



From a Van Along the 'Gringo Trail,' to a Very Independent Family Practice

Dr. Peter Birnstein succeeds with care and a lifelong sense of adventure.

No one in Dr. Peter Birnstein's family was a doctor, but he always had an aptitude for math and science. "I started in pre-med at Cal Berkeley and continued from there. It just felt like the right fit," Dr. Birnstein explains. "I went to USC Medical School and stayed there for my internship, then went to Stanford for a year for ENT."

If you are like most young doctors on this career track, you would likely feel compelled to go off and start your own practice. But Dr. Birnstein is not like most doctors. He headed straight for South America and started a drive along the "Gringo Trail" in a van. "It was sort of the hippie days, so I went traveling with a friend who had been in law school. I doubt a young doctor could take the same kind of hiatus today," Dr. Birnstein recalls with a smile.

It turned out to be more than just a youthful adventure. "It was an entirely different kind of education. It was a great opportunity to learn about people of all different cultures and backgrounds," he reflects. "I became fluent in Spanish. What really stuck with me was that unless you make an effort to really see things from another person's point of view, you'll be limited in what you can accomplish."

Some members of his family were worried that Dr. Birnstein would never settle down. But once he returned home, he started an independent family practice.

"The forces are all against my type of solo practice. But to have your independence and not be limited in the type of care you can deliver by some administrative body is great."

Amazingly, today – a full four decades later – he is still running that same practice. Still independent. Still working hard to see things from his patients' point of view.

"What I love about family medicine is continuity, getting to a level of trust. The most gratifying thing is when you have gotten through to the patient," Dr. Birnstein says. "To see your patients go forward and succeed, to change how they take care of their health never gets old." No wonder his practice cares for patients over several generations.

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DR. PETER BIRNSTEIN AT-A-GLANCE

Medical Specialty: Family Medicine

Practice Location: Santa Monica

Years in Practice: 40

CAP Member Since: 1991

Dr. Birnstein has been with CAP since 1991, and works on multiple CAP committees. "I chair the Medicine Subspecialty Peer Review Committee and also serve on the Closed Claims and Education committees."

He also teaches students from USC's Keck School of Medicine. "Students spend a month in my office as part of their course in family medicine. My first piece of advice to them is to always put patient welfare first, no matter what. Second, put yourself in the patient's shoes. Third, keep your balance. It's great to have confidence in your skills, but remember there is always more to learn," Dr. Birnstein says.

Despite his busy schedule, Dr. Birnstein likes to work out and play the piano, everything from Cole Porter and

Beethoven to Stevie Wonder. His wife, Lauren, is a Superior Court judge for Los Angeles County and his son, Elliott, is a Gastroenterology Fellow at New York's Sloan-Kettering Hospital.

Forty years later, Dr. Birnstein remains an adventurer. "The forces are all against my type of solo practice. But to have your independence and not be limited in the type of care you can deliver by some administrative body is great."

His independent spirit and dedication to putting patients first is why his patients stay with him, generation after generation. "We have families who have been with us for three full generations," Dr. Birnstein said. "And soon we'll see a fourth." ❄️

Budget for California Courts Improves Again

With the just-passed state budget, California's courts finally have made up the ground lost on court funding experienced since the recession.

On June 27, Governor Jerry Brown signed the state's 2016-2017 budget, which plans for \$122.5 billion in General Fund spending. In addition to the budget's many funding requirements and obligations set by the state constitution and voter-approved measures, the state's judicial branch continues to receive incremental increases to its once severely slashed budget.

Among those most impacted by recession-era budget reductions were the trial courts, which saw courthouse and courtroom closures throughout the state. California courts suffered some of the deepest budget reductions and limped along for several budget cycles until most recently when surpluses in 2014 allowed for gradual increases in funding levels.

Once again for the 2016-2017 cycle, the budget has allocated additional funding that has, for the first time,

taken the judiciary's budget past its pre-recession amount of \$3.7 billion. With the budget's bump in 2015-2016 to \$3.47 billion (from \$3.29 billion in 2014-2015), the 2016-2017 budget has now reached a total funding amount of \$3.8 billion. Of the total, \$2.8 billion is allocated to support trial court operations.

Some of the line items specific to trial court funding include:

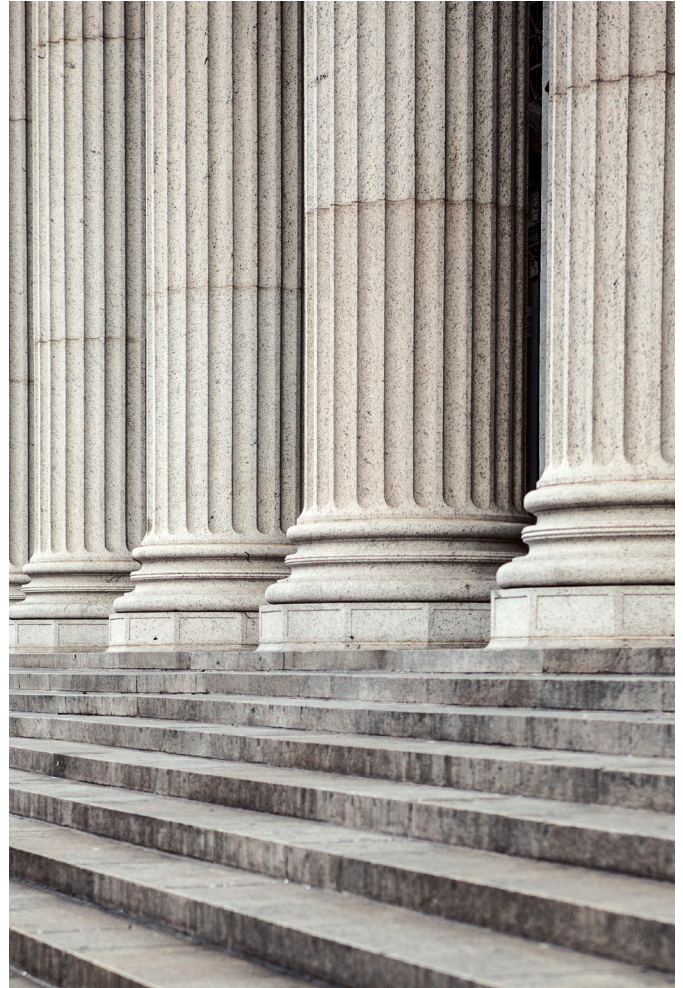
- An increase of \$20 million for discretionary trial court operations.
- A total of \$75 million to backfill an expected continued reduction of fines and penalty revenues expected. This is an increase of \$8.8 million over 2015-2016.
- The Court Innovations Grant Program – a one-time \$30 million grant that promotes improvement, efficiencies, and access to justice in the courts.
- An injection of \$7 million to the Judicial Council's current budget of \$94.5 million for its court interpreter services to help improve language access for court users with limited English proficiency. ❄️

Protections Against Employment Practices Liability

Every business that acts as an employer has the possibility of exposure to lawsuits from employees or former employees. We frequently hear from our doctors, "My employees love working here. They would never sue me." But, the reality of running a business is everyone who employs workers runs the risk of being sued. Companies such as medical practices do not always have definite human resources policies and procedures, which leave them more vulnerable to litigation.

As an employer, you can put in place protections against employment practices lawsuits by implementing the steps outlined below. These steps may help prevent a lawsuit or claim in the future, and help protect your practice from potential financial hardships.

- Develop a human resources manual specific to your practice with clear policies and procedures. It is important that the manual contain your practice's equal employment opportunity policy as well as an internal mechanism to complain about discrimination or harassment. You can download a customizable human resources manual on the CAP website by logging into the Member's Only section at www.CAPphysicians.com.
- Train supervisors in human resources procedures and policies and keep all policies in one place.
- Provide an employee handbook to all new employees and review policies and procedures with all new hires as part of an employee orientation.
- Keep your policies up-to-date by revising when there are changes in the law. Make sure your human resources manual reflects these changes.
- Prior to terminating an employee or if an employee has issues with your wage and hour or leave of absence policies, contact the CAP Human Resources Hotline at 213-473-8664 for a free consultation. It is also recommended you contact the hotline whenever you face discrimination allegations or employee misconduct issues.
- Purchase an Employment Practices Liability Insurance (EPLI) policy to protect you and your practice against any claims filed by disgruntled employees.



On average, 81 percent of employment practices liability claims settle for between \$22,000 and \$40,000, a significant amount for a small business. CAP physician members have a \$50,000 defense only benefit provided by your Employment Practices Plan (EPP), with a \$5,000 deductible for individual members. This EPP coverage would not pay for any settlements or fines and penalties.

CAP Physicians Insurance Agency, Inc. has competitive rates for EPLI coverage available exclusively for CAP member physicians. You owe it to yourself and your practice to get a quote. The agency stands ready to help you protect your practice. Contact us at 800-819-0061 or at CAPAgency@CAPphysicians.com for more information. ➤



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Capacity to Provide Informed Consent: Is a Patient's Competence the Issue?

by Dan Groszkruger, JD, MPH, CPHRM and Dona Constantine, RN, BS

The terms "capacity" and "competence" are often used interchangeably, but there are important differences. The term "competence" refers to a court's determination of a patient's legal status. That is, "competence" refers to a judge's conclusion, based on facts submitted by a physician, that a patient is legally able to make a decision. The term "capacity" describes the individual's mental ability to understand the nature and effect of a decision. Physicians supply the facts necessary to determine "capacity."

Statement of the Dilemma

Physicians regularly confront difficult legal issues that arise within the physician-patient relationship. Few are more problematic than informed consent, such as for end-of-life decisions, that depend upon a patient's capacity to consent. A legal definition of the term "competence" provides little guidance for a clinician faced with a patient whose faculties may be impaired.

- What standards should apply to a determination of capacity to consent?
- Should the physician follow an advance directive executed by a patient at a time when his or her mental faculties may have been impaired?
- What level of impairment will preclude the patient's capacity to provide an informed consent?
- When should a court determine the patient's competence?

Generally, a court's determination of competence is not required if the physician can adequately assess the patient's capacity (i.e., mental functions). The physician may inquire, after explaining recommended care, and note the patient's

response. Based on a patient's response, is the physician confident that the patient understands? If the patient appears to be confused or not responsive, additional questions probably are in order.

Where court intervention appears necessary, a petition under Probate Code § 3201 may be filed in Superior Court by the patient, by any family member, by the patient's physician, or by other interested persons. The petition should be based on the physician's findings that suggest a deficit in alertness and attention, inability to process information, agitation or distraction, irrational thought processes, or inability to modulate mood and affect.

The Legal Standard

A competent adult may make his or her own treatment decisions, including refusal of life-sustaining treatment. A competent adult understands the nature and seriousness of the medical condition, the purpose of the recommended medical treatment, alternatives, and the risks and benefits of consenting to or refusing the recommended treatment. A competent adult is able to answer questions about his or her condition or recommended treatment and demonstrates a rational thought process. A patient should be presumed competent unless there are indications to the contrary.

The Physician's Role

While no specific test or measurement is required, the attending physician is responsible for determining capacity to make a decision. The patient's behavior, clinical condition, and interactions with family and friends all are relevant. A psychiatric evaluation is not necessary, but the physician may consider one in close cases. The substance of discussions with the patient and family, consultations, and other relevant information should be

Case of the Month

by Gordon Ownby



State High Court Clarifies How to Classify Hospital Accidents

In a decision that aims to quell a long history of conflicting rulings on the topic, the California Supreme Court has adopted a wide view of when an accident in a hospital should be considered medical professional negligence instead of ordinary negligence.

Catherine Flores was a hospital patient who was injured when the rails on her hospital bed collapsed. The rails had been raised on a physician's order following a medical assessment of Ms. Flores' condition. She sued the hospital, claiming that it negligently failed to inspect and maintain the equipment. The timing of that suit, however, led to a dispute between the plaintiff and the defendant hospital as to the actual nature of the allegation.

The hospital contended that by waiting nearly two years to file her suit, Ms. Flores did not meet the one-year statute of limitations for medical professional lawsuits under California's Medical Injury Compensation Reform Act (MICRA). Ms. Flores' attorneys maintained that the alleged failure to properly maintain the bed rails fell outside the scope of professional medical care and that her suit should be allowed to proceed under the rules for ordinary negligence. The statute of limitations for ordinary negligence is two years.

The trial court judge agreed with the hospital's attorneys, but the intermediate Court of Appeal overturned that ruling and allowed the suit to proceed.

In *Flores v. Presbyterian Intercommunity Hospital*, the state's highest court ruled that because the plaintiff's injury resulted from alleged negligence in the use and maintenance of equipment needed to implement the doctor's orders, her claim falls into the category of professional, rather than ordinary, negligence.

Under MICRA, medical professional negligence is defined as "a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by a licensing agency or licensed hospital."

Ms. Flores' attorneys argued that the term "professional services" does not apply because the maintenance of hospital equipment and premises requires no "specialized education, training or skill." Counsel for the hospital countered that "the test is not whether the situation calls for a high or low level of skill . . . but rather the test is whether the negligent act occurred in the rendering of services for which the health care provider is licensed."

The Supreme Court unanimously ruled that the law on professional medical services does not apply only to those specific tasks that require advanced medical skills and training.

"A hospital's failure to prevent a patient from becoming separated from an oxygen ventilator, for example, occurs in the 'rendering of professional services' regardless of whether the separation was caused by an ill-considered decision of a physician or the accidental bump of a janitor's broom."

"Thus, if the act or omission that led to the plaintiff's injuries was negligence in the maintenance of equipment that, under the prevailing standard of care, was reasonably required to treat or accommodate a physical or mental condition of the patient, the plaintiff's claim is one of professional negligence...," the court said.

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Risk Management and Patient Safety continued from page 4

recorded in the chart. The physician's conclusion regarding the patient's mental capacity, or lack thereof, also must be documented in the chart.

A competent adult must be able to process sufficient information in order to make an intelligent decision about recommended care, including withholding or withdrawing life-sustaining treatment. The physician must disclose all "material" information, i.e., information that would be regarded as necessary or helpful by a reasonable person in the same or similar situation. Such disclosure includes a description of the recommended measures, potential adverse risks, complications, and expected benefits. Also, the physician should explain the likelihood of success and treatment alternatives, including the option of no treatment. Generally, it is not necessary to disclose minor risks or consequences that are remote or unlikely, although possible. The substance of the dialogue between physician and patient must be documented in the chart, as indirect evidence that informed consent was obtained.

Documentation Is Vital

Determining capacity to provide an informed consent is a threshold requirement for end-of-life decision-making. As with standard of care issues, a retrospective review of the physician's conduct and exercise of professional judgment often will focus on the written record, which carries more weight than the physician's recollection of past events. Proper documentation of discussions and findings regarding a patient's mental faculties and capacity to give informed consent and to make end-of-life decisions is the surest way to avoid or minimize exposure to malpractice liability. ↩

Dan Groszkruger is a healthcare attorney, a former hospital executive, risk manager, and compliance officer.

Dona Constantine is a Senior Risk Management and Patient Safety Specialist for the Cooperative of American Physicians.

Questions or comments related to this article should be directed to dconstantine@CAPphysicians.com.

Correction

In the hardcopy edition of our last issue, we incorrectly identified Ann Whitehead as the author of "Identifying Human Trafficking Victims in a Healthcare Setting." The article was actually written by Dona Constantine.

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But the court also explained that "professional negligence" does not extend to maintenance of equipment and premises that are merely convenient for, or incidental to, the provision of medical care to a patient.

The court pointed out that hospitals maintain tables, toilets, televisions, and the like that primarily provide comfort and convenience of patients and visitors but play no part in the patient's diagnosis or treatment.

"Although a defect in such equipment may injure patients as well as visitors or staff, a hospital's general duty to keep such items in good repair generally overlaps with the obligations that all persons subject to California's laws have and thus will not give rise to a claim for professional negligence." ↩

Gordon Ownby is CAP's General Counsel. Comments on Case of the Month may be directed to gownby@CAPphysicians.com.

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About Our Presenters



Christopher Giza, MD

Christopher Giza, MD, is Professor of Pediatric Neurology and Neurosurgery at the David Geffen School of Medicine and Mattel Children's Hospital and director of the UCLA Steve Tisch BrainSPORT program. He co-chaired the American Academy of Neurology's committee that developed an evidence-based Practice Guideline for Management of Sports Concussions from 2009 to 2013.



Catherine Miller, RN, JD

Catherine Miller is a Senior Risk Management and Patient Safety Specialist for the Cooperative of American Physicians, Inc.. She has more than 18 years of experience developing and implementing customized risk reduction solutions for the healthcare community.

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