A 70-year-old woman with dementia and no insight: the best approach

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Most patients with early signs of dementia have some impairment in their insight about the changes in their cognition and behaviour. Most tend to minimise the extent of the problem or simply put it down to age.

Case scenario

Dorothy, a 70-year-old retired physician, presented to her GP with a superficial lower leg injury. The attending GP was concerned when the patient appeared to find it difficult to follow simple instructions about how to care for the wound.

The GP later spoke privately to Dorothy's husband and learnt that Dorothy had become quite disorganised and forgetful over the preceding 12 months. She had apparently defended her lapses of memory by aggressively telling her husband that 'all older people have memory problems'. Her husband also commented that what had most concerned him was that she had entirely lost her previously sharp sense of humour. At a subsequent consultation with her GP, Dorothy denied any problem with her memory, and rejected out of hand the idea of even a general health assessment or referral to a geriatrician.

The following two questions will be answered in this article:

- What is the best approach when the patient with dementia has no insight?
- What legal responsibilities does the GP have in regards to the patient with dementia who refuses assessment? For example, what would be the approach to the patient making a new will or continuing to drive?

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Commentary

Most patients with early signs of dementia have some impairment in their insight about the changes in their cognition and behaviour. This particularly applies to patients with early frontal lobe involvement such as those with vascular dementia or frontotemporal dementia. However, insight is usually partially retained as most patients will acknowledge that their memory is 'not quite as good as it used to be'. Most tend to minimise the extent of the problem or simply put it down to their age. Few patients with early dementia have no insight.

In Dorothy's case, she may have some awareness of her declining cognition because of her medical training and her irritability may be partly a psychological reaction of denial to the change.

The best approach

The general approach I advocate is two pronged. It is essential to develop a therapeutic alliance with the patient, and in these circumstances it is often around an agreed relatively neutral issue. In Dorothy's case, management of her leg wound might serve the purpose. Over some sessions unobtrusive cognitive tests regarding her recollection of recent life and world events can be inserted into the conversation while observing her mental state. Other signs of cognitive impairment that may be evident on observation include poor self-care or hygiene, inappropriate affect or behaviour, word finding difficulties and repetitiveness. Frequently the patient will eventually accept a more thorough examination (e.g. on the grounds that it is a routine assessment that the doctor undertakes in all people over a certain age) and further investigations, including specialist referral. Dorothy may start to articulate her fears about her cognition if the issue is discussed in a less threatening way, for example, 'Do you feel you are as sharp as you used to be? Let's see how you go with some of these tests.'

The second prong involves the patient's carer. Dorothy's husband, apart from being the source of a detailed history of cognitive and behavioural change in the patient, is the key to ensuring that the appropriate assessments are carried out. Therefore, it would be useful to explain to Dorothy's husband the likely causes of her dementia and the investigations that would be helpful. He will also need

continued

support and guidance about managing her behaviour. I usually recommend contact with the Alzheimer's Association (www.alzheimers.org.au; National helpline: 1800 100 500) and in particular the help sheets on their website (www.alzheimers.org.au/content.cfm?topicid=26) are often useful.

By using this approach, the GP is already conducting an assessment, albeit in the early stages and not as thorough as would be ideal. The possibility of potentially reversible causes of cognitive decline (e.g. drugs, depression, space-occupying lesions, and metabolic and endocrine disturbances) is usually alerted by the history and basic examination (e.g. recent rapid cognitive decline, reduced alertness and sleepiness and severe depression). If one of these conditions is reasonably suspected, it is usually possible to gain sufficient patient co-operation to perform the requisite investigations to clarify the problem. If severe depression or psychosis is the issue, referral of the patient to the local community old age mental health team would be warranted.

Legal responsibilities

Although a diagnosis of dementia does not automatically exclude a person from driving, it should alert the GP to the need for the patient to undergo a driving assessment. In mild dementia there is no reliable bedside test to assess driving ability and so I would tell the patient and his or her family that a formal on-road driving assessment is required if the patient would like to continue to drive. By explaining to the patient that the nature of their condition means that they will have to eventually stop driving, many decide to do so at that point. Usually I find the assessments undertaken by rehabilitation services are more appropriate than those provided by licensing authorities because they are better trained to detect problems related to cognition and to handle any short-term emotional reaction. In moderate to severe dementia there is very little chance that the patient will be fit to drive and so a driving assessment usually would not be required.

Driving is an emotive issue and some patients can react negatively to GPs' efforts to deal with this issue. To preserve the patient–GP relationship, it may be helpful to either externalise the problem by saying that GPs are obliged by law to ensure the issue of driving is dealt with or involve a third person such as a geriatrician or an old age psychiatrist.

Assessment of testamentary capacity is only required if a person is actually making a will. Usually it is a request from a solicitor and the patient is informed by the solicitor of the need for a medical report. This medical report is best carried out by a specialist with medicolegal expertise. If the GP becomes aware that the patient plans to make or change a will and there are doubts about capacity, it would be wise to mention to the patient and their family that a medical assessment would be needed first. MT

DECLARATION OF INTEREST: None.