

Dementia : Patient's Right and Physician's Role

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Abstract : An elderly Thai widow with progressive dementia was transferred to Siriraj Hospital for properly continued supportive treatment. Due to the course of the disease, she lacked the ability to make any valid decisions related to giving consent to medical treatment and to manage her own affairs. Giving medical consent was a critical issue confronting the treating physician whereas the patient's relatives might face with the issue of administering her personal affairs and property. In order to establish the patient's lawful substitute decision maker and administrator for the patient's best interest, a declaration of the patient's incompetency and the appointment of suitable guardian were needed. The legal proceedings would inevitably be undertaken by filing a petition to the court. This would also have profound implications for the patient's rights and the physician's roles under the justice system.

Key words : dementia, incompetency, guardian, petition, patient's right, physician's role

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หญิงหม้ายไทยวัยสูงอายุ ป่วยด้วยโรคภาวะสมองเสื่อมที่มีการดำเนินโรคก้าวหน้า ได้รับการโอนย้ายมาที่โรงพยาบาลศิริราช เพื่อการรักษาแบบประคับประคองที่ต่อเนื่องอย่างเหมาะสม ด้วยลักษณะการดำเนินของโรคนี้เองจะทำให้ผู้ป่วยสูญเสียความสามารถในการตัดสินใจที่มีผลสมบูรณ์ตามกฎหมายได้ โดยเฉพาะในส่วนที่เกี่ยวกับการให้ความยินยอมในการรักษาทางการแพทย์และการจัดการกิจการของผู้ป่วย แพทย์ผู้ให้การรักษาจึงมักจะประสบปัญหาที่ผู้ป่วยไม่สามารถให้ความยินยอมในการรักษาด้วยตัวเองได้ และญาติของผู้ป่วยก็อาจจะให้ความสนใจเป็นพิเศษกับปัญหาที่ผู้ป่วยไม่สามารถจัดการกิจการของผู้ป่วยได้เอง ในการที่จะให้มีผู้ตัดสินใจและดำเนินกิจการแทนผู้ป่วยที่ถูกต้องตามกฎหมาย ทั้งนี้เพื่อผลประโยชน์ที่ดีที่สุดสำหรับผู้ป่วย จึงมีความจำเป็นอย่างยิ่งที่จะต้องมีการประกาศให้ผู้ป่วยเป็นบุคคลไร้ความสามารถและมีการแต่งตั้งผู้อนุบาลที่เหมาะสมขึ้น ซึ่งขั้นตอนดังกล่าวจะเป็นกระบวนการทางกฎหมายที่จะต้องมีการยื่นคำร้องต่อศาลเพื่อให้มีการพิจารณาคำขอก่อนเสมอ และการกระทำเช่นนั้นจะส่งผลกระทบต่อสิทธิของผู้ป่วยและบทบาทของแพทย์ต่อระบบความยุติธรรมอย่างมากด้วย

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INTRODUCTION

Modern advanced medicine has made significant impacts in improving the care and treatment of medical disorders, thus extending life expectancy and population demographics. Aging people have been identified as the fastest-growing segment of the population. The potential for illness increases with age. The diseases and disorders associated with the aging are general chronic illnesses and mental deficits, especially dementia caused by various factors. Alzheimer's disease (AD) is a common category of dementia with a prevalence of 10% among those aged 75 years and over and 20% among those aged 85 years and over.¹ Of particular concern, therefore, is the increasing implications of AD and other dementias on legal, financial, medical, and ethical issues. Legal aspects involve the elderly's legitimate rights, including health and long-term care planning, public benefits, surrogate decision-making, their legal capacity, the conservation, disposition and administration of their property, and the implementation of their decisions concerning such matters. Also, medical and ethical aspects of the physician's role in association with medical practice and legal proceedings is an important topic to be addressed.

CASE REPORT

A 75-year-old widow, upon the request of her niece, was brought to Siriraj Hospital for continuing adequate supportive treatment. She was transferred from a nearby private hospital where she was treated for dyspnea and a productive cough without a specific cause. At the time of presentation, she looked weak, without any signs of dyspnea, but had some productive coughing. She had had a little food and had been able to manage her daily life with her relative's help. She had been diagnosed with and been provided treatment for hypertension, chronic obstructive pulmonary disease, ischemic heart disease and Alzheimer's disease. Her cognitive capacity became impaired three years ago and had been gradually deteriorating. Last year her brain computed tomography scan (CT scan) demonstrated brain atrophy and generalized ventricular dilatation and

her mental status examination was 10/28. At that time she was diagnosed with Alzheimer's disease and was treated with a cholinesterase inhibitor drug, rivastigmine, 4.5 milligrams per day. She had had continued taking the medication, as well as other necessary drugs and an antidepressant drug without experiencing drug's side effects. She had no history of drinking alcohol, smoking cigarettes or having any injuries in the past few years.

Physical examination showed T 37.2° C, PR 80/min regular, RR 18/min, BP 136/82 mmHg, apathic, not pale, no jaundice, no dyspnea, no edema and no cyanosis. The results of other physical examinations appeared to be within normal limits, except for a coarse crepitation being heard at both lower lungs, especially on the left side. Investigations showed normal complete blood count and urine analysis. Blood chemistry and thyroid stimulating hormone levels were within normal range, except for a mild increase in lactate dehydrogenase (524 U/L) and decreased globulin (2.6 mg/dL). Chest radiography demonstrated no definitive infiltration. Psychological evaluation revealed that the patient looked alert, cooperative and euthymic. She had a limited verbal response, no evidence of dysarthria, no slurred speech and normal receptive language. She was disoriented to time, place and person. Her memory was lost. Her attention was not distractable. She was unable to perceive and assess information. At the time she was diagnosed as having severe dementia (Alzheimer's disease) based on her mental status evaluation score, 10/28, which showed severe cognitive impairment.

The diagnosis of severe dementia would necessitate an evaluation of the patient's ability to make cognitive decisions on matters relating to giving consent to medical treatment and considering various treatment options. Following such an evaluation a suitable legal guardian would need to be chosen. The legal issues would thus be addressed to the guardian for the patient's best interest. Since evidence of depression was unclear and other psychological diseases as well as some other functional disorders would be excluded, the indication for using an antidepressant drug was in doubt. Similarly, other medications needed to be revised and some unnec-

essary drugs would be withdrawn so as to avoid drug interaction and complications. In addition, the patient's nutritional status needed to be evaluated and improved appropriately.

DISCUSSION

Medicine Management

Dementia is an acquired, persistent clinical syndrome of decline in memory and other cognitive functions sufficient to affect daily life in an alert patient.² It predominantly affects older people, although a few individuals develop symptoms before the seventh decade.³ Alzheimer's disease (AD) is the most common form of dementia worldwide, accounting for over half of all dementias.⁴

Alzheimer's disease is characterized by a gradual onset and progressive decline in cognition with sparing of motor and sensory functions until later stages, which is consistent with this patient's illness. The average course of AD is approximately a decade, with a range of 3 to 20 years, duration from diagnosis to death, but the rate of progression is variable. Memory impairment is present in the earliest stages of AD. Other cognitive losses include aphasia, apraxia, disorientation, visuospatial dysfunction, and impaired judgment and executive functioning.⁵ Significant changes in behavior and mood such as personality changes, irritability, anxiety and depression, occur early in the disease process. Delusions, hallucinations, aggression and wandering often develop in middle and late stages.⁶ Such behaviors are the most troubling to care givers and frequently lead to family distress, elder abuse and nursing home placement. However, the patient in this report did not have these disturbing problems during the course of her illness.

The most important diagnostic tools for AD are the informant interview and a comprehensive physical examination, including a brief neurological and mental status evaluation. Also recommended is a laboratory evaluation to exclude treatable causes of dementia, such as depression, hypothyroidism, chronic subdural hematoma, normal pressure hydrocephalus, etc., generally including a complete blood count, blood chemistries, a serological test for

syphilis, and thyroid function test.⁷ Non-contrast computed tomographic (CT) head scans should be limited to atypical cases, such as rapid decline in cognition or function, short duration of dementia, or focal neurological findings.⁸ In this patient, the results of all blood tests were normal. CT head scan showed generalized brain atrophy, which is compatible with the diagnosis of AD.

The primary goals of treatment of patients with AD are to improve quality of life and maximize functional performance by enhancing cognition, mood, and behavior. Improving central cholinergic neurotransmission with cholinesterase inhibitors is the only treatment currently proven effective for treating the cognitive impairment resulting from AD. Donepezil, rivastigmine and galantamine, the three agents available in Thailand for treatment of AD, may improve cognition or delay decline and may also enhance clinician and family assessments and activities of daily living in patients with mild to moderate AD.^{9,10,11} However, only 40-50% of patients with AD respond symptomatically to cholinesterase inhibitors.

Working closely with family members as an alliance is critical. Information and emotional support may improve quality of life for patients and caregivers and even delay nursing-home placement. Financial and other legal issues should be discussed and planned for the future. Loss of insight, declining capacity to make reasonable decisions and risk to others must be carefully balanced against preservation of autonomy.

Psychological Management

It is reasonable to consider depression as one of differential diagnoses for any patient presenting with cognitive impairment. In one large series, 27% of the patients referred to a dementia clinic met criteria for a depressive disorder.¹² The impaired cognition occurring in the depressed patient, a condition called "depressive pseudodementia", may mislead clinicians to the diagnosis of dementia. The diagnosis of depressive pseudodementia is confirmed by recovery of cognitive function with successful treatment of mood disorder. Psychopharmacological treatment may produce recovery of mood and cognition. Neuropsychological features distinguish-

ing depressive pseudodementia from dementia include differential memory and language impairments. Unlike the patient with dementia, the patient with depressive pseudodementia retains self-awareness, has memory performance improved by prompting and organization of material, and lacks

aphasia. The cardinal feature of dementia is a slow, progressive decline in intellectual abilities that does not fluctuate over a period of hours or days. Practical points commonly used for differentiating dementia from depression are summarized in table 1.^{13,14,15}

Table 1. Differences between depression and dementia.

Clinical features	Depression	Dementia
Onset of symptoms	Subacute or rapid onset	Gradual onset
Age of onset	Any age	Mainly elderly
Awareness of cognitive difficulties	Often complain	Often deny
Response when cognitively challenged	"I don't know"	Confabulation: inadvertently fill the memory gap with inaccurate information
Pattern of memory loss	"Patchy" and inconsistent	Global and persistent
Guilt and negative attitude	Predominant	Minimal
Mood and affect	Depressed mood, dysphoria	Apathy, blunted affect
Decline in functioning	Rapid	Gradual
Presence of suicidal ideation	Frequent	Infrequent
Presence of aphasia	Rare	Frequent
Reversibility	Reversible when treated	Irreversible

Mental status examination (MSE) of this patient did not reveal any characteristic features of depression, i.e. depressed mood, dysphoria, guilty feeling and other negative thoughts. Instead, the patient demonstrated significant abnormal sensorium and cognitive impairment typically seen in demented patients. Therefore, the diagnosis of depression was omitted and the use of an antidepressant medication was no longer indicated.

In general, the patient who is capable of making decisions regarding medical treatment for his/her own illness must have the following abilities: 1) ability to understand the need for treatment, risks and benefits of treatment and the implication of refusing treatment; 2) ability to assess information and to relate it to personal values; 3) ability to make a decision based on that information; 4) ability to give a reason for making that decision; and 5) ability to convey that decision.¹⁶ Based on MSE, it is quite obvious that this patient was severely demented (TMSE = 10/28) and lacked all abilities described

above. Thus, it would be in the patient's best interest if she had a guardian, appointed by the court, who would make decisions for further appropriate treatment.

Forensic Medicine Approach

Since mental abnormalities may cause a person to demonstrate unacceptable behavior, self un-controlled status and even sudden violence, forensic concerns may involve both criminal matters and civil matters. From a criminal perspective, people suffering from mental illness may commit illegal acts ranging from minor offences to serious offences. These include minor criminal damage, indecent offence, sexual assault, theft, bodily assault, and murder. For the patient suffering from dementia, the effect of the disease may result in an increase in the patient's irritability, aggressiveness or suspiciousness, leading to verbal or minor physical aggression, or it may cause disinhibition, leading to offences such as sexually inappropriate behavior, or forget-

fulness, leading to behavior such as absent-minded shoplifting. In addition, there was a study showing that a fronto-temporal dementia is more likely to cause antisocial behavior than Alzheimer's disease.¹⁷

In committing an offence, two elements need to be proven in order to find a person guilty of a crime and subject him/her to the full rigours of the appropriate punishment. First, it has to be demonstrated that a criminal act or omission has occurred and been carried out by an identified person (*actus reus*). *Actus reus* means literally "guilty act" and is exercised by lawyers in an extended sense to include not only acts but also their consequences and any circumstances necessary for the crime. Second, it has to be illustrated that the person had the state of mind (*mens rea*) expressly proscribed in relation to that crime. To be found guilty means to have done the act and deserve punishment. A plea of "not guilty" may be based on an absence of *mens rea*. There are a few crimes which require no proof of *mens rea* where the act itself is adequate proof for an offence to have been committed, which are known as offences of strict liability.

Mens rea has a technical lawful meaning and refers to the mental state or quality of conduct required for the offence being considered. Mental state relies on, mostly, evaluation of the cognitive aspects of a person's mental condition whereas the quality of conduct requires a fault element. The term, thus, involves intentionality, recklessness, guilty knowledge, competence and responsibility. Full responsibility goes hand-in-hand with full rationality and consciousness or will. Impairment of either is taken to alter responsibility. Therefore, some people such as the young and the mentally abnormal are less responsible for their illegal acts than others. Nearly all legal systems, then, have provision for those people who are committing an offence while they have a sufficiently severe degree of mental disorder. Each country will have its own criteria for evaluating the degree of mental impairment of criminal responsibility. This is the basis of the concept of "diminished responsibility". The Thai judicial system has also accepted the concept as appearing in the Penal Code of Thailand Section 65.¹⁸

"Whenever any person commits an offence at the time of not being able to appreciate the nature, or illegality of his act or not being able to

control himself on account of defective mind, mental disease or mental infirmity, such person shall not be punished for such offence.

But, if the offender is still partially able to appreciate the nature or illegality of his act, or is still partially able to control himself, such person shall be punished for such offence, but the Court may inflict less punishment to any extent than that provided by the law for such offence."

Under Section 65, the criteria for evaluating the degree of mental impairment of criminal responsibility are that: 1) the offenders did not know the nature and quality of the act they were doing; or 2) if they knew it, they did not know that what he was doing was wrong; or 3) if they knew the nature and the criminality of the act, they were unable to control themselves to not commit the act. The law implies that rationality may be so impaired by mental disorder that the offender is not held responsible for his acts, resulting in the finding of not guilty by reason of insanity. Nonetheless, the lower liability that they deserve for their crime depends on the severity of their mental status.

Furthermore, if the offenders are insane at the time of their presenting at a criminal trial, they will be incapable of appreciating what is happening to them. Such circumstances will make them unfit to stand trial or plead, regardless of their perfectly normal mind at the time of committing the offence. In this scenario, it must be proven that they are unable to do as follows: 1) to understand the nature of the court proceedings; 2) to understand what they are being accused of, the details of evidence, and why they are there; 3) to challenge any of the judges as are their normal rights; and 4) to instruct the lawyers acting in their defence.¹⁹ The defendant will then be sent to a recognized secure mental hospital, usually the forensic psychiatry hospital, for examination and treatment for an indefinite period or until they recover at which time they will be brought back for trial. This probation will also be applied to the inquiry and preliminary examination process. The provision is stated in the Criminal Procedure Code of Thailand Section 14.²⁰

"Whilst holding an inquiry, preliminary examination or trial, if there is reason to believe that the alleged offender or accused is of unsound mind and is unable to put up a defence, the inquiry

official or the Court, as the case may be, shall instruct a medical officer to examine such person. After the examination, the medical officer shall be summoned to make a statement or testify as to the result of the examination.

In the case where the inquiry official or the Court is of opinion that the alleged offender or accused is of unsound mind and is unable to put up a defence, the official or the Court shall suspend the inquiry, preliminary examination or trial until he recovers his sound mind or is able to put up the defence, and have the power to send such person to a lunatic asylum or to deliver him to his custodian, the Commissioner of Changvad or any other person willing to take charge of such person, as is deemed expedient.

In case where the Court has suspended the preliminary examination or trial as provided in the above paragraph, it may strike out the case temporarily from the Case-List."

For civil perspective, mental disorders may also affect matters of civil law as codified in the Civil and Commercial Code Book I - VI. Mostly, it involves in making a contract, giving any judicial consent or executing a will. The followings present some essential and relevant Sections of the law.²¹

Section 28 "A person of unsound mind may be adjudged incompetent by the Court on the application of any spouse, ascendants, descendants, guardian or curator, a person taking care of the person or of the Public Prosecutor.

The person adjudged incompetent under paragraph one must be placed under guardianship. The appointment of guardian, power and duties of guardian, and termination of guardianship shall be in accordance with provisions of Book V of this Code.

The order of the Court under this Section shall be published in the Government Gazette."

Section 29 "An act done by a person adjudged incompetent is voidable."

Section 30 "An act done by a person of unsound mind but not adjudged incompetent is voidable only when the act was done at a time when he was actually of unsound mind, and the other party had knowledge of such unsoundness."

Section 31 "If the cause of the incompetency ceases to exist, the Court shall, on the application of the person himself or of any of the persons

mentioned in Section 28, revoke the adjudication. The order of the Court revoking the adjudication under this Section shall be published in the Government Gazette."

Section 32 "A person who has physical or mental infirmity, habitual prodigality or habitual intoxication or other similar causes that make him incapable of managing his own affairs, or whose management is likely to cause detriment to his own property or family, may be adjudged as quasi-incompetent by the Court upon an application by any of the persons specified in Section 28.

The person adjudged quasi-incompetent under paragraph one must be placed under curatorship.

The appointment of curator shall be in accordance with the provisions of Book V of the Code. The order of the Court under this Section shall be published in the Government Gazette."

"Unsound mind" is a legal term employed only by the court. It means any disorders or disabilities of mind causing one to be substantially impaired to a certain degree of incapability of perceiving physical acts and matters, forming a rational judgement as to whether an act is right or wrong, and exercising will power to control physical acts in accordance with that rational judgement. Its severity should be enough for the sick person not to be able to manage their own affairs and its incurability should be permanent. Patients with severe dementia, like the one in this case study, would fall into this type.

Apparently, the most civil concern in a mentally impaired person is the competency of the individual, which is the decisional capacity in any legal aspects involving one's life on one's own behalf. The notion is that "a particular person at a particular time has the capacity to make a meaningful choice" about a specific matter.²²⁻²⁴ Such a decision would be reasonable, right, and responsible. "Competency" is also a determination made only by court (competence in law). The law does not provide precise standards for assessing competency in relation to a number of particular acts, tasks, and choices. Since it focuses mainly on cognitive modality and proposed cognitively based criteria for its evaluation, a psychiatric perspective would play a major role. If a patient is found to be "incompetent in fact" by preliminary clinical assessment, a psychiatrist may be asked to deliver an

opinion to the court, which then "tests" this opinion through judicial validation. However, the clinician should realize that different levels of capacity are needed for different purposes (i.e., an individual may be able to make some basic daily life decisions, but not capable of spending a large sum of money or signing a contract); and that the law acknowledges that a person's degree of capacity fluctuates without one being lawfully incompetent.²⁵

For medical perspective, the law also forbids the nonconsensual administration of medication without a judicial declaration of incompetence and the appointment of a guardian. If the physicians consider the patient's consent or dissent as to medical treatment be neither valid nor rational, they may confront the patient with this belief and with the option of initiating a petition to have the patient declared incompetent and a proposed guardian appointed for the purpose of consenting to treatment. Then the legal action may be undertaken to protect the patient for the patient's best interest. Generally, a physician may have either a therapeutic collaborative relationship with a patient or a relationship where the physician acts as an impartial examiner so as to provide a report at the request of a third party. The physician's roles, therefore, are to do an examination, make a diagnosis, provide a treatment, discuss a prognosis, give medical counseling, prepare a report, and give a testimony during an inquiry, preliminary examination or trial. The mentally-ill-patient's treating physician may have two more roles, which are assessing the patient's competency and giving a necessary law related consultation to the patient and his/her relatives. The professional should be well advised not only to be familiar with accepted standards for medical and psychiatric assessment but to also obtain information on the appropriate legal standards.²⁶⁻²⁷ Application of the legal and medical standards of competency is essential when considering dementia patients. The clinicians should also realize that all legal documents can be only executed validly by competent people, thus making it crucial to complete them before the patient with a progressive dementia becomes incompetent. In this situation, the doctor who takes care of the patient will be called upon to attest to the patient's signing or mark of a document. In some conditions, the clinician may later be a valuable witness as an eye witness as well

as expert witness if the document is contested by dissatisfied relatives who may try to establish that it was made while the patient was of unsound mind or that undue influence was exerted on the individual.¹⁹ The doctor will then give evidence as to the capacity of the patient if the matter proceeds to court for trial.

An evaluation of competency may be done before any medical, legal, or financial decisions are made. The physicians should still be aware of the crucial statute of recognizing and defining a right to be eccentric and acknowledging religious beliefs and personal preferences. Apparently, competency is a legal issue that may need to be addressed before advising patients with progressive dementia and their families. Nonetheless, the clinician providing care should recognize and work within the limitations of their professional competence. Since the law uses its own definitions and concepts of mental disorders which differ substantially from standard medical understanding of abnormal mental states, the psychiatrist who provides an opinion on issues of competence should ensure that they have sufficient knowledge and training in assessing medicolegal aspects of mental responsibility. They should also confine evidence to assessment of the mental disorder, the likely future consequences of that disorder and the possibility of curing the condition in their report and notion. In addition, they should keep in mind that it is the judge who determines whether an incompetency judgement is appropriate or not after considering all the evidences including the medical evidence.

The holistic approach applied by the professionals, especially for older patients and their families, is that considerations should extend beyond the immediate problem or situation. Elderly patients commonly have assets that are considerable or complex in nature like in this case. Many elders live with people who are not blood relations and it is thus more difficult for them to maintain a sense of family. Furthermore, older patients may face a significantly higher risk of catastrophic events and the impact these events would cause. Accordingly, personal and family needs and the relationships between them need to be identified and addressed. Permission to disclose is valid only if the patient fully understands the nature and consequences of the disclosure. It is regarded as ethical to disclose relevant information to a relative or other appropriate people when it is

thought undesirable for a patient to be told the full implications of his/her condition, or if the patient is incapable of giving consent.

One of the patient's family members and associated people as specified in Section 28 may apply to the court for the adjudged incompetent person and the appointment of a proposed guardian as well. Those who are interested can initiate a petition to the court of proper jurisdiction alleging that the individual is incompetent and in need of a guardian. The proposed ward may be simply "unable to give consent to treatment", "incapable of managing individual's affairs" or "unable to care for individual's property or oneself". The alcoholics, drug addicts, physically disabled, spendthrifts and the like who are unable to administer their own affairs or whose behavior is likely to cause damage to their own property or family may also be subjects for guardianship proceedings, as stated in Section 32. Such people will be adjudged quasi-incompetent and their curator will be appointed. Once appointed, a guardian will have power to make all personal and financial decisions for the incompetent, with legally binding effects, as if the decisions have been made by the people themselves. Unlike the guardian, the curator will have some powers as specified only by the law. Under Section 31 and Section 32 guardianship and curatorship can be terminated, upon the application of the patient himself or of any of the persons mentioned in Section 28, if the course of the incompetency becomes non-existent or the ward no longer meets the criteria initiating the process. The petition will be accompanied by an affidavit from a physician attesting to the patient's incompetence or competence.

An ideal candidate to be a guardian or a curator, usually next of kin, may depend on the availability, the competence, the empathic intuition, the freedom from conflict of interest, the willingness, and the adequate remuneration and protection from liability of the patient's relatives. In this case, the patient did not have her own child, but an adopted son and a niece taking care of her. Both submitted an application for her guardianship. Obviously, her adopted son was neither her blood relative nor the person she had lived with. He would not likely to be a proper individual to be appointed as her guardian in accordance with Section 28.

CONCLUSION

In modern society which places an emphasis on individual rights, the right to choose is among the most highly valued of powers that human beings can possess. The right reflexes the rationality people take into consideration in order to make any decisions in any activities for themselves. When their rationality falls to a certain level, they become incompetent. Competence, therefore, seems to be a threshold requirement for people to retain the power to choose and also a major issue for the physicians who take care of patients with mental illness. Many such patients may have their competence called into question. Although incompetence is a legal concept and able to be determined by court only, clinicians should make their own assessments of a patient's likely incompetence in fact strictly according to medical criteria and in accordance with judicial concept. Legal declaration of incompetence will be a judge's role.

COMMENT

The most important clinical and ethical duty of the physician, especially the psychiatrist, who treats patients with dementia is to exclude the possibility that he/she is dealing with manifestations of the normal aging process or with some relatively benign and curable condition rather than the illness most dreaded by elderly people. When diagnosed as having severe dementia and adjudged incompetent by court, the patients may lose their capability to make a decision on legal aspects and no longer be able to manage their own affairs and property. They then have to rely on their guardians for decision-making and directing such matters on their behalf. It would be a disaster for the patients if they had an inappropriate finding of incompetence and an appointed unsuitable guardian. Thus, the treating physicians or psychiatrists should assess competence accurately and precisely based on medical standards, in accordance with proper legal standards, so as to maintain the patient's benefit and his/her family's benefit as well as society's benefit as a whole.

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