



Making the most of our time

Thank you for the editorial "Maximizing available time. Family doctors' challenges with dementia" in the February 2006 issue of *Canadian Family Physician*.¹ It is about time family doctors acknowledged that benefits of the medications available for Alzheimer disease are very limited compared with those of "providing information, educating, and supporting patients, families, and caregivers."¹ Treatment for Alzheimer disease illustrates how standards of care evolve without full assessment, including evaluation of clinical significance versus statistical significance.

Recently, I had in my practice a patient with early Alzheimer disease who was still capable of decision making. I discussed the risks and benefits of the available drugs, and the patient decided not to take any medications. In spite of full documentation of this discussion and decision prominently displayed in the chart, a locum tenens physician found this patient "untreated" for Alzheimer disease and promptly started the patient on one of the cholinesterase inhibitors. This illustrates how widely accepted these drugs are among family physicians, even though the benefits are so limited.

As family doctors we should focus our efforts for our patients with Alzheimer disease on areas like psychosocial interventions and family support, and we should lobby governments to fund effective interventions for patients with Alzheimer disease and their families, instead of funding drugs of minimal benefit.

—Catherine Oliver, MD
Toronto, Ont
by e-mail

Reference

1. Nazerali N. Maximizing available time. Family doctors' challenges with dementia. *Can Fam Physician* 2006;52:157-9 [Eng], 162-4 [Fr].

I enjoyed reading Dr Nazerali's editorial in the February issue of *Canadian Family Physician*, as well as the accompanying articles. I have submitted the results of my own research in this area, but the timing was such that it will be published in a future issue of *CFP*.

I led a group of researchers in the Dementia-NET group as we audited the practices of 160 family physicians in Ottawa, Ont; Toronto, Ont; and Calgary, Alta, to evaluate the extent to which family physicians follow the 48 key recommendations of the 1999 Canadian Consensus Conference on Dementia (CCCD). What we discovered, notwithstanding the limitations of chart audits, was interesting and perhaps disturbing. We found that family physicians had a very high referral rate (>80%), mostly to neurologists and geriatricians. This reflects, perhaps, family physicians' lack of comfort in managing dementia or,

perhaps, family members' pressure to refer patients to specialists. We also discovered that few physicians assessed caregiver coping, which is a predictor of early institutionalization. Finally, few physicians assessed driving status and safety (about 13%). As a practising family doctor, however, these results do not surprise me, and they fit with some of the issues that Dr Nazerali raised in her editorial.

First, time pressures are enormous for family physicians and are getting worse as we deal with more elderly patients with chronic illnesses.

Second, the CCCD guidelines were passively disseminated with the *Canadian Medical Association Journal*, a sure-fire way to ensure that a guideline is ineffective. I agree that guidelines are very important in aiding family physicians to care for complex patients, but they need to be generated differently. We should not rely on a top-down approach from our specialist colleagues. There needs to be far greater input from family physicians about both content and process. There should also be more input from patients and their families. Further, passive dissemination does not work. Guideline makers need to develop tool kits that offer family physicians several options for implementation in their practices, as Dr Nazerali mentioned.

Finally, there must be greater discussion, within the medical profession and within the community, about models of care. Among the options that need to be considered are shared-care models versus specialty-care models. The situation is becoming even more complex as primary care reform progresses. In family health teams, for example, which might have other providers available, the role of the family physician will need to be clarified.

The next phase in our research, which we have just started, is to conduct focus groups with family physicians aimed at exploring all of the questions that Dr Nazerali raised in her editorial, including the role and structure of guidelines and models of care that might help family physicians to define and optimize their role in dementia care. We hope that over time our research will improve care for dementia patients and the lives of family physicians.

Thanks for highlighting these important issues for Canadian family physicians.

—Nick Pimlott, MD, CCFP
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by e-mail

Residents only, please

I was concerned when I realized that the author of the Resident's Page in the latest issue of *Canadian Family Physician* was not in fact a resident.¹ Those who are new to practice certainly face a unique set of issues, but these