THE MONTHLY PUBLICATION FOR CAP MEMBERS

CAPsules®

COOPERATIVE OF AMERICAN PHYSICIANS

The elections for the Cooperative of American Physicians, Inc. (CAP) Board of Directors and for the Mutual Protection Trust (MPT) Board of Trustees are currently underway—and the July 25th annual meeting date is fast approaching!

All members of record (as of May 28) should have long since received their voting materials for the CAP and MPT board elections and MPT Agreement proposals, and we thank those of you who have already voted.

However:

- If you did not receive these materials, if you need another copy of your ballot and proxy card, or need help voting, please call the firm assisting us with the voting process, Innisfree, toll-free at **888-750-5834**.
- If you have questions about the proposals, please call Membership Services toll-free at **800-610-6642**.

It Is Critically Important That *All* Members Vote Without Delay

Please follow the instructions in your voting materials. You may cast your vote online, by telephone or fax, or by mailing the ballot and proxy card in the prepaid envelope provided (please remember to fill out forms completely, sign and date, ***prior*** to sending).

Please Save CAP and MPT the Expense of Additional Solicitation and Vote Today!

As a physician-founded and physician-directed organization, the members' best interests form the foundation of CAP. The robust health of the enterprise not only provided members in 2018 with superior medical liability protection at an affordable cost, it allowed CAP to work closely with our members to promote the strength and vitality of their individual practices.

When you support CAP, you are joining 12,000 of California's finest physicians who benefit from superior and affordable medical malpractice protection provided through our Mutual Protection Trust, as well as access to outstanding physician support benefits. Please vote today — your participation in the 2019 CAP ballot and MPT proxy helps all members!

June 2019

Risk Management and Patient Safety News

"You Didn't Tell Me That." Informed Refusal as a Defense

by Deborah Kichler, RN, MSHCA

The age-old discussion of "informed consent" and "the consent form" never ceases. A procedure, or treatment, is scheduled and there is an order to "obtain the patient's consent." The nurse takes the consent form to the patient for signature and the patient inquires, "What am I signing? I have not spoken to the doctor yet." A common allegation in malpractice lawsuits is the failure to obtain the patient's consent for treatment. It goes beyond just getting the patient to sign a piece of paper.

The cornerstone of the informed consent process is the discussion between the physician and the patient. A patient has the right to consent (or not) to any recommended medical procedure or treatment. The patient also has the right to enough information to give an informed and meaningful consent. Before proceeding, the patient should be informed about the proposed procedure or treatment; the risks, benefits, and alternatives; and the risks and benefits of any alternative treatments. This informed consent discussion, as well as any written materials and videos, must be provided in a language that the patient understands. The discussion should include enough information so that the patient has a clear understanding and can make an informed decision whether or not to undergo the proposed procedure or treatment. Include a copy of the written materials, drawings, photographs, and names of videos reviewed with the patient in the medical record as part of your informed consent discussion documentation.

The patient also has the right to refuse the proposed procedure or treatment. In this case, the physician should ensure that the patient understands the risks and consequences that may result from the decision to refuse, or failure to pursue, a recommended medical procedure. This documentation must be thoroughly noted in the medical record, as above.

Patient refusal and documentation also applies to a physician's recommendation that a patient see a specialist. The patient should be informed of the reasons for the recommendation and the possible consequences if the patient fails to obtain a specialist's advice.

Another example of refusal occurs when there is a patient emergency in the office that triggers a need for EMS transport. If the patient refuses to utilize the EMS transport, the healthcare provider should explain to the patient and family, regardless of the distance, that the ambulance service is the safest vehicle transportation. If the patient opts to go by private vehicle, document the informed refusal discussion in the medical record.

In litigated cases, jury instructions related to informed refusal include: "A (physician) must explain the risks of refusing a procedure in language that a patient can understand. The patient should be given as much information as (they) need to make an informed decision, including any risk that a reasonable person would consider important in deciding not to have the said procedure/treatment. The patient must

continued on page 3

Continued from page 2

be told about any risk of death or serious injury or significant potential complications that may occur if the procedure/treatment is refused. A physician is not required to explain minor risks that are not likely to occur." (CACI No. 534)

Tips for Patient Discussion

1. Provide enough information so the patient can make an educated decision whether, or not, to agree to the proposed procedure or treatment.
2. Provide the information in the language the patient understands. Provide written materials, drawings, videos to assist in discussion.
3. Evaluate the patient's understanding through teach-back methods; ask open-ended questions, allow time for patient questions.
4. Identify an alternative treatment plan.
5. Obtain the patient's signature, if possible, if the patient refuses the procedure or treatment. (Perhaps have a witness present when a patient refuses treatment.)
6. Document your discussion: diagnosis, proposed procedure/treatment, prognosis, risks and benefits of treatment and alternative treatments, and the consequences of refusing treatment. Whether your patient is refusing a surgical procedure, a medical treatment, referral for follow up, or other situation, document the discussion (risks, benefits, alternatives, and consequences) in the medical record.

Deborah Kichler is a Senior Risk Management and Patient Safety Specialist for CAP. Questions or comments related to this article should be directed to dkichler@CAPphysicians.com.

Want to Know More About State and Federal Policy?

Become a CAP Public Affairs Insider

Public Policy

Since CAP's inception, our physician members have demonstrated a commitment to public affairs, especially when it comes to preserving the Medical Injury Compensation Reform Act (MICRA). But the impact of activities in Sacramento and in Washington, D.C., on the practice of medicine does not stop with MICRA and CAP wants to keep our members informed on a wide range of state and federal public affairs activities.

CAP currently serves our members' appetite for public affairs intrigue through *CAPsules*, social media, and www.CAPphysicians.com. To give members even more current information on bill activities in California and in Washington, D.C., CAP now offers insider information to members who choose to opt in for regular email updates.

By becoming a CAP *Public Affairs Insider*, members can keep track of curated legislative and regulatory activities affecting the practice of medicine and access to care. To start receiving your *Insider* update by email, simply contact us at PACinfo@CAPphysicians.com with your name and preferred email address with the message: "I want to be a CAP Public Affairs Insider!"

CAP's new Public Affairs Insiders – and all CAP members – should also mark their calendars for **Saturday, September 7, 2019**, for CAP's first *Public Affairs Symposium* to be held at CAP's main office in downtown Los Angeles. For the symposium, we are preparing a special morning program providing top-level political and policy commentators on the state of MICRA and other healthcare-related topics. These are the experts who help guide CAP's all-physician state and federal Political Action Committees and they look forward to sharing their political observations and legislative analyses with the membership at large. Registration for the symposium is now open: just write us at PACinfo@CAPphysicians.com with your contact information and the message: "I Will Be at the CAP Public Affairs Symposium!"

CAP believes that our members are among the most sophisticated physicians in California when it comes to protecting access to care through public affairs activities. Through such programs as the Public Affairs Insiders and the Public Affairs Symposium, CAP hopes to not only provide new and detailed information to our members, but to also *learn more from our members* about how CAP can help physicians succeed in a complicated regulatory environment.

We look forward to providing you more information on the Public Affairs Symposium as September draws closer. In the meantime, there's no need to wait to become a Public Affairs Insider – just contact us at PACinfo@CAPphysicians.com today!

Case of the Month

by Gordon Ownby

Attending Surgeries With Limited On Call: Who Will Have Your Back?

When attending to a weekend surgery at the hospital, make sure you don't find yourself all alone with too much to do.

A 61-year-old patient was the only scheduled surgery on a Saturday morning, where he was to undergo an ERCP for suspected inflamed gallbladder/bile duct gallstones. The gentleman had Type 2 diabetes, major depressive disorder, essential hypertension, and a remote history of a CVA. Dr. A, the anesthesiologist for the surgery, classified the patient as ASA III and anticipated a difficult intubation.

On the morning of the scheduled surgery, Dr. A — the only anesthesiologist on call at the hospital that weekend — learned that he was also to attend to a Cesarean section for a patient with failed labor.

The ERCP started at 8:15 that morning and after a difficult intubation, proceeded without incident. Surgery concluded at 9:25 but hospital staff notes at 9:35 showed the extubated, bag-masked patient in the PACU as unresponsive. Dr. A ordered new dosages of relaxant-reversals without improvement. Dr. A then re-administered a muscle relaxant and

continued on page 6

Continued from page 5

attempted to re-intubate the patient. When the reintubation failed, Dr. A was successful in placing a laryngeal mask airway. At 10 a.m. with the LMA in place and connected to a ventilator, Dr. A left the patient in the care of the nursing staff and respiratory therapists as he began general anesthesia for the Cesarean section in the OR next door.

With Dr. A at the Cesarean section, the GI patient desaturated and staff called the emergency room physician, who arrived at 10:05 a.m. According to his records, the ER physician noted no breath sounds or chest rise. The ER physician asked the staff to call Dr. A back to the PACU stat to re-establish an airway and to call any other available anesthesiologist – as well as a general surgeon in the event of a cricothyrotomy. The ER physician made several unsuccessful attempts to intubate the patient and began an emergency cricothyrotomy when Dr. A returned to the PACU. The ER physician asked Dr. A to assist in establishing an airway, but Dr. A stated he did not think he could do that successfully as he had previously been unable to re-intubate the patient and that he needed to return to the Cesarean delivery. The ER physician unsuccessfully attempted the cricothyrotomy and a Code Blue was called at 10:22 a.m. Another anesthesiologist arrived at 10:40 a.m. and successfully intubated the patient. The patient remained pulseless, however, and was declared dead at 11:07 a.m.

In a subsequent lawsuit, the family sued Dr. A for medical negligence and for patient abandonment. Dr. A and the family resolved the litigation without going to trial.

In his deposition, Dr. A testified that he advised the OB surgeon to speak to the GI surgeon regarding whether the Cesarean delivery could be performed first. No such change occurred. Dr. A also testified that staff was unable to get another anesthesiologist to take the Cesarean section or to get a surgeon for a possible cricothyrotomy.

Jurors expect physicians to make more than just technical medical decisions: When a situation puts patient safety at risk, they will look for a physician's assertiveness. These are the times for the "patient's advocate" to be heard.

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

California Wildfires Changing the Insurance Market

Affluent physicians want to live in beautiful locations — high up on a hillside with a view, where their backyard investigates open space or in the middle of a lush green forest…

Due to the high number of devastating wildfires California has experienced in the past two years, homeowner insurance coverage is getting harder to place and sometimes next to impossible to obtain in these high-risk locations.

More frequently, insurance companies are casting a wary eye on Californians who live in wildfire-prone areas, choosing not to renew policies or drop some homeowner coverage altogether. It's a risk they are no longer comfortable taking.

When a carrier, mostly a specialty market like Lloyd's of London, is willing to issue coverage for a wildfire location it is likely to cost up to 300 percent more than your standard pre-fires policy, for a more comprehensive policy. For a policy with much less coverage and as a last resort only, The California Fair Plan will issue a policy that may not have enough coverage to rebuild your home or replace your personal items, as its policy limits caps at $1.5 million.

Things you need to know:

- Review your policy limits with your agent to be sure there is enough coverage to rebuild your home and cover your personal property.
- Pay your bills on time and do not let your policy lapse – there is a good chance it will not be reinstated for any reason
- If you are non-renewed, reach out to your agent immediately to replace coverage. This process can take weeks in this current insurance climate.
- If you are thinking about buying in a high-risk area, reach out to your insurance broker *before* going into contract with a lender.
- If you are thinking about selling your high-risk location home, reach out to a real estate broker to determine selling value before entering into a contract for a new home for yourself. These home values may be decreasing due to the difficulty of obtaining insurance coverage.

CAP Physicians Insurance Agency is a full-service Agency. We partner with Integro Group to bring you the best personal lines coverage to meet all your homeowner, auto, and personal umbrella needs. Reach out to us by calling **800-819-0061** or contact **Laura Schneider** at **Integro** at **925-852-0444**. Or you may also apply online at CAP Physicians website, www.CAPphysicians.com.

CAP PHYSICIANS INSURANCE®
License No. 0F97719

June 2019

COOPERATIVE OF
AMERICAN PHYSICIANS

Cooperative of American Physicians, Inc.
333 S. Hope St., 8th Floor
Los Angeles, CA 90071

June 2019

IN THIS ISSUE

CAPsules® is a publication of the Corporate Communications Department of the Cooperative of American Physicians, Inc.
333 S. Hope St., 8th Floor, Los Angeles, CA 90071 | 800-252-7706 | www.CAPphysicians.com.

We welcome your comments! Please submit to communications@CAPphysicians.com.