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In reply, please refer to:
File:

SENATE COMMITTEE ON HEALTH

SB1262, RELATING TO MEDICAL TREATMENT

Testimony of Chiyome Leinaala Fukino, M.D.
Director of Health

February 11, 2009
3:00 p.m.

1 **Department's Position:** The department appreciates the intent of this bill, but must respectfully oppose
2 it as currently drafted.
3 **Fiscal Implications:** Unquantified, but this bill would require additional staff time during a hospital
4 licensing survey to determine if this requirement is being met.
5 **Purpose and Justification:** Under HAR Title 11 Chapter 93, hospitals are required to have written
6 policies concerning the rights and responsibilities of patients. This includes that "the patient has a right
7 to have the patient's medical condition and treatment discussed with the patient by a physician of the
8 patient's choice ... and to be afforded the opportunity to participate in the planning of the patient's
9 medical treatment." Since the disclosure of the patient's condition is already included in their rights, it
10 would appear that this bill is redundant and unnecessary. It is also noteworthy that the prevailing culture
11 among hospitals is for healthcare workers to report errors without fear of punishment so that patient's
12 may be treated before their condition worsens and so that errors can be assessed for possible changes in
13 work processes. While it would appear to be a worthwhile requirement, the bill is unclear and may be
14 overly broad and too punitive if someone were to fail to comply. It is unclear whether the bill is aimed
15 at medical errors or for any cause resulting in a negative consequence. Negative consequences may

1 result from the natural progression of the injury or illness and not the result of care that is being
2 provided using evidence-based standards of care in accordance with hospital policy and practices. Yet
3 the failure to comply may result in license revocation and other penalties.
4 Thank you for the opportunity to testify.

THE QUEEN'S MEDICAL CENTER

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Senator David Y. Ige, Chair
Senator Josh Green, M.D., Vice Chair

Wednesday, February 11, 2009 – 3:00 p.m.
State Capitol, Conference Room 016
SENATE COMMITTEE ON HEALTH

In Opposition to SB 1262 Relating to Medical Treatment

Chair Ige, Vice Chair Green and Members of the Committee,

My name is Robin Fried. I am the Director of Risk Management at The Queen's Medical Center, the largest private tertiary care hospital in the State of Hawaii. I am testifying for The Queen's Medical Center in opposition to SB 1262, mandatory disclosure of adverse events.

Queen's is committed to ensuring the safety and quality of care for its patients 24 hours a day, 7 days a week. While we support open communication and appropriate disclosure to patients and/or patient's personal representatives, we find this bill to be unnecessary and duplicative of existing law and accreditation standards, as well as ambiguous in key aspects.

The proposed language is duplicative of existing law and accreditation standards as follows:

- HRS § 671-3(5) and longstanding case law holds that the treating physician has the duty to obtain informed consent. It follows that the physician has the duty of disclosure of any actual complications and is in the best position to address the medical issues.
- The Joint Commission currently requires accredited hospitals to ensure that the patient or surrogate decision-maker is notified about "unanticipated outcomes of care, treatment and services related to sentinel (major adverse) events".

The proposed language is ambiguous with regard to the following:

- The definition of provider includes both physicians and health care facilities. In situations where the physician is an independent practitioner, not a hospital employee, it is unclear who bears the responsibility for notification – the hospital or the physician.
- The definition of "adverse event" is overbroad and could include almost any complication that may occur.
- The bill provides that failure to comply may subject a health care provider to penalties, yet provides no clear standards for compliance, raising issues of due process.

The Queen's Medical Center urges you to defer SB 1262. Thank you for the opportunity to testify.

Robin Fried, JD, MS

TESTIMONY OF ROBERT TOYOFUKU ON BEHALF OF THE HAWAII ASSOCIATION FOR JUSTICE (HAJ) formerly known as the CONSUMER LAWYERS OF HAWAII (CLH) IN SUPPORT OF S.B. NO. 1262

February 11, 2009

To: Chairman David Ige and Members of the Senate Committee on Health:

My name is Bob Toyofuku and I am testifying on behalf of the Hawaii Association for Justice (formerly known as CLH*) in Support of S.B. No. 1262.

Purpose of Bill.

The purpose of this bill is to require health care providers to notify patients or their representatives of any adverse events that result in serious harm or death to the patient within 72 hours of discovery of the adverse event. The notification is not admissible as evidence of liability.

In 2007, the Legislature passed HB 1253 (Act 88) that made statements of sympathy inadmissible to prove liability. (HRS section 626-1, Hawaii Rules of Evidence Rule 409.5) In the context of medical errors, this bill takes the next step toward encouraging full disclosure of adverse medical events. This bill carefully balances two important and often conflicting interests: protecting a patient's right to know about any unexpected medical consequences that may harm them and the health care provider's concern that disclosure of an adverse medical event may be an admission of liability.

Background for "Sorry" Laws with Disclosure Requirements

In 1999, a report by the Institute of Medicine, "To Err is Human," indicated that up to 98,000 deaths occur each year in the United States as a result of medical errors. Since then, there has been a steady movement focused on patient safety and improving

communication between health care providers and patients to create a more transparent environment to avoid triggering an automatic adversarial situation.

Two significant organizations support disclosure of medical errors. The American Medical Association Code of Medical Ethics describes standards of professional conduct that includes disclosure to the patient of facts necessary to ensure understanding of what has occurred, without concern about legal liability.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires that hospitalized patients and their families be told of "unanticipated outcomes" of care (Standard - Ethics, Rights, and Responsibilities (RI) 2.90, 2005) and that clinicians and health care organizations inform patients and families of adverse events.

At least 29 states have adopted "sorry" laws as a means to reduce medical malpractice claims. These laws encourage full disclosure of mistakes or errors in judgments by eliminating a physician's fear that the admission will be used against them. Over the past several years, many of these states have added mandatory notification requirements that impose a duty on health care providers to inform patients of adverse medical outcomes. These states include Florida, Nevada, New Jersey, Pennsylvania, Vermont, Colorado and Illinois. This bill is patterned after the Colorado and Illinois statutes.

"Sorry" Laws and Disclosure of Medical Errors Reduces Medical Malpractice Claims and Malpractice Insurance

The Veterans Affairs Medical Center at Lexington, KY is a pioneer in adopting a full disclosure policy. The Lexington program requires immediate notification to the patient of a possible mistake, face to face communication of details, an apology, and if it

is determined that the hospital was at fault, restitution is offered. A study of the success of the Lexington Program was conducted by Kraman and Hamm, "Risk Management: Extreme Honesty May be the Best Policy," Annals of Internal Medicine, Vol. 131, No. 12, 12/21/99, which concluded that in comparison with other Veterans Affairs medical facilities, Lexington had lower payments than 30 other facilities, averaged payment of $15,000 versus $98,000 average of other facilities, quicker case closure than the average, in general, more positive economic outcomes.

Other medical centers, such as University of Michigan and University of Illinois, which have adopted policies of disclosure, also report reduction in malpractice claims and litigation expenses. See, attached New York Times article, "Doctors Say 'I'm Sorry' before 'See You in Court'," for a discussion of the success of disclosure policies in reducing malpractice claims.

Many insurance companies are also offering incentives for premium discounts for insured physicians who participate in the insurer's risk management and education program. For example, Med Pro offers a 5% discount. (as reported in www.sorryworks.net/article 44)

Disclosure of Medical Errors Leads to Improved Patient Safety as "lessons learned"

Health care providers have operated under the "deny and defend" model for too long. Unfortunately, when mistakes are covered up, no one learns from the mistakes or takes steps to correct practices and protocols that could prevent future errors. This bill will stop the "deny and defend" practice immediately and shift to the "lessons learned" approach to medical treatment. While most conscientious health care providers take

risk management very seriously, this bill puts patient safety as the highest priority for health care providers, without regard to concerns over liability.

Conclusion.

Our experience is that many clients come to attorneys because they simply don't know why something bad has happened in their medical treatment. They complain that no one has given them reasons, and worse, some have told them that they can't talk to them. One physician whose wife was seriously injured due to malpractice would not have initiated litigation if only the hospital had been candid, admitted its mistake and offered to help out with the additional medical costs necessitated by the malpractice. Patients deserve full disclosure when mistakes are made. This bill will lead to improved patient safety procedures, reduce medical errors, which in turn will lead to reduced malpractice claims and costs of insurance.

Thank you for the opportunity to present this testimony and we request that this committee pass this measure.

The New York Times
nytimes.com

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May 18, 2008

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

By KEVIN SACK

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

percent of medical errors are disclosed to patients.

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

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

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

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

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

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

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

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

in reducing medical errors.

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

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

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

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

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

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

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

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

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

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

"The filing of a lawsuit at the University of Michigan is now the last option, whereas with other

hospitals it tends to be the first and only option," said Norman D. Tucker, a trial lawyer in Southfield, Mich. "We might give cases a second look before filing because if it's not going to settle quickly, tighten up your cinch. It's probably going to be a long ride."

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