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Ophthalmic Risk Management Digest

OMIC DIGEST

Older Patients Need Additional Informed Consent Consideration

By Anne M. Menke, RN, PhD
OMIC Risk Manager

Older patients make up a significant portion of the patient population of most ophthalmologists, and their numbers will grow as life expectancy increases. At the recent American Academy of Ophthalmology meeting in Chicago, an ethics symposium addressed the challenges of obtaining informed consent from older patients. The panelists have agreed to allow OMIC to present some of their comments and suggestions here, particularly those related to aging, decision-making capacity, surrogate decision makers, and cognitive impairment.

Take the Impact of Aging Into Account

OMIC Director, Harry A. Zink, MD, speaking from the perspective of an ophthalmologist, pointed out that certain aspects of the physical condition of older patients impact the care and consent process. These include declining vision, hearing, and memory, as well as cognitive disorders such as dementia. Providing for the needs of these patients comes when many practices are already struggling with time constraints, so ophthalmologists will need to come up with a smarter process of care. Dr. Zink suggests enlisting staff and family members, repeating information and instructions, and providing them in writing, using large print whenever possible. Focus on a few main points and confirm understanding by asking the patient to repeat these main points. Ask a family member to be present during consent discussions, and ensure that decisions made by surrogate decision makers truly reflect the patient's wishes.

Evaluate the Patient's Decision-Making Capacity

Representing OMIC, I presented the medicolegal aspects of consent. Physicians know they have a legal obligation to inform patients of their condition, as well as the risks, benefits, and alternatives of the proposed treatment, including no treatment. If patients do not feel that surgeons have fulfilled this duty, they—as plaintiffs—may sue for "lack of informed consent." To succeed, they must prove that the ophthalmologist did not inform them of the risks, benefits, and alternatives, ***AND*** that they would have refused treatment if advised of the risks. Plaintiff attorneys have alleged lack of informed consent on the basis that patients did not have adequate time to make an informed decision or the information on which to base it. Additionally, they have claimed that patients were under the influence of mind-altering

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MESSAGE FROM THE CHAIRMAN

As 2010 comes to a close, so does my tenure as Chairman of OMIC. In January, I will begin my term as President of the American Academy of Ophthalmology, a position that will require an enormous time commitment and personal energy. In order to successfully fulfill my duties as President of the Academy, I will be stepping down as OMIC Chairman, although I will continue to serve on the Board of Directors as Chair Emeritus throughout 2011. One of my final, and most satisfying, responsibilities is to announce that John W. Shore, MD, of Austin, Texas, will succeed me as your new Chairman, effective January 1.

For more than a decade, Dr. Shore has played an active and distinguished role in OMIC's governance. His experience, leadership, and vision will be of great benefit to the ophthalmic community during this time of uncertainty and change in health care. Dr. Shore's entire career has exemplified insight and strong dedication in support of our ophthalmic profession.

An OMIC committee member since 1999, Dr. Shore has long served on the Claims Committee and chaired the Risk Management Committee.

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OMIC

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Ophthalmologists Working Longer, Retiring Later

Ophthalmologists are practicing into their later years, a trend that is likely to continue given shrinking retirement assets and uncertainty about the nation's financial future. In 2010, 25% of OMIC active insureds were over the age of 60, compared to 16% in 2000. The average age of an OMIC retiree in 2010 was 68 vs. 65 in 2000.

Ophthalmology has become a highly specialized field. Advanced subspecialty education and training delays the age at which young ophthalmologists start practice, and this late start may factor in to their decision to practice up to or past age 70.

Financial considerations play a role as well. During the 1990s, physician income dropped while practice expenses rose. The medicolegal and regulatory environments were hostile, and managed care was on the rise. Specialists, such as ophthalmologists, were particularly affected by lower Medicare and insurance reimbursement rates. Many senior ophthalmologists decided to stop practicing, and at one point, the average retirement age of OMIC insureds dipped to 61. That trend slowly reversed itself beginning in 2000, and today it approaches 70.

Practice trends in ophthalmology are similar to other physician specialties. The average retirement age for all physicians rose from 64 in 2000 to 67 in 2010. General surgeons retire earliest at age 62, while cardiologists are likely to practice until they're 71, 10 years longer than they did in 2000. Otolaryngologists are also retiring at a later age (69 in 2010 vs. 62 in 2000). The only drop in retirement age between 2000 and 2010 occurred among general and family practitioners (70 to 69) and general surgeons (64 to 62).

According to the Census Bureau, the average retirement age in the U.S. has steadily declined from 68 in 1950 to 64 in 1990 to 62 in 2010.

Message from the Chairman

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Under his leadership, OMIC's risk management program has become the leading loss prevention program for ophthalmologists in America, highlighted by joint educational alliances with 39 ophthalmic state and subspecialty societies.

These educational alliances not only improve the scope and quality of risk management education and services to members of both organizations, they help attract new members and make each organization stronger and more effective in carrying out its mission. In the past two years alone, OMIC has returned more than $2 million in special risk management credits to policyholders through these alliances.

I am proud to be turning over leadership of the Board at a time when OMIC has never been stronger. We lead all other malpractice insurance companies in a multitude of financial measures, an accomplishment that can be tied directly to our superior claims defense and reduction of risk exposures. This has translated into lower and stable rates for policyholders. Since January 2009, when I stepped up to chair OMIC, the Board has decreased the average premium paid per policyholder by 10% and returned nearly $10 million in dividends. We continued to add new policyholders and grew by 8% during this period, despite a very competitive cycle in the insurance market.

Having now spent nearly two decades involved in the governance of OMIC and seeing it emerge as one of the Academy's most well-known success stories, I believe this is a seminal moment for both organizations. In recent months, the Academy has lobbied aggressively on behalf of our profession against optometric scope of practice encroachment and fee and reimbursement cuts by the Centers for Medicare & Medicaid Services. OMIC has assisted the Academy and others in these advocacy efforts by providing the most comprehensive ophthalmic risk management and claims data available, data collected by OMIC over nearly a quarter century of insuring ophthalmologists.

In closing, I wish to thank you and the Board of Directors for providing me the opportunity to serve as your Chairman. I look forward to working with my friend and colleague, John Shore, in our new respective roles as we confront the challenges and take advantage of the opportunities awaiting all of us and our profession in 2011.

Richard L. Abbott, MD
OMIC Chairman of the Board

Coverage Options for Aging Insureds

By Kimberly Wynkoop
OMIC Legal Counsel

While we have looked at liability issues arising from the treatment of geriatric patients elsewhere in this issue of the *Digest*, this article will address coverage options for our aging insured ophthalmologists.

Rest assured, OMIC does not have any age restrictions in place that prevent insureds from continuing to be insured with OMIC or that limit the surgical activities covered as long as the insured maintains competency and has no health issues that affect his or her ability to practice safely. However, as they near retirement, some insureds choose to reduce their work hours or the types of procedures they perform. OMIC offers coverage options to respond to these changes in practice.

OMIC's policy can be endorsed to reduce the coverage classification of the insured from full surgery (Surgery Class 3) to Surgery Class 2, Surgery Class 1, or No Surgery. Premiums decrease as coverage classifications are reduced. Following is a summary of the procedures allowed in each reduced coverage classification. For the full list, see Section XI. Part II. of your policy.

Surgery Class 2 excludes coverage of the performance of any surgical procedures, except for various (non-refractive, non-retinal) laser procedures, punctal closure with cautery, wedge resection for suspected non-cancerous tumors, various tarsorrhaphy, temporal artery biopsy, various non-invasive, non-ablative cosmetic procedures, and injections other than intracameral/intravitreal, in addition to the procedures permitted in Surgery Classes 1 and No Surgery.

Surgery Class 1 excludes performance of any surgical assisting or surgical procedures, except for removal of sutures, fluorescein angiography, tear duct probing or irrigation done under local anesthetic, repair of minor lid or conjunctival lacerations, biopsy of lid tumors or the conjunctiva, removal of cysts and other non-cancerous skin lesions and tumors, removal of corneal epithelium, incision and drainage, hair removal procedures, intramuscular, intravenous, and subconjunctival injections, injection of Botox or fillers, stromal puncture, micropigmentation, superficial chemical peels, microdermabrasion, removal of papillomas and chalazions, cryotherapy of the lid, and non-incisional entropion or ectropion repair, as well as non-surgical procedures.

No Surgery excludes performance of any surgical assisting or surgical procedures. Coverage applies only to non-surgical ophthalmology, which includes diagnosis and non-surgical treatment of diseases (other than screening for or treating retinopathy of prematurity), prescription of glasses or contact lenses, mechanical epilation, punctal closure with plugs, and removal of superficial foreign bodies from the cornea and conjunctiva.

Physicians who treat retinopathy of prematurity and/or provide ROP screening services for infants at or discharged from Level 2 or Level 3 NICUs must carry Surgery Class 3 coverage. Physicians with a limited surgical or non-surgical practice who restrict ROP services to occasional screening of low risk infants may qualify for special rating consideration.

OMIC's policy can also be endorsed to provide part-time coverage with a corresponding premium discount. Discounts are available to ophthalmologists who practice 20 hours or fewer per week or 10 hours or fewer per week at Surgery Classes 1 and 2 or No Surgery. The premium is based on the insured's practice class, geographic location, limits of liability, and maturity year of the insured. A part-time premium discount may also be offered to qualified insureds at Surgery Class 3 who practice 20 hours or fewer per week and perform 100 or fewer surgical procedures per year, subject to review of their practice patterns, claims experience, and other factors affecting potential liability. Surgery Class 3 physicians who perform ROP services, full cosmetic facelifts, liposuction, or rhinoplasty are not eligible for the part-time discount. Insureds are still eligible for a part-time discount if they are insured elsewhere for any additional practice activity.

OMIC does require insureds (at any age) to report health conditions that may potentially affect their ability to practice safely. Section VIII.3. of the policy requires, in part, that insureds notify OMIC, in writing, within thirty days (1) of undergoing or being advised to undergo treatment for alcohol, drug, or other substance abuse, or for psychiatric illness or (2) after suffering an illness or physical injury which impairs, or is likely to impair, the insured's ability to practice ophthalmology for thirty days or more.

Finally, OMIC offers a valuable benefit to insureds who terminate coverage at any age due to death, disability, or retirement. Section X. of the policy explains that the premium for an extended reporting period endorsement (tail coverage) is waived if the insured has been continuously insured by OMIC for at least five years at the time of retirement. The tail endorsement is provided as soon as OMIC receives confirmation of the insured's retirement and the earned policy premium through the date of termination has been paid. Tail premium is likewise waived upon the death, permanent total disability, or judicial determination of incompetency of the insured, regardless of the length of time insured. In this case, the tail endorsement will be provided as soon as OMIC receives written notice of the applicable situation and the earned policy premium through the date of termination has been paid. The tail premium waiver applies only once per lifetime.

Contact your underwriter to discuss any of these coverage options at (800) 562-6642, ext. 639.

Older Patients Need Additional Informed Consent Consideration

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medications that impacted their judgment. Attorneys representing older patients may challenge the patient's ability to make an informed choice. Consider this scenario reported to OMIC by an oculofacial plastic surgeon.

A 70-year-old patient, accompanied by a man she identified as her boyfriend, requested a facelift. Her ophthalmologist determined that she was an appropriate candidate, clarified her goals, and obtained her informed consent. By the time the preoperative nurse called her to review the physician's orders, the patient could not recall that she was having surgery. The nurse determined that the problem was not simply a matter of forgetfulness. Before the nurse could contact the surgeon, the boyfriend called her to assure her that the patient remembered the surgery and still wanted to proceed. After hearing from the nurse, the ophthalmologist contacted OMIC's Risk Management Hotline.

While judges determine a person's competency, physicians use their clinical skills to decide if a patient has "decision-making capacity" or DMC. Adult patients are presumed to have DMC if they understand their condition and the risks associated with the recommended procedure and are able to communicate their wishes. The oculofacial surgeon and I discussed the need to re-examine the patient to determine if she had decision-making capacity and whether there were signs of elder abuse. If the patient's confusion persisted, the surgery would need to be cancelled.

Surrogate Decision Makers

If a patient lacks DMC, a surrogate decision maker must be found to make the informed consent decision before surgery is allowed to proceed. States recognize that some patients may temporarily or permanently lose their ability to make decisions on their own behalf and have developed mechanisms for determining who may decide in the patient's stead (see this issue's **Hotline** column).

Distinguish the Effects of Aging from Dementia

Patients who lack DMC, especially if they previously demonstrated it, need further evaluation. If you think the cause of the cognitive impairment is Alzheimer's, you would be right about 60% of the time, according to Chicago gerontologist Dr. Shellie Williams. As the proportion of the U.S. population age 65 and older increases, the prevalence of dementia (the general term for a decline in cognitive functioning) will also increase. In 2009, there were approximately 5.3 million patients with Alzheimer's, with a new diagnosis rendered every 70 seconds. Researchers estimate that Alzheimer's disease (AD) and other dementias affect approximately 5% of individuals age 65 and older and as many as 30% to 40% of individuals age 85 and older. In the absence of effective treatment to prevent AD, 8.5 million Americans may have this disorder by 2030.[1]

Far from a routine part of growing older, dementia is a progressive, terminal disease of the brain that destroys brain cells. (See **WHAT'S THE DIFFERENCE?**[2]) Dr. Williams explained that many diseases cause dementia, including Alzheimer's, Parkinson's, Lewy Body, and vascular disorders. Dementia increases the morbidity and mortality of other diseases and the risk of adverse events, and limits the patient's ability to follow medical directions and consent to care. The disease burden is significant: despite care totaling $148 billion, and the unpaid assistance of some 9.9 million caregivers, Alzheimer's is the sixth leading cause of death, Dr. Williams reported. Dementia is present when memory issues are accompanied by a decline in at least one other area, such as language, motor skills, recognition, or executive function (performance of complex tasks or judgment/reasoning). The combined impairment degrades the patient's baseline cognition and functioning and leads to a decreased ability to care for oneself and live independently.

Screen for Cognitive Impairment

Clues that a patient needs to be screened for dementia include poor control of a previously controlled medical condition as well as many of the attributes of "difficult patients," i.e., missed appointments, failure to refill a medication, change in behavior, and disheveled appearance. According to Dr. Williams, dementia is routinely unrecognized and undiagnosed despite its growing prevalence. Physicians were unaware of cognitive impairment in more than 40% of their cognitively impaired patients. Only 24% of patients had a documented diagnosis of dementia, even though their screening exam demonstrated moderate to severe dementia. Family members failed to recognize a problem with memory in 21% of demented seniors. As many of those who did notice a change attributed it to the normal aging process, only 53% of seniors with memory problems were referred to a physician.[3]

WHAT'S THE DIFFERENCE?

Signs of Alzheimer's/Dementia	Typical Age-Related Changes
Poor judgment and decision making	Making a bad decision once in a while
Inability to manage a budget	Missing a monthly payment
Losing track of the date or the season	Forgetting which day it is and remembering later
Difficulty having a conversation	Sometimes forgetting which word to use
Misplacing things and being unable to retrace steps to find them	Losing things from time to time

Family members can help the ophthalmologist determine if there is cognitive impairment. Dr. Williams suggests asking them the following questions about the patient: Does your family member repeat questions? Forget words or names? Have poor recall of familiar people and places? Fall often? Have difficulty taking medications? Talk less? Show poor judgment? Wander? Have trouble using tools and appliances? Misplace items? Seem irritated, angry, or aggressive?

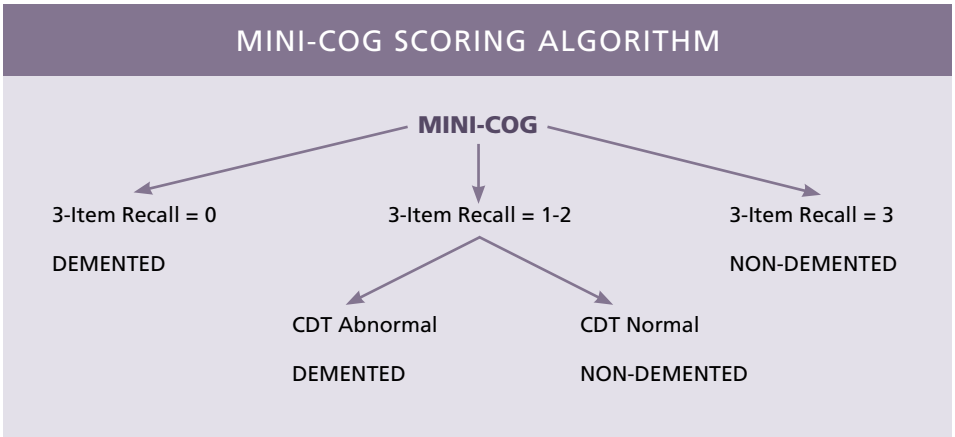
In addition to getting input from family members, physicians can use screening tools. Dr. Williams presented two brief screening methods, either of which can be utilized by ophthalmologists in a matter of minutes. The first is called the "Mini-Cog." Ask the patient to repeat and remember three words: BALL-FLAG-TREE. Next assign the clock-drawing task (CDT). Ask the patient to draw a clock with the hands set for ten after eleven. Once the clock is drawn, ask the patient to recall the three words. The CDT is considered normal if all numbers are present on the clock in the correct sequence and position and the hands readably display the requested time.[4] Abnormal clocks will be missing quarters or have bunched, repeated, or missing numbers. Each word the patient remembers is worth a point, and the CDT is scored as either normal or abnormal. (See **MINI-COG SCORING ALGORITHM**.)

The second possible screening test is called the "Six-Item Screener."[5] Short-term memory deficit is a hallmark of dementia. The authors chose to target disorientation in three of the questions, specifically temporal disorientation (problems recalling the day of the week, month, and year) since it occurs before disorientation to place and is rarely seen in those not experiencing dementia. Three-item recall helps to identify patients with cognitive impairment. Here is the script: "I would like to ask you some questions that ask you to use your memory. I am going to name three objects. Please wait until I say all three words, then repeat them. Remember what they are because I am going to ask you to name them again in a few minutes. Please repeat these words for me: APPLE-TABLE-PENNY."[5] The physician may repeat the names three times if necessary; the repetition is not scored. The script continues: "What year is this? What month is this? What is the day of the week? What were the three objects that I asked you to remember?" Each correct answer is worth a point. A score of ≤ 4 points is considered positive for cognitive impairment.

Arrange Additional Care for Cognitively Impaired Patients

Patients with a positive screening test for cognitive impairment need additional care. Explain to the patient and family member that the screening test indicates the need for a more detailed evaluation from the patient's primary care physician or a specialist. Patients with cognitive impairment may exhibit denial or feel that treatment would be futile. Explain that there are many conditions that can cause cognitive impairment and that earlier treatment affords the best chance for optimal functioning. In addition to documenting your assessment and discussion, contact the PCP's office to schedule an appointment for the patient, and send a referral note with the screening results.

Even with cognitive impairment, patients need to continue to treat their eye conditions. Review and simplify the patient's medication regimen. Provide medication and care instructions both orally and in writing in simple terms. Involve family members and friends in the patient's home care whenever possible. Evaluate the patient's ability to drive.[6] Alert staff to the patient's status so additional time can be provided for appointments and education, if needed. Taking these extra steps to obtain consent and screen for cognitive impairment will help patients and their families meet the considerable challenges of aging and dementia.



1. "Alzheimer's Disease." http://www.alz.org/national/documents/topicsheet_alzdisease.pdf. Accessed 12/3/10.

2. Alzheimer's Association. "Ten Warning Signs of Alzheimer's." http://www.alz.org/national/documents/brochure_10warnsigns.pdf. Accessed 12/3/10.

3. Chodosh J, Petitti DB, Elliott M, Hays RD, Crooks VC, Reuben DB, Buckwalter JG, Wenger N. "Physician Recognition of Cognitive Impairment: Evaluating the Need for Improvement." *J. Am Geriatr. Soc.* 2004; 52(7): 1051-9.

4. Borson S, Scanlan J, Brush B, Vitaliano P, Dokmak A. *Int. J. Geriatr. Psychiatry.* 2000; 1021-1027.

5. Callahan CM, Unverzagt FW, Jui SL, Perkins AJ, Hendrie HC. *Medical Care*. 2002; 40: 771-781.

6. See "Visual Requirements for Driving" on the AAO's web site (www.aao.org). The 2010 edition of the American Medical Association's *Physician's Guide to Assessing and Counseling Older Drivers* includes a 10-minute tool called the "Assessment of Driving-Related Skills," which screens for problems in cognition, vision, and motor/somatosensory functions that may affect driving (www.ama-assn.org).

Closed Claim Study

Dispute over Informed Consent with Elderly Patient

By Ryan Bucsi, OMIC Senior Litigation Analyst

ALLEGATION

Failure to provide adequate informed consent resulting in the loss of peripheral vision.

DISPOSITION

The case was tried and a defense verdict was returned.

Case Summary

At the time of this incident, the plaintiff was 80 years old with a significant history of macular degeneration OU with central vision loss OD. The insured's exam, which included a fluorescein angiography and an explanation of advanced macular degeneration, revealed that the patient had developed neovacularization OS causing a sudden drop in visual acuity from 20/70 to 20/200 with a large amount of submacular blood. The insured recommended evacuation of the blood to prevent the development of scar tissue and to preserve central vision. The insured documented in the patient's record that he "Advised vitrectomy with evacuation of subretinal blood and risk of subretinal blood involved." However, no procedure-specific consent form was obtained. Approximately two weeks after this examination, the insured performed a vitrectomy and membrane peeling OS to evacuate subretinal blood, which was a relatively new treatment at the time. Postoperatively, the patient had two retinal detachments OS and eventually lost both central and peripheral vision OS.

Analysis

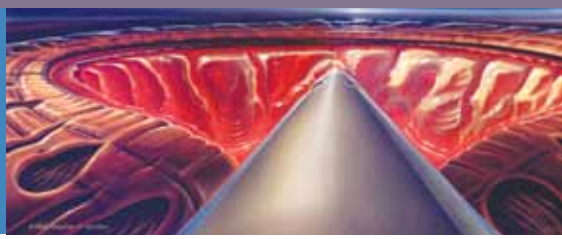
The main dispute in this case was over informed consent. Both the plaintiff and her daughter, who was present during the insured's examination, claimed the ophthalmologist never told them that a postoperative retinal detachment could lead to peripheral vision loss. The insured adamantly denied the allegation and specifically recalled discussing these risks with the patient; however, his documentation outlining the risks of surgery was cursory. The defense was also compromised because the only consent form signed by the patient was a general surgical consent form in the hospital chart. Furthermore, the plaintiff was a sympathetic witness and her daughter verified her testimony. Defense counsel reported to OMIC that there was a 50% chance for a defense verdict in a somewhat conservative venue. There was little question that the retinal detachment occurred because surgery had been performed. No one disputed that if the insured had not performed the surgery, this patient's retina would not have detached and she would still have peripheral vision OS. However, without the surgery, the patient would have lost the chance to regain any useful central vision OS.

Just prior to trial, the plaintiff attorney, who was married to the plaintiff's daughter, withdrew as counsel. Defense counsel warned OMIC prior to trial that the new plaintiff attorney was more formidable and that if a jury returned a plaintiff verdict, it was likely to be significantly higher. During the trial, plaintiff counsel approached defense counsel to initiate settlement discussions. The insured remained confident in his care and continued to oppose any settlement. A 7–1 defense verdict was returned in favor of the insured. The defense was able to convince the jury that the informed consent process took place even though the insured's consent documentation was minimal. The defense was strengthened by the insured's extremely credible testimony coupled with the fact that surgery was the only hope for saving the patient's central vision. By the time this case went to trial, the plaintiff had some memory problems and was only able to recall the facts that supported her claims, which may have diminished her credibility. Following the jury verdict, OMIC defense counsel commented that it was very likely that this case would not have even been litigated if the OMIC insured had obtained a procedure-specific consent form from the patient.

Risk Management Principles

Informed consent is a process that requires more than simply obtaining the patient's signature on a consent form. Detailed documentation of the indication for the procedure as well as documentation of all of the risks, benefits, and alternatives to the surgery are vital components of the informed consent process. Documentation of the consequences for delaying or refusing treatment is also advisable. In this case, the insured should have discussed and clarified with the patient and her daughter the ultimate goal of surgery—preservation of central vision—and documented in the chart that they were all in agreement with that goal and understood why surgery was being performed. The insured should have required the patient to sign a procedure-specific consent form and documented the patient's understanding that this was a relatively new procedure.

Risk Management Hotline



Advance Directives and Surrogate Decision Makers

By Anne M. Menke, RN, PhD
OMIC Risk Manager

A policyholder called for advice about a mentally handicapped patient who resided in a state-run home. As the patient had never had decision-making capacity, power of attorney (POA) for medical decisions had been granted to a relative. The relative was now 90 years old, lived in another state, and was no longer able to travel. Meanwhile, the patient had developed visually significant cataracts that, given his disability, were having a profound impact on his ability to take care of himself and participate in activities of daily living.

Q A state representative accompanied the patient and said the state is applying for guardianship. What is involved? Do I have to wait until this process is complete?

A This patient has been determined by a judge to be incompetent to make medical decisions. While it is likely that a judge will approve the state's application to assume POA duties, the state does not currently have the authority to make medical decisions on the patient's behalf. However, this patient would benefit from prompt surgery, so waiting is not advisable either. Arrange a conference call with the patient, the relative with the authority to make medical decisions, the state's representative, and someone from the ambulatory surgery center where the procedure will be performed. If the relative and state's representative agree that the surgery is appropriate, and the ASC is comfortable with the consent process, obtain the signature of the relative and proof of POA status, document the conference call, and proceed with surgery.

Q I'm on call and have a patient who is unconscious but needs repair of a ruptured open globe. May I proceed without consent?

A Possibly. Quickly check to see if the patient has an advance directive in his or her belongings or in the medical record. Advance directives address the kinds of decisions a patient would like someone to make if he or she is unable to participate in a consent discussion. If there is no available advance directive or person with POA, and you feel the patient requires emergent treatment, ask the ER physician and/or OR nurse to determine the facility's process for emergency exceptions to informed consent. Some hospitals require a second physician to agree that the care needs to be provided without delay. Both you and the second physician should document the need for emergent treatment and attempts to reach the patient's family. Direct a hospital staff member to continue attempts to contact a family member or friend, as consent for additional non-emergent treatment will need to be obtained from a surrogate.

Q How should I proceed if there is time to try to find a surrogate decision maker?

A The ideal surrogate is one who understands the patient's health care values and goals and will respect them during the decision-making process. Each state has a system for determining who may act as the surrogate decision maker and ranks them in decreasing order of authority. The top two are usually the individual who has been granted POA in an advance directive or a legal guardian with POA for medical decisions. Next come spouses, adult children, parents, and adult siblings. Adult children and siblings who do not have POA are able to act as surrogates only if they are in agreement. Many hospitals ask members of an Ethics Committee for guidance when these family members have different opinions on whether to proceed with treatment.

Q Our ASC suspends "do not resuscitate" and advance directives during surgery. My patient is quite upset and insists that her wishes be honored. How should we proceed?

A Your patient brings up a difficult issue that most ASCs and ORs have not addressed, even though all ask patients if they have advance directives. While you could simply try to find an ASC that will honor the patient's wishes, it would be worthwhile to discuss this problem with the facility's leadership team. The American Society of Anesthesiologists (ASA) has stated that "automatic suspension of DNR orders… may not address a patient's right to self-determination in a responsible and ethical manner."[1] Instead, the ASA suggests asking an anesthesiologist to review possible options with the patient. First, the patient may choose full resuscitation, thereby suspending DNR orders and other directives during anesthesia and the immediate postoperative period. Second, the patient could choose a limited attempt at resuscitation defined with regard to specific procedures. The anesthesiologist and surgeon would inform the patient of procedures that are essential to the success of the planned anesthesia and procedure. The patient consents to these but refuses any procedures that are not essential. Finally, the patient may opt for a limited resuscitation defined with regard to the patient's goals and values. The patient and family, after a discussion with anesthesia, agree to allow the anesthesiologist to use professional judgment. Full resuscitation procedures will be used to manage adverse clinical events that are quickly and easily reversible. The patient will not be treated for conditions that are likely to result in permanent neurological impairment or unwanted dependence on life-sustaining technology.

1. American Society of Anesthesiologists, "Ethical Guidelines for the Anesthesia Care of Patients with DNR Orders or Other Directives that Limit Treatment," http://www.asahq.org/For-Healthcare-Professionals/Standards-Guidelines-and-Statements.aspx. Accessed 12/3/10.

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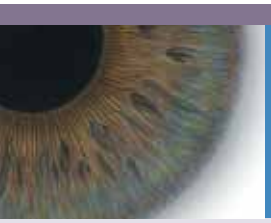

Calendar of Events

OMIC continues its popular risk management programs in 2011. Upon completion of an OMIC online course, CD or MP3 recording, or live seminar, OMIC insureds receive one risk management premium discount per premium year to be applied upon renewal. For most programs, a 5% risk management discount is available; however, insureds who are members of a cooperative venture society (indicated by an asterisk) may earn an *additional discount* by participating in an approved OMIC risk management activity. Courses are listed here and on the OMIC web site, www.omic.com.

Contact Linda Nakamura at (800) 562-6642, ext. 652, or lnakamura@omic.com for questions about OMIC's risk management programs or to register for online courses.

Upcoming Seminars

January

10–11 *Malpractice Claim Studies*
Northern Virginia Academy of Ophthalmology; McLean, VA; Date and Location TBA; 6:00 pm. Contact Linda Nakamura at OMIC Risk Management (415) 202-4652.

12 *Malpractice Claim Studies*
Washington DC Metropolitan Ophthalmological Society;* Acadiana Restaurant, Washington DC; 6:30 pm. Register at info@wdcmos.org.

14 *Malpractice Claim Studies*
Connecticut Society of Eye Physicians;* Aqua Turf Club, Plantsville, CT; Time TBA. Contact Debbie Osborn at (860) 567-3787.

22 *Malpractice Claim Studies*
Ohio Ophthalmological Society;* Hilton at Easton, Columbus, OH; Time TBA. Contact OOS at (614) 527-6799 or tbaker@ohioeye.org.

February

5 *Risk Management Seminar*
Illinois Assn of Ophthalmology;* Stephens Conference Center, Rosemont, IL; 11 am–noon. Contact IAO at (847) 680-1666 or http://www.ILeyeMD.org.

March

4 *Risk Management Seminar*
New England Ophthalmological Society;* John Hancock Hall, Boston, MA; Afternoon Session. Contact NEOS at (617) 227-6484.

28 *Malpractice Claim Studies*
American Society of Cataract & Refractive Surgery; San Diego Convention Center; 1:00–2:30 pm. Register at www.ascrs.org.

28 *Role of Office Staff in Medical Malpractice Lawsuits*
American Society of Cataract & Refractive Surgery; San Diego Convention Center; 3:00–4:00 pm. Register at www.ascrs.org.

March/April

30–3 *Risk Management Seminar*
American Assn for Pediatric Ophthalmology & Strabismus;* Manchester Grand Hyatt, San Diego, CA; Date and Time TBA. Register at www.aapos.org.

OMIC will be closed December 24 and 31 and will operate on a dramatically reduced schedule responding only to urgent matters December 27–30. If you have an urgent matter and must speak to a staff member during the holidays, please call (800) 562-6642, ext. 609, and leave a message. Staff will check this message line throughout the week and return urgent calls in a timely manner. Non-urgent calls will be returned on Monday, January 3. The OMIC staff wishes you and your family a safe and happy holiday.