

## Medical and forensic implications in dementia

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**Abstract:** Psychiatric medical and legal errors occurring in psycho organic pathology dementia types can be classified as errors of taxonomic, organizational origin which involve the interdisciplinary collaboration of medical and legal psychiatry/neurology/paraclinical specialties. An illustration of this source of errors is represented by the fact that dementias are classified in chapter V, mental and behavioral diseases, codes F00/F09 and in the class of neurological diseases, codes G 30, G 31.1. and G 31.2 regarding degenerative disorders of the nervous system. The failure to corroborate medical and non medical data, as well as incomplete data, are the most frequent underlying causes for errors in setting the medical criteria necessary for the justice system. The authors review the diagnostic challenges that various types of dementias represent: sub cortical dementias, degenerative dementia, pseudo dementias, depressive pathology or vascular clinical pictures, Pick disease, Alzheimer's disease under treatment. In forensic practice when dealing with psycho organic pathology of dementia type, it is essential to closely follow the mixed, psychiatric and neurological, criteria patterns for the diagnosis, including a minimum of paraclinical investigations, such as psychological examination, computerized EEG and CT scan. The interdisciplinary collaboration between neurology, psychiatry and forensic medicine becomes an essential requirement in order to prevent possible judicial errors.

**Key words:** dementia, subcortical dementias, degenerative dementia, pseudo dementias, Alzheimer disease

In Romania the activity of expert appraisal tangential to psychiatry is carried on within the network of forensic medicine, under the name of forensic psychiatric expert appraisal, having a mixed theoretical basis, a psychiatric one - analytical, and a forensic one - causal, thus representing, theoretically speaking, more than "legal psychiatry" as it is commonly called. The bases of this direction were laid by the psychiatrist Alexandru Sutu, but the applied and legal theoretical foundation remained with Mina Minovici, whose published cases represent models of interdisciplinary expert appraisals even nowadays.

The psychiatric medical - legal activity, through the domains of expert appraisals, research and assistance aiming at the category of persons with judicial involvements.

- Its object of activity is the healthy or the mentally ill person, as against the social norms established by the instruments of the lawful state, who has to find himself/herself, in agreement with the others in a given setting (while general

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psychiatry deals with the ill person who reports to himself/herself, in a given social setting);

- It analyses the whole and interprets synthetically the medical and non-medical findings according to the principles of forensic causality;
- It synthesizes all the information (involving other medical and non-medical approaches as well, and it interprets their cause). This synthesis becomes a conclusive document necessary for justice.

Forensic activity, including psychiatric forensic activity is regulated by law, government decision, codes of procedure, its methodology being very strict.

Thus, based on a beneficial tradition, legally statutory for more than a century, the activity of forensic psychiatry is carried on within the network of forensic medicine, by interdisciplinary boards led by a forensic doctor, the members being psychiatrists. The expert appraisals are performed on the basis of a written order, issued by one of the institutions qualified by law to request forensic reports. The forensic doctor, due to his training, represents the interface, the optimum rationale, synthetic connection between the psychiatrist whose duty is to perform a psychiatric examination and to reconstitute the psychiatric status prior to the date of the examination and the institutions appointed by law to request the determination of the mental capacity.

The roles, within the activity of legal psychiatry, appear now even more clearly defined: the lawyer evaluates “the guilty will”, the “absence of the capacity of free will” etc., the psychiatrist evaluates the cognitive - affective capacity, and implicitly the volatile capacity, the forensic specialist analyses the forensic causal system, and the psychiatrist specialized in legal psychiatry analyzes the global mental capacity to use free will, to understand the requirements and the constraints to which he/she has to be submitted and his/her motivational system, in order to include him/her in the norms of the justice system.

Within the interdisciplinary team, the last two specialists evaluate, according to forensic causal principles, the capacity of the person to understand the contents and the negative social consequences resulting from his/her unlawful acts (which are considered or not to be the expression of a free will) and gives an opinion in criminal cases about the degree of the social danger and of the necessary medical measures. In civil cases, the interdisciplinary board gives an opinion on the mental capacity. The conclusions of a forensic psychiatric expert’s report scientifically endorsed provide the requesting institutions the necessary medical criteria for analyzing the criminal responsibility or civil fitness of a person at the time when he/she caused an event stipulated by criminal or civil law. According to the law, only the forensic boards stipulated by law can make a decision on the above.

The theoretical bases of this approach start from the axiom according to which any forensic appraisal, including a psychiatric one, should not be mistaken for a diagnosis, as it represents a scientific report which provides to the justice system a complex, dynamic interpretation of a situation, of a behavior which resulted in an event stipulated by the criminal code or by the civil code. The analytical mechanism of approach, specific for legal psychiatry, aims at the existential race of the person, the relations between the person and the world, the mental status prior to the event, at the time of the commission of the act, afterwards and at the time of the examination, the synthesis of the intention and the concrete synthesis of all the acts, the phenomenological reduction in order to obtain the truth values, the analysis of the presence and co-presence of the elements possibly or actually involved, the forensic causality. This model of interdisciplinary approach leads to the necessary

phenomenological reduction for the corroboration of the data regarding the circumstances in which the event occurred due to which justice had to be brought in.

The medical and forensic relationships of psycho-organic pathology comprise the whole range of specific activities. Criminal cases and cases when there is a need to interrupt or postpone the penalty are easier to solve because the judicial implications are clearer and the inter-departmental and inter-disciplinary relationships are narrower; in civil cases the activity is more difficult especially due to a widening of the inter-disciplinary area and the passionate involvement of the parties, as material goods are involved.

In forensic psychiatry we use the terms of psychiatric capacity and mental fitness, the state of awareness being a must, but not enough to evaluate the wholeness of mental capacity.

Thus, in civil cases, the capacity of civil fitness is defined as a person's mental capacity to understand the content and especially the consequences of a unilateral civil document (wills) or bilateral ones (contracts, etc.). The state of mental normality or abnormality (the underlying condition), or particular transitory or comprehensible states are taken into account. In other cases, irrespective of the degree by which the mental capacity is diminished, or even absent, the capacity of mental fitness, a phrase which is synonymous to mental fitness in criminal cases, is absent (missing) because it is logical that in a court of law the validity of a signature cannot be graded. In these cases as well, the mental capacity is retrospectively assessed by reconstructing the mental state at a time prior to the examination or "on paper" examination. A special situation is present which requires the annulment of a dead person's signature when the forensic reports "on the documents" involve a complete, accurate medical evaluation of the documents in order to be able to analyze the pathoplastic biological background that could lead to a mental disease, being attributed to medical and non medical evidence.

In the other civil cases, the mental capacity at the time of the report with a predictive value for the foreseeable or non foreseeable future is assessed. In these cases we take into consideration the mental capacity to decide (decisional capacity) with free will about oneself or others (to decide on the way "to be" in relation to the legal civil rights and duties granted by the legal rules). Such examples are restraining orders, child care, adoptions, sexual identity, etc.

A special case is when a person claims civil damages on the grounds of a disease caused by another natural or legal person. Very often, claims for damages for physical trauma (accidents, fights), inadequate medical treatment or in hospital deaths fall into this category. In such cases, we operate with concepts of medical and legal causality, mental medical and legal causality and mental disability.

In medical and legal psychiatry, conclusions are drawn more on the basis of symptoms rather than on the underlying condition. Most symptoms refer to mental functions such as willingness and simulation, which are considered as secondary or irrelevant in hospital practice.

In civil cases, forensic medicine has to demonstrate the (in/)existence of the possibility to exhibit (display) one's free will at some point, involving a comprehensible or incomprehensible motivational background. As in all human activities, errors may occur and these can have either organizational or methodological causes, with both objective and subjective elements involved.

Psychiatric medical and legal errors occurring in psycho organic pathology dementia types can be classified as errors of taxonomic, organizational origin which involve the

interdisciplinary collaboration of medical and legal psychiatry/neurology/paraclinical specialities. These errors are the basis of the other types of errors.

According to the WHO international classification of diseases, dementias are classified in chapter V, mental and behavioral diseases, codes F00/ F09 and in the class of neurological diseases, codes G 30, G 31.1. and G 31.2 regarding degenerative disorders of the nervous system. For reasons which cannot be discussed within forensic medicine, other types of dementia are not discussed. This is why medical and legal difficulties arise especially concerning these nosologic classification.

The coding of degenerative dementias in both groups has to be accepted in the following way:

1. The neurologist does not have the competence to express his opinion on a person's mental capacity even if he or she has been diagnosed with dementia.
2. A person goes first to a psychiatrist or a neurologist.
3. If the patient goes to the neurologist first, the doctor determines the neurologic diagnosis as main diagnosis, secondary diagnosis and comorbidity.
4. Dementia is seldom the main diagnosis.
5. In order to diagnose dementia within degenerative diseases of the nervous system, irrespective of its written ranking, it is necessary to emphasize specific criteria for both neurological and psychiatric diagnosis, as well as specific mental examination.
6. The patient may refuse a psychiatric examination and under these circumstances the neurologist's responsibility becomes greater, as he has to mention this fact. The neurologist's statement has to be signed by the patient's family as well.
7. Laboratory tests are compulsory under these circumstances. Forensic medicine considers as compulsory the support of electro physiological computerized and imaging complementary exams for the diagnosis of degenerative diseases.
8. Forensic medicine does not dismiss a priori the diagnosis of dementia put by a neurologist, especially if there is the support of complementary exams, and considers that the stages can be recognized by any experienced physician, but it recommends the inclusion of critical symptoms for the out patient visits.
9. If the patient goes first to the psychiatrist, the doctor determines a multi axial diagnosis, on the diagnosis axis I being included dementia and on the axis III the associated organic pathology which is confirmed by an interdisciplinary examination and suitable paraclinical investigations. It is the psychiatrist's duty to establish the stage of the disease.

By observing the above mentioned activity parameters, neither group of specialists can be blamed for malpraxis. They offer the psychiatric medical and forensic boards at the same time a real clinical picture which can be associated with non medical evidence in order to assess the mental capacity of the patient concerning the criminal or civil case in which the latter is involved. Whereas in psychiatric forensic expert appraisals the actual physical examination of a person is easier (due to the fact that boards have the legal right to require the medical examinations that are considered necessary, including hospital admission, and the public health network is legally bound to fulfill such requirements), in expert appraisals based on documents the situation is more complicated.

These expert appraisals are commonly performed in order to establish a dead person's mental capacity at the time when he/she had a civil document drawn up which is contested by third parties. Large fortunes are generally at stake. In such expert appraisals, the person's mental capacity to manifest oneself with free will at the time the civil document under

litigation was drawn up is assessed. Implicitly, this involves a critical assessment of the legal and social consequences following that document. Under these circumstances, the forensic institution is tributary to the professional quality of the medical tests that have been performed and corroborated with the non medical evidence.

Forensic institutions are the only medical institutions which use, for medical and forensic work, non medical evidence.

The failure to corroborate medical and non medical data, as well as incomplete data, are the most frequent underlying causes for errors in setting the medical criteria necessary for the justice system.

The medical issue under discussion includes the nosologic classification, the symptoms that can be reconstructed for the time the expert must state his opinion regarding the document that was drawn up, the reconstruction of the motivational system and, finally, their association as underlying patterns of willingness capacity. In order for a civil document to be considered as having been drawn up with the observation of the legal norms and common sense principles: it must not be seriously detrimental to one party, not to have been obtained by fraud, and all the parties involved must have had their mental capacities. For people with a pathology which required an expert appraisal, the comprehensibility of the motivation and the absence of manipulation through volitional deficit have to be demonstrated.

As a matter of fact, within psycho organic syndromes, dementia syndromes included, the difficulty arises concerning the onset, especially for primary dementia.

Subcortical dementias, through the damage of the subcortical structures, especially the thalamus, and of the subcortical frontal connexions, are difficult to diagnose at onset. This is exactly at the time when the least visible behavioral changes occur, with a deficit to formulate strategies and to process new information.

In degenerative dementias with a slow onset through behavioral and affectivity changes, difficulties arise from the facade which is maintained for a longer period of time with apparently unchanged adaptability. In such cases, there are regularly mismatches among the non medical pieces of evidence, especially regarding the cognition apparently preserved. The detailed psychiatric examination is the main source for the data necessary to differentiate from pseudo dementias, depressive pathology or vascular clinical pictures

To illustrate this we present a case referred to the National Institute for Forensic Medicine by one of the well known teaching centers. The patient was a female with a psycho traumatic life experience, well educated, without children. She left her workplace and shortly afterwards she drew up a civil document, being at the same time robbed of some money. She went on a trip and when she returned she was admitted to hospital, where a state of the art medical file was drawn up: detailed mental examination, special social enquiry performed by the staff of the psychiatric system, psychological examination, electro physiological and imaging investigations, neurological and medical examinations. The diagnosis was unanimous: Alzheimer's dementia, first stage. Detailed notes were kept on a permanent basis. Death followed shortly.

After the patient's death, the family learned about the civil document and contested it. At the NIFM, the medical documents and especially the social enquiry, corroborated with the non medical evidence, proved that at the time when the document was signed, the person exhibited the early signs of Alzheimer's disease (concerning especially the progressive loss of the ability to use one's own experience, the progressive deficit in the individual adaptative ability, with an onset prior to the drawing up of the document, and the first signs of inconstant

spatial disorientation). If the medical file had not been detailed, if there had not been a social enquiry which is not regularly performed, it would have been impossible to present arguments and counter arguments only on the basis of the evidence.

A favorable circumstance in such difficult cases is also the fact that lawyers do not know about ICD 10 DCR and refer only to DSM, ICD 1 and textbooks when they ask us to explain why we support the absence of mental capacity once Alzheimer's disease and not dementia was diagnosed and to explain what was involved in diminishing the mental capacity. Also in connection with Alzheimer's dementia I would like to make a further point concerning prudence.

One patient was neurologically diagnosed in an out patient clinic on the basis of a check up in the out patient clinic and of an imaging examination, as having dementia. The neurologist correctly recommended the patient to be admitted in a psychiatric unit, which did not happen because of the patient's family lack of involvement. Thus, post mortem, forensic medicine specialists were involved. The first board made the diagnosis of Alzheimer's dementia on the basis of a CT scan. Only through thorough corroboration of non medical evidence with the neurologist's examination report could the specialists at the NIFM diagnose mixed dementia. Both the neurologist who failed to write down the critical symptoms, and the mixed board which used only a CT scan to diagnose the type of dementia were careless (imprudent).

As far as Pick disease is concerned, the psychiatric forensic actions are easier in the case of onset with strange childish behavioral and affectivity patterns but more difficult in the case of onset with an asthenic syndrome. In vascular and senile dementias affective instability, changes in behavior, the involvement of stressful events and even early cognitive changes can be reconstructed. As far as these dementias are concerned, the difficulties arise from interdisciplinary collaboration. These patients are regularly admitted in internal medicine departments, which do not ask for a neurologic examination since there is no vascular stroke as yet, nor do they ask for a psychiatric examination because the patient exhibits awareness.

Another quite delicate issue arises from modern therapy. From our observations, we can state that neurological vascular pathology, if treated correctly, does not cause changes in the mental capacity in all patients.

The problems are quite different for patients with Alzheimer's disease who receive modern treatment. We have repeatedly emphasized the fact that even if there are spectacular improvements as far as adaptability and even cognition are concerned, this does not apply to the volitional background. Under treatment with aricept or exelon, patients who give the impression that their behavior is normal or do not have cognition deficits, are left without home or money through manipulation. In such cases, the corroboration of all the pieces of evidence is not only compulsory, but also necessary.

To sum up, the problems of dementias involved in legal cases are dominated by the onset of the disease, by the evolution under treatment and by the beneficial collaboration between neurology and psychiatry and between the two and forensic medicine, with the observance of competencies and of the norms for drawing up the medical documents.

As a result of the previous points made, we would like to emphasize the following:

1. Forensic medicine cannot allow for errors which have legal consequences and, thus it must point out possible sources of errors.
2. In forensic practice concerning the psycho organic pathology of dementia type, it is necessary to closely follow the mixed, psychiatric and neurological, criteria patterns

- for the diagnosis, including a minimum of paraclinical investigations, such as psychological examination, computerized EEG and CT scan.
3. The interdisciplinary collaboration between neurology, psychiatry and forensic medicine becomes an essential requirement in order to prevent possible judicial errors.

## References

1. Costea Gabriela (1995), Proposals for Updating the Activity of Forensic Psychiatric Expert Appraisals, the Romanian Journal of Legal Medicine, 3,(4) 396-400.
2. Dermengiu D. (2002), Forensic Pathology, Edit. Romanian Medical Life
3. Dragomirescu V., Scripcaru G., (1997), Analytical Overview on the Current Methodological Organization of Forensic Expert Appraisal, Paper Delivered at the National Meeting of Forensic Psychiatry Medicine, 26 – 27 Sept., Bucharest;
4. Dragomirescu V., Hanganu O., Prelipceanu D., (1990), Forensic Psychiatric Expert Appraisal, the Medical Publishing House, Bucharest
1. \*\* Papers of the Colloquim Regarding Responsibility and Psychiatric Treatment (1986), the European Committee on Criminal Matters by the Council of Europe, Strasbourg;
2. \*\* Principles Regarding the Protection of Patients with Mental Diseases for the Improvement of Mental Health, (1991), UN;
3. \*\* Principles Regarding the Protection of People with Mental Diseases for the Improvement of Mental Health, (1991), UN;