THE MONTHLY PUBLICATION FOR CAP MEMBERS

CAPsules®

COOPERATIVE OF AMERICAN PHYSICIANS

2025 CAP and MPT Board Elections a Success

Thank You for Voting!

The Cooperative of American Physicians, Inc. (CAP) and Mutual Protection Trust (MPT) sincerely thank our physician members for completing their CAP ballots and MPT proxies to meet the 2025 election cycle voting deadline.

Because of your dedication to the success of the enterprise, we were able to achieve quorum and elect the CAP Board of Directors and MPT Board of Trustees at our Annual Meeting of Members on July 16th.

Congratulations to the Newly Elected CAP and MPT Physician Leaders

We are proud to announce the following seven members as CAP's and MPT's governing leaders who were elected to serve a two-year term:

CAP Board of Directors and MPT Board of Trustees

John J. Kowalczyk, DO, Chair and President, CAP, and Chair, MPT

Meagan M. Moore, MD, Vice Chair, CAP, and Vice Chair, MPT

Gracie-Ann E. Dinkins, MD, Secretary, CAP, and Secretary, MPT

Christopher J. Combs, MD

Steve E. Kasper, MD

Wayne M. Kleinman, MD

Lisa L. Thomsen, MD

Learn more about your CAP and MPT physician leaders at: www.CAPphysicians.com/Leaders

Because of their longstanding commitment and involvement in the organizations' committees and boards, these physician leaders are well positioned to help carry out our mission of supporting CAP members with affordable malpractice coverage and outstanding risk and practice management support.

JULY – AUGUST 2025

Case of the Month

A California Court of Appeal Recognizes the Applicability Of Health and Safety Code Section 1799.110 To Remote Physicians' Emergency Services

by Bryan Dildy, Esq., MPA, CPHRM, CPPS

In a medical malpractice case, the typical standard of care applied to review a physician's conduct is the "reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of the medical profession under similar circumstances." (Burgess v. Superior Court, 2 Cal.4th 1064, 1081 (1992)). However, Health and Safety Code section 1799.110 was enacted to provide physicians and surgeons in hospital emergency department settings additional protection from malpractice claims by modifying the general standard of care. Section 1799.110 provides such protection by 1) recognizing the need to apply a standard of care that considers emergency circumstances and 2) requiring expert medical testimony from physicians and surgeons with substantial professional experience in emergency medical care. Recently, in *Charlie L. v. Kangavari*, a question was raised regarding the applicability of Section 1799.110 to remote physicians providing emergency department services.*

In this case, a three-year-old patient with a history of mal-rotated bowels since birth, presented to the emergency department with abdominal pain.[1] The patient was assessed by an emergency department physician who ordered a stat X-ray and ultrasound imaging of the patient's abdomen.[1] The images were sent to an on-call, remote radiologist for review.[1] The radiologist determined the patient's bowel was unobstructed. After further monitoring, the patient was eventually discharged home with instructions to follow up with his pediatrician and gastroenterologist.[1] Shortly after returning home, the patient vomited and turned blue.[1] The patient returned to the emergency department nonresponsive with a faint pulse and breathing.[1] The patient was assessed and determined to have a small bowel obstruction.[1] The patient was transferred to a higher level of care where he had multiple surgeries to remove necrotic tissue and most of his small bowel.[1] Currently, the patient requires gastrostomy tube feedings and has challenges with his mental and emotional wellness.[1]

On April 23, 2021, the patient's mother filed a medical malpractice suit against the radiologist for failing to timely diagnose the patient's bowel obstruction.[1] The radiologist moved for summary judgment because he believed the standard of care was met as supported by a diagnostic radiologist witness.[2] The mother filed an opposition against the motion with support from a medical school professor.[2] The radiologist opposed the admission of the professor's declaration because he did not believe the professor satisfied section 1799.110 expert requirements.[2] The trial court agreed with the radiologist and granted summary judgment which led to an appeal.

On appeal, the court held section 1799.110 does apply to a physician who remotely reviews tests results on a stat basis as part of the emergency department. The court reasoned the statute's purpose was to eliminate physicians' fear that their emergency services would be scrutinized under the general standard of care lens.[2]

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The court opined remote physicians are under the same pressures and are subjected to the same liability as in-person emergency physicians; therefore, remote physicians should not be treated differently.[2] However, the court ultimately reversed summary judgment based on the separate issue that the defendant physician's expert witness also did not meet the expert requirements of section 1179.110.

Why It Matters

This recent decision moves away from an earlier case which held section 1799.110 requirements did not apply to on-call physicians who provided emergency medical services because such services were not considered emergency medical coverage.[3] Despite the difference in outcome between these two appellate court decisions, the Charlie L. decision acknowledges that remote physicians providing emergency services to an emergency department may indeed be included in the section 1799.110 provisions. Though the court's holding is favorable to remote physicians, the court acknowledged the same expert scrutiny of the "emergency" standard of care still applies. Therefore, it is important that remote physicians respond timely to stat orders and communicate findings. Further, documentation of a physician's clinical decision-making pathway should include:[4,5]

- Assessment of patient vitals and examination
- Information about any identified areas of concern and considerations made for each area
- Analysis of the patient's chief complaint
- The use of understandable language to clearly state findings
- Any reassessments that were completed

By following the previous tips, a physician providing remote services will not only support patient safety but will also help prevent any allegations of failing to meet the standard of care.

Bryan Dildy, Esq., MPA, CPHRM, CPPS, is a Senior Risk Management & Patient Safety Specialist. Questions or comments related to this article should be directed to BDildy@CAPphysicians.com.

*For purposes of Section 1799.110, remote physicians are physicians who are 1) on-call or consulting to the emergency department, 2) are not physically present within the department and 3) are providing emergency medical services to the department.

[1]*Charlie L. v. Kangavari,* 107 Cal. App. 5th 1117 (2025).

[2]*Charlie L. v. Kangavari,* 107 Cal. App. 5th 1117 (2025).

[3]*Miranda v. National Emergency Services, Inc.* 35 Cal. App. 4th 894, 900-907 (1995)

[4]Gabayan Gz, Gould MK, Weiss RE, et al. *Emergency Department Vital Signs and Outcomes After Discharge*. Acad Emerg Med. 2017;24(7): 846-854

[5]Christopher L. Moore, MD, Andrew Basking, MD, et. al., *Best Practices in the Communication and Management of Actionable Incidental Findings in Emergency Department Imaging*, Journal of American College of Radiology (Apr. 18, 2025, 1:54 PM), https://www.jacr.org/article/S1546-1440(23)00123-0/fulltext

RISK MANAGEMENT
AND
PATIENT SAFETY NEWS

Communication via Narrative Medicine—What Is It? Could It Work for You and Your Patients?

by Dona Constantine, RN, BSN

Evidence-based medicine dominates current medical practice. While this approach aims to offer medical treatments backed by scientific findings, it can depersonalize care delivery. Narrative Medicine, coined by Columbia University's Dr. Rita Charon, aims to address the feelings and experiences that occur when caring for persons with illness. This practice encourages patients to narrate their experiences and promotes creativity and self-reflection in the practitioner, which can lead to improved diagnosis and treatment of pain.[1]

At institutions like Columbia University, UCSF, and Keck at USC, Narrative Medicine has become a multidisciplinary program, integrating literary analysis and reflective writing into medical education to enhance clinical practice.

In the world of corporate medicine, where providers are allotted an average of seven to 10 minutes per patient, Dr. Charon illustrates the advantages of using Narrative Medicine in the following example:

The patient is an elderly female, complaining of lower back pain. **Physician A** represents a typical physician, **Physician B** represents a physician trained in Narrative Medicine.

Physician A: *Have you had an X-ray or are you taking any medication? Have you seen a neurologist?*

Patient: *Well, I can tell you what makes my back hurt. It's when I pick up my grandson, and I get this feeling at the base of my spine.*

Physician A: *What happens if you try aspirin or Motrin? Does that help?*

Vs.

Physician B: *Have you had an X-ray or are you taking any medication? Have you seen a neurologist?*

Patient: *Well, I can tell you what makes my back hurt. It's when I pick up my grandson, and I get this feeling at the base of my spine.*

Physician B: *Tell me about your grandson.*

Patient: *He is 18 years old and has autism, and I'm the one who's been raising him since birth, but he's bigger than I am now, so it's very hard to pick him up.*

Did Physician A's line of questioning lead you to jump to the conclusion that this patient was experiencing mild temporary muscle strain and pain from picking up a small toddler or child? Did you contemplate the patient's response to Physician B's request "Tell me about your grandson?" Would your assessment of the patient and treatment plan differ as a result? Charon states that this example demonstrates the difference that Narrative Medicine training can make in understanding the most fundamental issues for

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this patient. Physicians with grounding in Narrative Medicine will have a desire to know about the patient and their life circumstances, which can assist in creating personalized care plans and treatments tailored to the individual patient.[1]

John Launer, a scholar of Narrative Medicine, identifies seven critical principles, or the "7C's."[2]

1. Conversations: Thoughtful dialogue that prioritizes the patient's voice while allowing for exploration of possibilities.

2. Curiosity: A genuine eagerness to understand the patient's story and context fully.

3. Context: Awareness of the patient's personal, cultural, and situational circumstances.

4. Complexity: Recognizing the interconnectedness of illness and addressing multifaceted factors.

5. Challenge: Encouraging both the patient and provider to reexamine assumptions and seek new perspectives.

6. Caution: Exercising care and sensitivity when navigating vulnerable topics.

7. Care: A foundation of compassion and a nonjudgmental attitude that demonstrates genuine concern for the patient's well-being.

Implementing Narrative Medicine can benefit both patients and providers by:[3]

√ Deepening Patient-Provider Relationships

When doctors listen actively to their patients' stories, it helps create a more meaningful doctor-patient bond. A connection built on understanding encourages better dialogue, mutual respect, and more personalized healthcare.

√ Strengthening Trust and Respect

Patients often hesitate to share personal details. Narrative medicine builds a trusting environment, ensuring that a patient feels heard, not dismissed. This understanding fosters a supportive relationship and better adherence to medical advice.

√ Increasing Empathy Toward Patients

When providers listen to the full context of a patient's illness narrative, they gain insights into not just the symptoms, but also the psychological and social impact of an illness or injury. This enhances their ability to empathize and provide compassionate care.

√ Improving Communication

Narrative Medicine equips providers with the tools to communicate more effectively. Structured storytelling helps decode medical jargon into language patients can easily understand, ensuring that all parties are on the same page.

√ Supporting Physicians in Reducing Burnout

Practicing Narrative Medicine encourages clinicians to reflect on their work, cultivating self-awareness and resilience. A provider's ability to engage with human stories can renew their sense of purpose and mitigate emotional exhaustion.

√ Addressing the Overall Health of Patients

By emphasizing narratives, providers treat patients comprehensively, addressing social, emotional, and mental health needs alongside the patient's physical needs. This holistic approach ensures better care and higher rates of patient satisfaction.[2]

Narrative Medicine involves listening to and interpreting patient stories to better understand the emotional and psychological dimensions of illness. This powerful concept acknowledges that the unique life experiences and stories patients bring into their doctors' offices are as valuable as lab reports and physical exams.[2]

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Providers may worry that listening to patients' stories will lengthen office visits. In today's healthcare environment, should providers and institutions continue moving toward a transactional, efficiency-driven model aimed at maximizing capacity—or is it time to consider a relationship-centered redesign of the patient-physician dynamic? Some physicians have implemented artificial intelligence (AI) technology to improve office deficiencies, allowing them to spend more time with patients. Beware of the risks associated with certain AI programs. As AI becomes more integrated into healthcare—through tools like documentation assistance models designed to eliminate "chitchat"—we are faced with a critical decision: What direction should care take, and what do we value most in the patient-provider relationship?[3] We suggest that you consider the balance of technology with the benefits of Narrative Medicine, an approach that refocuses the practice of medicine on the person, and reenergizes providers through building human connection with those they serve.

Dona Constantine, RN, BSN, is a Senior Risk Management and Patient Safety Specialist. Questions or comments related to this article should be directed to DConstantine@CAPphysicians.com.

[1]Eve Glasberg, "Narrative Medicine Teaches Doctors How to Listen to Patients' Stories," (June 5, 2023), https://news.columbia.edu, https://news.columbia.edu/news/narrative-medicine-teaches-doctors-how-listen-patients-stories

[2]Kim Pace, "Improving Patient Care Through Storytelling Techniques," (Jan. 6, 2025), wgu.com, https://www.wgu.edu/blog/narrative-medicine-improving-patient-care-through-storytelling-techniques2501.html (6/16/25)

[3]Gordon D. Schiff, MD, "AI-Driven Clinical Documentation-Driving Out the Chitchat?,"(May 10, 2025), New England Journal of Medicine, https://www.nejm.org/doi/abs/10.1056/NEJMp2416064; (5/20/25)

Making Changes to Your Practice?

Update Your Membership Information To Help With Your Year-End Planning

If you are considering a change in your practice this year or in 2026, please notify CAP as soon as possible.

Our Membership Services team can work with you to ensure that any necessary coverage transitions are implemented smoothly.

Changes include, but are not limited to:

- Retirement from practice at age 55+
- Part-time practice (e.g., 20 or fewer hours per week, or 16 hours for anesthesiologists)
- Reduction or any 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 CAP membership

The Mutual Protection Trust (MPT) Board of Trustees will levy an assessment in November 2025. To allow ample processing time, we strongly recommend that you provide any updates to CAP no later than October 31, 2025, to be evaluated for reductions or proration of the 2026 assessment.

Contact Membership Services by phone at **800-610-6642** or by email at **MS@CAPphysicians.com** to update your CAP membership information today!

California State Healthcare Plan in Peril

by Gabriela Villanueva

In January of 2025, Governor Newsom proposed a $322.3 billion budget that, based on temporary financial maneuvering and optimistic revenue projections, did not include a deficit. However, by May—after releasing revised budget figures and following the announcement of new tariff policies by the Trump administration—the state projected a deficit between $12 billion and $16 billion.

Rejecting many of the cuts Governor Newsom initially proposed, legislators passed a bicameral bill signed by the governor on June 27th with additional trailer bills expected throughout the summer to finalize all funding requirements. The result is a $321 billion spending plan that increases general fund expenditures and delays major cuts to state programs for another year.

In final budget negotiations, lawmakers relied heavily on a mix of internal borrowing, fund transfers, reserves, and deferred payments to avoid deep cuts and close the deficit. This included drawing $7 billion from the state's rainy-day fund and $6.5 billion from other reserve accounts. Additionally, about $1.3 billion was shifted into the general fund from two climate-related sources: the cap-and-trade program and a voter-approved climate bond from the previous year.

A major policy focus in both the state and federal budget spending has been funding healthcare coverage for low-income individuals. Over the past several years, Governor Newsom made it a budget priority to expand coverage to more sectors of the population regardless of legal status. The expansion proved extremely popular with enrollments to Medi-Cal climbing higher than expected and therefore overextending the allocated state funds. In his May revision, Governor Newsom called for steep cuts to Medi-Cal coverage for immigrants with no legal status, including a $100 monthly premium. Many Latino Caucus legislators opposed the rollbacks, but an agreement was reached that includes a pause of new enrollment of those adult immigrants starting in 2026, while those with coverage will be charged a $30 monthly premium starting in 2027. Medi-Cal will no longer cover dentist visits for those immigrants already on the public health plan.

California's state budget includes more than $170 billion in federal funds, or over one-third (34.6%) of the total state budget. Of this amount, $121.1 billion is budgeted for Medi-Cal, California's Medicaid program. Following the passage of the federal budget reconciliation bill by Congress on July 3rd, California is expected to face significant cuts to federal funding. These cuts will trigger a ripple effect throughout the state, impacting county, city, and local budgets, and will place California in an even more precarious position as it struggles to cover the resulting shortfalls. A major concern is the shift of substantial social safety net costs—such as Medi-Cal—from the federal government to the state. As a result, the governor and legislators will face increased pressure on future budgets and will be forced to choose between backfilling the lost federal funds or making cuts to essential services.

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

Ask My Practice

by Andie Tena

SB 1061: What California's New Medical Debt Law Means for Your Private Practice

Senate Bill 1061 (SB 1061), passed in 2024, is a new law designed to protect consumers by prohibiting credit reporting agencies from including medical debt on credit reports. It also restricts healthcare providers, billing vendors, and collection agencies from reporting such debt to credit bureaus.

SB 1061 introduced two significant changes that directly impact how physicians' offices manage debt collection and communication with their patients. Effective January 1, 2025, physicians, their agents, and credit reporting agencies may no longer report medical debt to consumer credit reporting agencies (CRAs), regardless of the amount. Starting on July 1, 2025, any contract or financial agreement that creates a medical debt must include specific consumer protection language, or the debt will be considered void and unenforceable. This new legislation impacts how you communicate with patients, structure payment plans, and collaborate with billing services.[1]

What this means for private practices:

Effective January 1, 2025

- Physicians, billing vendors, and collection agencies may not report medical debt to credit reporting agencies.
- Medical debt will no longer impact a patient's credit score.
- If a person knowingly violates this law, the debt becomes void and unenforceable.

Effective July 1, 2025

- Any financial agreement or contract entered into after July 1, 2025, that creates medical debt must include the following language:

  "A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable."

- If the above language is not included in the contract or agreement, it will void the agreement and deem it to be unenforceable.[2]

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- A violation of this section by a person holding a license or permit issued by the state shall be deemed to be a violation of the law governing that license or permit.[3]

What is the definition of medical debt?[4]

- Medical debt is a debt that is any service, drug, medication, product, or device sold, offered, or provided to a patient.
- It does **NOT** include cosmetic surgery. Debt for cosmetic surgery can still be reported to CRAs.

As a trusted healthcare provider, your strength lies in the relationships you build with your patients. Proactive communication and insurance verification may help in assuring patients receive financial expectations up front and know what to expect as they arrive in the clinic. This forward communication can help alleviate issues in collecting patient co-pays and co-insurance responsibilities at the time of check-in.

What can you do:

- Train staff and any vendors involved in billing and collections on the requirements of SB 1061 to ensure understanding and compliance of the new law.
- Update all patient financial forms prior to July 1, 2025, with required language. You may consider updating the ABN (Advanced Beneficiary Notice) for Medicare patients to include this language for non-covered services.

SB 1061 isn't about removing responsibility for payment; it is about proactive communication with patients and setting the expectations of payment.

By updating your financial policies and communications, you will be well positioned to continue delivering compassionate care without the added stress of credit reporting concerns.

Andie Tena is Assistant Vice President, Practice Management Services. Questions or comments related to this column should be directed to ATena@CAPphysicians.com.

[1]Digital Democracy CalMatters. California State Legislature. SB 1061: Consumer Debt: Medical Debt. 2023–2024 Legislative Session. SEC. 4. Section 1785.27 is added to the Civil Code, to read: 1785.27. https://calmatters.digitaldemocracy.org/bills/ca_202320240sb1061

[2]Digital Democracy CalMatters. California State Legislature. SB 1061: Consumer Debt: Medical Debt. 2023–2024 Legislative Session. SEC. 4. Section, (2) 1785.27 is added to the Civil Code, to read: 1785.27. https://calmatters.digitaldemocracy.org/bills/ca_202320240sb1061

[3]Digital Democracy CalMatters. California State Legislature. SB 1061: Consumer Debt: Medical Debt. 2023–2024 Legislative Session. SEC. 4. (d) Section, 1785.27 is added to the Civil Code, to read:1785.27. https://calmatters.digitaldemocracy.org/bills/ca_202320240sb1061

[4]Digital Democracy CalMatters. California State Legislature. SB 1061: Consumer Debt: Medical Debt. 2023–2024 Legislative Session. https://calmatters.digitaldemocracy.org/bills/ca_202320240sb1061#

New! Long-Term Care + Life Insurance In One Flexible Policy Tailored for CAP Members For A Limited Time Until August 31

SYMPHONY RISK

As a physician, you've dedicated your life to caring for others, but have you planned for your own care? Nearly 70% of people turning 65 today will need long-term care at some point in their lives.[1] Long-term care is also essential for those diagnosed with a critical illness or anyone involved in a major accidents regardless of age.

The emotional and financial toll of caregiving is something you may have witnessed firsthand—and it's a burden that often falls on loved ones when no plan is in place.

That's why CAP, in partnership with Symphony Health, is offering an unique Group Long-Term Care (LTC) Insurance Program—designed specifically for physicians like you. This plan combines long-term care and life insurance into one powerful policy, with guaranteed coverage and no health exams required.*

Why It Matters

- **Rising Costs:** Private nursing home care can cost nearly $10,000/month today—and over $30,000/month in 25 years.[2]
- **Reliable Care:** For those who may no longer have family to count on to provide care for them.
- **Limited Coverage:** Medicare and private health insurance typically don't cover long-term care.
- **Self-Funding Isn't Sustainable:** Americans spend over $60 billion annually out-of-pocket for extended care.[3]

Protect Yourself and Your Family With a Long-Term Care Insurance Policy

- **Guaranteed Coverage:** Up to $200,000 in long-term care benefits and $100,000 in life insurance—no health exams or questions.
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- **Spousal Coverage:** Available at 50% of the physician's benefit. Conditional guaranteed issue maximum up to $75K, age 19-70.
- **Portability:** Take your policy with you, even if you leave CAP, at the same rates.
- **Affordable Group Rates:** Better value than individual LTC policies.
- **Peace of Mind:** For you and your family.

This policy helps protect your savings, ensures access to quality care, and relieves your loved ones from the burden of caregiving. With a streamlined enrollment process, there's never been a better time to plan ahead.

Hurry! Enrollment ends August 31, 2025! Contact Symphony Health to learn more!

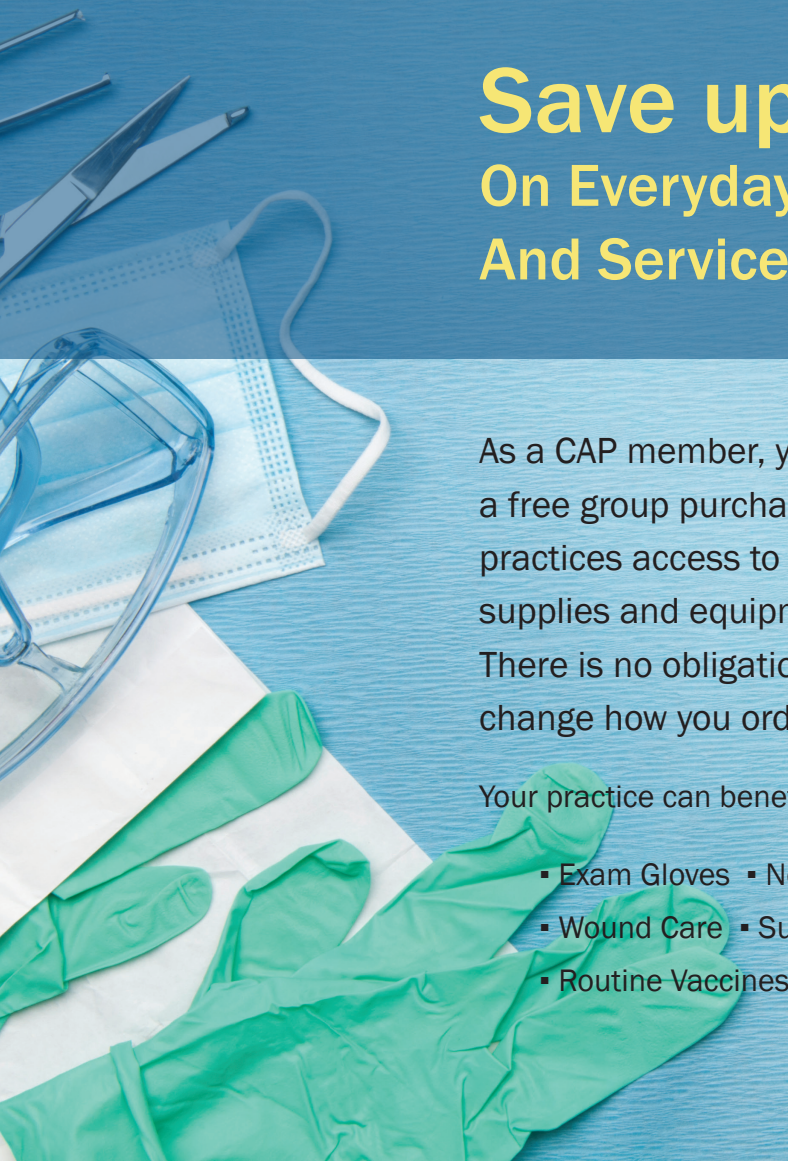
Call: 213-576-8530 Email: HealthCareServices@SymphonyRisk.com Visit: www.CAPphysicians.com/LTC

*Guaranteed for long-term care insurance on benefit amount of $200,000. Health questions asked for higher coverage amounts.

[1]*National Council on Aging: When Should You Start Investing in Long-Term Care Insurance?* https://www.ncoa.org/article/when-should-you-start-investing-in-long-term-care-insurance/

[2]*Genworth Cost of Care Survey 2023*. https://www.carescout.com/cost-of-care (Cost of care can vary. Check your area for more specific projections.)

[3]*Buddy Insurance: Understanding the Cost of Care in 2024* https://buddyins.com/learning-center/planning/understanding-the-cost-of-care-in-2022#.



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There is no obligation once you enroll, and you may cancel at any time.

Have Questions?

Chat with a CAP Purchasing Alliance Client Manager by emailing **support@cappurchasingalliance.com** or by calling **855-907-9227**.

If you have questions about this group purchasing benefit or any other practice management benefits available through your CAP membership, like one-on-one consults, please contact Andie Tena, Assistant Vice President, Practice Management Services, at 213-473-8630 or via email at ATena@CAPphysicians.com.

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We welcome your comments! Please submit to communications@CAPphysicians.com.