Persons with Acquired Cognitive Impairment

CMDA affirms the value of all persons with cognitive impairment and recognizes their inherent dignity. Within a Christian worldview, all people have worth and meaning regardless of their cognitive abilities and deserve our utmost respect.

Principles to consider:

A. Biblical

1. All deterioration, disease, and death are the result of the fall (Gen 3:16-22).
2. God is sovereign over all things including cognitive impairment (Ps 115:3). His ways are perfect and just (Deut 32:4, Job 37:23).
3. His ultimate purpose, in all things, is His own glory (Rom 11:36).
4. Cognitive impairment is not meaningless, as God's ways are often beyond our comprehension (Rom 11:33, Is 55:8-9, Deut 29:29) yet wonderful (Job 42:3).
5. He exists in eternity (Ps 90:2) and His purposes may not be understood during our earthly lives (Heb 11:35-40).
6. All humans are made in God's image (Gen 1:26-27) and receive life from God himself (Gen 2:7), thus imparting inherent dignity to all persons independent of their functional or intellectual capacities. Whereas humans tend to attribute their worth to their capacities, God loves every person, independent of their abilities, because love is his nature (Rom 5:8, 1 John 4:16) (See CMDA Ethics Statement Human Life: Its Moral Worth).
7. Serving the needy and disabled is part of serving Christ (Matt 25:40).
8. Human beings are living mysteries, fearfully and wonderfully made (Ps 139:14), whole persons, and embodied souls; we are not merely minds (Matt 10:28-29). A person's fundamental identity is grounded in God's relationship to him or her (Acts 17:28).
9. God is with us, even when our minds are dysfunctional. We can trust that the Holy Spirit is active on behalf of those who are cognitively impaired (Rom 8:20-27), and we give thanks that no impairment can separate us from the love of Christ (Rom 8:35-39).
10. God may use cognitive impairment to instruct us as to the true foundation of human value (Jer. 9:23-24).
11. Jesus showed care and compassion to those with cognitive impairment (Luke 4:33-35, 8:27-33, 38-39 and 9:37-43[a]).

B. Medical

1. Cognitive impairment encompasses a spectrum of clinical conditions ranging from mild memory impairment to dementia; these may occur transiently or permanently, and they may be static or progressive. Its causes include birth anoxia, encephalitis, head trauma, stroke, epilepsy, malnutrition, alcohol and other toxins, prescription drug adverse effects, illicit drug effects, and neurodegenerative disorders such as Alzheimer disease, among others.
2. All potentially correctable causes of cognitive impairment should be diligently sought before the patient is labeled as having an untreatable condition.[1]

3. Whereas the medical profession currently has no curative means to treat most of the causes of cognitive impairment, we should show respect for the patients' dignity through loving interactions that engage them to the greatest degree possible.[1-6]
4. There is currently no cure for degenerative dementias. There are pharmacologic interventions, such as memantine, that may slow the progression of cognitive deterioration in a subset of patients with dementia.[2,4-6] There are also some non-FDA-approved interventions and nutritional supplements that are claimed to improve declining memory, but such claims are not supported by valid scientific evidence.
5. It is imperative for the medical profession to attempt to relieve distress experienced by the cognitively impaired even when they are unable to express them verbally. CMDA cannot support physician-assisted death as a means to relieve this distress. (see CMDA statements on Physician-Assisted Suicide and Euthanasia).
6. Life-prolonging interventions may not be indicated in patients with profound dementia and may need to be carefully assessed by a shared decision-making model (see CMDA Statement on Artificially Administered Nutrition and Hydration).

C. Ethical

1. A person's inherent value is not diminished by physical or mental disability.
2. The person with cognitive impairment who displays inappropriate and/or abusive behavior may or may not be ethically culpable. HCPs should take appropriate precautions and protections in cases of violent or aggressive patients.
3. Despite the stress of caring for a person with cognitive impairment, it is always wrong to respond with any form of abuse.

D. Social

1. Caring for a person with dementia is demanding. The HCP should recognize the toll exacted on caregivers, particularly in the later stages of the disease, when the patient often becomes increasingly dependent, agitated, aggressive, or confused.
2. Caregiver strain is felt physically, emotionally, mentally, financially, and spiritually.
3. Caregivers should be encouraged to seek and utilize available resources to help in areas of need. The HCP should be familiar with locally available resources, including people who can be of assistance (e.g. social workers).[7]
4. The local church and its members may be of assistance to patients and their caregivers. Caregivers should be encouraged to reach out to their faith communities.

E. Clinical Implications

1. Persons with cognitive impairment may have no sense of time or memory. They may still be able to engage socially and may enjoy spending time in the presence of others. Time spent with loved ones, even if soon forgotten, is nevertheless of value.[1,8-11]

2. Individuals with cognitive impairment should be involved in decision-making to the extent of their current capacity. They may have preferences regarding items such as food or clothing, and these should be solicited and respected. Their current ability to make decisions will determine the appropriateness of involving the person in making choices.[1,12]
3. Patients with cognitive impairment should be encouraged to engage in activities meaningful to them.[4-6]
4. Patients with cognitive impairment may enjoy being reminded of memories and participating in activities enjoyed in the past.[1]
5. Persons with cognitive impairment may have delusions. Depending upon their medical condition or status of their disease, it may or may not be appropriate to address the delusions. At all times, it is important to respect the person and guard their dignity regardless of the delusions.[13]
6. Correction or criticism can be devastating to the dignity of one with dementia. Redirection or distraction may be more effective in addressing inappropriate behavior.[8,9]
7. Caregivers and HCPs should avoid referring to the patient in the third person, but rather to engage the patient the conversation as much as possible. Ideally, the person with dementia should be spoken to directly, maintaining eye contact.[1,4-6]
8. Emotional memories are more resilient than other memories. Persons with impaired cognition may not remember what they did, but may remember how they felt.
9. HCPs are encouraged to recommend only FDA-approved interventions that may slow the progression of cognitive deterioration.
10. Followers of Jesus should be reminded of the basic tenets and practices of their faith. Engaging patients in familiar activities such as prayers, liturgy, reading of Scripture, hymns, or worship music may encourage them powerfully in the exercise of their faith.[14]

Conclusion

All people with cognitive impairment have God-given worth and can lead meaningful lives. Their caregivers, too, deserve our help, support, and prayers.

---

[a] In these cases the individuals' cognition was impaired by demons but Jesus went out of his way to exorcise them and restore him to his right mind.

Approved by the House of Representatives
Passed with 40 approvals, 0 opposed, 0 abstention
May 2, 2021, virtual

References

1. Atri, A., 2019. The Alzheimer's Disease Clinical Spectrum. *Medical Clinics of North America*, 103(2), pp.263-293. 10.1016/j.mcna.2018.10.009.
2. Bourgeois, Michelle and Ellen Hickey, *Dementia from Diagnosis to Management A Functional Approach*,(Psychology Press, Taylor and Francis Group, New York, 2009), pg. 189-203.

3. Kitwood, Tom, *Dementia Reconsidered the Person Comes First*, (Open University Press, McGraw -Hill Education, Berkshire, UK, 1997), Chapter 4.
4. Scales, K., Zimmerman, S. and Miller, S., 2018. Evidence-Based Nonpharmacological Practices to Address Behavioral and Psychological Symptoms of Dementia. *The Gerontologist*, 58(suppl_1), pp.S88-S102. DOI: 10.1093/geront/gnx167.
5. Travers, C., Brooks, D., Hines, S., O'Reilly, M., McMaster, M., He, W., MacAndrew, M., Fielding, E., Karlsson, L. and Beattie, E., 2016. Effectiveness of meaningful occupation interventions for people living with dementia in residential aged care. *JBI Database of Systematic Reviews and Implementation Reports*, 14(12), pp.163-225. DOI: 10.11124/JBISRIR-2016-003230.
6. Tisher, A. and Salardini, A., 2019. A Comprehensive Update on Treatment of Dementia. *Seminars in Neurology*, 39(02), pp.167-178. DOI: 10.1055/s-0039-1683408.
7. Riffin, C., Van Ness, P., Wolff, J. and Fried, T., 2017. Family and Other Unpaid Caregivers and Older Adults with and without Dementia and Disability. *Journal of the American Geriatrics Society*, 65(8), pp.1821-1828. DOI: 10.1111/jgs.14910.
8. Dunlop, John, *Finding Grace in the Face of Dementia*, (Crossway, Wheaton, IL 2017), pg.113-127.
9. Harris, M., 2017. Cognitive Issues. *Nursing Clinics of North America*, 52(3), pp.363-374. DOI: 10.1016/j.cnur.2017.05.001
10. Regier, N., Hodgson, N. and Gitlin, L., 2016. Characteristics of Activities for Persons With Dementia at the Mild, Moderate, and Severe Stages. *The Gerontologist*, p.gnw133. DOI: 10.1093/geront/gnw133.
11. Walmsly, B. and McCormack, L., 2013. The dance of communication: Retaining family membership despite severe non-speech dementia. *Dementia*, 13(5), pp.626-641. DOI: 10.1177/1471301213480359.
12. Darby, R. and Dickerson, B., 2017. Dementia, Decision Making, and Capacity. *Harvard Review of Psychiatry*, 25(6), pp.270-278. DOI: 10.1097/HRP.0000000000000163.
13. Gallagher, D., Fischer, C. and Iaboni, A., 2017. Neuropsychiatric Symptoms in Mild Cognitive Impairment. *The Canadian Journal of Psychiatry*, 62(3), pp.161-169. DOI: 10.1177/0706743716648296.
14. Mast, Benjamin, *Second Forgetting Remembering the Power of the Gospel During Alzheimer's Disease,* (Zondervan, Grand Rapids, 2014), pg.15-28.