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Case of the Month

Malpractice Suits Must Connect All the Dots

by Gordon Ownby

To pursue a lawsuit for medical malpractice, it is not enough for a plaintiff to demonstrate that a defendant did not meet the standard of care in treating a patient and that a patient suffered a harm. A crucial component must bridge the two — the professional breach must have caused the harm.

A new California case illustrates this dynamic by dissecting expert opinions submitted in a motion for summary judgment, a tool used by defendants to terminate a lawsuit without a full trial. The case, *Fernandez v. Alexander*, demonstrates why a judge considering a motion for summary judgment need not accept an expert's conclusions if those opinions are not supported by reasoned explanations.

Plaintiff Victoria Fernandez fell and fractured her left wrist on November 14, 2014, had x-rays taken in the emergency room, and wore a splint until she visited orthopedic surgeon Charles Alexander, MD, 10 days later. Dr. Alexander reviewed the ER x-rays and upon examining Ms. Fernandez, assessed her as having a left distal radius fracture and left ulnar styloid fracture. After a discussion (the extent of which was later disputed), Dr. Alexander recommended placing the wrist in a cast, which was done by his physician assistant.

When the PA removed the cast on December 8, the hand looked deformed. New x-rays showed "callous formation with dorsal angulation of the hand." The PA put the patient in a freedom splint and prescribed physical therapy.

Ms. Fernandez visited Dr. Alexander's office for the third time on January 23. With the hand's status being suboptimal, Dr. Alexander instructed the patient to use alternating heat and ice and noted that, lacking improvement, an open reduction and fixation could be considered. The patient never returned to Dr. Alexander but instead underwent a bridge plate surgery by another physician.

In a subsequent lawsuit, Ms. Fernandez alleged Dr. Alexander and the PA "failed to inform or advise [her] that she could suffer and incur permanent left wrist injury including the dorsal angulation and ligament damage as a result of their treatment."

Dr. Alexander's attorney moved for summary judgment by submitting a declaration from orthopedic surgeon and hand specialist Charles Resnick, MD. In his written declaration, Dr. Resnick stated that the standard of care for the patient's injury permitted either the performance of surgery and/or casting, that the patient was properly advised of her treatment options, and that Dr. Alexander and the PA complied with the standard of care at all times.

Dr. Resnick's declaration went to explain that "nothing [Dr. Alexander and the PA] did or failed to do caused plaintiff any harm or injury. The

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callous formation and dorsal angulation of the patient's hand seen in imaging on 12-8-14 was a potential outcome of both casting and/or surgical intervention. [Plaintiff] understood that casting her hand could result in continued hand deformity and the patient agreed to proceed with casting after receiving an informed consent of her options."

In opposing the motion, Ms. Fernandez's attorney submitted a declaration from Dr. Robert Gelb, an orthopedic surgeon and hand sub-specialist.

In his declaration, Dr. Gelb criticized Dr. Alexander for not obtaining a new x-ray on the plaintiff's first visit, explaining that the standard of care "requires an x-ray be taken when there is a displaced fracture to assess any movement in the displacement and to provide the patient with treatment options." Dr. Gelb also declared that it was a violation of the standard of care to fail to discuss surgical treatment when x-rays revealed worse angulation and deformity after the cast's removal.

Dr. Gelb concluded that based on his review of the records, his education, training, and experience, it was his professional opinion that Dr. Alexander and the PA fell below the standard of care and caused the plaintiff's further deformity of her left wrist. Dr. Gelb stated Dr. Alexander "failed to monitor the plaintiff's condition and just accepted the deformity."

A motion for summary judgment may succeed only absent a dispute in a material fact (the resolution of such factual disputes being the realm of juries). At the trial court, the judge ruled that the plaintiff introduced sufficient evidence to establish a dispute over whether Dr. Alexander met the standard of care. However, "plaintiff did not meet her burden of producing evidence that defendant's acts or omissions were a substantial factor in causing plaintiff's harm."

The Los Angeles-based Court of Appeal agreed, upholding the lower court's dismissal of the suit against Dr. Alexander and the PA.

In examining Dr. Gelb's declaration, the Court of Appeal noted his opinion that Dr. Alexander's care "caused Plaintiff's further deformity of her left wrist" and his criticism of relying on the ER x-ray. That wasn't enough, according to the Court of Appeal.

"None of this explains, for example, how the failure to obtain a new x-ray at the initial consultation caused the further deformity in plaintiff's wrist, or how the (alleged) failure to discuss surgery at the initial consultation caused the further deformity shown by the imaging at the second consultation.

"Notably, Dr. Gelb does not opine that surgery would have produced a better outcome," the Court of Appeal observed.

"In short, Dr. Gelb offered no reasoned explanation connecting the factual predicates to the ultimate conclusion."

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

CAP Bylaws Amended

On February 1, 2019, the Cooperative of American Physicians, Inc., Board of Directors approved amending Article 4.3.2 and 4.3.3 of the CAP Bylaws, setting the time for a membership-petition nomination to the Board of Directors at 75 days before the date of an election and eliminating nominations from the floor at a meeting to elect directors.

A full copy of the amended Bylaws is available by logging in to the Members section of **www.CAPphysicians.com** or by requesting a paper copy from CAP.

Risk Management and Patient Safety News

Medical Assistant Liability — the CAP Risk Management Institute Offers Free Training

by Amy McLain, BSN, RN

Medication administration is commonly the responsibility of medical assistants (MAs) in many California medical offices and clinic settings. While MAs play a vital role in carrying out a variety of routine tasks that keep your office running smoothly, they may also represent an underappreciated source of risk for your practice. Unfortunately, many physicians fail to understand that MAs are unlicensed individuals with limited, if any, formal education in pharmacology and safe medication administration.

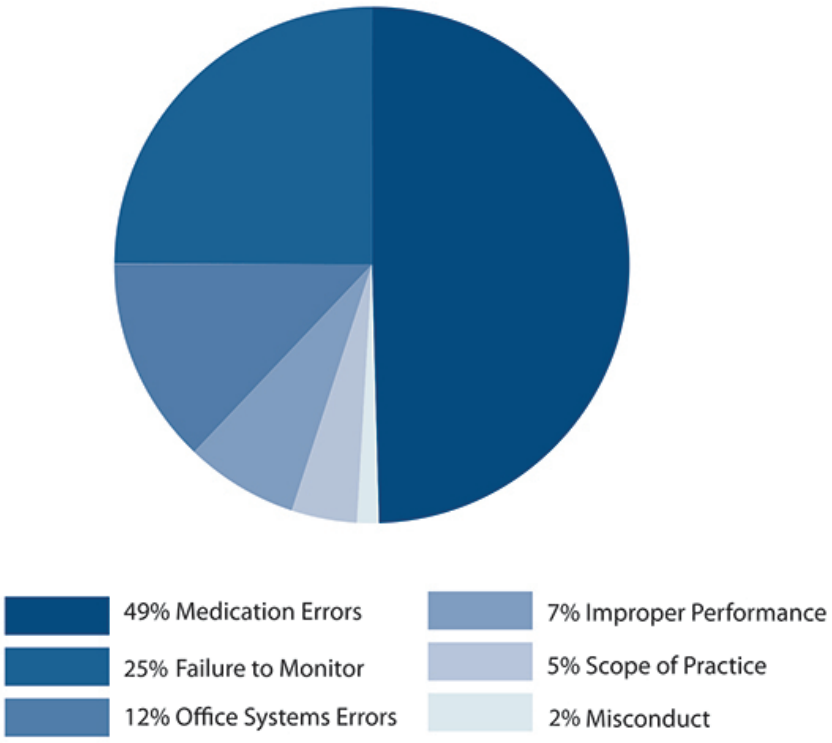
In fact, a recent focused review by CAP Risk Management and Patient Safety staff reveals that medication errors, where an MA was directly responsible for a patient's injury, accounted for the most frequent cause of loss in indemnity. These included:

Medication Errors — 49%

Failure to Monitor — 25%

Office System Errors — 12%

2006-2014 CAP Closed Claims Review Medical Assistant Study



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Interestingly, the majority of these medication errors occurred in busy primary care offices, such as Pediatrics, Family Practice, General Practice, and Internal Medicine, often as a result of the MA violating the tenets of safe medication administration — the right patient, the right drug, the right dosage, the right time, via the right route. It was discovered that 62 percent of these errors involved injectable medication, such as vaccines, antibiotics, numbing agents, and corticosteroids. A perfect example is a case where Patient A received the allergy medication intended for Patient B. Sadly, Patient A experienced anaphylaxis, an emergency trip to the hospital, and subsequent emotional distress. CAP paid $15,000 in indemnity and $16,917 in expenses.

Surprisingly, one particular medication made a frequent appearance in our closed claims review — the glucocorticoid corticosteroid, Kenalog. The most recent and notable case involved a 31-year-old female who was being treated for an insect bite and received a Kenalog injection in her right upper arm by an MA. The patient later complained of right arm weakness, as well as a palpable lump, a tingling sensation, and pain at the injection site. It was determined that the drug leaked out into the patient's surrounding adipose tissue, causing necrosis and dimpling. With proper training and supervision, the MA would have known to inject the drug employing a Z-track technique deep into the gluteal muscle using a needle at least 1.5 inches long, as indicated in the manufacturer's medication insert. The case settled for $29,999 with $20,679.57 in expenses.

The third-highest cause of claims where indemnity was paid resulted from a failure to monitor a patient within the office environment and exam room. Interestingly, more than half of the injuries sustained occurred from a fall shortly after the administration of a vaccine. Unfortunately, these patients were not monitored closely after receiving their immunizations. Many of them experienced side effects, including a loss in consciousness, causing them to fall and sustain injuries to their heads and faces.

So, how can you keep your patients safe and minimize the possibility that your MA will make a medication error? First of all, be familiar with your MA's full scope of practice, as described by the Medical Board of California. Hire individuals who can provide a certificate of training from a respected institution and demonstrate competency in pharmacology and safe medication administration. If your MA will be giving injections, such as Kenalog and vaccines, and administering inhalation medications, it is essential that you provide them with additional training required to do this safely.

Next, employ office systems and practices that emphasize medication safety. Develop and implement clear policies and procedures, including refill guidelines. Keep in mind, MAs may not call in new prescriptions or any refill prescriptions that have changes. Other recommended practices include:

- utilizing chart alerts for patient drug allergies
- storing "look-alike, sound-alike" drugs separately
- labeling syringes
- giving medication to only one patient at a time
- limiting distractions when giving meds

Last but not least, understand your responsibilities as supervisor. An MA can only provide patient care under your direct supervision or under the supervision of a physician assistant, nurse practitioner, or nurse midwife. You or the supervisor must be on the premises at all times when the MA is providing patient care. So, before an MA administers any authorized medication, a supervisor should verify that the right dosage, of the right medication, is given to the right patient, at the right time, via the right route, each and every time.

Medication errors are preventable. When well-trained medical assistants act within their scope of practice and adhere to comprehensive medication administration procedures and protocols under your direct supervision, the less likely a medication error will occur. Safe medication administration improves patient care and reduces your medical liability risk.

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CAP's Risk Management Institute

CAP's Risk Management Institute has provided online risk management training to more than 1,000 medical office staff. Designed specifically for front and back office staff, the Risk Management Institute is available exclusively to CAP member practices free of charge.

The six training sessions included in the Risk Management Institute address the questions most frequently asked by callers to our member hotline. The 20 to 25 minute sessions address the following topics:

- Informed Consent
- Medication Management
- Effective Office Communication
- Patient Education
- Tracking and Recall
- Medical Record Management

The program helps to ensure that your office staff members are focused on key risk management issues, as they more effectively serve your patients. CAP members find the program is helpful in reducing risk in the office.

To take advantage of this free member benefit, please contact our Risk Management and Patient Safety Department at 800-252-7706, extension 8502, or riskmanagement@CAPphysicians.com to obtain the necessary password and registration instructions.

Additional Call to Action Items

- **CAP Risk E-Notes**
  Visit our website at www.CAPphysicians.com/risk-management/publications#risk-enotes to review the library of issues
- **Medical Board of California**
  www.mbc.ca.gov

Amy McLain is a Senior Risk Management and Patient Safety Specialist for CAP. Questions or comments related to this article should be directed to amclain@CAPphysicians.com. This information should not be considered legal advice applicable to a specific situation. Legal guidance for individual matters should be obtained from a retained attorney.

Physician Supply Still a Concern in Face of Increasing Demand

by Gabriela Villanueva

A new report by the California Future Health Workforce Commission may serve as a road map for state leaders to begin work on avoiding workforce shortages in the healthcare field.

For the past several years, research has shown an increasing trend towards physician shortages across the nation. An Association of American Medical Colleges workforce study released in 2017 found that for every 100,000 California residents, there are 256 active physicians. The preferable benchmark is 291 active physicians per 100,000. The study also found — and the commission incorporated into its report — that one-third of California's active physicians are of retirement age.

The 24 health workforce commissioners represent leaders in health, policy, workforce development, and education. The report of the two-year-old commission lays out a plan to ensure the state will have enough doctors, nurses, and home health workers to meet the needs of the residents of California, especially for the increasing medical needs of the baby boomer generation. The report provides a $3 billion plan with recommendations that include a state focus on recruiting and preparing more students from underrepresented and low-income communities and implementing incentives such as student loan forgiveness and scholarships for students who pledge to work in rural areas. Along with student recruitment, the state must also expand the number of residency slots to help increase the number of doctors and psychiatrists in the state. The commission also recommends the creation of a California Health Corps to engage students, health workers, and retirees in addressing health workforce gaps.

A more controversial proposal is a recommendation that would allow nurse practitioners to work independently from physicians and expand their scope of practice. Previous legislative fights have ensued over this issue and the California Medical Association is now pushing back on this recommendation, arguing that an expansion would lower the standard of care. The California Association for Nurse Practitioners is applauding the recommendation.

The commission's chair, Janet Napolitano, President of the University of California system, will be presenting the commission's report and recommendations to Governor Newsom and legislative leaders in the coming weeks. The recommendations are coming at a time when Governor Newsom wants to dramatically expand healthcare access as reflected in his 2019-2020 budget proposal.

The full report of the California Future Health Workforce Commission can be found at: http://bit.ly/healthfinalreport

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

Public Policy

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Short-Term Disability and CAP Pregnancy Disability Plan Benefits

Did you know that your CAP membership provides you not only amazing medical liability protection, but excellent value-added benefits as well? Among these benefits is the CAP Pregnancy Disability Benefit Plan[1].

CAP Pregnancy Disability Benefit Plan highlights:

- 30-day waiting period
- Up to $2,000 monthly benefit
- Up to 60-day maximum benefit period

Benefits are payable under this plan:

- Whether pregnancy is complicated or not
- Regardless of whether member receives state disability or if they happen to have our Short-Term Disability coverage
- Whether or not the member qualifies for a Disabled status with MPT

This benefit can be used multiple times and there is no pre-existing condition exclusion.

Additionally, if you are a participant in the CAP Short-Term Disability Plan[1] you can receive a weekly benefit that supplements your eligible State Disability Insurance and your Pregnancy Disability Plan benefit and closes the gap for any required 90- or 180-day waiting period plans.

Plan features (pre-existing condition exclusions do apply[1]):

- $1,000 weekly benefit
- 14-day waiting period
- 11- or 24-week[2] benefit duration
- No medical underwriting

Please call 213-473-8747 for Short-Term Disability coverage enrollment instructions and/or additional information about the CAP Pregnancy Disability Plan or email benefits@CAPphysicians.com, and we'll be happy to assist you.

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[1]Must be working at least 17.5 hours per week and not currently disabled to apply; if you are currently pregnant at time of enrollment, benefits will not be payable under this plan for that pregnancy. All other pre-existing conditions are subject to policy exclusion.

[2]This benefit period is available only if not currently enrolled in CAP's supplemental long-term disability plan.

CAP WISHES ALL OF ITS MEMBERS A VERY HAPPY DOCTOR'S DAY 2019!

National Doctor's Day is held every year on March 30 in the United States. All of us at the Cooperative of American Physicians, Inc. extend our thanks and gratitude to our dedicated physician members for your gift of healing.

7 Ways to Mitigate Risk

by Julie Yorumez, Vice President, Medical Memory

Medical malpractice lawsuits are no longer based solely on medical errors or missed treatments. Many of these cases are becoming more about the experience of the patient: how he or she feels, and whether he or she felt they were treated fairly or felt mistreated. Also, tracking engagement experience is becoming more and more prevalent among healthcare providers. Here are some tips to mitigate risk and strengthen the patient experience.

1. Speak Clearly and at a Sixth-Grade Level

It is important to recognize that the medical language providers are used to utilizing throughout school and with their peers is not always effective language to use with a patient. Most patients don't understand medical jargon and terminology and can find themselves not fully understanding what the doctor is telling them.

2. Take Away the He Said/She Said

Many providers are starting to utilize recording devices during clinical consultations. One app, Medical Memory, records the clinical meeting on a HIPAA-compliant app. The app then sends a video both to the patient and to the provider for record. The benefit to patients is that they can review the important details of the appointment they may have missed. In addition, this takes away any "he said, she said" confusion about the care.

3. Recognize "White Coat" Syndrome

Many patients have a genuine fear of the doctor. They see a white coat and forget everything the provider has told them about their care. Recognize the anticipation and anxiety of a doctor appointment (especially one where patients may be learning their diagnosis). Take the time to acknowledge any patient anxiety and do what you can to make sure the patients in a relaxed space to really hear what you're saying.

4. Use Images or Videos

Using resources to show treatment plans, models to explain surgery, and more, can be incredibly effective tools to help patients understand their care. For example, Medical Memory Inform allows providers to pre-record important content, informed consent conversations, pre-op/post-op, and more. Providers use this resource in the clinic, and patients also can access these resources at home. Often, the images and videos will help a patient understand the details, risks, and benefits better.

5. Track Patient Engagement and Ensure Complete Documentation

If you are using any patient engagement system, be sure that you're documenting the ways you are going above and beyond to ensure your patient has the resources to understand. Many programs, like Medical Memory, have a system built in that shows whether patients have watched, or even shared medical content. Work with your team to ensure effective documentation in your practice of all conversations and resources presented to patients.

6. Pause to Empathize

Patients recall hearing their diagnosis. Many patients will say that after the provider has explained to them their diagnosis, that their mind went completely blank and they can't recall almost anything the provider has stated

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afterwards. Take a moment to pause and empathize with patients after giving them their diagnosis. That way, when you start talking more about the treatment options, your patients are in a space where they are open to hearing it.

7. Establish a Good Relationship with Your Patients

It goes back to the age old quote, "you don't sue your friends." Take the time to show kindness, respect, and true empathy and concern for your patients. Take the time to make sure you patients feel comfortable with you, taking 30 seconds to ask about work or family.

Medical Memory is a HIPAA-compliant app that pushes custom content to patients. Some providers will record live consultations and give patients a copy of these visits. Other practices will use the Inform tool where providers can prerecord important information for their clients (pre-op or post-op instructions, informed consent, logistics of surgery, etc). Both tools are saving providers time, mitigating risk, and strengthening the patient experience.

Medical Memory is part of CAPAdvantage. For more information, please contact **Julie Yorumez** at **julie@themedicalmemory.com** or **855-667-4000**.

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