DEMENTIA–ETHICAL AND LEGAL IMPLICATIONS IN PSYCHIATRIC MEDICAL ASSISTANCE. CASE REPORT

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DEMENTIA-ETHICAL AND LEGAL IMPLICATIONS IN PSYCHIATRIC MEDICAL ASSISTANCE (CASE REPORT) (Abstract)*:* In psychiatric pathology, patients suffering from dementia are part of the vulnerable population category. The Universal Declaration of Human Rights and the law of mental health and psychiatric disordered patient's protection brings new changes for patients that temporarily lack decisional ability, by adding the notion of conventional representative. The purpose of this research paper is to present and evaluate the necessity of conventional representation, in the case of a patient diagnosed with medium-severe stage mixed dementia. This case is representative of the many cases of dementia in clinical practice that raises many ethical and legal discussions, and for which the conventional representation may be a solution. **Keywords*:*** INFORMED CONSENT, CONVENTIONAL REPRESENTATIVE, DEMENTIA.

Dementia constitutes a class of neurodegenerative disorders characterized by persistent and progressive alteration of cognitive functions, ascending to disability and premature death. The most common cognitive functions affected in dementia are memory, attention, orientation, language, thinking and judgment (1).

Due to this impairment of the ability of logical thinking and understanding of the patient with dementia, especially in the early stages of medium and severe illness, the question is whether to fully inform the patient about the necessary investigations required for diagnosis, the application of therapeutic methods and about performing the medical interventions necessary for restoring personal autonomy. In this situation, a person with difficulties in assessing the consequences of a decision that impacts himself can benefit from the assistance of a legal or conventional representative, that can provide a valid, informed and documented consent. Conventional representatives are people with full legal capacity, designated by the patient, that have the full legal and mental capacity to assist the patient and to represent him during medical treatment.

The legal representation will be achieved through the signing of an agreement by the patient – following a model made available by the health unit, under conditions that follow the law.

If the hospitalized person was declared as lacking decisional capacity, it will have the support of the legal representative, appointed according to law. If the patient

does not have a legal representative or has not appointed a conventional representative due to lack of mental capacity, the health unit is obliged to immediately notify the guardianship authority to establish protection measures (4-6).

CASE REPORT

The case presented below relate to patient of 58-years-old, male, from a rural area, grade 3 medically retired, having secondary education, married.

Patient presents to a doctor's office, at the "Socola" Institute of Psychiatry, in Iasi, with her daughter, with symptoms manifested by partial space-time and auto and allo-psychically disorientation, bradypsychia, psycho-cognitive slowness, episodes of confusion and anxiety, hypo-amnesic fixation and evocation, spontaneous and voluntary hypoprosexia, depressed mood, psycho-emotional lability, tearfulness.

The doctor communicated to the patient and its accompanying daughter the need for hospitalization for diagnosis and treatment plan. He presents and explains, in clear language, comprehensible to the patient, the elements of informed consent, that the patient accepts by signing the consent to admission to the "Socola" Institute of Psychiatry in Iaşi.

General history

From the patient's statements, his mother deceased at 70-years-old, showing elements of dementia syndrome (space-time disorientation, stopped recognizing family members) in the later years of her life.

Chest effort angina. Myocardial stroke, chronic stage. Stage II, grade 3 essential arterial high blood pressure, high additional risk. Grade II obesity. L4-L5 operated herniated disc. Headache syndrome. Vertiginous syndrome.

Lives at home, with his wife, non-smoking, denies alcohol consumption.

Disease history

The patient first presented at the "Socola" Institute of Psychiatry in Iasi, in 2011, for depressive symptoms, manifested by depressive mood, demobilizing ideations, pessimistic, bradypsychia, bradyphrasia, bradykinesia and mixed insomnia. At that moment, he was showing a slight cognitive deterioration (MMSE=26 points). Given the symptoms, the patient receives antidepressant treatment, with neurotrophic and neuroprotective medication.

Subsequently, he is overseen through the territorial network of psychiatry, his condition being relatively good and stable. Approximately 6 months ago, the depressive symptoms began to reappear, alongside with a dementia syndrome (partial space-time disorientation, attention and memory deficits bradypsychia, paraphrasia, dyspraxia), due to which the patient presents himself, along his family, at the hospital, for clinical and therapeutic reevaluation.

Clinical and psychiatric examination

Good general condition, grade II obesity (BMI=36 kg/m^2), abdomen increased volume due to fat tissue, lumbar postoperative scar (L4-L5).

Psycho-diagnosis of expression. The patient has a cooperative attitude, hypomobile mimicry, reduced gesturing, depressive facial aspect, wrinkled forehead, omega-melancholic, lowered mouth commissures, mobile sight, intermissive eye contact with the doctor, feels the need to frequently gaze back to his daughter to receive help answering the questions or for confirmation ("the turn-head-back sign"),

low tone and intensity voice, clothing care and proper hygiene.

Cognitive functions. The patient presents hyperesthesia, with irritability and reduced tolerance to frustration, without perception disorders such as hallucinations during the examination. Attention reveals spontaneous and voluntary hypoprosexia, difficulties in focusing and evoking (incomplete auto-biography data such as "I don't remember where I had been working". "I don't know if I took my treatment" and "I don't know why I came here"). Thought reveals ideation and verbal slowness (bradypsychia), with episodes of confusion, decreased ability to abstraction, generalization and reasoning, decreased decisional capacity, impoverished thinking, auto-depreciative and demobilizing ideation, feelings of hopelessness. Low levels of imagination.

Affective and motivational functions. The patient manifests a depressive mood, tearfulness psycho-emotional lability, generalized anxiety, physical and mental asthenia, fatigue, anhedonia, apathy. Instincts highlight eating instinct disorders, with its reduction, sexual instinct disorders with decreased libido and an exaggerated defense instinct, manifested through the fear of disease.

Effector functions. His volition is manifested through hypobulia, with lack of initiative and capacity to act. Communication is difficult, with paraphrasia, answers questions with difficulty (due to the difficulty in remembering certain information). Verbal language disorders are present, such as dysphasia with verbal amnesia and paraphrasia. Motoric conduct reveals hypokinesia with slowness and episodes of psychomotor restlessness, bradykinesia. The patient presents hypnic disorders such as mixed type insomnias.

Synthesis functions. The patient is partially space-time oriented, auto and allopsychic, disease awareness is partially present, presents derealisation, depersonalization.

Psychological evaluation. Moderate psycho-cognitive deteriorative configuration with depressive manifestation in psycho-somatic and pre-involute context. MMSE=15 points (orientation –6 points, fixation memory–2 points (4 points after rehearsals), calculus=0 points, language=6 points).

Clinical explorations

Neurological examination conducted by the neurologist in the psychiatric hospital finds an intermittent L5 radicular syndrome (possibly remaining after surgery for L4-L5 disc herniation in 2013) and raises the suspicion of lacunar cortex and vascular dementia, a reason for which he calls for a CT examination. Treatment recommendations from the neurologist were: Actovegin 200 mg x 3/day, Milgamma N 1 capsule x 3/day, Cerebrolysine 10 ml 1 vial/day, 10 days, Aflanil 100 mg 1 capsule x 2/day.

Native CT examination performed in axial plain reveals: Cortical-subcortical cerebral atrophy, predominantly supratentorial. Stage 1 leukoaraiosis, ASC predominantly in the internal carotid system. Rare cerebral ischemic gaps are present. It also highlights the thickening of the mucosa in all levels of aerial paranasal sinuses. The procedure shows a mucosa polyp in the left maxillary sinus, with a diameter of approximatively 19 mm, for which an ENT consult is recommended.

The electrocardiogram recorded a sinus rhythm with a pulse rate of 83 bpm, a blood pressure of 130/90 mmHg and sequelae of lower myocardial infarction (of which the patient claims he suffered in 2011 – did not

submit supporting documents).

Blood and urine samples didn't highlight pathological changes.

Internal medicine examination established the following diagnoses: Painful chronic ischemic heart disease; Effort chest angina; Lower myocardial infarction in chronic stage; Grade II obesity; Stage 2, grade 3 arterial high blood pressure with additional risk; Cerebral hypo-perfusion in the ascendant basilar-vertebra system. Therapeutic recommendation was: Aspenter 74 mg/day, Noliprel 1 capsule/day, Nitromint 2.6 mg 2 capsules/day.

THE POSITIVE DIAGNOSIS

The positive diagnosis determined after the clinical examination and complementary investigations is: Severe dementia in medium-severe stage. This diagnosis is supported by both ICD-10 criteria as well as DSM IV.

ICD-10 criteria

Diagnosis is based on the presence of dementia (decline in memory and thinking that compromise personal activity). Memory deterioration typically affects recording, storage and playback of new information and is accompanied by a deterioration in thinking, reasoning and reduced ideation flow, spontaneous and voluntary hypoprosexia, consciousness is retained for at least 6 months. Impaired cognitive functions are usually unequally present with: memory loss, intellectual deterioration and neurological focal signs. Judgement and understanding can be relatively well kept. Associated features: hypertension, carotidal murmur, emotional lability with transitory depressive mood, explosive crying or laughter, transitory episodes of consciousness dizziness or transitory delirium. Personality is relatively unmodified or apathy or disinhibition changes may occur, increasing previous features such as: eccentricity, paranoid attitude and irritability (2).

DSM IV criteria

A. Multiple cognitive deficits, with manifestations in both sections below:

1. Memory deterioration (impairment of the ability to learn a new information or to recall a previously learned information);

2. One or more of the following cognitive disturbances:

- Aphasia (language disturbance);
- Apraxia (deterioration of the capacity to perform motor activities, despite the sensorial function being intact);
- Agnosia (inability to recognize or identify objects, despite the sensorial function being intact);
- Disturbance in the execution function (planning, organizing, sequencing, abstracting).

B. Cognitive deficits from A1 and A2 criteria both cause a significant deterioration in social and professional functioning and represent a significant decline from the previous level of functioning.

C. Neurological focal signs and symptoms (ROT exaggeration, pseudo-bulbar paralysis, walking abnormalities, decrease of muscular strength in an extremity) or laboratory data that indicate cerebral-vascular disease (multiple infarcts involving the cortex and underlying white matter), of which it is etiologically connected with the disorder.

D. The deficits do not occur exclusively during delirium (3).

TREATMENT

From 2011 to date (patient initially diagnosed with depressive disorder) he received the following treatment: Tianeptine

12.5 mg 3 capsules/day, Alprazolam 0.25 mg 2 capsules/day, Clonazepam 2 mg/day, Nicergoline 30 mg/day, MagneB6 3 capsules/day and regular cures with Cerebrolysine vial 5 mL, 1 vial/day, 10 days per month. During the hospitalization in 2016, in addition to the anti-depressant treatment, an anti-dementia therapy is initiated with Rivastigmina patch 5 mg/day. This treatment was increased after a month to 9.5 mg/day and Memantine 5 mg/day. Medication is increased step by step, with 5 mg/week until it reached 20 mg/day. Remaining are therapeutic schemas recommended by the neurologist and internist respectively, as previously mentioned.

The patient is referred for hospitalization and monitoring in the territorial psychiatry network where he belongs, recommending continuing the treatment initiated in the hospital, returning to hospitalization if necessary, as well as the beginning of procedures to establish social protective measures of which the patient benefits given the affection of personal, social and professional functioning (GAFS=28).

EVOLUTION AND PROGNOSIS

Negative prognosis factors, in this case, are: family history (mother with dementia syndrome), debut at a relatively young age (55-58-years-old), associated somatic affections (myocardial infarction, hypertension, ischemic heart disease, obesity, brain atrophy) and a relatively rapid evolution. Positive prognosis factors are represented by family involvement and support, appropriate treatment of the associated diseases as well as a good socio-economic condition.

The evolution of this case will largely depend on anti-dementia treatment which initially appears to be satisfactory, an improvement in cognitive functions and general mental state of the patient being observed during hospitalization. Generally, the evolution of patients with dementia receiving treatment is relatively stable or slowly progressive.

DISCUSSION

This case represents one of multiple cases of dementia that question the validity of informed consent to be hospitalized in a medical institution for evaluation and treatment. The dilemma that arises in this situation is if the patient with moderate-severe cognitive deterioration has the capacity to make the right choices, to participate in the process of evaluation and diagnosis communication and to accept subsequent therapeutic conduct at any time during these stages. For many patients with moderate stage dementia (MMSE=12-15), especially those with a vascular component, a variability in cognitive symptoms exists, which makes these patients to have a fluctuating decisional capacity. When this ability is integral, the patient can appoint a conventional representative that will assist him during hospitalization, informing him clearly about the legal limits of this representation.

In our case, the patient signed the informed consent, at under the law admission, without assigning a conventional representative. During hospitalization, the patient had numerous episodes of confusion with a decrease in abstraction, generalization and reasoning capacity and a reduction in decisional capacity, moments during which the patient was assisted and supported by his daughter, without bringing into discussion the signing of the conventional model to appoint his daughter as his representative. After approximately 10 days after admission, the patient stopped experiencing these episodes of confusion, com-

pletely regaining his decisional capacity. This is a typical case in which appointing a legal representative would have been useful by allowing the family to legally intervene on necessary decisions to be taken during hospitalization, in the patient's moments of confusion.

The new rules for implementing the law of mental health and protection of mentally disordered people, approved by Order No. 488/2016, entered force on May 4th, 2016, create the legal framework for the appointment of a conventional representative. Therefore, Annex 5 of the mentioned rules contains the model of the convention for these cases, clearly establishing the rights and obligations of both parties. This representation is done free of charge. The duration of the convention is agreed by both parties and both the representative and the person represented can unilaterally terminate it.

CONCLUSIONS

Thus, starting from this case report and given these new regulations, it is recommended to more carefully evaluate the decisional capacity of the patient, both during admission as well as its likelihood of evolution during hospitalization. Taking the example of our patient situation, in the cases where there is a suspicion of deterioration of the decisional capacity, besides informed consent, patients are informed of the possibility to appoint a conventional representative and they are presented with the conventional model of the present rules. By signing the informed consent and the agreement to appoint a conventional representative, the patient is protected and given the insurance that his wishes are respected, even in times of decisional incapacity.

In our case, the early diagnosis enable patient to actively and autonomously engage in decision-making, before this capacity starts to be affected by illness. This way, the information necessary to understand the symptoms is found out early, which allows taking decisions regarding the future, how medical and psychosocial nursing will be carried out and an improved quality of life.

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