COGNITIVE DISORDERS:

A FORGOTTEN SOURCE OF PHYSICIAN IMPAIRMENT

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Agenda Questions

- In addressing cognitive disorders, what are the key terms and general concepts that clinicians need to know?
- What are major DSM-IV diagnoses that present with cognitive deficits?
- How does one screen for cognitive deficits?
- What are the indications for a referral to a neuropsychologist for formal assessment of cognitive functioning?

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- How can neuropsychological testing assist in FFD evaluations?
- What issues face the aging population of physicians?

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II. Definition of Key Terms

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Framework for Understanding Disorders of Cognition

- Chronic dementias
- Acute and subacute conditions:
  - Delirium (days, weeks or months)
  - Toxicity (intoxication)
  - Withdrawal (acute)
- Intermediate conditions:
  - Protracted withdrawal syndromes

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Cognition

A general term:

- Encompassing all the various modes of knowing and reasoning
- The mental process of comprehension, judgment, memory, and reasoning
- Intellective functions in contrast to emotional processes

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Dementia

- A cognitive disorder characterized by defects in memory, aphasia, apraxia, agnosia, and executive functioning.
- Replaces Organic Brain Syndrome
- DSM examples include: Alzheimer's Disease and other neurodegenerative disorders; HIV infection; head trauma; drug, medication, toxic exposure; other medical causes

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- Aphasia (language disturbance)
- Apraxia (impaired ability to carry out motor activities despite intact motor function)
- Agnosia (failure to recognize or identify object despite intact sensory function)
- **Executive functions (planning, organizing, sequencing, abstracting)**
- **Change of personality**

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Delirium

- Disturbance of consciousness and a change in cognition
  - that develops over a short period of time
  - is not accounted for by dementia
  - due to general medical condition, substance induced, other, NOS

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Ageism

- Age discrimination
- Negative stereotyping of an individual or groups because of their age resulting in discrimination and subordination
- Politically incorrect
- Illegal in business and professional settings

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"Pseudodementia"

Cognitive impairments due to Major Depressive Episode:

- Cognitive symptoms mimic dementia: problems with memory, difficulty thinking and concentrating and overall reduction in intellectual abilities.
- Typically, associated with a relatively normal premorbid state and abrupt cognitive decline v. dementia in which, typically, there is a premorbid history of declining cognitive functions.

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Challenges in Diagnosis

- In the elderly, cognitive deficits can be the result of either pseudodementia or dementia, or both.
- Therapeutic medications can have positive effects as well as negative side effects on cognition. Is the cognitive impairment:
  - due to the underlying depression?
  - or, due to medication effects?
  - or, due to both?

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III. DSM-IV Diagnoses Associated with Cognitive Deficits

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Cognitive Disorder Not Otherwise Specified

Disorders characterized by cognitive dysfunction *presumed* to be due to the direct physiological effect of a general medical condition that does not meet criteria for specific deliriums or dementias.

Example: Mild neurocognitive disorder as evidenced by testing or clinical assessment

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PTSD & Cognitive Deficits

- The essential feature of PTSD is the development of characteristic symptoms following (direct or indirect) exposure to an extreme traumatic stressor…
- Research shows that PTSD can cause brain changes that can change personality and cause cognitive deficits that appear late in the time course of the condition and worsen over time.

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Major Depressive Disorder

- “Psuedodementia”: Cognitive deficits are associated with severe depression, especially protracted severe depression
- Can be +/- reversed with treatment
- Watch for comorbid substance use and poor nutrition that can cause or contribute to cognitive deficits
- May be complicated by medication and ECT

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Dementia Due to Head Trauma Traumatic Brain Injury (TBI)

- When related to combat, cognitive deficits can be complicated by emotional factors (PTSD)
- Rule out comorbid alcohol and substance abuse
- TBI can result from repeated minor head traumas with no loss of consciousness

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Dementia of the Alzheimer’s Type

- Development of multiple cognitive deficits manifested by memory impairment and other cognitive disturbances
- The course is typically gradual onset with continuing decline
- Diagnosis based on R/O other etiologies
- Evolving concepts based on research findings:
  - Diabetes Type II is a risk factor
  - Cognitive stimulation (in early and midlife) can lower brain deposition of the major protein component of amyloid plaques.

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Dementia Due to HIV Infection

- HIV virus has a predilection for CNS cells
- Mood and cognitive disturbance may be the first and primary symptoms
- Dementia can be caused by:
  - Infection of CNS
  - Opportunistic CNS tumors or other infections

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Dementia Due to Parkinson's Disease

Slowly progressive neurological condition characterized by tremor, rigidity, bradykinesia, and postural instability

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Parkinson's Disease: Typical Presentation

- Motor slowing, rigidity, and tremor
- Micrographia, mask-like faces, lack of associated movements
- Dementia:
  - Occurs in 20-60% of Parkinson patients
  - Executive dysfunction with memory retrieval impairment
  - More likely to present in older individuals and those with more severe/advanced disease
- Oftentimes associated with depression (~40%)

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Dementia Due to Hep. C Infection

- Can be associated with the following:
  - effects of virus on brain cells
  - liver failure
  - effects of curative treatments (interferon)
- Hep C can be asymptomatic
- Hep A & B can be prevented with vaccination, but not Hep C

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DSM-IV Substance-Induced Persisting Dementia

- Cognitive deficits of the dementia type persist beyond the usual duration of intoxication or withdrawal.
- Cognitive deficits are etiologically related to the persisting effects of substance use, even after the substance use has ceased.
- Examples of toxins include alcohol; inhalants, sedative, hypnotics, and anxiolytics; marijuana
- Paradoxically, symptoms may worsen with cessation of the substance.

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Protracted Withdrawal Syndrome

- For example, acute alcohol withdrawal is typically complete within a week to 10 days. Protracted withdrawal can last from months to years.

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Other Etiologies of Dementia

Systemic conditions:
- Hypothyroidism
- Vitamin B-12 deficiency
- Folic acid deficiency
- Niacin deficiency
- Hypercalcemia
- Neurosyphilis

Treatable

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Prevalence

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Take-Home Points

- PWBCs & mental health professionals need to know:
  - general indicators of cognitive impairment and what to look for in an evaluation
  - when to refer to a neuropsychologist
- Consider cognitive disorders in your rule/out differential.
- Look for comorbidity & multifactorial causation
- Can be combined types (acute and chronic)

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- Organic changes in the brain can cause changes in personality:
  - Emotional conditions (PTSD; depression)
  - Toxins (alcohol and drugs, esp. if chronic and heavy use)
- Early detection of cognitive deficits: Look for subtle and atypical presentations
- Find appropriate treatment resources
- Think out of the box; keen observation

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IV. Screening for Cognitive Deficits

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Central Nervous System

- Cognition
- Mood and affect
- Behavior
- Movement
- Personality

- Exaggerated or retarded effects on normal functions or abnormal manifestations

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Cognitive Deficits: Clinical Presentation

- Can be difficult to recognize in intelligent, well educated, verbally adept professionals
- "Denial" may represent:
  - Genuine lack of awareness
  - Deceptive cover over to preserve practice or avoid consequences
  - Unconscious defense against feeling overwhelmingly upset
- History of red flag conditions: Drugs; alcohol; trauma; metabolic illness; neurodegenerative disorders associated with the aging process; mental illness ("pseudodementia" of depression; chronic PTSD)

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Cognitive Deficits: Evaluation Process

- Can require in-depth clinical evaluation by single evaluator sensitive to subtle cues
- Application of screening tools
- May require collaborative input from other specialists:
  - Neuropsychological evaluation by expert who understands medical systems
  - Neurologist
  - Primary care physician

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Screening Methods: Clinical History

Reynolds structured interview & MSE:

- Discrepancies/inconsistencies between history and records
- Conversational cognitive slippage (sequencing, chronologizing)
- Mistakes, loses things, and problems following directions

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Screening Methods: Screening Tests

- Caldwell MMPI
- MicroCog
- Mini-mental status exam
- Others

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MicroCog: Screening Tool

- Useful as a screening tool to assist in determining which examinees should be referred for complete neuropsychological testing evaluation.
- Can be administered by non-professionals who are not neuropsychologists.
- Computer administered: Requires the examinee to be comfortable with computer use.
- Measures multiple cognitive functions.
- Automatic computer scoring immediately available on completion of test
- Reasonable cost

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MicroCog: Limitations

- Although there are physician-normative data for an earlier version of the MicroCog, these data cannot be directly applied to the published version, which is normed on a different sample.
- Has not been widely studied. Need more research to determine its utility regarding competency to practice medicine.

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V. Referral for Neuropsych Testing

- What are the indications to refer?
- When to refer?
- How to make the referral?

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Indications for Neuropsychological Testing
(LL Thompson)

- Detection of subtle (but professionally significant) impairments in highly functioning professionals that are not picked up by other evaluation methods.
- Differentiate depression from dementia.
- Evaluation of behavioral manifestations of neurological disease (e.g., Parkinson's Disease), systemic illness (e.g., chronic obstructive pulmonary disease), or substance abuse/ dependence in order to determine safety to practice.

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- Monitor mental functioning in the presence of expected recovery from illness (e.g., stroke) or injury (traumatic brain injury) in order to help determine safety to practice.
- Monitor progression of cognitive impairment in chronic illnesses (e.g., multiple sclerosis) to determine safety to practice.

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Indications to Refer:
Clinical indicators of Cognitive Deficits

- Errors (verbal instruction; casual conversation; serious conversation; written instruction; directions)
- Can't focus; loses the point (tangential, circumstantial); things don't add up or make sense
- Inconsistencies/discrepancies:
  - Internal (story changes)
  - External (compared to records)
- Forgetting
- Loosing things
- Lack of awareness of the above; lack of concern when pointed out

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Indications to Refer: Results from Screening tests

- MicroCog
- MMPI
- Mini Mental Status Exam
- Other

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When to test?

- Under best circumstances (delay until better)
- As is (now)
- Benchmarking with serial re-evaluations (unstable condition likely to improve or decline)

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Why test?

- Convince client and family of difficulty in order to help make decisions about treatment, FFD, …
- Establish baseline/ benchmark to compare:
  - Progress in recovery/treatment
  - Decline in functioning (e.g., neurodegenerative disorders)
- FFD evaluation

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Factors that can impact results

- Alcohol, drugs, medications
- Sleep deprivation
- Stress
- Acute illness
- Pain
- Test anxiety
- Depression

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Conditions of Evaluation

- What are the referral questions?
- Who gets the report?
- What is the nature of consent?
- Who pays for the evaluation?
- Is there an option for second opinion?

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Reynolds Referral Template

See Handout

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Confidentiality/Consent Issues

- CMIA:
  - Send letter of referral in advance of the first meeting
  - FFD: Yes or No (and functional limitations)
  - Limited consent (relevant to referral questions and issues of employment)
  - Broad consent (to treater)
- Federal:
  - ADA (work function limitations & accommodations)
  - Protection for release of drug & alcohol records

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VI. Role of the Neuropsychologist in Evaluation of Cognitive Disorders

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Tasks

- Define the nature and extent of deficits
- Assist with diagnosis
- Assist with defining limitation & accommodations
- Offer treatment & remediation recommendations
- Offer prognosis
- Assist with FFD determination
- Determine the need for re-testing at later date

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Domains Assessed

- Pre-morbid Ability
- Language
- Visual Perceptual/Spatial
- Attention/Executive
- Learning/Memory
- Sensorimotor
- Emotion/Personality

Criteria for Selecting Neuropsychologist

- Certification
- Experience:
  - Evaluation of physicians
  - Familiarity with medical systems and cultures
- Fair-minded
- Collaborative with referring clinician

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- **Ability to translate test findings into determinations about (FFD) suitability to work and safety to patients.**
- **Writes good reports that are understandable to non-neuropsychologists and legally defensible; no cookie cutter or one size fits all approaches**

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VII. Fitness-for-Duty Determination

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FFD Questions to be Answered

FFD issues:

- Safety to practice?
- Need for treatment/remediation?
- Limitations?
- Accommodations?
- Monitoring?
- PWBC assistance, or discipline, or both?
- MEC necessity to report to the MBC?

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Confounding Factors

- Cognitive deficits may be reversible over time, especially with treatment
- May not be disabling depending on the nature of practice and accommodations
- May worsen over time despite "treatment"

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Challenge of FFD Decision Making

- Easy case (serious deficits or none)
- Difficult case (borderline/marginal), possible options:
  - Competency evaluation, simulated cases
  - Proctoring
  - Serial re-evaluations

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FFD Considerations

- If RTW, is there a danger to the health or wellbeing of the physician?
- If not RTW, is there a danger to the health or wellbeing of the physician?
- In particular, is there a risk of suicide?
- FFD report analysis: Individualized; not one size fits all

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Assistance v. Discipline

- Roles of medical staff committees:
  - MEC (discipline)
  - PWBC (assistance)
- Medical board reporting issues (legal counsel)

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Role of PWBC in Offering Assistance

- Do the PWBC members have the skill sets to conduct in-house monitoring?
- Should the PWBC serve an oversight function and refer to an external professional monitoring program?

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Questions/Issues

- Against what population norms have the test results been scored?
- Should FFD evaluations always screen for cognitive deficits?
  - And if so, what screening tools/methods should be utilized?
- If cognitive deficits are present, what are the indications for ordering a clinical competency exam?
  - How long has the physician been out of practice?

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Resources

- FSMB policy on Physician Impairment, 2011, section & others: www.fsmb.org/pdf/grpol_policy-on-physician-impairment.pdf
- FSPHP policy: www.fsphp.org/publications.html
- ADA: www.ada.gov
- CMA: www.cmanet.org

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VIII. AGING PHYSICIANS & RETIREMENT

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Ageism

- Age discrimination
- Negative stereotyping of an individual or groups because of their age resulting in discrimination and subordination; coined by Neil Butler in 1968
- Politically incorrect
- Illegal in business and professional settings

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DSM-IV 780.9 Age-Related Cognitive Decline

The focus of clinical attention is an objectively identified decline in cognitive functioning consequent to the aging process that is within normal limits given the person's age. Individuals with this condition may report problems remembering names or appointments or may experience difficulty in solving complex problems; not attributable to a specific mental disorder or neurological condition.

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Questions

- At what point does “normal” aging cross over into suboptimal performance and impairment?

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Attitudes toward Older Physicians

Ageism: Cultural attitudes and devaluation of the older generation; prejudice

- No natural role or place: Not revered or have it easier as we get older
- Attitude of natural selection: Survival of the fittest
- Squeeze out the dinosaurs

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Realities of Aging

- Decreased mental acuity and physical energy
- Age and shift work: Decreased stamina and resiliency with each passing decade
- Challenges of learning new information and applied technologies
- Cognitive issues and impairment
- Physical issues and impairment
- Range of individual responses to aging. No one size fits all.
- Context: Physician shortage

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Value of Older Physicians

- Value relationships with patients
- Wisdom & perspective

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Impact on Older Physicians

- Disenchanted
- Low professional esteem
- Low self-esteem and depression
- Empty nest and family issues (self-neglect and sacrifice for professional needs at the expense of family and personal relationships)
- Isolation
- Suicide

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Checks and Balances

Education:
- CME professional development courses
- Retooling: Fellowships

Competency evaluation:
- Specialty Board Recertification

Fitness-for-duty evaluation:
- Physical
- Psychiatric
- Neuropsychological

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Options

- Transitional options within medicine as move toward retirement:
  - Self-limit practice: scope, hours
  - Committee work
- Alternative non-medical options:
  - Teaching outside medicine
  - Volunteer work
  - Avocations: writing
  - Recreation
- Resources: Financial planning and consultation; readjust priorities; acceptance of limits
- Opportunity for new and different life (anxiety & rewards)

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Laws

- California Fair Employment & Housing Act: Forbids unlawful discrimination against persons age 40 and older.
- Federal Age Discrimination and Employment Act of 1967: Prohibits employment discrimination based on age with respect to employees 40 years of age and older.
- ADA: focus on abilities v. disabilities

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"So *Little Time*"

Ralph D'Ambrosio

So little time ... to make amends,
Or seek out some forgotten friends;
To say "I'm sorry," if you were wrong,
To smell a flower, or sing a song.
So little time ...

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