Managing Mature

Some years ago, during a Clinical Skills Foundation Course (known in those days as Elementary Clinics) tutorial, a young and eager medical student presented to me and his tutorial group a case he had just clerked. It was probably one of the first few cases he had clerked in his young career as a clinical apprentice. He related, almost in verbatim, every detail that the patient had shared with him, including details such as his son's refusal to pay his medical bills, which led to being denied hospital discharge, and that his jealous neighbours were stealing his money to prevent him from buying medications. The patient even asked the slightly troubled medical student to get help from his Member of Parliament to rescue him from the hospital. There were also other points about the patient's history that did not sound right. Intrigued and amused, I decided to refer to the case records to determine the accuracy of the history taken. Lo and behold, the patient was a case of dementia with paranoid symptoms and a tendency to confabulate. His language functions were significantly intact, and would appear normal to an unsuspecting observer until the logic behind his statements were questioned with some contextual and background knowledge. This will then change the clinician's entire perspective and approach to the case.

Over the years, I have come to realise that whenever elderly patients present with a failure to control their chronic diseases, such as hypertension and diabetes mellitus, one of the questions a clinician must ask is whether there are cognitive impairments affecting the patients' ability to comply to their medication regimes, many of which involve multiple drugs with complex instructions. Many of these patients, who have retained their ability to converse effectively, will insist that they have been following the instructions carefully and religiously. Some even appear offended and retort sarcastically with the question: "Do you think I will risk my health by fooling around with the medications, which I've waited so long in your clinic to obtain?"

Yet, in spite of their protests and denials, medication accidents remain a major problem for patients with cognitive impairment. A forgetful patient can miss his medications, leading to poor control of his medical conditions. Even more dangerous is the patient who takes repeated doses due to his poor short term memory, a key clinical feature in those with Alzheimer's disease and many other types of dementia. These patients frequently end up with emergency department visits, hospitalisations, or even more serious complications, such as fractures after a fall, which are caused by a plunge in blood pressure, hypoglycaemia or giddiness – just to name a few more common examples.

Dementia is an age-prevalent and progressive neurodegenerative condition. With an ageing population, the increase in the number of patients suffering from dementia with varying degrees of cognitive impairment is inevitable. The reality is that regardless of whether we practise in primary or tertiary care, hospital or community care, Renal Medicine, Orthopaedic Surgery or even Ophthalmology, we will not be able to avoid having elderly patients with dementia. Even a friend, who is a paediatrician, remarked to me some time ago that she had to deal with a grandparent who she suspected has cognitive impairment, and possibly early dementia. The implications of this is clear: doctors, regardless of where they practise and what their specialties are, will soon, if not now, need to equip themselves with working knowledge of the disease, and be able to recognise or suspect a case when they see one. The challenge is, of course, in the early cases, where clinical features are subtle, and can be easily missed in a busy clinical practice environment.

I am not advocating an ageist approach and suggesting that doctors eye all their elderly patients suspiciously, doubting the things that they say just by virtue of their advanced age. But when the family members of dementia patients are probed retrospectively, they will almost invariably recall some subtle memory-related functional decompensation that immediately preceded the overt symptoms leading to the eventual diagnosis.

Therefore, what is important for us is to maintain a reasonable index of suspicion, and to sound the alarm when a patient inexplicably fails to adhere to his medication accurately, fails to turn up for his appointment on the correct day, or when his history reveals suspicious features. Even a patient who presents with food poisoning

Minds

By A/Prof Chin Jing Jih

frequently may be a victim of his failing cognitive abilities to identify expired and unsafe food. Although a definitive cure for dementia is still not available today, early diagnosis remains critically important as it helps avoid accidents and adverse clinical events. It also allows the patient's family and healthcare professionals to plan a holistic and sustainable care strategy aimed at providing a better quality of life for the patient.

As many clinical interactions and engagements involve some form of decision making by the patient, another important area which doctors need to be familiar with is the assessment of a patient's decision making capacity, either in agreeing to a treatment regime, or to an invasive procedure. If cognitive impairment is suspected in a patient, a doctor needs to at least be able to screen the patient's decision making capacity. Even if the patient were to agree with the doctor about a medical decision, the consent or agreement may be premised on the wrong comprehension or appreciation, which can certainly happen when a patient has dementia. Therefore, for those patients with either a suspicious history, such as head injury, major cerebral stroke, psychiatric condition, or have recent symptoms of forgetfulness, the doctor should be able to conduct a basic screening of the patient's decision making capacity, probing his comprehension, appreciation and reasoning with respect to the decision or task at hand. And for the challenging cases, especially those with concomitant mood issues, a referral to our psychiatric colleagues can be made for further expert evaluation.

In the coming years, the profession will likely see an increased number of legal and financial issues involving elderly patients, such as fitness to continue driving and working, testamentary capacity and fitness to make lasting power of attorney. Even the non-psychiatrists among us will do well to equip ourselves with basic skills to handle the simple and straightforward cases, or we may overload our psychiatric colleagues if all cases are referred to them.

Many developed countries with rapidly ageing populations are beginning to make dementia a national agenda, in order to provide a holistic and comprehensive national healthcare strategy to manage the long term sustainability of care. In 2010, the World Alzheimer Report estimated the total worldwide costs of dementia to be a staggering quantum of US$604 billion, accounting for around 1% of the world's gross domestic product (GDP). For a high income country, this rises to 1.24% of the country's GDP. Notably, the model of estimation in this report excludes indirect costs, such as loss of income by family members who had to quit their jobs or reduce their working hours in order to provide care for their loved ones. It also does not include medical costs of caregivers, who may be physically and mentally exhausted by the burden of care. As such, the real costs of dementia may be even higher.

In a country with a rapidly maturing population such as Singapore, we will have to look beyond mere mortality statistics of diseases for planning and allocation of healthcare resources, but also look at burden of care data, where diseases which are chronic and incur a huge burden of care, such as dementia, will become immediately prominent in the near future. It is encouraging to know that our Government has recognised this for some years, and has been actively ramping up the capacity of the healthcare and social care sectors to both diagnose and manage dementia better.

Certainly, relying on public healthcare services alone is not going to be adequate. The private sector, especially the private GPs, will be an important resource in the overall management of this new "epidemic". Initiatives, such as the National Dementia Network, including dementia under the Community Health Assist Scheme, partnerships between tertiary dementia services with GPs, strengthening of community dementia care and caregiver support services, are all crucial to the endeavour of managing dementia in Singapore. The medical profession will have to answer the call of duty, and see dementia care as a core competency and a national agenda. And I am confident we can. SMA

A/Prof Chin is President of the 53rd SMA Council. Like most doctors, he too has bills to pay and mouths to feed, and wrestles daily with materialistic desires that are beyond his humble salary. He, however, believes that a peaceful sleep at night is even more essential.