Appointment of a Guardian for the Institutionalized Mentally Frail: Is It Necessary?

To the Editor:

Senior citizens are the most rapidly growing age group worldwide. They are also aging; in 2007, 27% of the 65+ age group were octogenarians or older. More than 20% of those 80+ suffer from a moderate to severe form of dementia, their needs often exceed the resources of their families, and placement in a nursing home is sometimes inevitable. In Israel, approximately 4% of the elderly reside in long-term care institutions. Of the 30,200 total number of beds in the 403 institutions for the elderly, there are 19,900 beds (65.8%) for nursing home and mentally frail patients.

In Israel, departments for the mentally frail are registered as hospital departments, and are under the supervision of the Ministry of Health Ordinances for registration of hospitals, which is distinct from homes for the independent aged and/or the infirm that are subject to the “Residential Home Supervision Regulations: living conditions and treatment of independent and/or infirm elderly.” Before admission to a residential home, the candidate independent or infirm elderly person must have a written expert evaluation by the home’s physician and social worker confirming his or her capacity to express his or her opinion, and must then sign informed consent for admission. When capacity is lacking, a legal guardian (for the body of the patient), who is appointed by court order, or a person who was granted Power of Attorney for Health Care by the patient, when he or she was still able to do so, must provide written informed consent for admission.

The authors retrospectively reviewed patient files, and interviewed the staff of 2 psychogeriatric departments at Lev-Hasharon Mental Health Center, Israel, to examine guardian status of inpatients diagnosed as mentally frail.

Of the 65 inpatients, 60 had legal guardians for their person and property, 1 had a guardian for assets only, and 4 patients had no legal guardians. Thirty patients had legal guardians before admission, who indeed consented to admission to the closed wards for the mentally frail. The remaining 31 guardians were appointed at the initiative of the hospital staff, following diagnosis of "mentally frail," and admission to the department for the mentally frail.

Of the 60 patients who had legal guardians, 29 were family members (brother, sister or children; none were spouses). Thirty-one of the guardians were public agencies, including state-appointed attorneys, and the 1 guardian for assets was appointed by the Office of the General Guardian. Family Court decides who the guardian will be. There was no correlation between the 30 patients who had guardians before admission and the type of guardian (family or public agency).

The Israeli Law for the Treatment of the Mentally Ill deals with the subject of involuntary hospitalization and the restriction of freedom of the patient when necessary; however, although consent for care or hospitalization from an "authorized body" is required, there is no law that determines, for example, that a person cannot enter a department for the mentally frail unless he or she has a legal guardian. When the mental decline is gradual, the patient can often continue to live at home with assistance and supervision, until additional decline requires the transfer of the patient to a more protective environment. The law provides for institutionalization in a long-term care facility via the social welfare department.

Society has the responsibility to enable the infirm elderly person to exercise his or her right to receive treatment commensurate with his or her situation and illness, and to be in the appropriate treatment setting. In addition, provisions must be made to appoint an appropriate individual to manage the affairs of the mentally frail citizen.

This survey elucidates the dilemma of guardian appointment for the elderly. The issue arises when an elderly individual is admitted to a department for the mentally frail. In our opinion, special care must be taken to complete the legal guardian appointment process when necessary and to ensure elderly patients are not admitted to departments for the mentally frail without appropriate informed consent.

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How Frequent is Normal Pressure Hydrocephalus?

To the Editor:

The Hakim-Adams syndrome (normal pressure hydrocephalus; NPH) represents the only condition that mimics neurodegenerative dementias that can be successfully treated with a surgical procedure.1,2 As such, it is a saving alternative to an inevitable progression of dementia. The question is, how often is this syndrome the cause of dementia?3

Our experience is based on 3 sources of observation:

1. Between 1965 and 1988, more than 900 postmortem examinations were performed in a psychiatric VA hospital. The clinical history of patients who were diagnosed with NPH and had a shunt placed did not result in any clinically significant improvement. Of course, the source of this material is biased because not all of these individuals had NPH but did have one of the neurodegenerative dementias.

2. Between 1976 and 1998, in the Ohio State University Cognitive Disorders Clinic, we examined and followed more than 1000 patients. The clinical evaluation required, in the initial years, admission to the Clinical Research Unit for 6 to 8 days so as to administer all the tests. The procedures were later streamlined to outpatient visits only. We diagnosed 2 patients with NPH and referred them for shunt placement. The results in both cases were spectacular. They both presented initially with the pathognomonic triad, and their cognitive impairment was by today’s criteria a little more than mild cognitive impairment, with gait disturbance and incontinence being the initial and dominant symptoms. We have evaluated numerous patients for possible NPH, but did not recommend surgical intervention. The accuracy of our diagnoses in Cognitive Disorders Clinic was verified by postmortem examination with detailed brain studies, and between 1976 and 1984 we had 85% necropsies on deceased patients. The postmortem examinations confirmed that the only errors were in the types of neurodegenerative dementias diagnosed and none of the patients had NPH.

3. In the Columbus Alzheimer Care Center, a 100-bed dementia-dedicated facility, between 1991 and 2011 we had more than 1100 admissions. Nine individuals previously had ventriculoperitoneal shunt placement, which had neither a significant nor a lasting effect.

The diagnosis of Alzheimer disease or any other neurodegenerative dementia is a devastating event, both for the patient and the family. The spectacular results in accurately diagnosed neurodegenerative dementia are a powerful incentive for the patient and family to hope for NPH. The frequency in our material was 0.2%. We need long-term follow-up on the 11,500 patients who are diagnosed with NPH annually. Short-term follow-up would be misleading because even a sham surgical procedure can produce a strong placebo effect. Therefore, the 5% frequency of NPH may be a dangerous overestimate, because it reinforces the desire to treat. The emotional aspect of the relationship among patients, their families, and the treating physicians should not be overlooked because the desire to help and hope against all odds is very common.4 In patients who enter long-term care facilities with advanced dementia that is followed by incontinence and gait disturbance, it is essential to educate families that this is not the NPH triad, but the usual progression of neurodegenerative, untreatable dementing illness.

We have to wonder how many accurately diagnosed and successfully treated cases of the Hakim-Adams syndrome truly exist, and how many shunting procedures are performed inappropriately.

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Eldercare in Danger

To the Editor:

It is paradoxical that at a time of increasing numbers of elderly with complex health care needs, the field of geriatric medicine appears to be disappearing.

Geriatricians have advanced training preparing them to care for the most complex older patients. Geriatrics providers typically work within interdisciplinary teams resulting in comprehensive, coordinated care for the elderly. Research suggests this approach can improve outcomes, maintain functional integrity, and at the same time be more cost effective.

Some unique features of geriatricians include their ability, based on an understanding of the normal physiology of aging, to recognize atypical presentation of common diseases and to integrate this within the context of multiple simultaneous illnesses. Geriatricians have the required training to set practical goals and effectively manage elderly patients with multiple complex medical conditions, low organ reserve, limited social support, and functional impairment. The geriatrician knows the value of an interdisciplinary team, creating a care plan with input from the patient and family, and providing in-depth education. As time and an evolving clinical picture emerge, the geriatrician is able to recognize when goals are no longer realistic and can assist the patients and their loved ones through the process of altered expectation and types of care. Geriatricians often spend significant amounts of time with patients and families, and in primary care coordination with a multiplicity of providers and support staff.