

## MODERN VIEWS ON THE TREATMENT AND REHABILITATION OF PATIENTS WITH DEMENTIA

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**Abstract.** *Alzheimer's is a clinical diagnosis. At the same time, Alzheimer's pathology begins long before clinical manifestations, and research is increasing to assume that biomarkers such as positron emission tomography and fluid tests directly prove this pathology. It is assumed that the diagnosis can be distinguished from the clinical expression of Alzheimer's disease. It is debated whether Alzheimer's preclinical disease changes the boundaries between "normal cognitive aging" or "healthy brain aging" and disease, which should change the notion that Alzheimer's disease belongs to the most feared aging diseases among late age-specific diseases fear of getting sick.*

**Keywords:** *treatment, rehabilitation, dementia, Alzheimer's disease, cognitive disorders.*

**Introduction.** Alzheimer's disease is exacerbated by negative or ambiguous signs in the title. It should be noted that in Japan, the government officially changed the sign of dementia to cognitive illness. In promoting knowledge about patients with dementia, their friends and relatives, especially the early and intermediate stages of the disease [1]. Dementia stigma is constantly studied in research by the International Alzheimer's Association [2], including in the study of criticism in patients and caregivers, the risk of suicidal tendencies [3]. Stigma is seen as one of the main barriers to understanding the disease, seeking help, diagnosing, and using support services. This closes the ways to openly discuss the disease and makes doctors think that they cannot offer anything. Consideration of various aspects of stigma focuses on finding ways to overcome stigma [4]. In modern classifications, dementia diagnosis and stigma elimination in DSM-5, radical changes in dementia diagnosis are determined by combining different levels of cognitive decline into a rubric called "neurocognitive disorders" [5].

This new diagnostic team derives from the old label "delirium, dementia, amnesic and other cognitive disorders" in DSM-IV and "organically identified mental disorders" in ICD-10. The basic concept is the definition of "neurocognitive disorder", recently introduced into scientific circulation, the main symptom of which is the cognitive decline acquired in the six main areas (domains) [6]. These include attention complex, executive functions, learning and memory, speech, perception and motor skills, and social cognitions. For all these domains, individual cognitive functions are indicated, on the one hand, there are clinical syndromes and, on the other hand, quantitative tests for evaluation [7]. Neurocognitive disorder is diagnosed as large or small based on the following criteria: - small neurocognitive disorder includes: moderate decrease in cognitive function, no loss of patient independence.

This condition is similar to mild cognitive decline (MCI); - major neurocognitive impairment implies a significant decrease in cognitive ability, leading to self-inability and dependence on support [8]. Neurocognitive disorder replaces the concept of "dementia". The advantage of its introduction is the possible reduction of the "stigma" present in the concept of "dementia". From a medical point of view, this relieves the problem of treating dementia from theoretical disappointment [9]. At the same time, the exceptional concepts of "dementia" as a medical diagnosis can pose new risks, since special medical and socio-legal measures in the field of guardianship and trusteeship are associated with it. After all, at present, it is these areas that take on the main burden of ensuring the life of people with dementia [10]. Minor neurocognitive disorder poses another additional problem in Alzheimer's disease. Since the neuropsychological and clinical signs of this subtype are often difficult, first of all, to distinguish from physiological aging, the diagnosis of "probable" small neurocognitive disorder in Alzheimer's disease can only be made if very strict conditions are met, namely: with a clear statement of the genotype or with a sufficient number of biomarkers and values specific to Alzheimer's disease. In ICD-11 it is also assumed that the diagnosis of late-age dementias using the concept of "neurocognitive disorder" is presented in a similar way, which improves the understanding of the internal picture of dementias necessary for therapeutic communication, elimination of stigmatization, optimization of cooperation between specialists, patients and their loved ones. self-help societies, the presence of biopsychosocial approaches with proven resource-saving potential [11]. Helping with aging dementia is a health priority. Insufficient assessment of the problem leads to delayed and insufficient assistance, aggravating the burden of the disease; condemned the sick and their loved ones [12]. The ethical aspects of the extended stage of dementia during dementia arise many ethical questions, both daily and in special situations.

They include, but are not limited to, the following points [13]: - the balance between patient privacy and family awareness (including diagnosis); - the balance between the patient's previous views and values and current perceptions and opportunities, including the role of supporting decision-making; - the balance between security and freedom-keeping; - the use of assistive technologies (often the balance between security and Privacy); - making a decision to end life, including saving life in the absence of data and pre-orders for palliative care [14]. This attitude must meet high moral standards, but must be flexible and sensitive in certain situations. Moral principles that recognize basic human rights imply equal availability of resources and assistance for all members of society, regardless of their social status, culture, and geographical affiliation [15]. Over time, patients lose the ability to independently make decisions. Driving rights are lost in the intermediate dementia stage, where the use of a standardized assessment algorithm in depriving Lysen Zii of driving is considered morally correct [16].

Moral aspects at this stage of the disease can be more associated with the behavior of relatives who resort to "soft" lies or even direct lies. It is preferable to follow the patient's peace of mind than to achieve reality. for example, by repeating the same issue over and over again or not recognizing loved ones [17]. The same "holy lie" methods include hiding or reporting at the last minute about an event the patient is afraid of (visiting a doctor, placing it in a care unit). Any separation from loved ones, a violation of unity is seen as stress, and on the contrary, it is positive to maintain communication and interaction, which, according to autopsy, is pathogenetically justified by stimulating alternative mechanisms of the brain to compensate for the deficiency [18]. M. Roth noted that in the advanced stage of the disease, moral, medical and psychological

problems appear in a paradoxical and problematic form to solve before the persons responsible for the patients. For some relatives, living with a beloved mother, father or spouse retains its dignity. While they are influenced by ideas about the former importance of a loved one, it is surprising that in the early stages of ad, the need or expediency of treatment is needed [19]. For them, death is an enemy that needs to be fought until all individual traces of personality and spiritual life disappear. These feelings should be perceived with respect and meaning. Discussing the ethical problems of therapy modern symptomatic agents – cholinesterase inhibitors and memantine-are relatively easy to consume, but their availability is limited in many countries for economic reasons or due to therapeutic nihilism [20]. Although their effects are moderate, they affect the design of new drug testing protocols, as the use of placebo in clinical trials in Diagnosed Patients is rarely resolved beyond 3 months [21]. In addition, the opinion of psychiatrists may differ whether psychiatrists should prescribe antipsychotics to patients with dementia [22]. It is believed that these drugs increase the risk of serious adverse events or even death, but they can effectively weaken arousal and aggression, facilitating contact with caregivers who can take longer home care. Both patients and family members should be informed about this appointment [23].

Even if the patient misunderstands, it is important to show respect by involving him in the discussion [24]. At the same time, it is noted that the position of the doctor should be very flexible, make exceptions. This is due, in particular, to the appointment of antiandrogens for sexual dysinhibition. It is ethical to first Test behavior correction measures and only then prescribe antiandrogens. Physical compression measures are still widely used in the moderate to severe dementia stage. Alternative non-pharmacological therapy types and caregiver training programs have not been adequately evaluated in randomized studies [25]. The behavior of patients with dementia can be stressful for others and for themselves. The ethics of caring for AD patients are based on changing the socio-environmental situation and supporting activities to maintain independence and self-affirmation, such as creating stereotypical action or safe places to walk. The Prohibition of mechanical and chemical containment measures has been recognized as morally justified [26]. From the point of view of ethics, the question of whether psychiatrists should encourage cognitive stimulation exercises in ad is debated. It is believed that it is necessary to compare their benefits and risks, the latter means self-esteem, loss of self-esteem during mistakes, sometimes the fear of offending loved ones, that is, it is always necessary to take into account the impact on relationships with loved ones. Moral optimization of this situation involves performing these exercises together, solving crosswords, composing puzzles [27]. Moral dilemmas of the late stage of the disease moral problems of the last stage of dementia are often and to the greatest extent discussed. More than a quarter of a century ago, the classic of modern gerontopsychiatry M. Roth has dedicated a special work to this issue [28]. This followed the passage of a law regulating euthanasia in Denmark. Recognizing that the clinician's desire to cure or alleviate the disease and the experience of compassion can be undermined by impractical evidence over time, M. Roth notes that in the last years of the disease, most patients with AD are in a special vegetative state without traces of residual personality [29]. At the same time, the author pays attention to the fact that in the middle stage of the disease, apathy, inhibition, lack of attention and even partial cognitive decline are associated with a long stay in the institution [30]. In a number of patients with AD, a routine examination will determine a complete collapse, but in some cases different abilities may be retained. At the same time, with the development of pneumonia or coma, the ad is the only human and moral m in the management of the patient at the terminal stage. Roth allows the death

process to continue to the end, as attempts to reconstruct such patients return them to a state where there is no longer life in the real sense [31]. The most controversial issue from the point of view of Bioethics is the issue of voluntary active euthanasia. M. According to Roth, this measure is directly contrary to the doctor's moral sense. This medical position leads decision-making due to tradition, training, and experience. In relation to Ba, the intensity of this moral imperative is resilient, despite the pressing of ideas about the possibility of accelerating death [32]. Assessing the achievements of scientific research in recent decades, the researcher believed that "light has appeared at the end of the tunnel" due to the development of new drugs hope for the possibility of stopping the development of the disease and possibly preventing it [33]. It is recognized that there are no morally, morally and legally impeccable ways to solve problems of the last stage of dementia, since the choice is made not between good and evil, but between smaller and larger Evil [34]. The use of the latest technologies makes it possible to save the lives of patients whose body has forever lost the ability to independently cope with the most important functions of life [35]. Thus, the noble and human task of Medicine — the fight against disease — becomes its opposite — the struggle to preserve the disease for a long time. The main thing is the question of when and when to continue life with dialysis for treatment, prescribing antibiotics for pneumonia or kidney failure [36]. Patients present the problem of getting rid of pain that they cannot complain of, just like artificial (probe) feeding when swallowing is impaired. In the implementation of life support measures, it is recognized that it is necessary to explain complications and risks to relatives [37]. Other ethical problems in the final stage of dementia are related to the standards used in the appointment of antipsychotics, participation in research, decision-making for the deeply vulnerable. These decisions are based on what once sick people were or how they appeared, which explains the existence of diametrically opposed views [38]. Drawing up pre-orders or a statement of Will in relation to intervention in the Terminal stage is seen as a morally justified way out in these situations [39]. During the period of preparation of orders, the patient's condition should be considered as a real, competent and informative demonstration of the preference for actions in the event of an infection of the respiratory or gastrointestinal tract or the appearance of coma at an incurable stage [40]. This should not be done under the influence of depression or nihilistic despair, feelings of guilt or suicidal thoughts. Since the situation may change, the possibility of changing commands should be given. If such an order provides for the continuation of life, the doctor must ensure the treatment and maintenance of life [41]. This can lead to conflict with the doctor's clinical judgment and moral standards, but there is no law for the doctor that allows you to take the patient's life away. The second is that there is a difference between killing and allowing one to continue dying without interference. A doctor who does not recognize the latter is not only a healer, but also a performer. An alternative is Hospice Care [42]. Thirdly, patients who are in a state of complete dementia should be protected from undermining their self-esteem and being allowed to die. In these cases, discontinuation of treatment and artificial feeding should not be considered illegal or immoral acts. But these last principles do not apply during the course of the disease, but only apply to the last 2-3 years [43]. This idea should be further developed on the basis of widespread judgments about irreversible "brain death" in recent years. It is equivalent to the death of an individual, but this applies only to a long-lasting coma. It has become common for early stage patients to be asked about the decision-making advantages of terminal stage treatment and care (artificial feeding, compression measures, artificial respiration, etc.) [44]. Avoiding this discussion is associated with a depressive state and a fear of generating other fears (fear of

aggressive behavior, etc. At all stages of the disease, most patients want to be fully involved in determining their future as much as possible and in the life of the family. Opposite feelings are characteristic of family members. Without prior orders, they must deal with these morally difficult issues [45]. As long as patients are qualified, psychiatrists take a paternalistic position and encourage patients to discuss these issues with relatives, making sure that this discussion does not injure the psyche. It is necessary to discuss the experiences that arise with the patient, this is self-psychotherapy. There are extreme positions-on the one hand, to continue life in the stage of deep dementia, on the other hand, to give the opportunity to stop a meaningless being [46]. The intermediate position-the desire to continue life-becomes clear until it is accompanied by Joy and suffering. The psychiatrist should know that even if patients have given prior instructions, their benefits can vary significantly depending on the outcome of the disease. Finally, it is not always clear when to stop discussing with the patient his instructions at the end of his life. If this is a mental trauma, you should definitely do it [47]. The question of ethics is also whether a psychiatrist and family members should forcibly hold on to the integration of their relationship with the patient. The situation at the end of the life of individuals who have not left an order in advance and whose preferences are unknown should be discussed at the meeting of the Ethics Committee [48]. When the disease progresses and the ability to understand and choose information is lost, clinical, ethical and legal issues of informed consent are differentiated in clinical and research institutions. The international Alzheimer's Association's ethical guidelines regarding the terminal stage provide for the rejection/cessation of pre-given treatment and adherence to hospice care guidelines [49]. This is such medical, psychological and social assistance to a dying person when his death becomes a "death by Dignity". In the works of modern bioethics researchers [50] it is noted that F. Bacon formulated the essence of modern palliative medicine 350 years before the opening of the first hospice in 1967. At the end of its life, care for patients with dementia gradually shifts to a palliative approach similar to that of the last stage of cancer [51]. Ataraxia (Greek. ataraxia-equality) - the term ancient ethics, means the state of mental peace, the transfer of attention from external conditions to internal ones, the focus on the "most common and fundamental", which helps to abandon thoughts about death in the first place. In a generalized form, the morally sound actions of a practicing psychiatrist are reduced to the following rules [52]; - in the early stages of dementia, keep in mind that it is important for these patients to be under control and participate in family life as much as possible. Moral priority consists in properly informing about the disease, involving it in the treatment and assistance plan, discussing the preparation of orders in advance; - as the deterioration continues, this position of honesty may not be the best [53]. The goal is to relieve stress, and a moral attitude should meet the emotional needs of patients. Allowing falsehood to manifest or maintain honesty is individually variable. A psychiatrist should also support caregivers; – at the last stage of ad, with the possibility of death in the near future - discussing artificial feeding issues with relatives, sometimes speech and the desire to live can be preserved, it is important to maintain the absence of pain and contact with loved ones [54]. That is, both possibilities are considered – to allow to die and start life-saving measures. The role of the psychiatrist is not to make decisions for the patient, but to help the patient and family members make decisions. Clinical research ethics is an area of biomedical ethics that defines the relationship between the subject and the object in the process of conducting clinical research (CI) in human participation [55]. Ki provides for compliance of the conditions of transfer with generally accepted moral standards, requirements for compliance with the rights, interests and personal dignity of ki

participants, subordination of the interests of Science and other interests to the priority of the rights and freedoms of the individual. The CI is regulated by the GCP (good clinical practice) rules, compliance with which is considered as a public guarantee for the rights and health of the subjects, as well as the protection of their privacy and the reliability of the collected clinical data [56]. The ethical issues of conducting clinical research in patients with dementia are an independent problem. In clinical studies conducted in patients diagnosed with dementia, it has already been mentioned that the use of placebo is rarely resolved outside 3 months [57]. The main issues are the involvement of dementia patients in research and the protection of their well-being, informed consent, risks, benefits and burdens, brain and tissue donation, publication and dissemination of research results, end of life and various aspects related to medical research (clinical studies, epidemiological and genetic studies) [58]. The main thing is to get informed consent of the patient. In the United States, the government established 8 General informed consent rules to participate in research. Patients with cognitive decline cannot cover these complex data, so researchers and control groups should carefully consider the risks and benefits for these patients and consider protocol modifications to protect patients. Finally, family members or surrogate caregivers must be involved in the consent process [59]. It is interesting that in 1971, the United States Department of health was transformed into the Department of Health and human welfare. He founded the public council for the supervision of modern-type ethics committees, specifically scientific institutions, which in the United States is a public body. The basic principles of his activities are largely repeated in the activities of all ethics committees. The committee must assess compliance with the ethical principles of research projects, especially the procedure for obtaining consent informed in writing to participate in experiments from subjects, monitor the progress of experiments and, if necessary, suspend them. It is known that the requirements for biomedical ethics when conducting clinical research are based on the 10 rules of the famous Nuremberg Code, a type of ethical code for conducting medical and biological experiments in humans. The Geneva Declaration adopted by the World Medical Association is a modern analogue of the "Hippocratic Oath", a series of moral documents created later regulate the activities of doctors and researchers. Education is considered necessary to receive education in ethics.

**Conclusions.** Such training of specialists should be aimed at recognizing the ethical aspects of decision-making and assistance planning, knowing the rules and laws and applying them in certain situations, supporting people with dementia, their families and non-professionals. The objectives of optimizing this process should consist of the following steps recommended by the author: - development of morally adequate care standards based on the UN Convention on the rights of persons with disabilities; - provide specific strategies and mechanisms to achieve these standards; - prevent abuse of dementia patients, make decisions, provide end-of-life care and create legal restrictions and relationships in human rights issues; - professional clinicians, care of family members, and Human Rights training programs for non-professional caregivers. in all civilized countries, today National Associations of physicians interested in the development of Bioethics, the development and appropriate level of support for professional medical ethics standards in health care institutions. Biomedical ethics is the most important Institute of modern society, one of the tasks of which is the development of measures to protect the rights and health of the adult population as a whole, and an increase in the number of elderly people with various degrees of cognitive decline.

## REFERENCES

1. Abdurazakova Robiya Sheraliyevna, Turaev Bobir Temirpulatovich 2023. Characteristic features of affective disorders in children with autism. *Iqro jurnali*. 2, 2 (Apr. 2023), 722–727.
2. Aleksandrovna S. M. et al. Integrated approach to correcting neurocognitive defects in schizophrenia // *Science and Innovation*. – 2023. – T. 2. – №. 11. – C. 76-81.
3. Allambergenov A. J. et al. Postcovid syndrome and its neuropsychiatric consequences after covid-19 in patients with alcoholism // *European Journal of Interdisciplinary Research and Development*. – 2023. – T. 11. – C. 42-46.
4. Anatolyevna S. Y. et al. Protective-adaptive complexes with codependency // *Science and Innovation*. – 2023. – T. 2. – №. 11. – C. 70-75.
5. Asliddinovich M. O. et al. Psychological characteristics of patients with gastrointestinal diseases // *IQRO*. – 2023. – T. 3. – №. 1. – C. 225-230.
6. Hamidullayevna X. D., Temirpulatovich T. B. Clinical and psychological features of alcoholism patients with suicidal behavior // *IQRO*. – 2023. – T. 1. – №. 2. – C. 711-720.
7. Holdorovna I. M., Murodullayevich K. R., Temirpulotovich T. B. Problems of consciousness disorder in modern psychiatry // *Journal of healthcare and life-science research*. – 2023. – T. 2. – №. 10. – C. 20-27.
8. Holdorovna, I.M. and Temirpulatovich, T.B. 2023. Features of Psychopharmacotherapy in Patients with Severe Mental Disorders. *Scholastic: Journal of Natural and Medical Education*. 2, 7 (Jul. 2023), 40–46.
9. Holdorovna, I.M. and Temirpulatovich, T.B. 2023. Optimization of complex methods of treatment of patients in schizophrenia. *Journal of education, ethics and value*. 2, 8 (Aug. 2023), 59–67.
10. Holdorovna, I.M. and Temirpulatovich, T.B. 2023. The Role of the Family in the Formation of Internet Addiction. *Scholastic: Journal of Natural and Medical Education*. 2, 7 (Jul. 2023), 10–15.
11. Murodullayevich K. R., Holdorovna I. M., Temirpulotovich T. B. The effect of exogenous factors on the clinical course of paranoid schizophrenia // *Journal of healthcare and life-science research*. – 2023. – T. 2. – №. 10. – C. 28-34.
12. Murodullayevich K. R., Temirpulatovich T. B., Holierovna K. H. Social assistance in patients with phobic anxiety disorders // *Iqro jurnali*. – 2023. – T. 2. – №. 2. – C. 408-413.
13. Nikolaevich R. A. et al. Social, socio-cultural and behavioral risk factors for the spread of hiv infection // *Science and Innovation*. – 2023. – T. 2. – №. 11. – C. 49-55.
14. Ochilov U. U., Turaev B. T., Zhumageldiev N. N. Peculiarities of the formation and course of alcoholism in persons with character accentuations and personality disorders // *Bulletin of Science and Education*. – 2020. – №. 10-4. – C. 88.
15. Temirpulatovich T. B. Depressive disorders in alcohol recipients and its socio-economic consequences during the covid-19 pandemic // *Web of Scientist: International Scientific Research Journal*. – 2023. – T. 4. – №. 1. – C. 162-168.
16. Temirpulatovich T. B. et al. Alkogolizm bilan kasallangan bemorlarda covid-19 o'tkazgandan keyin jgardagi klinik va laborator o'zgarishlar // *journal of biomedicine and practice*. – 2023. – T. 8. – №. 1.

17. Temirpulatovich T. B., Hamidullayevna X. D. Neuropsychiatric disorders that develop in a complication of covid-19 to alcoholism //European Journal of Interdisciplinary Research and Development. – 2023. – T. 11. – C. 47-51.
18. Temirpulatovich T. B., Murodullayevich K. R. Characteristic features of postkovid syndrome in patients with alcoholism, the presence of various liver diseases //Open Access Repository. – 2023. – T. 4. – №. 2. – C. 266-277.
19. Temirpulatovich T. B., Uzokboyevich T. A. Biochemical Changes in the Liver After Covid-19 Disease in Alcohol-Dependent Patients and Their Effects on the Course of Alcoholism //The Peerian Journal. – 2023. – T. 15. – C. 28-37.
20. Temirpulatovich T. B., Uzokboyevich T. A. Effects of exogenous psychological effects on alcohol consumption during the covid-19 pandemic //Web of Scientist: International Scientific Research Journal. – 2023. – T. 4. – №. 1. – C. 157-161.
21. Temirpulatovich, T.B. 2023. Crisis Behavior in Anxiety-Depressive Disorders in Alcoholic Patients after the Covid-19 Pandemic. Scholastic: Journal of Natural and Medical Education. 2, 7 (Jul. 2023), 23–27.
22. Temirpulatovich, T.B. 2023. Laboratory Changes in Chronic Alcohol Abusers in Postcovid Syndrome. Scholastic: Journal of Natural and Medical Education. 2, 7 (Jul. 2023), 55–64.
23. Temirpulatovich T. B. Effects of social factors in children with anxiety-phobic disorders //Journal of healthcare and life-science research. – 2023. – T. 2. – №. 10. – C. 35-41.
24. Temirpulatovich T. B. et al. The Impact Of Medical And Social Factors On Alcohol Abuse In Patients With Alcoholism During The Covid-19 Pandemic //Journal of Pharmaceutical Negative Results. – 2022. – C. 8195-8200.
25. Temirpulatovich T. B. Somatoform variant post-traumatic stress disorder //Journal of healthcare and life-science research. – 2023. – T. 2. – №. 9. – C. 45-52.
26. Turaev B. the course of the disease during the covid-19 pandemic in patients with alcoholism //Science and innovation. – 2022. – T. 1. – №. D8. – C. 130-134.
27. Shernazarov Farrukh ORGANIZATION OF DIGITALIZED MEDICINE AND HEALTH ACADEMY AND ITS SIGNIFICANCE IN MEDICINE // SAI. 2023. №Special Issue 8. URL: <https://cyberleninka.ru/article/n/organization-of-digitalized-medicine-and-health-academy-and-its-significance-in-medicine> (дата обращения: 20.11.2023).