World Association For Medical Law

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Guest editor December 2021

Associate Professor Melinda Truesdale
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Introduction:

It is a pleasure to be the guest editor for the next two newsletters. I joined WAML in 2017 after the Los Angeles meeting and became a member of the WAML risk committee during the Tokyo Meeting. I am an emergency physician who has an interest and postgraduate qualifications in medical law and am an Associate Professor with the University of Melbourne and Adjunct Professor with Monash University in Melbourne, Australia. As an Australian, I hope to be able to welcome you next year at the meeting scheduled for Australia on the Gold Coast.

As an emergency physician at one of the major tertiary trauma centres in Melbourne, the Royal Melbourne Hospital I held the position of Divisional Director of Critical Care Services during Victoria's second wave of CoVID 19 last year. I have been the Director (Chief) of the Emergency Department and still hold the Director position of the co-located Royal Women's Hospital while continuing to work as an emergency physician as we battle through the now sixth lockdown in Victoria. Each of us has been impacted by CoVID 19. l have been at the frontline with CoVID 19 and seen the sickness which this brings, first-hand.

There have been several WAML newsletters over the last 18 months where this has been the central theme. Therefore, while we cannot escape it completely, I have deliberately chosen to steer away from this topic as the focus for this first of our two newsletters. The authors I have chosen are all highly respected in the fields of medicine and law and each has also worked in the area of medical law. They are exemplar women, who hold leadership positions and each has been recognised at state, national and often international levels. The first article which I have contributed discusses the Voluntary Assisted Dying Law which has been implemented in Victoria Australia since June 2019.

Associate Professor Carmel Crock OAM is the Director of the Victorian Eye and Ear Hospital Emergency Department, Melbourne. She has led the Australasian College for Emergency Medicine's Quality Committee for over a decade. She is a passionate advocate of diagnostic excellence and shared decision making and has a special interest in the prevention of diagnostic error and improving healthcare culture and communication.

Dr Christine Bessell practiced in obstetrics for 25 years before transitioning her career into health care management with a particular interest in healthcare quality and safety. She was a Chief Medical Officer at The Royal Women's Hospital for more than 10 years and she has also been on the Victorian Board of the Medical Board of Australia and is now a Clinical Advisor, Australian Health Practitioner Regulation Agency.

Each person has chosen their own reflective piece to contribute to this newsletter. I hope you'll find it a brief break form this global pandemic as you read the articles authored by these fine women leaders.

A brief discussion on The Voluntary Assisted Dying Act (2017) Victoria, Australia

The Voluntary Assisted Dying Act (2017) Vic (VAD Act) was implemented in Victoria, Australia on June 19th 2019. Over the previous two decades, there had been more than 50 attempts at law reform in various Australian jurisdictions; however, it was Victoria, the second most populous State with just over 6.5 million of Australia's population of nearly 26 million, which has permitted adults to seek assistance to die, from medical practitioners if they meet specific eligibility criteria. Subsequent to this law being enacted, one further state has passed and (recently) implemented a VAD law and three further states have passed similar laws. Each State has its own specific content and plans for implementation and VAD laws now cover over 70 percent of Australia's population.,

Over the last 30 years, there has been an increased focus on patient autonomy and the recognition that patients should be given information to make informed decisions and choices. Countries with VAD laws in place include Netherlands, Belgium, Switzerland, Luxembourg, Estonia and Albania, Quebec in Canada and some States of United States with some locations having had experience for many years. During the consultation phases of the Victorian VAD Act there was a review of each of these jurisdictions as well as wide consultation with key groups such as consumers and medical practitioners. The result is one of the most restrictive rigid laws of its type in the world with 68 "safeguards" and tight eligibility criteria.

One of the safeguards which is explicit and essentially unique is the specific prohibition of any medical practitioner suggesting or raising the topic of the law to a patient, the patient's family or Medical Treatment Decision Maker. Specifically, the section 8 states that a registered health practitioner who provides health services or professional care services to a person must not, in the course of providing those services to the person (a) initiate discussion with that person that is in substance about the VAD; or (b) in substance suggest VAD to that person. Hence, all registered health practitioners, not only those who are eligible to provide VAD, are prohibited from initiating a discussion.

The intent of this section is to ensure patients are not coerced or unduly influenced into VAD, not to discourage open discussion. Medical practitioners are in a bind however, as for a patient to make an informed decision of patient needs to know all the relevant options, including VAD. By not allowing practitioners to raise this as an option, arguably this could inhibit the patient from being fully informed and restrict the key aspect of full communication between practitioner and patient. The onus is put onto the patient; the patient needs to have enough knowledge about VAD and then needs to raise the subject and indeed the applicant needs to initiate the topic on three separate occasions, over a duration of at least nine days. By this expressed prohibition and therefore reliance solely on the patient to inquire, one would argue it is counterintuitive in the process of autonomy and ultimately means it is more restrictive as it does not allow a practitioner to discuss full care options for their patients. It could be argued this is an even more paternalistic approach, suggesting that people need to be "protected" from the influence of their health practitioners.

The "authorisation" process is another safeguard of VAD in the Victorian legislation. For each applicant, two medical practitioners must be authorised to partake; one is the coordinator and the other has the role of medical consultant for the applicant. To be authorised as a practitioner in VAD, firstly one must not have a philosophical objection to the process. Next, a willing practitioner must have undertaken mandatory legal training in the area which is in the form of on-line learning and a compulsory exam. Of the two doctors required, one of the two assessing doctors must hold relevant "expertise and experience" in the applicant's medical condition.

The "pre-authorisation" process where the practitioner coordinating the process must review all relevant documentation, complete a form and apply for a permit to the State Government's Department of Health. There are two types of permit available: self-administration (the default) or practitioner administration. Only if the patient does not physically have the capacity to self-administer or digest is the latter permit given.

To comply with the pre-authorisation submission, all of the eligibility aspects must have been met which include: the patient being at least 18 years of age, an Australian citizen or permanent resident and who ordinarily is resident in Victoria; the person has the decision-making capacity to contemplate VAD; the patient must be diagnosed with a disease, illness or medical condition which is either incurable, advanced or progressive and will cause death (within six months for cancer or 12 months for a neuro degenerative condition) and is causing suffering which cannot be relieved by a tolerable manner for the patient. The concerns with the pre-authorisation are that it may lead to undue delays in getting a timely response and for more severely ill patients, it may impact on a patient receiving the VAD.

For the first 18 months since commencement, 836 people were assessed for eligibility to access VAD, 597permits had been issued and 331 people had died from taking the prescribed medications, with the majority taking the medications themselves. Some people died before the medication was dispensed or did not take it under the VAD process. After a patient has died by VAD, the death is notified to the coroner and reviewed by the Voluntary Assisted Dying Review Board which has oversight of the legislative scheme and which reports to Parliament. Permit numbers issued and deaths are reported and are publicly available. The Act has a statutory requirement for review in five years.

Victoria, Australia has been successful in legislating and implementing VAD even if some may regard it as being in a restricted manner. No doubt as time passes other States and Territories of Australia will consider the potential for a similar VAD option for the citizens in their location. Some of the more controversial aspects of the Victorian Act have been mentioned in this summary.

Do you have an idea, comment, or suggestion?

Please contact
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Addressing Diagnostic Error: Initiatives to Create a Diagnostic Safety Culture in Medicine

Associate Professor Carmel Crock OAM
University of Melbourne
Adjunct Fellow at Macquarie University

Since 2009 I have been the Director of the Emergency Department at The Royal Victorian Eye and Ear Hospital in Melbourne, Australia. Our hospital is a busy public hospital, responsible for training ophthalmologists and ear, nose and throat surgeons, as well as emergency medicine trainees. The hospital is a fertile ground for education, research, mentoring and above all, collaboration between these medical specialties. Our emergency department has over 40,000 presentations per year with trainees of these three craft groups working side by side to assess and treat patients with often sight threatening or ENT emergencies.

In my first days of becoming ED Director I was confronted with dealing with medical error in our department, and whilst procedural and medication error seemed often preventable with excellent processes, diagnostic error seemed more complex and harder to solve. Harm from diagnostic error can be devastating, and it is now appreciated that consequences are often more severe than from other forms of medical error. In our department the consequences of diagnostic error included vision, hearing loss and loss of independence.

There were two key influences in our approach to reducing diagnostic error in our department. My College, the Australasian College for Emergency Medicine, developed a Quality Framework that offered us a roadmap for quality and safety. Alongside this tool, a yearly trip to the USA for the Diagnostic Error in Medicine conference provided further inspiration for improving diagnosis in our ED. The conference draws together a multidisciplinary group including physicians, surgeons, lawyers, psychologists and patients, all contributors to this emerging field of

diagnostic quality and safety. In 2015, this group formed the Society to Improve Diagnosis in Medicine (SIDM) and in 2019 we formed our own affiliate the Australian and New Zealand Affiliate of the Society to Improve Diagnosis in Medicine (ANZA-SIDM). The work of SIDM includes research, practice improvement and education aimed specifically at the reduction of diagnostic error in medicine.

I would like to share some of the practical initiatives we have introduced in our ED to tackle this problem of errors in the diagnostic process and our efforts to create a diagnostic safety culture.

Our day in ED begins with the team gathering for a comprehensive handover from the night team. As cognition degrades at night, this morning handover has developed into a diagnostic cross checking of all overnight presentations. The day team reviews the decision making of the night doctors, suggesting alternative diagnoses and management plans, contacting patients in the morning where appropriate and acting in effect as a safety net. Moreover a culture of questioning and collaborating, with the notion of 'team diagnosis' is created on a daily basis. There is a flat hierarchy, reinforced where all team members including medical students feel safe to contribute their thoughts about a diagnosis.

In order to have consistency in our assessment and management of patients we have developed over forty evidence based clinical practice guidelines. Underlined in these guidelines are high risk clinical situations and diagnoses that we have observed as recurrent error traps in our department. They are living documents that, in the event of an adverse incident, are reviewed and updated to reflect risks. It is refreshing and reassuring to hear in our morning handover comments relating to overnight presentations being diagnosed and treated according to the guidelines.

Like all public hospitals in Australia we have an incident monitoring system, where adverse events can be entered. Often these systems are underused and lie idle. In our department we encourage clinicians to enter incidents where patient care could have been improved, including where a diagnosis was missed, delayed or wrong. On a monthly basis, we meet and review these incidents and share them with the department. Again, recurrent error traps in the department are shared.

We use patient complaints to actively seek out and share diagnostic errors. Each patient who gives feedback on their diagnosis receives a phone call to clarify how and why they feel a diagnosis may have been missed or overlooked. Incidents are again logged into the incident monitoring system so that patterns of difficult diagnoses can be collated and shared.

Our department is involved in research into specific conditions that can create difficulties in diagnosis, such as penetrating eye and ear injuries for example, which can present in a subtle manner. By publishing both case series and reports of our own diagnostic error, we aim to create a culture of sharing clinical scenarios that present challenges in diagnosis.

Diagnostic uncertainty is ever present in medicine, and particularly in emergency medicine where there are time pressures and the patient is unfamiliar to us. Acknowledging and sharing that uncertainty with patients and colleagues, as well as creating safety nets around our diagnostic decisions are steps towards safer diagnosis. Patient and family understanding of the need to be engaged in the diagnostic process is crucial. Accurate diagnosis takes a team, and that includes the patient at the centre.

Providing open disclosure in maternity care - a reflection on my personal experience -

Christine Bessell
MBBS FRANZCOG FRACMA MPH
Clinical Advisor, Australian Health Practitioner Regulation Agency
Director, Austin Health Board, Melbourne

Being invited into a couple's home for an open disclosure conversation about the loss of their baby has been for me the most humbling experience of a long career.

Open disclosure is defined by the Australian Commission on Safety and Quality in Healthcare as "the open discussion of incidents that result in hurt to a patient while receiving health care with the patient, their family, carers and other support".

Ethically it is the right thing to do. It is what we would all want, isn't it?

Back to Index

Open disclosure has been 'implemented' across many jurisdictions for nearly 20 years and many policies, guidelines and resources have been produced to train and support organisations and clinicians to disclose error when an adverse event occurs.

In all jurisdictions, the culture of patient safety, risk management and quality improvement is inextricably entwined with that of local legal frameworks and societal expectations.

The key stakeholder is of course the patient (and their family), but others include individual practitioners, healthcare organisations, funders, insurers and legal representatives, each approaching disclosure from a different perspective.

The 'what' and the 'why' of open disclosure are well articulated, but the 'how' remains challenging.

The following is a reflection on my experience of undertaking open disclosure with families who have experienced the death of a baby before or soon after birth.

Perinatal loss poses its own specific set of challenges. While the adverse outcome is obvious to all, it is frequently unclear that a causative error is involved. If the administration of the wrong drug or wrong dose is witnessed and documented, there is no doubt an error has occurred, but in many clinical incidents there are often shades of grey, and the claimed 'error' may simply reflect professional clinical disagreement.

Patients who experience harm from a clinical mistake often want an apology and to know what happened, and can be motivated by a wish that no one else should suffer from the same error.

Patients who are satisfied with the discussion about error and harm can be less likely to litigate.

Patients who seek legal redress are frequently motivated by reasons other than financial compensation. While they want an apology and the truth about what happened, they frequently do not trust the involved healthcare provider to give them that truth. An adversarial legal suit (or the threat of one) will almost certainly ensure that the process will be prolonged (often for years) and establishing the truth is not necessarily or primarily the aim of proceedings.

Even assuming all of the stakeholders are working together to achieve a patient centred open disclosure outcome, there are a myriad of difficulties.

This is what I have learned and what I think I know about open disclosure.

Serious error leading to serious harm must be managed quickly, with the inclusion of all stakeholders and be led by an experienced clinician.

Clinicians must understand that an apology is not an admission of fault.

A formal review of the case by a respected independent expert (provided under legal privilege if thought necessary) may provide significant reassurance to stakeholders.

The expert opinion provides the 'agreed facts' of the case which can be disclosed.

Plan the open disclosure carefully. On occasions, it can involve a cold call to a patient who does not know an error has occurred (although often they suspect it has)

Decide who will meet with the patient. Nominate and train clinicians in your organisation who are known for their communication skills. In a maternity care setting, I usually partnered with an experienced midwife.

Consider whether a clinician independent of the practitioner or organisation who provided the healthcare is better placed to meet with the family. It is my experience that I could be more frank without the (subconscious) inclination to protect my own reputation or that of my own organisation or colleagues. On the other hand, patients sometimes want to confront the practitioner who made the error (frequently there is no single practitioner or single error) and hear an apology directly.

Patients do not necessarily trust healthcare providers to tell them the truth. An independent clinician may engender trust in the process, but hearing an apology and explanation from the practitioner involved in the care may also build trust in the healthcare system. I do not know which is better, but both options can be part of the open disclosure.

It is important to put the patient and family in control of the meeting. Agree to meet within hours or days, whenever it suits them. Agree to meet with anyone that the patient wishes to have present (but not legal representation). My experience is that fathers receive less support than the 'patient' in the maternity setting and that unresolved emotional distress on their part is very common. Grandparents grieve too. They all have many misconceptions and many questions.

Agree to meet anywhere. I have flown to New Zealand from Australia to meet a family! I have undertaken many meetings in family homes, sat at kitchen tables, met with extended families, viewed shrines to their lost baby and looked through photo books. It is much harder to intellectualise what happened and stay emotionally disconnected in that environment. But it importantly puts the family in control.

Go prepared. Review the case record and be prepared for any question. Stick to the facts, but don't stick to the script. Families will have many questions, most of which won't have occurred to you. Be prepared to hear about conversations with clinicians or events that are not recorded in the medical record. We rely on the medical records as the documented source of truth, but those records never do and never will cover every aspect of conversations during care or details of care provided.

Start with an unconditional apology and a brief outline of the facts and regarding the adverse outcome.

Most discussions are two way, cordial and at the time seem productive. Be prepared for anger and tears.

Offer clinical information if qualified to do so, to undertake to follow up on questions to which you don't have the answer, and to arrange recommendations or referrals to specialists who can answer questions and/ or provide follow up or ongoing clinical care.

Offer to be available for any follow up and provide your phone number.

Take the original medical record with you. Show it to the patient through the conversation and offer to provide them with a copy.

Make an upfront offer of counselling support for the patient and family. Be prepared to ensure urgent psychological support is available. These conversations can be incredibly distressing.

Consider in advance if the insurer is able to make a payment without litigation, and recommend that they seek legal advice before accepting such an offer.

Don't wait for the family to demand any of these things.

Has open disclosure helped such families? I think so, but it really hard to be sure.

What I do know is that is that it has been an enormous privilege when undertaking open disclosure to be accepted into families' homes and hear their stories.

President Report

Thomas T. Noguchi
President of WAML

Due to the COVID epidemic, it was necessary to have unexpected postponements of the World Congresses, first Toronto in 2020 and then Istanbul in 2021. We are now hopeful that we are able to have a face-to- face meeting in Gold Coast Australia in 2022. Professor Roy Beran is program chair and looking forward to having an excellent program.

After the WAML Congress meeting in Gold Coast, The Australian College of Legal Medicine is planning a program in Sidney on Saturday, August 6. So far, the COVID epidemic has been handled vigorously in Australia. We hope we will have a meaningful get together in Australia.

World Association for Medical Law

Ken Berger
Secretary-General report

Covid-19 continues to test our resilience with resurgence of cases in Europe with booster shots becoming available and child vaccination.

With some lifting of travel restrictions, the Secretary General was able to attend a recent Medical-Law meeting in Oklahoma, representing the association and promoting future travel to our planned future annual congresses. The meeting was sponsored by the ACLM.

There were excellent presentations from the judiciary and participants. From this experience, it is reminder to all that there is a certain amount of Regional approaches to medical-legal issues that translate across borders.

The Executive Committee continues to monitor the situation closely.

Lest we forget once again, we strongly encourage all members to register now to attend for the Gold Coast meeting and submit abstracts. The links to register and submit abstracts are available on the WAML website. Should there be a need to postpone this meeting, registration fees will be refundable or transferrable to future WAML annual congresses.

On behalf of the EC, I wish everyone continued good health, prosperity, and safety.

Very truly yours,

Ken J. Berger

Ken J. Berger MD, JD

Secretary-General and Board of Governors,
World Association for Medical Law

Program Chair, 2024, 29th WAML meeting,
Toronto, Canada

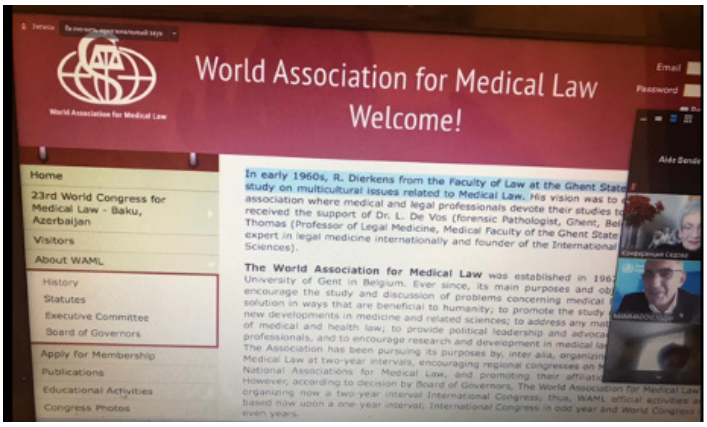
EVP Report

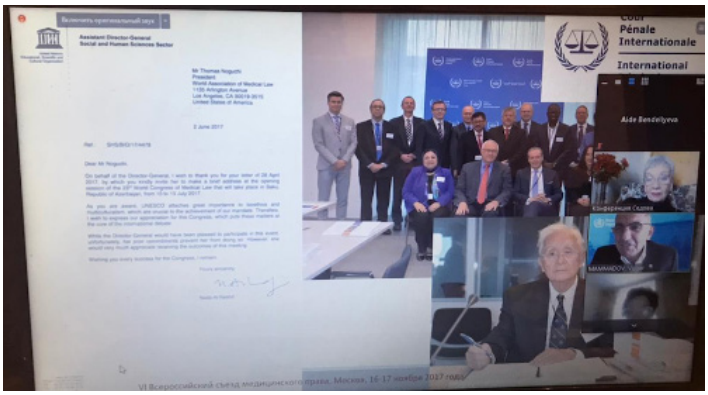
Prof. Dr. Vugar Mammadov
WAML Executive Vice-President
Chairman of WAML Education Committee
Professor of Azerbaijan Medical University
Professor of Law School, Baku State University

Hope you are well and your families are safe. We are finishing the second pandemics year and I am glad that, for the first time since March 2020, we will speak in the Newsletter not about COVID-19, but about a return to regular WAML educational and promotional activities which we have actively started before the global lockdowns. Certainly, taking into account coronavirus restrictions, we can not make our travels, but have significantly intensified online activities to minimize health risks and time losses due to possible contamination and quarenthines. Cancellation of two consecutive WAML Congresses 2020 and 2021 in Toronto and Istanbul...and also postponing a number of regional and national events initiated and planned by the WAML Educational Committee, including long time waiting WAML/Latin American Medical Law Association/Costa Rica Medical Law Association meeting with Costa Rica National Forensic Medical Congress in San Jose in early March 2020, Baltic States Medicolegal Forum, medico-legal conferences in India, Indonesia, China, Pakistan, Russia, Singapore, etc. impacted things significantly. The last events of the WAML Education Committee to promote WAML were meetings with Mycolo Romeris University in Vilnius, Lithuania; National University of Singapore in Singapore; India Medical Law Association in Kochi; National Bar Association of Ukraine in Kiev; the WAML workshop at the 7th European Association of Health Law Conference in Toulouse; medico-legal associations of Malaysiya in George Town, Penang and South Korea in Seoul.

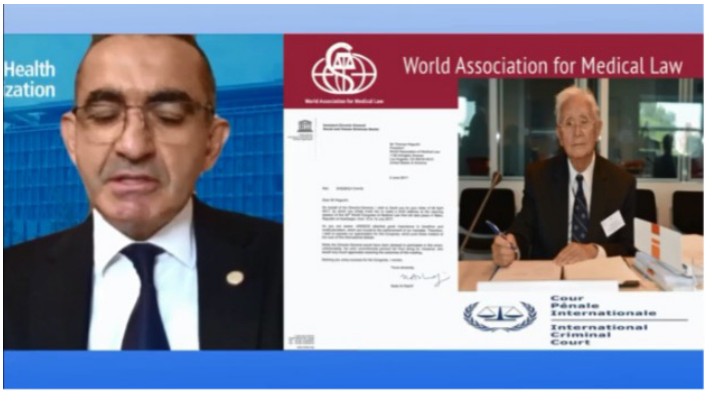
Among those educational activities in the recent period we would like to update our WAML colleagues about the WAML Educational Committee talks at the World Bioethics Day, organized by UNESCO Bioethics Chair in Lahore, Pakistan, plenary sessions of important Russian congresses of the National Bioethics Society, All-Russian Forensic Medical Congress with international participation, devoted to the 90th Annivesary of the All-Russian Forensic-Medical Center led by the Russian minister of health, international Caspian Summit, organized by Astrakhan State University (Russia), 28th meeting of the National Ethics Councils (NECs) Forum, oganized by European Commission and Ministry of Health of Slovenia. Thus it is obvious that interest in medical law increases on national levels, but what is also felt is that the voice of scientists and specialists is not generally heard by national governments, policy- and decision makers. We believe post-pandemic times will bring a lot of opportunities for development of understanding the importance of medicolegal knowledge and expertise, role of human rights protection and ethical values in the fields of modern health and medicine.The last two years provided massive amounts of information

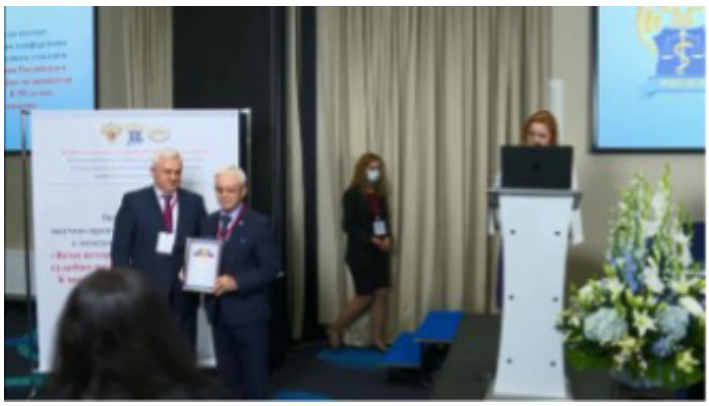
and data to be scientifically analyzed and converted both into scientific outputs and also in to international health policies and legislation. If trends go this way the WAML's role may be tremendous here to strengthen our multilateral links with influential international organizations.





"Photos from Russian National Bioethics Society meeting with international participation 15th October, Volgograd Medical University with Russian top Bioethics scientists prof. Sedova, prof. Siluyanova and others..."





I wish to You all strong health, happiness, wealth and prosperity in the coming year! Happy New 2022 Year! Merry Christmas! Look forward to seeing you soon in Gold Coast in August 2022!

Best regards

Back to Index

WAML Meeting Planning and Administration

Denise McNally,
WAML Administrative Officer and Meeting Planner

JOIN US FOR THE 26TH WORLD CONGRESS ON MEDICAL LAW (WCML) AUGUST 1 – 3, 2022 GOLD COAST, AUSTRALIA

AUGUST 1 - 3, 2022

WAML is now accepting ABSTRACTS for the 26th World Congress on Medical Law (WCML). Deadline April 29, 2022.

We encourage you to join the leading experts in medical law, legal medicine and bioethics by submitting your abstract in English only online at https://app.oxfordabstracts.com/stages/1415/submissions/new

Congress Themes

1. IMPACT OF COVID ON LEGAL MEDICINE

2. MEDICINE AND TECHNOLOGY

3. CONCUSSION AND TRAUMATIC BRAIN INJURY

You may register for the Congress at http://wafml.memberlodge.org/event-2746302/Registration

HOTEL RESERVATIONS

QT Gold Coast
7 Staghorn Avenue
Surfers Paradise QLD 4217 Australia
W: www.qthotelsandresorts.com.au

The QT Gold Coast is offering a bed and breakfast group room rate. Reserve your room at www.qthotelsandresorts.com.au and use Code **WAML22**

ACCOMMODATION

Prices listed below are AUS

MOUNTAIN RIVER VIEW
(per room per night)
$224.00 with breakfast for 1
$249.00 with breakfast for 2

OCEAN VIEW
(per room per night)
$254.00 with breakfast for 1
$279.00 with breakfast for 2

QT KING SUITE
(per room per night)
$354.00 with breakfast for 1
$379.00 with breakfast for 2

https://www.qthotels.com/gold-coast/?utm_source=google&utm_medium=organic&utm_campaign=gmb

Organizing Committee and Supporting Organizations can be found http://wafml.memberlodge.org/Organizing-Committee-and-Supporting-Organizations

About Gold Coast can be found http://wafml.memberlodge.org/About-Gold-Coast

Membership Dues

The purpose of the World Association for Medical Law (WAML) is to encourage the study and discussion of health law, legal medicine, ethics and forensic medicine for the benefit of society and the advancement of human rights.

Membership in WAML is Annual and your 2022 membership dues are due by December 31, 2021. Membership dues are $150. If you received a notice that your membership has lapsed you still have the ability to login to your profile, generate a dues invoice and pay.

WAML members enjoy many benefits which include access to quarterly

E-Newsletters, discount registration fees to the WAML Congress, notice of upcoming events, active website information, the "Medicine and Law" electronic Journal and discounted access to activities of affiliated organizations.

We encourage you to log into the WAML website http://wafml.memberlodge.org/ and pay. After logging in choose 'View Profile' (located top right), click 'Membership' and then "Renew'. You also have the option to pay by check or wire transfer.

If your membership dues are paid, thank you!

Back to Index

FUTURE MEETINGS

Of Affiliated National Associations and Collaborating Organizations

Medical Law Professionals Association of Nigeria (MELPAN)
December 7, 2021
Maitama, Abuja Nigeria
2021 Medical Law Conference and Induction of Members
(melpan.com)

26th Annual WAML World Congress
August 1 – 3, 2022
Gold Coast, Australia
Website: www.thewaml.com

27th Annual WAML World Congress
August 2 – 4, 2023
Vilnius, Lithuania
Website: www.thewaml.com

28th Annual WAML World Congress
August 8 – 11, 2024
Toronto, Canada
Website: www.wcml2020.com
www.thewaml.com

29th Annual WAML World Congress
August 6 – 8, 2025
Istanbul – Turkey
Website: www.thewaml.com

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Back to Index