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COOPERATIVE OF AMERICAN PHYSICIANS

August 2021

Passing the Torch

CAP Celebrates Long-Time COO's Success as Retirement is Announced; Promotes Hammon Acuna and Alyson Lewis to Serve in Key Executive Leadership Roles

Hammon Acuna

Chief Operating Officer of the Cooperative of American Physicians (CAP)

Alyson Lewis, JD, CPCU

President and Chief Operating Officer of the Cooperative of American Physicians Insurance Company, Inc. (CAPIC)

After two successful decades, Cindy Belcher has retired and stepped down as CAP's esteemed Chief Operating Officer.

Ms. Belcher's achievements will have a lasting impact throughout the CAP enterprise. She played a pivotal role in evolving CAP's membership development, membership services, and practice management services functions and in developing the company's marketing and communications, underwriting, and human resources departments. She also held executive management responsibility for CAP Physicians Insurance Agency, Inc., which supplies a full line of insurance products beyond the company's professional liability protection to CAP's 12,000 members, and for CAPAssurance, a Risk Purchasing Group, that brings CAP's unique approach to medical professional liability coverage to large groups, hospitals, and healthcare facilities.

As one era in exceptional leadership ends, a new one begins. CAP is pleased to welcome Hammon Acuna as CAP's new Chief Operating Officer and Alyson Lewis, JD, CPCU, as President and Chief Operating Officer

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of the Cooperative of American Physicians Insurance Company, Inc. (CAPIC), a Hawaii-domiciled subsidiary of CAP that is rated A- (Excellent) by A.M. Best.

Having joined CAP in 2007, Mr. Acuna brings to his new role a proven track record of 30-plus years in the medical professional liability industry, with a wide range of expertise in marketing, sales, retention, and customer/member service. He has been managing all CAP business development and membership services functions since 2015 and most recently served as CAP's Senior Vice President and Chief Membership Officer. He holds a BA from the University of California, Santa Cruz, and studied in the MBA program at California State University, Northridge.

Ms. Lewis joined CAP in 2016 as Senior Vice President and Chief Underwriting Officer. She will continue to be responsible for overseeing the underwriting functions of the entire CAP enterprise and will now assume full executive responsibility for all CAPAssurance business development, along with ascending to her new role as CAPIC President and COO. Ms. Lewis earned her BA at the University of Southern California and her JD from Concord Law School.

Among CAP's greatest assets are the committed executive leaders who work in tandem with our physician governing bodies to strengthen the future of the enterprise and serve the needs of our members, their practices, and their patients. As we celebrate and honor Ms. Belcher for her excellence in leadership, we are ever grateful for her significant contributions; one of which includes passing the torch to Mr. Acuna and Ms. Lewis, whose skill sets and deep knowledge of the medical professional liability industry will ensure CAP's continued success.

Informed Consent Best Practices – How to Minimize Risk

by Cynthia Mayhan, RN, BSN, PHN

What Is Informed Consent?

When we hear the term "informed consent," we often automatically think of an informed consent form; however, that is but one element of the informed consent process. Informed consent is a critical process in which detailed communication between the physician and patient allows the patient to collect enough information to help him or her consent or decline a recommended treatment or procedure. This process is then memorialized through documentation in the medical record as well as by the patient/patient representative's signature on the informed consent form.

Why Is This Important?

According to the California Medical Association (CMA), it is well established under common law that a competent patient/patient representative has the right to the following:

1. To make their own medical care decisions about their body.
2. Be provided enough information to make their consent meaningful.
3. To consent or reject any proposed treatment or procedure.

When a physician fails to obtain proper consent prior to initiating a treatment/procedure in which consent is required, this may constitute battery and/or negligence. This can also be true if the provider exceeds the scope of the consent after it is obtained or if it is determined that the physician failed to provide the patient with enough information, such as significant risks or possible complications.

Case Study: A 17-year-old patient requested a tubal ligation following the birth of her first child; however, her OB/GYN, Dr. OB, who had been her physician since birth, declined. Instead he advised that if she still wanted it at age 21, he would perform it at that time. Once she turned 21, she did in fact return and Dr. OB agreed at that time. In early fall, Dr. OB performed a bilateral tubal ligation without complication. Unfortunately, five months later, the patient returned with a positive pregnancy test, but ultimately suffered a spontaneous miscarriage.

In this case, it was determined that Dr. OB failed to advise the patient that while tubal ligation is an effective means of sterilization, there still exists a possibility of failure. This case was settled.

Required Elements of Informed Consent

What elements must be included during the informed consent discussion? According to the CMA, the following information must be disclosed in order to satisfy the informed consent requirements:

- Explanation of the nature and purpose of the proposed treatment.
- The risks, complications, and expected benefits of the recommended treatment, including the likelihood of success or failure.

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- Any alternatives to the recommended treatment and their risks and benefits.
- The risks and benefits of declining the proposed treatment.

Mitigation/Risk Strategies

To avoid the allegations that are associated with improper or incomplete consent, we recommend the following strategies be considered:

- For planned procedures, do not wait to obtain consent on the day of the procedure. The informed consent process should begin as early as two weeks prior to the planned procedure, preferably in the provider's office setting. This allows enough time for the patient and physician to have a detailed discussion and to answer all the patient's questions in a stress-free setting as opposed to a pre-op holding area.
- Thoroughly document the informed consent discussion, being sure to include all the previously mentioned elements. Also be sure to include any pertinent questions that the patient had and what answer was provided.
- Don't just rely on the language in a standardized or general consent form. Your documentation of the informed consent conversation and the potential risks should be specific to the procedure being performed.
- Ensure that the copy of the signed consent form is placed in the patient's medical record and a copy in the hospital record as well if the procedure takes place in a hospital setting.
- Stay within the scope of the procedure noted on the signed consent form. Outside of an emergent life-threatening occurrence that would require the physician to take immediate life-saving measures, do not be tempted to "fix other problems" you might encounter intraoperatively. For example, if the patient consented to an appendectomy and during the operative course an ovarian cyst is also discovered, it would serve the surgeon well to leave it alone and inform the patient post-operatively. If something is identified that would be better served to be addressed at the time, the best practice is to consult family member(s) or a patient representative for consent.

Summary

Implementation of the recommendations above will not only help the physician should the patient later allege that he or she was not warned of the risks, but it will also allow the physician to ensure that the patient's expectations are reasonable.

Cynthia Mayhan is a Senior Risk Manager and Patient Safety Specialist for CAP. Questions or comments related to this article should be directed to CMayhan@CAPphysicians.com.

Sources

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R-E-S-P-E-C-T Between the Patient and Physician

by Gwen C. Spence, MBA

In her hit song, Aretha Franklin said, "R-E-S-P-E-C-T, find out what it means to me;" however, we have come to a time in our society when many of us do not know and understand the meaning of respect. According to *Definitions from Oxford Languages*, respect is "due regard for the feelings, wishes, rights, or traditions of others."

Patients and Respect

The question of respect bleeds into the discussion of the practice of medicine. Things have changed since Dr. Marcus Welby and Dr. Ben Casey ruled prime time television. The solo physician is not the only game in town anymore. Technology has given patients the gift of choice and the power to make their own decisions. Patients are now consumers with the ability to choose their medical providers and the type of desired care. Technology has had a huge impact on patient expectations and demands. The manner in which the doctor is approached can be troubling.

One study found that doctors are likely to make more diagnostic errors when dealing with a disrespectful patient than a neutral patient. In order to maintain medical services with quality and safety in mind and to avoid future untoward malpractice claims, doctors must take steps to manage the patient.

In his book, *Clinical Methods*, Steven A. Cohen-Cole suggests a three-function model to deal with difficult or disrespectful patients:

Changing the patient's behavior. If a patient is disrespectful by exhibiting rude behavior to the staff, arriving late for appointments on a consistent basis, or not showing up for appointment times, these issues can be met by advising the individual of "patient policies." A discussion with each new patient will confirm requirements as it pertains to visit etiquette. Usually this interaction helps to promote better behavior.

Gathering information to find the source of the issue. Communication is important. One never knows what an individual's motivations or issues are unless a meaningful conversation occurs to unravel the mystery. Patients want to be heard. This exchange can open an opportunity for trust and garner a mutual respect between the patients and the doctor.

Dealing with the patient's emotions. The important thing to remember is that bad behavior on the part of the patient shouldn't be met by retaliation or frustration in return. It is natural for the doctor or staff to feel defensive in return, but instead it is helpful to acknowledge the patient's frustration and work out a plan to come to a mutual agreement regarding the issue.

Physicians and Respect

When Hippocrates (460-370, BC) penned his famous oath, he established principles ensuring that doctors practiced medicine with the highest of standards and respect in mind.

- Maintain a positive attitude toward the dignity and value of others
- Remain nonjudgmental toward diversity and the uniqueness of others
- Ensure patient autonomy
- Pay attention to codes of conduct
- Maintain confidentiality and privacy

The benefits of mutual respect between the patient and the physician are many.

Communication garners trust. This trust allows the patient and doctor to work together to come to agreements that will result in maximum medical improvement.

Positive satisfaction surveys occur as a direct result of excellent outcomes due to open communication and collaborative approaches to treatment plans.

Patients who enjoy a positive experience with their physicians refer their friends. Now, the doctor has become the "provider of choice" and likely to benefit by

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welcoming many new patients.

When there exists open communication and trust between a physician and patient, even if there was an untoward error or miscommunication that resulted in a negative outcome, the patient is less likely to file a complaint or lawsuit.

"So, it goes both ways. Medical providers and patients must work together in a climate of mutual respect, with the patient being on an equal playing field with the provider," says Keith Carlson, RN, BSN, NC-BC: *Inspirations from Nurse Keith.*

Gwen Spence is Assistant Vice President, Membership Services for CAP. Questions or comments related to this article should be directed to GSpence@CAPphysicians.com.

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

If you are considering a change in your practice this year or in 2022, 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 (e.g., 20 or fewer hours per week or 16 hours for anesthesiologists)
- Reduction or *any* change in the scope of your practice
- Employment with a government agency or nonprivate 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 2021. To allow ample processing time, we recommend that members advise us in writing no later than October 31, 2021, of any of the above changes to be considered eligible for waiver or proration of the next assessment.

The online Coverage 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.

Public Policy

California's Budget – When There's Too Much of a Good Thing

by Gabriela Villanueva

The state's budget for fiscal year 2021-2022, which began on July 1, amounts to $262.6 billion. Unprecedented by a $76 billion state surplus and $27 billion in federal aid, the record-busting budget reflects new agreements between state legislators and Governor Newsom.

The windfall of funds came into state coffers primarily from California's progressive tax model on its top earners (i.e., tech companies), professionals who were able to continue working during the state's COVID-19 closures, and a surging stock market. And while the news of a surplus is welcomed by all, it complicates a process in which stakeholders must balance any new commitments with what can be sustained down the road.

Following a state constitutional mandate to "pass" a budget by June 15 to enable lawmakers to keep getting paid, what initially got passed was a bevy of placeholder bills populated with trailer language describing the legislative intent for each bill. Even with the enormity of this year's budget dollars — or because of it — the placeholders were necessary to give time for lawmakers and the Governor to negotiate their priorities and reach agreements on spending levels.

Aiming to address some of the most urgent challenges facing the state, such as preventing wildfires, alleviating drought-induced challenges, and mitigating dangers posed by climate change, the budget also includes a big expansion in healthcare.

Of significance during this budget cycle is the Democrats' years-long effort to allow unauthorized immigrants to participate in the state-funded healthcare program for low-income residents. Toward that end, lawmakers agreed to offer expanded Medi-Cal health insurance coverage to undocumented residents age 50 and older. Previous budgets have opened the program to undocumented children, followed by young adults as old as 26. This will make California the first state in the nation to provide government health insurance to undocumented immigrants at age 50. This moves California another step toward universal healthcare. Will it hold? Time and future budgets will tell.

As the pandemic has colored almost every situation, so it has the state budget negotiations. As local public health departments have come under enormous stress throughout the pandemic, lawmakers proposed at least $200 million of surplus funds go to annual new funding for these departments and agencies. The extra money would go toward hiring more public health workers, buying new equipment, and modernizing computer systems.

Gabriela Villanueva is CAP's Government & External Affairs Specialist. Questions or comments related to this article should be directed to GVillanueva@CAPphysicians.com.

Save the Date

CAP's 3rd Annual Public Affairs Symposium

Date: **Wednesday, September 22, 2021**

Time: **Noon-1:30 p.m.**

Registration Details Coming Soon

The physician members of the Cooperative of American Physicians have a long tradition of participating in public policy activities relating to their ability to care for patients. We invite you to join our panel of policy and political experts during CAP's 3rd Annual Public Affairs Symposium, held virtually, to discuss today's most pressing healthcare issues being debated in Sacramento and Washington, D.C.

Ransomware Criminals Now Using Triple Extortion Tactics

Cyber extortion tactics are ever evolving and becoming increasingly egregious. Hackers are finding new sophisticated ways to hold data, website, computer systems, or other sensitive information hostage until you meet their demands for payment, which if not satisfied, can result in devastating and costly damage to the business owner. Medical practices continue to be increasingly vulnerable targets. Cyber criminals recognize the value of confidential and protected patient data and are now doubling and even tripling their efforts to take advantage of healthcare organizations.

Ransomware criminals have used double extortion tactics since late 2019. One widely used approach is to decrypt data stored on local servers, computers, and other devices while another is to threaten to publicly leak stolen data. Both tactics are working. Last year, more than 1,000 companies found that their data was leaked after they refused to pay the requested ransoms.

Criminals are now upping their game to three levels of extortion

What is now becoming the third popular extortion tactic? Targeting individuals whose data has been stolen in the attack. In some instances, these individuals are issued a demand to prevent their personal data from being sold or put in the public domain. This third extortion tactic is particularly popular in the healthcare world where sensitive health information is the subject of the threat.

This triple tactic started in late 2020 and has gained traction in 2021, with the first case affecting the Vastaamo Clinic in Finland in October 2020 when attackers stole medical data and issued ransom demands to the clinic and the patients, threatening to publish patients' psychotherapy notes if they failed to pay. In another example, the Revil ransomware gang announced, in addition to the double extortion ploy, it would deploy distributed denial-of-service (DDoS) attacks and phone calls to the victim's business partners and the media.

Ransomware is growing and getting more dangerous. Protect yourself now

Implement these best practices to protect yourself against ransomware and these dangerous extortion scams.

- Close all **remote dektop ports (RDP)** if you're not using them. Otherwise, place all RDP services behind a VPN and protect them using **a two-factor authentication method (2FA)**.
- Protect all accounts (including email) and remote access points with 2FA.
- Keep all **software up-to-date** and implement a patch management program.
- **Train** your employees to recognize phishing emails and how to report them to IT.
- Implement geo-IP filtering to block web traffic from entire countries.
- For cloud **backups**, use separate, dedicated credentials for access and consider any immutable storage options.

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- Segment your networks to build internal barriers to prevent ransomware from spreading.
- Apply "least privilege" principle to all user accounts.
- Backup your data regularly using the **3-2-1 back up rule**: Create 3 copies of your data, 2 on different media types, and 1 copy isolated off site.

CAP is committed to helping you protect all aspects of your practice. Members automatically receive $50,000 CyberRisk protection and are eligible and encouraged to purchase additional coverage with limits of $1 million.

Additionally, as part of their automatic CyberRisk policy, members and their staff have free access to numerous online employee cybersecurity training modules.

These courses include:

- Introduction to Breaches
- Data Security Basics
- Social Engineering
- HIPAA Training Series (with printable certificate)
- Safeguarding Information
- Payment Card Industry – Identifying Fraudulent Payment Cards

To access these courses, please visit **https://cap.nascybernet.com**. First-time users will need to register using your CAP member number as your sign-up code.

As the exposure to cybercrimes continues to increase, CAP Physicians Insurance Agency, Inc. is here and ready to help answer your questions and guide you. Work with one of our insurance professionals for a free consultation and no-obligation quote for higher limits on your CyberRisk policy. You can contact CAP Agency by emailing CAPagency@CAPphysicians.com or calling 800-819-0061.

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- Documentation
- Informed Consent
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Case of the Month

by Gordon Ownby

MD's Dispute Over Prescriptions Must Go to Pharmacy Board First

A physician's legal challenge to a pharmacy's decision to not fill his prescriptions must first be heard by the state pharmacy board, a court has ruled.

Kenneth S. Bradley, MD, treats patients with chronic pain from conditions such as cancer, surgeries, and degenerative disk disease and has referral relationships with about 30 HMOs in the Los Angeles area. Most of his patients receive medical insurance through Medicare or Medi-Cal, according to the facts set out in the recent appellate opinion, *Bradley v. CVS Pharmacy, Inc.*

Dr. Bradley's pain management treatment often includes prescriptions for controlled substances, including opiates such as oxycodone, hydrocodone, and morphine and most of his patients fill their prescriptions at their local CVS pharmacies.

In 2018 and 2019, CVS contacted Dr. Bradley to ask him about increases in his prescriptions for Norco. The physician explained to CVS that the hydrocodone is a low-potency opiate and therefore has a "lower potential for overdose while still controlling pain." CVS took no action following these communications.

In April 2020, Autumn Miller, a CVS pharmacist in Carson, contacted Dr. Miller to advise him that she would not fill his prescriptions unless he provided a plan for his patients to "taper off their opiate medications." Dr. Bradley responded by explaining his office procedures and his practice of using "great caution when prescribing opiates." Dr. Bradley, however, "refused to comply with Ms. Miller's demand that I create plans to reduce and ultimately eliminate the dosage levels of opiate medications that I had concluded were necessary for my patients." After that conversation, Miller adopted a policy of refusing to fill Dr. Bradley's controlled substance prescriptions in her pharmacy.

The next month, a CVS senior manager wrote to Dr. Bradley concerning CVS' review of the physician's "prescription dispensing records." The letter stated that "[b]ased on our data we have identified that your controlled substance prescribing may be outside the normal range in comparison with other prescribers in your specialty and geographic region."

After receiving the letter, Dr. Bradley spoke with CVS representatives, who had questions about the physician's prescriptions for Norco for a majority of his patients, his prescriptions for Valium, and a spike in Dr. Bradley's controlled substance prescriptions during March and April 2020. The physician explained that his prescription options were limited by HMO requirements; Norco is a low-potency opiate; and Valium is a low-potency drug that is helpful for sleep. Dr. Bradley also explained that his prescriptions spiked for several month because of the Los Angeles COVID-19 stay-at-home order. Also, because he was the only person in his practice certified to do e-prescribing, he had "temporarily carried the prescription load" for two other prescribers in his office while the office was closed.

On June 17, CVS wrote to Dr. Bradley informing him that effective the next week, "CVS/pharmacy stores will no longer be able to fill prescriptions that you write for controlled substances." The letter stated

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that "[d]espite our attempts to resolve the concerns with your controlled substance prescribing patterns these concerns persist."

According to CVS, it took this step based on a prescription monitoring program that uses algorithms to gather aggregate data on physicians to identify physicians who "demonstrate extreme patterns of prescribing certain highly regulated drugs."

Dr. Bradley filed a lawsuit against CVS on June 25, 2020, alleging claims for declaratory relief, unfair competition, tortious interference with contract and prospective economic advantage, and civil rights violations under the state's Unruh Act.

In opposing Dr. Bradley's various legal theories, CVS argued that the trial court should defer to the California State Board of Pharmacy. After a hearing on September 15, the trial court denied Dr. Bradley's request to enjoin the pharmacy's stoppage and concluded that the physician's claims "raised issues that should be dealt with by the Pharmacy Board."

On Dr. Bradley's appeal, the Court of Appeal agreed with the trial court's direction, though under a slightly different legal theory. (The appellate court applied a "primary jurisdiction doctrine" instead of the administrative remedy "exhaustion doctrine" used by the trial judge. The alternate approach did not change the outcome.)

According to the Court of Appeal, the critical allegation in Dr. Bradley's lawsuit is that "[a]s matter of California law, CVS and its pharmacists are required to honor any prescription issued by a physician . . . subject only to a corresponding duty to confirm that the prescription has been issued for legitimate medical purposes related to the patient's care." Noting that Dr. Bradley's legal complaint relied on California Business and Professions Code Section 733 as the source of CVS' obligation, the appellate court concluded that the Pharmacy Board was the appropriate place for the physician's complaint to be heard. That is because while a pharmacy licentiate "shall not obstruct a patient in obtaining a prescription that has been legally prescribed" the statute also provides discretion to a pharmacist through language stating that he or she has no duty to fill a prescription if "[b]ased solely on the licentiate's professional training and judgment, dispensing . . . the prescription is contrary to law."

The court explained why the matter must first be heard at the Pharmacy Board: "By virtue of its composition and its role, the Board has a unique ability to evaluate whether a decision not to fill prescriptions was justified by a pharmaceutical licensee's 'professional training and judgment.'"

The appellate court also noted that CVS' statutory obligations arise in the context of a national opioid problem, quoting with approval the trial judge: "'Opioids is a very serious issue that I don't think the court has nearly enough information to make the call on.'"

According to the appellate court, following a final Pharmacy Board decision on Dr. Bradley's complaint, the trial court action could resume to resolve any remaining issues.

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

August 2021

Ask My Practice

by Andie Tena

Keeping Your Medical Practice Compliant with Cal/OSHA Regulations

In today's environment, it is increasingly difficult to know what guidelines to follow to ensure your practice is compliant with Cal/OSHA regulations and safety standards, especially as the pandemic continues to evolve. As mandates and safety standards seem to change regularly, being prepared and knowing what resources you can rely on for the most up-to-date information is key to ensuring a safe, healthy, and compliant medical practice.

The California Division of Occupational Safety and Health, or Cal/OSHA, is the division within the Department of Industrial Relations that helps protect California workers from health and safety hazards on the job in almost every workplace, including medical practices.

Even as COVID-19 remains in the spotlight, it is critical that medical practices stay ahead of other Cal/OSHA compliance requirements and guidelines. With hazards like bloodborne pathogens, chemical exposure, and others, it is no wonder the healthcare industry has one of the highest rates of non-fatal injuries and illnesses. It can be overwhelming for an independent practice to navigate detailed Cal/OSHA regulatory requirements and reporting procedures, but protecting yourself and your employees from workdays lost to job-related injuries, illnesses, and disabilities can help your practice succeed in the long run.

To help you address Cal/OSHA safety standards and compliance in your practice, you can take advantage of exclusive programs and benefits available through your membership, including discounted training courses for you and your staff, articles, and personal guidance from practice and risk management experts.

To learn more, contact Andie Tena, CAP's Director of Practice Management Services, at ATena@CAPphysicians.com or at 213-473-8630.

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