

## Maximizing available time

### *Family doctors' challenges with dementia*

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**D**oes the medical world ask too much of family doctors? When it comes to the field of dementia, I believe it does. In our busy outpatient practices, we are expected to be specialists in the ever-evolving diagnosis of different types of dementia, to prescribe and monitor medications with their subtle side effects, to be aware of prevention, and to assess and manage progress.

Across the spectrum of practice locations, from our offices to nursing homes, we are expected to be experts in behaviour management and ethical issues. Along the way we have to help and educate families and caregivers of patients with dementia.

#### Challenges in an office setting

Apart from the increasing incidence, the natural course of many types of dementia is progression of disease with deterioration of cognition and the appearance of behavioural symptoms. Each patient will progress differently. This is like trying to grasp a moving target. Diagnosis has to be individualized, involves collateral history, and therefore generally requires a great deal of time. Is this time realistically available to the busy office or clinic physician?

Research on prevention for Alzheimer disease, the most common form of dementia, is mostly inconclusive, as suggested by Scalco and van Reekum in this issue of *Canadian Family Physician* (page 200). To date medication management, primarily with cholinesterase inhibitors, is limited to Alzheimer dementia, and more recently to mixed (eg, Alzheimer and vascular) dementia. These medications are not funded in all provinces, have side effects, and have time-consuming monitoring obligations. Given that results are modest at best, family physicians may well question whether prescribing medication for these conditions is the best use of their time. The article by Hillmer and colleagues (page 208) explores family physicians' prescribing practices, noting great variability. Some specialists

start cholinesterase inhibitors and request family physician follow up. How responsibility is shared is not always clear. The challenge for family doctors then becomes how to monitor, modify, or stop medication over time.

Providing information, educating, and supporting patients, families, and caregivers is also time-consuming, because this can be as much an art as a science, as one of my busy office colleagues always says. Could we argue that this is time well spent, with a greater effect than prescribing and monitoring medication, if a family physician had to prioritize? After all, maximizing precious time is the reality for family physicians.

As dementia progresses, community and institution-based resources have to be mobilized in a timely fashion. The quantity and quality of these resources can be poor. Optimal care at this point is best done by a team, a luxury not always available in an office setting.

#### Settings other than offices

Here the situation is different. Diagnosis and management of dementia in nonoffice settings, such as home care and institutions, is also largely done by family doctors. Many have become experts in this arena and provide a much-needed service. Family doctors may also work in specialized clinics. In all these locations, they prescribe and manage anti-dementia medication, as well as medications for behavioural and psychiatric symptoms. The myriad ethical issues typically encountered in dementia need to be addressed. These can even include determining when to stop cholinesterase inhibitors. Nonoffice settings lend themselves to better and more appropriate care for patients suffering from dementia, possibly because of more available time and the availability of other health care workers, including nurses and social workers, who comprise a precious team.

## Maximizing limited time

Here is what I suggest. I would be interested in readers' comments.

**Diagnosis.** Many of us do not screen for dementia in office settings, but will get involved if a patient or family member questions memory loss or other cognitive impairment or if we suspect it. I think this is an acceptable and realistic approach.

An excellent guide was developed especially for family physicians by the Canadian Consensus Conference on Dementia.<sup>1</sup> I am told an updated version will be published in March 2006. This guide gives clear common-sense recommendations about how to diagnose the most common types of dementia, what tests should be done, and when to refer patients to specialists. We need to remember that dementia is not synonymous with Alzheimer disease; there are many other types. We need to be familiar with common tools, such as the Mini-Mental State Examination,<sup>2</sup> and with how to administer a simple clock-drawing test (alone, or as part of the Montreal Cognitive Assessment),<sup>3</sup> as these can accelerate screening and monitoring of cognitive impairment. We should not mistake depression for dementia, which is an unforgivable error, especially as depression is treatable, although, depression sometimes coexists in early dementia. And we must be sure to limit medications that might impair cognition, including anticholinergics, benzodiazepines, and over-the-counter medications.

Some cities have cognitive impairment clinics, which are excellent resources for early diagnosis of mild cognitive impairment and dementia. Everyone wins because early referral can save family physicians considerable time, and patients may be pleased to participate in much-needed research on dementia. Unfortunately, these resources are becoming very sought after, and waiting lists are growing.

**Prevention.** I would rather focus my time on preventing vascular dementia, emphasizing the prevention of hypertension, stroke, cardiovascular disease, smoking, obesity, diabetes, hyperlipidemia, and the like, as I feel I get more "bang for my buck" than attempting prevention of Alzheimer dementia, given the lack of evidence to do so. Prevention,

as described above, is what we do anyway for many other disorders commonly managed by family physicians; it still boils down to promoting healthy lifestyles. My opinion might change if a vaccine for Alzheimer disease is developed.

**Management.** I do not want to suggest that there is no place for starting and monitoring medications for dementia in office settings; but once medications are started, physicians must find the time to monitor their effects and side effects optimally.

Get to know a local neurologist or geriatrician for referral and advice as appropriate. Some geriatricians are pleased to monitor use of cholinesterase inhibitors. Insist on shared responsibility.

A self-administered chart audit to compare what you think you do for your dementia patients with what you actually do is a useful exercise to gauge your practice.<sup>4</sup>

We should be familiar with local home-care and community resources and with how to refer patients for institutional care, all of which might have to be mobilized quickly. Management involves a global approach: caregivers also need education and help. We know that emotions, such as loss, guilt, isolation, and a sense of being burdened, are complex and need support. The Alzheimer Society can be very helpful in this regard ([www.alzheimer.ca](http://www.alzheimer.ca)). We might also have to call upon day-care centres for respite care for caregivers. Family doctors need to be comfortable with determining driving ability when cognition decreases, and with guiding end-of-life decision making, including writing wills and mandating surrogates. There are tools available to help, but they are inconsistently used.

Management of behavioural and psychiatric symptoms in moderate to advanced dementia is a challenge, and the article by Omelan (**page 191**) in this issue provides an excellent guide.

## Wish list: what would make managing dementia easier?

We should ask our specialist colleagues to develop more consensus guidelines and tools for screening, diagnosis, and management in busy office settings. We need high-quality tools for distribution to families, such as reading material, videos, kits,

and lists of resources, whether they be for respite care, information, or education on managing ethical issues. These tools should be evidence-based, recommended by consensus, validated, and widely available, and their use should be standardized across the country. Second, I think family physicians and specialists need to continue to discuss ways to optimize shared care of patients suffering from dementia. Third, the health care system needs to facilitate family physicians' access to other professionals to optimize collaborative team care. ❁

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#### Acknowledgment

*I would like to thank Dr Paul Lysy, my busy colleague, for allowing me to bounce ideas off him.*

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**The opinions expressed in editorials are those of the authors. Publication does not imply endorsement by the College of Family Physicians of Canada.**

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## PubMed Central—at last

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**W**e are delighted to announce that *Canadian Family Physician* has been accepted into the PubMed Central (PMC) database.

Eighteen months ago, the staff at *Canadian Family Physician* debated whether or not to try for membership in PMC in order to increase exposure for our substantive research and education articles. Given the added rigour and prestige associated with PMC, as opposed to a straight link to our own website, we decided to apply for PMC membership.

This was part of our Print short, Web long strategy, which was meant to increase the number of research articles we could publish while we managed the smaller size of the print journal. In this format, our research articles have been available on our website in full text since January 2005.

To be included in PMC, journals must qualify on two levels: on the scientific and editorial quality of the content, and on the technical quality of the digital files. *Canadian Family Physician* has been indexed in PubMed-MEDLINE since 1993, and has fully met the criteria for scientific and editorial quality. We have worked very hard in the last year and a half to meet PMC's technical requirements as well. Happily, we can now report that we have met their standards and will be accepted by PMC starting in February 2006. We intend to archive previous work on PMC, beginning with all the articles for 2005.

### PubMed-MEDLINE and PubMed Central

What is the difference between these databases and what does it mean for *Canadian Family*