Dr. LeCraw: First I want to say what an honor it is to present before this committee on the house, study committee, and the audience. Because you care so much about the health and wellbeing of your fellow Georgians.

Um, in the first part of my talk, I'm gonna be speaking in my role as a physician who has practiced anesthesia for over 35 years. So let me back up. Let me tell you a story. So Marilee and I, a few years back, were eating lunch and she told me about a time, a lecture she attended by a patient safety expert who presented a case where the, um, the nurse was taking care of an OB patient, had an epidural for labor.

The anesthesiologist had ordered IV antibiotics. She got the solution bag, which looked, you know, looked like IV antibiotics and hooked it up to the IV. A few minutes later she thought, oh my God, could that have been the IV anesthetics, which was supposed to have gone into the epidural IV?

Local anesthetics, or what you use to numb the patients, you give it through the epidural. She was really worried about it because if you give IV antibiotics in an IV, you can kill 'em. So she ran back to the room, but it was too late. The patient was dead. So Marilee said Florence, that happened to my husband, she said her husband's doctor, Fred Grover, who was an OBGYN, she said, fortunately for them, they had an anesthesiologist coming down the hall at the time that the patient arrested. So they were, um, able to resuscitate the patient. So she said, suffered no injury. So I looked at Marilee. I said, Marilee, that happened to me.

I said, same thing. Exact same thing. And I said, um, I, we, fortunately, God bless it, had an angel looking over my patient because another nurse came in to check on something in her room and discovered that, and that the IV anesthetic solution had connected up to the IV. She promptly took it off so there was no injury.

The hospital did an investigation because, you know, this was horrible, super dangerous, a near miss. And what they discover is they have solution administration sets in the hospitals. You can order that, have this bright yellow line down the tubing that is only for epidural solution sets. I mean, it's very distinctive.

So you know, as far as I know, that hospital has never made that mistake again. Now, Marilee's case was in 1998. The case, the patient safety person was in Wisconsin in the early 2000. My case was in Atlanta at another hospital in 2006, 18 year span. Different hospitals, different states. Why is it taking so long for our United States Hospital to correct what could be a simple correction and we have the tubing.

I believe enough is enough. You know, this is horrible. And that is why I'm here today because I think together we can improve this system. It's a, and I will go into why this is such a, been, such a failing system. We don't need to take 18 years to fix something that could be easily fixed the next day.

So now, um, let's talk, okay, what do I do? Right? For my talk today, I'm gonna give you a description of Candor. This program that we, um, think, and we're gonna, I'm gonna be describing, explaining why studies are showing, have demonstrated that Candor is a better way for Georgians, especially those patients who have suffered harm under medical care.

As opposed to what the practice that we've been using in the United States for decades. Um, I'll briefly explain House Bill, Georgia House Bill 807 and, um, and why we believe that passing this bill could help Georgians. And as far as my next, our next steps is we want to be here to answer any questions, you know.

Call us. You know, we can, you know, we've got a lot of experts here, but we have a lot more. We've got tons of papers we can give you, we can bring other people in to talk to you. We want you to make you know, as much as possible, have the most information. We want you to make the best decision based on the most complete information you have.

That is what we're here for. So this is hopefully just the start of our process. So CANDOR stands for Communication and Optimal Resolution Program. In essence, it is an open and candid discussion between the physician hospital and the patient and family about what happened when something went wrong.

When a patient suffered an injury. And they have studies have found that it is a better way to serve patients and their families when something goes wrong.

Now, Georgia House Bill 807, I'm just gonna briefly say we call it a Candor enabling bill. That means it is easier. For the hospital and physicians to use Candor if they want to. They don't have to, but they can. And 600 hospitals in the United States have implemented Candor, and they're not all in states that have done it.

But when teams have gone into hospitals, healthcare systems to see about implementing it, they found it is much easier to do it if there's a Candor law. So that's, and we've got, um, Jean Martin and Karen Lorenzen will be explaining this much more in detail and they're in Colorado, Iowa, and can give the impact of it.

It is extremely important. You realize this is not a tort reform bill. You know, we are not in any way trying to change the litigation process. And since it's a voluntary program, if they want, they don't wanna do it. The patients, their attorneys, they advise, let's not do this, let's go through normal litigation.

That's fine. We will do what makes you comfortable? 'cause this happened to you or your loved one. What do you want to do? Well, we'll do that program and our bill is modeled after Iowa and Colorado's. So, 'cause we have found, um, there's, they, we've gotten good feedback from attorneys and physicians on this.

So we really like this bill. Now why? We have 600 hospitals that implemented Candor, I mean, it's a lot. It can be a lot of work for the hospital to implement and it can cost money. Well, you have to think about why don't they, why don't they use what they've been using for decades? You know, they've already got that down pat.

Because we have now a lot of studies, multiple studies showing that the previous system is not good. In fact, medical liability experts have coined the term, deny, delay, and defend for this process. And the studies now looking at Canor versus comparing it with denied delay and defend have found that Candor fixes the problems that deny delay and defend, have created.

So now, and the reason I say this, let's talk a little bit about Deny Delay Defend's problems. When a physician has an adverse outcome, something bad happens to their patients, we call our attorney and say, this happened. How do we talk to the patient? How can we communicate effectively? And they tell us, don't talk.

Don't talk to your colleagues. Don't talk to your friends, don't talk to the hospital, and definitely do not talk to the patient and family. There is even a clause in, uh, several malpractice insurance carriers saying that if you talk to the family, then, uh, patient without their permission, they don't have to pay your defendant's costs.

I mean, it's a serious issue. And the physicians, it is horrible. You know, we can't talk to our patients. We can't tell 'em what was going on. And this is a huge problem, and I've heard this from other plaintiffs' attorneys too.

Malpractice cases are one of the most expensive. Civil litigation, civil cases to litigate. There is a fixed cost that happens. And so those cases where the patient suffers a milder injury and will not get as much compensation, the attorneys lose money. They, you know, and, and in all fairness to the attorneys, they have bills to pay.

They have to have a roof over their head. You know, I, they, this, a lot of 'em, they can't take the cases. So this results in these patients not being able to get any financial help when they're suffering financial injury because of this, you know, I mean, they may be out of work for a couple of weeks, is they're resting in bed after something.

Or they can't take care of the kids. They have to get childcare help or whatever. And as we all have known, especially with the pandemic, we're seeing a few weeks of lost paycheck can be demon devastating to these people. So that is really, those are the two biggest problems that I see. And there are some more we'll go into, but those are the biggies.

So the CANDOR program, what is it? I just, does everybody have a little handout that we gave? Okay. Or the audience, if audience needs any, somebody to

distribute. Oh, thanks Kay. If you can distribute to those, raise your hand and we'll distribute them to you. It's just an outline explaining this in very simple terms.

Take it home if you wanna look at it. More references on, on the second page. So, or you just feel free to give it to your friends or any colleagues you think may be interested. Okay. Yes. Thank you. Alright, so Candor. Um, so the hospital organizes a reporting system. So they want their medical staff to report any medical error, any, uh, unprofessional behavior, any racism, sexism, anything, to the hospital with, and there can be no fear of reprisal. This is key. And then the hospital has to organize teams to investigate the complaint 'cause, and you've got to have an OR team organizing it because if you're not doing anything about it, they're not gonna report it anymore. So they do this.

And in the meantime, the patient and their family are, um, are notified about the investigation. They're given updates and they're supported during it. Uh, we also, hospitals are, um, create the care for the caregiver program because obviously the patient and their family are devastated. It's horrible. They're injured. No one's talking to them as well, but the physician, the nurse, the pharmacist.

Went into this to help patients and if they've made a mistake. And they've hurt somebody and killed them. That's, that's real hard and devastating for them, and they could use some counseling and help to do this. So now the investigation team has found out what happened and why they meet with the family.

They recommend to the family and patient to have a legal counsel to have an attorney with them to help give them advice. If the team finds out there's a medical error, then they explain what happened. Why it happened and they apologize. They say, we're so sorry this happened. Um, then they describe what they're gonna do, as Sharon said, um, to make sure it doesn't happen again.

They do not want this awful mistake occurring to other families too, and then they offer economic and non-economic compensations. They want to give the patients what they want and need. And the best example I've ever had of a non-economic conversation is a risk management person told me at her hospital they had a really bad error resulting in the death of a little baby. It was horrible. And so when they

had the meeting with them and went through the process and, and they said, what can we do? What can we do to help you? What, what would you know? And they said, talk about it. Think about it. You know, talk to your attorney. You know, you have that rabbi or a minister or family members, and come back and tell us what you want.

So they did. And when they came back they said, we don't want money. We don't want money. That's not going to help us. That's not what we want. What we want you to do is build a memorial garden in the name of our baby so people can come who are suffering as their loved ones are in the hospital and pray or have quiet time, and that is what they did.

So let's say, and it's not uncommon that the team finds no medical errors. Um, the most common is, known complications from a procedure and the surgeon will describe the procedure, the complications that may occur. Nothing's ever a hundred percent and they have to sign that they understand this and do it.

And oftentimes the patients know this, but the complications even worse if they don't do it. So that's why the odds are better if they do it. So they find out that there was no error. So, um, they still support the family 'cause it's still traumatic. The patient's hurt, but there's no offer of compensation because the hospital feels that the nurse, the pharmacist, the physician did not do anything wrong and they should not be held accountable for a known complication.

Okay. Now let's say they've done the Candor process and they can't resolve it. For instance, the patient's family attorney thinks that the investigating team got it wrong and there was an error. There is a definite error. You, you killed my mother or that the compensation that the hospital deemed was fair, they said, no, no, it's not fair.

We should get a lot more. So, and then like they can, the hospital can say, well, they can offer formal mediation if that's what they want. Or they can go, you can litigate, it's whatever you want and you're comfortable with, we will do whatever you want it. It's okay. We're not gonna push you. It's okay.

So now I'm gonna talk to you in my role as a, um, adjunct professor, the end school, um, policy studies at Georgia State University. I'm gonna be talking about the research about some of these, um, studies, looking at the impact of Candor and that, am I doing okay for time? You want me to speed up? These are the, these are the short ones.

Okay. Five minutes. Five minutes. Okay. Alright. Anyway, so this is Candor on the middle. Deny, Delay and Defend impact. In essence, the research teams were looking at various outcomes of the two comparing them. So let me go through this quick. So was there an explanation of what happened? Candor, yes.

Absolutely had to do it. Deny, Delay and Defend? Seldom 'cause we're told not to talk. Was there an apology if the error caused injury? Yes. Candor. You, you have, you're required to, uh, deny, delay, defend. Well, if you're not talking to 'em, how do you apologize? Uh, offer of compensation if the error caused injury.

Again, yes, by definition, uh, compensation. You know, sometimes they'll do it. But you know, if you're not admitting error, that's, it's a little hard for them to offer money, but you know, you'll see it. What about time to resolve the case? And this is from the time of the event to the time to the case resolved, how long it takes.

Deny, Delay, and Defend can take years. We've got studies showing it years, five years or more. Candor. We have several studies have shown dramatic drop in the time to resolve it. It can occur in months or even days, so that's good stress after the event. We briefly touched on that it is so stressful for the patient and their family because no one's talking to 'em, no one's apologizing.

They're not getting any help. It is horrible, but as I said, and, um, Dr. McDonald will go into some more detail. It can be traumatic for us, as, you know, if we've killed that patient and we didn't mean to, I mean, uh, we, uh, he'll, he'll tell you what's happening with us 'cause of, of the horror we have for that.

So what about the relationship between error and compensation? What I'm referring to is if there was an error, was there compensation? If there was no error then was there no compensation In science, we call this the concordance rate.

Studies on Nando say the concordance rate was medium, whereas Candor we found at high.

We looked at that. We looked at all cases where there was an error. They found a hundred percent of the time they offered compensation. Now they found the cases where there was no medical error. Only one time did they give any money. They fought it for over four years. They spent tens of thousands of dollars.

They eventually gave $10,000. And let me tell you, the plaintiff's attorney lost his shit. So I mean, they hold fast now. Healthcare costs. Let's talk about money. We all know that healthcare, we all know that healthcare costs way too much in the United States in 2018. Uh, the average healthcare cost for an individual in the United States with 11,000 a year.

Uh, another study then showed of the 3 trillion that the US spent in healthcare, and this was federal level, state, and individual. Of the 3 trillion, 1 trillion was wasted on healthcare spending. Just think what we could do with a trillion dollars. Our country. So, what does deny delay defend do compared to candor?

And we've got some lovely studies. Dr. Helm's gonna describe this in detail. Delight, de delight, and defend it. Makes it worse, more increased. Spending. Candor appears to make it less. Okay. This is my favorite though. This is the one. As a physician, I just adore patient safety. Deny, delaying the thing, slows it down, improves patient care.

Candor speeds it up. And why is that? And why am I so excited about that? Because in 2000 there was a, um. Uh, landmark Study Institute of Medicine in 2000 to Err as Human, they found an estimated a hundred thousand people a year died from error. So that was the beginning of the patient safety movement in the United States.

Massive patient safety initiatives all over. Well, how successful have they been? Not much. Because the McCarey and his colleagues of Hopkins in 2016 found he, they titled their paper Medical Error, third, leading Cause of Death. Four of a

million people here died from medical error. So we're going, patients saying, what are we doing wrong?

This is not working. What industry has been successful at? At improving safety, and we have some pilots here who could answer that in two seconds. The airline industry. So if you notice on the y axis is aviation, uh, fatalities, um, per air per mile flown. And on the X axis you've got the year, the one on the far left is 1970.

On the far right, 2018. Gorgeous drop. Gorgeous drop. We want that. So the question is how did they do it? What is the root? Because of how they did it. And I can tell you in one word it is the flight recorder is what was really the thing. It's the black box. You know, after a plane goes down, the first thing they do is try to find any survivors.

The next thing, find the black box. Gotta find the black box. What happened? Why did it happen? Let's fix it. The airline industry has been great at realizing their pilots ain't perfect. And they make their systems designed for that. So the pilots don't screw up. Well Deny, Delay, Defend, in essence, they're saying hide it.

Hide that black box. Whereas CANDOR says, find it as soon as possible. We wanna fix it so it doesn't happen the others. We want that that merely case occurred in 1998. We don't, we don't wanna say it again because that's gone out and fixed it and it, that's what we want. So Georgia House Bill 8 0 7 benefits, Georgians it.

We have plenty of studies showing it. We'll be happy to get 'em to you. It will demonstrate, it helps hospitals, physicians and nurses, future patients, all patients in the state of Georgia. But of all the people it benefits. It is the patient and the family who have suffered an injury, they are hurting, and this is what Candor's main goal is.

I'm happy to take any questions if I have time.