



## Welcome to Our New CAP Fellows



From left to right: Dr. Dennis T. Jordanides, Dr. Atashi Mandal, Dr. Huynh Wynn Tran, and Dr. Roger S. Eng.

CAP Fellows is a leadership development program designed to help ensure that our organization is the very best it can be by preparing a group of top physicians to eventually assume leadership roles. In addition to gathering together periodically, CAP Fellows attend committee meetings ranging from Education and Patient Safety, Risk Assessment Peer Review, Finance, Board of Directors, and more.

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*"We're grateful for the tremendous response to our request for new CAP Fellows. The quality of the physicians who chose to participate is outstanding."*

—Sarah Pacini, JD,  
CEO, Cooperative of American Physicians, Inc.

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### Our new CAP Fellows are:

**Dr. Roger S. Eng**, who practices diagnostic radiology at Golden Gate Radiology in San Francisco.

**Dr. Dennis T. Jordanides**, who practices internal medicine in Newport Beach.

**Dr. Atashi Mandal**, who is an adult and pediatric hospitalist who practices in Huntington Beach.

**Dr. Huynh Wynn Tran**, a rheumatologist who practices in Rosemead. Dr. Tran is also the CEO/ Founder of VietMD.

Please join us in welcoming these dedicated, hard-working physicians to the CAP Fellows program. Their efforts will benefit every CAP member. ➦

# Risk Management — and — Patient Safety News



## Dealing with the Noncompliant Patient

One of the most sacred and honored types of professional relationships is the doctor/patient relationship. Just like every type of relationship, it takes a concerted effort by both parties to make it work. Physicians are expected to uphold their ethical obligations toward the patient, and, in turn, the patient is expected to honor the suggestions and recommendations offered by the physician. What steps can the physician take to set these expectations, and what is the best course of action for the physician to follow in the case of the noncompliant patient?

The importance of developing proper expectations early in the doctor/patient relationship is critical to any effort to minimize the occurrence of the noncompliant patient. In doing so, the terms of compliance are defined. An excellent method of laying the groundwork for compliance is a “doctor/patient contract.” CAP has one available, entitled the “Patient Partnership Plan,” which may be obtained through the Risk Management and Patient Safety Department. Although not a binding contract, this type of agreement can serve to establish comprehensive and attainable expectations to which both the physician and patient can be held accountable. It is a simple process for the physician to go over the agreement with the patient during his or her initial appointment, and it can go a long way to develop a positive and proactive approach to the doctor/patient relationship.

Noncompliance can be attributed to a number of situations. Patients may miss scheduled

appointments. Perhaps they simply refuse to follow the recommendations of the physician. Patients may not pay their bills, or they may act in an unacceptable, belligerent, or dangerous manner towards the physician or the physician’s staff. Whatever the reason may be, the single most important factor for the physician to remember at this point is to document both the issues at hand and the steps that were taken to resolve them. This documentation should be entered into the patient’s medical record and should be comprehensive and objective.

Dealing with noncompliant patients presents a very complex set of challenges. The implementation of risk management strategies is crucial. These strategies include:

- 1 Have a policy and procedures about terminating a patient-physician relationship.
- 2 Keep accurate and detailed documentation.
- 3 Speak with the patient prior to making a final decision regarding the relationship termination. And, consider sending a “pre-withdrawal letter” that gently expresses your concern over his or her noncompliance.
- 4 Discuss the situation with a colleague, risk management professional, or legal advisor.
- 5 Explain to the patient that he or she is being terminated from care, and provide an explicit reason. Do not delegate this task; speak directly with the patient.

- 6 Inform clinic staff of the termination, particularly your scheduler.
- 7 Send a certified letter with return receipt to the patient and the insurance carrier stating the termination and that care will be discontinued in 30 days' time, noting the specific date. Notify the patient you will be available for emergency treatment until a specific date. Offer the patient interim care.
- 8 Provide names and contact information for suggested alternate providers. Offer to transfer records when given written permission.

In the event of noncompliant patients, the physician should:

- Stay objective, both in discussions with the patient, and in documentation of the issues.
- Document, document, document.
- Do not attempt to resolve this alone. Seek the guidance of a risk management specialist.

Remember – the patient's right to care is foremost, and that basic care must be continued until a reasonable alternative can be found. ↩

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

If you are contemplating a change in your practice, 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
- Reduction or change in the scope of your practice
- Employment with a government agency or non-private 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 2018. To allow ample processing time, we recommend that members advise

us *in writing* no later than October 31, 2018, of any of the above changes to be considered eligible for waiver or proration of the next assessment.

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. ↩





# A Study of Defensive Medicine

by Gabriela Villanueva

As the conversation around healthcare revolves heavily upon reining in costs, a new study out of the National Bureau of Economic Research has been able to focus on how “defensive medicine” contributes to the costs.

Jonathan Gruber, health economist at MIT, and Michael D. Frakes, a Duke University economist and lawyer, found a segment of the population, active-duty members of the military and their families, to offer what is perhaps the most precise estimate yet of how much defensive medicine matters, at least for care in the hospital.

Their study “Defensive Medicine: Evidence From Military Immunity” highlights that physicians, when faced with the possibility of being sued, did increase the amount of healthcare patients received by up to five percent — but that such extra care did not necessarily result in better outcomes.

While active duty military patients are barred from suing for medical malpractice, care to their family members are not so immunized. Drawing from that variation, the authors found “suggestive evidence that liability immunity reduces inpatient spending by five percent with no measurable negative effect on patient outcomes.”

Advocates of reforms to the country’s medical liability system say that the threat of litigation forces physicians to order unnecessary tests and procedures to protect themselves in a lawsuit. Here in California, the Medical Injury Compensation Reform Act (MICRA) limits awards for noneconomic damages in medical professional liability lawsuits to promote patient access to medical care. Lisa Maas, executive director of Californians Allied for Patient Protection, said of the new study: “The benefits of medical liability reform laws like California’s existing MICRA stabilize medical liability costs and, encouraged by the results of this study, it is another example of how strong liability reforms empower physicians to minimize the use of defensive medicine.” ↩



Link to study:

<http://www.nber.org/papers/w24846>

*Gabriela Villanueva is CAP’s Public Affairs Analyst. Questions or comments related to this article should be directed to [gvillanueva@CAPphysicians.com](mailto:gvillanueva@CAPphysicians.com).*



## Reminder

# CURES: Mandatory Use Begins October 2

by Kimberly Danebrock, JD, RN, CPPS

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The Department of Justice (DOJ) has certified California's Controlled Substance Utilization Review and Evaluation System (CURES). Therefore, effective October 2, 2018, it will become mandatory for all healthcare practitioners who prescribe to consult and review the CURES 2.0 system prior to prescribing, ordering, administering, or furnishing a Schedule II-IV controlled substance. A healthcare practitioner who fails to consult the CURES database must be referred to their state professional licensing board for administrative sanctions, as deemed appropriate by that board.


The law requires a healthcare practitioner to check when prescribing a Schedule II-IV medication for the first time and at least once every four months thereafter if the medication remains part of the patient's treatment plan. Prescribers will also be required to obtain and use tamper-resistant prescription forms ordered only from state-approved security printers.

The Medical Board of California provides further information on everything you need to know to prepare for October, including exemptions and what to do in the case of technical difficulty. Please visit these online resources:



[http://www.mbc.ca.gov/Licensees/Prescribing/CURES/CURES\\_Mandatory\\_Flyer.pdf](http://www.mbc.ca.gov/Licensees/Prescribing/CURES/CURES_Mandatory_Flyer.pdf)

CURES 2.0 User Registration:

<https://www.cures.doj.ca.gov/registration/confirmEmailPnDRegistration.xhtml> 

*Kimberly Danebrock is Director of Risk Management for CAPAssurance and Director of Risk Assessment Peer Review, MPT. Questions or comments related to this article should be directed to [kdanebrock@CAPphysicians.com](mailto:kdanebrock@CAPphysicians.com).*

# Linked Benefit Coverage — A Unique and Financially Sound Alternative to Traditional Long-Term Care Insurance

It's difficult to consider that at some point in our lives we may need help with basic everyday living needs, and even more difficult for some to discuss with family members who will care for you when you can no longer care for yourself.

Long-term care insurance has traditionally been considered a prudent purchase to help defray the exorbitant expenses incurred when you or a loved one need assistance for daily care, due to physical and/or dementia-related challenges. However, many of us resist buying traditional long-term care insurance because of its high cost and money lost if the benefits aren't used.

If you've been holding off acquiring long-term care insurance because of the perceived financial risk, let us introduce you to another excellent option: linked benefit coverage. Linked benefit coverage simply combines long-term care with another type of insurance, like life insurance or an annuity. **This means, if you never need to use the long-term care benefits, your heirs receive a life insurance death benefit or the cash value of the annuity.**

The most common type of linked benefit long-term care insurance is life insurance with an extended long-term care rider. This will allow the policyholder to exhaust the death benefit to pay for long-term care and provide additional money for long-term care that extends past the death benefit.

Another type of coverage is a deferred annuity that doubles or triples your money if you need long-term care. You may want to consider this if you already have an existing annuity that can be rolled over tax-free into a new annuity with long-term care benefits.

In 2010, the Pension Protection Act (PPA) offers new tax benefits for long-term care plans tied to a qualified life insurance or fixed annuity contract. PPA allows tax-free distribution of life insurance or annuity cash value to pay for long-term care. Protect your loved ones from shouldering the financial and emotional burden of care and loss, and build a legacy for their future.

To learn more, contact CAP Physicians Insurance Agency at 800-819-0061 and ask for Janet Hemphill or email us at [CAPAgency@CAPphysicians.com](mailto:CAPAgency@CAPphysicians.com) to learn more about this valuable coverage. ➔



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## Help a Colleague Launch His or Her Own Practice: Share CAP's Free New Action Guide

CAP knows that owning your own practice comes with a unique set of challenges, but also countless rewards, including the priceless feeling of professional independence.

If you know any employed physician colleagues or residents who may be interested in starting their own practice, we have recently published a comprehensive how-to guide to ease the process: *The Physician's Action Guide to Starting Your Own Practice*. Topics include:

- Laying the foundation for success
- Getting your legal, regulatory, and administrative house in order
- Your new space: making it yours
- Staffing up and building relationships

In addition, you'll find a pull-out Implementation Timeline and Checklist, as well as a robust list of valuable practice management resources.

We've stocked our shelves with free copies earmarked just for members to pass along to colleagues who might be looking for the right motivation to take the plunge. To request free hard copies, contact CAP Membership Services at:

phone: **800-610-6642**, or  
email: **ms@CAPphysicians.com**

To download a digital copy, you or your referred colleagues can visit **[www.CAPphysicians.com/SYOP8](http://www.CAPphysicians.com/SYOP8)**.

This guide has gotten stellar reviews, so you can feel confident that you're providing a resource that could change a colleague's life for the better! ➦

# Case of the Month

by Gordon Ownby



## Court Details Difference Between Negligence and Abuse

In a new opinion addressing allegations of elder abuse, the Court of Appeal explains how evidence of simple “negligence” differs from “recklessness” in a nursing facility setting.

Following a loss of weight, episodes of passing out, and falls, Harvey Cohoon was diagnosed with stage 2 colon cancer. Mr. Cohoon started a treatment of chemotherapy and radiation and moved from a hospital to a skilled nursing facility, where he planned to stay for the duration of his cancer treatment.

On admission to the facility, Mr. Cohoon was malnourished, had a stage 3 pressure ulcer, and exhibited muscle wasting. Following a comprehensive assessment, social service admission evaluation, and assessments on activity, nutrition, dietary risks, the facility staff prepared an extensive care plan.

According to the facts in *Cochrum v. Costa Victoria Healthcare, LLC*, Mr. Cohoon’s condition improved over his first 19 days at the facility. Despite his cancer treatment, he gained weight and his protein levels improved. One of his relatives commented that it was obvious Mr. Cohoon was “getting better day by day.”

At one point, however, a nurse observed Mr. Cohoon having problems eating and ordered a speech therapist to evaluate him. Following that evaluation,

the therapist ordered that Mr. Cohoon’s diet be changed to “mechanical-soft” (food cut into pieces a half-inch or smaller) with pudding-thick liquids.

The next evening, however, a nurse noted an inattentive Mr. Cohoon during his dinner time. Unsuccessful in arousing Mr. Cohoon, who had a pulse but was not breathing, the nurse initiated a code blue. The family was notified of the situation as 911 was called.

Prior to initiating CPR with an Ambu bag, the nurse did a finger sweep of Mr. Cohoon’s mouth and found no food present. The nurse did not perform a Heimlich maneuver because in addition to the negative mouth sweep, Mr. Cohoon’s chest was rising and falling with the Ambu bag. When paramedics arrived, Mr. Cohoon was in full a respiratory and cardiac arrest. When a paramedic inspected Mr. Cohoon’s throat, he used forceps to remove two solid pieces of chicken. At the hospital, a physician removed some 10 pieces of chicken from Mr. Cohoon’s airway, ranging in size from a dime to a quarter.

Mr. Cohoon’s death the next day was attributed to a complete airway obstruction, respiratory and cardiac arrest, and resulting brain damage.

In a subsequent lawsuit and trial against the facility and its owner and service providers, Mr. Cohoon’s estate presented expert testimony opining that

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staffing, training, and management at the facility were inadequate. The plaintiffs also presented expert testimony on precautions the facility should have taken with regard to monitoring Mr. Cohoon's dinner meal under the diet change and on the nurse's failure to perform a Heimlich maneuver.

A jury found in favor of the estate under California's Elder Abuse and Dependent Adult Civil Protection Act. Under that law, a jury may award enhanced damages if it finds that the defendant acted recklessly. After finding of negligence and recklessness by agents and employees of the center and its owner, the jury awarded \$15,511 in economic damages, \$350,000 in noneconomic damages for wrongful death, and \$900,000 in noneconomic damages for elder abuse.

After the verdict, the trial court judge reduced the awards for wrongful death and elder abuse to \$250,000 under California's Medical Injury Compensation Reform Act (MICRA). Later, the court granted a defense motion for a "judgment notwithstanding the verdict"—a rare act in which a judge overrules the finding of the jury.

In granting the new judgment, the judge acknowledged substantial evidence to support the jury's finding that Mr. Cohoon was not served a mechanically soft-chopped meal, that the facility negligently served him an improper meal, and that it inadequately monitored him during the meal.

"What the jury got wrong, however," the judge wrote, "was the verdict that the acts of the facility amounted to elder abuse under the Elder Abuse Act." In concluding that the defendants' conduct amounted to negligence — but not recklessness as required to support a claim for elder abuse — the judge reasoned: "The entire episode concerning Mr. Cohoon was over in less than 12 hours, from the change in dietary plan to the choking. There were no complaints to the facility and no ongoing refusal

to provide service and no evidence that Mr. Cohoon had been abused or was in any danger before being served his meal."

In upholding the trial judge's decision, the Orange County-based Court of Appeal noted that the Elder Abuse Act requires proof of either "physical abuse . . . or neglect . . . and that the defendant has been guilty of recklessness, oppression, fraud, or malice in the commission of this abuse." Citing past California cases, the appellate court said that "recklessness involves 'deliberate disregard' of the 'high degree of probability' that an injury will occur and rises to the level of a 'conscious choice of a course of action . . . with knowledge of the serious danger to others involved in it.'"

The Court of Appeal found no substantial evidence of such recklessness in Mr. Cohoon's care and addressed the plaintiff's claims of inadequate staffing, training, and monitoring. In that review, the court said that "at least in principle, understaffing could amount to recklessness if it is sufficiently egregious. That was not the case here."

Similarly, the appellate court found that evidence claiming inadequate monitoring did not rise to the level of recklessness and as for training, the court said, "there is nothing in the record to suggest that an additional educational program on choking prevention would have changed anything" and that a failure to require licensed nurses to attend a choking program that year "was, at most, negligent." ↩

*Gordon Ownby is CAP's General Counsel. Questions or comments related to "Case of the Month" should be directed to [gownby@CAPphysicians.com](mailto:gownby@CAPphysicians.com).*



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*Legal guidance for individual matters should be obtained from a retained attorney.*