

Ethical and medico-legal aspects of dementia

Dementia is a condition in which others often have to take responsibility for the patient's affairs.

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Geriatric psychiatry is one of the branches of medicine in which ethical issues are particularly prominent. Five main reasons have been identified that must be kept in mind as they may implicitly distort an argument without applying to the individual problem under discussion:^[1]

- The frequency of mental illness (especially of dementia) means that the question of competence often arises.
- Physical and mental illness and also the frailty accompanying normal ageing results in many elderly being to some extent dependent on others.
- Many illnesses, especially dementia, are incurable and thus decisions are made in the context of an expectation of progressive decline.
- Old people have long lives behind them, and have developed a complex personal identity based on past actions, preferences and relationships. Friends and family have knowledge of this identity and will attempt to preserve it when it is threatened by illness or the perceived desires of others.
- Old people, especially when ill, are often seen as being non-contributors to society. Resources which are used to help them are easily seen as wasted or charitably bestowed, rather than as an entitlement or natural consequences of their equal participation in society.

When it comes to dealing with ethical and legal issues in psychiatry there is, unfortunately, no ready check-list or algorithm. Doing the

right thing requires the art of good judgement, and judgement is not merely an intellectual process, nor is it based purely on feelings, sensations or intuition. Instead, it should be the product of well-balanced decision-making involving the health professional, the patient and society (Table 1).

Although ethical issues are implicit in most psychiatric encounters, they tend to become explicit when brought to the surface by conflict.^[2] Three groups of patients are usually involved: the mentally ill, the cognitively impaired (dementias), and the mentally disabled.^[3] Ethical questions concern patients' autonomy and rationality, quality of life, and to some extent, quality of death. Although there is no simple method of analysing ethical issues, there are three approaches that are complementary to each other.^[1]

Analysis of ethical issues

The patient's evaluation of a given situation needs to be integrated with the reality of the situation. The first approach, then, is one of perspective.

Perspectives

Any person's perception of reality is, to varying degrees, governed by four psychological functions: sensation assesses its face value, thinking recognises its intellectual meaning, feeling gives it emotional value, and intuition computes its origins and future direction.^[4]

In practice, therefore, realistic perspective is achieved by considering the full range

of relevant factors and interests through gathering the opinions from all those concerned.

Principles

Four principles have been identified as being central to medical ethics.^[1,5]

1. Autonomy refers to the preservation of the patient's right to individual decisions on the basis of relevant information, and within the options available. However, many ethical problems in psychiatry turn on the issue of competence.^[2]
2. Non-maleficence asserts an obligation not to inflict harm, but in medical practice many treatments have both benefits and risks, and some risk of harm usually has to be taken.
3. Beneficence requires the action that is of most benefit to the patient. For many purposes, the principles of beneficence and non-maleficence can be combined into a single concept of maximising benefit and minimising harm. The main reason for keeping them separate is that they have different scopes – i.e. a duty not to harm may encompass all human kind, but we do not (or cannot) owe a duty to benefit everyone.
4. Justice relates to fairness and entitlement that includes not only the patient and immediate family, but society at large. In the medical setting, it is distributed justice that is of most relevance – e.g. how resources (money, the doctor's time) should be distributed in a fair manner. There is also the question of retributive justice – how those who break the law should be punished – that may arise, e.g., when a psychiatrist is asked to advise a court with regard to a plea of diminished responsibility.

How does utilisation of these four principles determine which of the various possible actions is right or wrong? The foreseeable consequences, according to utilitarianism,^[1] holds that the right actions in a particular situation are those which maximise happiness and minimise unhappiness – 'the greatest

Table 1. Succour – to come to the assistance of/to give aid to

Situation	Understand the situation?
Useful options	Aware of available options?
Consequences	Aware of consequences?
Consistency	Consistent in choices?
Opinion	Relevant collateral opinion?
Undue influence	Present?
Reasons	Reason for the decision?

good for the greatest number of people.^[5] If a conflict arises between them, however, the right to one may overrule the right to another – e.g. autonomy v. consequences.

Casuistry and narrative

In addition to considering an issue from different perspectives, and in analysing it using different principles, there is a third approach to moral reasoning that is known as casuistry and narrative.^[6] Casuistry involves comparing the problematic situation with a related setting that is less puzzling. The narrative, requiring an intimate knowledge of the true richness of each individual's life, helps to identify their similarities and differences. This comparison often shows what changes to the original patient's present situation would make it easier to decide what is right to do.

Consent

Regardless of whether an individual's consent is implicit or explicit, both legal and ethical analyses highlight the components of valid consent: that the subject is informed, competent and not unduly influenced (voluntariness).^[2]

Informed consent refers to the disclosure of information (by the physician) and comprehension of this (by the subject), while the consent component refers to both a voluntary decision and an authorisation to proceed.

In medical practice, the requirements of informed consent include information about the illness, the recommended treatment and its probable duration, benefit and risk, and the consequences of lack of treatment or any reasonable alternatives.^[6]

Increasingly, legal, regulatory, philosophical, medical and psychological factions tend to favour five elements as the components of informed consent: competence, disclosure, understanding, voluntariness and consent. Of these, competence is the most contentious.^[5]

Competence

Competence is the ability to make autonomous, informed decisions and to take the necessary action to put these decisions into effect.^[7] The capacity requires several sub-capacities that include the ability to acquire, retain and understand information, to integrate this with personal preferences or values, to deliberate and make a reasoned choice, and finally, to

communicate that choice together with, where necessary, the reasoning behind it.^[2,5]

Competency issues normally arise when those functions are impaired by mental illness, especially if chronic or irreversible.^[6] The question of whether a person is/is not competent is complex. Competence is task-specific and not global. The criteria for someone's competence to stand trial, raise animals, write out cheques or teach class are radically different. Competence is, therefore, relative to the particular decision to be made. Thus, a person who is incompetent to decide about financial affairs may be competent to decide to participate in medical research or able to handle simple tasks easily.^[5]

Competence may vary over time, be eroded suddenly (as in stroke), gradually (as in dementia) or intermittently (as in delirium).^[2,5]

The law regards all persons as competent until proven otherwise. While informal assessments of competency are made in everyday life, formal legally-binding determinations of incompetency can be made only by a court.^[6]

Questions about competence often centre on standards for its determination – i.e. the conditions a judgement of competence must satisfy.^[5] In criminal law, civil law and clinical medicine, standards for competence cluster around various abilities to comprehend and process information and to reason about the consequence of one's actions. The seven standards of competence for a given person range progressively from one requiring the least ability to the other end of the spectrum and are used either alone or in combination to determine competence.^[6]

Testing for incompetence

While it is now accepted that a diagnosis alone (e.g. Alzheimer's disease or vascular dementia) does not imply any particular level of intellectual function or automatically determine the presence or absence of any type of competency, it none-the-less sets the tone against which the findings can be valued and judged. In this context, a mini mental status examination (MMSE) has a place. For example, from clinical experience we know that a patient suffering from vascular dementia may have a patchy and less predictable loss of cognitive functions for a given MMSE score, or that if a patient with Alzheimer's disease or vascular dementia with a MMSE of 10/30 were recently to have signed an intricate will, the

latter would be treated with morbid suspicion. Cognition and behaviour impact on a patient's level of function. This determines whether patients can still perform more complicated tasks such as taking their medication, difficult household chores, shopping, cooking and finances (instrumental activities of daily living (IADL)) or only wash, dress, feed and toilet themselves (basic activities of daily living (BADL)). The watershed between IADL and BADL usually occurs at an MMSE score of 16/30. A diagnosis and MMSE are thus important as supporting evidence.

Ultimately, one may need the input of an occupational therapist or social worker, if not also a neuropsychologist (especially in the early stages of dementia) to help decide on competency. Weighty decisions are usually made easier by the input of more than one person.

In broad terms, the above standards rely heavily on a patient's insight and judgement. In practical terms, the patient's ability to understand the degree and consequences of his/her impairment (i.e. self-awareness) denotes insight and the ability to act rationally on this information.

Judgement is usually considered as being synonymous with decision-making. However, a rational decision will often express itself as 'reasonable' rather than 'rational' because of the influence of emotional factors.^[8] Judgement

recognises a continuum of quantitative judgement at one end to qualitative and intuitive judgement at the other with peer-assisted judgement lying somewhere between. Judgement is thus an essential issue in the process of good decision-making, ranging from rational analytic reasoning to intuition. An essential ingredient of the process is the integration of the feedback loop that constantly monitors and adjusts our decisions or behaviour (Table 1).

Undue influence

The question of undue influence (willed by a stronger party to the detriment of a weaker party) is commonly raised with a diagnosis of neuropsychiatric illness in conjunction with a chain of lack of testamentary capacity and in connection with contested trusts, contracts and gifts. Examples of a range of 'undue-influence situations' include isolation, fostering of dependence, and the use of fear and deception to manipulate or control the patient.^[6]

Testamentary capacity

As far as civil law is concerned, competence is most commonly questioned in respect to money; specifically the ability of the testator to make a will.^[2]

Assessment of this capacity, by a psychiatrist together with a general practitioner working in

Table 2. Affidavit for a will

I, the undersigned Dr John Smith do hereby take oath and say that:

1. I am a registered (list registration and degrees)
2. I attended to (person's name and DOB) from (dates)
3. Ms Gladys Brown signed her will on (date and place)
4. Ms Gladys Brown had reasonable knowledge of the extent of her assets and was not influenced by mental illness at the time of drawing up and signing of her will. She knew what a will was and adequately explained who her beneficiaries were going to be, making a reasonable will
5. Ms Gladys Brown is granted testamentary capacity for (date)
6. I am unrelated to Ms Brown and have no personal interest in her will

co-operation with a lawyer, requires detailed notes of relevant interviews, telephone calls and collateral communications as well as an assessment of the mental state of the patient. It specifically covers the following points relevant to the patient:

- understanding of the nature and effect of a will; a simple statement such as 'when I die my children get all my things' will do
- a reasonable knowledge of the extent of the estate
- the influence of the illness on the will (valid if made during a 'lucid' interval)
- claims to the inheritance which follow the rules of intestate succession serve as a good guide as to what constitutes a 'reasonable' will (here, the surviving spouse inherits, if also deceased, then the offspring; in the absence of the latter, the parents of the deceased, and failing that, the siblings of the deceased or in turn their offspring inherit)
- as far as civil law is concerned, competence is most commonly questioned in respect to money; specifically, the ability of the testator to make a will
- should the will not be 'reasonable' in that others are favoured, an explanation should be given to make the 'unreasonable' will 'reasonable'; this helps to prevent family disputes, feuds and law suits.

Ensure that the wishes of the patient meet the above five criteria and are consistent over time.

Match your notes against the legally drawn up will, which the person then signs in your presence and supply an affidavit to this effect (Table 2).

Power of attorney, curatorship and administration

Transfer of authority to a reliable and trustworthy member of the family by means of power of attorney will usually still work

Table 3. Criteria for financial competence

1. A knowledge of income
2. A knowledge of expenses
3. An ability to handle everyday financial expenses
4. The ability to delegate financial wishes

well in early dementia where competency is still preserved. Power of attorney, however, lapses when capacity is lost; for it to remain in place, a durable or enduring power of attorney would be required (not yet available in South Africa). But, where no family members are available, or the interests of the patient are not primary, or in situations where disputes are likely, curatorship should be sought.

Unlike testamentary capacity, no clear criteria have been defined for incompetence to manage one's own financial affairs. Criteria for financial competence include knowledge of income and expenses, management of everyday financial transactions and ability to delegate financial wishes (Table 3).^[9]

As is the case with the curator personae (for personal care and welfare) under current law, a *Curator Bonis* may be appointed by the court in terms of the Mental Health Act to administer the property of a mentally ill patient.^[10] Curatorship is an intensive, radical solution to a problem and frequently uncomfortable for all persons involved. The attorney facilitating the application will require an affidavit from both a general practitioner and a psychiatrist. The text of the affidavits may be identical as this signifies agreement between the two parties (Table 4).

However, the process is expensive and time consuming. On the plus side, the accounts of the person are frozen almost immediately, thereby preventing abuse.

Table 4. Affidavit for Curator Bonis

I, the undersigned Dr John Smith do hereby take oath and say that:

1. I am a registered (list registration and degrees)
2. I attended to Mr Peter Gordon Brown (DOB) from (dates)
3. Mr Brown suffers from **Alzheimer's disease** resulting in disorientation, poor memory, lack of insight and judgement
4. The nature of his illness is such that any improvement in his condition is extremely unlikely; progressive deterioration instead is to be expected
5. As a consequence of his illness he is unable to conduct his own financial affairs
6. I hereby recommend the appointment of a *Curator Bonis*
7. I am unrelated to Mr Brown and have no personal interest in terms of any order sought for the appointment of a curator

Administratorship covers those persons who are unable to afford curatorship. Here a person's income is usually <R3 000 per month and the total assets worth <R400 000.

Licence to drive

By law a person physically or mentally impaired to such a degree that they pose a danger to others is not allowed to drive a vehicle (Act 93 of the Road Traffic Act, 1996) (II).

After all methods of persuasion have failed, the practitioner is ethically obliged to notify the local traffic authority, having informed the patient of this decision.

While speeding, alcohol and inexperience are recognised as key factors in motor vehicle accidents (MVAs) where the youth are involved, the elderly mirror their statistics for a variety of other reasons. Normal elements in senescence bring about a slowing in reaction times and a more sluggish response to visual and auditory stimuli with delayed speed in compensation for unexpected events.^[12] They have an impaired ability to rapidly process what is seen, divide attention and distinguish target from background.^[6] Although normal age-related changes may impair driving ability, age-related diseases may be a more important cause of MVAs in the elderly.

The patient may be in the early phases of mental disease unbeknown to the spouse or general practitioner. Patients in the early phases of Alzheimer's disease are often capable of driving a motor vehicle, especially if accompanied by a spouse or friend, and when driving is restricted to day time, off-peak times, short distances and uncongested roads.^[6,12,13] There is also general agreement that although activities of daily living, visuospatial skills, insight and judgement may give some indication of a person's driving ability, MMSE results along with psychometric measures of visual tracking ability (trail-making B test) tend to be the best predictors of driving ability.^[6,12]

A history from a reliable caregiver with a cautious attitude, a patient with an MMSE score >20/30 displaying at least partial insight and judgement, preserved visuospatial skills (such as correctly drawing intersecting pentagons or a cube) and absence of traffic violations, accidents or near misses, goes some way towards the person being allowed to continue to drive. Re-assess at a minimum of 3-monthly intervals.

Conclusion

There is a dynamic tension between ethics and law, and ethical issues are broader in scope and may not be addressed by specific laws.^[3] However, it is often difficult to do

what is perceived to be right if it is different from what is legal; hence the need for ethical guidelines, a working knowledge of basic ethical principles and an ability to reason ethically in areas where there is disagreement.^[2]

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SUMMARY

- When it comes to dealing with ethical and legal issues in psychiatry there is, unfortunately, no ready check-list or algorithm
- Three groups of patients are usually involved: the mentally ill, the cognitively impaired (dementias), and the mentally disabled
- The components of valid consent are: that the subject is informed, competent and not unduly influenced (voluntariness)
- Competence is the ability to make autonomous, informed decisions and to take the necessary action to put these decisions into effect
- Examples of a range of 'undue-influence situations' include isolation, fostering of dependence, and use of fear and deception to manipulate or control the patient
- As far as civil law is concerned competence is most commonly questioned in respect to money; specifically the ability of the testator to make a will
- Transfer of authority to a reliable and trustworthy member of the family by means of power of attorney will usually still work well in early dementia where competency is still preserved
- Power of attorney, however, lapses when capacity is lost
- By law a person physically or mentally impaired to such a degree that they pose a danger to others is not allowed to drive a vehicle (Act 93 of the Road Traffic Act, 1996) (II)