether cases should be dismissed or transferred to be tried in other countries under forum non conveniens. Our courts have, and likely will continue to, adjudicate the application of Islamic shariah.

There have been dozens of instances in which Shariah has been invoked in US courts, mostly unsuccessfully, *but not always.*

Here are two of the most infamous cases:

- In S.D. v. M.J.R. in the state of New Jersey, a New Jersey judge saw no evidence that a Muslim committed sexual assault of his wife — not because he didn't do it, but because he was acting on his Islamic beliefs: "This court does not feel that, under the circumstances, that this defendant had a criminal desire to or intent to sexually assault or to sexually contact the plaintiff when he did. The court believes that he was operating under his belief that it is, as the husband, his desire to have sex when and whether he wanted to, was something that was consistent with his practices and it was something that was not prohibited." Fortunately, an appellate court overturned this atrocious decision, and a Shariah ruling by a U.S. court was not allowed to stand.

- In a Maryland case, Hosain v. Malik, 108 Md.App. 284, 671 A.2d 988 (Md.1996), a Maryland Court granted comity and enforced a Pakistani custody order turning a child brought to the US by the mother over to the father. The Maryland Court held that: the burden was on the mother to prove the Pakistani court did not apply law in "substantial conformity with Maryland law" by a preponderance of the evidence; the case was "not about whether Pakistani religion, culture, or legal system is personally offensive to us or whether we share all of the same values, mores and customs, but rather whether the Pakistani courts

> applied a rule of law, evidence,or procedure so contradictory to Maryland public policy as to undermine the confidence in the trial"; the best interest of the child should not be "determined based on Maryland law, i.e., American cultures and mores," but rather "by applying relevant Pakistani customs, culture and mores";"a Pakistani court could only determine the best interest of a Pakistani child by an analysis utilizing the customs, culture, religion, and mores of ... Pakistan"; "in the Pakistani culture, the well being of the child and the child's proper development is thought to be facilitated by adherence to Islamic teachings"; the Pakistani order was not the result of "a trial by fire, trial by ordeal, or a system rooted in superstition, or witchcraft"; the "longstanding doctrine [of Hazanit1] of one of the world's oldest and largest religions practiced by hundreds of millions of people around the world and in this country, as applied as one factor in the best interest of the child test, is [not] repugnant to Maryland public policy"; and, the granting of the order by the Pakistani Court without representation for the mother was not repugnant to Maryland public policy because although she may have been arrested for adultery if she returned to Pakistan for the custody proceedings and have been subject to "public whipping or death by stoning," such punishments were "extremely unlikely."

The founders of our nation believed that the United States of America and its individual states should never be subservient to any foreign power, country or legal system and that no foreign power, country or legal system should be allowed to encroach upon our rights under the Constitution.

The purpose of American and Kansas Laws for Kansas Courts is to preserve the sovereignty of the US and Kansas and their respective Constitutions by preventing the encroachment of foreign laws and legal systems, such as Shariah law, that run counter to our individual constitutional liberties and freedoms.

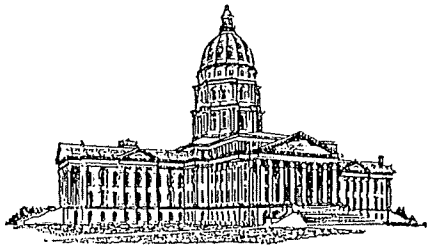
By passing American and Kansas Laws for Kansas Courts, you will be preserving *individual* liberties and freedoms which become eroded by the encroachment of foreign laws and foreign legal doctrines, such as Shariah.

It is imperative that we safeguard our Constitutions' fundamentals, particularly the individual guarantees in the Bill of Rights, the sovereignty of our Nation and its people, and the principles of the rule of law—*American and Kansas laws, not foreign laws.*

MARY ANN TORRENCE, ATTORNEY
REVISOR OF STATUTES

JAMES A. WILSON III, ATTORNEY
FIRST ASSISTANT REVISOR

GORDON L. SELF, ATTORNEY
FIRST ASSISTANT REVISOR



OFFICE OF REVISOR OF STATUTES
KANSAS LEGISLATURE

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To: Chairman Kinzer and members of the House Judiciary Committee

From: Tamera Lawrence, Assistant Revisor of Statutes

Date: February 9, 2011

Subject: House Bills 2069 and 2123

HB 2069 and HB 2123 would prevent apologies and other similar statements made by healthcare providers from being admitted as evidence in civil actions. Current law allows apologies and other similar statements to be admitted as evidence in civil actions under the admissions exception to the Kansas hearsay rules.

HB 2069 is identical to 2010 substitute for SB 374. It is similar to HB 2123, but does have some differences, including additional types of apologetic expressions and allowing the defendant to waive the inadmissibility of such statements so the apology could be introduced as evidence.

House Judiciary
Date 2-9-11
Attachment # 7

300 SW TENTH AVE - STE 010-E, Statehouse—TOPEKA, KANSAS 66612-1592
PHONE (785) 296-2321 FAX (785) 296-6668 E-mail: Revisor'sOffice@rs.state.ks.us

Session of 2010

Substitute for SENATE BILL No. 374

By Committee on Judiciary

2-16

AN ACT enacting the Kansas adverse medical outcome transparency act; concerning evidence in civil actions; expression of apology, sympathy, compassion or benevolent acts by health care providers not admissible as evidence of an admission of liability or as evidence of an admission against interest.

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

Section 1. (a) This section may be cited as the "Kansas adverse medical outcome transparency act."

(b) In any claim or civil action brought by or on behalf of a patient allegedly experiencing an adverse outcome of medical care, any and all statements, activities, waivers of charges for medical care provided or other conduct expressing benevolence, regret, mistake, error, sympathy, apology, commiseration, condolence, compassion or a general sense of benevolence which are made by a health care provider, an employee or agent of a health care provider, shall be inadmissible as evidence and shall not constitute an admission of liability or an admission against interest.

(c) A defendant in a medical malpractice action may waive the inadmissibility of statements defined in subsection (b) that are attributable to such defendant by expressly stating, in writing, the intent to make such a waiver.

(d) As used in this section:

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

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

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

Session of 2010

SENATE BILL No. 374

By Committee on Judiciary

1-14

AN ACT concerning evidence in civil actions; expression of apology, sympathy, commiseration or condolence not admissible as evidence of an admission of liability or as evidence of an admission against interest.

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

Section 1. 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 provide 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.

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

Session of 2009

SENATE BILL No. 32

By Committee on Public Health and Welfare

1-15

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

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

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

(b) As used in this section:

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

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

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

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

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

Sisters of Charity of Leavenworth Health System

House Judiciary Committee
State of Kansas
February 2, 2011

Written Testimony on House Bill 2069
The Kansas adverse medical outcome transparency act
concerning evidence in civil actions; expression of apology, sympathy, compassion or benevolent acts by health care providers not admissible as evidence of an admission of liability or as evidence of an admission against interest.

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.

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.

House Judiciary
Date 2-9-11
Attachment # 8

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 Senate 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 in 2010 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. Our version was adopted as 2010 Substitute Senate Bill 374 and passed favorably out of the Senate Judiciary Committee, but was returned and referred to interim study. The interim committee recommendation, as you have heard, was to start over again with Senate Bill 374 as introduced in 2010. We want the committee to start with the Substitute, and so requested House Bill 2069. The language of House Bill 2069 is identical to 2010 Substitute Senate Bill 374.

Public Policy purpose and results

The logic of the public policy of "sorry works" 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, even when what happened was not anyone's fault.

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.

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.**

Background on Apology Bill debate in Kansas

When the Senate Judiciary Committee referred the apology bill to the Kansas Judicial Council for study in 2009, we 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 to doctors 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* required that whether an apology will be excluded from evidence must be – *in each case*, *after the fact* – decided in court.

The Judiciary Council report was flawed because it asserted that apologies could be successfully dealt with that way, by denying physicians any assurance whatsoever, saying "Hawaii's approach leaves that decision squarely in the capable hands of the trial judge..."

Hawaii's law does not -- and the Judicial Council's Hawaii model would not -- do anything to improve communication or reduce unnecessary litigation. It would be useless. We have to wonder if that is exactly what is wanted by the segment of the legal community advocating for the Hawaii language.

In hearings in 2010, SCLHS -- joined by **Via Christi Health System, Saint Luke's Health System, and Shawnee Mission Medical Center** -- asserted that under a law based on the Hawaii law, 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 agreed with us and 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, which had a good line-up of witnesses but a disappointing turnout of legislators and, equally disappointing, vote recommending the legislature start over again with the Judicial Council's Hawaii model.

Fault

The primary question raised about an apology bill is whether statements of "mistake" or "error" or "fault" should be excluded from evidence. House Bill 2069 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 then have to be examined by a judge after the fact to determine whether it was an admissible statement of fault.

Best case scenario: statements of apology will occur, but be so carefully scripted as to be unsatisfactory to either the patient or the doctor.

Worst case scenario: 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.

Other Interim issues

SCLHS considered revising the bill to address issues which emerged during the interim hearings, but ultimately we believe the same bill was best left alone. For example, we considered requiring that Apology and Disclosure be mandated as an alternative for Continuing Medical Education, but were advised that it would not be good precedent to put into statute. We considered allowing an exception for impeaching a witness, but were advised that there would then always be a demand for an exception so it would render the law useless and unreliable. We believe that House Bill 2069 is a good bill which would give Kansas the most effective law in the United States and serve health care providers and patients the best.

Law vs. Policy

The University of Michigan Health System was able to achieve success with a policy which demands 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 expect 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 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 Committee to support adoption of House Bill 2069.

Respectfully submitted,
Cynthia Smith, JD
Advocacy 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
- Hawaii statutes HRS Sec. 626-1
- 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

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 *

Benjamin Ho
Cornell University

Elaine Liu
University of Houston

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.

* The authors wish to thank Ori Heffetz, Ren Mu, Christine Durrance and Emily Owens as well as seminar participants at Stanford University, Cornell University, University of Houston Center for Public Policy, Hong Kong University, Brigham Young, National Taiwan University, the American Economic Association Annual meetings and ASHE for helpful comments. Direct correspondence to Benjamin Ho 322 Sage Hall Cornell University Ithaca, NY, 14853.E-mail: bth26@cornell.edu

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.

> 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.

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:

$$\log Y_{st} = \lambda controls_{st} + \beta apology_{st} + \sum_t \delta_t Year_t + \sum_s \delta_s State_s + \varepsilon_{st} --Eq(1)$$

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.

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.

8-19

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.

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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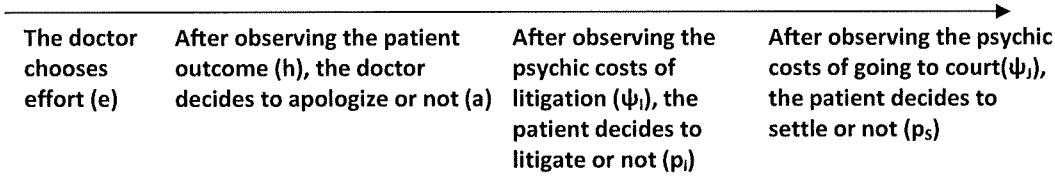
Appendix

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).

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.

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[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.

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:

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

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:

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

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

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:

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

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

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

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.

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[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.

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

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

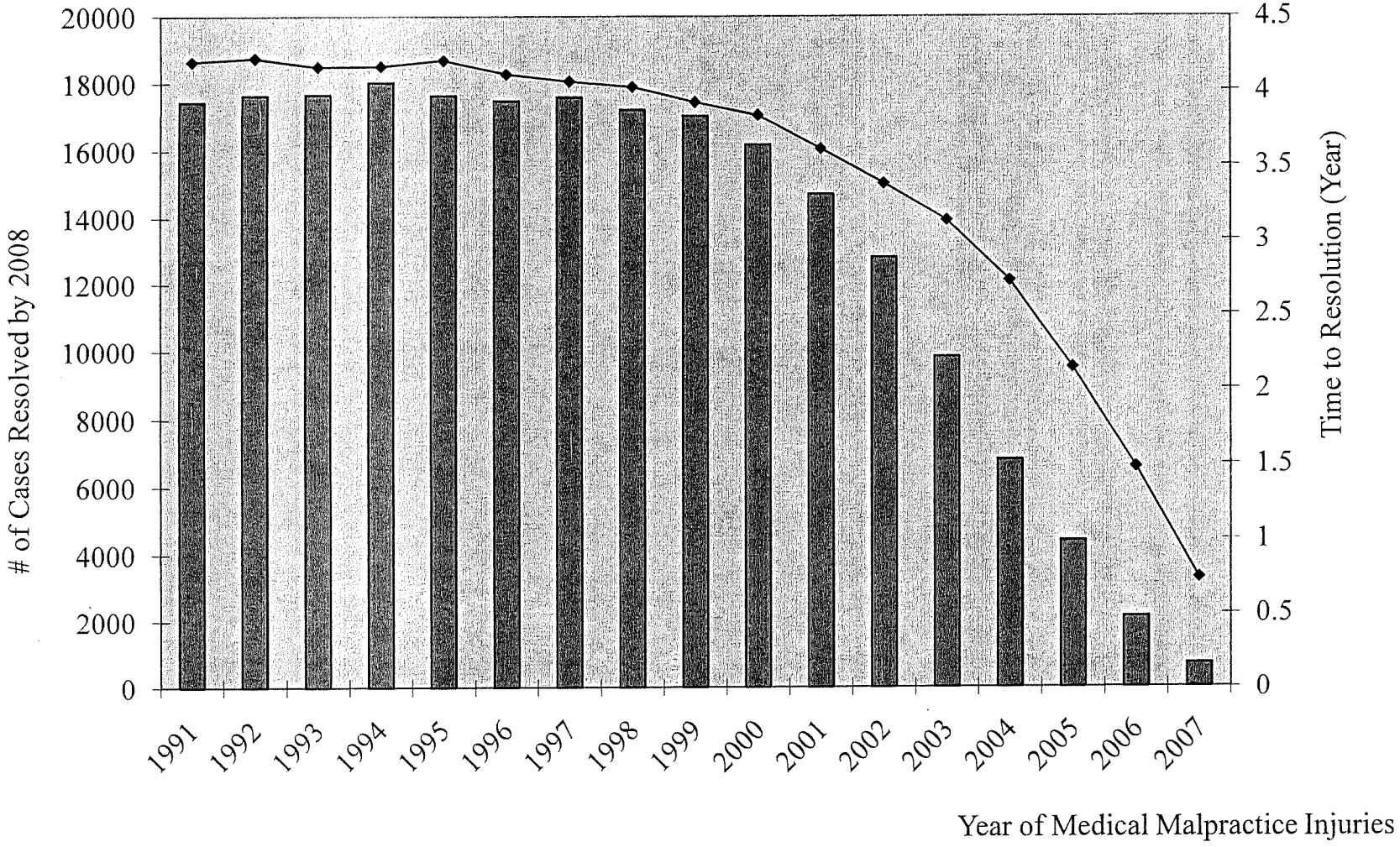

Figure 2: Histogram of Claims By Time to Resolution

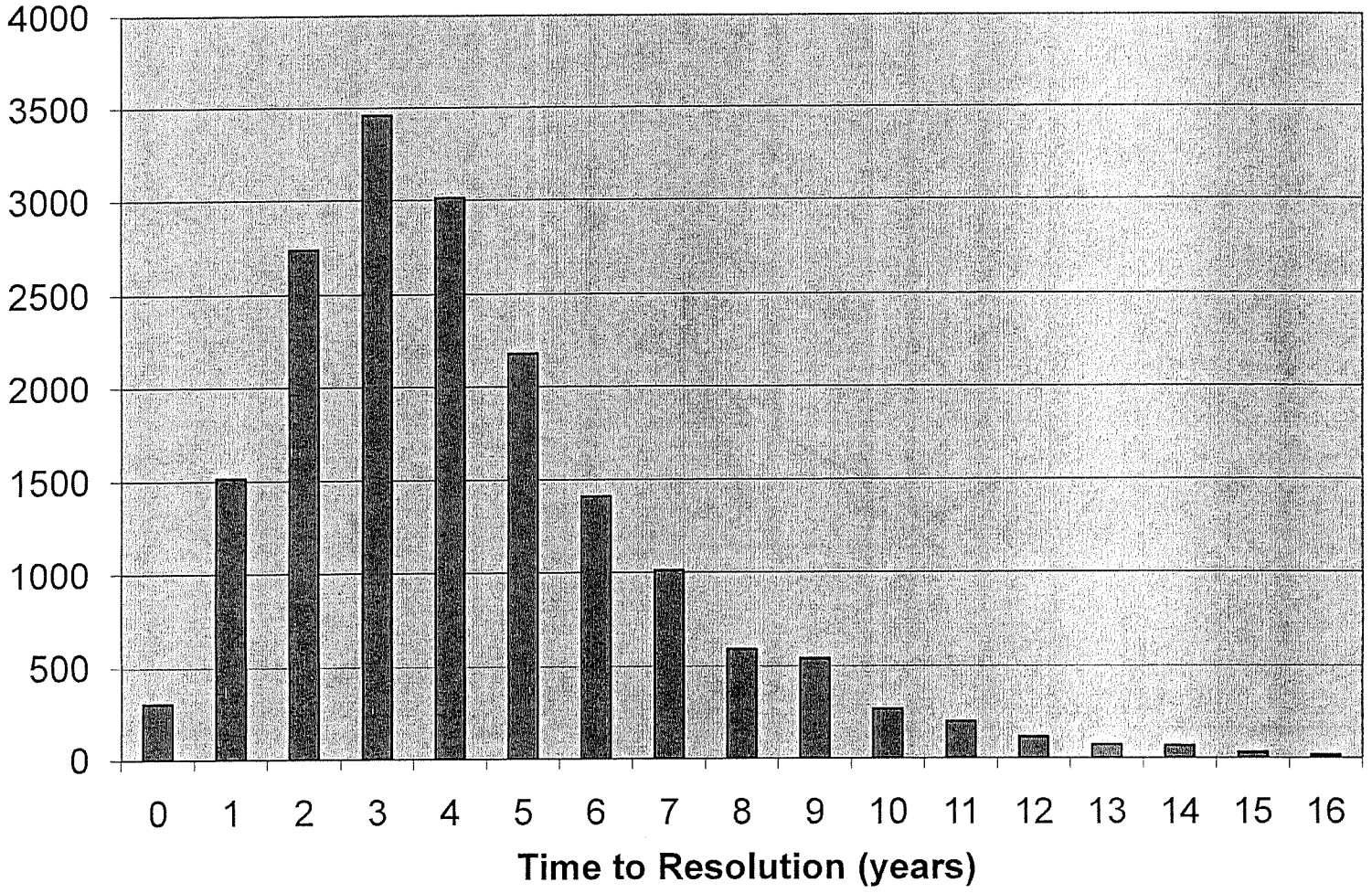

Figure 3: Two Scenarios of Shifting of Distribution

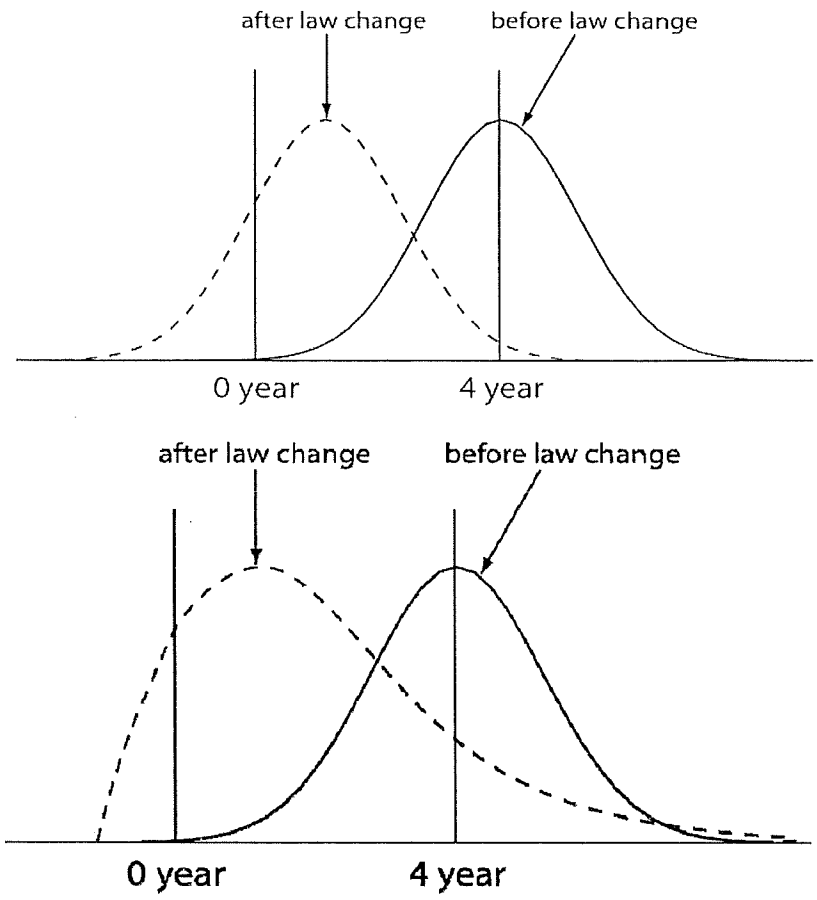

Table 1. State with Statutes Pertaining to Apology Law

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)

Depentant 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	-0.182	-0.194	0.118	0.091	0.047	0.27	0.265	0.217
	(0.099)*	(0.104)*	(0.101)*	(0.124)	(0.124)	(0.121)	(0.129)**	(0.133)*	(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	632	3,132	-24,017	-27,264	-16,990	-73,097	-67,645	-55,248
	(4,236)	(4,132)	(3,894)	(13,432)*	(13,564)**	(9,538)*	(17,334)***	(21,188)***	(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)

Depentant Variable	*Randomly Assign Law Year*			*Earlier Law Year*		
	(1)	(2)	(3)	(4)	(5)	(6)
Apology Law Change	0.044	0.041	0.046	0.044	0.041	0.046
	(0.032)	(0.032)	(0.032)	(0.032)	(0.032)	(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	0.075	0.186	0.27	0.369	0.392	0.008	0.152
	(0.084)	(0.056)	(0.096)*	(0.104)**	(0.122)***	(0.129)***	(0.142)	(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

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,

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."

[4] The Sorry Works Coalition

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"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]

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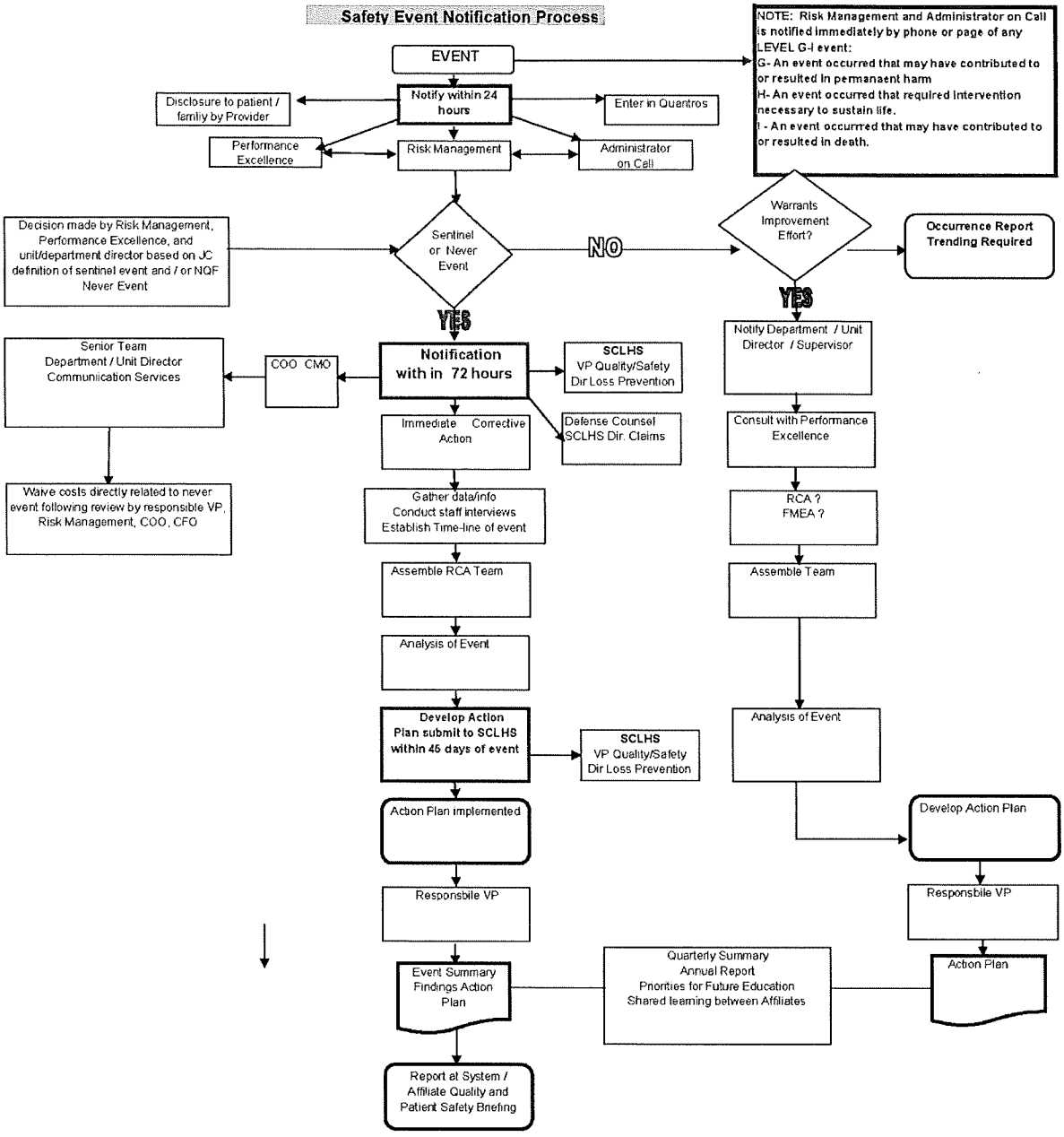
[5] **American Medical Association,** *Code of Medical Ethics* (2000-01 edition), "It is a fundamental ethical requirement that a physician should at all times deal honestly and openly with patients...Concern regarding legal liability which might result following truthful disclosure should not affect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


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

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Hawaii statutes HRS Sec.626-1

[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. [L 2007, c 88, §1]

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.

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."

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.

... 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.

8-63

...ne 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.

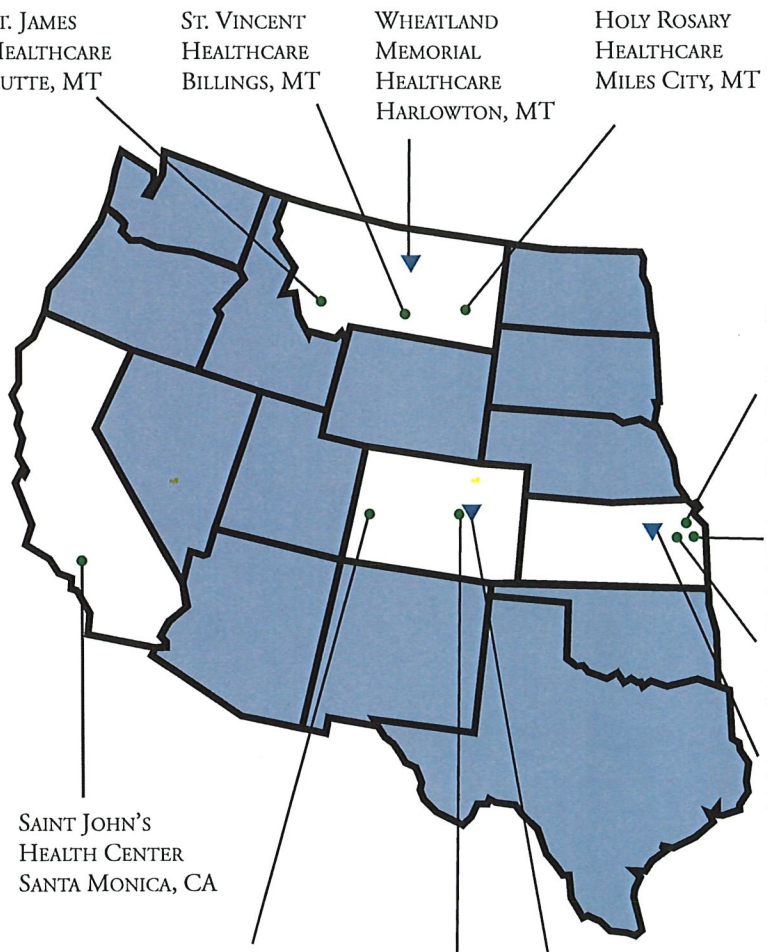
Ms. Valdez said she was gratified that the hospital quickly acknowledged its mistake, corrected it without charge and later improved procedures for keeping track of electrodes. "They took the time to explain it and to tell me they were sorry," she said. "I felt good that they were taking care of what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

Where We Serve



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Marillac Clinic • Exempla Good Samaritan Medical Center • Exempla Lutheran Medical Center • Exempla Saint Joseph Hospital

8-65

Kansas House Judiciary Committee
February 2, 2011

Testimony on House Bill 2069
The Kansas adverse medical outcome transparency act

I have defended well over a thousand cases alleging medical malpractice during my career, likely as much or more cases than any other currently active lawyer in Kansas, plaintiff or defendant. What the system has consistently overlooked is the emotional impact of these cases on the parties involved, both plaintiffs and defendants. Invariably, the lawsuit postpones the emotional "healing process" for the plaintiff and the threat of it prevents the participation in that process by the health care provider involved in the adverse outcome. While that side effect may be a necessary adjunct to those meritorious cases that should or need to be filed, that is not the case if the lawsuit could have been avoided in the first place.

Medical malpractice lawsuits are born from adverse unintended or unexpected outcomes related to medical treatment. I frequently hear when taking the deposition of plaintiffs that they pursued litigation in the first place to "get answers" related to the adverse outcome. The same health care providers who commonly assist patients in confronting their health problems frequently freeze up and become distant in the setting of an adverse unintended outcome. The fear by the health care providers that they will say something that will be misinterpreted or misconstrued before a jury by an attorney pursuing a medical negligence action later on, clearly plays a role in the disconnect that often occurs following adverse unintended outcome.

As a result, many lawsuits are filed that likely never would or should have been filed and the adversarial process takes over, clouding the search for and delaying the patient's receipt of an "answer". As important, the pursuit of the lawsuit creates additional emotional burdens for the patient and patient's family and the health care providers involved, regardless of the outcome. Insulating the conversations and interactions between health care providers and patients and patients' families from use as evidence in the litigation process eliminates the barriers to free and open discussion between them with little, if any, damage to the pursuit of meritorious malpractice claims. The need to completely insulate these discussions (regardless of whether

what is said is interpreted as a statement of fault or guilt or otherwise) from use in evidence is essential rather than leaving it up to the uncertainty of a judge's decision in the future based upon a judge's own subjective conclusion as to the meaning and intent of what was said at the time. Such a provision would prevent the statute from having any beneficial effect because of the uncertainty associated with it. There is a reason that experienced defense lawyers seldom, if ever, agree to waive a jury trial to allow a judge to be the sole fact finder in a medical malpractice case.

As other witnesses have pointed out there is empirical data that provides evidence for the beneficial effect of an open, candid and supportive exchange that is fostered by statutes such as that proposed in HB 2069. Regardless of one's conclusions as to the significance or reliability of that data, the undeniable fact is that HB 2069 at least has the potential to lessen unnecessary litigation and the financial and emotional burdens such litigation bring with it, with little if any harm to the pursuit of legitimate claims. The evidentiary use of statements made during a mediation or settlement conference are likewise prohibited and the policy reasons supporting that are no more important than those supporting HB 2069.

While probably not as significant as the "lottery" decision now pending before the Kansas Supreme Court (also known as the "cap" constitutionality case), HB 2069 would likely play an important role in reducing non-meritorious litigation. For these reasons I would urge the committee to favorably recommend the passage of HB 2069 in its present form.

Respectfully submitted,

Thomas L. Theis
Foulston Siefkin LLP
Bank of America Tower, Suite 1400
534 South Kansas Ave.
Topeka, Kansas 66603-3436

9-2

Polsinelli Shughart PC

Memorandum

TO: The Honorable Lance Kinzer, Chairman
House Judiciary Committee

FROM: William W. Sneed, Legislative Counsel
The University of Kansas Hospital Authority

SUBJECT: H.B. 2069

DATE: February 9, 2011

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I am Legislative Counsel for 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 H.B. 2069.

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 H.B. 2069 facilitate the continuation of the patient-health care provider relationship following an adverse event.

We appreciate the opportunity to present this testimony, and we will be happy to answer questions.

Respectfully submitted,

William W. Sneed

WWS:kjb

House Judiciary
Date 2-9-11
Attachment # 10

Tom Bell
President and CEO

February 9, 2011

TO: House Judiciary Committee

FROM: Chad Austin, Vice President of Government Relations

RE: HB 2069 - Kansas Adverse Medical Outcomes Transparency Act

The Kansas Hospital Association appreciates the opportunity to testify regarding this important proposed legislation. The practice of medicine is both an art and a science and therefore the treatment of patients does not always proceed as planned. KHA strongly believes that 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 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 this proposed legislation authored by The Sisters of Charity of Leavenworth.

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 HB 2069 as proposed by the Sisters of Charity of Leavenworth.

Thank you for your consideration of our comments.

House Judiciary
Date 2-9-11
Attachment # 11

Kansas Association of Osteopathic Medicine
1260 SW Topeka Boulevard
Topeka, Kansas 66612
Phone (785) 234 5563
Fax (785) 234 5564

TESTIMONY

House Committee on Judiciary
HB 2069

My name is Bob Williams, Executive Director of the Kansas Association of Osteopathic Medicine. Thank you for this opportunity to address the committee regarding HB 2069.

The Kansas Association of Osteopathic Medicine (KAOM) is in support of HB 2069. Many Doctors of Osteopathic Medicine practice in a family practice setting and frequently in rural communities. In some cases they have been providing health care to a family over several generations and are therefore very connected to the family. When an "adverse outcome" occurs, the natural human response is to provide condolences, be it an apology or an expression of sympathy. Given the adversarial nature of our legal system, when an "adverse outcome" occurs, health care providers have been advised, and in some cases prohibited, from communicating or expressing any type of condolence to families for fear it will be used against them in a legal proceeding. This prohibition can result in external and internal conflict for both the family and health care provider as they do their best to cope with the "adverse outcome".

As was stated by a KAOM member regarding HB 2069, "It's rather sad that our legal system has evolved to a point whereby we need a law passed to allow us to express our condolences to patients and their families." HB 2069 will go far in allowing health care providers, their patients, and families to obtain closure.

We encourage your support of HB 2069.

Thank you.

House Judiciary
Date 2-9-11
Attachment # 13

KANSAS VETERINARY MEDICAL ASSOCIATION 816 SW Tyler, Suite 200, Topeka, KS 66612-1635 ■ (785) 233-4141 ■ FAX: (785) 233-2534

Testimony on H.B. 2069
House Judiciary Committee
3:30 p.m. Wednesday, February 9

Rep. Kinzer and members of the House Judiciary Committee, thank you for the opportunity to appear today and testify on H.B. 2069.

The KVMA is the organization advocating on behalf of the Kansas veterinary profession through legislative, regulatory, educational, communications, and public awareness programs.

The KVMA respectfully urges the Committee to add veterinarians to H.B. 2069.

Veterinarians play a crucial role in public health issues in through their efforts in detecting, identifying, treating, and reacting to food animal disease outbreaks, thereby becoming the first line of defense in protecting the nation's food supply and ultimately human health.

The same vital role is played in companion animal veterinary medicine through the administration of vaccinations, treatments, and procedures.

It has been shown that in many cases the human-animal bond goes a long way in improving the overall health and welfare of humans who have pets as their companions.

Kathleen Bonvicini, associate director of the Institute for Healthcare Institute, speaking to the American Veterinary Medical Association, said, "Being open and honest with clients about medical errors can help rebuild trust, preserve professional integrity, and reduce malpractice lawsuits."

The Kansas Veterinary Medical Association respectfully requests the Committee to include veterinarians in H.B. 2069.

Respectfully submitted,

Gary Reser
executive vice president
Kansas Veterinary Medical Association

House Judiciary
Date 2-9-11
Attachment # 13

Session of 2010

Substitute for SENATE BILL NO. 374

By Committee on Judiciary

2-16

AN ACT enacting the Kansas adverse medical outcome transparency act; concerning evidence in civil actions; express of apology, sympathy, comparison or benevolent act by health care providers **and veterinarians** are not admissible as evidence of an admission of liability or as evidence of an admission against interest.

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

Section 1. (a) This section may be cited as the "Kansas adverse medical outcome transparency act."

(b) In any claim or civil action brought by or on behalf of a patient **or an animal owner** allegedly experiencing an adverse outcome of medical **or veterinary** care, any and all statements, activities, waiver of charges for medical **or veterinary** care, provided or other conduct expressing benevolence, regret, mistake, error, sympathy, apology, commiseration, condolence, compassion or a general sense of benevolence which are made by a health care provider **or a veterinarian**, an employee or agent of a health care provider **or a veterinarian**, shall be inadmissible as evidence and shall not constitute an admission of liability or an admission against interest.

(c) A defendant in a medical **or veterinary** malpractice action may waiver the inadmissibility of statements defined in subsection (b) that are attributable to such defendant by expressly stating, in writing, the intent to make such a waiver.

(d) As used in this section:

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

(2) "Adverse outcome" means the outcome of a medical **or veterinary** treatment or procedure, whether or not resulting from an intentional act, that differs from an intended result of such medical **or veterinary** treatment of procedure.

(3) "Veterinarian" has the meaning prescribed in K.S.A. 47-816, and amendments thereto.

(4) "Animal" has the meaning prescribed in K.S.A. 47-816, and amendments thereto.

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

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

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

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[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**

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DOUGLAS COUNTY

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300 SW 10TH AVENUE
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JOINT COMMITTEE ON ENERGY AND ENVIRONMENT

February 9, 2011

Testimony on HB 2123 – Kansas Adverse Medical Outcome Transparency Act
House Judiciary Committee

Mr. Chairman, Members of the Committee: I first introduced a bill in 2007 to permit health care providers to say "I am sorry that the outcome from the treatment/procedure was not as successful as you and I anticipated/hoped" without such a human statement being construed as an admission of malpractice, malfeasance, or a mistake.

HB 2123 is very similar to HB 2069 – the difference being the absence of the words "mistake," "error," and "apology" on line 13. My rationale for leaving such words out of the bill were that such words connote an error by the health care provider and my intention, after speaking with health care providers in the Lawrence community, is that most often people are seeking reassurance that the health care provider is human, sincerely sorry that the outcome was not better, did his/her best, and identifies with the patient/family members' fears/sorrows.

I sincerely believe that patients, families, and health care providers will benefit from the ability of the health care provider to say that he/she "is sorry at the outcome" without it being construed as an admission of guilt and thus the basis for another lawsuit.

Indiana has a similar law and was the basis for my initial introduction of a bill in 2007. I am pleased that this Committee is considering the matter and believe that passage of HB 2123 or a similar measure will help families and health care providers heal after an adverse outcome. Most adverse outcomes are not the result of health care provider error, they are the result of medical knowledge and techniques not yet being advanced enough. Health care providers with whom I have spoken believe that letting health care providers be empathetic and supportive will reduce lawsuits and, more importantly, reduce anger and frustration by patients and family members. They also believe the ability to show support and empathy will help reduce health care provider stress.

Thank you for considering my testimony and HB 2123.

House Judiciary
Date 2-9-11
Attachment # 14

KANSAS MEDICAL SOCIETY
Established 1859

To: House Committee on Judiciary

From: Dan Morin
Director of Government Affairs

Date: February 9, 2011

Subject: HB 2069; Enacting the Kansas adverse medical outcome transparency act
HB 2123; Enacting the Kansas adverse medical outcome transparency act

The Kansas Medical Society appreciates the opportunity to provide comment today as you consider both HB 2069 and HB 2123, bills which are commonly referred to as, "I'm Sorry" or "Apology" legislation. The bills would provide that statements or gestures, including, but not limited to, expressing an apology, sympathy, commiseration or condolence concerning the consequences of an adverse outcome of medical care would not be admissible as evidence of liability in any civil claim arising from such event.

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. Because plaintiff attorneys often attempt to characterize such apologies and expressions of sympathy as an admission of guilt, it creates a very real obstacle to effective communication with patients at a time when they need it most.

The only difference between the two bills is a provision in HB 2069 (subsection (c), at lines 19-22) which makes it clear that a defendant in a medical malpractice action may waive the inadmissibility of any statements of regret or expressions of empathy. That provision arose from concerns that were expressed during previous legislative sessions when similar bills were discussed, that without such a provision the defendant's case could be harmed.

Both bills before you today would represent logical step toward potentially reducing medical liability lawsuits. We urge you to report either bill favorably for passage.

House Judiciary
Date 2-9-11
Attachment # 15

Via Christi HEALTH

Date: February 2, 2011

To: Representative Lance Kinzer, Chair
House Judiciary Committee
Members of the House Judiciary Committee

From: Shelley Koltnow, JD
VP, Corporate Responsibility
Via Christi Health

Re: HB 2069

Testimony on House Bill 2069

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

Via Christi Health supports HB 2069 and urges the Committee to recommend its passage. HB 2069 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, HB 2069 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.

HB 2069 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 human. 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

House Judiciary
Date 2-9-11
Attachment # 16

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 HB 2069. 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 $82.8 million in benefit to the communities we serve. This included more than $48.5 million in charity care and more than $17 million in unpaid costs of Medicaid services provided. Via Christi Health employed more than 10,000 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.

Saint Luke's Health System

saintlukeshealthsystem.org

Malcolm Baldrige National Quality Award
Saint Luke's Hospital 2003 Award Recipient

House Judiciary Committee
State of Kansas
February 8, 2011

Written Testimony on House Bill 2069
The Kansas adverse medical outcome transparency act

Saint Luke's Health System is a faith-based, not-for-profit aligned health system that delivers care at 11 hospitals and related health care services in the Kansas City metropolitan area and surrounding region. Founded in 1882, SLHS is dedicated to enhancing the physical, mental and spiritual health of the communities we serve.

In addition to the three hospitals that we operate in Kansas – Saint Luke's South in Overland Park, Cushing Memorial Hospital in Leavenworth, and Anderson County Hospital in Garnett – Saint Luke's Health System employs 2,445 people who live and/or work in the State of Kansas.

SLHS is supportive of the current efforts in Kansas to codify public policy that would allow expressions of apology or compassion and other benevolent acts by health care providers without fear of such expressions being used as evidence of liability when a patient experiences an adverse medical outcome. Not only do we believe that such a policy would improve the legal climate for providing care in Kansas, but we also believe that such a policy would reduce the costs associated with providing such care.

Respectfully submitted,
Tim Van Zandt, RN, MPA
Director of Public Affairs

House Judiciary
Date 2-9-11
Attachment # 17

Kansas Advocates for Better Care

*"Advocating for Quality Long-Term Care" since 197_*

February 2, 2011

Dear Chairman Kinzer, Vice Chairman Patton and Judiciary Committee Members,

I am writing to you today on behalf of the members, volunteers and Board of Directors of Kansas Advocates for Better Care. We are a citizen group whose mission for 35 years is to support public policies that will improve health and safety for frail elders and vulnerable adults who receive long-term care in nursing homes, assisted living and their own homes.

We respectfully oppose HB 2069 and HB 2123.

We are not opposed to legislation that allows for statements of apology, and supported the provisions of the Judicial Council bill which was introduced in 2010 as 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 year or about 39% of all nursing facilities. In the last year we've responded to residents and families who have called seeking help for serious concerns including sexual abuse by staff, being dropped by care staff and not receiving medical attention, being given prescription medications past their expiration date including insulin and psychotropic meds, among others.

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 has accepted the responsibility and money 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 the protection that they deserve.

Thank you,

Mitzi E McFatrich

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Date 2-9-11
Attachment # 18

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TESTIMONY

TO: **The Honorable Lance Kinzer, Chair**
And Members of the House Judiciary Committee

FROM: **Whitney Damron**
On behalf of the Kansas Bar Association

RE: **HB 2069 – The Kansas Adverse Medical Outcome Transparency Act**

DATE: **February 9, 2011**

Good afternoon Chairman Kinzer and Members of the House Judiciary Committee. I am Whitney Damron and I appear before you today on behalf of the Kansas Bar Association to offer our comments on HB 2069, the Kansas Adverse Medical Outcome Transparency Act.

By way of background, the Legislature first considered similar legislation, often referred to as "the apology bill" during the 2009 session (SB 32). SB 32 was introduced into the Senate Committee on Public Health and Welfare, but later re-referred to the Senate Committee on Judiciary. The Senate Committee on Judiciary did not act on the bill, but rather requested a review of the proposal by the Kansas Judicial Council and SB 32 died in Committee at the conclusion of the 2010 session.

The Legislature often refers complex legal issues to the Kansas Judicial Council for review and recommendations before enacting changes in statutes. The Judicial Council is composed of practicing attorneys from the plaintiff and defense bar, law professors and judges (district court, appellate and Kansas Supreme Court).

In 2009, the Civil Code Advisory Committee of the Judicial Council reviewed apology statutes enacted in 35 other states before drafting its own version of the apology bill, which was presented to the Legislature in 2010 the form of SB 374.

The KBA did not take a position on SB 374 as originally introduced. However, a substitute bill was adopted by the Senate Committee on Judiciary at the request of the leading proponent of this legislation and advanced out of Committee. The KBA and others expressed strong concerns with the amended bill before it was scheduled for floor debate and it was eventually returned to Committee, where it also died in Committee at the conclusion of the 2010 session.

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Following the 2010 session, the proponents of the bill before you today sought a review of their proposal in the form of an interim study. The Special Committee on Judiciary heard from a number of conferees during the 2010 interim hearing process, including several of those before you today and recommended the Judicial Council version from the 2010 session be adopted as introduced (copy attached), not the bill that is before you today.

In testimony provided to the Senate Committee on Judiciary in 2010, the Sisters of Charity of Leavenworth Health System extolled the virtues of The University of Michigan Health System and how they (The University) "reduced malpractice claims by 55 percent between 1999 and 2006 and reduced litigation costs by greater than 50 percent. Average claims processing time dropped from 20 months to about 8 months."

What is often overlooked is the fact that the University of Michigan accomplished these results without an apology statute. The State of Michigan does not have an apology statute or a law similar to HB 2069.

Of note in the interim hearing was testimony from a disclosure training consultant (Mr. Douglas Wojcieszak) from *Sorry Works*, a company that promotes their consulting services related to disclosure, apology and upfront compensation. During his testimony, Mr. Wojcieszak stated "legislation is not necessary to effectuate a policy to make a person feel whole and to focus on customer service."

Translation: Health care providers do not need the Legislature to mandate how they tell a patient they are sorry when an adverse medical outcome occurs, but rather providers are capable of developing their own internal policies and procedures to insure the rights and well-being of both the care giver and the patient are considered.

In closing, the Kansas Bar Association supports the work product of the Judicial Council, which is not limited exclusively to health care providers. If this Committee believes legislation is necessary, we would request you consider adopting the language contained in SB 374 as originally introduced in 2010. However, we would respectfully suggest this legislation is not needed at all and the trial and appellate judges are appropriately empowered under current law to render decisions as to what statements should be admitted into evidence in a tort case (or any other case for that matter).

On behalf of the Kansas Bar Association, I thank you for your time and consideration of our position on HB 2069 and would be pleased to stand for questions at the appropriate time.

WBD
Attachment

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

Session of 2010

SENATE BILL No. 374

This year # SB 142.

By Committee on Judiciary

1-14

AN ACT concerning evidence in civil actions; expression of apology, sympathy, commiseration or condolence not admissible as evidence of an admission of liability or as evidence of an admission against interest.

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

Section 1. 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 provide 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.

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

KANSAS ASSOCIATION FOR JUSTICE

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To: Representative Lance Kinzer, Chairman
Members of the House Judiciary Committee

From: Gary D. White *Presented by Callie Denton*
Palmer, Leatherman, White & Dalton, LLP, Topeka

Date: February 9, 2011

RE: HB 2069 and HB 2123

The Kansas Association for Justice is a statewide, nonprofit organization of trial lawyers. KsAJ members support protection of the right to trial by jury and fair laws that protect all parties in a dispute.

Both HB 2069 and HB 2123 change the rules of evidence. The rules of evidence are procedural rules that apply to both sides of a dispute up to, and during a trial. The rules of evidence spell out what information is provided to a jury, when and how it is provided, and the purpose for which it is provided. The rules assure that the process is fair to both sides and that neither side is advantaged or disadvantaged in presenting the facts of the case.

KsAJ believes the rules of evidence must be balanced so that the judge and jury can fairly consider both sides of a case. KsAJ opposes changes to the rules of evidence that would favor one party and create an unlevel playing field. KsAJ also opposes changes that keep relevant, truthful evidence from the consideration of a jury or encourage concealment of evidence.

If the Committee chooses to adopt changes to the rules of evidence, KsAJ recommends the Committee support the language of the bill recommended by the Kansas Judicial Council (2011 SB 142)

KsAJ supports the Judicial Council recommendations. If the Committee chooses to adopt any changes to the rules of evidence, KsAJ recommends adopting the changes drafted by the Kansas Judicial Council, which were

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also recommended to the 2011 Legislature by the Interim Judiciary Committee of the Legislature.

The Judicial Council is the appropriate expert body to make neutral policy recommendations regarding the rules of evidence. The Council's Civil Code Committee, which contains attorneys with experience representing patients, hospitals, and doctors, conducted an exhaustive review of previous Kansas bills, academic and law review articles, and apology laws enacted in 30+ other states. After completing its research, the Council drafted and recommended changes to the rules of evidence to the Legislature relating to statements of apology.

SB 142 strikes an appropriate balance between encouraging open communication and heart-felt apologies while at the same time allowing juries to consider truthful and relevant evidence. SB 142 applies to all types of civil disputes and is not limited to disputes involving health care providers. SB 142 does not protect apologies that are intended to conceal evidence of wrongdoing, gross negligence, or medical errors. SB 142 is reasonable and fair to all parties, and offers increased protection to sincere apologies than the current law.

HB 2069 has already been considered several timesand problems were revealed. The language of HB 2069 contains concepts that were specifically rejected by the Judicial Council. In addition, HB 2069 (as 2010 Substitute for SB 374) was considered in 2010 and did not pass the Kansas Senate. It was also reviewed by the Interim Judiciary Committee and it was not recommended to the 2011 Legislature.

- **HB 2069 is NOT the same as the South Carolina medical outcome transparency act.** South Carolina's law requires protections that balance patients' rights to information with providers' concerns about litigation. HB 2069 contains no similar protections.
    - **The South Carolina law protects only communications between the health care provider and the patient, the patient's family, and the patient's representative.** The South Carolina law is narrowly tailored; it does not protect communications between third parties or information in medical records.
    - **The South Carolina law protects only communications made to the patient during a "designated meeting"** held specifically for the purpose of discussing an unanticipated outcome. The designated meeting is not mandatory; it is called only at the discretion of the health care provider, and

only when the provider is ready to have a full and frank conversation about an unanticipated outcome.

- **HB 2069 protects gross negligence and intentional acts that harm patients.** Robert R. Courtney, a pharmacist in Merriam, Kansas and Kansas City, Missouri, diluted chemotherapy drugs he filled for cancer patients. Law enforcement estimates that he diluted 98,000 chemotherapy prescriptions for 4,200 patients. At his criminal sentencing Mr. Courtney stated "I am guilty and accept full responsibility. To the victims, I am extremely sorry."

  Under HB 2069, not one of the thousands of victims of Robert Courtney could introduce in a civil case his admission of guilt and his apology. Mr. Courtney's admission/apology is *still* the only evidence of the true extent of how many people he harmed. He got away with diluting chemotherapy medications for so long because he preyed on his most vulnerable patients. For the vast majority of his victims, his crime was virtually impossible to prove without his admission of guilt and his apology to his victims

- **HB 2069 permits concealment of evidence.** HB 2069 permits a health care provider to conceal from the jury evidence of mistakes, errors, or gross negligence never reported to the patient but recorded in medical records or discussed among medical personnel or other third parties. If a medical error results in death or permanent injury, the patient and the patient's family have a right to facts about what happened.

- **HB 2069 discourages accountability.** A provider's apology *and* willingness to be accountable are what truly expedites settlements and prevents litigation. HB 2069 merely prohibits the patient from introducing evidence of the error, and potentially receiving the justice of a jury. Patients that suffer medical errors may have ongoing medical needs and other expenses as a result of the medical error. Health care providers that make an error and are negligent must be willing not only to apologize but also to be accountable.

HB 2130 is new language not yet considered in the Legislature. As with any changes to the rules of evidence, the implications to both parties of a dispute must be carefully weighed to assure that neither side is advantaged or disadvantaged, the rules are fair to all, and the jury is able to consider relevant and truthful evidence.

Even though it is similar to HB 2069, HB 2130 does not appear to be as one sided or to exclude evidence to the same extent as HB 2069. At the same time, HB 2130 has not received the same scrutiny as SB 142.

If the Committee chooses to adopt changes to the rules of evidence, KsAJ recommends the Committee support the changes recommended by the Kansas Judicial Council (SB 142).

On behalf of the Kansas Association for Justice, thank you for the opportunity to offer our comments on HB 2069, HB 2123 and changes to the rules of evidence.

The New York Times
nytimes.com

February 27, 2002

Man Pleads Guilty To Diluting Drugs

KANSAS CITY, Mo., Feb. 26— A pharmacist accused of watering down chemotherapy drugs pleaded guilty today and could be sentenced to 30 years in prison in a case that shocked cancer patients and their families.

The pharmacist, Robert R. Courtney admitted that he had diluted 158 prescriptions for 34 patients and said he had "no rational explanation" for what he did.

"I have had a long period of time in isolation to reflect on my conduct," said Mr. Courtney, 49. "I am guilty and I accept full responsibility. To the victims, I am extremely sorry."

Prosecutors said Mr. Courtney made hundreds of dollars extra per dose.

The authorities have not said whether any patients died as a result of his actions. Legal experts have said prosecutors would have faced a daunting task in trying to prove that a cancer patient would have lived with the proper medicine.

Mr. Courtney pleaded guilty to all 20 federal counts of adulterating, tampering with and mislabeling the chemotherapy drugs Taxol and Gemzar. Prosecutors will recommend a prison sentence of 17 1/2 to 30 years. No sentencing date was set.

If he had gone to trial and been convicted on all counts, he could have been sentenced to 196 years.

Mr. Courtney also faces up to $15 million in fines. His estimated assets of more than $10 million will be used as restitution for victims.

He has said he began diluting medications to help pay taxes and fulfill a $1 million pledge to his church.

20-5

South Carolina Unanticipated Medical Outcome Reconciliation Act

Ch. 1, Title 19 Code of laws 1976, 19-1-190 (2006)

SECTION 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 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.

(F) Nothing in this section affects the South Carolina Rules of Evidence.

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February 9, 2011

The Honorable Lance Kinzer, Chair
House Judiciary Committee

HB 2069: Adverse Medical Outcomes Transparency Act.
HB 2123: Adverse Medical Outcomes Transparency Act

Good afternoon Chairman Kinzer and members of the House Judiciary Committee. My name is Robert Harvey and I volunteer for AARP Kansas. While I currently serve as a member of the AARP Kansas Diversity Council, I have also 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 an attorney and a retired judge.

AARP has more than 341,000 members living in Kansas. We are dedicated to enhancing the quality of life for all as we age. Thank you for this opportunity to express our opposition to HB 2069 and HB 2123.

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 Affordable Care 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 a provision for grants to states to test malpractice alternatives (this may not be 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.

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.

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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.

For these reasons, 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) 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. HB 2069 and HB 2123 will not provide those patient protections. We believe that under HB 2069 and HB 2123 health care providers who 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 oppose both HB 2069 and HB 2123.

Thank you for this opportunity.
Robert Harvey