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(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2011-12
(session year)

Assembly
(Assembly, Senate or Joint)

Committee on Health...

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (October 2013)

Assembly

Record of Committee Proceedings

Committee on Health

Assembly Bill 147

Relating to: inadmissibility of a statement of apology or condolence by a health care provider.

By Representatives Severson, Nygren, Strachota, Kaufert, Bewley, Bies, Brooks, Jacque, Ripp, Spanbauer, Tauchen and Thiesfeldt; cosponsored by Senators Galloway, Cowles, Darling, Holperin, Schultz and Wanggaard.

May 23, 2011 Referred to Committee on Health.

June 1, 2011 **PUBLIC HEARING HELD**

Present:	(11)	Representatives Stone, Severson, Kaufert, Van Roy, Strachota, Petersen, Litjens, Richards, Pasch, Pocan and Seidel.
Absent:	(0)	None.
Excused:	(0)	None.

Appearances For

- Rep. Eric Severson — 28th Assembly District
- Norm Jensen, MD, Madison — WI Medical Society
- Dr. Charles Shabino, Madison — WI Hospital Assn
- Mark Grapentine, Madison — WI Medical Society

Appearances Against

- Mike End, Madison — WI Assn for Justice

Appearances for Information Only

- None.

Registrations For

- Sen. Pam Galloway — 29th Senate District
- Michael Heifetz, Madison — St Mary's Hospital
- Michael Heifetz, Madison — SSM Health Care-Wisconsin
- Maureen McNally, Milwaukee — Froedert Memorial Lutheran Hospital
- Karla Ashenhurst, Milwaukee — Ministry Health Care
- Paul Merline, Madison — WI Hospital Assn
- Michael Welsh, Madison — WI Academy of Family Physicians
- Eric Jensen, Madison — WI Academy of Ophthalmologists

- Eric Jensen, Madison — WI Chapter, American College of Emergency Physicians
- Eric Jensen, Madison — WI Society of Anesthesiologists
- Wendy Varish, Cleveland, WI
- Russ Leonard, Madison — WI Chiropractic Assn
- Tony Driessen, Madison — WI Society of Podiatric Medicine
- Tony Driessen, Madison — WI Assn of Nurse Anesthetists
- Jeremy Levin — Rural WI Health Cooperative
- Lisa Maroney, Madison — UW Health
- Katie Walby, Madison — Aurora Healthcare
- Mara Brooks, Madison — WI Dental Assn
- Jason Johns, Madison — WI Physical Therapy Assn
- Kyle Fischer, Madison — Self
- Mary K Grasmick, Madison — Self

Registrations Against
- None.

Registrations for Information Only
- None.

August 24, 2011 **EXECUTIVE SESSION HELD**

Present:	(10)	Representatives Stone, Severson, Kaufert, Van Roy, Strachota, Petersen, Litjens, Richards, Pasch, Pocan.
Absent:	(0)	None.
Excused:	(1)	Representative Seidel.

Moved by Representative Richards, seconded by Representative Stone that **Assembly Amendment LRB a1459/1** be recommended for introduction.

Ayes:	(3)	Representatives Richards, Pasch and Pocan.
Noes:	(7)	Representatives Stone, Severson, Kaufert, Van Roy, Strachota, Petersen and Litjens.
Absent:	(1)	Representative Seidel.

INTRODUCTION OF ASSEMBLY AMENDMENT LRB A1459/1 NOT RECOMMENDED, Ayes 3, Noes 7

Moved by Representative Kaufert, seconded by Representative Severson that **Assembly Bill 147** be recommended for passage.

Ayes: (7) Representatives Stone, Severson, Kaufert, Van Roy, Strachota, Petersen and Litjens.
Noes: (3) Representatives Richards, Pasch and Pocan.
Absent: (1) Representative Seidel.

PASSAGE RECOMMENDED, Ayes 7, Noes 3

Marsha Dake

Marsha Dake
Committee Clerk

Vote Record
Committee on Health

Date: 8-24-11

Moved by: Richards Seconded by: Stone

AB 147 SB _____ Clearinghouse Rule _____

AJR _____ SJR _____ Appointment _____

AR _____ SR _____ Other _____

A/S Amdt LRB 1459/1

A/S Amdt _____ to A/S Amdt _____

A/S Sub Amdt _____

A/S Amdt _____ to A/S Sub Amdt _____

A/S Amdt _____ to A/S Amdt _____ to A/S Sub Amdt _____

Be recommended for:

☐ Passage ☐ Adoption ☐ Confirmation ☐ Concurrence ☐ Indefinite Postponement

☒ Introduction ☐ Rejection ☐ Tabling ☐ Nonconcurrence

Committee Member	Aye	No	Absent	Not Voting
Representative Jeff Stone, Chair	☐	☒	☐	☐
Representative Erik Severson	☐	☒	☐	☐
Representative Dean Kaufert	☐	☒	☐	☐
Representative Karl Van Roy	☐	☒	☐	☐
Representative Patricia Strachota	☐	☒	☐	☐
Representative Kevin Petersen	☐	☒	☐	☐
Representative Michelle Litjens	☐	☒	☐	☐
Representative Jon Richards	☒	☐	☐	☐
Representative Sandy Pasch	☒	☐	☐	☐
Representative Mark Pocan	☒	☐	☐	☐
Representative Donna Seidel	☐	☐	☒	☒
Totals:	3	7	1	+

☐ Motion Carried ☒ Motion Failed

Vote Record
Committee on Health

Date: 8-24-11

Moved by: Kaufert Seconded by: Severson

AB 147 SB _____ Clearinghouse Rule _____

AJR _____ SJR _____ Appointment _____

AR _____ SR _____ Other _____

A/S Amdt [redacted]

A/S Amdt _____ to A/S Amdt _____

A/S Sub Amdt _____

A/S Amdt _____ to A/S Sub Amdt _____

A/S Amdt _____ to A/S Amdt _____ to A/S Sub Amdt _____

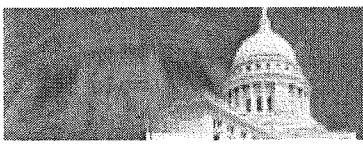
Be recommended for:

☒ Passage ☐ Adoption ☐ Confirmation ☐ Concurrence ☐ Indefinite Postponement

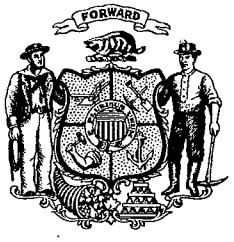
☐ Introduction ☐ Rejection ☐ Tabling ☐ Nonconcurrence

Committee Member	Aye	No	Absent	Not Voting
Representative Jeff Stone, Chair	☒	☐	☐	☐
Representative Erik Severson	☒	☐	☐	☐
Representative Dean Kaufert	☒	☐	☐	☐
Representative Karl Van Roy	☒	☐	☐	☐
Representative Patricia Strachota	☒	☐	☐	☐
Representative Kevin Petersen	☒	☐	☐	☐
Representative Michelle Litjens	☒	☐	☐	☐
Representative Jon Richards	☐	☒	☐	☐
Representative Sandy Pasch	☐	☒	☐	☐
Representative Mark Pocan	☐	☒	☐	☐
Representative Donna Seidel	☐	☐	☒	☒
Totals:	7	3	1	*

☒ Motion Carried ☐ Motion Failed



WISCONSIN STATE LEGISLATURE



Gundersen Lutheran

June 1, 2011

The Honorable Jeff Stone
Chairman, Assembly Health Committee
Room 314 North
State Capitol, P.O. Box 8953
Madison, WI 53708

Re: A.B. 147/S.B. 103- Apology Law

Dear Chairman Stone:

I am writing on behalf of Gundersen Lutheran Health System to express our support of Assembly bill 147/S.B. 103 relating to inadmissibility of a statement, a gesture, or conduct expressing apology or condolence by a healthcare provider in a medical malpractice lawsuit. We believe this legislation is a positive step toward lowering malpractice claims, reducing malpractice insurance costs, and decreasing the cost of healthcare in the state of Wisconsin.

In a complex industry as medicine, when a procedure does not turn out as expected, a physician's open communication with the patient and their family is an important time to explain what occurred and express sympathy, condolence, apology and compassion. In a legal environment with apology laws, health systems can implement full disclosure policies, so a procedure is in place when an unintended outcome occurs. A physician should be able to openly discuss what caused the unexpected outcome without fear the conversation will become evidence against them in a medical malpractice suit.

Healthcare systems have implemented full disclosure policies in state with apology laws, to ensure a procedure is in place to address situations that occur due to an unintended medical outcome. A study performed at the University of Michigan revealed a reduction in the number of medical malpractice claims by 50% as a result of such laws. Full disclosure and open communication between the provider and patient and/or patient's family shows compassion and honesty and helps deter lawsuits.

On behalf of Gundersen Lutheran, we urge the Assembly Health Committee to pass A.B. 147. Please contact us with any questions or if we can provide assistance in moving this legislation forward.

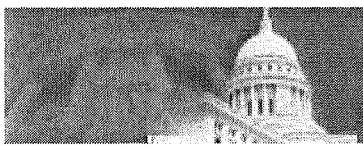
Sincerely,

Michael D. Richards
Executive Director
Government Relations & External Affairs

External Affairs Department 1900 South Avenue, H02-009 La Crosse, WI 54601
ExternalAffairs@gundluth.org Phone: 608-775-1400

Cc: Assembly Health Committee
Senator Pam Galloway

External Affairs Department 1900 South Avenue, GB2-004 La Crosse, WI 54601
Phone: 800-362-9567 x 51400 or 608-775-1400 Fax: 608-775-6225



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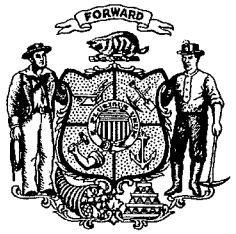

Wisconsin Medical Society

Your Doctor. Your Health.

TO: Assembly Committee on Health
Representative Jeff Stone, Chair

FROM: Norman Jensen, MD, MS
University of Wisconsin Emeritus Professor of Medicine
President, American Academy on Communication in Healthcare
(www.AACHonline.org)

DATE: June 1, 2011

RE: **Support** for Assembly Bill 147 – Physician Apology Legislation

Good morning and thank you for the opportunity to testify in support of Assembly Bill 147, often called the "I'm Sorry" law. I testify on behalf of myself, the Wisconsin Medical Society and the medical staff of University of Wisconsin Hospitals and Clinics. It is appropriate that Wisconsin join the growing majority of states with similar laws and we commend you for promoting this socially responsible policy.

By day, I serve as Emeritus Professor of Medicine at the UW School of Medicine where I have for 40 years maintained a primary care practice for adults and taught communication skills and professionalism to medical students, residents, practicing physicians and faculty. I also currently serve as President of the American Academy on Communication in Healthcare.

COMMUNICATION IS THE MAJOR MEDIUM OF HEALTHCARE! Little of the awesome biomedical-technical enterprise is deliverable without skillful communication and trust. It will also be the most peaceful means of reducing cost while improving quality.

A single event triggered my interest in apology as a healing act of compassion.

The dominant value of AB 147 is to conserve the essential trust between physician and patient by encouraging open and unguarded communication. No one wants compassionate communication inhibited by fears of legal action, and at no time is this more important than times of adverse outcomes of health care. A silent physician is perceived as uncaring and untrustworthy, and at such critical times, patients feel abandoned. Yet I know the vast majority of physicians care deeply even as they remain silent, paralyzed by fear of legal action.

Adverse outcomes are nearly a daily experience in the work of physicians. Medical examinations often result in "bad news," a new disease or progression of disease, and along with this, new limits on life plans and hopes of real people, ourselves, family members, relatives, and constituents. Yet, because of the paralyzing fear of a malpractice claim, physicians are too often unwilling to have a compassionate conversation that includes apology.

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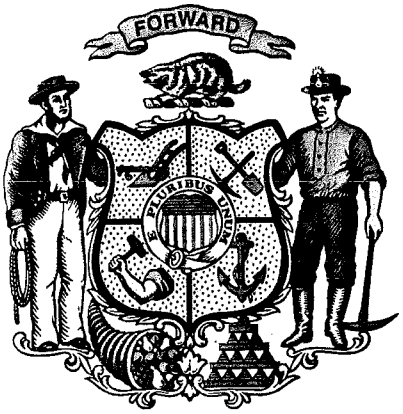
The landmark 1980s study of medical malpractice in New York State by the Harvard School of Public Health showed the vast majority of adverse outcomes involve no malpractice. So then why are physicians so fearful and overestimate their risk by as much as 45 times? One answer was also reported in the study: 15 percent of claims failed to meet one or more of the three legal criteria for malpractice; they were so called "frivolous claims." Another answer is that a medical malpractice claim is costly and painful for everyone but the attorneys. Physicians understandably become risk averse and protect themselves through silence and excessive testing and imaging that was recently estimated to cost the U.S. $54 billion over the next 10 years; even for government, that's a big number, and not just a number, but facts that adversely impact the health of the people of Wisconsin.

Since the last iteration of this bill, evidence shows that compassionate communication following an adverse event significantly lowers litigation costs and results in more injured patients receiving fair compensation more quickly.

Some claim the Trial bar opposes apology laws because apology results in fewer malpractice claims. I believe the high ethical standards of the Legal profession make this most unlikely.

I do appreciate the concern of plaintiff's attorneys regarding the potential for an "apology law" to frustrate the prosecution of a legitimate malpractice claim. I believe they exaggerate. How likely would it be that if a medical record and expert witnesses cannot substantiate a claim of malpractice that a physician's apology would be sufficient? And in the exceptional case, I argue the greater good is served by protecting this critical time in the patient-clinician relationship.

Finally, I am grateful for this opportunity and commend you, Representative Severson and the many co-sponsors for promoting this good-government policy; I encourage you to make it law as soon as possible.


FORWARD

Wisconsin Medical Society

Your Doctor. Your Health.

TO: Assembly Committee on Health
Representative Jeff Stone, Chair

FROM: Mark Grapentine, JD
Senior Vice President - Government Relations

DATE: June 1, 2011

RE: Support for Assembly Bill 147

On behalf of more than 12,000 members statewide, the Wisconsin Medical Society thanks the committee for this opportunity to share our strong support for Assembly Bill 147, promoting statements of apology or condolence following an unexpected or negative health care event. The bill would provide statutory protection for such statements, promoting more full and frank communications between a physician and a patient or the patient's family at a time when such communication is needed the most. We urge the committee to approve the bill.

The Society believes physicians should not be forced into a situation where they feel compelled to avoid frank or sympathetic conversations with patients or family members because they fear that any statements could be used against them in a lawsuit. In today's litigation environment, that is too often the case. Studies show that timely communication with a patient and/or a patient's family following an adverse event can greatly reduce the incidence of medical liability lawsuits. Laws such as AB 147 promote that goal of timely communication between physicians and patients or patients' families.

The Society supports broad protections for these important conversations – the corollary is that the Society opposes amending the bill to restrict the types of statements, gestures or forms of conduct that are covered under the introduced version of the bill. Indeed, recent analysis of various states' laws show that ideally, nothing should interfere with potential physician-patient communication – including any situation where a physician is forced to choose his or her words carefully for fear of stepping over a legal line. All topics need to be covered in order for the law to work as intended. Otherwise, rather than a frank discussion, physicians might worry about the legal ramifications of their word choice and limit their communication with a patient or patient's family due to fear of legal exposure.

The attached *Health Affairs* article, "The Flaws in State 'Apology' And 'Disclosure' Laws Dilute Their Intended Impact on Malpractice Suits," analyzes the weaknesses in some statutory constructs that do not go far enough to protect statements of sympathy as well as responsibility. The article specifically discusses states which have laws protecting statements of sympathy or promoting disclosure of an adverse event:

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> Our analysis reveals that most of these laws have structural weaknesses that may discourage comprehensive disclosures and apologies and weaken the laws' impact on malpractice suits. Disclosure laws do not require, and most apology laws do not protect, the key information that patients want communicated to them following an unanticipated outcome. Patients view the apology and disclosure processes as inextricably intertwined, seeking not only an expression of sympathy but also information about the nature of the event and why it happened, and how recurrences will be prevented.
>
> . . .
>
> Legislation can be ineffective or even counter-productive if it is drafted too narrowly, if health care providers overestimate the protection it offers, or if the resulting disclosures or apologies are interpreted by patients as insincere.

Therefore, in order to promote the overall goal of better communication between a physician and a patient/patient's family, the language of AB 147 needs to remain as it is currently drafted. When emotions are running strong, that is not the time for a physician to feel a need to choose words cautiously – the discussion needs to be full and frank for the patient or family members to trust what the physician is saying. And in the current lawsuit environment, those conversations will not occur as often as they could without legislative protection.

Finally, it is important to note what the bill does not do. It does nothing to remove the ability of a capable plaintiff's attorney to utilize current discovery methods and other legal means to explore whether a medical outcome warrants a lawsuit. AB 147 is a well-reasoned bill in the critical area of physician-patient communications, nothing more.

Thank you again for this opportunity to share the Society's support for Assembly Bill 147. If you have questions about this or other issues, please feel free to contact us at any time.

Dunagan WC, et al. U.S. and Canadian physicians' attitudes and experiences regarding disclosing errors to patients. Arch Intern Med. 2006; 166(15):1605–11.
14 Robinson AR, Hohmann KB, Rifkin JI, Topp D, Gilroy CM, Pickard JA, et al. Physician and public opinions on quality of health care and the problem of medical errors. Arch Intern Med. 2002;162(19):2186–90.
15 Studdert DM, Mello MM, Brennan TA. Medical malpractice. N Engl J Med. 2004;350(3):283–92.
16 Wei M. Doctors, apologies, and the law: an analysis and critique of apology laws. J Health Law. 2007; 40(1):107–59.
17 Liebman CB, Hyman CS. A mediation skills model to manage disclosure of errors and adverse events to patients. Health Aff (Millwood). 2004; 23(4):22–32.
18 McDonnell WM, Guenther E. Narrative review: do state laws make it easier to say "I'm sorry"? Ann Intern Med. 2008;149(11):811–6.
19 Robbennolt JK. Apologies and legal settlement: an empirical examination. Mich Law Rev. 2003;102: 460–516.
20 Agency for Healthcare Research and Quality [Internet]. Rockville (MD): AHRQ; c2010. Press release, HHS announces patient safety and medical liability demonstration projects; 2010 Jun 11 [cited 2010 June 18]. Available from: http://www.ahrq.gov/news/press/pr2010/hhsliabawpr.htm
21 The Appendix can be accessed by clicking on the Appendix link in the box to the right of the article online.
22 Gallagher TH, Lucas MH. Should we disclose harmful medical errors to patients? If so, how? J Clin Outcomes Manage. 2005;12(5):253–9.
23 Mazor KM, Simon SR, Gurwitz JH. Communicating with patients about medical errors: a review of the literature. Arch Intern Med. 2004;164: 1690–7.
24 Taft L. Apology subverted: the commodification of apology. Yale Law J. 2000;109:1135–54.
25 Full Disclosure Working Group. When things go wrong: responding to adverse events: a consensus statement of the Harvard hospitals. Boston (MA): Massachusetts Coalition for the Prevention of Medical Errors; 2006.
26 Lazare A. On apology. Oxford: Oxford University Press; 2004.
27 National Quality Forum. Safe practices for better healthcare—2009 update. Washington (DC): NQF; 2009 [cited 2010 June 18]. Available from: http://www.qualityforum.org/Publications/2009/03/Safe_Practices_for_Better_Healthcare%e2%80%932009_Update.aspx
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29 Studdert DM, Mello MM, Gawande AA, Brennan TA, Wang YC. Disclosure of medical injury to patients: an improbable risk management strategy. Health Aff (Millwood). 2007; 26(1):215–26.
30 Wojcieszak D, Banja J, Houk C. The Sorry Works! Coalition: making the case for full disclosure. Jt Comm J Qual Patient Saf. 2006;32(6): 344–50.
31 Weissman JS, Annas CL, Epstein AM, Schneider EC, Clarridge B, Kirle L, et al. Error reporting and disclosure systems: views from hospital leaders. JAMA. 2005;293(11):1359–66.
32 American Society for Healthcare Risk Management of the American Hospital Association. Disclosure of unanticipated events: the next step in better communication with patients. Chicago (IL): The Society; 2003 May.
33 Flynn E, Jackson JA, Lindgren K, Moore C, Poniatowski L, Youngberg B. Shining the light on errors: how open should we be? Oak Brook (IL): University HealthSystem Consortium; 2002.
34 Joint Commission. Health care at the crossroads: strategies for improving the medical liability system and preventing patient injury [Internet]. Oakbrook Terrace (IL): Joint Commission; 2005 [cited 2010 Jun 19]. Available from: http://www.jointcommission.org/NR/rdonlyres/167DD821-A395-48FD-87F9-6AB12BCACB0F/0/Medical_Liability.pdf
35 Citations for all statutes are available in the online Appendix, as in Note 21.
36 The states with both types of laws are California, Florida, Oregon, Tennessee, Vermont, and Washington. The states without laws are Alabama, Alaska, Arkansas, Illinois, Kansas, Kentucky, Mississippi, Minnesota, Missouri, New Mexico, New York, Rhode Island, and Wisconsin.
37 The states with general apology laws are California, Florida, Hawaii, Indiana, Iowa, Massachusetts, Missouri, Nebraska, Tennessee, Texas, and Washington.
38 Lazare A. Apology in medical practice: an emerging clinical skill. JAMA. 2006;296(11):1401–4.
39 The states with this kind of sympathy-only law are California, Delaware, Florida, Hawaii, Indiana, Louisiana, Maine, Maryland, Missouri, Nebraska, New Hampshire, South Dakota (for purposes of impeachment), Tennessee, Texas, Virginia, and Washington.
40 The states with relevant apology laws are California, Florida, Oregon, Tennessee, Texas, and Vermont.
41 Hobgood C, Peck CR, Gilbert B, Chappell K, Zou B. Medical errors—what and when: what do patients want to know? Acad Emerg Med. 2002;9(11):1156–61.
42 40 Pa. Cons. Stat. Ann. 1303.308 (b).
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44 McDonald T, Smith K, Chamberlin W, Centomani N, Mayer D. Full disclosure is more than saying "I'm sorry." Focus on Patient Safety. 2009:1–3.
45 Wu AW, Huang IC, Stokes S, Pronovost PJ. Disclosing medical errors to patients: it's not what you say, it's what they hear. J Gen Intern Med. 2009;24(9):1012–7.
46 Leape LL. Full disclosure and apology: an idea whose time has come. Physician Exec. 2006;32(2): 16–8.
47 Kraman SS, Hamm G. Risk management: extreme honesty may be the best policy. Ann Intern Med. 1999;131(12):963–7.
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51 Gallagher TH, Quinn R. What to do with the unanticipated outcome: does apologizing make a difference? How does early resolution impact settlement outcome? Paper presented at the Medical Liability and Health Care Law Seminar. Defense Research Institute; Phoenix, AZ. 2006 Mar 3.
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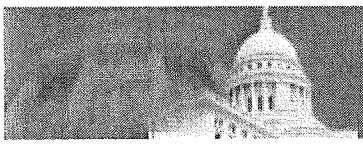


WISCONSIN STATE LEGISLATURE

WISCONSIN ASSOCIATION *for* JUSTICE

Testimony of J. Michael End
on behalf of the
Wisconsin Association for Justice
before the
Assembly Health Committee
Representative Jeff Stone, Chair
2011 Assembly Bill 147
June 1, 2011

Good morning Representative Stone and Committee members. My name is Mike End. I am a partner in the law firm of End, Hierseman & Crain in Milwaukee, Wisconsin. I serve as president of the Wisconsin Association for Justice. Thank you for the opportunity to testify here today.

Wisconsin Association for Justice (WAJ), established as a voluntary trial bar, is a non-profit corporation with approximately 900 members located throughout the state. The objectives and goals of WAJ are the preservation of the civil jury trial system, the improvement of the administration of justice, the provision of facts and information for legislative action, and the training of lawyers in all fields and phases of advocacy.

I am an advocate for patient safety. I was a participant in the Wisconsin Patient Safety Summit held at the Medical College of Wisconsin in 1999 and I was a board member of Safe Care Wisconsin from 2007 through 2009. The Wisconsin Association for Justice was an active participant and financial contributor to that effort. I have also participated in meetings conducted by the Wisconsin Society for Healthcare Risk Management, Dean Health System for Risk Management, and Aurora Health Care Risk Managers.

I want to start with general background information about the scope of the problem we're dealing with when we talk about medical malpractice. The April 2011 edition of *Health Affairs* contained three important articles about medical errors and their costs. One study found that medical errors occur in one-third of hospital admissions, as much as ten times more often than previously estimated. The Institute of Medicine found in 1999 that as many as 98,000 people die every year due to preventable medical errors.

A second study analyzed insurance claims from 2001 through 2008 and found approximately 564,000 injuries to patients admitted to U.S. hospitals and 1.8 million injuries to people using outpatient services. The cost of these preventable medical mistakes was estimated at $17.1 billion in 2008.

The final study looked at medical errors in 2006. Lost lives and disabilities caused by medical error cost between $393 billion and $958 billion in 2006, equivalent to 18-45% of total U.S. health-care spending in that year. "For every dollar that was spent in the health care system, about 18 to 45 cents of that dollar went to hurting someone," explained co-author Pamela Villarreal.

Despite these horrendous statistics, medical malpractice cases are rare and continue to decline. When we extrapolate from the numbers cited in the studies published in the medical literature, there are at least 20,000 people who die or are injured every year in Wisconsin as a result of medical negligence. Yet in 2010 there were only 147 medical malpractice lawsuits filed here. The last five years have had the lowest number of cases filed since the Director of State Courts began keeping the data. In fact, last year's number of cases was half of the number filed in 1999. There was one malpractice case filed last year for every 38,467 people in the state.

The National Practitioner Data Bank, which was established by Congress in 1986, tracks all payments made to patients as a result of doctor negligence. The last four years are the four lowest number of payments made to people in Wisconsin because of doctor negligence, averaging 64 payments per year. That is about 3.7 payments for every 1,000 doctors practicing in our state.

The numbers show that the number of medical malpractice lawsuits filed in Wisconsin is miniscule compared to the number of deaths and injuries caused each year by medical negligence. Similarly, the number of payments made to injured people is miniscule.

As Tom Baker, Professor of Law at the University of Pennsylvania said, "We have an epidemic of medical malpractice, not of malpractice lawsuits." This legislation does nothing to address the epidemic of medical errors.

Having represented individuals and families hurt by medical malpractice, I can tell you that one of the most distressing things many experience is the lack of communication between themselves and the health care providers. Often family members don't learn what happened to a loved one except through an autopsy and lawsuit. Studies have shown that it is lack of communication that leads to distrust with

health care providers. That is why several VA hospitals and the University of Michigan Health System have programs to tell patients and their families immediately when something goes wrong and do what they can to fairly compensate the injured people. There is no immunity involved, but those institutions have learned that the "I'm sorry" system has reduced malpractice costs because the problem is addressed and the patient and family can move forward in recovery.

WAJ welcomes the concept of the inadmissibility of a health care provider's statement of apology, condolences, or sympathy because encouraging such communications may help the doctor-patient relationship. We do object to the inadmissibility of statements relating to fault and liability.

Many "I'm sorry" statutes specifically admit use of admissions of liability or fault. Thirteen states have adopted this version: California, Delaware, Florida, Hawaii, Idaho, Indiana, Maryland, Missouri, South Dakota, Tennessee, Texas, Virginia, and Washington. An example would be Missouri, "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 and made to that person or family of that person shall be inadmissible as evidence of liability in a civil action. However, nothing in this section shall prohibit admission of a statement of fault." Mo. Stat. Rev. § 528.229.

WAJ is also concerned about the use of the word "conduct." Including "conduct" makes this broader than some other proposals. One could also argue that the proposal applies more than to a case of a medical error.

That is one reason Delaware includes a definition of "unanticipated outcome," which limits the situations where this would apply to cases involving medical treatments.

> (2) 'Unanticipated outcome' means the result of a medical treatment or procedure that differs from an expected medical result.
> (b) Any and all statements, writings, gestures, or affirmations made by a health care provider or an employee of a health care provider that express apology (other than an expression or admission of liability or fault), sympathy, compassion, condolence, or benevolence relating to the pain, suffering, or death of a person as a result of an unanticipated outcome of medical care, that is made to the person, the person's family, or a friend of the person or of the person's family, with the exception of the admission of liability or fault, are inadmissible in a civil action that is brought against a health care provider."

Chapter 43, Title 10 of the Delaware Code, § 4318. Compassionate Communications.

Michigan recently became the 14th state to pass "I'm sorry" legislation that follows this same format:

> Sec. 2155. (1) A statement, writing, or action that expresses sympathy, compassion, commiseration, or a general sense of benevolence relating to the pain, suffering, or death of an individual and that is made to that individual or to the individual's family is inadmissible as evidence of an admission of liability in an action for medical malpractice.
> (2) This section does not apply to a statement of fault, negligence, or culpable conduct that is part of or made in addition to a statement, writing, or action described in subsection (1).
> (3) As used in this section, "family" means spouse, parent, grandparent, stepmother, stepfather, child, adopted child, grandchild, brother, sister, half brother, half sister, father-in-law, or mother-in-law.

Michigan Public Act 21 of 2011. Effective April 20, 2011

Another version of the "I'm sorry" statute that would be acceptable is one that doesn't discuss admissibility of liability or fault. Sixteen states have this version: Illinois, Iowa, Louisiana, Maine, Massachusetts, Montana, North Carolina, North Dakota, New Hampshire, Ohio, Oklahoma, Oregon, South Carolina, Vermont, West Virginia and Wyoming. An example would be Oklahoma: "In any medical action, any and all statements, affirmations, gestures, or conduct expressing apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence which are made by a health care provider or an employee of a health care provider to the plaintiff, a relative of the plaintiff, or a representative of the plaintiff and which relate solely to discomfort, pain, suffering, injury or death as the result of unanticipated outcome of the medical care shall be inadmissible as evidence of a liability or as evidence of an admission against interest." 63 Okl.St.Ann. § 1-1708.1H.

Utah recently passed legislation, which is awaiting the Governor's signature that reflects this type of format:

> **Rule 409. Payment of medical and similar expenses; expressions of apology.**
>
> (b) Evidence of unsworn statements, affirmations, gestures, or conduct made to a patient or a person associated with the patient by a defendant that expresses the following is not admissible in a malpractice action against a health care provider or an employee of a health care provider to prove liability for an injury:
> (1) apology, sympathy, commiseration, condolence, compassion, or general sense of benevolence; or

(2) a description of the sequence of events relating to the unanticipated outcome of medical care or the significance of events.

Utah H.J.R. 38 Enrolled Copy

The difficulty this creates is seen firsthand in a medical malpractice case, where the doctor apologized, but also provided factual information about the cause of death to a family member. Here is a statement from an actual deposition of a family member:

Q Okay. And then your statement says, "[The doctor] sat
5 me down and said," quote, "I'm sorry. Simply due to
6 fatigue, I made an error. I was tired and had
7 accidentally pulled the wrong line. It filled his
8 heart with air and killed him"?
9 A Yes.

Under the bill, would any of this statement be admissible?

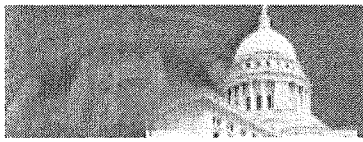
What if later at deposition, the doctor

- denies he was fatigued; or
- denies he made an error; or
- denies he accidentally pulled the wrong line; or
- denies he killed him?

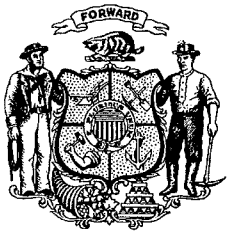
Would the statement be admissible for impeachment purposes?

In most states this statement would be admissible. WAJ supports legislation that would clearly state that admissions of fault are admissible. We believe that oral statements, writings and benevolent gestures of regret, sympathy or benevolence because of an unanticipated outcome should be inadmissible.

Finally, the legislature should consider addressing the enormous problem of medical errors. It would be a way to bring down health care costs and protect patients. Thank you for your time.



WISCONSIN STATE LEGISLATURE



MINISTRY HEALTH CARE **MEMO**

TO Members, Assembly Committee on Health

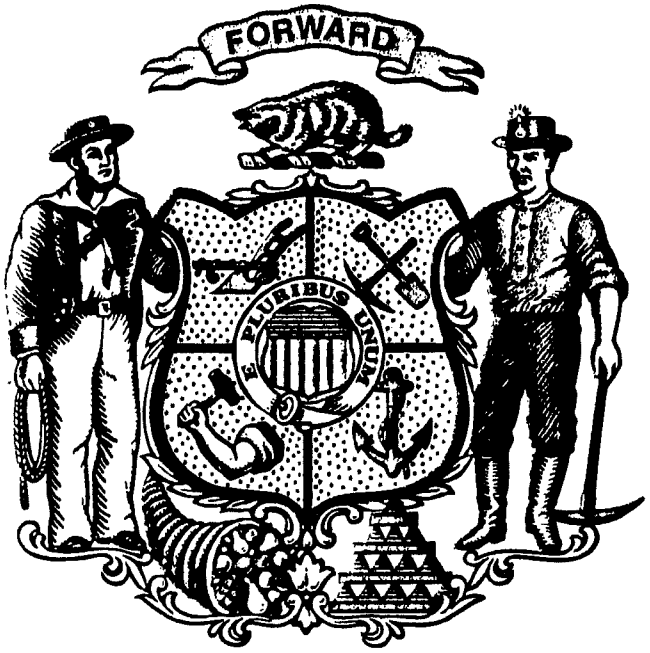
FROM Karla Ashenhurst
Ministry Health Care, Director of Government Affairs

DATE June 1, 2011

SUBJECT Assembly Bill 147 (companion SB103)

Ministry Health Care supports Assembly Bill 147, which prevents an apology or condolence from being used in litigation. An integrated health care system of hospitals, clinics, and affiliated services, Ministry Health Care employs approximately 12,000 health professionals, including nearly 300 physicians who pride themselves on strong relationships with patients and families. At the heart of this strong relationship is open communication. The fear or threat of litigation can shut down communication at a time when families need and deserve communication more than ever.

Passage and enactment of this legislation will provide physicians and other providers the opportunity to engage in a dialogue that may enhance the patient-provider relationship. Thank you for your consideration of our support of the bill.


FORWARD
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Froedtert HEALTH

Date: June 1, 2011

To: Members of the Assembly Health Committee
Representative Jeff Stone, Chair

From: Maureen McNally, Director of Government Relations, Froedtert Health

Re: Support for AB 147, Relating to Inadmissibility of a Statement of Apology or Condolence by a Health Care Provider

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I am writing on behalf of Froedtert Health in support of Assembly Bill (AB) 147, relating to inadmissibility of a statement of apology or condolence by a health care provider.

The legislation is straightforward: when a healthcare outcome is not as planned, expected or hoped for, a health care provider can make a statement of concern, condolence or apology to the patient or the patient's family without fearing that the statement will be used in court.

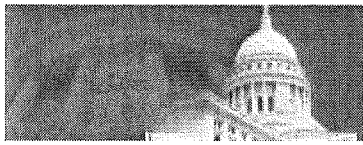
As patients, we look for healthcare providers who have both the clinical expertise to meet our medical needs and the compassion to meet our human needs. When the unexpected happens, patients or their families can benefit from knowing why the outcome occurred as well as from the empathy of those involved with their situation. Under current law, providers may avoid making any statement of empathy out of concern that these words will be used to suggest guilt or accountability.

An apology or statement of concern to a patient and their family should not put a health care professional or facility at risk. These statements help to foster open discussion and can help all concerned reach a resolution. It is important to note that the legislation does not preclude an injured patient from seeking resolution through the courts; the legislation simply helps to facilitate open and honest communication when an unexpected outcome occurs.

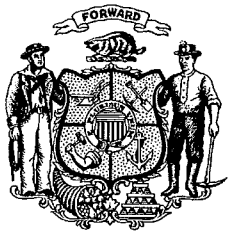
If you have questions or need additional information, please contact me at 414.805.5284.

About Froedtert Health

Froedtert Health is a regional health organization made up of Froedtert Hospital, Milwaukee; Community Memorial Hospital, Menomonee Falls; St. Joseph's Hospital, West Bend; and Froedtert Health Medical Group. Joining the capabilities of an academic medical center affiliated with The Medical College of Wisconsin, two community hospitals and a primary and multi-specialty physician group, Froedtert Health delivers highly coordinated, cost-effective health care to residents of southeastern Wisconsin and beyond. In 2010, combined adult patient admissions for the three hospitals exceeded 44,000. For more information, visit froedterthealth.org.



WISCONSIN STATE LEGISLATURE



WISCONSIN HOSPITAL ASSOCIATION, INC.

Date: June 1, 2011

To: Members of the Assembly Health Committee – Representative Jeff Stone, Chair

From: Dr. Charles Shabino – Chief Medical Officer, Wisconsin Hospital Association

Re: Support for AB 147, Relating to inadmissibility of a statement of apology or condolence by a health care provider

The Wisconsin Hospital Association (WHA) asks you to support Assembly Bill (AB) 147, which would allow health care providers to express an apology, condolence, or sympathy to a patient or patient's family without those statements being used as evidence against the provider.

While simple, this bill has a very powerful objective. When a health care outcome is not what was planned or expected, when an error has occurred, or when any other combination of events has led a patient or patient's family to be deeply disappointed by the health care they received, a heartfelt statement of concern or apology not only is often appropriate, but also can be very helpful.

An expedited healing process begins when both practical and emotional feelings are taken into consideration. A patient and often the patient's family want to know that the outcome is being addressed and that all those involved empathize with their situation. Unfortunately, statements expressing apology or condolence are often not made because of the provider's concern that these words will be used against the provider in a medical malpractice action.

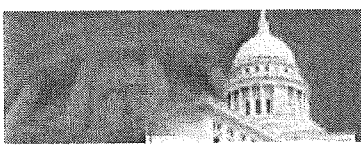
This bill would encourage open conversation among providers, patients, and families, encouraging a better resolution of unfortunate events. Statements of concern by all providers involved in patient care can allow the patient, family, and provider to move toward solution and resolution. These positive outcomes are more difficult to achieve when there are barriers to good communication.

WHA believes that open and honest communication between providers and their patients results in the best health care environment and adds greatly to the provider/patient relationship. WHA urges you to support AB 147.

About WHA

The Wisconsin Hospital Association (WHA) represents over 140 hospitals and health systems in Wisconsin, nearly all of which are not-for-profit. WHA's mission is advocating for policies that enable our members to provide high quality, affordable and accessible health care services that result in healthier communities. WHA takes a leadership role in fostering a climate of collaboration, respect, and interdependency between and among various stakeholders that affect health care.

5510 Research Park Drive P.O. Box 259038 Madison, WI 53725-9038 P (608.274.1820) F (608.274.8554) wha.org



WISCONSIN STATE LEGISLATURE

Wisconsin State Senator
PAM GALLOWAY
Senate District 29

Testimony on Assembly Bill 147
Assembly Committee on Health
June 1st, 2011

Mr. Chairman and Committee Members:

Thank you so much for having a public hearing today on Assembly Bill 147. I would also like to thank Representative Severson for his leadership and hard work in the Assembly on this issue. Many familiar with this proposed legislation have come to call it the "I'm sorry" bill.

I know that some committee members may be sitting here asking themselves, "are we really discussing the need to legislate apologies?" The unfortunate reality is that due to the litigious nature of our society that answer is yes.

A medical malpractice claim alleging negligent care is almost always the result of a combination of an adverse patient outcome and a flawed doctor-patient relationship. What causes a doctor patient-relationship to become flawed? The answer to that is complex, but without a doubt, honesty is the foundation of that relationship.

In the course of a surgeon's career it is an unfortunate reality that adverse outcomes will occur. These include unanticipated intra-operative findings as well as intra and postoperative complications. It is imperative that the patient and their family receive an open and honest discussion of how the adverse event occurred. No surgeon or physician ever wants to be the bearer of bad new. We want the best for our patients and if an adverse event does occur, we want to be able to express this news in an empathetic manner.

STATE CAPITOL
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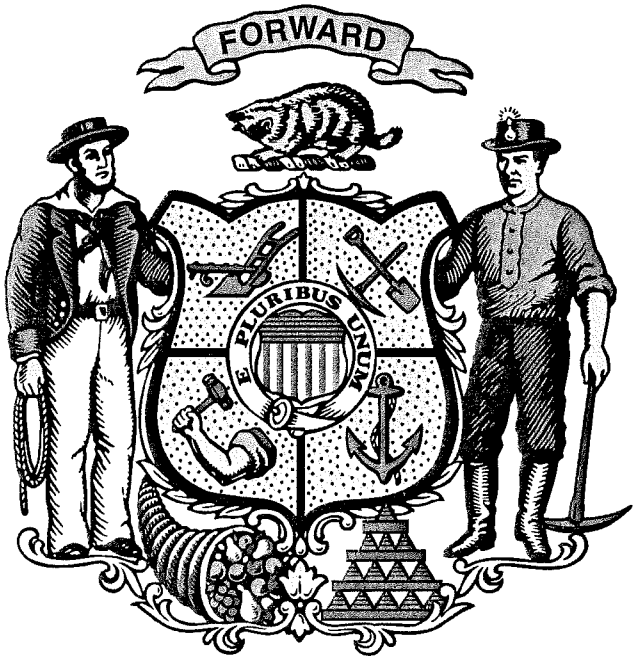
One of the most basic forms of compassion or sympathy that one can offer their fellow man is the simple expression, "I'm sorry." It is an unfortunate reality that this simple phrase can be used as an admission of liability. Certain aspects of humanity have literally been sued out of the medical profession. It has come to the point that at least 36 other states have adopted laws of some form that do not allow a physician's expression of sympathy with regard to the pain, suffering, or death of a patient to a patient or their family as an admission of guilt or liability in a medical malpractice suit.

Once again I would like to thank the Committee Chair for holding a public hearing on this legislation. Thank you for your consideration and I would urge your concurrence on this bill.


FORWARD
PLURIBUS UNUM

By Anna C. Mastroianni, Michelle M. Mello, Shannon Sommer, Mary Hardy, and Thomas H. Gallagher

DOI: 10.1377/hlthaff.2009.0134
HEALTH AFFAIRS 29,
NO. 9 (2010): 1611–1619

The Flaws In State 'Apology' And 'Disclosure' Laws Dilute Their Intended Impact On Malpractice Suits

ABSTRACT **Apologies are rare in the medical world, where health care providers fear that admissions of guilt or expressions of regret could be used by plaintiffs in malpractice lawsuits. Nevertheless, some states are moving toward giving health care providers legal protection so that they feel free to apologize to patients for a medical mistake. Advocates believe that these laws are beneficial for patients and providers. However, our analysis of "apology" and "disclosure" laws in thirty-four states and the District of Columbia finds that most of the laws have major shortcomings. These may actually discourage comprehensive disclosures and apologies and weaken the laws' impact on malpractice suits. Many could be resolved by improved statutory design and communication of new legal requirements and protections.**

Anna C. Mastroianni (amastroi@u.washington.edu) is an associate professor at the University of Washington School of Law, in Seattle.

Michelle M. Mello is a professor of law and public health in the Department of Health Policy and Management, Harvard School of Public Health, in Boston, Massachusetts.

Shannon Sommer is a research associate at the University of Washington School of Law.

Mary Hardy is a nurse with the medical emergency team of the University of Virginia Health System, in Charlottesville.

Thomas H. Gallagher is an associate professor in the Department of Medicine and in the Department of Bioethics and Humanities at the University of Washington.

Patients justifiably expect that they will be told about mistakes or errors—sometimes known in the medical industry as "unanticipated outcomes"—in their care.[1,2] This expectation is increasingly being codified into state laws, accreditation requirements for health care facilities, and medical society consensus statements.[3–5] However, a sizable gap exists between current practice and the expectation that patients will be notified of a medical error.[6–8] The failure of health care providers to communicate information about unanticipated outcomes may impair patients' decision making, increase their distress, and heighten their desire to seek legal redress.[9–12]

A key barrier to more-open communication between health care providers and patients is the concern that such conversations might precipitate lawsuits, especially when an adverse health outcome may have been preventable.[1,13–15] In response, many states have recently passed laws encouraging health care providers to discuss unanticipated outcomes with patients.[16–17]

One approach uses what are called "apology laws" to protect aspects of a provider's conversation with a patient from use as evidence of liability in a lawsuit.[18] A second approach, using "disclosure laws," typically mandates disclosure of certain unanticipated outcomes to patients and may protect the communication from being used in a legal or administrative action. Both types of laws are intended to encourage providers to share more information about unanticipated outcomes with patients by reducing liability exposure and shaping standard practices.

Although these laws are motivated by noble intentions, it is unclear whether they will achieve their goals. It is too early for a rigorous empirical evaluation of these initiatives, and key data on disclosures and malpractice litigation costs are not systematically collected outside of individual institutions. Predicting the effect of these laws is further hampered by the scarcity of research exploring the impact of specific communication strategies on patients' intent to sue.[19]

Notwithstanding this lack of evidence, both state and federal policy makers remain intensely interested in disclosure and apology approaches. For example, the U.S. Department of Health and Human Services (HHS) has committed $23 mil-

lion to funding pilot projects of innovative medical liability reforms, including several institutional programs that provide for disclosure, apology, and rapid offers of compensation.[20]

Because such programs generally do not bar patients from filing suit, the scope of legal protection in existing state laws is important. State disclosure and apology laws may also influence what is communicated to patients through these programs, and in what form.

In this article we contribute preliminary findings to inform these policy deliberations, based on an analysis of existing statutes (Appendix Exhibit 1).[21] We then address three policy questions. First, are the existing laws likely to foster transparency around medical injuries and reduce malpractice litigation? Second, do the strengths and weaknesses of disclosure and apology laws suggest best practices for designing future laws? Finally, on balance, are these laws worth adopting, or can their goals be more effectively achieved through alternative public or private initiatives such as disclosure and settlement offer programs?

Background

DISCLOSURE AND APOLOGY Disclosure and apology are conceptualized differently in the medical literature than they are in state statutes. In the medical literature, the term "disclosure" refers to informing the patient that an unanticipated outcome has occurred and providing some explanation for it.[1] Specifically, studies have shown that the information that patients desire following an unanticipated outcome includes an explanation of what happened, whether the outcome was caused by an error, how it happened, and plans for preventing recurrences.[22,23] The term "apology" refers at a minimum to an expression of sympathy, although some commentators suggest that a "full" apology for an unanticipated outcome caused by an error also includes providing an explanation, accepting responsibility, and making amends.[24–26]

CONVERSATION ABOUT UNANTICIPATED OUTCOMES In contrast, state laws recognize three distinct components of conversations with patients about unanticipated outcomes: "expression of sympathy," "explanation," and "admission of fault." The first two are roughly equivalent to the concepts of apology and disclosure. However, "admission of fault" does not have a close analogue in current disclosure guidelines promulgated by the medical profession, such as those from the National Quality Forum.[27]

The growing interest in communication between health care providers and patients about unanticipated outcomes has been stimulated in part by research suggesting that such communication might improve outcomes, including a reduction in litigation, amounts awarded, and greater patient satisfaction.[28–30] Nonetheless, health care workers and the institutions where they work still identify fear of malpractice suits as a major barrier to disclosure conversations.[31]

LEGAL RAMIFICATIONS Lawyers and insurance carriers have traditionally advised clients to avoid expressions of sympathy, explanations, and admissions of fault to patients out of concern that such statements could be used in litigation.[32–34] Worries about stimulating rather than ameliorating litigation persist. One group of scholars recently described disclosure as "an improbable risk management strategy."[29]

Study Data And Methods

We identified and reviewed statutes, regulations, judicial cases, and legislative histories of the fifty states and the District of Columbia that concerned the use in litigation and other legal proceedings of health care providers' statements of apology and disclosure to patients following unanticipated outcomes. The review is current through June 18, 2010.

We used online legal databases (LexisNexis and Westlaw) and annotated compilations of state laws. We then analyzed the laws for common themes (Appendix Exhibit 1),[21] categorizing them through a rigorous classification scheme. In states that have adopted both an apology law that is specific to the medical context and a more general apology statute that applies to other kinds of accidents, we analyzed only the law that would apply to medical malpractice litigation. (Appendix Exhibit 2 provides legal citations by state.)[21]

Study Results

PREVALENCE OF LAWS Thirty-four states and the District of Columbia have adopted an apology law, and nine states have adopted a disclosure law.[35] Six states have both types of laws, and thirteen have neither.[36] Among the states with apology laws, eleven have laws of general applicability,[37] and twenty-five have laws specific to the medical context. One state, Washington, has both a general apology law and an apology law specific to the medical context.

Sixteen states do not currently have any apology law. In these states, sympathetic statements by a provider could be used by a plaintiff as evidence of provider liability.

VARIATIONS IN FEATURES OF APOLOGY LAWS The vast majority of the apology laws—found

in twenty-five states and the District of Columbia—are sympathy-only laws, which protect only the expression of sympathy made after an unanticipated outcome (Exhibit 1). Although some experts assert that a meaningful apology includes an explanation for the injury and an acceptance of responsibility,[38] the legal protection provided by sympathy-only laws does not inherently extend to statements of explanation or fault. Indeed, more than half of the sympathy-only laws explicitly indicate that expressions of fault made in conjunction with an expression of sympathy are admissible in litigation.[39]

These laws suggest that portions of a statement that explain or acknowledge responsibility—such as, "I'm sorry *I hurt you*," or, "I'm sorry *I made a mistake when I administered the wrong medication*"—could be used in litigation.

In the remaining sympathy-only laws, the statutes are less clear about whether a statement of fault embedded in a statement of sympathy would be admissible in litigation. In states with those laws, any expression of fault or liability would be likely to be admissible, as other evidence rules generally permit plaintiffs to use such statements against defendants.

Three states have sympathy and explanation-apology laws. These laws protect expressions of sympathy as well as the description of the event, such as, "I'm sorry you had an unexpected reaction to the medication." Like the sympathy-only laws, they do not explicitly protect expressions of fault. Therefore, the portions of statements that identify the responsible party—for example, "I'm sorry you were hurt *when I prescribed the wrong dose of medication*"—may be admissible in litigation.

Six states have laws that protect both a provider's expression of sympathy and any admission of responsibility or fault. We assumed in our

EXHIBIT 1

Characteristics Of State Apology Laws

Provision	Number
CONTENT OF COMMUNICATION RECEIVING LEGAL PROTECTION	
Statement of sympathy, explanation, and fault	0
Statement of sympathy and fault	6
Statement of sympathy and explanation	3
Statement of sympathy	26
COVERED PARTIES	
Not restricted to health care providers	9
Institutional and individual health care providers	25
Institutional health care providers only	1
TRIGGERING EVENT	
All accidents[a]	6
Unanticipated outcomes of medical care[a]	25
Serious unanticipated outcomes of medical care	0
Medical errors/alleged negligence	4
TIMING OF COMMUNICATION	
No time frame specified	33
Communication must be made within X days of discovery	2[b]
FORM OF COMMUNICATION	
May be oral, written, or by conduct	34
May be oral or written	0
Must be written	0
Must be oral	1
Must be both oral and written	0
RECIPIENT OF COMMUNICATION	
Not limited to certain recipients	7
Recipient must be injured patient, family, representative, or friend	3
Recipient must be injured patient, family, or representative	23
Recipient must be injured patient	1
Recipient must be family (wrongful death cases only)	1

SOURCE Authors' analysis of LexisNexis and Westlaw searches of state statutes, regulations, and case law, last updated June 18, 2010.
NOTES $N = 35$, which includes thirty-four states and the District of Columbia. [a]The category "all accidents" includes statutes that do not specify a triggering event, if the statute is not limited to incidents involving health care providers. The category "unanticipated outcomes of medical care" includes statutes that do not specify a triggering event, if the statute is limited to health care providers. [b]30 days (VT, WA).

classification scheme that the protection for admissions of fault would be construed to cover any accompanying explanation of the event, and therefore that these sympathy-and-fault statutes provide the most expansive legal protection for providers.

In most jurisdictions, the protected communication may be verbal or nonverbal. For example, oral and written "statements," "affirmations," "gestures," "activities," or "conduct" are forms of protected communication. One state, Vermont, protects only oral communications. Two states encourage timely disclosure by protecting statements made within a defined time period. Although nearly all of the laws apply to apologies for unanticipated medical outcomes, four statutes apply more narrowly to medical errors or allegedly negligent care.

VARIATIONS IN FEATURES OF DISCLOSURE LAWS Since 2002, seven states have passed mandatory disclosure laws, and two have passed discretionary disclosure statutes (Exhibit 2). Mandatory disclosure laws require health care facilities to notify patients or their families, or both, of unanticipated outcomes of medical care. The discretionary disclosure law in Washington allows health care facilities to determine when disclosure of unanticipated outcomes to patients is appropriate. Oregon's discretionary law allows hospitals to voluntarily participate in the state's patient safety program, which mandates patient disclosures of serious unanticipated outcomes.

Six of the nine states with mandatory or discretionary disclosure laws provide legal protection for the communication in subsequent litigation. In five of those states, the protected communication is limited to a statement that an unanticipated outcome occurred, such as, "During the operation, your ureter was injured." Only one state, Washington, also protects explanations and expressions of sympathy such as, "I'm sorry your ureter was injured during the surgery." All six of the states whose disclosure laws provide legal protection also have separate apology laws that may be relevant.[40] The remaining three states offer no protection.

Among the nine states with mandatory or discretionary disclosure laws, Washington's approach is unique, offering the most comprehensive protection of disclosure conversations for health care providers. It adopted what reads like a combination disclosure-and-apology law. The statute explicitly provides protection for an explanation of the event and an expression of sympathy offered as part of a voluntary disclosure conversation with the patient, such as, "I'm sorry your ureter was injured when a surgical tool malfunctioned during the operation." Washington also has a separate apology law that could extend protection to an admission of fault.

Except in Florida, state disclosure laws apply to health care facilities only, not to individual providers. Although most apology laws apply to all unanticipated outcomes, disclosure laws typically apply only to events that have caused serious harm. Only two states—Oregon and Pennsylvania—require that the notification be in writing. For these two states, oral communications are permitted but not sufficient. Four states' disclosure laws require that the communication be made within a specified time frame.

All nine state disclosure statutes require institutions to inform patients that an unanticipated outcome occurred, but none requires disclosure of specific information. One state requires disclosure of the patient's legal rights in certain situations. None requires or even suggests that the institution explain what happened, what impact it will have on the patient's health, or how institutions will follow up on the incident. Thus, an institution could adhere to the letter of the law simply by telling a patient, "The outcome of your surgery was unanticipated."

Discussion

Our research revealed that more than two-thirds of states have apology laws. The majority of such laws protect only the provider's voluntary expression of sympathy to the patient from use by a patient in malpractice litigation. A small number of states also protect explanations of the event or expressions of fault, or both. The definitions and scope of coverage vary in other ways, including requirements for timely communication in two state laws.

Nine states have disclosure laws, most of which require health care facilities to notify patients of events that have caused serious harm. States vary on whether the disclosure receives protection from subsequent use by a plaintiff in malpractice litigation. For the most part, states provide limited, if any, procedural guidance; some states require written—versus oral—communication or timely communication.

LIKELY EFFECTIVENESS OF EXISTING LAWS Our analysis reveals that most of these laws have structural weaknesses that may discourage comprehensive disclosures and apologies and weaken the laws' impact on malpractice suits. Disclosure laws do not require, and most apology laws do not protect, the key information that patients want communicated to them following an unanticipated outcome. Patients view the apology and disclosure processes as inextricably intertwined, seeking not only an expression of sympathy but also information about the

EXHIBIT 2

Characteristics Of State Disclosure Laws

Provision	Number
CONTENT OF COMMUNICATION RECEIVING LEGAL PROTECTION	
Statement of sympathy, explanation, and fault	0
Statement of sympathy and fault	0
Statement of sympathy and explanation	1
Statement of sympathy	0
Statement that an unanticipated outcome occurred	5
None	3[a]
COVERED PARTIES	
Not restricted to health care providers	0
Institutional and individual health care providers	1
Institutional health care providers only	8
TRIGGERING EVENT	
Unanticipated outcomes of medical care	1
Serious unanticipated outcomes of medical care	7
Preventable serious adverse outcomes of medical care	1[b]
Medical errors	0
TIMING OF COMMUNICATION	
No time frame specified	5
Communication must be made within *X* days of discovery	4[c]
FORM OF COMMUNICATION	
May be oral, written, or by conduct	0
May be oral or written (not specified)	6
Must be written	2
Must be oral (if patient is available)	1
Must be both oral and written	0
RECIPIENT OF COMMUNICATION	
Not limited to certain recipients	0
Recipient must be injured patient, family, or representative	9
VOLUNTARINESS	
Communication is mandatory	7
Communication is discretionary	2
INFORMATION REQUIRED TO BE CONVEYED	
Statement that unanticipated outcome occurred	9
Explanation of facts, context of unanticipated outcome	0
Acknowledgment of harm	0
Explanation of impact on treatment plans or health status, or both	0
Explanation of investigation or follow-up done or to be done	0
Explanation of cause of unanticipated outcome	0
Offer of support services	0
Statement of accountability or responsibility	0
Statement of patient's legal rights	1

SOURCE Authors' analysis of LexisNexis and Westlaw searches of state statutes, regulations, and case law, last updated June 18, 2010. **NOTE** $N = 9$. [a]One state (TN) has no explicit statutory protection for patient notification but does provide explicit liability protection for hospitals reporting the same event to the state. [b]This state (NJ) also requires disclosure of adverse events arising from allergic reactions. [c]Range: 24 hours to 7 days (NJ, CA, NV, PA).

nature of the event and why it happened, and how recurrences will be prevented.[1,2,41]

Yet disclosure laws require only a bare-bones statement that an unanticipated outcome occurred. And most apology statutes protect only an expression of sympathy, failing to appreciate the importance of providing additional information to patients.[16]

A related problem is that some disclosure laws do not appear to extend protection to communications about events that occur outside the narrow context specified in the law. Pennsylvania has no apology law. However, the state does protect certain communications under a mandatory disclosure law that requires a health care facility to provide written notification to patients affected by a "serious event."[42] A reasonable interpretation of this law is that a clinician who

orally apologizes to a patient risks having that communication used by a plaintiff as evidence of fault. Physicians may be unaware of such limitations and may mistakenly assume that an entire disclosure conversation is legally protected.

Where legal protections are unclear or perceived to be inadequate, health care workers and facilities might not provide all of the information that patients want about unanticipated outcomes. Merely expressing sympathy without sharing information about an injury's cause and prevention or accepting responsibility may strike patients as insincere,[43] provoking rather than appeasing a potential plaintiff.

Similarly, laws that protect only expressions of sympathy and explanation may make for awkward communications, as it may be difficult to explain an error without discussing the different but closely related issues of responsibility or fault. For these reasons, narrowly crafted disclosure and apology laws might not achieve their objectives of fostering transparency and deterring lawsuits.

Because apology and disclosure statutes are fairly new, it is unclear how they will be interpreted and implemented in practice. For example, in a sympathy-only state, the legal system will have to determine exactly what language constitutes a protected expression of sympathy and what constitutes an unprotected explanation or admission of fault.

Lastly, the impact of mandatory disclosure laws may be limited by the difficulty of enforcing them.[28] To our knowledge, none of the states with disclosure laws has plans to monitor the occurrence or quality of disclosures.

Many of these problems could be resolved by improved statutory design and communication of new legal requirements and protections. But even well-designed laws might not dampen some patients' propensity to file malpractice claims and indeed could stimulate claims.[29] Although a provider's words to a patient may be legally protected, the communication can still alert the patient to a potential legal claim. The legal discovery process can then be used to obtain independent evidence to prove malpractice.

Even a sincere apology might not dissuade some patients from suing, particularly if the injury entails large economic losses and there is no offer of compensation. These considerations do not mean that providing legal protections for disclosures and apologies is valueless, but they should militate against unqualified optimism about the impact of improvements in transparency on malpractice claims.

Determining the effectiveness of these laws will ultimately hinge on future research. As institutions, insurers, and states begin tracking the disclosure and apology process, research projects can assess the real-world impact of different communication and compensation strategies on patient trust and satisfaction, on provider distress and burnout, and on malpractice claims and malpractice insurance premiums.[44–48]

BEST PRACTICES FOR DISCLOSURE AND APOLOGY LAWS Research into patients' needs surrounding unanticipated outcomes of care, the National Quality Forum's recommendations on disclosure, and analysis of existing disclosure and apology laws suggest some recommendations for future statutory design (Exhibit 3).[27,49] Several principles should inform design choices: Disclosure requirements should acknowledge both patients' needs and providers' anxieties about legal risk; disclosure and apology should be considered as an integrated process; and legal protection should be broad, in order to encourage comprehensive disclosures and willingness to accept responsibility for error.

These principles suggest that apology and disclosure laws should be drafted in more expansive terms than most existing statutes. Legal protections should apply to individual as well as institutional health care providers; to both oral and written communications; and to statements of explanation and fault as well as sympathy.

The principles also point toward greater specificity in disclosure laws. Such laws should require the disclosure of all serious unanticipated outcomes and articulate a minimum set of information to be disclosed, beyond a simple statement that an unexpected event occurred. Legislatures should delegate responsibility for specifying the information set to a state agency, so that modifications can be implemented in response to evolving knowledge about best practices without legislative amendment.

Based on current research about patients' needs, disclosures should include what is known about the event's cause, plans for prevention, and available patient support services. Disclosure laws should also provide mechanisms for monitoring disclosures to ensure compliance with the law, such as reporting and audit provisions.

What accounts for the gap between current laws and best practices in provider-patient communication? The language on the books probably reflects political compromises in the legislative process. Some legislatures have been motivated to pass apology laws because of the potential emotional benefit to providers and patients of more-open communication.

The most common rationale, though, has been that apologies could decrease medical malpractice litigation and related costs. State trial law-

EXHIBIT 3

Best-Practice Recommendations For State Disclosure And Apology Laws

Provision	Recommended practice
Protected content	Disclosure and apology laws should be drafted broadly to protect statements that an unanticipated outcome occurred and statements of sympathy, explanation, and fault
Covered parties	Disclosure and apology laws should cover individual and institutional health care providers
Triggering event	Apology laws should apply to statements made in response to any unanticipated outcome; disclosure laws should require disclosure of all unanticipated outcomes
Timing of communication	Apology laws should not limit protection to a specific time frame; disclosure laws should specify a time frame in which communications must be made The time frame should encourage prompt initial disclosures that an unanticipated outcome occurred but should permit additional investigation time before an explanation of the outcome is required
Form of communication	Apology laws should protect oral statements, written statements, and conduct; disclosure laws should require both oral and written notification for serious unanticipated outcomes, but should permit oral communications to suffice for less serious events The statute should provide a definition of a serious unanticipated outcome
Recipient of communication	Disclosure and apology laws should apply only to communications made to the injured patient, his or her family, representative, or friend
Voluntariness[a]	Disclosure laws should mandate communications following unanticipated outcomes
Required content	Disclosure laws should require that the communication include a statement that an unanticipated outcome occurred, an explanation of the facts or context of the event, an acknowledgment of harm, an explanation of the impact on the patient's treatment plans and health status, an explanation of the investigation or follow-up done or to be done, and an offer of support services, where available

SOURCE Authors' analysis. [a]Applicable to disclosure laws only.

yers' associations do not share that goal and have often opposed apology laws, concerned that evidentiary exclusions make it more difficult to bring successful malpractice claims. The limited scope of protection in the laws eventually passed may have been an attempt to accommodate such concerns.

Disclosure laws, on the other hand, have typically been enacted as part of patient safety reform efforts and are frequently paired with provisions that mandate state reporting. We can only speculate, but the lack of specificity about disclosure content may be a response to health care providers' concerns about liability exposure for explanations of the cause of an injury, particularly in states where apology protection is limited or absent.

ALTERNATIVE MECHANISMS FOR ENCOURAGING DISCLOSURE Are apology and disclosure laws a desirable means of fostering transparency in health care? On balance, the answer is yes.

Some experts have argued that the aims of apology and disclosure laws can be more effectively pursued through private initiatives. In particular, health care institutions can implement their own disclosure policies, accompanied by early settlement programs.[50] Although none of the existing institutional programs has yet been studied by external evaluators, program administrators report success in fostering transparency around medical injuries and reducing malpractice litigation costs.[28,48]

These programs show promise, but they are best viewed as complements, rather than alternatives, to apology and disclosure laws. They now exist at only a handful of institutions, and widespread change beyond these early adopters is unlikely in the current legal environment without substantial legislative encouragement. Further, although some programs appear to be flourishing even in the absence of a law, others have benefited from having such legal structures in place.[28] Colorado's comprehensive apology law, for example, has been credited with contributing to the success of the program implemented by COPIC Insurance, which reimburses patients up to $30,000 for "loss of time" and out-of-pocket expenses associated with adverse events, without regard to whether the standard of care was met.[51]

Particularly in programs like COPIC's that extend beyond the walls of a single institution, the legal environment in a state may greatly influence providers' willingness to participate in disclosure, although insurers could promote disclosure by making it a condition of having

an incident covered by malpractice insurance. In contrast, in closed systems such as self-insured academic medical centers, the institution can exert greater leverage over its physicians, and the legal regime may play a secondary role in shaping practices.

States should recognize that advances in disclosure and apology are likely to continue at individual institutions and support institutions committed to transparency. Legislators can also collaborate with other state agencies to support institutional disclosure and apology programs. COPIC, for example, believes that its program's success is linked not only to the state's apology law and tort reforms, but also to close ties with key stakeholders, including the state board of medicine and the state insurance commissioner's office.[51]

Conclusion

Honest communication with patients is a moral imperative.[52] States are to be commended for confronting the serious deficiencies in how patients are currently informed about unanticipated outcomes. Substantial conceptual and practical problems, however, are likely to diminish the effectiveness of existing apology and disclosure laws.

Legislation can be ineffective or even counterproductive if it is drafted too narrowly, if health care providers overestimate the protection it offers, or if the resulting disclosures or apologies are interpreted by patients as insincere. Policy makers and health care providers need to have realistic expectations about what these laws will accomplish. They should not rely on laws as the primary means of changing the culture of communication with patients following unanticipated outcomes. Such culture change is likely to be most effective when it originates from within institutions that develop systems to support health care workers in conducting these difficult conversations.[5]

Practical policy options do exist for state legislators to increase transparency with patients. By understanding the relationship between disclosure and apology; ensuring that broad legal protections for disclosed information are in place; and collaborating with all key stakeholders, including health care institutions, states can support the development, evaluation, and dissemination of effective disclosure and apology programs. ■

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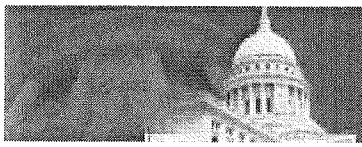

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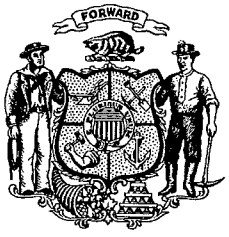

AMERICAN OSTEOPATHIC ASSOCIATION

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August 24, 2011

The Honorable Jeff Stone
Chair, Assembly Committee on Health
Room 314 North
State Capitol
P.O. Box 8953
Madison, WI 53708

Dear Chairman Stone:

The American Osteopathic Association (AOA) is writing to ask you to support AB 147. This bill would reform state law relating to the admissibility of statements by health care providers: making any statement or conduct of a health care provider that expresses apology, benevolence, compassion, condolence, fault, liability, remorse, responsibility, or sympathy to a patient or patient's relative inadmissible as evidence in any civil action or administrative hearing.

The AOA proudly represents its professional family of more than 78,000 osteopathic physicians (DOs); promotes public health; encourages scientific research; serves as the primary certifying body for DOs; is the accrediting agency for osteopathic medical colleges; and has federal authority to accredit hospitals and other health care facilities.

We believe that reforming the medical tort liability system is one of the most pressing issues facing our nation and remain committed to working with states to address this important issue. The current liability system continues to undermine our nation's health care delivery system and adversely affects patient access to care. Unobtainable and unaffordable medical liability insurance forces physicians to limit the services they offer their patients, relocate their practices to states with more favorable medical liability laws, or simply retire. Hospitals are forced to eliminate high-risk departments, trauma centers are forced to close, and teaching hospitals eliminate residency programs.

All of these actions, caused by the medical liability crisis, result in the same outcome: a reduction or loss of access to health care for patients. Medical students, along with interns and residents, increasingly avoid certain specialties due to the higher liability risks they pose. In addition, physicians are gravitating toward states that have reasonable professional liability laws and, subsequently, affordable medical liability insurance rates. In fact, studies have shown that reforms such as caps on noneconomic damages increase the number of physicians per capita by 2.2 percent relative to states without caps.[1] Making statements of apology or compassion inadmissible in civil and administrative actions could similarly attract health care providers to Wisconsin, and increase patient access to health care services.

[1] William E. Encinosa and Fred J. Hellinger, *Have State Caps On Malpractice Awards Increased The Supply Of Physicians?*, HEALTH AFFAIRS, May 31, 2005, at W5-250-W5-W258.

Under current Wisconsin law, evidence of remedial measures taken after an accident, as well as written or oral communications relating to a dispute in mediation, are already inadmissible or subject to discovery in any judicial proceeding or administrative action. The language proposed under AB 147 would ensure that statements of condolences or apologies by health care providers' are provided the same protections as other remedial efforts under current Wisconsin law.

In addition to access to care issues that have arisen from the current tort system, experts agree that costs continue to increase as a result of defensive medicine practices. These actions contribute heavily to our nation's rising health care costs as patients are forced to undergo additional tests and procedures to prevent potential malpractice claims.

The reform contained in AB 147 would facilitate greater provider-patient communication, and have the potential to reduce defensive medicine and the costs associated with this practice. **We urge you to protect access to care for Wisconsin patients by approving AB 147 in committee**. Should you need any additional information, please feel free to contact Nick Schilligo, AOA Director of State Government Affairs, at nschilligo@osteopathic.org or (800) 621-1773 ext. 8185.

Sincerely,

Martin S. Levine, DO, MPH
President, AOA

CC: Ray E. Stowers, DO, President-elect
John W. Becher, Jr., DO, Chair, Dept. of Government Affairs
Joseph A. Giaimo, DO, Chair, Bureau of State Government Affairs
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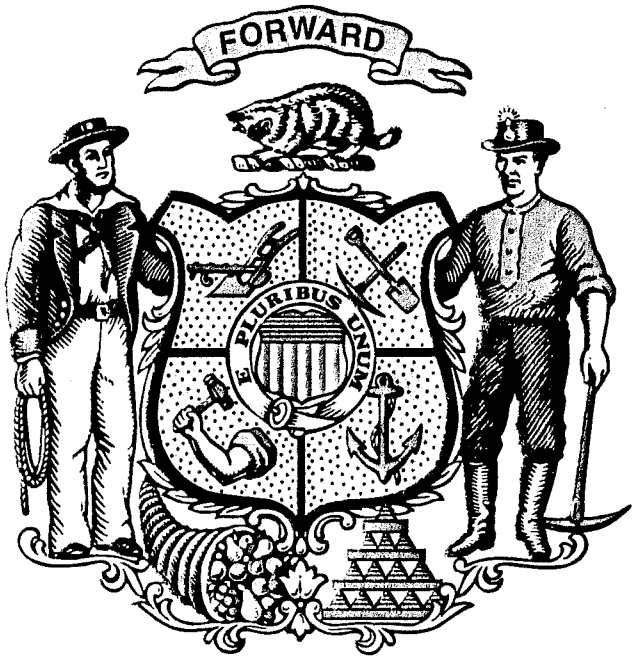
Amy Bolivar, Manager, Executive Projects and Communications


FORWARD
E PLURIBUS UNUM

WISCONSIN ASSOCIATION *for* JUSTICE

PLEASE SUPPORT
Amendment to Assembly Bill 147

Eliminating the words "Fault, Liability & Responsibility"

ISSUE: "I Am Sorry" (AB-147) and Amendment

Encouraging health care providers to openly communicate with their patients, and express apologies and condolences, is something WAJ welcomes because such communications may help build the doctor-patient relationship. But AB-147 goes far beyond that. It would make inadmissible statements and conduct that express fault, liability or responsibility.

The difficulty this creates is seen firsthand in a case where the nurse apologized, buts simultaneously provided factual information about her conduct:

> A child was hospitalized where a breathing tube had to be inserted. The young child kept attempting to pull out the tube. At night the child was left in a bed without restraints, but with special instructions to check on the child throughout the night. When the parents returned to the hospital the next morning, the child was dead with the breathing tube pulled out. The parents started a wrongful death lawsuit. During a deposition of a nurse, she breaks down sobbing that she is sorry but she falsified the medical records. She had altered the record to show she had checked on the child when in fact she had not been in the child's room that night to check on him.

In most states that have "I'm Sorry" legislation, the admission of falsifying medical records would be admissible. However under AB-147 it would be inadmissible. The sad fact is without an admission in this case, the parents probably could never have proven the medical records were falsified.

WAJ believes that oral statements, writings and gestures of regret, sympathy or benevolence because of an unanticipated outcome should be inadmissible. However admissions of fault, liability or responsibility should be admissible.

The words fault, liability and responsibility should be removed from AB-147. Please support the Richard's amendment.

For more information contact:
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