THE MONTHLY PUBLICATION FOR CAP MEMBERS

CAPsules®

COOPERATIVE OF AMERICAN PHYSICIANS

Every Vote Mattered – 2019 CAP Ballot and MPT Proxy Results

Thanks to our members' demonstrated dedication to their organization, the governing boards of the Cooperative of American Physicians, Inc. and the Mutual Protection Trust have been elected. On behalf of the Cooperative of American Physicians, we want to extend our gratitude and appreciation to our members during the election cycle.

We know how busy our members are in their daily medical practices. That is why CAP is so fortunate that our physicians greatly value their role in how the CAP enterprise meets the challenge of providing the best services possible. Our members' responsiveness in the election process was simply outstanding.

The following CAP Board of Directors were elected to two-year terms: Sheilah Clayton, MD; Roger S. Eng, Jr., MD; Dennis T. Jordanides, MD; Wayne Kleinman, MD; Gregory Lizer, MD; Graham Purcell, MD; and Paul Weber, MD.

The following MPT Board of Trustees were elected to two-year terms: Othella T. Owens, MD; Stewart L. Shanfield, MD; Charles Steinmann, MD; Lisa Thomsen, MD; and Phillip Unger, MD. (Earlier in July, the MPT Board of Trustees elected Dr. Thomsen to fill the vacancy on the board caused by the June 30 retirement of Dr. Mearl Naponic.)

Together, CAP will continue its efforts to make our members' practices the best they can be.

MPT Agreement Amendments Approved

By the vote of the membership on July 25, 2019, the Mutual Protection Agreement has been amended.

Part 1, Section 4.A of the MPT Agreement has been amended to explain that MPT will exclude coverage for a claim when any Covered Person or Worker (as defined in the MPT Agreement) improperly alters a medical record.

Part 1, Sections 4.B and 5.C of the MPT Agreement have been amended to reinforce MPT's claims-payment exclusion should a Member or Covered Entity be sued as a party allegedly responsible for the sexual, illegal, or other unlawful acts of another.

Part 2, Section 1 of the MPT Agreement has been amended to modify the process for the nomination of candidates to the MPT Board of Trustees.

The full version of the MPT Agreement is available to members by logging in at www.CAPphysicians.com and clicking on "Member Documents." A physical copy of the MPT Agreement is available to members by contacting CAP at communications@CAPphysicians.com.

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Risk Management and Patient Safety News

Chaperones in Your Medical Practice

by Catherine Miller JD, RN

The sexual abuse scandals of the past decades and the current #MeToo movement have exposed unthinkable acts of abuse at the hands of our most trusted professionals and public figures. The sheer volume of these cases and the wake of destruction caused by even a single "bad actor" woke the public to the uncomfortable truth that sexual harassment/abuse is pervasive and tends to flourish where there is a distinct power differential between the perpetrator and the victim: employer-employee, professor-student, coach-player, clergy-parishioner, physician-patient.

And yes, now the spotlight is on medicine. Recent accusations of sexual acts against physicians have alerted the public to the need for increased vigilance. Patients are now empowered to speak up and are inclined to complain to law enforcement and medical licensing boards when they feel that boundaries have been breached, rights have been violated, or whenever something just doesn't feel quite right.

The physician-patient relationship is strengthened when physicians respect the patient's need for modesty and privacy, when they care enough to educate the patient on the nature of sensitive procedures before performing them, and by using chaperones when conducting intimate physical exams.

Tips on Promoting Privacy and Using Chaperones in Your Practice

- A chaperone is encouraged for all exams of an intimate nature including genital, rectal, breast, and full-body skin exams.
- Chaperones exist for the mutual protection and comfort of the physician and the patient.
- Family and friends should not serve as chaperones nor should physicians assume that patients wish to have a family member present during a sensitive physical exam. While family may remain in the room per patient request, an additional chaperone who is not a family member should also be present.
- Be sensitive to the patient's need for modesty by allowing the patient to disrobe and dress in private. Provide gowns and drapes for comfort. Knock and request permission before entering the exam room.
- Consider that the details of a pelvic or breast exam may be completely unfamiliar to your patient. Explain what it is you plan to do, why you're doing it, and what the patient is likely to feel before you begin! This shows respect for the patient and helps prevent shock or surprise.
- Refrain from making any comment that could be construed as sexually provocative. This includes complimenting the patient on his or her physical appearance, discussing intimate subjects such as dating or relationship status, or using epithets or terms of endearment such as "honey," "sweetie," or "darling," etc.
- Examinations of pediatric patients may require additional education, discussions, awareness, and sensitivity.

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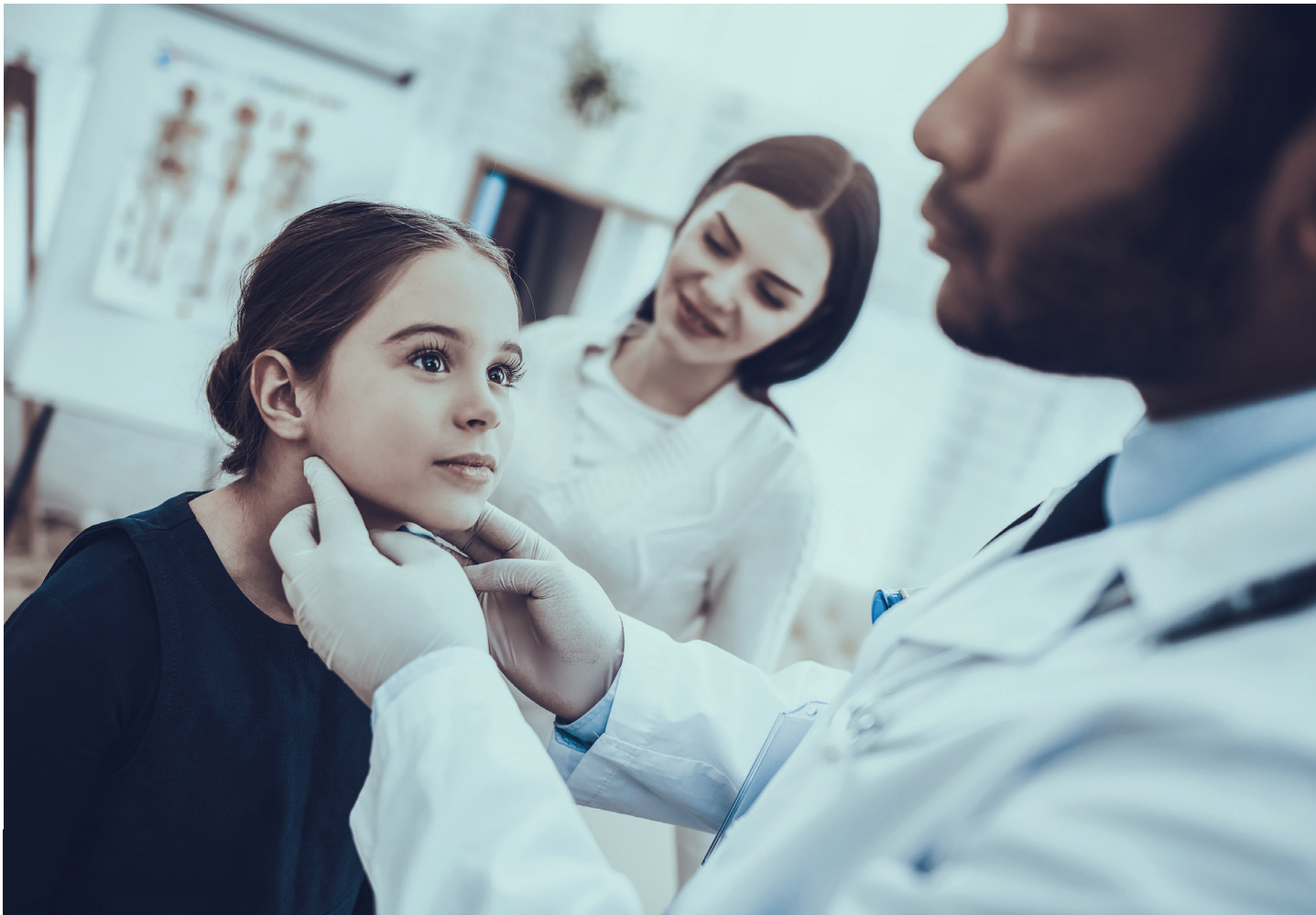
- Physicians should be sensitive to their patients' need for confidential communication. The presence of a chaperone should be limited to the duration of the physical exam to allow time for private discussion.
- Document the name of the chaperone and anyone else in attendance and indicate that he or she was present throughout the entire exam.
- Be aware of your own feelings. Physicians who develop romantic feelings for a patient should consult the AMA or medical licensing board guidelines for discontinuing the physician-patient relationship.
A romantic relationship with a patient is a breach of professional ethics even when the relationship is consensual.
- Develop an office policy for the use of chaperones including situations where chaperones are required, accommodation of the patient's request for a chaperone, and documentation requirements. The policy should apply to both male and female physicians.
- When patients first visit your office, inform them of the use of chaperones and chaperoned exams.

While a "few bad apples" certainly won't erode the respect and trust we place in our healthcare providers, medical professionals are well-advised to exercise sensitivity and caution when conducting intimate physical exams and are encouraged to observe the basic rules of etiquette and professionalism when interacting with patients.

Catherine Miller is a Senior Risk Management Specialist for CAPAssurance and for Risk Assessment Peer Review, MPT. Questions or comments about this article may be sent to cmiller@CAPphysicians.com.



The Importance of Protecting Your Assets

From having excellent malpractice coverage to remaining compliant with strict regulations, CAP members are well-versed in protecting themselves from the potential liabilities associated with practicing medicine. However, even outside of the clinical setting, physicians still run the risk of being sued because of the common perception that they have "deep pockets."

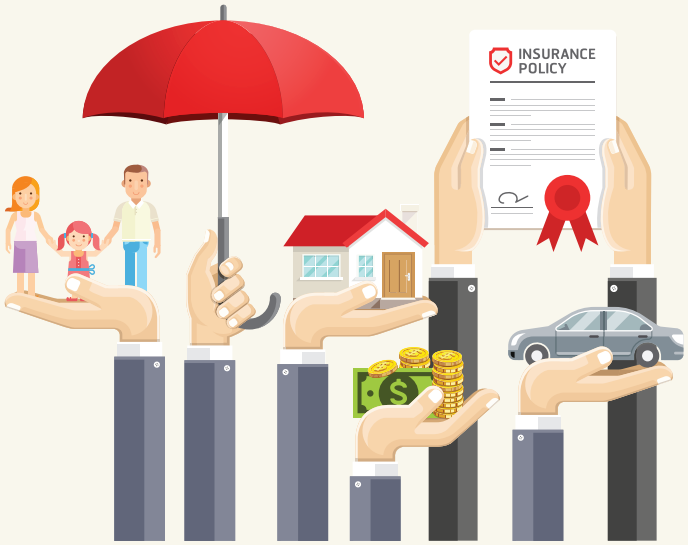
If you are ever found liable for unfortunate accidents resulting in damages that exceed the limits of your existing personal insurance policies, you could face catastrophic financial loss. Physicians should consider purchasing a personal umbrella insurance policy, an often overlooked yet very important and affordable piece of coverage that supplements the basic liability coverages provided by your home and auto insurance.

Chances are you and your family members like to engage in regular activities and hobbies where accidents can occur. If you frequently entertain guests, someone could injure himself or herself on your property. Your dog could bite a passerby during your daily walk. You could be sued for slander or defamation if your family members like to post online reviews. Or, if you enjoy playing sports, you could end up accidentally hurting another player.

Most of us do not like to think about the "what ifs," but bad luck can strike at any time and inadequate liability insurance coverage can prove to be financially devastating.

You may think that your current homeowners, automobile, and other property policies already offer enough protection. However, without a personal umbrella liability policy, any claim that is greater than your current coverage limits could wreak havoc on your financial assets or negatively impact your future earnings if you do not have enough to pay the balance of the damages.

While significant assets do require more coverage, the fact is, a personal umbrella policy can protect both



individuals with amassed wealth and those who are building their portfolio.

As a CAP member, you can purchase a personal umbrella policy that provides $3 million in excess liability coverage for just $675 per year through CAP Physicians Insurance Agency (CAP Agency).* Additional limits are available for purchase for up to $10 million in excess liability coverage. CAP's personal umbrella coverage also includes, at no additional cost, $1 million dollars in uninsured and underinsured motorist coverage. No underwriting is required.

To enroll, please visit: https://capgpel.integrogroup.com. If you would like to learn more, please contact CAP Agency at CAPAgency@CAPphysicians.com or at 800-819-0061.

*Existing policies must meet the minimum requirements to be eligible to purchase an umbrella policy.

Underlying primary insurance requirements apply. Annual premiums are prorated depending on enrollment date. Policy will renew on January 1 of the next calendar year. Premiums are subject to rate increases.

CAP PHYSICIANS INSURANCE®
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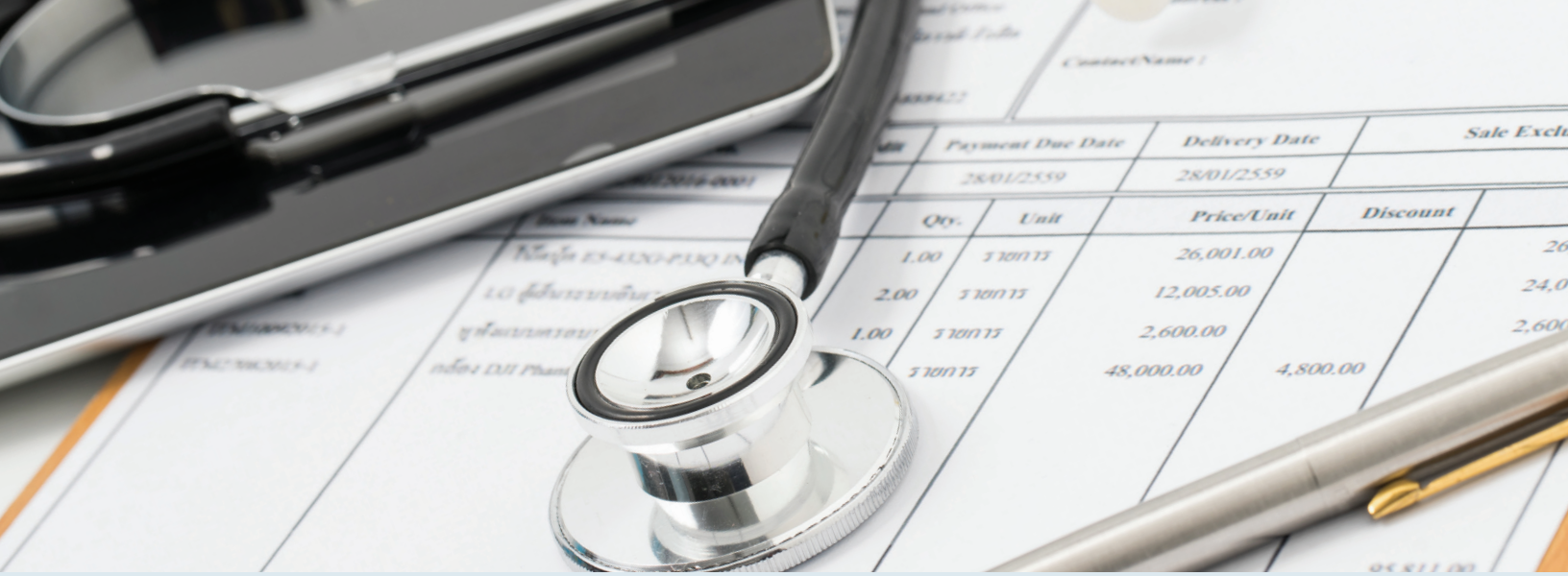

Federal Momentum Gathers to Address "Surprise" Medical Bills

by Gabriela Villanueva

The topic of "surprise" medical bills has been gaining traction with federal legislators even as some states have begun to pass their own laws intended to protect patients from the financial challenges these bills can create. Several members of Congress are taking on the issue, including U.S. Senator (and physician) Bill Cassidy (R-LA), who has introduced language in the Senate Health Committee, and U.S Representative (an emergency room physician) Raul Ruiz (D-CA), who has crafted an approach in the House of Representatives. Surprise billing is seen as one of the few areas in healthcare where more action can be taken this year on a bipartisan basis.

California itself passed a bill in 2016 forbidding balance billing for out-of-network care at in-network facilities. That law took effect on July 1, 2017.

There is wide agreement among both Democratic and Republican legislators that patients should not be left with an unexpected bill, especially when the patient is complying with his or her insurer's requirements and accessing services within network. But a large point of contention is how to craft bill language that will not create a greater advantage for one stakeholder over the other when it comes to provider payments and a process to settle disputed claims. Those stakeholders are the hospitals, providers, and insurers.

While the insurers would prefer Congress to set reimbursement rates, something the Senate Health Committee proposes with a cap (benchmark payments) on providers, hospitals and providers are advocating for an independent dispute mediation process. The mediation approach is included in the approach by Congressman Ruiz.

Back in March, Ruiz, along with his Republican colleague, Congressman and physician Larry Bucshon (R-IN), began the work of outlining a bipartisan legislative proposal titled "Protecting People from Surprise Medical Bills." That proposal was introduced to the House on June 28 as H.R. 3502 and at the time of introduction included the cosponsorship of 40 other House members (18 Democrats and 22 Republicans).

A few days before H.R. 3205 was introduced, CAP member James Strebig, MD, joined CAP's federal lobbyist and CAP's public affairs staff to visit with the legislative directors of multiple members of California's Congressional Representatives – and of its two U.S. Senators – in Washington D.C., to speak in support of the balanced approach taken by H.R. 3205.

Gabriela Villanueva is CAP's Public Affairs Analyst. Questions or comments related to this article should be directed to gvillanueva@CAPphysicians.com.

Public Policy

Orange County Members: Register Now for the Next Litigation Education Retreat

Whether you are in the middle of a medical professional liability lawsuit or are still feeling the effects of a past event, CAP's Litigation Education Retreat can provide valuable support and guidance. During this daylong, interactive event, you will learn techniques to help you secure the most favorable litigation result and alleviate the anxiety that most physicians experience during this exceptionally stressful time.

This event is free to CAP members and spouses are very welcome. CAP, a CME-accredited provider, designates this educational activity for a maximum of six AMA PRA Category 1 Credit(s)™.

The next Litigation Education Retreat in Orange County is on **Saturday, October 19.** If you are interested in attending one of the retreats, please contact **Andrea Crum** at **800-252-7706** or at **LERinfo@CAPphysicians.com**.

Save the Date for 2020!

CAP will also offer Litigation Education Retreats in Los Angeles on May 2, 2020 and in Orange County on October 17, 2020.

Register Now for CAP's Inaugural Public Affairs Symposium

Join us and your fellow CAP members for a morning of stimulating conversation on government policy trends and concerns. At the event, an esteemed panel of experts will cut through the political rhetoric to discuss the most pressing issues at both the state and federal level.

Get the inside track on potential threats facing California's Medical Injury Compensation Act (MICRA) from special guest Lisa Maas, Executive Director, Californians Allied for Patient Protection (CAPP). Hear from CAP's political advisors on state and federal campaigns for 2020 and the effects of California moving up its primary election to March.

Date: **Saturday, September 7, 2019**

Time: **9:00 a.m. – 12:00 p.m.**

Location: **333 S. Hope St., Los Angeles, CA 90071**

This event is free for CAP members and you are welcome to invite a colleague. Breakfast will be served and complimentary self-parking will be available to members. Not only will you gain a deeper understanding of CAP's advocacy efforts, you will learn how you can become involved. To register, please email PACinfo@CAPphysicians.com or call 213-473-8762.

Update Your Membership Information to Help with Your Year-End Planning

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If you are contemplating a change in your practice, please notify CAP as soon as possible so our Membership Services Department can review your options with you and make your coverage transition a smooth one. Changes include, but are not limited to:

- Retirement from practice at age 55+
- Part-time practice
- Reduction or change in the scope of your practice
- Employment with a government agency or non-private practice setting
- Employment with an HMO or other self-insured organization
- Joining a practice insured by another carrier
- Moving out of state
- Termination of membership

The Board of Trustees of the Mutual Protection Trust will levy an assessment in November 2019. To allow ample processing time, we recommend that members advise us in writing no later than October 31, 2019, of any of the above changes to be considered eligible for waiver or proration of the next assessment.

The online Membership Information Update form will be available soon in the Members' Area of the CAP website at www.CAPphysicians.com. Members will be notified via email when the form goes live, so keep an eye on your inbox.

If you have not yet registered for the Member's Area, please register for an account at https://member.CAPphysicians.com/register. You will need your member number and last four digits of your Social Security number.

Request a Risk Management Onsite Practice Survey

A proactive risk management system is important to prevent and mitigate risk, but it's only effective if all physicians and staff are trained on the concepts and understand how to implement patient safety strategies. CAP members can request for a senior risk manager to visit his or her practice to provide specific recommendations on how to reduce risk and keep patients safe.

One of our senior risk managers will visit the member's practice to understand the current procedures in areas such as documentation, EHR, medical record review, medication management, and much more.

To request an onsite visit from a senior risk manager, please fill out the Risk Management Onsite Practice Survey Form at https://www.CAPphysicians.com/risk-management/risk-reduction

Case of the Month

by Gordon Ownby

Indirect Communications and a Rare Situation Need Special Attention

Some communications among a patient's healthcare team may not be as direct as one would prefer, but they may still trigger a duty on the recipient to follow up.

Dr. P, a general pediatrician, was called to attend a vaginal delivery of a newborn with a history of three fetal transfusion surgeries. Dr. P ordered for his newborn patient a transcutaneous bilirubin test and when that test revealed hyperbilirubinemia, Dr. P ordered phototherapy. An initial screening report from the California Department of Public Health Newborn Screening Program on blood collected at 25 hours included results consistent with carnitine transporter deficiency. As to hemoglobin, however, the report noted that "because of transfusion, no interpretation is possible" and that "further testing on whole blood is recommended to rule out hemoglobinopathies. Call your Newborn Screening Coordinator for assistance. . . ."

The fetus had started receiving the transfusions at 29 weeks for moderate to severe anemia secondary to Rh(D) and Rh(C) alloimmunization. Under the care of a fetal surgery specialist associated with a regional maternal fetal health institute, the fetal hemoglobin was 6.9 prior to the first transfusion, converting to 14.2 post transfusion. Two further transfusions showed changes from 8.4 to 15.1 and from 8.7 to 15.9. The specialist recommended that a neonatology team be prepared for an immediate transfusion at delivery. No transfusion was noted in the records, though the umbilical cord was milked to give the baby as much blood as possible.

A hemogram drawn at two days of age showed hemoglobin of 16.7 and hematocrit of 46.6. That report, however, included no warning on transfusion issues. Though the in utero blood transfusions had been noted in the baby's admission history as a risk factor, Dr. P's discharge did not address anemia follow-up. The discharge documentation carried the hemogram values from the baby's second day.

At the baby's office visit the next day, Dr. P noted that his patient had received intrauterine blood transfusions and had been jaundiced at the hospital. His physical exam of the patient that day was normal, as was the parents' report on their child's activity. Dr. P noted the possible carnitine transporter issue and advised the parents to return in one week – or sooner if the baby showed a change in behavior. Dr. P also noted the need for the baby to see a metabolic geneticist for additional testing. Bilirubin tests ordered that day came back normal.

In a letter three days later to Dr. P from a university newborn screening program confirming metabolic screening for the baby, the program coordinator went on to state that since the initial hemoglobin pattern after a transfusion is not interpretable, optional follow-up testing is available through the program. The letter explained that "1 cc of whole blood is required to do white blood cell DNA analysis to determine the presence/absence of hemoglobinopathies. Please let me know if you would like to complete this follow-up testing. There

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is no charge to complete this test." Enclosed with the letter was a pamphlet titled "Why Does My Baby Need More Testing for Metabolic Diseases?" Another handout, titled "FAQs about Newborn Screening and Transfusion Follow-Up," explained that after a transfusion of packed red blood cells, the hemoglobin test pattern is not valid because the donor's blood cells mask the hemoglobin results for the newborn. A fax cover sheet included a question about whether Dr. P was interested in following up on the transfusion matter.

At the one-week follow-up visit by the parents and baby, Dr. P's examination and review of the baby's development were all normal. Carnitine labs delivered the next day were mostly normal and by one week later, carnitine tests were all within normal limits.

At the baby's one-month visit, Dr. P noted the patient's history of possible carnitine deficiency and his examination showed a normal baby. A few days later, Dr. P received a fax advising him that the physician overseeing the carnitine issue had resolved the case as having no screenable metabolic condition.

Later that month, however, while being fed by her mother, the baby started coughing, turned blue, and stopped breathing. At the ER, the baby was noted to have pancytopenia with a white blood count of 1.1, hemoglobin of 1.5, and platelets of 7. She received packed red blood cells during transport to a specialized hospital, but intervention there failed to improve on her "incredibly poor prognosis." The baby died after the decision was made to remove her from CPR.

A subsequent lawsuit by the baby's parents alleged that given his knowledge of the intrauterine transfusions for anemia following alloimmunization, Dr. P should have referred the baby to a specialist or monitored the patient himself for signs of anemia requiring treatment. Dr. P resolved the lawsuit informally.

The record shows Dr. P aggressively addressing the patient's bilirubin issues and carefully monitoring her carnitine course. But they also show no targeted inquiry into hemoglobin patterns after discharge or investigation into the risks alloimmunization may have had on the baby's ability to produce healthy blood.

Granted, the patient's history presented a very rare set of circumstances for Dr. P and no one chose to call him to talk through the anemia issues directly. The documented warnings on suspect hemoglobin patterns and the written invitations for assistance, however, would likely have had a strong influence on a jury.

Gordon Ownby is CAP's General Counsel. Questions or comments related to "Case of the Month" should be directed to gownby@CAPphysicians.com.

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