THE MONTHLY PUBLICATION FOR CAP MEMBERS

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COOPERATIVE OF AMERICAN PHYSICIANS

Case of the Month

Jury Solves Mystery of Retained Foreign Object

by Gordon Ownby

While it is not unusual for a retained foreign object to move around a bit, some apparently can travel farther than others.

A gentleman in his mid-60s presented to the hospital for a total knee replacement. Dr. A, the anesthesiologist, had significant difficulty and made several attempts to place a needle for spinal anesthesia before seeking assistance from a colleague. Together, they were able to place a needle using a straight-in approach.

The surgery was completed without further difficulty and with no apparent anesthetic complications.

Two months later, Dr. A learned that a foreign body had been found in the patient's lumbar spine after an MRI had been ordered as part of a sciatica workup. Reportedly, the MRI was compared to spine films from three years earlier, which showed no foreign body. The patient was advised of the finding and Dr. A discussed a subsequent CT report with him.

Six weeks later, the patient underwent lumbar surgery. The surgeon removed a 2.1 cm "needle" from the spinal canal at L2-3, performed a fusion at that location, a posterior osteotomy, partial reduction/decompression of spondylolisthesis, partial laminectomy, bilateral foraminotomy and nerve root decompression, pedicle screw fixation, placement of bilateral rods, and a bone graft.

After the surgery, the patient reported relief of his pre-operative pain symptoms but complained of atrophy and lower extremity weakness. The patient did not return to work and was terminated from employment the next year.

The patient filed suit against Dr. A, alleging that she placed a needle through the spinal canal and through the dura, causing the needle to break and lodge in his spine. The plaintiff further alleged it was negligence to fail to recognize a needle fracture when the needle and introducer were removed.

The litigation was initially worked up on the assumption that the foreign body removed in the lumbar surgery was a needle fragment from the anesthesia administered for the knee surgery. The spinal surgeon testified that he could not state whether the patient's pain was from the "needle" or from the patient's pre-existing spinal stenosis but that in any case, the object needed to be removed.

Discovery revealed that the plaintiff had an urgent consult with a neurosurgeon three years earlier for

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severe leg pain, back pain, and a foot drop after moving pavers during some home landscaping. That neurosurgeon ordered flexion and extension films and had planned, depending on the films, to recommend surgery at L2-3 or L4-5, but the patient never returned.

During the litigation, however, further examination of the foreign object showed that it bore no resemblance to a spinal needle and matched nothing used in the needle drawer at the hospital where Dr. A administered the anesthesia.

During the workup of the case, Dr. A's defense counsel questioned the plaintiff if he had received medical treatment during a trip that he had made to India three years prior. The plaintiff denied receiving surgical care in India during that time.

Defense counsel then obtained from India samples of cannulas used by physicians in that country. The samples matched the object removed from the patient. Despite the finding, the plaintiff's counsel refused to dismiss the case, but instead presented an expert who theorized that Dr. A used some blunt needle as an introducer which broke and that the fragment was pushed by a spinal needle through to the ligamentum flavum.

At trial, Dr. A's defense attorney proposed that the plaintiff traveled to India after suffering from stenosis and underwent either minimally invasive spine surgery or an epidural injection and it was then that the foreign object was introduced and retained. In trial, the plaintiff testified that he had no procedures performed after hurting his back while landscaping his yard three years earlier because his back got better by itself.

When Dr. A testified at trial, her defense attorney asked her if she could think of a theory other than that put forward by plaintiff's expert. Dr. A responded that she had done some research into the matter and learned that physicians in some Commonwealth countries, like the former British colony of India, use cannulas in their suction procedures.

After 12 days of trial, the jury deliberated for one day to give a defense verdict to Dr. A by a vote of nine to three.

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

Risk Management and Patient Safety News

November 2020

Focused Review: A Look into Long Term Care

by Deborah Kichler, RN, MSHCA

With the ever-growing aging population, the demand for physicians to move outside their traditional work setting and into skilled nursing facilities is growing. Physicians practicing in Long Term Care (LTC) settings often treat patients with a multitude of issues, including chronic health conditions, skin care issues, medication management, loss of independence, and cognitive deficits. These patients present significant challenges to any practitioner of LTC medicine.

It is important for physicians to be aware of regulatory requirements and be familiar with other rules pertaining to LTC staff qualifications, certifications, licensing, knowledge, and expertise. The LTC practitioner must further understand the level of services available at each facility they practice in.

The latest Focused Review explores issues specific to LTC practice as well as specific elder abuse statutes. The risk management and patient safety experts at CAP identified four common areas of liability risk associated with claims against physicians who provide care to LTC patients:

- Lack of informed consent
- Medication management
- Documentation (wound care)
- Regulatory Compliance

Each of these issues are reviewed with supporting case studies. Effective and actionable risk reduction strategies are provided for each area. While this focused review does not include all the potential areas of liability that an LTC physician may face, it does bring to light the common allegations and contributing factors that are seen most often in claims.

COOPERATIVE OF AMERICAN PHYSICIANS

Risk Management & Patient Safety
Focused Review

A Look into Long Term Care

Deborah Kichler, RN, MSHCA
Senior Risk Management & Patient Safety Specialist

Long Term Care (LTC) Facilities provide services for people with severe physical and/or cognitive impairments, multiple comorbidities, and significant polypharmacy needs. Physicians practicing in LTC settings often treat patients with a multitude of issues, including chronic health conditions, skin care issues, medication management, loss of independence, and cognitive deficits. These patients present significant challenges to any practitioner of LTC medicine.

Physicians caring for LTC patients need to be familiar with the rules and regulations governing LTC care as issued by the Department of Health and Human Services, which sets the minimum standard for physicians to follow when providing medical supervision and services for LTC patients. One specific standard outlined by the Centers for Medicare and Medicaid Services requires that patients "must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter".[1]

It is important for physicians to be aware of such regulatory requirements and be familiar with other rules pertaining to LTC staff qualifications, certifications, licensing, knowledge, and expertise. The LTC practitioner must further understand the level of services available at each facility they practice in.

These issues specific to LTC practice, as well as specific Elder Abuse Statutes discussed later, make the LTC practice one that presents unique medical risks to patients, and serious legal risks to the practitioner. This focused review is designed to provide guidance to the LTC practitioner in both areas.

In this Focused Review . . .

The risk management and patient safety experts with the Cooperative of American Physicians, Inc. (CAP) identified four common areas of liability risk associated with claims against physicians who provide care to LTC patients:

- Lack of informed consent
- Medication management
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The Risk Management and *Patient Safety Focused Review: A Look into Long Term Care* can be downloaded at www.CAPphysicians.com/reviews.

Questions or comments about the focused review may be sent to riskmanagement@CAPphysicians.com.

The well-being of CAP members and their patients remains a priority for our team of risk managers and patient safety specialists, who are committed to providing easily accessible resources and publications designed to improve healthcare, patient safety, and reduce your medical liability risk.

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CAP members may seek assistance if a situation arises that calls for guidance on how best to handle an adverse event or outcome, reduce exposure, or manage the risks involved via the Risk Management Hotline at 800-252-0555. Experienced risk managers are available to members 24/7 to provide guidance and answer questions.

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.

Public Policy

Are Your Prescription Pads Complaint?

by Gabriela Villanueva

In response to the growing public health and safety crisis associated with prescription drug abuse, California lawmakers have introduced a series of legislative bills creating a set of rules and practices to help curb prescription drug abuse and increase controls over the prescribing process itself.

While California does not mandate that all controlled substances be prescribed electronically (e-prescribing), measures have been established to safeguard the system.

Currently, the California Department of Justice's Security Printers Program regulates the third-party printing of prescription pads. Legislation passed in 2018 created a structure for the California DOJ's Security Printers Program. AB 1753 by Assemblyman Evan Low (D-Santa Clara) granted the DOJ the authority to regulate vetted vendors selected to manufacture prescription pads by adding new controls, including limiting the number of vendors the state approves for printing, and linking uniquely serialized pads with the Controlled Substance Utilization Review and Evaluation System (CURES). These regulations intend to help combat fraudulent prescriptions and create stricter reporting controls by vendors as conventionally produced pads are very difficult to track by law enforcement.

Starting on January 1, 2021, all security prescription forms will be required to have a uniquely serialized number, a corresponding barcode, and other security features.

California-approved security printers have been issuing these prescription pads since the beginning of 2020. Beginning on January 1, 2021, except for limited emergency situations, pharmacists will be unable to fill a controlled substances prescription that is not on a compliant form.

Physicians who do not already have these prescription pads should place an order as soon as possible from a DOJ-approved security prescription printer to ensure they have compliant prescription pads before the January 1, 2021 effective date.

January 1, 2021 also marks the implementation date of a new law that requires pharmacists and prescribers who dispense controlled substances to report the dispensing of controlled substances to the Controlled Substance Utilization Review and Evaluation System (CURES) within one working day after the medication is released to the patient or the patient's representative. Previously, pharmacists and prescribers had seven days after dispensing. This law requires pharmacists and other prescribers to report the dispensing of Schedule V drugs, in addition to Schedules II, III, and IV.

For more information on CURES and prescription pad requirements, visit the Medical Board of California's CURES web page at www.mbc.ca.gov/Licensees/Prescribing/Forms_Compliant.aspx

For California Department of Justice approved list of approved vendors, visit https://oag.ca.gov/security-printers/approved-list

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

Ransomware Prevention Tips

Ransomware rates exploded in 2019 and predictions indicate it will not slow down in 2020. Indeed, ransomware affects a business every 40 seconds. Some ransoms are even more than $1,000,000. What are you doing to protect your company? Here are protective measures you should be taking against ransomware.

Backups

Backups are an effective strategy to reduce ransomware damages and business disruption.

Use the 3-2-1 backup rule:

- create 3 copies of your data
- 2 on different media types
- 1 copy isolated offsite

Recent ransomware has been effectively attacking backups that are not protected. Importantly, all backups (even cloud drives) should be segregated or isolated from your operating network. Segregating backups protects them from being infected by malware as it spreads through your operating network. All backups connected to the network are vulnerable to malware/hackers. Strong access controls can mitigate the risk of compromise.

Always Update Your Software

Criminals deploy ransomware on your organization through software vulnerabilities on your organization's network. Make sure your organization has a patch management policy ensuring patches and updates are tested thoroughly and timely rolled out organization wide. Patch management is the timely deployment of security patches designed to address vulnerabilities or mitigate the risk. The most effective method to ensure timely deployment of patches is to enable automatic updates. If there is a business reason why automatic updates are not possible, consider developing a process to timely test, assess, and deploy patches.

Train Your Employees

"Phishing" emails are a common ransomware deployment method. Creating and maintaining a culture of security and phishing awareness is one of the most important action items you can take to protect your company. Employees should never click on an attachment or a link in an email from an unverified sender.

Conducting a live phishing simulation is another great way to train employees to recognize dangerous phishing emails. Phishing simulations help identify those employees susceptible to phishing attacks so additional training can be issued.

Your cyber insurance policy gives you free access to phishing simulation services and numerous employee cybersecurity training courses. Contact www.CAPphysicians.com if you want to deploy a phishing simulation on your employees.

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Your Privacy with the Cooperative of American Physicians, Inc.

The Cooperative of American Physicians, Inc. (CAP) promotes a range of products and services designed with the welfare of physicians in mind. From the professional liability coverage provided through the Mutual Protection Trust (MPT) and the CAPAssurance Risk Purchasing Group (CAPAssurance) to the range of services and products offered through CAP and its affiliates, CAP's goal is to match healthcare providers with the best products and services — all tailored to fit their needs.

Information We Collect

When you join CAP, you provide us with pewrsonal information. We collect and use that information to service your needs at CAP, MPT, and CAPAssurance. We treat this personal information as confidential, limit access to those who need it to perform their jobs, and take steps to protect our systems from unauthorized access. The personal information we obtain falls into two general categories:

- Information we receive from you on the application and other forms you complete (e.g., first name, last name, organization, phone number, address, email, and CAP identification number) relating to:
  - CAP enrollment;
  - Professional liability coverage through MPT and/or CAPAssurance;
  - Other products and services available through CAP for which you request quotes or purchase
- Information about your transactions with CAP, MPT, CAPAssurance, and CAP's affiliates, including the CAP Physicians Insurance Agency, Inc. and the Cooperative of American Physicians Insurance Company, Inc.

Reasons We Share Your Information

We want you to feel secure about the non-public personal information you give to CAP. There are several reasons why we may need to share this information:

- For CAP's everyday business purposes – for example, to process your requests, maintain and service your records and accounts, administer CAP benefits and programs, and respond to court orders or legal investigations.
- For everyday business purposes of MPT, CAPAssurance, and CAP's affiliates.
- For CAP's marketing purposes with service providers we use, including affiliated group purchasing organizations and vendors – to offer our products and services to you.

To Limit the Sharing of Your Information

All CAP members and participants have the opportunity to tell us if they do not want to receive direct marketing offers from CAP, its affiliates or other affiliated service providers. You may choose not to receive marketing offers by any method, be it direct mail, email, or fax.

To tell us your preference, you may:

Write us at: CAP Membership Services
333 S. Hope Street, 8th Floor
Los Angeles, CA 90071

Call us at: 800-252-7706
Email us at: ms@CAPphysicians.com
Fax us at: 213-473-8773

In order to ensure that we accurately fulfill your request, please provide your full name and street address, member number, telephone number, fax number for fax requests, and email address for email requests. Even if you elect not to receive product information by direct mail, fax, or email, you will continue to:

- Be contacted as necessary for routine CAP services
- Receive marketing information through our regular monthly *CAPsules* publication
- Receive notices regarding political activities affecting the medical professional liability industry and solicitations for contributions to CAP's political action committees

Of course, if you wish to continue receiving valuable and convenient product and service offers, no action is required.

November 2020

Ask My Practice

by Andie Tena

Question: The lease for my medical office space is set to expire at the end of the year. Should I try to renegotiate my lease with my landlord? I don't know where to start.

Answer: To answer this question, we asked a dedicated physician consultant from Bailes & Associates, a valued CAPAdvantage program vendor, for a few tips. Before you renegotiate your current lease, here are steps to consider:

1. Consider a financial analysis to determine your wants and needs. Some things to consider are the size of your suite, your minimum and maximum of the new base rent, your desired maximum term, the cost of your parking requirements, and so on.
2. Conduct a market analysis to determine the area's market rents and the availability of space in the target area. Determine what the landlord's concessions are.
3. Tour several comparable sites to determine the pluses and minuses of each.
4. Analyze and compare the findings of the strategic planning, market analysis, financial analysis, and the site tours.
5. Propose your terms and concessions to the landlord's leasing agent, based on Item 4. Then prepare for the Landlord's rejection or his or her counter proposal, which starts the negotiation phase.

Bailes & Associates, Inc. can help CAP members by offering commercial real estate support at no cost. For more information, contact your dedicated medical office specialist Gary Pepp at 562-743-1695 or gpepp@bailesre.com.

Bailes & Associates, Inc. License No. 00831364 Gary Pepp; License No. 00925108

CAPAdvantage is a program of CAP that offers members a suite of no-cost or competitively priced practice management benefits extending beyond superior medical malpractice and risk management protection.

Andie Tena is CAP's Director of Practice Management Services. Questions or comments should be directed to atena@CAPphysicians.com.

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

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333 S. Hope St., 8th Floor, Los Angeles, CA 90071 | 800-252-7706 | www.CAPphysicians.com.

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The information in this publication should not be considered legal or medical advice applicable to a specific situation. Legal guidance for individual matters should be obtained from a retained attorney.