NEW JERSEY CHAPTER
AMERICAN COLLEGE OF SURGEONS

NEWSLETTER

Volume 3; Issue 3 **Fall, 2011**

60th Annual Clinical Symposium

Saturday, December 3, 2011

9:00 a.m.—5:00 p.m.

The Renaissance Hotel & Conference Center, 515 Route One South, Iselin, NJ

A minimum of 7.5 Category 1 CME credits will be available.

Early Morning Session: 7:00 a.m.—9:00 a.m.

Cancer Commission; Dr. Jarrod Kaufman, Moderator

New Initiates Breakfast
8:00 a.m.– 9:00 a.m.

Guest: David Hoyt, M.D., Executive Director, American College of Surgeons

Morning Session: 9:00 a.m.—12:00 p.m.

General Surgery : Dr. Adam Kopelan, Moderator
Otolaryngology: Drs. Paul Carniol & Gabriel Wong, Moderators
Special Joint Session Otolaryngology/Plastic Surgery: Dr. Daniel Alam:
"The First Face Transplant in the US"
Plastic Surgery: Drs. Valerie Ablaza and Gregory Greco, Moderators
Residents/Young Physicians: Drs. Harry Agis and Ronald Chamberlain, Moderators
Surgical Oncology: Dr. Lawrence Harrison, Moderator
Urologic Surgery: Dr. Mark Jordan, Moderator
Vascular Surgery, Dr. Michael Curi, Moderator

Luncheon : 12:00 p.m.—2:00 p.m.

12:00 p.m.—12:45 p.m.: Business Meeting, Frank T. Padberg, Jr., M.D., President
12:45 p.m.—1:45 p.m.: Sheen Award Lecture, Jonas T. Johnson, M.D.

Afternoon Session: 2:00 p.m.—5:00 p.m.

Bariatric Surgery: Dr. Michael Bilof, Moderator
Cardiothoracic Surgery: Dr. Donald Syracuse, Moderator
Colon & Rectal Surgery: Dr. Howard Ross, Moderator
Neurosurgery: Dr. Arno Fried, Moderator
Trauma Surgery and Surgical Critical Care: Dr. Felix Garcia, Moderator

NEW JERSEY CHAPTER, AMERICAN COLLEGE OF SURGEONS
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ANNUAL MEETING RSVP
DECEMBER 3, 2011

_____ Yes, I am a member and will be attending the 60th Annual Clinical Meeting.
_____ I will attend the Morning Session _____ I will attend the Afternoon Session
_____ I will attend the Sheen Award Luncheon
_____ Members: $75.00 _____Non-Members: $150.00 _____ Residents: $25

Name: _____MD/DO

Address:_____

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Telephone:_____ FAX: _____ E-mail address:_____

Specialty:_____

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E-Mail registration to: njsurgeons@aol.com
New Jersey Chapter, American College of Surgeons
52 Elm Street, Suite #A7, Morristown, NJ 07960

SOCIAL MEDIA AND YOUR MEDICAL PRACTICE

Social media is a relatively new phenomenon to be considered by medical practices. Facebook was only launched in February 2004. By August 2008, Facebook had 100 million users worldwide, and now has more than 750 million worldwide. This includes 95 million users in the United States alone. Essentially, medical practices cannot afford to be ignorant of social media, even if they choose not to actively participate. By taking time to consider the risks involved in employees' (including physician principals') use of social media and ways to prevent or limit their exposure, medical practices can avoid expensive litigation.

The HIPAA privacy rule became effective on April 14, 2003. When it was drafted in 1996, the concept of social media was simply beyond imagining (at least for most of us). Yet today, it is an integral part in many people's lives and medical practices must consider the legal implications of social media if they are to best manage the associated risks.

Presuming that your practice qualifies as a "covered entity" for purposes of HIPAA (which is a safe assumption), the primary concern for medical practices involves the sharing of protected health information (PHI), either intentionally or inadvertently, through social media. PHI is broadly-interpreted, and as defined by the law includes any part of a patient's medical record or payment history which can be linked to that patient.

The problem arises, of course, when practice employees, either during the course of their employment or outside of the workplace, share information about work via social media. Given the widespread acceptance of general privacy practices, it is rare that people distribute information with a high degree of specificity, such as "I just treated John Doe in the ER for XYZ condition." However, recent cases show the surprising ways PHI or other sensitive information can be shared. For example, in a recent Minnesota lawsuit an employee told a relative that he had seen the medical records for the wife of an acquaintance and they described her treatment for a sexually transmitted disease. He also told the acquaintance that the wife informed her doctors she had a new sexual partner, in addition to her husband. After this information flowed through several other individuals, the husband's relative posted it on a social networking site, leading to a lawsuit against the clinic where the employee worked, the relative, and the employee.

The lesson from this case is that a medical provider should be prepared for attenuated means of communication of PHI through social media. A prudent practitioner should take some time to consider the ways an employee can gain access to PHI he or she should not see and consider policies to prevent dissemination of such information. In addition, a policy addressing the situation where an employee knows a patient outside of work may be prudent.

The sharing of patient information in this way is curious, considering most healthcare providers would generally never consciously violate privacy protections. Yet, in the context of social media, people let down their guard and are simply willing indiscriminately to share the most intimate details of their personal lives and those of others. As a sign of the times, sadly, this is rapidly becoming the social norm. Given this radical change in what is generally considered acceptable behavior, it is not surprising that healthcare providers share, often without thinking, protected health information. Providers also appear to share PHI via social media thinking that they have sufficiently 'sanitized' the information of details as to make the practice acceptable. Simply put, this is a practice that can never be condoned.

A recent case involving a nursing school illustrates this premise that by sharing details of one's personal life through social media, one can also share a patient's health information. In Yoder v. University of Louisville, 2009 WL 2406235 (W.D. KY 2009), the plaintiff was enrolled at a nursing school and taking a class on childbirth. As part of her classwork the plaintiff was required to "shadow" a pregnant mother up through delivery. Through social media she later described the delivery of the baby, in graphic detail, non-identifying information about the mother, and her views on child birth. The nursing school expelled the plaintiff for violation of its confidentiality code which provided that students should maintain the confidentiality of all information obtained through clinical rotations. Litigation ensued about whether the school should have allowed the plaintiff an opportunity to challenge the expulsion and whether it was warranted.

This case illustrates why medical practices need to adopt policies and procedures that are social media 'aware' and ensure that these policies are distributed, accepted and enforced. The policies should not be complex, as they will basically be adopting traditional privacy protections into the social media context. They need, however, to provide clear cut definitions of what information should be considered private. Given the real-world difficulties in ensuring that distributed information is, in fact, adequately sanitized of PHI, and the realities that there are virtually no legitimate work-related reasons to share this information, these policies should adopt a no-tolerance policy to sharing of any patient information via social media.

Employees often take a contrary position, citing both "free speech" protections, and an unfounded argument that employers cannot regulate employee conduct outside the workplace. It is beyond the scope of this article to delve into the details about why these arguments are misplaced, but suffice it to say that employers can, in fact, prohibit employees from the unauthorized and inappropriate discussion or distribution of patient information. One important reason for this prohibition is that HIPAA is not the only legal consideration which must be addressed in this context. Individuals have other privacy protections, both by statute and common-law, which can open providers and practices to civil, administrative and criminal liability. In short, the risks dramatically outweigh any possible reason to share patient information via social media, and so any sharing of patient information in this manner should be strictly prohibited.

Recently, there has been a flurry of activity surrounding social media and what is referred to as "protected concerted activity" by the National Labor Relations Board. In Short, employers, subject to the

(Continued on Page Four)

(**Continued from Page Three**)

Board's jurisdiction, cannot prohibit employees from discussing the "terms and conditions" of employment, as it would tend to discourage employees from forming organized labor unions. It is easy for employers to run afoul of this consideration by drafting policies that are overbroad and prohibit any discussion, at all, of workplace issues in the social media context. While this may be problematic, a prohibition against the sharing of patient information is certainly not, and should not present any problem in this regard.

Another area of consideration in the social media context is inappropriate online conduct. Again, individuals seem to forget that conduct which is prohibited directly between individuals in the workplace is similarly prohibited when conducted via social media. This conduct includes, but is not limited to, sexual harassment, racial discrimination and otherwise creating a hostile work environment. These concerns are actually aggravated in the social media context, as these issues used to be primarily verbal actions and conduct, when conducted via social media there is usually an easily-proven and documented record created. Again, this is a simple area to address, as policies which prohibit discriminatory or harassing conduct between individuals should also prohibit identical conduct via social media.

Recommendations for medical practices when addressing social media issues include:

- Consult legal counsel prior to drafting any policies that implicate social media, and have any existing policies reviewed for appropriate content and protections.
- Create procedures to address situations where staff members are acquainted with patients and interact with them outside of work.
- Establish specific policies for social media in the workplace which include photographs and videos, and are neutral as to the social media site.
- Ensure that existing policies and procedures also include provisions for social media, including privacy practices and workplace conduct.
- Ensure that staff members are trained in these policies, and that the training and acceptance of the policies is well-documented.
- Monitor social media sites for inappropriate conduct.

Follow these steps and use common sense and you should be better able to protect your practice from the risks presented by this new form of media.

Robert J. Conroy, Esq., Matthew R. Streger, Esq., Svetlana Ros, Esq. and Peter D. Espey, Esq.

Robert J. Conroy, Esq., is a principal of Kern Augustine and is a nationally-recognized authority on health law matters. Matthew R. Streger, Esq., and Svetlana Ros, Esq. are associates at Kern Augustine Conroy & Schoppmann, PC, in Bridgewater, New Jersey, and focuses their practices on healthcare litigation. Peter D. Espey, Esq., is an associate-intern with Kern Augustine.

ACS LEADERSHIP CONFERENCE & FIRST ANNUAL ADVOCACY SUMMIT

March 25-27, 2012
J W Marriott
Washington, DC

For information, contact Rhonda Peebles at (888) 857-7545.

TERMINATION OF THE PHYSICIAN/PATIENT RELATIONSHIP

NJAC 13:35-6.22 requires that physicians notify patients in writing of termination of care no less than thirty days prior to the date of termination. The notification is to be mailed certified mail, return receipt to the last known address of the patient. Physicians are required to provide all necessary emergency care and services including prescriptions.

Physicians are not required to comply with the requirements if the physician/ patient relationship has been terminated by the patient or if the physician has discontinued providing services to a particular managed care carrier or HMO in which the patient is enrolled.

Copies of the regulations can be obtained by calling the Chapter office, **(973) 539-4000.**

REMINDER

The following certificates are required to practice medicine in New Jersey.

NJ State BME
Mr. William Roeder
Executive Director
P.O.Box 183
Trenton, NJ 08625-0183
(609) 826-7100

CDS Registration
Susan Gartland
Chief Drug Control
Department of L& P Safety
P.O. Box 45022,124 Halsey Street, 7th Floor
Newark, NJ 07101
(973) 504-6545

County Clerk Registration Certificate
NJ SBME regulation 45:9.17 requires that you register your license with the County Clerk in the County in which you reside.

Drug Enforcement Administration
80 Mulberry Street
Newark, NJ 07102
(973) 273-5063
FAX: (973) 297-4842
(800) 882-9539
www.deadiversion.usdoj.gov

PRESIDENT'S MESSAGE

Your New Jersey Chapter is offering an exciting opportunity to share collegial interaction and obtain Continuing Medical Education credits locally at our Annual Chapter meeting scheduled for Saturday December 3, 2011. The program continues to bring special guests to New Jersey to share their expertise with you, the NJ surgeon. The program this year was organized by President-Elect Ron Chamberlain with a comprehensive distribution of topics. Featured participants at this year's meeting include National Executive Director David Hoyt, Robert Bahnson representing the American Board of Urology, Jonas Johnston the Sheen Awardee, and Daniel Alam describing facial transplantation in a joint Plastic and Otolaryngology session.

Recipients of the Student Loan repayment program, initiated, organized, and Directed by your Chapter under the guidance of Michael Goldfarb, Vice-President, will be introduced at the annual meeting. Special thanks are extended to the law firm of Kern, Augustine, Conroy & Schoppmann for their invaluable assistance in development of this special project. If you have a chance during the meeting, please express your thanks.

In addition to the Governors, your council was asked to make recommendations for participation in our 5 New Jersey Committees on Applicants. Its function is to interview candidates for Fellowship in the American College of Surgeons. Multiple specialties, Governors, and active recent initiates are participants in these committees. Recognizing a geographic disparity in the long-standing districts, an adjustment was recommended to provide a more even representation across the state.

A new event this at this year's annual meeting is the Initiate's Breakfast. This is designed to make New Jersey Fellows feel welcome in their NJ Chapter. The council unanimously voted to sponsor this opportunity for new young fellows to meet their officers and councilmen on a less formal basis.

You will notice a new feature in the Fall newsletter highlighting the "other" things our member surgeons do when not engaged in the practice of surgery. Surgeons are unique individuals with many talents, but we often become so deeply invested in our profession we miss out on some of the other aspects of life. We discover new and different talents when we direct our enthusiasm and energy to other endeavors. To inaugurate this section, I invited Former President George Saj to share some of his Wood Sculptures. While these are surely unique, he has considered making some available for purchase for the enthusiast. —Thus, this new concept Surgical Alter Egos, Hobbies, or "what do we do with our non-surgical time?" We would like to feature more of our Chapter members' involvement in non-surgical endeavors; please contact the Chapter Office or myself with suggestions and volunteers.

As this will be my last message in the President's Column, I would like to thank each of you for the privilege of serving as your President this past year. Your Chapter is recognized as an active organization and can only continue to grow with the outstanding leadership from the current officers and councilmen and the enthusiasm of our new members.

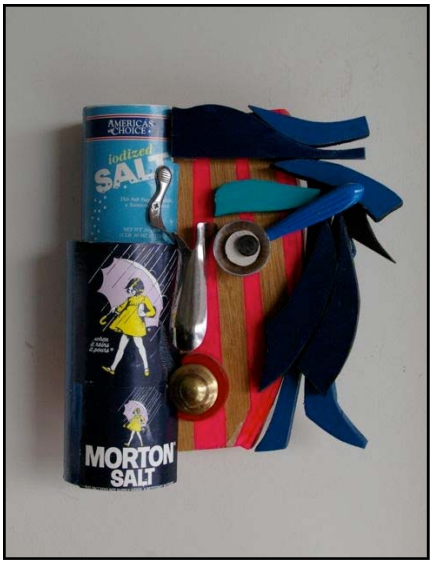
Yours in Fellowship.
Frank T. Padberg, Jr., M.D., FACS
President

Frank T. Padberg, Jr., M.D., FACS

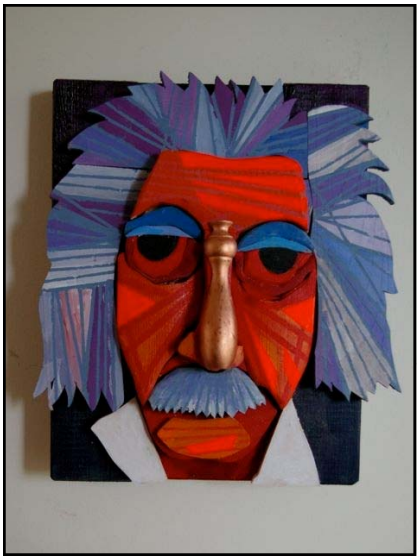
"SURGEONS' ALTER EGO"
George Saj, M.D.

Surgery is an intense, all consuming pursuit. To maintain their equilibrium and good humor surgeons need to have ways of escape and restoration. As Churchill said about this, "the master key is change". I found that change in the pursuit of art, producing images from pieces of painted wood and found objects. Now, retired after 45 years in medicine, art has given me a second career. It is intense, though less risky and without night-call. Here are several examples of my current work.

George Saj, M.D.
Past President



Lot's Wife



Einstein

PORTUGAL PILGRIMAGE
April 15, 2012-April 22, 2012

Join your colleagues for an exciting educational exchange and sight seeing with the Portugal Chapter of the American College of Surgeons.

The price is $2,899 per person, double occupancy (includes $420 per person fuel surcharges). For single occupancy, add $849.

Air taxes are an additional $89 per person. Fuel surcharges and air taxes are valid at time of printing and are subject to change. Price is based on 20 fully paid travelers. (Price reduction for 30 and 40 paid travelers).

The price includes:

- **Featured Event: Academic & Medical Presentation with the Fellows of the Portuguese Chapter, ACS at The Oncologic Institute.**
- Round-trip air transportation from Newark on the services of TAP airlines.
- ABC Destinations handles your baggage outside of the airport for your arrival and departure. (Based on
- one bag per person).
- An experienced professional English speaking assistant will assist you on the vacation upon arrival in Lisbon.
- Round trip transfer to Hospital with English speaking assistant.
- Five-star hotel accommodations for six nights at the centrally located Tivoli Lisboa Hotel. (including hotel tax and service charges.)
- Daily breakfasts, two lunches, two dinners (water and wine included).
- Half-day guided tour of Lisbon with English speaking tour guide, including entrance of Jeronimos Monastery Cloisters and St. George Castle.
- Half-day guided tour of Sintra with English speaking tour guide, including entrance of Villa Palace

Optional tour to Algarve available at an additional cost starting at $245 per person (lunch and entrance fees are extra). Tour includes Cape St. Vincent, Sagres, Ponta da Piedade and Vilamoura. Depart hotel at 7:00 am and return 8:00a.m..

Registration form on page eleven. For additional information please **call the Chapter office or ABC Destinations at (800) 227-5858.**

2011 LONDON PILGRIMAGE

2011 London Pilgrimage—May 26, 2011
Andrew Spedick, Dr. Lewis Wetstein, Nancy Wetstein and Dr. Michael Spedick

2011 London Pilgrimage—May 2011
Dr. Stephen Fletcher, Cathy Rough, Dr. William Rough, Dr. H. Brown Elmes, Ann Elmes, Sharon Davidson, Dr. J. Thomas Davidson and Justine Fletcher

NEW MEMBERS WELCOMED!

Michael A. Baskies, M.D.
Orthopedic/Hand Surgery, Livingston
Adam Berman, M.D.
Urology, Denville
Steven J. Binenbaum, M.D.
General Surgery/Bariatric Surgery, Eatontown
Marson Davison, M.D.
General Surgery, Hackensack
Gregory Greco, M.D.
Plastic Surgery, Red Bank
James W. Herrington, M.D.
Vascular Surgery, Somers Point
Kevin Holzman, M.D.
Colon & Rectal Surgery, West Orange
Mark Jordan, M.D.
Urology, Newark
Seth Kipnis, M.D.
General Surgery
Adam Kopelan, M.D.
General Surgery, Millburn
Gregory Lovallo, M.D.
Urology, Maywood
David May, M.D.
General Surgery, Egg Harbor Township
Domenico Savatta, M.D.
Urology, West Orange
George Tsioulias, M.D.
General Surgery, East Orange
Nirman Tulsyan, M.D.
Vascular Surgery, Morristown
Gary Tuma, M.D.
Plastic Surgery, Ewing
Alexander M. Wohler, M.D.
Cardiothoracic Surgery, Paterson

The Painless Goodbye

Talk to any Human Resources Director and they will tell you that one aspect of the position **no-one** enjoys performing is employee termination. Whether by employee or employer decision, this can be an involved process.

Granted, if the employee is leaving by their choice to move onto a bigger and better opportunity, to relocate, or to retire, the process can be a positive and pleasant experience. If the employee is leaving at the employer's discretion due to layoff, job consolidation, poor attendance, poor performance, or a policy infraction, the process can be difficult and often unpleasant. *(Please see the Note at the end of this document regarding immediate termination.)* Being organized and handling the situation with diplomacy and professionalism can make the burden of "the exit a lot easier.

No matter what the reason or circumstance, preparedness is crucial so that nothing is forgotten.

Formulating a Ten Step Employment Termination Checklist can help with the exiting process.

STEP ONE: If an employee verbally tells you they are leaving the company's employ, ask that the notice be put in writing and that the resignation date is clearly stated in the notice of intention to terminate.

(Note: This is especially important should the employee later decide to file for unemployment benefits.)

STEP TWO: Notify the Human Resources Department, or the person within your organization who is responsible for benefits coordination so they can provide the employee with a written document outlining the status of benefits upon termination. Include COBRA instructions to continue health insurance, or other plans the employee was enrolled in through their employment.

(Note: If any monetary advances were made, be certain that all funds are returned in full prior to the issuance of a final paycheck.)

STEP THREE: Make arrangements to pay any unused PTO (or sick, vacation, personal) time the employee is entitled to, in accordance with the policies listed in your Employee Handbook. If severance is being offered be sure this is included.

(Note: If there was any advance of unearned time, be certain your Accounting Department (or person/company responsible for your payroll is informed so this amount can be subtracted from the employee's last paycheck.)

STEP FOUR: Inform the IT Department Head or the Network Administrator of the date and time the termination is effective. This will enable the employee's access to the computer and telephone systems to be terminated. Verify the employee's passwords and access ID's and be sure to designate who all future calls and emails should be routed to.

STEP FIVE: Make arrangements to prohibit the employee's ability to enter the building, including setting or disabling the alarm system. Make certain to have all keys or access cards associated with the business returned and provide a written notice that same were received to the departing employee.

(Note: Many organizations have a set policy to have all locks changed, new access cards issued, and all alarm codes changed.)

STEP SIX: Establish a plan for the return of all company property. Do not forget written materials (books, training manuals, grafts, business plans, floor plans, client/patient lists, Employee Handbooks, Policy and Procedural Manuals, OSHA and/or HIPAA manuals, etc.) as well as all electronic and cellular devices.

STEP SEVEN: Review, in detail, any Non-Compete, Trade Secret and Confidentiality Agreements the employee signed during their employ. Be sure to stipulate that these policies will continue to be strictly enforced.

STEP EIGHT: Perform in an Exit Interview. Explain that information ascertained during this process will remain confidential.

STEP NINE: Have the employee provide the Human Resources Department with an address to send all future correspondence to (this will be important during tax season, for all future pension/401K statements, and should COBRA payments not be received in a timely fashion).

STEP TEN: Obtain written consent from the employee for any future reference checks. Be sure this coincides with your company policy on who and what information can be released and to whom.

While this HR function can be daunting, following these steps will help you….EXPERIENCE SUCCESS!

(Note: In the event of an immediate termination, the employer may choose to assign someone to go with the employee being dismissed to their work area to pack their personal things, collect the company's property and escort the individual from the premises.)

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Emerging Liability Insurance Risks

While the healthcare provider landscape changes, so too does the healthcare liability insurance landscape. Physicians who are selling their practices, or partnering or working with larger systems are sometimes encouraged to accept a new liability insurance plan. Other physicians are being approached by representatives touting the latest concepts in professional liability insurance. With new plans though, come new issues, and sometimes, new lawsuits. To avoid litigation tomorrow, physicians should be asking five essential questions today.

What Type of Coverage Will I Have?

The two main types of professional liability insurance coverage are occurrence and claims-made. Occurrence coverage provides "permanent" protection, as long as coverage is in place when a covered incident that leads to a claim occurs.

Claims-made coverage requires a policy to be in effect both at the time an incident that leads to a claim occurs, and at the time the claim is made. Therefore, if there is any interruption, lapse, or termination in coverage, some claims may not be covered. Some examples of prior cases, which involve claims-made policies that have led to denials of coverage, include:

- Expiration of extended reporting ("tail") coverage prior to a claim being made.
- Failure to align retroactive dates when changing carriers.

If coverage is claims-made, physicians should confirm, in writing, the terms of the tail.

What are My Claim Reporting Obligations?

Reporting obligations under an occurrence policy are relatively flexible, as coverage is triggered based upon the occurrence of an event, not the reporting of an incident or claim. Nevertheless, physicians should err on the side of caution, and always consult their personal attorneys or brokers - prior to contacting a carrier - when an adverse event occurs.

Reporting requirements under a claims-made policy are generally stricter, especially if a physician is changing carriers. Before changing carriers, physicians should report, *and verify*, coverage for any adverse incidents. Even when physicians are not changing carriers, it is important to understand what circumstances give rise to a "claim," and when they should be reported.

Notably, there are variations on claims-made policies, such as "claims-made and reported" policies, which preclude coverage for any adverse incident that could reasonably lead to a claim if it is not reported before the policy renews. Many problems can arise when physicians switch policies without performing sufficient due diligence. Examples include:

- When switching carriers, not notifying *both* carriers of a potential claim.
- Notifying a carrier of a claim, but not getting confirmation of coverage.
- Not reporting a claim to a carrier prior to renewing a policy.
- When an adverse incident occurs, physicians should always contact their legal advisor(s).

Is My Tail Guaranteed? By Whom?

Even if an employer provides coverage to an employee while he or she is working on its behalf, this does not guarantee that coverage will remain in place after the employment relationship ends. In one recent NJ decision, a court essentially held that an employer is not responsible for an employee's tail coverage in the absence of contractual language to that effect. Therefore, the burden is on physician-employees to ensure that their coverage survives post-employment.

Significantly, some liability insurance programs do not even allow individual physicians to address tail coverage upon the termination of an employment relationship, and are beholden to the employer to ensure that coverage remains in force.

For example, if a medical group has a "blanket" claims-made policy that covers all employed-healthcare providers, the group alone is responsible for renewing the policy every year. If the group fails to renew the policy, the policy can cancel without the physician having the ability to obtain his or her own tail.

Examples of tail issues that can occur:

- A hospital system declares bankruptcy and cannot meet its insurance payment obligations, so coverage for itself and all employees terminates.
- Other physicians within an insurance pool experience significant losses, leading to a collapse (insolvency) of the program (see number 6).

A group breaks up, or an individual leaves a group, and is unable to purchase a long-term tail.

Physicians should always have the terms of liability coverage in writing.

Do I Have a Consent to Settle Clause?

As new medical malpractice insurance options continue to become available to physicians, important provisions that have traditionally been automatically included in policies have quietly been removed for the benefit of insurers, or insured-systems. One such provision is a "consent-to-settle clause," which can be important to protect a physician's reputation. Some small carriers and/ or self-insurance plans take this right away from individual physicians, effectively shifting control of the claims process to either the carrier or employer. Two main problems can occur:

- Hospitals settling a claim without a physician's consent, and unilaterally apportioning a percentage to that physician
- A carrier settling a claim without the consent of one of its insureds, making it reportable to the national practitioner databank and the NJ division of consumer affairs, and also potentially making it more expensive to secure coverage in the future.

Physicians should request a consent-to-settle clause prior to signing on to a policy when possible.

Is The Plan Financially Stable?

Despite a history of many company failures, medical malpractice has been a highly profitable area of insurance over the past few years. This revelation, along with the relatively insignificant amount of capital needed to start an alternative risk model to insure physicians (e.g. captive or risk retention group) has spawned numerous professional liability programs. Some of these programs have already failed.

The best way to track a program's financial strength is to inquire about its AM Best (financial strength) rating. Since many new programs do not have the financial ability to qualify for an AM Best rating, physicians should ask their accountants or other advisors to review the annual financial statements. Two common issues that occur with financial hardship:

- Financial inability of a healthcare system to purchase tail coverage for employed-physicians.
- Failure of an insurance program, leaving physicians personally liable to defend against lawsuits.

Conclusion

The changing medical malpractice insurance market has prompted new waves of litigation over coverage, and much of it involves physicians that have become accustomed to certain protections, but lost them because they signed on to plans that they perhaps did not fully understand. A little due diligence before making these important decisions could save physicians considerable resources down the road.

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Argent Professional Insurance Agency, LLC
30 Technology Drive, Warren, NJ 07059
(908) 769-7406

NJ Chapter, American College of Surgeons - 2012 Pilgrimage to Lisbon April 15-22, 2012

Name ______________ □ M □ F ______ ______ ______ ______
Passenger 1 (As it appears on your passport) Date of Birth Nationality Passport #

Name ______________ □ M □ F ______ ______ ______
Passenger 2 (As it appears on your passport) Date of Birth Nationality Passport #

Address ______________________________ City ______________

State ______________ Zip ______________ Home Phone ( ) ______________

Business/Cell Phone ( ) ______________ E-mail address: ______________

□ I/we request a Business Class upgrade for $2499 per person (subject to availability on date of booking)

□ Please reserve me in a single room (limited availability) □ Please reserve me in a double room

□ I will share a room with: ______________

□ Optional Full-day Tour to Algarve ($245 per person). Includes transportation from Lisbon; English speaking tour guide; sightseeing.
Based on a minimum of 11 fully paid participants

Method of payment for your deposit:
Credit Card: □ Amex □ Discover □ Visa □ MasterCard or Personal check # ______________

Credit Card # ______________ Security code # ________ Exp. date: ________

Name that appears on the card: ______________ Signature: ______________

Deposit: $500 per person to reserve your space. Final payment is due on or before January 14, 2012. I authorize $__________ to be charged to my card.

Make Checks payable to: ABC Destinations and send to: NJ Chapter, American College of Surgeons, 52 Elm Street Morristown, NJ 07960. For additional information please contact Andrea Donelan, Executive Director at NJ Chapter, American College of Surgeons by telephone (973) 539-4000, fax (973) 539-3493 or email njsurgeons@aol.com

Notes: ______________________________

Cancel for any reason Insurance: The Insurance can be purchased at anytime up to the final payment due date. The insurance premium is based on the final cost of the tour, including optional tours, or extensions that may be taken. [illegible] The policy price is based on the total cost of the tour including taxes. Insurance premium per person: [illegible]

Please Note: I have read the schedule of activities for the NJ Chapter, American College of Surgeons - 2012 Pilgrimage to Lisbon program and agree that my signature below represents my acceptance of the general terms and conditions as outlined in this brochure.

Signature: Date:

Terms and Conditions Policy for Groups

[illegible]

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