THE MONTHLY PUBLICATION FOR CAP MEMBERS

CAPsules®

COOPERATIVE OF AMERICAN PHYSICIANS

Calling All CAP Heroes

Every day, CAP honors and celebrates the extraordinary impact our members have on the lives of their patients. It takes courage, strength, and dedication to meet their needs and help them thrive.

Naturally, a physician's passion and lifelong commitment to selfless giving and caring for others often goes well beyond the clinical setting.

That is why the Cooperative of American Physicians, Inc., through its CAPtivating Causes initiative, would like to promote and support the efforts of physicians who are actively engaged in medically-related philanthropy, working to advance causes that improve the health and well-being of individuals in our own communities and/or those across the globe.

CAPtivating Causes Community Hero and Community Leadership Awards: Call for Nominations

This year, CAP will present the organization's first-ever Community Hero Award to a CAP member whose charitable service merits special recognition. The award will include a $5,000 grant for the charitable organization affiliated with the physician's work. One runner-up will receive the Community Leadership Award, which will include a $1,000 grant for the recipient's associated charity.

If you are interested in celebrating the work of a fellow CAP member who has made significant contributions to a charitable cause by offering his or her time, talents, leadership, and service, you may submit your nomination to **Communications@CAPphysicians.com**. Self-nominations are welcome.

Nominations must include:

- Name of physician
- Statement summarizing charitable service

The deadline for nominations is August 30, 2019. CAP membership is required to qualify as a nominee. If there is a physician you would like to refer for membership, please contact Membership Development at **800-356-5672** or **MD@CAPphysicians.com**.

After a thorough vetting and selection process conducted by CAP employees, the CAP Membership Education and Engagement Committee, and CAP's Board of Directors, selections will be announced in November 2019 and award payments will be issued no later than January 2020.

From supporting local hospitals and fundraising efforts for medical research, to contributing to our local youth and women's organizations, CAP is committed to a variety of causes representing the socially-conscious interests of the physicians we serve and the organization's ever-growing focus on giving back to our communities.

July 2019

Risk Management and Patient Safety News

The Genus of Subpoenas – A Member of the Court Family

Let Us Help You Decipher the Unknowns

by Lee McMullin, CPHRM

When it comes to identifying subpoenas, they really are more in a family than a genus simply because they come in so many different varieties. So much in fact, that we can only discuss them from a generic standpoint considering we have 50 state civil court systems — not to mention 50 state criminal justice systems. For example, in California we have the Superior Court and a Supreme Court in terms of name and hierarchy.

Subpoenas from a state court system will have similar formats and structures, but may appear quite different when compared to another state. Suffice it to say that the most common creature you will encounter is a subpoena issued by your state court system, while out-of-state and U.S. District Court subpoenas are the likely exception. You will benefit from becoming familiar with your state's format and structure. That said, there are traits common to all subpoenas we can discuss.

1. They all require an action of some sort. It may be to produce documents and records, to provide a deposition, or both.
2. They all have a time frame or date when the action is required, such as when records are to be produced or when a deposition will be done.
3. They all must be "served," meaning given to you via a method of service defined by the issuing state court rules. For example — in person. Email and fax have yet to evolve as a means of "service of process."
4. Subpoenas don't cross state lines, meaning a state court's "jurisdiction" is limited by its borders. For example, a Nevada state-issued subpoena is not valid when "served" on a party residing in California. In such a case, the party in Nevada must first obtain California "jurisdiction." Each state court system has its own methodology. *The Feds are the exception – a U.S. District Court subpoena is effective throughout the U.S. and its territories.*
5. Remember that HIPAA applies to confidentiality until the time specified and conditions on the subpoena come into play. Only when the time comes to pass as stated on the subpoena are the HIPAA exceptions for disclosure in legal proceedings triggered.
6. In California, most forms of subpoenas allow the person whose records are sought to "object" in advance of the disclosure, and if needed, to present "argument" before the court why their PHI should remain private. Other state systems have similar processes. Premature disclosure before the time and dates specified can land you in HIPAA trouble (see trait 5).

In closing, you will greatly benefit by understanding the genus and species of subpoenas that operate in your state. The wise person seeks advice if they encounter an unknown species. The Risk Management and Patient Safety Hotline can assist you in deciphering these unknowns and is available to

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respond to your questions about a variety of risk and patient safety topics. The hotline number is: 800-252-0555.

Lee McMullin is a Senior Risk Management and Patient Safety Specialist for CAP. Questions or comments related to this article may be directed to lmcmullin@CAPphysicians.com.

Protect Your Practice from Lurking Cybersecurity Threats

Free Training for CAP Members and Their Staff

The healthcare industry is one the most targeted industries for data breaches, accounting for 41 percent of breaches across all industry sectors.* Unfortunately, the rising incidents of data breaches among healthcare organizations continue to increase at an alarming rate. Cyber predators recognize that medical practices fail when it comes to solid cybersecurity infrastructures and thrive off the wealth of data extracted from even a single patient record.

The reality is, if a data breach occurs, the long-term ramifications of exposure, like damaged patient relations, legal battles, and hefty fines, could cost you your practice.

Employee cybersecurity awareness and training is one of the most effective ways to prevent a data breach and one of the most effective ways to prove compliance and reduce penalties should a breach occur.

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

As part of their automatic CyberRisk policy, members and their staff have prepaid access to numerous online employee cybersecurity training modules. One of those modules focuses on ransomware attacks.

Ransomware is a type of malicious software that takes control of a user's system, requiring a ransom be paid to the hacker to unlock the encrypted files.

In this eight-minute module, physicians and their employees will learn how not to fall victim to a ransomware attack that can cause serious business interruption.

To access the training, visit https://www.capphysicians.com/sites/default/files/How_to_Access_Free_HIPAA_Training.pdf

* https://www.hipaajournal.com/beazley-increase-healthcare-hacking-malware-incidents/

July 2019

Does Your Business Have Sufficient Workers' Compensation Coverage?

You already know that all California employers are required by law to have workers' compensation insurance. This coverage pays for the medical expenses of injured employees as well as compensation to the employees for lost income.

Most policies also protect physician-owners against lawsuits stemming from workplace accidents. According to the U.S. Bureau of Labor Statistics, the private healthcare sector reported having the highest number of non-fatal occupational injuries and illnesses in 2017. The top causes cited were overexertion, slips/trips/falls, and contact with objects or equipment. Due to these unfortunate events, healthcare professionals may decide to work through the pain and/or discomfort while risking the possibility of worsening the injury or illness.

CAP Physicians Insurance Agency, Inc. (CAP Agency) intimately understands medical practice challenges — and how to insure against those challenges most cost effectively. We are a full-service agency with knowledgeable professionals who can answer your questions and help you find the best solutions for your insurance needs.

Filing a claim should not be the first time you review your business insurance. CAP's Specialized Workers' Compensation Program, provided through Hanover Insurance Group, offers comprehensive workers' compensation coverage for medical practices at negotiated low group rates for CAP members. Our insurance professionals at CAP Agency also can help you evaluate whether you have adequate coverage for your practice.

We are always looking for ways to save our members money. If you need to purchase coverage or would like us to get you a competitive quote for insurance you already have, call us at 800-819-0061 or send us an email at CAPAgency@CAPphysicians.com.

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For more information about physician-specific insurance programs, request a free copy of *Physician's Guide to Choosing the Right Insurance*.

When seeing patients, the physician's practice is no place for taking chances. The same goes for running a unique business like yours. Customization is key when securing the right insurance and the first step is understanding the options available.

Get the free guide today and discover a convenient and easy way to approach your insurance portfolio. To get your copy, please call 800-819-0061 or email CAPAgency@CAPphysicians.com.

Case of the Month

by Gordon Ownby

Court Limits Use of ER Testimony Restriction

An important component of a medical professional liability lawsuit is the requirement that the plaintiff prove a causal connection between a breach in the standard of care and a claimed injury. A new case from the Court of Appeal provides an excellent illustration of this concept.

(Typical of most Court of Appeal opinions highlighted in Case of the Month*, the underlying facts alleged by the plaintiff are assumed true so that the court can address the legal lesson at hand. In a trial, the defendant would have the opportunity to dispute such facts.)*

Clara Stokes presented to the hospital's emergency department complaining of sudden pain in the back of her head radiating to her neck. She told the ER physician, Ellen Baker, MD, she experienced the pain and a migraine headache since twisting her neck two days earlier. She also reported a recent increase in migraine headaches, that she was suffering from the worst headache in her life, that her primary pain intensity was "10/10," that she had vomited the evening before, and that she felt right sciatic pain.

Dr. Baker's exam found neck tenderness, no neurological deficit, and full strength in the patient's arms and legs. A CT scan was negative for head or brain injury and a lumbar spine x-ray was unremarkable. A cervical spine x-ray showed a congenital fusion abnormality and degenerative changes. Dr. Baker contacted the on-call neurologist, who said he could see Ms. Stokes in a few days.

Dr. Baker concluded Ms. Stokes had an acute migraine headache, dehydration, and severe nerve degeneration. She prescribed pain medication and advised her to contact the neurologist for a follow-up visit.

Ten days later, Ms. Stokes suffered an intracranial bleed secondary to a ruptured aneurysm and underwent a craniotomy and clipping, leaving her with persistent cognitive and physical impairments. She sued Dr. Baker for not properly addressing her condition in the ER.

In a motion for summary judgment, Dr. Baker's defense lawyer presented a sworn declaration from Jonathan Lawrence, MD, an emergency room physician. In his declaration, the Dr. Lawrence stated that Dr. Baker conformed with the standard of care in her treatment of Ms. Stokes. Dr. Lawrence also stated his further opinion "that no act or omission by [Dr. Baker] caused or contributed to any injury" as alleged by the plaintiff.

In opposition to the motion, the plaintiff's attorney submitted the declaration of Michael Ritter, MD, also an emergency room physician, who stated his opinion that Dr. Baker fell below the standard of care by failing to order tests to rule out a subarachnoid hemorrhage. When the CT came back negative, Dr. Ritter opined, the standard of care required a lumbar puncture. When such a puncture revealed blood in the cerebral spinal fluid, as it would in Dr. Ritter's view, the standard of care would have required Dr. Baker to refer Ms. Stokes to a neurosurgeon or neurointerventional surgeon.

But it was a second opinion submitted by the

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plaintiff that made things legally interesting. That is because in a medical professional liability case against a physician performing emergency medical care in an acute care emergency department, California Health and Safety Code Section 1799.110(c) requires that "the court shall admit expert testimony only from physicians who have had substantial professional experience within the last five years while assigned to provide emergency medical coverage in a general acute care hospital emergency department."

The second declaration submitted by plaintiff, however, was by George Rappard, MD, a neurointerventional surgeon. According to Dr. Rappard, had Dr. Baker diagnosed a subarachnoid hemorrhage (which he described as an "early warning" bleed indicative of an aneurysm likely to soon rupture) and referred her to a neurosurgeon or neurointerventional surgeon, that specialist would have identified the aneurysm and performed repair surgery on an emergent basis. In claiming that such failure by Dr. Baker was a substantial factor in causing the plaintiff's injury, Dr. Rappard explained that the morbidity for repair of an unruptured aneurysm is two percent, compared to 70 percent following a subarachnoid hemorrhage from a ruptured aneurysm.

On the request of Dr. Baker, the trial court excluded Dr. Rappard's declaration on the basis that Dr. Rappard lacked the emergency-room credentials required by H&S Section 1799.110(c). With Dr. Rappard's testimony on causation now gone, Dr. Lawrence's statement that there was no causation between Dr. Baker's acts and the injury became uncontested, allowing the trial court to render judgment in favor of Dr. Baker.

On appeal, the Court of Appeal conceded that excluding Dr. Rappard's declaration was "consistent with the strict letter of the expert qualification clause" in the Health and Safety Code.

However, the Los Angeles-based Court of Appeal in *Stokes v. Baker*, continued: "Although ambiguity is generally a condition precedent to interpretation, the literal meaning of the words of a statute may be disregarded to avoid absurd results or to give effect to manifest purposes that, in the light of the statute's legislative history, appear from its provisions considered as whole."

In this setting, then, the question was whether the Legislature intended to permit expert testimony only from emergency room-qualified physicians on *all* medical issues in a trial, as Dr. Baker contended, or whether it was just testimony on *standard of care* that required an expert to have recent experience in the ER.

In looking through the statute's legislative history, the Court of Appeal noted that in 1978, then Gov. Jerry Brown nearly vetoed the bill creating the ER experience requirement for witnesses out of concern that its language could be read to "bar expert medical testimony on issues other than the standard of care expected of emergency room physicians." In other words, the exact issue faced in *Stokes v. Baker*. The Governor let the bill become law without his signature, however, on its author's commitment to address the issue in subsequent legislation.

Though that follow-up legislation did not pass, the author of the original bill stated in a letter printed in the Assembly Journal a few months later: "The Legislature intended that this expert witness qualification apply only to those witnesses testifying as to the standard of care required of an emergency department physician and not to those witnesses testifying to the issue of recoverable damages."

The Court of Appeal found the legislative history consistent with interpreting the statute "on how a jury would judge the reasonableness of an emergency room physician's conduct — not the causation or damages element of a negligence claim" and reversed the trial court's defense judgment.

The court also commented on "obvious absurdities" that would result from the position advocated by the

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defense. "The practical effect . . . would be to close the courthouse doors to plaintiffs in cases like this one, where causation and damages implicate medical issues outside the practice of emergency department physicians."

And in another wrinkle, the Court of Appeal pointed out that the defense expert, Dr. Lawrence, is an emergency room physician with "no specialization or apparent experience in either neurosurgery or neurointerventional surgery." As such, the Court of Appeal wrote that "unless Dr. Lawrence is able to show he has special skill, experience, training, or education regarding the neurosurgical issues raised by plaintiff's theory of liability," he is not qualified to offer medical testimony on causation under the California Evidence Code.

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

New Practices for Probation Status Disclosure

by Gabriela Villanueva

A new California law requiring practitioners to disclose a probation status to their patients went into effect on July 1, 2019.

Last September, then-Govenor Jerry Brown signed the "Patient's Right to Know Act of 2018" (SB 1448 by Senator Jerry Hill, D-San Mateo), the first-in-the-nation law requiring practitioners to notify their patients if their license is on probation for the following offenses:

- Any act of sexual abuse, misconduct, or relations with a patient or client;
- Drug or alcohol abuse directly resulting in harm to patients or to the extent that such use impairs the ability of the practitioner to practice safely;
- Criminal conviction directly involving harm to patient health; or
- Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

Previously, when a physician was put on probation, he or she was only legally required to notify their malpractice coverage provider and any affiliated hospitals or clinics. Under the new law, the Medical Board of California (MBC) will now require all physicians disciplined by their regulatory board to obtain a signed disclosure from all patients before a patient's next appointment. The disclosure must include:

1. The physician's probation status.
2. The length of the probation and end date.
3. The practice restrictions placed on the medical licensee by the MBC.
4. An explanation of how the patient can find further information about the licensee's probation on the licensee's MBC website profile page.

The new law applies to physicians and surgeons (including osteopaths and naturopathic doctors), chiropractors, podiatrists, and acupuncturists.

The MBC has long-carried physician information on its website but amendments to the law placed the focus on the minority of doctors who commit egregious misconduct. "We never tried to protect those doctors, and we never will," said Ted Mazer, MD, CAP member, and past president of the California Medical Association when interviewed by a local news channel. Dr. Mazer added that it was important to the CMA that physicians who had been disciplined for lesser wrongdoings that did no harm to patients — such as deficits in medical recordkeeping — would not have to reveal the disciplinary action to their patients.

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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