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UMIA Online Education Debuts July 1, 2008

THE UMIA BOARD OF DIRECTORS is proud to announce the launch of UMIA Online Education, the online risk management program that provides insureds with real-time access to risk management education and CME credits. Physicians no longer have to travel to scheduled risk management workshops. Instead, they can take courses and earn credits at their convenience from the comfort of their homes and offices. The online risk management program will save physicians time and resources, and improve convenience and accessibility to risk management information.

The program content is similar to current workshops with plans for ongoing upgrades as development moves forward. Web technology allows for a coordinated audiovisual presentation followed by a short CME test. The program can be taken as often as desired, but no less than once every three years for physicians who wish to secure the risk management discount and do not otherwise qualify for the discount. Physicians insured more than ten years without a significant claim, those that participate in risk management, and those in exempt specialties automatically qualify for the risk management discount. If you are unsure of your status contact Jeri James at jjames@umia.com.

To access UMIA Online Education, visit www.umia.com and click on "Online Education." Required information for secure log in includes your last name, UMIA policy number, birth date, and a valid email address. Once signed in, your progress in the online curriculum is easily tracked through your individual profile under "My Profile." You can find your policy number on the declaration page of your UMIA policy or your UMIA invoice.

Each specialty has a unique curriculum taken in a prescribed order. The program involves multiple presentations by different faculty allowing for natural breaks so it can be done in half hour



www.umia.com

to one and a half hour segments. Once a segment is started, it has to be completed within 2 days. In addition, the entire program must be completed three months prior to the expiration of your risk management discount or completed 3 months prior to the quarter you want the discount to start. All discounts expire at the end of a quarter; thus, if your discount expires on September 30, 2008 you must complete the program prior to the end of the previous quarter on June 30, 2008 to prevent an interruption in your discount. You can view your current discount and expiration date in the "My Profile" section of the UMIA Online Education website.

CME certificates can be printed upon completion of each segment. After you complete all the courses in the curriculum for your specialty, the discount is automatically applied to your premium at the beginning of the next billing quarter. Comments, suggestions, or support can be handled directly through the website.

Please log on at www.umia.com and check your status or begin the program at your earliest convenience. ■

Negotiating the Slippery Slope of Talking with Attorneys About a Patient's Care

Tom Greene
UMIA Senior Claims Investigator
A. Thomas Williams, MD
Assistant Medical Director, UMIA

AT SOME POINT DURING A PHYSICIAN'S PRACTICE, there is a high probability that he or she will be engaged by a plaintiff's attorney to discuss the care of a patient either as a potential expert or as a subsequent treating physician. These conversations—always a slippery slope for well-intentioned and ethical physicians—just became more treacherous due to the February ruling by the Utah Supreme Court (*Sorensen v. Barbuto*, 2008 UT, Feb. 1, 2008).

In *Sorensen v. Barbuto* the Court ruled that a plaintiff's physician (treating or subsequent treating M.D.s) may not engage in any discussions with defense counsel without prior notification being given to the plaintiff. In this case, the plaintiff filed a negligence action against a vehicle driver for damages sustained in an accident. During discovery, the plaintiff's physician participated in an ex parte (one-sided, no plaintiff counsel present) communication with defense counsel. As a result, he agreed to act as an expert witness for the defense. Following trial for the negligence action, the plaintiff filed various claims against the physician for the ex parte communication. The physician filed a motion to dismiss the suit, which the Court of Appeals granted. The Utah Supreme Court reversed the ruling judging that even when a patient puts his/her medical condition at issue in litigation, the patient can still prevent the physician from communicating with defense counsel unless specific permission is granted or representation is present. The Supreme Court seems to believe that private, one-sided (ex parte) conversations with a defense attorney deprive the plaintiff of a just opportunity to secure potential supportive witnesses and experts from among treating physicians if the plaintiff is not represented or a party to the conversations.

What does this mean for UMIA-insured physicians?

If you are approached by a lawyer to discuss your role in a patient's care, the following steps are the recommended method of engaging the inquiring attorney:

1. Identify who the attorney represents, plaintiff or defense, and get the attorney's name and phone number.
2. Do not provide any specific information or opinion about the patient or the care rendered.
3. Indicate any further communication can be gladly accomplished once you make arrangements for counsel to be present.
4. Notify a UMIA claims investigator by phone of the request to meet the attorney. An investigator is always available.
5. Resist any temptation or the seduction of a casual request by an attorney to discuss care or opinions over the phone or in person without appropriate legal representation.
6. Understand that even if a patient has authorized his/her attorney to speak with you ex-parte, you are not compelled to do so without your own attorney present.



What happens next?

UMIA claims investigators will arrange, at no expense to the physician, for expert legal representation to be present for any required communications with the requesting attorney. To be in compliance with the above ruling, the plaintiff needs to be notified if the meeting is requested by defense counsel. If a meeting is planned with the plaintiff's attorney, it is important that the discussion be well documented to avoid embarrassing contradictions in testimony that can occur with informal, friendly conversations.

What happens if you talk to lawyers about a patient's care without counsel present?

Several unfortunate and embarrassing events can occur if a physician opts to engage in conversations with an attorney about a

patient without appropriate legal support. First, you can be in violation of the above ruling, which could result in a secondary claim against you by the involved patient (plaintiff). Second, any information collected at an informal and casual meeting with a plaintiff's lawyer could result in your becoming an additional named physician in the suit. Third, it is possible any conversation you have could be taped by an attorney without your knowledge. Any statements you make may be used to contradict subsequent testimony and invalidate you as a witness to the detriment of you and any defendants.

The Bottom Line

The following examples of physician interactions with attorneys point out the common pitfalls awaiting the unwary physician.

Examples

Here are two real examples of the kinds of problems physicians created for themselves by talking to plaintiff's counsel without proper representation and knowledge of the potential pitfalls. (Names and details have been changed to protect the privacy of the involved parties).

Example 1: The Experience of Dr. A and His Recorded Conversation

Dr. A acted as subsequent treating physician for a patient who filed a liability claim against a UMIA insured physician. The UMIA attorney scheduled the deposition of Dr. A to obtain his opinion about the cause and the permanency of the damage to the patient. No negligence claim existed against Dr. A.

One week prior to the deposition, the plaintiff's attorney met with Dr. A at his office to "run a few things by him" before the scheduled deposition. The plaintiff's attorney nicely and congenially asked Dr. A to comment on the issues discussed in a report from an out-of-state expert for the plaintiff, which he did.

At the scheduled deposition requested by the defendant physician's attorney, Dr. A provided testimony that proved to be very supportive and helpful to the defen-

dant physician on causation and long-term prognosis. When the plaintiff's attorney began questioning Dr. A, he revealed for the first time he had spoken to Dr. A the week before. He then proceeded to question Dr. A in a very accusatory way suggesting that he agreed with the plaintiff's expert report in their meeting just a week before. He emphasized Dr. A's testimony with quotes from his written notes made during the earlier conversation. As one might imagine, Dr. A clearly experienced significant discomfort and embarrassment as the plaintiff's attorney used Dr. A's words to refute his own testimony. The context of the questions ended up being very different during the deposition than in the earlier informal discussion with the plaintiff's attorney when he seemed to only be seeking clarification. Defense counsel could not re-establish Dr. A's credibility and Dr. A went from being helpful to the defense to a discredited witness for both sides because of conflicting statements that were now permanently recorded in deposition record.

Dr. A did not inform anyone of his meeting with the plaintiff's attorney, including the institutional risk manager. Had he mentioned his planned meeting with the plaintiff's attorney to a risk manager or to UMIA staff, he would have been advised that it might not be in his best interest to discuss the case informally as anything said could be used against him in his formal deposition.

Example 2: The Friendly Neighborhood Attorney

Dr. J, a pathologist and UMIA insured, examined an intra-operative, fragmented, frozen section during the course of routine work and determined it to be free of malignant change. A subsequent review of the permanent tissue sections, and confirmation by a gynecologic pathologist, revealed a very rare form of cancer. The final pathology report reflected the nature of the malignancy and its likely size as indicated by measurement of the fragmented sample aggregate. The report did not indicate a volume estimate because of the fragmented and limited nature of the specimen.

The patient asserted a negligence claim against the operating surgeon for failure to pre-operatively anticipate the presence of the malignant tumor based on the pathologic report of the estimated tumor size. The claim did not include the pathologist.

The plaintiff's attorney knew the pathologist socially from the neighborhood, and Dr. J considered this attorney to be a friend. The attorney approached Dr. J and inquired about whether he had any slides from the case from which he could estimate the quantitative size of the tumor in centimeters. The pathology report indicated the mass approximated 10 cm. Dr. J indicated he could not put a determinate measurement on the sample because of fragmentation, but agreed it likely approached a 5 cm size.

Several months later, the pathologist received a subpoena to give his deposition in the claim. The plaintiff's attorney again phoned the pathologist to review what he would say in the deposition, and for the first time, informed Dr. J he had taped their prior phone conversation.

Concerned, Dr. J contacted UMIA for assistance

and indicated he may have made some statements during his first conversation with the attorney that he might not be able to support during a deposition. UMIA retained counsel to attend the deposition with Dr. J, and counsel wisely demanded, and received, a copy of the transcript of the taped phone conversation prior to the deposition. Needless to say, the relationship between the attorney and the pathologist cooled significantly because the attorney did not inform him he recorded the call until two days prior to the deposition.

At deposition, the relationship between Dr. J and the plaintiff's attorney remained tense and adversarial. The plaintiff's attorney tried to hold Dr. J to his statements from the taped transcript even though they would likely not be admissible in court and were objected to on the record. Dr. J confirmed that the measurements noted in the report represented the combined diameter of the entire tissue sample and not the measurement of the cancerous tissue. He tried to explain this point in the initial phone conversation, but it had been overlooked in the plaintiff's interpretation of his comments. The transcript showed Dr. J to be very distracted during the call as one of his children had been involved in an accident, and he had to deal with that issue in the middle of the conversation about the tumor with the attorney.

Dr. J. clearly believed the plaintiff's attorney used his personal relationship with him to try to elicit statements that did not accurately reflect the facts of the case. Fortunately, the duplicitous action of the plaintiff's attorney to elicit favorable, but inaccurate statements from Dr. J was thwarted by the support and guidance of UMIA counsel. Dr. J's statements during the deposition remained consistent with the phone transcript in spite of the plaintiff attorney's attempt at misinterpretation.

Negotiating the Slippery Slope...

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The best policy is for a physician to avoid making statements to a plaintiff's attorney regarding the care and management of a patient except in a formal meeting with representation from UMIA or other counsel and only after careful, complete review of the records. Plaintiff's attorneys may record anything you say without revealing they are doing so, particularly in

Anything you say in these casual conversations may make it very difficult to give proper, accurate testimony at deposition; the information could be used against you should an error or lapse on your part be discovered.

phone conversations. Anything you say in these casual conversations may make it very difficult to give proper, accurate testimony at deposition; the information could be used against you should an error or lapse on your part be discovered. Conversations with defense attorneys without plaintiff approval may result in secondary action against the physician.

Although generalizations are to be avoided, it is not unusual for a plaintiff's attorney to be solicitous when gathering information, and adversarial and aggressive when it comes down to giving testimony. Be especially wary of casual "friends" who are attorneys that just want a "curbside opinion," or want to "run something by you" regarding a specific patient or medical condition. It is best to follow the above recommendations for any conversations with attorneys that are not your own. ■

If you have questions about the Sorenson ruling or how to deal with providing information to inquiring attorneys, please contact Jeri James at the UMIA at 801.531.0375.

From The President and CEO

Martin J. Osowski
President and CEO, UMIA

Software Conversion Successful

2007 was our first full year of operation utilizing the Delphi Technology Oasis Software. The 2008 renewals were processed with the new software. As with any data conversion, problems plagued us throughout the year, and in several instances, data conversion errors affected the accuracy of some renewals. These errors are being addressed and corrected as they are discovered. If you have been affected by any of these problems, we appreciate your understanding and patience. We have always prided ourselves on outstanding customer service, which we pledge to continue to provide to you, our policyholders.

This spring, several advancements enhanced our information technology capabilities, which allow us to continue to improve our service. These improvements included a software upgrade to the Oasis system and the addition of several new, faster, and bigger servers. Because of our increasing IT demands, the IT department was reorganized. In the near future, we will also be implementing a Disaster Recovery Strategy.

Our plan to go "paperless" was accelerated in conjunction with the move to the new office location and the conversion of our software. Since spring 2007, three million images have been scanned into the system including all claim files and underwriting files. We are now operating in a "paperless environment." As documents arrive in the office, they are prepped and then scanned into Imageright, our document management software. Email communications containing important information are copied directly into Imageright. The benefits of this conversion include the elimination of rental costs for storage of paper files and immediate electronic access to underwriting and claim information via computer terminals. Multiple people can view a document at the same time. The system incorporates protection from accidental deletion and loss of data. Once a document is scanned it cannot be deleted or altered.

We need your email address!

In order to complete our conversion to a paperless enterprise, we need your email address! It is the desire of the UMIA to communicate with policyholders about Exchange operations, elections, and other matters via electronic newsletter. Not only will electronic communication save operational costs, time, and resources, it also allows us to provide you with information in real time. For these reasons, please complete the postage-paid card contained in this newsletter and return it to UMIA. Future Exchange newsletters, notices, and risk management information will be sent electronically via email. If you wish to receive this information via hard copy, please let us know. Your email address will be kept strictly confidential. ■

Laparoscopic Related Trocar Injury Experience and Literature Review

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A REVIEW OF MALPRACTICE CLAIMS FILED AGAINST UMIA insured laparoscopic surgeons reveals a significant dollar loss associated with vascular or other organ injury from use of trocars for port placement. These types of claims did not exist before 1992 and have recently increased in frequency and severity. This article reviews these losses, the relevant medical literature, and offers some suggestions on how to minimize these injuries. Hopefully this brief review will heighten surgeon's awareness of this known, but difficult complication of laparoscopic surgery.

Trocar and needle injuries are rare complications of laparoscopy and can be sustained with open, closed, or visualized entry techniques.¹ Unfortunately, it is not rare to see or hear of a major accident or death related to first trocar insertion. These events are always catastrophic for the patient, of course, but also for the surgeon.²

UMIA Loss Experience

Over the last ten years, UMIA identified eleven trocar related injury claims. Six of these claims were closed with indemnity payments of \$1.94 million dollars and defense costs of \$464,000 and rising. Five of the eleven claims remain open. The single largest loss involved injury to the aorta and adjacent organs, including the pancreas, with a trocar in a thin, muscular male undergoing a laparoscopic fundoplication. Two closed claims involved injury to the iliac arteries with a trocar, one leading to death in a 34 year old. All closed claims resulted in an indemnity payment with the average payment amounting to \$324,000.

Review of Laparoscopic Literature

There are very few controlled, randomized studies looking at closed versus open trocar placement. These come down slightly in favor of an open technique.^{2,4} Unfortunately, this technique is not without trouble, and the medical literature primarily contains studies done prior to the advent



of optical trocars. Initial teaching, when laparoscopy was in its infancy, suggested trocar placement at a forty-five degree angle downward into the pelvis. Later studies showed that this may have a higher risk of vascular injury. Subsequent experience demonstrated that placing trocars at an angle may make their manipulation difficult, particularly in advanced laparoscopic procedures where a larger field of vision and multiple working vistas are required. In these instances, a perpendicular approach is favored.

Certain populations of patients are at greater risk for trocar injuries, particularly during the initial entry. These include the very obese, the elderly, post-partum women, re-operative surgery candidates, and the very thin or muscular patient.

The very obese have a varied amount of subcutaneous fat making the depth of abdominal fascia widely variable.

Most bariatric surgeons now opt for an optical trocar entry. Visualizing each level of tissue makes loss of orientation less of a risk.

The elderly and post-partum women tend to have a lax abdominal wall making intra-abdominal injury more of a risk. Grasping the fascia and tenting it up may prevent injury. In the pregnant woman, attention to fundal height and staying away from the uterus both in location and trajectory is important.

During re-operative surgery, the basic tenet is to stay away from the previous operative scar and site of operation. Re-operative laparoscopic surgery holds less of a risk because of less scarring and fewer adhesions compared to open surgery. Many favor a left upper quadrant location for initial placement.³ Subsequent exploration of this area for occult injury is also important. Additionally, it is critical to stay away from the epigastric vessels with the initial trocar placement as well as subsequent trocars. Some individuals advocate transillumination of the abdominal wall to assist in visualizing these vessels.

The thin and muscular patient presents a challenge because of tough fascia. An approach similar to that advised for the elderly or post-partum patient of tenting up the fascia can reduce the chance of a trocar injury.

Even more troublesome is the injury sustained after initial entry. Visualization of the placement of subsequent trocars can ameliorate any unrecognized injury. In other words, if the placement of subsequent trocars is visualized, any injury sustained will be immediately evident.

Suggestions for Minimizing Injuries from Trocar Placement

The following is a checklist for laparoscopic surgeons to consider before proceeding with trocar placement:

- Is this a higher risk patient for a trocar injury? (Obese, elderly, post-partum, re-operation, pregnant, or thin and muscular)
- Do I have the optimal equipment and is it functional? Has it been checked?
- Do I have the optimal location for my ports?
- Do I know where my needle went?
- Have I checked carefully for any collateral organ damage?
- Is there any sign that I have a trocar injury?

These are questions a good surgeon will ask himself/herself as he/she prepares for and proceeds with the procedure, be it a general surgeon, obstetrician, or family physician.



What if an injury occurs?

Surgeons are not expected to be perfect, and it is well recognized that errors can occur even in the best of hands. First, the best outcomes occur when the surgeon provides the patient with reasonable, pertinent information during the pre-operative discussions and decision-making, and these conversations are well documented. A procedure-specific consent form is best for elective procedures, but a pen and good notes also work well.

Second, it is important to recognize the injury at the earliest possible time. This is obvious for a direct arterial injury, but may not be so obvious for venous, bowel, or other organ injuries. Always be suspicious and alert for injuries during the procedure and specifically look for them at the end of the procedure. When detected, repair the injury appropriately or get help to get it repaired. Third, with the patient taken care of, explain in a very open, honest, and transparent way what you know about the injury and how it happened, the prognosis, and your commitment to do everything to help the patient recover as fast as possible.

Finally, continue to monitor the patient post-operatively. If there are unexplained vital signs and findings, suspicion of an occult injury and return to the operating room is best for everyone involved. Maintain close and open communication with the patient and family, irrespective of how personally painful or embarrassing it may be to you. Keep monitoring the patient and document clearly the events in a factual way. Contact UMIA to discuss the event with a claims investigator and to get help with early intervention if it appears appropriate.

Following these guidelines will put the operating surgeon in the best possible position to weather whatever may evolve in terms of the patient's course or a potential future claim.

If you have questions or comments about this information, please contact A. T. Williams, M.D. at UMIA at 801.531.0375. ■

References:

1. *Surg Endosc* (2001) 15: 275-280
2. *Surg Endosc* (2005) 19: 1667
3. *Cont Surgery* (2006) 62 (10): 470-473
4. *World J Surg* (1997) 21: 529-530
5. *Cont Surgery* (2006) 62 (11):527



News

UMIA Appoints Beth Hanlon, M.D. as a Board Member

The UMIA Board of Directors appointed Beth C. Hanlon, M.D. as a new board member to replace Patrice Hirning, M.D. who resigned to accept a position as Assistant Medical Director of UMIA. Dr. Hanlon, an internist practicing in Salt Lake City, started her medical practice in 1993 after completing an internal medicine residency at the University of Utah. She then worked as an attending physician and instructor in the University of Utah–VA system for two years before entering private practice. She continues to be involved in teaching as a volunteer faculty physician training medical students and residents. As the senior partner in a five-physician practice affiliated with Salt Lake Regional and LDS hospitals, Dr. Hanlon likes to focus on health maintenance and preventative health issues involving hypertension, diabetes, risk modification following myocardial infarction, and medical issues involving pregnancy. During the course of her practice she assumed a number of administrative and committee positions focusing on senior issues, medical ethics, hospitalists, and drug therapies.



Dr. Hanlon balances her practice with her family responsibilities including her three teenage children and her husband who works as a commercial real estate broker. She finds time to enjoy hiking, skiing, cooking and working in the garden with her family.

Dr. Hanlon is committed to the values and mission of UMIA, and to spending the time and effort required to be an effective member of the Board of Directors.

Ron Miller, M.D., Chairman of UMIA Board of Directors, Named *Montana Family Physician of the Year*

The Montana Academy of Family Physicians named UMIA Board of Directors Chairman, Dr. Ron Miller of Whitefish, Montana, as the *Montana Family Physician of the Year*. Dr. Miller will be honored at the annual Academy Primary Care Conference in June 2008 at Chico Hot Springs. A member of the UMIA Board of Directors since 1989, Dr. Miller has served as Chairman since 2000. In addition to his dedication and energetic leadership of the Board, he finds time to continue his private practice of Family Medicine in Whitefish, and spend time with his family enjoying the great outdoors—Montana style. Congratulations to Dr. Miller on the achievement of this recognition and honor bestowed by his peers. ■