Facilitator’s Guide

Target Audience: This case is designed to be used by medical students during their third-year psychiatric clerkship. (It can also be used during a fourth-year elective rotation focused on geriatric psychiatry or geriatric medicine.) It can be taught in a group of up to 20 students at a time, but is probably best suited for a group of 8 – 12.

Facilitator: It can be taught either by an attending physician, or an appropriately trained senior resident (e.g., the chief residents). The facilitator’s role is to walk students through the case using a Socratic dialogue seminar format, allowing students to answer questions, correcting mistakes, and guiding the discussion.

Credit is based upon active participation in the small group during the PBL case discussion. Each of the three parts can be covered in 20 – 30 minute intervals, for a total of 1.0 to 1.5 hours of instruction and active learning.

Learning Objectives: at the end of the case discussion, the medical student should be able to demonstrate the following:

Knowledge
1. Understand the core symptoms of Alzheimer’s disease and other forms of dementia. (Part 1, q 1 – 3.)
2. Appreciate the distinctions between various subtypes of dementia, and develop a differential diagnosis for elderly patients presenting with cognitive impairment. (Part 1, q 1 - 3)
3. Explain the role of historical, clinical, neuroradiological, and neuropsychological tests in making the diagnosis of dementia. (Part 1, q 2)

Skills
1. Recognize potential signs of elder abuse. (Part 2, q 2)
2. Appreciate the specific psychosocial vulnerabilities inherent in geriatric populations. (Part 2, q 1, 3)
3. Recognize that elder abuse can come in many forms (e.g., not just limited to physical abuse or neglect, but can include things like financial abuse or subtle forms of manipulation). (Part 2, q 2, Part 3)
4. Recognize when conservatorship may be appropriate for an elderly patient with cognitive impairments. (Part 3, q 1, 3)

Attitudes
1. Demonstrate the appropriate threshold of suspicion for reporting elder abuse. (Part 2, 3)
2. Recognize that a physician has a duty, under law, to report suspected elder abuse in a patient. (Part 3, q 1,2)
3. Demonstrate empathy and compassion for the unique situation of someone in the early or mid-stages of dementia. Appreciate the difficulties and challenges for the individual, family, and society, of assisting those with Alzheimer’s disease. (Part 1, Part 3)
4. Demonstrate an appreciation for, and ability to recognize, the common phenomenon of “caregiver burnout”. (Part 3, q 3)

### Facilitator’s Teaching Guide

**Part 1 Talking Points for Discussion, and “Take Home” Learning Points:**

- The differential diagnosis for cognitive impairment in a case like this can be extensive, including several psychiatric conditions (e.g., dementia, depression, delirium), conditions secondary to general medical conditions (e.g., hypothyroidism), several neurological conditions (e.g., CVA), or substance-induced or substance-related conditions (e.g., various alcohol-related cognitive disorders such as Korsakoff’s syndrome). For purposes of the case presented here, the most likely conditions is major depressive disorder and/or one of the dementias.

- Primary dementia would be a diagnosis of exclusion, made only after disorders secondary to general medical conditions, substance-induced disorders, or other neurological disorders are ruled out. Screening labs, including B12 and Folate levels, TSH, and syphilis screening, electrolytes and CBC are warranted here. Head imaging is also indicated to rule-out CVA or other neurological processes. Neuropsychological testing can be helpful for determining dementia and differentiating subtypes, but the diagnosis can also be made by a thorough case history and clinical presentation, with basic cognitive testing (MMSE or MOCA) in the clinic.

- Pharmacological treatment for dementia does not reverse the process of cognitive decline, but can slow the rate of progression. Treatment includes acetylcholinesterase inhibitors (e.g., donepezil) or NMDA receptor antagonists (e.g., memantine). The former are FDA approved for all stages of dementia, and the latter for moderate to severe stages of dementia.

- Based upon history and mental status exam, this woman does not appear to be suffering from depression. However, it is important to note that depression in the elderly often presents with symptoms that can be mistaken for delirium (e.g., poor concentration or other cognitive symptoms of depression can look like memory impairment). Individuals with delirium have high rates of co-occurring depression, which may be superimposed upon the delirium.

- When depression is found to be present in a patient with underlying demential, pharmacological treatment for depression should be initiated once other disorders are ruled out. SSRIs with low protein binding (e.g., escitalopram) are useful for elderly patients that are concurrently taking several other medications. Antidepressants with anticholinergic properties, e.g., the family of tricyclic antidepressants, should be avoided in favor of “cleaner” agents such as SSRIs, SNRIs, Mirtazepine, or Buproprion. As with most elderly patients, the dosing strategy should be to start at a low dose and titrate slowly, monitoring closely for adverse effects.
Parts 2 and 3: Talking Points for Discussion, and “Take Home” Learning Points:

☐ In addition to attending to her cognitive problems, the physician has responsibilities to take into account and address her psychosocial difficulties, which in this case are closely bound up with her cognitive difficulties. Assessing the safety and suitability of her living condition is an important part of the physician’s psychosocial assessment (and not an issue that can be entirely relegated to a case manager or social worker, even when such staff are available). The physician must assess not just her cognitive or neuropsychiatric condition, but also the ways in which such impairments are affecting her daily functioning.

☐ A patient that lacks the ability to adequately provide food, clothing, or shelter for herself (or avail herself of resources to do this) due to a medical or neurological condition is legally considered “gravely disabled”. Most states have legal measures in such cases to allow family members or friends to take on the role of conservator and assist the patient. The process for assigning a conservator is often triggered by a medical evaluation, and clinicians should be familiar with their state’s process in regards to conservatorships, in order to advise families regarding how to proceed.

☐ Capacity is the ability to understand and rationally appreciate the risks, benefits, and alternatives of a proposed treatment, and to thereby freely consent or refuse such treatment. Capacity is presumed to be present until proven otherwise; capacity is necessary for the process of free and informed consent to occur. Capacity and the process of informed consent are treatment and decision specific: the higher the risks, the more extensive the informed consent process needs to be.

☐ Competence is a legal judgment that a patient lacks capacity (though often in the literature the terms capacity and competence are used interchangeably). Capacity can and should be assessed by any physician – indeed, such an assessment is implicit every time informed consent is obtained.

☐ When a patient is incapacitated, a surrogate decision maker is required to consent for procedures. The surrogate can be designated in advance via a legal instrument (durable power of attorney for healthcare, or advance directive). If this is not available, the next of kin (spouse, children, parents) or someone else who knows the patient is designated as a proxy.

☐ Whenever possible, the “substituted judgment” criteria should be used by a surrogate decision maker: what would the patient have wanted in these circumstances, if he could speak for himself. This is ascertained by considering prior expressed wishes, and the patient’s overall life values and decisions. When substituted judgment is not possible (i.e., it’s not clear what the patient would have wanted in such circumstances), the surrogate in conjunction with the physicians should act according to what they deem to be in the “best interest” of the patient.

☐ Elder abuse is a common and often unreported problem. It can take many forms beyond physical abuse. Neglect and financial abuse are common and growing problems in our society, particularly with aging demographics. As with child abuse, physicians are mandatory reporters of elder abuse: if abuse is suspected, physicians have an ethical and legal obligation to report this to the local Adult Protective Services agency. As with child abuse, proof that such abuse is occurring is not necessary in order to report. The
investigation is the responsibility of the APS agency, whereas the physician’s responsibility is to report whenever suspected, and to cooperate with the agency if an investigation into the situation is warranted.

☐ As with reporting of child abuse, the physician is legally protected when he or she reports suspected elder abuse in good faith, even if it is eventually discovered that such abuse is not in fact occurring. Therefore, the rule of thumb is to “err on the side of over-reporting” of abuse or neglect: whenever suspicion is raised, a call to APS is warranted. This grows out of the ethical duty of the physician to protect his or her patient from harm.

☐ When family members are acting as primary caregivers for elderly individuals, the physician should be attentive to the problems of “caregiver burnout” that often occur due to the stress and strain of the caregiving role. Resources and options for providing care should be discussed on a routine basis with incapacitated patients and their caregivers.
Case: Part 1:

BJ is a 73 year old Caucasian female with no prior psychiatric history, who is brought to your outpatient psychiatric clinic by her only daughter, who is concerned about the patient’s memory problems. The patient, who is widowed and lives alone, initially stated that she does not think she needs to see a doctor: “What is all the fuss about? I’m fine.” The daughter, who lives in New York, reports that she has been in California visiting her mother for two weeks, and has noticed that “she’s just not the same person anymore.” The daughter has noticed that while her mother’s memory of distant events is remarkably intact (she can tell stories of her youth with great detail included), she often cannot recall things that happened earlier in the day, or a few days before. “She’ll forget things I just told her a few minutes ago, and ask me the same question three times in ten minutes,” the daughter says. The daughter was also concerned about the state of her mother’s house, which was quite disheveled and dirty when she arrived. She reports that her mother used to be very organized and meticulous about cleanliness, but now her house is a mess, and “I have to remind her at times to eat.” She says it appears her mother has lost weight, though the patient denies this. The daughter reports also that the patient is more irritable and short-tempered than usual.

The patient denies feeling depressed, and reports that her appetite is normal and she has no problem sleeping. She admits that while she used to enjoy gardening, she does not do it much anymore, but cannot explain why. She admits also that her energy level has declined over the past year: “I am getting older, you know.” She does miss her husband, who died four years ago, but says, “The nice young man down the street comes by from time to time to keep me company.” The remainder of her psychiatric and medical review of systems was unremarkable. She scored a 20/30 on the Mini Mental State Exam (missed 3 on short-term recall, 2 on orientation to place, 2 on orientation to time, 1 on past presidents, and 1 on three-step command; 1 on copying a design and 1 on writing a sentence).

The patient is on Lipitor for hypercholesterolemia, but otherwise is not being treated for any medical conditions. Her family history is significant for hypertension in her mother, and a paternal aunt who may have had a “nervous breakdown” (the patient or daughter cannot elaborate upon this).

Part 1 Discussion Questions:

1. How do you explain the patient’s cognitive impairment? Create a differential diagnosis for this presenting problem.
2. Are there further psychological tests that need to be ordered prior to making a diagnosis? Is there more history that it is necessary to gather?
3. Would you order any structural or functional neuroimaging exams? If so, which ones and why? What labs should be ordered?
4. Would you initiate pharmacological treatment at this time? If so, with what agent?
Part 2:

A head CT that you order shows enlarged ventricles and widened sulci, but is otherwise unremarkable. A basic metabolic panel, thyroid function cascade, complete blood count, and B12 level all are within the normal range. At the first visit, you initiated treatment with donepezil (Aricept).

The patient misses her first follow-up appointment two months later, and so it is four months before she returns to your clinic, at the urging of her daughter. Knowing that she no longer drives, you ask how she got to the clinic, and she says that the “nice young man who lives down the street” dropped her off, and that she will catch a bus home. This person is not available for you to talk to, but the patient reports that “Dan started coming by my house after my husband’s death. After a few visits, he offered to go grocery shopping for me – all I have to do is give him my bank card and the PIN number, and he takes care of it…. He’s so sweet.” You enquire about how much money she has in the bank; the patient is not sure, but says that her husband, who was a successful business man, “left me enough to live very comfortably for a long time… I don’t really know, since Dan pays all my bills for me.” The patient, who only has one daughter, is considering writing the young man down the street into her will. “He suggested it, and I don’t see why not… he’s such a nice fellow, and there’s plenty to go around.”

On MMSE, her score has dropped to 18 (missed an additional point on orientation to time and three step command). Her sleep, appetite, energy, and level of activity are unchanged since her first visit. When asked whether she is taking her Aricept, the patient claims that you never prescribed her a medication. On mental status exam, she appears somewhat more disheveled and poorly groomed compared to the first visit. On physical exam, her heel-to-toe gait is somewhat unsteady, and finger-to-nose motor movements are mildly impaired.

Part 2 Discussion Questions:

1. Is the patient, in your judgment, currently able to care for herself living alone at home? If not, what other options should be discussed with the patient and her daughter?
2. Are you concerned about Dan’s involvement in the patient’s life? If so, why? What should you do to address these concerns?
3. Describe the various forms that elder abuse can take. If a physician suspects that his or her patient may be the victim of elder abuse, what is the physician required to do? What are the potential legal ramifications if the physician is wrong about the suspected abuse?
Part 3:

After placing a report to Adult Protective Services regarding potential financial abuse of the patient, you contact her daughter in New York (with the patient’s permission) to discuss your concerns about her living situation, lack of medication compliance, cognitive and functional state, and the potential elder abuse. The daughter flies out the following week, and accompanies the patient to a follow-up visit.

During the visit, the daughter expresses concerns that the patient can no longer manage her own finances. The patient adamantly disagrees, and defends Dan’s role in her financial affairs. The patient also reports that she does not want to take the medication you recommend because, “I am just fine.” When confronted by her daughter with the reality of her memory loss, the patient becomes defensive and irritable. “I raised you, and now you are treating me like I am the child!” When the daughter suggests that the patient move into a facility where she can have more assistance with basic activities of living, the patient responds, “I’ve lived in that house for thirty years, and I’m not about to move out now.” The daughter reports that moving her family from New York in order to care for her mother is not feasible at this time, and asks you what options are available to help her mother if she refuses to make sound decisions regarding her finances, medical and mental health care, and living situation.

Part 3 Discussion Questions:

1. Are there legal options available that would allow the patient’s daughter to make financial, medical, or living situation decisions on behalf of the patient? What is the next step to initiate this process?
2. Is the potential problem of financial abuse relevant to the question of the patient’s decision-making capacity? What role do you, as the physician who has evaluated her cognitive status, play in this process?
3. Other than her cognitive impairments, what additional stressors is the patient currently experiencing? If her daughter did attempt to move in and care for her, what stressors might she experience as her mother’s disease progressed?

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