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Ophthalmic Risk Management Digest

OMIC DIGEST

Older Patients Need Additional Informed Consent Consideration

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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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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?

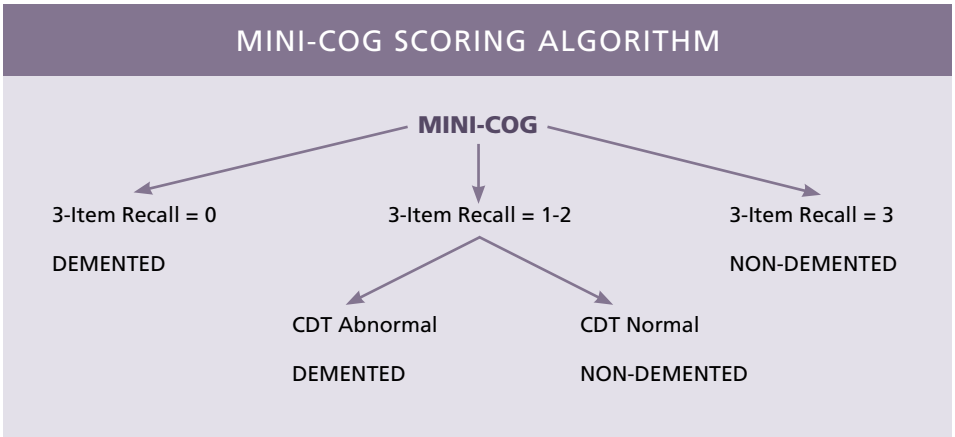
In addition to getting input from family members, physicians can use screening tools. Dr. Williams presented two brief screening methods, either of which can be utilized by ophthalmologists in a matter of minutes. The first is called the "Mini-Cog." Ask the patient to repeat and remember three words: 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.



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

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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).