2011 PIAA Medical Liability Conference
May 11-14 • Scottsdale, Arizona
INTERNATIONAL MEDICAL INDEMNITY FORUM
Sharing Intelligence & Innovation

PIAA INTERNATIONAL SECTION CONFERENCE

6-8 October 2011
MELBOURNE, AUSTRALIA

Join us in Melbourne in October 2011 as thought provoking presenters from around the world share their views on topics ranging from new medical therapies to the latest investment and insurance strategies.

Melbourne is one of the World’s Most Liveable Cities. It’s Australia’s sporting capital and home to fine dining, great wines and a full calendar of arts and entertainment.

With an exciting social program built around some highlights of this beautiful city, the networking opportunities will complement the innovative conference program.

If you play a role in medical indemnity anywhere in the world, you should be there!

Go to www.piaa2011.com for more information or to register.
RPNews is the first and only magazine in Latinamerica that is exclusively dedicated to “Professional Liability”. Since January 2003 we have been periodically approaching the professional community and the insurance industry, reaching thousands of professionals that receive RPNews by mail and e-mail. Our readers can find articles and interviews, jurisprudence, cases, information about seminars, statistics, news from around the world, and more. The priority of the contents of RPNews are, especially those issues linked to medical malpractice.

At RPNews we are committed to generating a free and pluralist media where all those who have something to say can count with a special section, a space where the public in general and the professionals particularly, can be well informed and get prepared to cope with and confront the issues related with “malpractice”. Also RPNews was the first magazine to publish a book in Latinamerica (“Medical Professional Liability –The Power of Communication”), originally from the US, but with remarks done by argentine doctors and lawyers. Since 2008, with 2 other magazines (one from the insurance industry and one from the health sector) we put together an annual Conference on Professional Liability, the main event on this field in Latinamerica.

It makes me proud that, as we did it for the PIAA Conventions in Montreal-Canada (2006), Seattle-Washington-USA (2007), Paris-France (2008) and Chicago-Illinois (2010), you are reading now our SPECIAL EDITION “RPNews-PIAA/ARIZONA 2011”. This edition will not only be in the hands of all the professionals attending the Conference, but also will reach thousands worldwide after the Conference.

You’ll have the chance to read here about the PIAA, and the PIAA INTERNATIONAL SECTION and also the opinion and vision from many experts representing various countries.

I would like to express our special gratitude to the PIAA for giving RPNews the opportunity to reach the most important “audience” related with the medical professional liability from the US and so many other countries.

With the conviction of the importance of a International Convention, we want to invite you to participate in the next PIAA INTERNATIONAL CONFERENCE 2011 to be held in Melbourne, Australia in October, where we will be there with another RPNews-PIAA special edition

Best regards,

Dr. Fernando Gómez.
DIRECTOR
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2011 PIAA Medical Liability Conference

EDITORIAL. Dr. Fernando Gómez.

WELCOME. Larry Smart

INTERNATIONAL SECTION. John E. Gray

INTERNACIONAL CONFERENCE OF HEALTH LEADERS IN MADRID.

SURGICAL ADVANCES, MORE RISKS. Christine Tomkins

IT HAPPENED TO ME... Dr. Pedro San Juan

RESPONSIBLE THINKING. Doctor Without Borders (MSF)

MEDICAL PROFESIONAL LIABILITY. Harry Henschen

SHARING INTELLIGENCE AND INNOVATION. Claire Leonard

MEDICAL MALPRACTICE CLAIMS. Fernando G. Mariona
Welcome to Scottsdale and the PIAA's 34th Medical Liability Conference, where we expect more than 500 attendees from the United States and many other countries around the world. This year marks a big change in the PIAA's meeting program, as we have altered the tempo of the conference by adding more educational sessions and speakers. Our keynote speaker, CEO Joe Plumeri of Willis Group, is recognized as one of the senior leaders in the global insurance industry, and he will set the tone for a conference that features a faculty of highly qualified and experienced individuals from the insurance, healthcare, and legal professions. We hope that this high-quality educational and collegial experience, blended with the unbeatable venue of the Westin Kierland and surrounding Arizona opportunities, will make this the best insurance gathering that you will attend this year.

When the PIAA began hosting this annual conference in 1977, attendance was targeted at the boards and management of the 16 U.S. domiciled physician-owned and/or -operated medical professional liability (MPL) companies that comprised the Association. Since that time, the PIAA has expanded greatly in size and scope, and we now have members from Argentina, Australia, Belgium, Canada, France, Sweden, The Netherlands, and the United Kingdom. Our 68 primary insurer and indemnification organization members insure more than 700,000 physicians and other healthcare professionals in many countries around the globe. Expanding on the focus of the founding PIAA companies, today's PIAA members insure most of the professions and institutions that comprise the healthcare community.

The growth from insuring physicians to gradually include insurers of dentists and oral surgeons, hospitals, podiatrists, and chiropractors occurred during the PIAA's first 20 years. Recognizing the need for the Association to continue to grow and be representative of all MPL companies, the Board of Directors has offered a Bylaws amendment to be considered at the 2011 Annual Meeting of Members which, if adopted, will create a new Industry Associate Member category which will be available to commercial carriers not meeting the requirements for Regular Membership. Also proposed is the re-categorization of insurers owned/operated by healthcare providers other than physicians, dentists, or oral surgeons as voting Regular Members. Regular and Industry Associate Members will enjoy the same membership rights and pay dues at the same level, except that Industry Associate Members will not have the right to vote at meetings of the Members. This is in recognition of the PIAA founding core value that it be the voice of the physician and other provider-owned/operated MPL insurance industry.

The PIAA International Section has become a permanent and viable voice in the Association. It will conduct its annual planning meeting during the Medical Liability Conference, and later in the year, hold the fifth PIAA International Section Conference in Melbourne on October 6-8, 2011. Open to PIAA members and non-members, the theme of the Melbourne meeting is sharing intelligence and innovation, evidencing the commonality of issues and challenges faced by MPL insurers and indemnification organizations across the globe. As international commerce increases and populations become more mobile, the need for coordinating and sharing information among PIAA members in other countries becomes increasingly important and essential.

This will be my last Medical Liability Conference at the helm of the PIAA. I have greatly enjoyed knowing and working with our International Members since we developed this category of membership in the mid-90s, and held our first educational conference in Amsterdam. My wife Lori and I have made many great friends through our participation in International Section events, and have laughed and learned from a most memorable treasure of experiences. We have seen the Section membership change as careers grow or mature, and still, count our time here as most valued over the past almost two decades as faces come and go. We hope to still have a presence in the industry going forward, and wish all of our friends and associates Buena Suerte!
The PIAA International Section consists of 10 different medical liability protection firms that provide professional indemnity and related services to over 400,000 health professionals around the world. These 10 firms offer a wide range of professional indemnity services delivered through a range of operations, health care delivery and legal systems.

The PIAA International Section members operate within a variety of structures and business models, with some providing claims-based insurance and others offering occurrence-based, discretionary protection. Some firms restrict their protection to physicians, while others have a much wider mandate. This diversity is a strength for the International Section and for the firms that benefit from the enhanced perspectives of its members.

In addition to our closely aligned objectives, our member firms face a number of common issues that impact the provision of services to members. These include cost pressures, a greater emphasis on patient safety, and changes in the demographic make up of members and of the patients those members treat. These demographic trends will have significant impacts on the work of the firms. At the same time, changes in health care delivery are accelerating, regardless of the country involved. Improved technology plays a major role in this change, and technological advancements will undoubtedly continue. Moreover, the overall medico-legal environment in which we operate is changing, and legal systems seek to keep up with the pressures they are facing.

Recent activities of the International Section can be grouped into five main categories: data sharing; publications and risk management information sharing; the annual risk management session; exchange visits between member companies; and the triennial conference.

Claims experience is a rich source of research into the underlying issues that result in medical negligence cases. By sharing claims information, we can develop an international overview of claim trends and identify common areas of physician liability. Information sharing also enables us to exchange valuable information for use in risk management programs and claims management. Information sharing also sets the conditions for additional benchmarking, for example on how firms code files or conduct analysis of the data.

In keeping with the advantages of data sharing, the PIAA International Section has launched a pilot data sharing project related to cancer diagnostics issues for family doctors. We intentionally selected this limited pilot to test how effectively we could share aggregate data. The firms are now finishing the second exchange of data, and will be discussing next steps at a meeting in May.

Through the pilot project, we discovered a number of challenges related to data collection, from the variety of data sources (such as hospitals and physicians’ offices), to the varying level of coding maturity (including definitions and methods). Fortunately, we gained agreement early on about the key elements of the pilot project, and this helped us to address a number of implementation issues at the outset. The group has a good base for project expansion in the future.

In closing, the International Section is hosting its next triennial international conference on medico-legal issues in Melbourne, Australia in October 2011. The theme is Sharing Intelligence & Innovation. All sessions are designed to maximize information exchange. The program includes sessions on no fault schemes, trends in the delivery of health care and their impact on indemnity, and the role of physician insurers in quality and safety. We hope you will join us.
The PIAA Annual Meeting has a new name—and a new focus!

2011 PIAA Medical Liability Conference

May 11-14 • Westin Kierland Resort • Scottsdale, Arizona

The 2011 PIAA Medical Liability Conference will be the year’s most important event. This conference, formerly known as the Annual Meeting, has been renamed to reflect the PIAA’s new vision for this annual event, and its more focused content.

The 2011 PIAA Medical Liability Conference features:

- High profile speakers, including Joseph J. Plumeri, Chairman and CEO, Willis Group Holdings plc
- More concurrent sessions! Topics include:
  - The diminishing pool of solo-practitioners and small physician groups
  - Formulating an effective defense in multi-defendant cases
  - ACOs—what are they and how will they impact MPL?
  - Transfer of care—avoiding MPL claims
  - MPL insurers and electronic data
  - And many more!
Dr. Héctor S. Vazzano, President of FecLiba and Executive Director of FLH (Federación Latinoamericana de Hoteles) and OIPSS (Organización Iberoamericana de Prestadores de Servicios de Salud), and Mr. Norberto Larroca, President of Argentina Salud Comunidad and FLH (Federación Latinoamericana de Hoteles), were invited to take part in the Internacional Conference of Health Leaders and Meeting of Latin American Leaders, held in Madrid in December.

The aim of said meeting was to reflect on the healthcare situation worldwide, its interrelations in a globalized world and its effects on economy. The Honour Committee of the meeting was presided by HRH Prince Felipe de Borbón and sponsored by the Portuguese Health Engineering and Management Association José Soto and Carlos Tomás, respectively; and by the General Secretary of the Bamberg Foundation, Mr. Salvador Arribas.

In short, they all agreed on the fact that healthcare systems should be man-centered, that there should be health policies as sustainable as Government policies, that there should be less fragmentation between the Financing and Services sections, with higher levels of efficiency; furthermore, are borne with State income nor in countries with a private system of healthcare services.

Mr. Barroca, President of FLH and of Argentina Salud Comunidad made a deep humanistic analysis of healthcare issues, and urged the whole health community to start considering human beings as the real center of the healthcare system.

Dr. Vazzano lectured on the Universal Models of Sustainable Health, and he placed special emphasis on the Argentine model, and how it improved as from the implementation of the CIDCAM Certification Program and the CENAS Certification.

CONCERNS AND PROPOSALS AGREED UPON DURING THE CONFERENCE

Situations that foster worldwide crisis in this area.

- Increase in the number of persons over 65 years of age.
- Increase of population urbanization. The consequences are social welfare deficit and lower quality of life.
- Healthcare does not only depend on Health Institutions, but also on economic policies, housing policies, education, sanitary conditions, drinking water availability, sewage control and many other facts that have an indirect impact on the possibility of having access to adequate healthcare for everyone.
- Epidemiological problem with recurrent communicable diseases, and chronic non-communicable diseases, due to increased life expectancy.
- Prevailing of chronic problems in relation to household income: obesity for the rich and no changes for the poor.
- System aging represents a risk for Healthcare services.
- Today the society is much more demanding, mainly due to computing, which allows for a better access to information, although not always quality information.
- Expense of catastrophic expenses
was analyzed: the poorest fifth seems to be the most harshly hit, due to medicine and ambulatory attention expenses. More than 20% of a household income spent on health represents economic catastrophe. Great fragmentation between financing and healthcare services, not only economical but also in regard to quality inherent to system efficiency.

- There has been no real evidence that decentralization is a solution to the problem.

- As regards generic drugs (suggested as an important means to lower costs), the studies show that they greatly differ in price from one country to the other.

- Imaginary diseases take up a great amount of resources, more medicines are prescribed for healthy people; therefore unnecessary expenses are generated in households.

- In the future, the costs of preventive medicine are expected to go up (biological medicines, diseases detectable by DNA – Human genome).

- The quality of life of a certain population is measured by the quality of life of its poorest member.

- 1.3 trillion people all around the world have no access to health care.

- Professionals do not bear the costs of services, thus acting without any consideration for the patients.

- Pandemics of new diseases clearly show that Epidemiologic Watch Programs should be strengthened.

- Climate issues are part of the Global Healthcare agenda.

**Global Healthcare Challenges**

- Healthcare providers migrations, brain drain.

- Vulnerability when responding to communicable diseases, changes in climate and biotechnology.

- Access

- Planning

- 20% to 40% of resources wasted

**Innovative financing in many countries**

- Foreign Exchange market (rate - proportional rate)

- 50% increase in Tobacco Taxes

- Increase in the Alcoholic Beverages Tax

**Solutions**

- Team work

- Improved and efficient management

- Private and public coordination to rationalize resources

- Public and private healthcare providers should take on responsibility for patient safety and welfare. Citizens should be co-responsible for the

**Healthcare System.**

- Increased productivity and competitiveness

- New management model based on patient security and overall quality of Certification and Accreditation Programs.

- Before looking for instances to cut down expenses in healthcare provision, we need to look for other options, like using resources in a better way.
An analysis of bariatric surgery claims, by the Medical Defence Union (MDU), the UK’s largest medical defence organisation, reveals that there has been a dramatic rise in the number of cases notified during a recent two years period.

The MDU says that while the numbers of medical negligence claims arising from bariatric surgery, notified by its members working in independent practice, remains relatively low, with 35 cases notified since 2003, more than half of these were notified during 2008 and 2009.

These claims involve a relatively new type of surgery, where the stomach is banded or bypassed to produce weight loss in obese patients. Not all of the cases will lead to compensation being paid to patients, as many are likely to be discontinued, but the MDU has identified some common themes that may help surgeons avoid problems.

Dr Christine Tomkins, MDU chief executive, said: “We are starting to see the emergence of medical negligence claims being notified by our surgeon members working in independent practice who perform bariatric surgery. This is not surprising given that this type of surgery is fairly new and there is usually a time lag between an incident occurring and a claim being made. However, given that this type of surgery is likely to increase in popularity, we want to try to help our members to avoid some of the common problems our analysis has highlighted.”

Common problems highlighted by the MDU analysis include post-operative complications such as infections; bands slipping or leaking and delays in diagnosing these problems, difficulties and complications in adjusting bands; and alleged failure to obtain consent from patients, for example about the risks involved or the post-operative diet required.

While most problems were not life-threatening, in a handful of cases the outcomes were severe for the patients concerned. In at least one case the patient died following an infection, which it is alleged was caused by perforation of the gut. In another case a patient had to be placed on a ventilator after a leak following a gastric bypass led to an infection.

The majority of the claims are still ongoing and many will not result in compensation being paid to patients, but the estimated value of active cases ranges from £2,500 to £500,000.

Further information

The MDU is a mutual, not for profit, organisation owned by our members who include over 50 per cent of the UK’s hospital doctors and GPs. Established in 1885, we were the world’s first medical defence organisation. We defend the professional reputations of our members when their clinical performance is called into question. Our benefits of membership include insurance for claims of clinical negligence and a wide range of medico-legal advisory services.
The MDU issued risk management advice to its members performing bariatric surgery in the UK including:

- Patients should be given information, in a format they can understand, about the recognised risks of the procedure, the post-operative diet required and weight loss to be expected.

- If the surgeon delegates responsibility for getting consent to a colleague, that person should be qualified and experienced enough to understand the procedure, its risks and any complications so that he or she can fully answer the patient’s questions.

- If there has been a time lag between the initial discussion and the date of surgery, it is important to check the patient still consents to the procedure and that it remains appropriate.

- The consent discussion must be documented.

- Surgeons need to be aware of nationally recognised clinical guidelines and be prepared to justify their actions if they do not follow them.

- Surgeons need to ensure they are adequately trained and experienced to undertake bariatric surgery and that training grade doctors are adequately trained and supervised.

- The surgical team should include staff with relevant experience and expertise and it is advisable to have protocols which define appropriate standards of care and roles and responsibilities.

- Patients need to have information about what to expect in terms of the recovery time and process, what problems may occur and what to do if they have any difficulties. Patients’ GPs should be kept informed.
A NEW TESTIMONY ON HOW A PHYSICIAN FEELS WHEN FACED WITH A MEDICAL MALPRACTICE COMPLAINT. DR. PEDRO SAN JUAN, PLASTIC SURGEON AND FORENSIC EXPERT SHARES HIS OWN EXPERIENCE ON THE SUBJECT.

RPN: How long have you been a surgeon?

I started practicing on May 19th, 1975.

RPN: What is your field of specialization?

I am a general and plastic surgeon, as well as a specialist in Health Services Management and forensic expert.

RPN: When did it all start?

In February, 1986, as a consequence of an operation performed in November, 1985.

RPN: What was the claim, and how much was the compensation desired?

The claim was filed due to a facial paralysis that took place 5 days after performing a lifting for the plaintiff. The amount requested as compensation was U$S 500.000. The first noticed served requested me to appear at a correctional court to be examined. Back in 1986, no one was really acquainted with such a situation, and there was only one book on medical liability written by Mosset Iturraspe. At the hearing I testified for 4 hours and explained why it was technically impossible to have caused such an injury with a lifting procedure. My lawyer was a specialist on labor matters. He was defending me just because I was his client, but did not really believe in my innocence.

RPN: Did you have medical malpractice insurance at the time?

I do not think there was a doctor in those years that had one, nor do I know of any insurance company that was actually offering that sort of insurance coverage back in 1986.

RPN: What happened next?

All medical expert witnesses reports were unfavorable, so I had to hire a criminal lawyer, who was finally able to get the action dismissed due to a statute of limitation. At the same time, they filed a claim against me at a civil court and, as I realized that in fact everyone thought that I was really responsible for the injury inflicted, I started studying the subject from a legal point of view (I read Mosset Iturraspe, Yungano, Bueres, Vázquez Ferreira), as well as from the medical point of view (I contacted a physician specialized in the peripheral nervous system, who was kind enough to give me information on facial nerves).

Furthermore, I began to analyze the results of the three EMGs performed in the three tests done at the CMF and, based on those results, I could finally show that the injury had been caused in fact by a compression exercised by a big edema, which affected both facial nerves at the

RPN: I imagine there were many moments of incertitude during the whole proceedings, what was this first stage like? How did you feel? Did you ever think about giving up your professional practice?

The process was utterly traumatic for me because the injury the patient suffered was really serious and caused her face to be distorted. I genuinely felt sorry for her, but I was deeply convinced that the injury had not been caused by the plastic proceeding I had performed, as neurological symptoms appeared only gradually and five days after the operation.

I never gave up my professional practice, but every time a patient came requesting a lifting procedure, I felt incredibly tense.
trunk: even though the patient experienced some improvements at an electromiographical level, she still had some difficulties in her facial features, particularly as regards her eyes and lips.

Under these conditions, and with the medical and legal information I had acquired, I myself wrote the answer to the complaint, the presentation of evidence and the final argument to be presented at the court of first instance. As the plaintiff's lawyer had requested some preliminary proceedings for the appearing of five different expert witnesses (neurologist, neurosurgeon, otolaryngologist, ophthalmologist and a psychiatrist); which of course were all against me, I decided to take a huge risk and I summoned the neurosurgeon that had acted as plaintiff's expert witness in the preliminary proceedings for cross examination. I wrote the questions myself.

When the expert witness arrived to the court, I told him he was about to sit for a neurology and neurosurgery examination; and that he might pass it or not, but that if he dared lie at the cross examination, he would certainly know what it was like to be sued. When he answered the first question he specified that when he wrote the word "neurotmesis" in his report (irreversible injury due to mechanic destruction of the nerve), he had in fact made a mistake when typing. What he had meant to write was "axonotmesis", which is a very characteristic injury when nerves are compressed and which can be reverted without an operation.

I need not say that the expert witness "passed" his examination, and as from that moment everything changed. After that, that same neurosurgeon was appointed as expert witness in the civil proceedings and performed a new test which was absolutely favorable to me: it was then that the plaintiff's attorney started urging me to reach an agreement, but he wanted me to pay for all the expert witnesses he had requested at preliminary proceedings. I did not agree to that.

When finally a decision was pronounced, I learned the real concept of the word "equity": if a woman has a plastic surgery performed and some neurological damage is evident on her face, she should be redressed in someway. So, I was therefore sentenced to a compensation of only $50,000.

And that is how I wrote my first appeal document, and luckily my appeal ended up in a Court chamber where one of the Judges was Dr. Gladis Estela Álvarez, one of the pioneers as regards mediation processes in Argentina. I can never be grateful enough to this woman. Up to that moment I had always felt nothing more than a file number in a universe of millions of cases, something completely devoided of all humanity, both in the criminal and in the first instance court.

RPN: How did you feel in this part of the proceedings, with the beginning of mediations, expert witnesses tests and reports, evidence presentation, etc?

What I felt was that if I did not take the whole matter in my hands, my life would be very difficult for many years to come.

RPN: Did you actually go to court or could you reach an agreement at mediation?

The mediation meeting was held at the mediator's office, and Dr. Álvarez there expressed her wish to meet the parties involved as she was willing to help them come to an agreement. I personally told her that I was absolutely sure that the injury the plaintiff had suffered had not been my responsibility. I further told her that I had won the Best Surgery prize at the 1995 Plastic Surgery Conference specifically for the surgery practiced on that patient, but that I had not been able to offer said writing as evidence as I did not have it ready when the complaint was first filed.

I also told her that, however, I still remembered every single minute of the 9 years the proceedings had lasted,
and I recalled a time when the plaintiff’s lawyer had told me, “Doctor, pay a compensation of U$S10,000 and you will not make the news”. It was then that I decided to offer that amount of money as compensation for damages caused, and the original compensation requested of U$S500,000.- turned into an agreement for the payment of U$S10,000 + $2000 for lawyers fees. All this happened in 1995 and I was allowed to divide the payment in three installments. Dr. Alvarez asked me for a copy of my award-winning report, and the plaintiff did so as well.

RPN: Which was the final decision?

There was no final decision, but when the agreement was signed at the Appeals Court a special clause was included in the agreement. Said clause clearly stated that the agreement signed did not imply acknowledgement of any liability whatsoever on my part, and did not in any way affect my good name and professional reputation. Furthermore a non disclosure clause was included in the agreement.

RPN: How did you feel in this final stage of the proceedings?

There were moments of unbelievable happiness, when I felt I would win, and others of deep depression, when faced with the risk of losing.

RPN: Did you ever consider living up your professional practice? What made you change your mind?

I could have never given up my career; medicine is all we, doctors, know about. Besides it takes so many years to reach the specialization level I had reached within the medical field in any other field of study.

However, while still practicing as plastic surgeon, I decided to set up a firm exclusively dedicated to the counseling of physicians and medical institutions in regard to medical malpractice claims, with a customer service available 24 hrs a day which was the first of its type in Argentina. It is still working at present, and we give advice to more than 100 people per month.

In the end, I had to make my choice: keep on working as plastic surgeon or dedicate myself exclusively to risk management in regard to Medical Professional Liability.

I must admit that, though it all started up your professional practice? What made you change your mind?

In regard to medical malpractice, it was first established to allow a person who thinks has suffered damages due to his physician’s performance to file a complaint against said doctor without having to pay for litigation costs and fees. The underlying idea is that all people have a right to litigate, notwithstanding their financial situation.

RPN: Do you relieve economic problems in a way influence the relationship established with patients?

I think that we are losing the relationship with patients. But this is not only due to economic problems. The doctor-patient relationship should be based on mutual confidence, but nowadays doctors do not trust patients and patients do not trust doctors as well.

And neither side is doing anything at all to build that confidence bond between them again. Therefore, we arrive to the first problem: the patient

resorts to another professional, and seeks a lawyer as well.

RPN: In your opinion, what is the concept of exemption of litigation costs?

In regard to medical malpractice, it was first established to allow a person who thinks has suffered damages due to his physician’s performance to file a complaint against said doctor without having to pay for litigation costs and fees. The underlying idea is that all people have a right to litigate, notwithstanding their financial situation.

Unfortunately, as with many other good ideas, the present application of this principle has been totally distorted. And as it is nowadays, it allows people who claim to be poor to file complaints with no legal background to obtain astronomical compensations.

Guilty until proven innocent

This is what some patients, some expert witnesses and even some legal officers think of physicians who are prosecuted. However, there are still some officers that go into the complaints filed seriously and objectively. The law establishes that the defendant is considered innocent until proven otherwise, but in our present day legal system, the truth is some decisions clearly show an alarming lack of evaluation and consideration of legal presumptions.
Introducing a great prescription for LOWER medical professional liability rates.

J.M. Woodworth RRG, Inc. has teamed up with TCP Hispana and the Hispanic Medical Professional Liability Association in an effort to bring down insurance rates for member physicians. Working together, we’ve developed a specialized program that offers exceptional coverage for Hispanic physicians at the most competitive rates possible.
RPNEWS INTERVIEWED ONE OF ITS MEMBERS: LUCAS MOLFINO, A 33- YEAR-OLD ARGENTINE PHYSICIAN. HE EXPLAINS THE KIND OF TASKS THIS ORGANIZATION CARRIES OUT, AND GIVES US A SPECIAL, RESPONSIBLE AND COMMITTED POINT OF VIEW ON THE MEDICAL PROFESSION.

**RPN: How long have you been a doctor? What is your field of specialization?**

I finished my university training at the Medical School of the Buenos Aires University in 2002, and then I specialized to become a clinician or General practitioner. In 2006 I finished my medical residency; it was then that I decided to join MSF. I have taken part in many missions in different countries.

**RPN: How did you decide to join MSF and why?**

I had heard about the organization some time before I actually joined them, but it was in 2006 that I became seriously interested in it, and started considering the idea of joining it as a real possibility for me. At the beginning of 2006 I submitted my resume, then I had a series of personal interviews, I received training in regard to the main standards of the organization and finally I joined one of the teams working in Northern Uganda, in a refugee camp.

It is somewhat difficult to explain why a person decides to join, at a certain point in his or her life, a humanitarian organization like MSF, but in my case, I guess I felt the need to see more of the “real” world, maybe find something that would give to my profession the right magnitude or importance, something that would basically fulfill me as a human being.

There are a million ways of fulfilling oneself as a human being, but I found my own way working for MSF. I may also say that it was through MSF and where we work, how we work and who we help that I have become fully convinced that we are actually “doing” something for those in need, and at the same time I am doing something for myself. Working for MSF is an exhausting activity, and at the same time it represents a huge challenge for myself, that I would have never had the chance to live otherwise. In order to work here you have to give a lot and overcome the most difficult living conditions; you need to work hard to understand other human beings, to tolerate, to fully comprehend different ways of thinking, different beliefs and different working methods.

**RPN: What do you do within the organization?**

I have performed many different tasks in the different missions I was a part of, but all of them were closely connected to my profession. In my first missions I was a camp doctor; later I fulfilled medical team coordination tasks. In my latest mission, I had to coordinate medical activities for different MSF projects in Cambodia.

**RPN: Which places did you work in?**

I worked in many countries in Africa between 2006 and mid-2009: Uganda, Liberia, Ethiopia and Zambia. My last mission, which lasted a year and a half, was in Cambodia. In Uganda I helped and cured people in refugee camps. In Liberia, we concentrated on mothers and children. In Ethiopia we worked hard on a nutritional emergency, and in my last two missions in Zambia and Cambodia we concentrated on tuberculosis and HIV-AIDS issues.

**RPN: Apart from working for MSF, do you also practice in more traditional environments, like a surgery or clinic?**
The duration of the missions is not always the same, it depends on the context and tasks to be fulfilled. Since I started working in MSF, all my missions have been almost one after the other. Therefore, between one mission and the other, I just spent my time with my family and friends. At present, due to family needs, I have decided to stay in Argentina for the time being, so I am working in a hospital that belongs to a social security company.

RPN: In your opinion, what should a doctor have to join MSF?

In my opinion any person willing to join MSF, and I say person and not doctor because the organization also needs other professionals like psychologists, accountants, etc., should have some previous working experience in the area he or she wishes to work in; should also speak English or French fluently and then, one of the most important things is that he or she is willing to be part of a team and also used to working this way; the person should be versatile enough to adapt to different working environments and challenges. To sum up, anyone willing to join should be capable of helping and understanding other people without trying to change them, as should be any humanitarian worker.

RPN: How did your participation in MSF change your views?

In all this time, many things have changed, like the way I regard Medicine and the world in general. As regards Medicine, I came to know a whole new set of diseases that were previously unknown to me; but what moved me the most was being faced with the fact that thousands of millions of people suffer from hunger, malaria, tuberculosis, cholera or meningitis, all treatable diseases (that could easily be prevented as well) that kill millions of people all around the world every year and nobody really cares or does anything to stop this. Meanwhile, world leaders use millions and millions of dollars to save banks and a financial system that is completely unsustainable.

RPN: Are you always welcomed when you arrive to a new place? Which are the most common problems you find?

My personal experience is that people are always happy to receive our help and assistance. Most people are truly grateful. And I believe the reason for this is we always go to places which are almost destroyed, or where few people ever go: most of these places have been forgotten by the rest of the world. But we do also have to work hard to gain their confidence: we need to adapt to new cultures, laws, popular beliefs. Sometimes, the most-difficult-to-solve problems are bureaucratic, security and logistics issues; some others, the natural disaster itself makes it virtually impossible for us to assist the victims.
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This popular PIAA publication covers the essential subjects in the complex field of MPL insurance. It explains insurance fundamentals in easy-to-understand text, for insurance industry professionals, physicians, dentists, oral surgeons, allied healthcare professionals, and medical residents.

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- MPL company structures and basic operations
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- Updated and expanded glossary of terms

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To purchase, go to www.piaa.us or call 301.947.9000

Note: Customized orders (company name and logo), bulk hard-copy orders, and electronic license pricing are available. Contact the PIAA for details.
RPN: In traditional medical practice, medical professional liability is directly related to the correct performance of a certain practice (i.e. avoid incurring in medical malpractice). From the point of view of MSF and the humanitarian activity you carry out, what does “medical liability” relate to?

The doctor has the responsibility to apply all his professional expertise to achieve the recovery of the healthy condition lost. I personally believe that a physician should use the best of his knowledge and skills to achieve said goal. If one does not do so, one should answer for the negative events arising from one’s errors in a court.

I worked in places where the Government was completely absent, sometimes even without a working legal system to resort to. Therefore I believe that the professional liability of a humanitarian worker is almost embedded within his moral responsibility. Our objective is to avoid as many willful errors as possible and furthermore, try to minimize involuntary errors arising from human weaknesses, our own weakness or other people’s negligence. In regard to this concept of medical responsibility, it is also necessary to highlight the importance of the professional selection system of the organization (for example, the requirement of having at least two years of practicing experience) and the correct organization of the medical departments, in charge of monitoring physicians’ performance in situ.

RPN: Are there any MSF missions in Argentina at present?

MSF worked in Argentina twice: in 2001, in Jujuy and Salta, and in 2003 during the great floods in Santa Fe. At present, the MSF office in Buenos Aires is focused on recruiting qualified staff for carrying out and coordinating humanitarian missions worldwide. Also important are the tasks aimed at promoting and raising public awareness on the missions being developed. Lately, we have made a campaign to raise funds for financing the missions that the organization has all over the world.

RPN: Do you know the number of Argentine doctors working actively in MSF at present?

I think there are about 80 Argentine doctors working in different missions worldwide at present.

RPN: Finally, what is it you enjoy most about being part of MSF?

My personal evaluation of the last years is absolutely positive. Of course, as in any job, there are both good and bad things, but I believe the best of this incredible experience is the people I met, my patients, my colleagues, my experiences, which have helped me become a better person, or at least have helped me learn that it is necessary to invest some time in trying to understand other human beings in depth.
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RPN: What are the measures your company takes to reduce risks, as regards patient protection?

HH: We use our claim history of 18 years for our risk management activities.

We have set up a list of criteria for the ER and OR to reduce the most common causes of errors. As a result we see at this moment a reduction of claims in these areas.

We also give lectures in the hospitals and publish, on a regular basis, all kind of information about Risk management in our magazine. Our company has also been involved in the development and implementation of a nationwide code of conduct on handling medical liability cases.

RPN: What are, at present, the challenges to be faced in connection to new technologies, health system reforms, etc.?

HH: The introduction of Electronic Medical Records, the costs of plaintiff lawyers, telemedicine and bariatric surgery are (becoming) issues. So is the financial crisis to hospitals, that make them more cost-aware. We also see more competition in the area of ML insurance. There is also more media attention Last but not least: the impact of Solvency II.

RPN: Do you believe insurance premiums will rise as a consequence of the increase in risks?

HH: We expect a moderate rise of premiums.
Acompaña a sus establecimientos asociados, apostando al bienestar de todos los bonaerenses.

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THE PIAA INTERNATIONAL SECTION PROVIDE PROFESSIONAL INDEMNITY AND RELATED SERVICES TO OVER 400,000 HEALTHCARE PROFESSIONALS AROUND THE WORLD. BASED IN 8 NATIONS, THEIR OPERATIONS COVER PARTS OF NORTHERN EUROPE, SCANDINAVIA, SOUTH AMERICA, CANADA, AUSTRALASIA, THE UK AND A VARIETY OF OTHER BRITISH COMMONWEALTH NATIONS.

These groups come together every three years for the PIAA International Section Conference which plays an important part in information exchange within the industry globally. The location rotates through the member countries and each conference is organised and hosted locally.

In 2011, the Conference will be held in Melbourne, Australia and hosted by the Medical Indemnity Industry Association of Australia (MIIAA).

The Australian Hosts

Established in September 2005, the MIIAA provides the Australian Medical Indemnity Industry with a vehicle to work collaboratively to meet the needs of the medical profession, the community and government.

The member organisations of the MIIAA are committed to a sustainable, quality health system in Australia. This commitment drives the association’s role as a thought leader and key communicator on the medical indemnity issues that relate to the delivery of healthcare in this country. This role complements the hosting of the PIAA International Section Conference and provides the opportunity to share valuable international industry knowledge and experience.

About Melbourne

With a population of more than three million, Melbourne is Australia’s second largest city. It is regarded as the cultural and fashion capital of Australia and renowned for its fine restaurants. It is a truly international city with more than one quarter of Melbourne’s inhabitants being born overseas.

Melbourne is one of the great cities of the world. Its unparalleled attractions are its gardens and parklands, food precincts, arcades and great sporting facilities. Most of these attractions are situated around the Central Business District (CBD) or within an easy tram or train ride.

Although Melbourne sprawls around much of Port Phillip Bay, the main focus for visitors is the Yarra River, which forms the southern perimeter of the CBD. The river separates the city from the Southbank development and the parklands that surround the Royal Botanic Gardens.

As a major hub for international travel, a base in Melbourne makes it easy for visitors to access other parts of Australia and make the most of the unique attractions our country has to offer.
The Academic Program

The academic program has been developed around the streams of Intelligence and Innovation. Sessions throughout the program are focussed either on sharing information on issues that impact medical indemnity globally or examining the potential impacts of changes in society, technology and advances in research.

Additionally, the variety of sessions allows for considerations of financial/insurance, legal and medical issues, ensuring there is content to suit all the different areas of the industry.

SOME OF THE SESSIONS WITHIN THE PROGRAM ARE:

No-Fault Schemes - A Snapshot of International Experience

With many different styles of compensation used in medical indemnity throughout the world, this session aims specifically to increase delegates understanding of No Fault schemes. The speakers from France, Sweden, Belgium and New Zealand will provide an overview of the system they work within and the perceived strengths and weaknesses in terms of compensating the patient and representing the needs and reputation of the medical practitioner.

Cerebral Palsy Workshop

Presenting perspectives from Canada, Sweden and Australia, this session will visit the science and legal implications of CP so that delegates get an accurate picture of the current state of the medical research and the legal problems in this difficult area.

Handling the Physician Who Exhibits Disruptive Behaviour

Featuring the keynote speaker, Dr Gerald Hickson from the Center for Patient and Professional Advocacy at Vanderbilt University, Tennessee, USA, this session will give an evidence based insight into the latest proven strategies for dealing with Physicians who can be disruptive at times - from the organisational and the regulatory perspective. The session is of interest to those who indemnify, regulate or work with physicians and other health care workers and will include additional presentations from Canada and Australia.

Trends in International Tort Law

Focussing on recent trends in international tort reform, this session is expected to address issues of broad interest to those who may have the opportunity to interact with the civil justice system in a variety of capacities. Speakers from Australia, the UK, Canada and the USA will provide an overview of how their systems are adapting to meet changes in the law and the practice of law, based on new legal developments and changes in societal values.

Innovations in Risk Management

Education and risk management programs are evolving in line with changes to the practice and delivery of medicine. This session will profile some new and exciting programs from the UK, Sweden, Argentina and Australia that may impact on the way medical indemnity providers interact with the profession.

The Social Program

As well as the outstanding academic program, the conference offers an extraordinary social program with the Conference Dinner on Friday 7 October to be held at the Melbourne Cricket Ground (MCG), ranked among the greatest sporting arenas in the world.

From its foundation in 1853, the MCG has established a marvellous history, hosting international cricket including the first-ever Test and the 1992 World Cup final, countless Australian Football Grand Finals, the 1956 Olympic Games and the 2006 Commonwealth Games.

As part of a ’progressive dinner’ through the stadium, the final course will be served in the MCG’s National Sports Museum, the home to over 2,500 objects relating to the greatest moments in Australia’s rich sporting history.

The cost of this once-in-a-lifetime experience is included in the delegate registration and additional tickets can be purchased for accompanying persons and guests.

Register NOW!

Registrations are available online at www.piaa2011.com, the rates are shown below.

Attendees at the 2011 PIAA Medical Liability Conference in Scottsdale, Arizona, can also take the opportunity to register and discover more about the International Section Conference at Booth 28 in the Exhibition Hall.

We look forward to welcoming you to Melbourne in October!

Claire Leonard
National Coordinator
MIIAA
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*NOTE: Exchange rate shown as at 20 April 2011*
Besso Re is a London based International Reinsurance Broker, is independent, experienced and knowledgeable in handling all forms of reinsurance and programmes, in particular medical professional liability, on a world-wide basis. Our team of experienced professionals focus on each client and work with them to develop a programme that is appropriate for the best use of capital and capacity. We look forward to the opportunity to work with you in finding a solution.
AFTER ALMOST EIGHT YEARS OF HARD WORK, THE MEDICAL PROFESSIONAL LIABILITY CLAIMS DEPARTMENT OF TPC, INSURANCE COMPANY S.A., AN ARGENTINE COMPANY SPECIALIZED IN THIS TYPE OF INSURANCE, WAS ABLE TO SIGN A SIGNIFICANT AMOUNT OF AGREEMENTS BY PAYING COMPENSATIONS BOTH IN MEDIATIONS (ALSO KNOWN AS ADR, ALTERNATIVE DISPUTE RESOLUTION) AND IN LEGAL PROCEEDINGS IN COURTS.

The results thereof (between March 1st, 2004 and May 31st 2010), as well as behavior of the professionals and errors of the institutions involved, have been fully analyzed in order to set up strategies together with the Insured (person or institution) to avoid repeating said mistakes or errors. Furthermore, the aim of such an exhaustive analysis was also to assess the impact the claim had on the economy and professional reputation of the professional/institution.

Of a total of 380 cases, 34 were given up by the plaintiff, i.e., the plaintiff decided to drop the case after being explained why the damage was inflicted. One of the cases was dismissed by the Supreme Court. However, still 33 of said cases generated expenses. Of the 345 cases closed with an agreement and compensation, we found that 37 insureds concentrated from 3 to 33 cases, i.e., 69.86% in 241 cases; 15 insureds with two cases closed, i.e., 30 cases in all (8.69%) and 74 insureds with 1 case closed, i.e., 21.45%.

The total amount of money spent in the signing of those agreements, including the 32 cases which were not tried and the complaint overruled by the Supreme Court, was $51,247,190.99 (fifty one millions two hundred and forty seven thousand, one hundred and ninety nine cents), approximately twelve million dollars. The average amount of each claim was $152,805.46 (us$38,201.36), where the minimum amount claimed was $1100.- and the maximum amount was $2,303,000 (us$575,000).

The total amount paid by TPC (compensation plus fees and expenses) was $5,229,295.96. The average amount paid was $13,834,12, with a maximum amount of $198,948,78.-

$2,398,024.94 were paid in fees and expenses for claims, the average being $6,950,80, and the maximum amount paid $98,851,43.

The amount paid for TPC only as compensation was $2,606,586,96. The average amount paid was $6,718,60; the minimum amount paid was $227 and the maximum was $178,916. In 84 cases, no compensation was actually paid, there were only some expenses incurred in the Medical/Legal Risk Analysis performed for each case by physicians not working for the Company, as well as some extra expenses.

Damages suffered by patients or patients’ heirs were classified in two groups (after a thorough analysis of clinical registries and documents and behavior of professionals involved):

a) Damages that might have been avoided had Risk Management and Patient Security Programs been applied, and

Being the physician the protagonist in said procedures and also one of the most important parts of a very complex medical organization, all errors by him committed are directly related to damages suffered by patients. It is therefore necessary to integrate the error correction system.
b) Unavoidable damages resulting from iatrogenic complications inherent to medical acts.

69.09% of the claims filed were acknowledge as avoidable damages, i.e., 267 cases. Under this group of cases we included those events caused by the acts of a physician or a member of the health team, pursuant to the information included in the reports of medical experts and lawyers who analyzed the cases. The damages resulted from the acts or omissions of said team, or the fact that they did not follow or disregarded the rules for the correct and safe performance of medical procedures. Herein we also include all mistakes made due to lack of training, which makes it virtually impossible for professionals or organizations to recognize the potential mistakes that may be incurred in, according to each patient’s pathology.

These discoveries have helped establish two different kinds of medical accidents: those resulting from a mistake made by the physician and those resulting from organizational errors. Accidents not resulting from a physician’s error cannot be prevented since they are, a priori, completely fortuitous. Medical accidents caused by a physician can be minimized or reduced as it is possible to apply a corrective measure to any mistake made.

The analysis performed on these cases has also allowed them to establish the fact that medical accidents resulting from a medical mistake are the most common. Therefore, being the physician the protagonist in said procedures and also one of the most important parts of a very complex medical organization, all errors by him committed are directly related to damages suffered by patients. It is therefore necessary to integrate the error correction system.

A safe system is not one in which no mistakes or errors are made, but one which is protected from operators (against potential faults that may favor or foster mistakes) and which sets up a thorough defense system to reduce or even cancel the consequences of errors made.

My first conclusion would be that Professional Medical Liability Risk insurers should be willing to actively help their insureds, whether persons or institutions, to set up Risk Management and Patient Safety programs.

All of the cases analyzed showed that the average period of time between the actual error and the filing of the claim was 11 months; being the minimum period 1 day and the maximum period 52 months.

The average time elapsed between the above mentioned claim and the signing of the final agreement was 8 months.

The minimum time elapsed between the filing of the claim and the final agreement was 1 month and the maximum time was 50 months.

(*) Director of TPC Insurance Company
UNA COMPAÑÍA SÓLIDA Y SUSTENTABLE, POR PATRIMONIO Y PRINCIPIOS
Don’t Miss the PIAA Fall Workshops!

September 14–16, 2011
Technology, Human Resources, and Finance Workshop
Omni Shoreham Hotel
Washington, D.C.

Sessions include:

- Finance: MPLI Investment Results and Capital Market Opportunities — You’ll hear a 360-degree overview of the current investment market for insurance companies, against a background of trends in the general economy. The speaker will provide detailed information on the year-over-year performance in the MPLI insurance industry, and suggest some smart options for portfolio strategies. He will highlight in particular the more attractive alternative investment vehicles currently on offer.

- Human Resources: Compensation Update — PIAA human resource professionals need to keep up with compensation trends in the MPLI industry. But is your compensation plan competitive? Does it need to be updated regularly? Are your compensation policies working for hiring and retaining a high-caliber staff? The session will explain recent compensation trends, and tell you about the policies that need to be in place for a competitive and compliant plan.

- Information Technology: Technology Hot Topics — This session is a compact format, addressing several IT topics by a panel of presenters. The results of the Information Technology Survey Results (data from 2010), an overview of the PIAA Data Sharing project, and electronic vaulting (sending data off-site as part of a disaster recovery plan) will be covered in-depth.

October 5–7, 2011
Underwriting Workshop
The Fairmont Olympic Hotel
Seattle, Washington

Sessions include:

- Physician Re-entry to Practice: What Does This Mean for MPLI Carriers? — Many physicians are going back into clinical practice, sometimes after a long period of inactivity. To meet requirements for re-licensure, the AMA has been encouraging re-entry programs. But what about the physician who hasn’t yet relinquished his license? How do MPLI insurers evaluate an applicant’s current clinical competence, in underwriting? You will hear about one company’s experience with a task force on physician re-entry to practice.

- Med/Day Spas: What is the Real Exposure? — Given the proliferation of med/day spas, what is the real exposure for physicians working as medical directors there? Can the medical director be held liable for actions of employees, even if they aren’t under his supervision? Learn the answers to these questions and more in this informative session.

- Minimally Invasive Surgery: Does Less Invasive Mean Less Risk? — You’ll get invaluable guidance on the risks associated with the most common minimally invasive procedures. You will find out what kinds of additional training physicians need to perform these procedures. It will also cover the risks in each of the settings for the procedures: the physician’s office, the ambulatory surgical setting, and the hospital (inpatient).

- Early Detection—Is It Too Expensive? — Two causes of action for MPLI claims are delay in diagnosis and delay in treatment. But new healthcare guidelines tell physicians to order fewer screening examinations (or delay screening) for many potentially serious conditions, making early diagnosis virtually impossible. The speaker will discuss these issues and offer strategies for underwriting physicians while accounting for these new recommendations in the underwriting process.

November 2–4, 2011
Claims/Risk Management Workshop
Charleston Place Hotel
Charleston, South Carolina

Sessions include:

- Claims: Overview of Robotic Assisted Surgery — This session will review various types of surgical procedures where robotic assisted surgery is now in use. The speaker, a widely recognized expert in the field, will discuss the benefits, required training, and associated risks with robotic assisted surgery.

- Risk Management: Simulation in Obstetrics—What is it and How Do I Use it? — Simulation in medicine has become a hot topic once again. This session will tell you how to use simulation in the training of obstetricians and in maintaining their competency. The speakers will explain how simulation has been used in their organizations and talk about the benefits of this tool.

- Claims: Anti-coagulation Therapy—the Medicine, the Monitoring, and the Malpractice — The presenters will discuss the range of clinical applications of anti-coagulation treatment, the drugs presently in use, and the new drugs coming on line in the near future. Correct procedures for monitoring blood levels of anti-coagulant will be covered as well.

- Risk Management: Share with Me! What Works for You? — Participants will join in a discussion with their colleagues in risk management to offer each other the essentials of practical risk management needed to improve patient safety. You’ll hear about risk-management guidelines, checklists, forms, sample policies and procedures, and the clinical management tools that have proven effective, reducing claims.

To view the complete agendas for any of these workshops,
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