The Kansas Disclosure of Unanticipated Medical Outcomes and Medical Errors Act

About the bill

This bill requires that if a patient experiences an unanticipated medical outcome or is harmed by a medical error, this information is shared with the patient (and family, when appropriate). This bill also requires medical institutions to develop policies for disclosure and to provide training to administrators and providers on how to have disclosure conversations. In addition, the information that medical institutions now provide to licensing agencies about "reportable incidents" will be expanded to indicate whether or not a disclosure conversation has taken place. Fines will be imposed for failure to disclose.

Why this bill is needed

When hospital and physicians are given a choice whether or not to tell a patient about harm that has occurred, too often the choice is to not tell. For example, one published study (L. Iezzoni *et al*. 2012. *Health Affairs.* 31(2):383-391) found that only 65.9% of physicians completely agreed with the statement "Physicians should disclose all significant medical errors to affected patients."

Patients have both a right and a responsibility to be active participants in their own healthcare. This requires transparency within the healthcare system.

My family's experience

This bill is being proposed because of the experiences my children and I went through with my late husband, Glenn Clarkson. Glenn was severely burned on March 30, 2012 while taking part in a controlled grass burn. I took him to my local emergency room where he was admitted to the ICU, even though the hospital was not equipped to treat severe burns. His condition deteriorated rapidly during the night as he became severely dehydrated. Not until fifteen hours later, when he was near death, was he transferred to the burn center at Via Christi in Wichita. While at the burn center Glenn underwent extensive skin graft surgery, but died on April 11.

After his death my daughter and I investigated guidelines for transfer of burn victims and learned that he should have been transferred immediately. We met with the CEO of my local hospital in search of answers as to why Glenn was not transferred sooner and why he did not receive the amount of fluids needed for a burn patient. But instead of a having a meaningful conversation, we were met with the "wall of silence."

The way our family was treated prompted us to study the issue of medical errors and their disclosure. We learned that medical errors occur with alarming frequency and that the "wall of silence" is the norm, not the exception. This set us on a journey to lift the veil of secrecy and silence about medical errors in Kansas. We believe that patients (and their families) have the right to know when they have been harmed by a medical error. It is time for hospitals and physicians to act with honesty, transparency, and integrity when errors occur. We ask for your help.

Please contact me with any questions or comments.

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How frequently are patients harmed in hospitals?

One early study of New York hospitals found that 3.7% of hospitalized patients experienced injuries, and 0.5% of patients experienced an injury leading to death.[1] A more recent study of Medicare patients found that 13.5% experienced a serious adverse event while hospitalized, and 1.5% experienced an event that contributed to their death.[2]

Estimates for the number of Americans who die each year due to medical harm range from 44,000–98,000 to 210,000–440,000.[3, 4] This means that medical harm is at least the sixth, if not the third, most common cause of death in this country.

What are other states doing to mandate disclosure of harmful medical errors?

A number of other states have statutes that require patients to be informed about medical harm, including Nevada, Florida, New Jersey, and Pennsylvania.[5] Unfortunately, these laws do not specify the types of information to be included in disclosure conversations. "Thus, an institution could adhere to the letter of the law simply by telling a patient, 'The outcome of your surgery was unanticipated.'"[6] Therefore, our bill specifies the minimal information for disclosure.

What are "apology laws"?

Physicians have given many reasons for failure to disclose harmful medical errors to patients. One is the fear that what they say will become evidence during a malpractice lawsuit. In an effort address this fear, many states have passed laws that disallow the use of apologies and expressions of sympathy as evidence of malpractice. Unfortunately, the moral promise implied by these laws has not been fulfilled. By leaving disclosure optional, patients remain uninformed.

Aren't there already too many medical malpractice lawsuits? Wouldn't disclosing errors make this worse?

First, the amount of *medical malpractice* far exceeds the number of *medical malpractice lawsuits* that are filed. Second, the majority of lawsuits have merit. One study from the Harvard School of Public Health found that 97% of claims involved injury. 63% of those injuries were due to medical error.[7] Third, one of the major reasons patients and their families file lawsuits is because that is their only way to get information.

Some states, such as Washington state, are embracing disclosure-and-resolution programs. These can be an excellent alternative to the current "deny-and-defend" approach common in Kansas. However, there is a danger that without proper regulatory oversight many patients and families will be pressured to accept a settlement that is much too low—placing the economic burden of the medical harm on the patient and family. In order to protect the rights of patients, they need to be represented by their own lawyer. Therefore our bill requires that if a financial settlement is proposed, patients must be advised of their right to consult an attorney.

What will it take to make healthcare in Kansas safer?

The first step must be to acknowledge when patients are harmed and to disclose that information to patients. Our bill is the catalyst for this first step. Only then, once it is established that patients have a right to know when they have been harmed—and healthcare providers have been trained in disclosure—will institutions and providers have a mindset to truly focus on preventing patient harm.

Kansas has an organization, the Kansas Healthcare Collaborative (KHC), that could take a leadership role in honest conversations about medical harm and patient safety. The question is whether the parent organizations of KHC—The Kansas Medical Society and The Kansas Hospital Association—are willing to support this.

1 T. A. Brennan *et al.* 1991. *New England Journal of Medicine* 324(6): 370–376.

2 Office of the Inspector General. November 2010.

3 *To Err is Human.* 1999. The Institute of Medicine.

4 J. T. James. 2013. *Journal of Patient Safety* 9(3): 122-128.

5 Nevada (Nev. Rev. Stat. 439.855), Florida (Fla. Stat. Ann. 395.1051, 456.0575), New Jersey (N. J. Stat. Ann. 26:2H-12.25(d)) and Pennsylvania (40 Pa. Stat. Ann. 1303.308).

6 A. Mastroianni *et al.* 2010. *Health Affairs* 29(9): 1611–119.

7 D. M. Studdert *et al*. 2006. *New England Journal of Medicine* 354:2024–33.