The Breadth and Depth of Clinical Care in Dementia

by Kenneth Rockwood, MD, FRCPC

One joy of teaching is the opportunity to see yourself in others’ reactions. Most colleagues either appreciate skilled care across the spectrum of age and cognitive illness (through clinical experience, mature reflection or the salutary lesson of needing it for their parents) or are able to hide their disdain. Medical students, by contrast, often fail to mask their disappointment in having to deal with a demented patient.

That they should be disappointed is, at least initially, understandable. Students are taught that the history is key. They are held accountable for what can seem a bewildering array of facts (“You say this man complains of problems breathing; Are his ankles swollen? How many pillows does he sleep on?”). Consequently, to a medical student, few crimes are worse than being a “poor historian” (even though it is the historian who collects from primary sources and analyses to present a coherent synthesis). So, it is understandable that the experience can engender not the assumption of yet another complex set of clinical skills to be mastered, but the denigration of the entire clinical interaction in dementia.

A little time spent with this issue of The Canadian Alzheimer Disease Review, however, should make clear the comprehensive set of clinical skills needed for effective care. Communication with Alzheimer’s disease (AD) patients is addressed by Dr. Pierre Parenteau’s article (page 5), which opens with Pascal’s adage, echoed in Saint-Exupéry’s advice that “You can only see things clearly with your heart.” While Pascal committed the unforgivable premodern sin of faith, his instinct to privilege an aspect of our essential selves which is distinct from our capability to reason is likely to resonate with those who care for people with dementia. Even when the ability to reason is quite lost, we can see in people moments of their true selves. In the words of Lennie Gallant (from his song, “Shutters”): “I catch a glimpse of you inside.” Such moments can be precious for families, even when heartbreakingly brief. Gallant again: “But a gust of the wind/and it’s all blown away./There’s no time for hellos or good-byes.” The ability to communicate effectively, and even to orchestrate such a moment, is a magnificent skill.

An admirable clinical skill set also is at work in disentangling mood and cognitive disorders in patients with depression and dementia. As Dr. Bernard Groulx points out (page 9), our approach is evolving. Only a few years ago a dichotomy was proposed; now we recognize a synergy. The clinical interview again is key, as is so much of the patient encounter in a field with few useful biological markers. In this regard, I also find useful the advice of Pierre Tariot, who, cautioning against over-reliance on diagnostic criteria designed for patients with only one thing wrong at once (child’s play in comparison to the real-life model of patients with multiple medical problems), encourages us to think of behavioural metaphors in dementia1 (e.g., does the metaphor of depression explain the actions and thoughts of this patient with cognitive impairment?).

Much of the plight of AD is brought into sharp relief when people live alone, a situation which is very common (about one-third of all community-dwelling elderly people with dementia in Canada).2 Dr. Anne Décary’s summary (page 14) of the special problems therein makes clear that the help of others is essential. Their ability to fully realize that helpfulness depends chiefly on communication, clinical skills, and good judgment about when the interests of autonomy and safety may collide.

Dr. Lillian Thorpe provides a discussion about the special challenge of dementia diagnosis and management in adults with pre-existing intellectual impairment (page 18). The clinical interview, as Dr. Thorpe notes, requires special skill with patients who may be awkward, afraid or just plain shy. Such clinical skills should be celebrated: to take a history from someone who wants to tell you what is happening is, again, child’s play, at least by comparison.

Safety is perhaps most at odds with autonomy in patients who wander. Here, the Alzheimer Wandering Registry (page 22) can be of vital help. And here, too, clinical skill in understanding and redirecting the wandering patient is essential. Does the wandering represent a medical problem? Is it understandable as someone with the feeling of being lost trying to return to a more familiar environment? Is it the persistence of a lifelong behaviour to reduce anxiety or stress?

Sometimes, those who care for people with dementia are to blame for the apparent lack of appreciation of the depth and breadth of their clinical skills. For many, these skills now come as second nature, but that does not make them any less worthy. Take a moment, after reading this issue, to celebrate these skills in a colleague, caregiver or student. See what it says about yourself, and about those for whom you care.

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References