

# the EXCHANGE

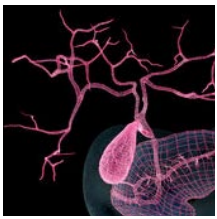
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## UMIA Board of Directors Announces Rate Actions for 2008

Martin J. Osowski  
President and CEO



THE UMIA BOARD OF DIRECTORS voted on rate changes at the August board meeting. The Board decided not to increase rates for insured physicians in Montana, Wyoming, and Idaho. During the Utah Rate Level Review, however, Jim Hurley of Towers Perrin, the actuarial firm for UMIA, noted an abnormally high payout pattern

*Maintaining adequate rates to cover losses is the number one priority of the Board.*

for the 2005 report year. The payout patterns in all other states in which UMIA writes business are following typical development. Mr. Hurley indicated that this payout pattern may be the sign of another high, atypical loss year for Utah

physicians similar to the one experienced in 2000, the largest loss year for the state of Utah in UMIA history. Mr. Hurley acknowledged that the Utah development may simply be a change in the payout pattern and may not represent another high loss year; however, it is difficult to know exactly what is happening for a particular loss year until years after the fact.

As a result of this data, the Chairman of the Board, Dr. Ron Miller, reported that the Board voted to increase rates 4.1% in Utah. Dr. Miller stated that overall, UMIA has kept rates as low as possible while still keeping the Association financially healthy by maintaining adequate reserves and surplus. Maintaining adequate rates to cover losses is the number one priority of the Board. This minimal increase provides the Board with additional flexibility and protects against a double digit increase in 2009. ■

# Prescribing Opiate Medications

Patrice Hirling, M.D., Internist  
Private Practice, Salt Lake City  
Member, UMIA Internal Medicine Patient  
Safety and Quality Review Committee  
Board of Directors, UMIA

Mrs. Y is a 56 year old, white female with fibromyalgia. She has seen a number of physicians in the past including a respected rheumatologist at a nearby university who concurred with the fibromyalgia diagnosis. Mrs. Y has been treated with various NSAIDs and muscle relaxers. She has not used narcotics chronically in the past. She presents to Dr. X, a family practice physician, complaining that her myalgias and fatigue are significantly limiting her life. She reports nonrestorative sleep. Mrs. Y is 5'8" tall and weighs 190 pounds. Her physical examination reveals no evidence of tenosynovitis. She has multiple trigger points consistent with the clinical diagnosis of fibromyalgia. Her lab results reveal a normal CBC, a normal CMP, normal thyroid function, an ESR of 2, and negative ANA and rheumatoid factor.

Dr. X changes her Naprosyn to Celebrex 200mg QD. He adds amitriptyline 25mg QHS. He prescribes Lortab 5/500 #90 1-2 every 4-6 hours as needed for pain. Mrs. Y returns for follow up one month later and states that while her sleep is improved, she still awakens several times each night. She rates her pain as 6-7/10 compared to 8-9/10 initially. Dr. X increases her amitriptyline to 50mg QHS and adds Neurontin 300mg QHS. He refills her Lortab 5/500 #90. Dr. X also prescribes Flexeril 10mg 3 times a day as needed for muscle spasm. Mrs. Y returns one month later reporting that she is a little better. She rates her pain as 4-5/10. She feels like her sleep is better with rare awakenings. Dr. X prescribes methadone 10mg BID on July 10. Mrs. Y takes her methadone that evening and the next day. She complains to her husband about sedation and shortness of breath. Her husband asks her to call Dr. X, but she does not. Mrs. Y takes her methadone on July 12th and the next morning she is found dead in her bed.

**The prescription of opiate pain medications by physicians has become a high-risk procedure due to the advent of more medications and longer acting forms of opiates.**

THE UTAH MEDICAL EXAMINER reported the rising number of deaths from prescription medications in *Morbidity and Mortality Weekly Report* (MMWR) in January 2005 (Volume 54, Number 2; January 21, 2005). From 1991 until 2003, the number of deaths in Utah from prescription medications increased five fold. In the years following the MMWR report, deaths continued to rise. This trend is being noted across the United States as is the fact that more deaths across the United States are associated with the appropriate use of these medications (using the medications as prescribed) not intentional overdose or overuse.

The largest risk in prescribing opiate pain medications is associated with the prescription of methadone. This medication has unique pharmacology and has been associated with the largest number of deaths. The pain control effect of methadone is shorter than the respiratory depressant effect. If patients take the medication earlier or in higher doses, therefore, the risk of respiratory depression and death is increased. The *British Medical Journal* reported that the half-life of methadone ranges from 25 hours to as long as 52 hours. This variation in metabolism correlates with a greater risk of





respiratory depression. In addition, the longer acting opiates like OxyContin and fentanyl patches are associated with a higher risk of respiratory depression and death. This risk is especially high in opiate naïve patients (see case above).

The other significant risk is the prescription of multiple CNS depressant medications in the same patient (e.g., carisoprodol, cyclobenzaprine, alprazolam, lorazepam, clonazepam, gabapentin and topiramate). More than 70% of the deaths in Utah occurred

*More than 70% of the deaths in Utah occurred during the first week after initiation of opiates.*

during the first week after initiation of opiates while taking other CNS depressant drugs, or after an increase in the dose of the opiate.

Undiagnosed or inadequately treated sleep apnea is another risk factor for death in patients receiving opiate medications as well as other CNS depressant medications. Physicians who choose to prescribe opiate medications to their patients must adequately document that the patient has been informed of the risks of these medications (including dependence, tolerance, and death). The Physician Insurers Association of America reports that half of the malpractice suits associated with narcotics involve addiction while the other half involve overdose and/or death. Documentation of the absence of sleep disordered breathing or adequately treated sleep disordered breathing should be in the record prior to prescribing potent and long acting opiates. In addition, educating the patient's family is critical as a number of the patients that died were noted as snoring loudly or struggling to breathe prior to their deaths and the spouse simply moved to sleep in another room and found the patient dead the next morning. There are excellent patient handouts available on the Internet. For example, the FDA has a methadone handout for patients and families as well as critical information for health care providers. (<http://www.fda.gov/cder/drug/InfoSheets/HCP/methadoneHCP.htm>). A well educated patient and family are critical to assisting the physician in optimizing the care of the patient who requires chronic narcotic medications. ■

## News

### New Initiative Brings Risk Management Directly to Physicians' Practices

In April 2007, the Board approved a two-year initiative aimed at making the risk management program more accessible to physicians through the new UMIA Online Education risk management website. The new site, planned to launch in 2008, will allow physicians to complete risk management CME requirements online. Whether in the office or the home, physicians will have 24/7 access to the site, providing additional flexibility to physicians who were previously required to attend day-long seminars in order to earn CME credits. Insured physicians will log on to the site, create a password, and participate in online courses targeted at their individual specialties. Physicians will also evaluate the courses and can print CME certificates for completed courses directly from the site.



UMIA Online Education risk management programs are available to any UMIA insured physician and will be updated to reflect important and current risk issues, and to facilitate self-assessment and practice improvement in accordance with the new ACCME requirements.

### Board Explores Coverage for Systematic Risk

Willis Re London, UMIA's reinsurance broker, recently presented a new product covering "systematic risk" to the Board. Systematic risk is risk inherent to the market and systematic loss is loss caused by a series of errors, omissions, business practices, accidents, occurrences, medical incidents, or negligent acts arising out of an "originating cause." Examples include claims made against physicians arising from the dispensation of Fentanyl, or a physician who is found to have incorrectly or inappropriately performed the same operation (i.e. coronary bypass) on multiple patients. The Board will explore implementing this coverage in 2008. ■

# Addressing Common Bile Duct Injuries

*Six general surgery claims against UMIA surgeons reported in the last two years involve injury to the common bile duct during laparoscopic gall bladder surgery.*

THIS IS AN OCCURRENCE RATE OF 7% of all general surgery claims reported during this time period. The UMIA General Surgery Quality and Safety Committee reviewed a total of eight claims for 2006, two of which involved common bile duct injuries during a laparoscopic cholecystectomy. This seemingly high incidence prompted a review of all UMIA claims related to common duct injuries.

Since 1980, UMIA has handled 26 claims involving common bile duct injuries. Five of these claims closed without payment, while six claims remained open. UMIA spent \$3,256,633 to close the remaining claims with an average cost of \$217,600 per claim and a defense cost of \$23,000 per claim. All claims reported injury to or severance of the common bile duct. Only two of these cases occurred prior to 1992 and the introduction of laparoscopic procedures. Beginning in 1992, UMIA averaged 1.5 common duct claims annually with the high being four claims in one year. Not all common duct injuries result in claims; therefore, the actual incidence of these injuries is likely higher than indicated by the claims reported.

Before the introduction of laparoscopic cholecystectomies, the incidence of common bile duct injuries associated with *open* cholecystectomy was 0.06% – 0.3%. The reported incidence of common bile duct injuries associated with *laparoscopic* cholecystectomy is 0.5% – 1.4%. The reason for the difference has not yet been clearly identified.

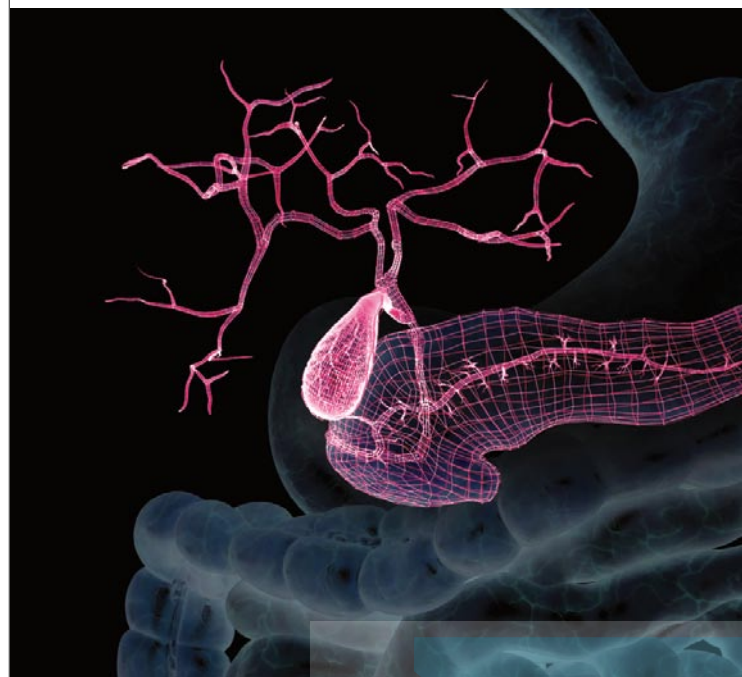
Certain methods of prevention remain controversial. Elective vs. routine use of intraoperative cholangiography is the primary point of debate. Lateral retraction of the gall bladder neck with dissection of all tissue except for the cystic duct and cystic artery in the triangle of Calot allows confirmation of the true cystic duct. Many feel that if this “critical view” method of dissection is performed correctly, a cholangiogram is not routinely required and can be performed selectively to find common duct stones. Others believe that routine cholangiography can prevent common duct injury by clarifying the anatomy.

In 2003, Flum and associates reported a common bile duct injury rate of 0.5% in 1,570,361 cholecystectomies performed between 1992 and 1999. 76% of these cholecystectomies were performed laparoscopically. Intraoperative cholangiograms (IOC) were performed in 39% of the

cholecystectomies. Common bile duct injury was found in 0.4% of the patients undergoing cholecystectomy *with* IOC while common bile duct injury was found in 0.58% of the patients undergoing cholecystectomy *without* IOC. There has been much debate regarding the quality of the data used for this report. In the end, the question remains: Did performing the proper dissection for the cholangiogram or actually performing the cholangiogram itself lower the incidence of common bile duct injury? At the very least, having a completed cholangiogram documents any injuries that occur, although they are not all recognized immediately.

When the approach becomes difficult, as with cholecystitis, it is important to be willing to convert to an open cholecystectomy and dissect the gall bladder immediately against the gall bladder wall from the fundus to the distal infundibulum.

Experience does not seem to protect surgeons from having a bile duct injury; thus it is always prudent to mention it as a possible complication during pre-op teaching (informed consent). When bile duct injuries



occur, they are often difficult to identify. Frequently, these injuries are not identified until sometime after the operation. There are several categories of injury and how you deal with the situation depends on many variables. The most important variables are the surgeon's competence and his or her confidence in operating on the bile duct system under the stress caused by creating the injury. If you are competent and confident, proceed with the appropriate repair. If you are not feeling confident, get help. In general, simple injuries require simple repairs over a T-tube. Once you get past "simple," however, referral to a tertiary care center where bile duct surgery is performed more often may be the most prudent thing to do. Roux-en-Y drainage of the common bile duct is the most common repair for a severed common bile duct. Bile drainage and control of infection with antibiotics are the most helpful actions prior to transferring the patient. If you do not operate at a tertiary care center, make sure you know someone trustworthy who does. It is very important that you, personally, without assigning blame, explain the situation to the patient and the family, and share your concern and sympathy over the situation. Then, stay involved with the case until all issues are resolved. Pay more attention to the patient, not less, when such an injury occurs. ■

1. "Intraoperative Cholangiography and Risk of Common Bile Duct Injury During Cholecystectomy" David R. Flum, E. Patchen Dellinger, Allen Cheadle, et al. *Journal of the American Medical Association* 289(13):1639-1644, Apr. 2, 2003
2. "Routine Vs. Selective Intraoperative Cholangiography During Cholecystectomy" Mark A. Talamini *Journal of the American Medical Association* 289(13): 1691-1692, Apr. 2, 2003
3. "Bile Duct Injuries 12 Years after the Introduction of Laparoscopic Cholecystectomy" William C. Chapman, Michael Abecasis, William Jarnagin, et al. *Journal of Gastrointestinal Surgery* 7(3):412-416, Mar./Apr. 2003
4. "Surgical Management of Bile Duct Injuries Sustained During Laparoscopic Cholecystectomy: Perioperative Results in 200 Patients" Jason K. Sicklick, Melissa S. Camp, Keith D. Lillemoe, et al. *Annals of Surgery* 241(5):786-795, May 2005
5. "Bile Duct Injury During Laparoscopic Cholecystectomy: Results of a National Survey" Archer, Hunter, et al. *Annals of Surgery* 234:549-559, 2001



# UMIA Encourages Insured Physicians to Support Health Care Notification Network

A. T. Williams, M.D., FACS  
Assistant Medical Director, UMIA

IN AN ATTEMPT TO IMPROVE PATIENT SAFETY related to prescription medications and other medical products, the FDA has requested assistance in getting *product-related patient safety notices* delivered to healthcare providers in a more timely, efficient, and effective electronic manner, rather than relying on the current use of paper and U.S. mail. The current process is slow, expensive, and inefficient leading to delays in physician notification. The failure to notify physicians and patients about important patient safety issues in a timely fashion is a critical problem as noted by the FDA. In an effort to improve *patient safety*, the FDA is encouraging the delivery of patient safety notifications to physicians via email.

Over the past two years, a group of medical societies, liability carriers, and other groups formed a not-for-profit corporation (the iHealth Alliance) with the goal of improving patient safety using electronic means. The AMA has been a leader in this area. The iHealth Alliance worked with

1. Notifications are free to physicians and are sent via email. Physician email addresses are used only for patient safety notifications (i.e. no marketing or selling of lists, and no use by other 3rd parties).
2. Physicians receive warnings days to weeks ahead of current paper/U.S. mail-based notifications.
3. Physicians can identify additional email recipients for office staff who should also receive these warnings.
4. Funding for the HCNN comes from user fees paid by manufacturers.
5. Providers can opt out of the HCNN at any time.

The Health Care Notification Network (HCNN) will provide rapid online communication with physicians for FDA-mandated product recalls and warnings that will replace the existing paper notifications sent via U.S. mail. Physicians not enrolled in the HCNN, or who enroll but do not open their email notification, will be notified via standard mail. Physicians can have additional practice staff members notified via email to increase efficiency and office workflow if the notification requires patient follow up. Practices can also forward notifications to their patients via email and post them on their websites.

The iHealth Alliance will also be working with the CDC on the appropriate use of the HCNN for national public health emergencies. In addition, the CDC has been offered a liaison seat on the iHealth Alliance board similar to the FDA's liaison participation in the Alliance. It is possible that emergent CDC public health warnings and bioterrorism alerts will be added to the HCNN in the near future.

**Utah Medical Insurance Association endorses the HCNN because disseminating FDA product recalls and warnings more quickly has the potential to reduce malpractice claims and improve patient safety.** UMIA is asking its insured physicians to enroll in the HCNN and receive their FDA-related patient safety notifications online. UMIA will be providing you with specific instructions for HCNN enrollment in the near future. Physician enrollment will be available online, via fax or 800#. ■

the FDA, manufacturers, medical societies, and others to create an electronic network that delivers online patient safety notifications to providers; fulfills FDA regulations; and makes delivery of notifications by email timely, effective, and efficient for physicians. Key aspects of this network (the Health Care Notification Network or "HCNN") include the following:



# 2008 Risk Management Workshops

## Dates & Locations

DATE	CITY/STATE	VENUE
January 12, 2008	Ogden, Utah	Ogden Eccles Convention Center
March 15, 2008	Whitefish, Montana	Grouse Mountain Lodge
April 12, 2008	St. George, Utah	Dixie Convention Center
May 10, 2008	Jackson Hole, Wyoming	Snow King Resort
September 27, 2008	Billings, Montana	Sheraton Hotel
November 1, 2008	Sandy, Utah	S.L. Community College, Larry H. Miller Campus

## Approximate Time Scheduled for Utah

NOTE: Wyoming and Montana workshops begin with Registration/Breakfast at 7:30 A.M. and the Physician Communication session at 8:00 A.M. Montana workshops adjourn at approximately 3:00 P.M. and include lunch and a one and one-half hour Montana Malpractice Legal Discussion.

<b>7:00 A.M. – 7:30 A.M.</b>	<b>Registration / Breakfast Buffet</b>	<b>9:30 A.M. – 10:30 A.M.</b>	<b>General Risk Management</b> Current Liability Trends Human Error / Distraction Documentation / Electronic Medical Records (EMR) Arbitration (Utah Only)
<b>7:30 A.M. – 9:15 A.M.</b>	<b>Physician Communication</b> Effective Communication and Medical Liability Patient Education and Informed Consent How and Why to Use Empathy and Apology Intra-Professional Communication	<b>10:30 A.M. – 10:35 A.M.</b>	<b>Break</b>
<b>9:15 A.M. – 9:30 A.M.</b>	<b>Break</b>	<b>10:35 A.M. – Noon</b>	<b>Specialty Breakout Sessions</b>
		<b>12:00 Noon</b>	<b>Adjourn</b>

## To Register

Please contact Irma Brander or Jeri James at 1-800-748-4380, (801) 531-0375, [ibrander@umia.com](mailto:ibrander@umia.com), or [jjames@umia.com](mailto:jjames@umia.com). The registration card can also be printed from the UMIA website at [www.umia.com](http://www.umia.com). NOTE: NAME AND ADDRESS MUST BE COMPLETE ON REGISTRATION CARD.

## Disability

In accordance with the ADA (Americans with Disabilities Act), please notify us of any special needs or accommodations required to attend a workshop.

## Workshop Objectives

The objectives for the workshop are:

- 1) To offer a risk management definition of medical malpractice
- 2) To convey the magnitude of the malpractice losses in dollars and cents
- 3) To discuss recent trends and causation identified using UMIA claims data
- 4) To discuss concepts of cognitive psychology as it relates to human error, patient injury, and medical liability
- 5) To identify “distraction” as the major common denominator in human error and show how it applies to the practice of medicine

- 6) To facilitate the use of these concepts to identify intervention points and mechanisms for reduction in the frequency and severity of patient injury, medical errors, and medical liability claims

## Purpose

The purpose of these workshops is:

- To identify causes of medical liability claims
- To develop and enhance physician communication skills
- To provide data collection tools and patient encounter forms that assist in the reduction of patient injury and misdiagnosis
- To identify and recommend efficient data management systems to collect, organize, and document critical patient-related data and information

The workshop includes sessions on critical communication concepts, general risk management principles, and breakout sessions for the following specialties:

- Anesthesiology/Pain Medicine
- Emergency Medicine
- Family Practice & Family Practice Medicine with Obstetrics



## 2008 Risk Management Workshops... *continued from p.7*

- Internal Medicine/Internal Medicine Subspecialties
- Neurology
- Obstetrics/Gynecology
- Pediatrics
- Radiology
- Surgical Subspecialties

### Accreditation

The Utah Medical Insurance Association (UMIA) designates educational activities in the states of Utah and Wyoming for a maximum of 4.50 AMA PRA Category 1 Credit(s)<sup>™</sup>, and in the state of Montana for a maximum of 5.75 AMA PRA Category 1 Credits(s)<sup>™</sup>. Physicians should claim credit commensurate with the extent of their participation in the activity.

### Risk Management Policy Holders' Premium Discount

Policyholders insured in the states of Utah and Wyoming will receive a 5% premium discount. Policyholders in the state of Montana will receive a 7.5% premium discount. These discounts begin in the next quarterly billing cycle following attendance. The discount duration is three years from the date you last attended a workshop.

The following guidelines and requirements apply:

1. The premium discount applies to INDIVIDUAL policies only.
2. Based on risk severity, some specialties or subsets of physicians may be required to attend.
3. Physicians in the following specialties may receive the Risk Management premium discount by either attending a UMIA Risk Management Workshop or submitting five (5) hours of CME documentation for risk management program attendance in their respective specialties: Dermatology (Class 1), Occupational Medicine, Pathology, Psychiatry, and Radiation Oncology (Class 2). This discount will begin in the next quarterly billing cycle following receipt of documentation.
4. Any physicians receiving a "New Practitioner" discount (defined as new to the practice of medicine) will have one year from the effective date of coverage to attend a workshop to continue this discount. **IF YOU DO NOT ATTEND A RISK MANAGEMENT WORKSHOP WITHIN ONE YEAR OF INCEPTION, YOUR "NEW PRACTITIONER" DISCOUNT WILL EXPIRE.**

### UMIA Website

Please visit the UMIA website for more details at [www.umia.com](http://www.umia.com). ■