

This response was submitted to the consultation held by the Nuffield Council on Bioethics on *Dementia: ethical issues* between May 2008 and July 2008. The views expressed are solely those of the respondent(s) and not those of the Council.

Q2: People with a close family or social circle will be more likely to have them for support and care when diagnosed

Q3: When it is certain that they have dementia, although at earlier stages they should be told that dementia could be a possibility.

Q5: Yes, but not in all cases, it would depend on where in the brain neuron loss was occurring.

Q7: Yes, although this would need to be done carefully so as not to make a spectacle of the sufferers.

Q8: It really depends on the family of the sufferer. Not everyone is able or willing to take on the responsibility of caring for someone. If people need help and support the government should be able to provide this.

Q10: Perhaps this could be discussed with a health professional, who could then decide if responsibility for decision making needs to go to someone else, or if they are still capable.

Q11: I believe they are useful and should be suggested to everyone, but not everyone may want one. People should take a lot of thought when completing one and allow for future advances in treatment.

Q12: A welfare attorney although should be listened to, does not have the same knowledge as a doctor or other health professional, and so it is essential that all options are clearly explained to the welfare attorney so they understand the full extent of their decisions.

Q14: If the person can still carry out these tasks, they should be allowed to do so. This should really be assessed according to the individual.

Q15: I do not think that pharmacological restraint should be used, as these are often given too easily, and further diminish the quality of life. If completely necessary, physical restraint should be used if a situation arises. But afterwards it should be examined to see if they could indicate a trigger and so limit use again in future.

Q16: Yes, perhaps these would be discussed along with advance directives to see if the individual would want to use them.

Q19: Funding need to cover both research and benefit sufferers now, and in the future. A greater understanding of the causes needs to be addressed.

Q20: This should be put in an advance directive or be down to a welfare attorney. If a study would be distressing or harmful perhaps it should not be being carried out, and more work in vitro or invivo could be done to assess how necessary it is.