MPS

CLAIMS-MADE PROTECTION FOR OBSTETRICIANS

CARIBBEAN AND BERMUDA

medicalprotection.org

CONTENTS

GLOSSARY

ADVERSE INCIDENT
Any event or circumstance that might give rise to you seeking assistance and/or indemnity from us.

CLAIM
A demand for monetary compensation or damages as a result of an adverse incident either through a solicitor's letter before action or service of proceedings, or a letter of demand from a patient or their representatives.

CLAIMS-MADE PROTECTION
Protection for incidents that both occur and are reported during membership, or occur during membership, and are either reported in the 30-day window at the end of membership or during extended reporting benefits (ERBs).

DISCRETION
Discretion allows us to respond to changes in the medicolegal environment and assist members with emerging problems that may not have been foreseen. All the benefits of membership of Medical Protection are discretionary, as set out in the Memorandum and Articles of Association.

EXTENDED REPORTING BENEFITS (ERBS)
Enable you to report adverse incidents when your membership has ended.

INDEMNITY
Protection against losses, damages, costs, charges and expenses connected with an action, proceeding, claim or demand against you arising from your professional practice.

PROTECTION FOR OBSTETRICIANS

Having professional protection is essential. This means protection against the potentially harmful costs of litigation, as well as the other challenges you might face throughout your career.

You need this protection at all times; while you practise, when you retire and even after your death. It is important to understand that claims are rarely made immediately after an adverse incident occurs.

We have tailored the type of professional protection we offer obstetricians who manage pregnancies after 24 weeks' gestation. This is due to the challenges and risks associated with obstetric claims and obstetric litigation.

The length of time between a birth injury and the settlement of an obstetric claim can be 20 years or more, compared with an average of five years for non-obstetric claims.

This delay means that there are many factors that can impact on the final value of the claim, such as:

- changes in legislation
- changes in the claims environment
- increased willingness of patients to make a claim.

These have all changed dramatically during the past 20 years, so accurately pricing obstetric risk is difficult due to the huge degree of uncertainty.

Our claims-made protection for obstetricians can provide you with protection against a clinical negligence claim. When we take on a member's case, we can take care of the legal costs and compensation payments up to a discretionary indemnity limits for all adverse incidents reported in a single membership year are:

Bahamas	US$10 million
Barbados	B$12 million
Bermuda, British Virgin Islands	BED$10 million
Cayman Islands	CI$10 million
Grenada, St Lucia	EC$3 million
Jamaica	J$270 million
Turks and Caicos	US$6 million
Trinidad and Tobago	TT$36 million
Antigua, Anguilla, Belize, Dominica, Guyana, Montserrat, St Kitts and Nevis, St Vincent and the Grenadines	US$3 million

HOW DOES OUR CLAIMS-MADE PROTECTION WORK?

Accessing the benefits of membership with claims-made protection depends on two things:

1. the date on which an adverse incident occurs
2. the date that the matter is reported to Medical Protection.

Your annual membership subscription provides you with the right to seek assistance with complaints and claims arising from adverse incidents in that year of membership.

In order to request assistance, support and advice for complaints or claims resulting from your practice:

You must report an adverse incident to us as soon as reasonably practicable. This should be immediately after it occurs, or when you become aware that it has occurred.

AND either

You remain in continuous membership between the date on which the adverse incident occurs and the date you report it to us.

OR

If your membership has ended, you have reported an adverse incident that occurred while you were in membership, within the 30-day notification period at the end of your membership.

OR

If you have purchased ERBs, you have reported an adverse incident that occurred while you were in continuous membership, as soon as reasonably practicable during the ERBs period.

And you must tell us as soon as reasonably practicable, if a complaint or claim is made against you.

LEAVING CLAIMS-MADE PROTECTION

Our experience shows us that claims are rarely made immediately after an adverse incident occurs. Indeed, a patient can potentially make a complaint or claim against you even after you have stopped practising – whether through a career change, retirement or even after your death.

Which is why, in order to be eligible to request assistance with any future complaints or claims that may arise, you must tell us about any adverse incidents that occur while you're in membership, as soon as you reasonably can. In addition, it is essential that you have adequate indemnity in place to protect you when you leave Medical Protection membership.

NOTIFICATION PERIOD

You will have a 30-day period at the end of your membership to report any adverse incidents that occurred during your continuous membership, but that you only just became aware of. This 30-day notification period does not form part of your Medical Protection membership, and you will not be able to report or subsequently request assistance for any adverse incidents that occur during this time.

ALTERNATIVE PROTECTION

If you do not continue your membership with Medical Protection, but do continue to practise, you will need to make sure that you purchase protection or insurance from a new provider that covers you for adverse incidents that occurred during your membership, but which were not reported to us while you were a member (or within the 30-day notification period). This is sometimes referred to by insurers as 'nose cover'.

FAILURE TO PROTECT YOURSELF

If you do not purchase ERBs from us, or arrange alternative cover through a new provider, you will be exposed to any complaint or claim in the future which resulted from adverse incidents that occurred during your time as a member, but which you did not report to us.

AN EXAMPLE OF CLAIMS-MADE PROTECTION

Melissa, an obstetrician, becomes a Medical Protection member with claims-made protection. For her first year, Melissa's membership subscription protects her against complaints and claims arising from adverse incidents in that year, provided that she reports the adverse incidents to us as soon as she becomes aware of them.

In Year 2 of her membership, Melissa once again pays a subscription which protects her against complaints and claims from incidents arising in that year, so long as they are reported to us as soon as she becomes aware of them.

She also pays an extra amount within her subscription to protect herself against any Year 1 incidents which she has not yet been made aware of, and so has not reported to us.

Because she is buying more protection in this second year, Melissa's Year 2 subscription is more expensive than her first year.

Similarly, Melissa's Year 3 subscription not only includes an amount to protect her against complaints and claims from incidents arising and reported in that year, but also against any Year 1 and Year 2 incidents which she is not yet aware of, and so has not reported to us.

Each year, the pattern is repeated, with the cost of reporting any previous years' adverse incidents being added to Melissa's current subscription rate.

Over time, the risk of an adverse incident from Year 1 needing to be reported decreases, and as a result, the cost of including protection for this year in Melissa's subscription also decreases, until eventually, the subscription we collect no longer includes an amount for her first year.

The same will subsequently be true for Years 2, 3, 4 and so on.

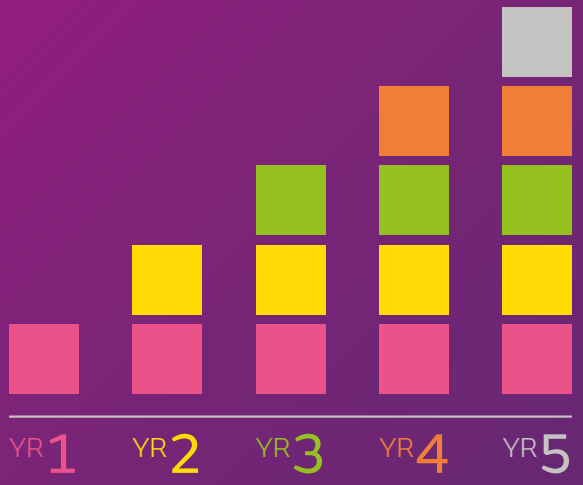
Membership subscriptions are usually lower than our traditional occurrence-based protection in the early years. As time goes on and the accumulated risk increases, the cost of your annual claims-made protection will typically rise in steps, until the annual subscription is broadly similar to the annual subscription that would be payable for an occurrence-based membership.

After many years, Melissa decides to retire.

There may still be adverse incidents that took place during her membership which may lead to a complaint or claim, but of which she remains unaware, and so has not reported to us.

In order to report adverse incidents that occurred whilst she was practising, but that she only became aware of after she had retired, Melissa will need to apply to purchase ERBs from us. As she is retiring, Melissa can make a single payment for ERBs to cover her retirement, subject to availability and eligibility.

To learn more about ERBs and how they work, please go to pages 7 – 8.



EXTENDED REPORTING BENEFITS (ERBs)

ERBs enable you to request our assistance and report adverse incidents that occurred during your membership, but that you only become aware of after your membership with claims-made protection has ended.

This is important because it is not always obvious that an adverse incident has taken place, and you may only become aware of an issue when the complaint or claim is received, which could be years later or even after you have retired.

If you do not purchase ERBs and later learn that there were adverse incidents that you were unaware of during your membership (or in the 30-day post membership notification period), and therefore had not reported to Medical Protection, you would not have the right to request assistance with any subsequent claims that related to these adverse incidents.

QUALIFYING CRITERIA

RETIREMENT

If you choose to retire and permanently stop clinical practice, you will need to apply to purchase ERBs.

ERBs in this circumstance can currently be purchased in one payment to cover your whole retirement.

MAKING CHANGES TO YOUR PRACTICE

If you permanently change your practice, for example by ending obstetric practice and moving exclusively to gynaecology, then ERBs will allow you to report adverse incidents that relate to your obstetric practice, but that you only become aware of after your obstetric membership period has ended.

ERBs in this circumstance are currently available to purchase on an annual basis.

MOVE OVERSEAS TO PRACTISE

If you stop practising in the Caribbean to move overseas, ERBs will allow you to report incidents that occurred while you were a member in the Caribbean, but that you only become aware of after your claims-made protection has ended. You will also need to make sure you have suitable protection in the country you choose to practise in, in line with that country's indemnity or insurance requirements.

ERBs in this circumstance are currently available to purchase on an annual basis.

EXTENDED BREAK FROM PRACTICE

If you wish to take a career break, or are unable to practise for a period of up to 12 months, for example to go on maternity leave, you will need to continue paying a membership subscription. This will allow you to

report adverse incidents that occurred from past practice. You may be eligible to pay a reduced amount during your extended break from practice because you are only seeking protection against the risks of earlier adverse incidents, as you will not be exposed to new risk while on an extended break.

If you take an extended break from practice, or are otherwise unable to practise for more than 12 months, ERBs in this circumstance may be available on an annual basis, subject to approval.

Please contact us to discuss your individual circumstances.

DEATH

DEATH WHILE IN MEMBERSHIP

In the event of your death while in membership with claims-made protection, your personal representatives can act on behalf of your estate to report complaints or claims which you would have been entitled to report. Your personal representatives can also apply, within 90 days of your death, to purchase ERBs.
ERBs in this circumstance are available to purchase annually or in a single payment.

DEATH AFTER YOUR MEMBERSHIP HAS ENDED

If you are no longer a member with claims-made protection at the time of your death but have previously purchased ERBs, your personal representatives can continue to report any complaints or claims.

If you leave membership, but die within 30 days of leaving, then your personal representatives will have 90 days from your last day of membership to apply to purchase ERBs.

If at the time of your death you had left membership and had not purchased ERBs in the 30 days following the end of your membership, your personal representatives will not be able to apply to purchase ERBs or report any adverse incidents.

APPLYING FOR AND PURCHASING EXTENDED REPORTING BENEFITS (ERBS)

APPLYING FOR ERBs

You can apply to purchase ERBs if you meet one of the qualifying criteria outlined on page 7.

To be considered, your application must be received within 30 days of the end of your membership with claims-made protection. In the event of your death, your personal representatives must submit an application to purchase ERBs within 90 days of your death.

If you purchase annual ERBs and want to purchase further ERBs, this must be done within 30 days of the end date of your current ERB period.

Granting ERBs is at the discretion of Medical Protection, in accordance with the Memorandum & Articles of Association.

In order to make an application, please contact priority@medicalprotection.org

COST OF ERBs

Costs for ERBs are determined on an individual basis.

Predicting the final price of a period of ERBs is difficult because of the rapidly changing claims environment and because it will also depend upon the length of your career and practice history.

We do understand the desire to know what the likely cost will be. So for illustrative purposes, we would say that if you are considering retiring, provided the litigation environment remains as it is now, and the basis upon which we are able to offer ERBs remains unchanged, we do not anticipate that the cost will be more than double your final year's membership subscription with claims-made protection.

LIMITS TO ASSISTANCE AND INDEMNITY

Where we do provide assistance or indemnity, there will be a financial limit for each membership year. When we take on a member's case, we can take care of the legal costs and compensation payments up to a discretionary indemnity limit.

The limit is set in advance for each membership year and applies to all adverse incidents that are reported in that year. The current limit for each country is listed on page 3.

The limit applies whether this is for one individual adverse incident, or for the total of all adverse incidents reported in a single membership year. These limits have been set with a view to offering fair and affordable subscriptions, and protecting the interests of the membership as a whole.

SOME EXAMPLES:

A member in Barbados has an indemnity limit of B$12 million.

If they have a single claim in a single year worth B$10 million, they will be below the limit.

If they have 10 claims worth B$1 million each in a single year, they will be below the limit.

If they have two claims in a single year – one worth B$5 million and one worth B$10 million – they will have exceeded the limit.

If they have a single claim for B$15 million, they will have exceeded the limit.

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