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SENATE JOINT RESOLUTION NO. 21

Offered January 14, 2026

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Directing the Joint Commission on Health Care to study options for establishing a non-punitive, protected reporting system for medical errors in the Commonwealth. Report.

Patron—Favola

Referred to Committee on Rules

WHEREAS, the delivery of modern health care is inherently complex, involving intricate systems, advanced technologies, and collaborative human efforts, and such complexity can regrettably lead to unintended medical errors; and

WHEREAS, unintended medical errors are a significant cause of patient morbidity, mortality, and increased health care costs nationwide, and improving patient safety is paramount to the public health and welfare of the citizens of the Commonwealth; and

WHEREAS, studies have shown that a culture of fear of reprisal, including civil litigation and criminal prosecution, can deter health care providers and practitioners from truthfully and promptly reporting errors to institutional patient safety teams or the appropriate health care regulatory body or board; and

WHEREAS, suppressed reporting impedes the ability of hospitals and health care systems to conduct thorough root cause analyses, implement systemic safety improvements, and learn from mistakes, thereby increasing the risk of recurring errors and further patient harm; and

WHEREAS, establishing a protected, non-punitive system for the internal reporting of unintended errors to patient safety teams is essential to fostering a culture of safety, continuous improvement, and ultimately, better patient outcomes; and

WHEREAS, any proposed system must be carefully constructed to ensure that while providers are encouraged to report unintended errors without fear of unjust penalty, such protections do not extend to instances of willful misconduct, intentional patient harm, gross negligence, or malfeasance; and

WHEREAS, it is vital to preserve the rights of patients and victims to receive support, pursue justice in cases of intentional or criminal acts, and ensure the proper administration of justice by the Commonwealth's judicial and law-enforcement entities; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care be directed to study options for establishing a non-punitive, protected reporting system for medical errors in the Commonwealth.

In conducting its study, the Joint Commission on Health Care shall (i) evaluate and report on current practices and any established methodologies for reporting medical errors to determine the current rates of report of unintended medical errors by a health care provider to designated patient safety teams or organizations, or to health care regulatory authorities; (ii) analyze the current potential impacts of reporting unintended medical errors committed by a health care provider providing health care, as those terms are defined in § 8.01-581.1 of the Code of Virginia, including future legal matters alleging criminal liability, impacts to health insurance costs for a health care provider providing health care, potential damage to the reputation of the health care provider or health care facility, medical facility, or other office or location where such health care provider is employed, or negative impacts to such health care provider's licensure as determined by the Department of Health Professions, Board of Medicine, or other regulatory board with the authority to oversee licensure, certification, or regulation of health care providers; (iii) determine the feasibility of establishing a non-punitive, protected reporting system for medical errors committed unintentionally by health care providers providing health care and recommend options for establishing such a reporting system; and (iv) provide a recommendation as to the feasibility of providing immunity from criminal liability in certain situations where an unintended medical error is committed by a health care provider providing health care, and where an injury or death allegedly arises as a result of such act or omission relating to the provision of such health care, but where such act or omission is not determined to be an act of gross negligence or willful misconduct by such health care provider.

All agencies of the Commonwealth shall provide assistance to the Joint Commission on Health Care for this study, upon request.

The Joint Commission on Health Care shall complete its meetings by November 30, 2026, and the chairman shall submit to the Division of Legislative Automated Systems an executive summary of its findings and recommendations no later than the first day of the 2027 Regular Session of the General Assembly. The executive summary shall state whether the Joint Commission on Health Care intends to submit to the General Assembly and the Governor a report of its findings and recommendations for

publication as a House or Senate document. The executive summary and report shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.