

Original Article

On reasonable truth-telling for unreasonable patients

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Abstract

The aim of this article is to explain to what extent the mechanisms of truth-telling diagnostics and other relevant information to the patients suffering from vascular dementia (VaD) must be adapted to the seven stages of evolution represented by the pathology of this disease. We argue in favor of preserving a deontological moral approach of truth-telling for the first three stages of VaD in order to shift to a consequentialist moral background of guiding the moral actions and communicative acts of speech with VaD patients in the last three stages of their disease. The middle stage, known as stage 4, appears to be the most problematic since empirical observations of the patient's medical state are needed to shift from a deontological to a consequentialist approach at the first sign of the patients' compromised autonomy. As we develop and critically expose pro and against deontological and consequentialist mechanisms of truth-telling to VaD patients, our arguments lead to a puzzle of moral beliefs that we engage in these two moral backgrounds. We argue that the shift of these two moral types of truth-telling mechanisms depending on the patient's cognitive decline lies in the following assumptions: autonomy is a moral principle related to memory, and autonomy is regarded as a principle merely assigned to lucidity.

Keywords: vascular dementia, non-Alzheimer's dementia, truth-telling, moral beliefs, autonomy, lucidity, deontological principles, consequentialist principles.

Introduction

This article is devoted to the moral undertaking of truth-telling practices in communicating diagnostics and other related information to patients suffering from VaD (vascular dementia) [1] in different scenarios that put aside the lenses of direct medical clinical experience and keeps a neutral, nonbiased theoretical approach of moral reasoning exclusively, broadly philosophically framed. Two directing questions inspired this research: (1) If VaD patients are not in severe states, thus losing cognitive skills and judgment in time, then how is altering the voluntary hidden truth by family members and, occasionally, by doctors, the capacity of reasoning and decision-making of such patients, in-

stead of contributing to preserve their current state as long as possible?; (2) To what extent are moral grounds of intention still relevant in truth-telling to VaD patients if lying is morally strengthened by the principle of non-maleficence (formally reduced to the colloquial formula "if you cannot do good, then do not harm") which is rather consequentialist? Moral dilemmas should be handled more prudently in the cases of VaD patients since the pathology of this disease imposes a peculiar progress of mental degradation directly proportional to the increasing moral complications of decision-making for such sufferings. On the one hand, this process falls under the initial premise that patients are unreasonable, thus their autonomy is deontological suspended, at least in a Kantian reading, when, in



fact, memory loss is progressive, uneasily quantifiable (Mini-Mental State Examination (MMSE) measurements are an insightful tool in this regard, and yet, approximate). Our thesis wants to prove that practices of truth-telling that affect the patient's skills of reasoning and judging should be constantly adapted to the stages of VaD evolution.

On the other hand, the pathology of VaD dictates, in our opinion, the dominant moral background of such issues by being an irreversible disease; the main objectives assumed in treatment focus on conserving the current state of the patient as long as possible by this controlling pathological effects on consequentialist realms of moral reasoning. This is, however, a meta-moral approach. In fact, we consider that truth-telling involves, in this gradual evolution of VaD, a moral compass that shifts deontological criteria invested in the onset of the disease, with consequentialist standards of moral reasoning that tend to prospect a larger spectrum of both psychic and moral protection of the patient, in his advanced stages of sickness or his ultimate states. However, the implications of this commutability of moral standards in communicative action [2, 3] are larger than they appear at first glimpse. The value of autonomy is as well progressively sacrificed. As long as deontological insights are excluded from the truth-telling practices in communicating with VaD patients in the early or middle stages, autonomy is compromised at once – as an effect of the moral decision of doctors or family – and not increasingly, as the direct proportion between the pathological progressive memory loss alongside the degradation of judgment capacity, and the dissolution of autonomy reveal happening.

Material and methods

We will argue that in the puzzle of moral beliefs on which we raise the practices of truth-telling, there is a high risk of generating a pattern reducible to the following predictable structure, which is not sustainable: each time we tend to pursue and save a deontological perspective – “you have to tell the truth to the patient”, the autonomy of the patient is conserved, whereas each time we involve consequentialist criteria – “you have to keep the truth from the patient”, you hope to induce to the patient reliable confidence in his independency and capacities that might psychologically or emotionally contribute to his welfare. Are these two values, autonomy and well-fare, concurrent and exclusively disjunctive in the effects caused by the moral mechanisms

of truth-telling to VaD patients? Nobody questions this because we usually fall into the loop of opposing deontological and consequentialist standards of moral reasoning. Actually, the principle of non-maleficence can be equally treated in deontological terms: “you cannot heal the patient, but you can contribute to preserving his current state, which is better than any other future hypostasis in which the patient will find himself in such disease; therefore, if you cannot do good in order to restore his health, since there is no chance for remission, then do not harm him: you have to tell the truth helping him to exercise reasonable decision-making as long as possible”.

We intentionally choose “reasonable”, instead of “rationally”, to emphasize that this should be the practical moral tone embraced by such arguments: we seek to keep patients as reasonable as possible, even though all the communicative actions that we engage in contacts with VaD sufferings start from the premise that tactically we must provide the most optimal reasonable truth-telling practices addressed and applied to unreasonable individuals. For this research, we have engaged methods such as: hermeneutics, observation, comparative analysis, moral reasoning by deontological and utilitarian paradigms, logical formalization and philosophical pragmatism.

Results

Adapting ethical frameworks of truth-telling to symptoms of dementia

In the symptomatology of dementia, memory and language impairment became more profound as the sickness evolved. In the beginning, loss of attention weakened perceptions, and vulnerable awareness concurs with unreasonable judgment, “visuospatial difficulties, and changes in the speed of action and response” [4, 5]. Progressively, different stages of dementia converge towards other symptoms, such as “unpredictable anger and aggression, depression and apathy”, that patients develop through inappropriate and uncontrollable behavior. Strictly in what concerns VaD, patients might either confront a gradual mental decline, corresponding to the loss of their primary abilities in time, or a sudden decline due to strokes [5].

The simple nature of this degenerative pathology raises problems not only for tracking symptoms in diagnosing different stages of the disease but also in distinguishing the sickness from other similar, related

forms of dementia. Current researchers argue that “vascular cognitive impairment” might be a more appropriate term for this disease. This nominal reorientation regains most of the basic historical dilemmas that emerged from the evolution and analysis of VaD, such as the uncertainty of using “dimensional (continuous decline) or categorical (dementia vs. no dementia) approaches” to classify the disease or the search of new hypothesis and instruments “to understand the relation between cerebrovascular disease and cognitive impairment, and vascular and degenerative pathology” [6]. The first impulse would be to attempt a proper and plausible accommodation of the table of stages of VaD, with their signs and symptoms, to different ethical frames of truth-telling and moral dialogue with patients, gaining, in this manner, a branch of predictability in adjusting mechanisms of ethical reasoning and communication to their deficits and needs. Even though different types of VaD should be taken into account by their specific particularities, what is at stake in this research is rather a general, ethical framework of truth-telling mechanisms in multiple stages of VaD; therefore, the GDS table [7] provides enough references to correlated symptoms and stages of dementia, in order to track the loss of autonomy and reasonable decision-making of patients that affect their status as moral subjects in deontological or consequentialists approaches.

Suppose stages 1–3 describe normal and increased forgetfulness, decreased work performance and difficulties in identifying exact words in certain contexts of dialogue, thus framing the beginning of the cognitive decline, starting with stage 4. In that case, patients confront a “moderate cognitive decline” [7], affecting their socialization capacities, willingness to expose to new social circumstances of dialogue and interaction, occasional loss of orientation in new places and unfocused concentration in reasoning. Two symptoms are significant in providing a moral framework of truth-telling in this context: “the decreased memory of recent events” and the possibility that patients “may be in denial about their symptoms” [7]. They both indicate alterations of autonomy that patients as moral subjects confront, albeit autonomy is not fully compromised at this stage. Therefore, the main moral problem regarding the adjustments of truth-telling mechanisms in incipient and moderate stages of VaD is to what extent a deontological approach can stand in circumstances that reveal a partial exercise and disposal of autonomy?

A radical deontologist would argue that deontological approaches to truth-telling mechanisms are

possible only in the first three stages, with possible extensions to the fourth and fifth stages being assigned to a territory of moral relativism. Nevertheless, the situations in which patients can make use of their volition and reasonable judgment are intertwined with episodes of temporary and easily unreasonable judgment caused by loss of accuracy and efficiency. Stage 5 describes moderately severe cognitive decline, in which patients have “major memory deficiencies” and nursery assistance needs expansion to a larger specter of daily activities: “dressing, bathing, preparing meals” [7]. The loss of memory concerns elements that might be strongly related to the biographical nuances, to the identity of the patient, and to the self-disposal in space and time – “people might not remember their address or phone number, and may not know the time or day when they are” [7].

Consequently, this symptomatic background develops two possible paths of moral reasoning and acting in the interest of patients with VaD. One would recall the exact temporal and spatial coordinates of the patient in order to help him preserve, as long as possible, the sense of orientation, identity and decision-making; one would give him calendars, agendas, and notes to the patient, to create contexts for writing memories as personal journals, that equally allow tracking pertinence, affectivity and loss of accuracy in reasoning, by this encouraging the patient himself to be attentive as possible to his current state. In this case, the patient is told about his diagnosis whenever he is lucid and does not confront loss memories episodes, being carefully and repeatedly introduced to the general symptoms of his illness.

The other possible situation proposes a different protocol: contrary to the first case, one would increase the surveillance of the patient and hide the diagnostic from him, considering that once autonomy is compromised, even in lower degrees, then any action and decision must be taken in order to ensure the comfort and happiness of the patient, avoiding, by this conduct, potential strikes of depression, anxiety or anger that can be caused by confronting him with his true medical state.

The similarity between stage 4 and stage 5 lies in a common moral assumption that truth-telling mechanisms must be reconsidered at the first sign of the patients’ compromised autonomy. However, consistent reflections on moral reasoning developed in this scheme of evolutionary symptomatology should put a spotlight on an implicit hypothesis that seems important, reluctant and widespread in the context of

medical acts: autonomy is a moral principle related to memory. At the slightest memory loss, the value of autonomy is compromised and deontological mechanisms of truth-telling fall into a moral relativism for which there are no precise standards of measuring the capacity of self-reasoning and lucidity other than the empirical testing of a patient's discourse, actions and disconcerts.

Nevertheless, whenever consequentialist frameworks of truth-telling are preferred against deontological ones, especially in these particular forms of VaD, autonomy is regarded as a principle merely assigned to lucidity. We go back, through this formula, to the modern Cartesian argument [8] that even those who suffer from madness can make judgments, lucidity representing the additional condition of integrating their actions, behaviors and discourses under the sign of truth. Later on, the Foucault-Derrida polemics on self-consciousness and the role of lucidity in acts of judgment, inspired by Descartes' arguments, created a powerful delimitation of "a-mens" from "de-mens", of high importance for the history of philosophy, but imported from the medical domain [9, 10]. "Amens", "which is doubtless negation", represents "the one who does not have his mind", whereas "demens" (which is doubtless privation) depicts "the one who is disposed of it, who no longer has benefits from it, who deviated" [11]. In fact, the principle of autonomy can be traced back to this Cartesian-rooted dispute. As Foucault observes, in the history of medical practice, the couple *amens-demens* has been subscribed to the term of *insani*: "to be insanus is to take oneself to be what one is not, to believe in fancies, to be the victims of illusions" [9]. The terms "demens" and "amens", which were in the first place of juridical importance and only afterward received a medical discursive privilege, designated "a whole category of people incapable of certain religious, civil and judicial acts" [12]. Both terms had the connotation of disqualifying individuals from certain capacities of "speaking, promising, pledging, signing, starting legal action" [12] and, ultimately, from their rights of doing so.

The juridical and the medical domain converge in this regard, *demens* representing, in both scientific jargons, the impossibility of lucidly conducting human reasoning and actions. There is no intention of taking the intended puzzle of moral beliefs of VaD in what concerns the constitution of truth-telling mechanisms from contemporary states of the art back to the modern Cartesian times; however, this historical background reveals that even its Foucauldian later philosophical

restoring confines that a compromised autonomy on the loss of lucid reasoning, memory and self-identity [13] reflects a vulnerable moral subject, an insanus whose rights [14] – even those of knowing the truth of his own diagnostic – are renegotiated on newer moral grounds. This argument makes stages 6 and 7 of severe, respectively, very severe cognitive decline easier to be handled in rather consequentialist terms. Patients in stage 6 have inexact short-term memory, often "forget names of close family members" and prove to remember as accurately as possible "details of earlier life" [15].

Different types of incontinence make the patient dependent on the constant nursery. On the one hand, in stage 6, patients experience the loss of the ability to speak, which makes conditions of the deontological approach difficult to fulfill – in these terms, the patient's will can hardly be communicated or indicated, language and dialogue being compromised. On the other hand, patients suffer from "personality changes", delusions and compulsions intertwined with anxiety, agitation, and depression. In the last stage, psychomotor abilities are fully endangered and weakened, patients can no longer communicate and memory loss is fully installed. Through this, the patient's welfare becomes the only left value to be protected and the truth-telling mechanisms fall into the shadow. Dialogues are barely possible; if they are occasioned, we tend to inspire and depict affection, confidence and protection, avoiding any emotional complications. A preliminary conclusion can be easily derived from the evolutionary trend of VaD and the values pursued by truth-telling mechanisms: deontological approaches are focused on respecting and preserving patients' autonomy as long as possible, whereas consequentialist approaches prioritize the welfare of the patients. Such values do not compete, but the interest towards them must be balanced considering the different stages of sickness along which moral subjects are not always capacitated to respond to their moral and axiological conditions. In deontological frameworks, protecting autonomy and considering it the core value of medical and family interactions, as well as of nursery practices, involves capacitating the patient himself to contribute to his welfare.

However, the degradation of constant lucidity and memory loss provoke the shift from deontological to consequentialist truth-telling mechanisms. Stages 1–3 are deontological oriented, stages 5–7 are consequentialist oriented, whereas stages 4–5 ensure a balance between deontological and consequentialist truth-telling mechanisms, as in Figure 1.

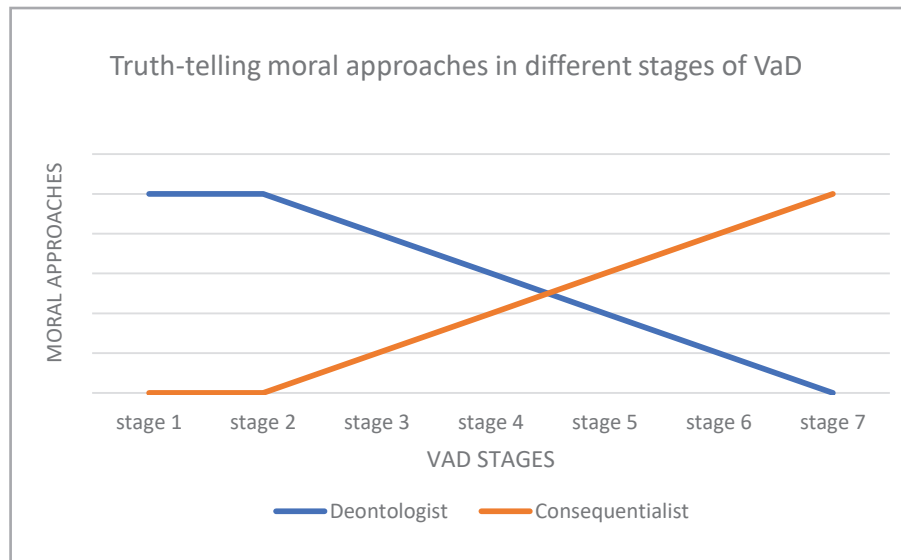


Figure 1: Truth-telling moral approaches in different stages of VaD.

Discussion

Pro and against deontological and consequentialist mechanisms of truth-telling to VaD patients. Puzzling reasonable options

By this point of research, we have reached some clear remarks on the preference of applying in the first three stages of sickness deontological mechanisms of truth-telling that insist on disclosing diagnostics and other related information to the patients suffering from VaD in the name of their autonomy and in order to help the preservation of their decision-making capacities as long as possible, by increasing awareness. We have equally drawn some plausible arguments for shifting deontological approaches of truth-telling to consequentialist perspectives in the last three stages, that advocate for hiding the truth in order to not harm the patient by provoking depression, anxiety or anger caused either by the confrontation with their own medical state or by the recalling of traumatic or painful events from the past, such as the death of a beloved one, forgotten as the sickness advanced. However, we have remained with a loop of moral relativity concerning the expected suitable truth-telling mechanisms in stages 4 and 5. How can we correctly know when deontological standards are preferable in moral reasoning and decision-making to consequentialist criteria?

The general answer is that such a shift depends on the patient's medical state, his biological particularities and the dominant symptoms presented in such stages of sickness. For example, if psychometric capacities that enhance the need for diversified and

permanent nursing reveal to be more affected than the flux of coherent memories than the deontological approach should be preserved as long as possible. If the name or the situation of family key persons is forgotten and their recalling might provoke affective disorders, then consequentialist criteria should be engaged in creating and applying narratives and discursive practices. Sometimes, consequentialist approaches do not necessarily involve or oblige to lying: this represents, however, a general and more extended discussion from ethics, that behind any epistemological standards of analysis remain attached to the idea that withholding the truth is not synonym with lying. In these two cases, intentions differ, as well as the expected results.

Nevertheless, these areas of uncomfortable uncertainty interfere not only with universal moral standards of behavior but also with particular problems such as the doctor-patient confidence or the tangential contradiction with the medical professional oath. Some might consider that this decision between deontological and consequentialist ethical frameworks of truth-telling to VaD patients is influenced, in large, by certain health education and cultural mentality in the name of which, historically, have been created two general trends, one whose dominancy was raised on the decision of not disclosing real diagnostics, fashionable before the 1960s, and one that advocated for honesty and full disclosure, which determined 20 years later around 98% of the doctors being for revealing diagnostics to their patients [16]. In fact, deontological approaches focused on autonomy and consequentialist perspectives, devoted to the principle of non-maleficence, serve different goals that are not necessarily

incompatible but “often lead to different decisions about what information is given [16].

The easiest path towards an appropriate and reasonable option, which equally represents a profitable version for those who seek to exclude themselves from moral responsibilities and blame, would be to introduce policies of prospecting along our life preferences regarding the will to know the truth in cases of diagnostics such as VaD. However, even if these policies were introduced in a different context of health care, moralists might still find a path of uncertainty, as long as, in theories devoted to personal identity, the fact that the corporal identity is respected both in cases of health and in scenarios of the suffering of VaD, the mental identity fluctuates. A patient’s desires in different stages of sickness might be other than those prospected during his healthy times, becoming more vulnerable, affective, nostalgic or fearful. However, recent studies performed on patients with diagnosed VaD reveal they confessed the will to know what is wrong with themselves [17], being frustrated by the lack of transparent communication and feedback. There through, in the puzzle of moral beliefs of truth-telling mechanisms to VaD patients that we sketch in this article, starting with the general principle of shifting from deontological approaches to consequentialist perspectives as the sickness evolves in different stages, some other moral problems and principles must be added: (1) Introducing policies of questioning through health care programs the will of healthy individuals to benefit from full disclosure of their diagnostics in case of VaD, other forms of dementia or other incurable maladies, such as severe and advanced forms of cancer; (2) Identifying pro and against arguments for applying deontological and consequentialist truth-telling mechanisms in medium stages of sickness and adapting such ethical frameworks to patients’ needs and biological particularities; (3) Dealing with moral responsibility in scenarios in which: (3.1.) lying is morally wrong but psychologically good for the state of the patient, in terms of a “therapeutically lie”; (3.2.) withholding the truth is considered not lying and yet does not represent a morally neutral action.

Taking them one step at a time (1) confirms being a powerful problem but with solutions related to state values and public health policies. Anticipative reactions to the possibility of introducing such medical interrogatory concern some people’s resistance, considering that there would be only one step left until serious public discussions about euthanasia contexts and practices. It is not the purpose of the present re-

search to address these projective situations. However, they reveal to be, even in premature and hypothetical conjectures, serious depictions of the effects that such a public program might have once installed in health care systems. Secondary implications related to the dynamics of personal identity in scenarios of health and scenarios of middle stages of sickness are still dilemmatic by their morally inflicted attitudes, values and beliefs, but there are entirely focused on the prevalence that the principle of autonomy should have in such contexts of investigation and reasonable dialogue. The main question is whether or not a person who is still capable of lucid and reasonable arguments, even though they are interrupted by loss of memory or impaired language disorders, is an autonomous person and an integer moral subject, able to dispose of his wills and to self-govern. The problem listed as (2) on my list must be discussed as a territory for validating pro and against deontological, respectively consequentialist approaches of truth-telling. In short, arguments in favor of disclosing diagnostics share premises such as respecting autonomy, strengthening confidence and trust in the doctor-patient relationship, increasing the interest of the patient to participate in clinical trials and studies [16], allowing the individual to prepare with medical directions, for personal affairs, including “power of attorney making wills, choice in future care” [16], by confessing preferences for home nursing, if allowed, or specialized institutional clinical nursing, upholding autonomy, reducing fear and anxiety that patients might have when they observe the loss of different abilities, without any explanation [18], avoiding “involuntary hospitalization” [19].

In the end, arguments that advocate in favor of deontological approaches insist on the idea that truth is intrinsically good and can support moral action for both sides, for patients, on the one hand, and for doctors and families, on the other hand. Nevertheless, some of the same premises that work for supporting deontological values and approaches are used in consequentialist frameworks. This shift opens the path for a moral conflict between these two possible scenarios of moral reasoning and decision-making. As an example, fear and anxiety that might appear while observing disorders might impulse the patient towards anger, unreasonable behaviors and ultimately extreme decisions, such as suicide. For the same reasons, disclosing the truth might be suspected in consequentialist frameworks as principal sources of “destroying hope” and increasing “concerns” [16]. Additional arguments gather to these previous observations: sometimes doctors or

families consider that some patients would not want to know the truth about their medical state, as they knew them based on their long experience and contact or precise information regarding their behavior. Important is what the patient wants if it is possible to know in different stages of sickness or what he would have wanted in particular circumstances. To this personal and direct interaction, the medical ought to respect patients should be applied in contexts of VaD [17].

Nevertheless, symptomatology is important, once again, in solving these moral dilemmas regarding possible conduct and truth-telling decisions. Suppose the patient is no longer capable of understanding abstract notions and proves language impairment. In that case, diagnostics should be withheld, given the fact that the patient lost the inability to understand, operate the information and address it in other contexts, either decisional or interrogative. These multiple occurrences lead to the third listed problem.

If (3.1.) lying is therapeutic, then immorality is excused because an immoral act of lying conducts towards a greater good, that of the patient's welfare. In any case, it should be noticed that lying here is quite circumstantial: only if the patient succeeds in asking if he confronts mental disorders or explicitly if he has dementia and the answer would be negative, a good lie would occur. Otherwise, the general trend of this moral scenario is to withhold the truth, which essentially is not lying, even though, deontological, one withholds a truth that is not about himself but about another person who is morally entitled to know everything that has to do with his autonomy. Therapeutic lies [20] and withholding truth comport the same reasons but for different intentions. Sometimes the former insists on not provoking harm, whereas, in other particular circumstances, the latter helps to maintain hope and psychologically satisfying tonus of the patient. Similarly, consequentialist terms of truth-telling – meaning withholding the truth or lying – confront other areas of moral relativism: are such decisions resting on compassion? Is moral the entire set of practices and values reduced to a sort of compassionate care? From a moral standpoint, would it not be more appropriate to adopt a deontological perspective [21] from the beginning to avoid accusations of compassion and pity, even though they are not the same thing? Such interrogations enroll our moral consciousness in contexts of higher awareness and responsibility, but in the end, the puzzle of moral beliefs of VaD truth-telling mechanisms reveals that the progress of the sickness makes relative in different stages the shift from deontological to con-

sequentialist approaches. Precise information on the exact capacities lost by the patient can offer a suitable context for moral decision-making. The patients' biological particularities and symptoms must be progressively correlated with the best-fitting deontological and consequentialist approaches to truth-telling. This offers a final and intuitively uncomfortable conclusion for any actor that might be part of a VaD scenario: moral relativism, in such cases, can be defeated and taken to a clear zone of deontological or consequentialist approach only by adjusting theoretical, moral knowledge, to empirical contexts regarding the progress of the sickness [22, 23].

Conclusions

Uprising some final considerations on this moral evaluation of adjusting truth-telling mechanisms to VaD patients, the most striking aspect is that truth-telling proves to be instrumental and related to the disease's empirical states of progress. Regardless of the deontological or consequentialist framework of moral decision-making, truth-telling strategies must be evaluated from both sides to meet the patient's best interests. As medical practice and knowledge hold a profound dependence and affinity for empirical realms, so does the moral dilemma born in such contexts. Symptomatology offers criteria for moral reasoning that adjust deontological truth-telling mechanisms to particular cases of easy forms of forgetfulness and consequentialist frameworks to severe cognitive decline. The most important aspect of solving moral conflicts between our moral duties, our moral intentions and the expected behaviors of the patient to us must be considered as parts of the processual decision-making. In the end, the sickness itself is a process, and its progress complements the principles, the values and the final actions of the moral evolution of its framework. Reasonability, meaning testing whether deontological approaches might be more suitable in particular circumstances than consequentialist approaches, especially in moderated stages of sickness, must be separate from the beginning, with moral compromises. Both disclosing diagnostics and withholding truth register different degrees of reasonability and moral justification that depend, from philosophical standpoints, on the dynamics of the mental, and personal identity of the patient, on his lucidity, autonomy capacities and wills, and from a medical perspective, on the table of concrete symptoms in certain stages of the VaD evolution.

Conflict of interest

The authors declare no conflict of interest.

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