

# Family physicians and dementia in Canada

## Part 2. Understanding the challenges of dementia care

Nicholas J.G. Pimlott MD CCFP Malini Persaud MN PhD Neil Drummond PhD HonMFPHM(UK) Carole A. Cohen MD FRCPC  
James L. Silvius MD FRCPC Karen Seigel MD CCFP Gary R. Hollingworth MD CCFP FCFP William B. Dalziel MD FRCPC

### ABSTRACT

**OBJECTIVE** To explore the challenges Canadian family physicians face in providing dementia care.

**DESIGN** Qualitative study using focus groups.

**SETTING** Academic family practice clinics in Calgary, Alta, Ottawa, Ont, and Toronto, Ont.

**PARTICIPANTS** Eighteen family physicians.

**METHODS** We conducted 4 qualitative focus groups of 4 to 6 family physicians whose practices we had audited in a previous study. Focus group transcripts were analyzed using the principles of thematic analysis.

**MAIN FINDINGS** Five major themes related to the provision of dementia care by family physicians emerged: 1) diagnostic uncertainty; 2) the complexity of dementia; 3) time as a paradox in the provision of dementia care; 4) the importance of patients' families; 5) and familiarity with patients. Participants expressed uncertainty about diagnosing dementia and a strong need for expert verification of diagnoses owing to the complexity of dementia. Time, patients' family members, and familiarity with patients were seen as both barriers and enablers in the provision of dementia care.

**CONCLUSION** Family physicians face many challenges in providing dementia care. The results of this study and the views of family physicians should be considered in the development and dissemination of future dementia guidelines, as well as by specialist colleagues, policy makers, and those involved in developing continuing physician education about dementia.

### EDITOR'S KEY POINTS

- Evidence suggests that diagnosis of dementia by primary care physicians is inadequate and that their management of dementia is suboptimal. This study used focus groups to explore some of the challenges family physicians face when providing dementia care.
- Because dementia is so complex, participants said they were often unsure of their diagnoses. Patients' family members could facilitate (by sharing their concerns with physicians) or hinder (by "covering" for patients) diagnoses. Time was also identified as a barrier and enabler: short appointments might, for example, help limit patients' expectations, but they also limit physicians' ability to perform comprehensive assessments or follow guideline recommendations, especially in the context of comorbid conditions.
- Given the uncertainty of diagnosis, the complexity of dementia, and the time constraints of practice, family physicians require substantial support to provide dementia care. Such support might come in the form of new coordinated, interprofessional models of care, such as family health teams. Research will be needed to understand whether or not such models will offer improved care for dementia patients.

\*Full text is available in English at [www.cfp.ca](http://www.cfp.ca).

This article has been peer reviewed.

*Can Fam Physician* 2009;55:508-9.e1-7

## Le médecin de famille canadien face à la démence

### Deuxième partie : Comprendre les défis associés au traitement de la démence

Nicholas J.G. Pimlott MD CCFP Malini Persaud MN PhD Neil Drummond PhD HonMFPHM(UK) Carole A. Cohen MD FRCPC  
James L. Silvius MD FRCPC Karen Seigel MD CCFP Gary R. Hollingworth MD CCFP FCFP William B. Dalziel MD FRCPC

#### RÉSUMÉ

**OBJECTIF** Examiner les défis auxquels est confronté le médecin de famille canadien qui traite la démence.

**TYPE D'ÉTUDE** Étude qualitative à l'aide de groupes de discussion.

**CONTEXTE** Cliniques universitaires de médecine familiale de Calgary (Alberta) et d'Ottawa et Toronto (Ontario).

**PARTICIPANTS** Dix-huit médecins de famille.

**MÉTHODES** On a tenu 4 groupes de discussion qualitatifs regroupant de 4 à 6 médecins dont nous avons vérifié la pratique dans une étude antérieure. Les transcriptions des discussions ont été analysées selon le principe de l'analyse thématique.

**PRINCIPALES OBSERVATIONS** L'analyse a révélé 5 thèmes principaux reliés au traitement de la démence par le médecin de famille: 1) incertitude du diagnostic; 2) complexité de la démence; 3) effet paradoxal du temps consacré au traitement de la démence; 4) importance de la famille du patient; 5) et familiarité avec le patient. À cause de la complexité de la démence, les participants disaient être incertains du diagnostic et avoir grand besoin de vérification experte. Les facteurs que sont le temps, les membres de la famille du patient et la familiarité avec le patient pouvaient aussi bien être considérés comme faisant obstacle ou facilitant la dispensation des soins.

**CONCLUSION** Le médecin de famille qui traite la démence rencontre plusieurs défis. On devrait tenir compte des résultats de cette étude et de l'opinion des médecins de famille dans le développement et la diffusion des futures directives sur la démence, tant par les collègues spécialistes, les responsables des politiques et les responsables de la formation médicale continue sur la démence.

#### POINTS DE REPÈRE DU RÉDACTEUR

- Les données donnent à penser que les médecins de première ligne font un diagnostic inadéquat de la démence et qu'ils la traitent de façon sous-optimale. Cette étude a utilisé des groupes de discussion pour examiner certains des défis rencontrés par les médecins de famille qui traitent des patients atteints de démence.
- En raison de la complexité de la démence, les participants se disaient souvent incertains du diagnostic. Les membres de la famille du patient pouvaient aider au diagnostic (en faisant part de leurs inquiétudes au médecin) ou y nuire (en « couvrant » le patient). On citait aussi le temps comme pouvant faire obstacle au diagnostic ou le faciliter: ainsi, des rencontres courtes pourraient aider à limiter les attentes des patients, mais pourraient aussi réduire la capacité du médecin de faire une évaluation complète ou de suivre les directives, surtout en présence de comorbidité.
- Compte tenu de l'incertitude du diagnostic, de la complexité de la démence et des contraintes de temps, le médecin de famille a besoin de beaucoup de soutien pour traiter la démence. Ce soutien pourrait prendre la forme de nouveaux modèles de soins interdisciplinaires coordonnés, tels que des équipes de médecine familiale. Il faudra d'autres études pour déterminer si ces modèles permettront de mieux traiter la démence.

\*Le texte intégral est accessible en anglais à [www.cfp.ca](http://www.cfp.ca).

Cet article a fait l'objet d'une révision par des pairs.

*Can Fam Physician* 2009;55:508-9.e1-7

A number of published studies have examined the knowledge and attitudes of family physicians or GPs about dementia. Many of these studies have focused on the role of family physicians in diagnosing the condition, and their ability to diagnose it.<sup>1-4</sup> Such studies have been motivated, in part, by evidence that the detection and diagnosis of dementia by primary care physicians is inadequate, and their management of dementia is suboptimal once a diagnosis has been made.<sup>1,5,6</sup>

There has been much less research exploring the reasons why such problems exist from family practitioners' perspectives. Boise et al conducted focus groups with US family physicians to explore and understand low rates of dementia diagnosis in primary care.<sup>7</sup> They identified failure to recognize and respond to dementia symptoms, lack of perceived need to make a diagnosis, negative attitudes about the importance of assessment and diagnosis, and lack of time as barriers. Using similar methods, Connell et al<sup>8</sup> explored US family physicians' attitudes toward the diagnosis and disclosure of dementia. They identified a mismatch between physicians' perceptions about the process of disclosure and those of patients and families, with the latter recounting more negative emotional responses to disclosure of the diagnosis.

The purpose of our study was to contribute to this knowledge by exploring the challenges Canadian family physicians face in providing dementia care. In the first part of this study,<sup>9</sup> we explored the awareness of, attitudes toward, and use of dementia clinical practice guidelines (CPGs) among Canadian family physicians in academic settings. Strong recurrent themes emerged in our analysis with regard to the process of dementia care; therefore, this paper presents and discusses those results specifically and compares and contrasts them with the literature from other countries.

## METHODS

### Study design and sample

A qualitative focus group format was used. Using focus groups is an effective way to capture communication between research participants and to examine their attitudes, values, and understanding in a particular area,<sup>10</sup> while also maximizing resources. Criterion sampling was used.<sup>11,12</sup> The inclusion criterion was that family physicians had to practise at 1 of the 6 university-affiliated clinics that were assessed in our previous chart audit study (3 clinics in Calgary, Alta; 1 in Ottawa, Ont; and 2 in Toronto, Ont). Eighteen (7 male and 11 female) out of a possible 34 family physicians who participated in the previous study formed the focus groups, which were conducted in meeting rooms at 3 of the clinics.

### Data collection

Interviews were conducted by trained facilitators using a semistructured interview guide. All groups were audiotaped and the recordings transcribed verbatim for analysis. Research ethics approval was granted by the 3 universities affiliated with the clinics.

### Data analysis

Data were analyzed using iterative thematic analysis<sup>13,14</sup>: 1) becoming familiar with the data; 2) generating initial codes; 3) searching for themes; 4) reviewing themes; 5) defining and naming themes; and 6) producing the report. An inductive approach was taken, meaning that the research team did not enter into data analysis with preconceived theoretical frameworks; instead, they allowed the themes to emerge from the participants' dialogue and group interaction.

The principal investigator (N.P.) listened to the audiotapes while simultaneously reading the transcripts to verify quality and to become familiar with the data. Transcripts were circulated among the entire research team for their input and familiarization with the data. The principal investigator and another research team member (M.P.) engaged in initial coding. Using a table, quotes were entered alongside illustrative codes organized by the interview guide questions. Coding facilitated the process of finding themes and categories. Using the facilitators' field notes, attention was given to group dynamics, including disagreements, mutual reinforcements, and humour.<sup>10</sup>

After reading the transcripts and coding the data according to its content, several themes were evident. Research team members assessed agreement on codes and later reviewed the themes emerging from the data, checking for whether or not the coded extracts illustrated the themes. After clarifying meanings through discussions over teleconferences and in writing, all research team members agreed on naming and defining the themes. Researchers were satisfied that saturation was reached when no new themes were identified from the transcripts. The final report was a collaborative effort among the entire team to select the most compelling extracts. Respondents are identified by letter and focus group number.

## FINDINGS

Participants identified several key factors that enabled or hindered the identification, assessment, and management of dementia (**Table 1**). Some factors, such as family, time, and guidelines themselves, were identified as both enablers and barriers.

Given that patients with dementia typically have multiple medical diagnoses, when guidelines for the proper care of each condition exist these can help

**Table 1. Enablers and barriers in the identification, assessment, and management of dementia**

ENABLERS	BARRIERS
<ul style="list-style-type: none"> <li>• Family member corroboration reporting on ADLs</li> <li>• Family member initiation of investigation of memory problems</li> <li>• Assessment tools (eg, MOCA, MMSE, Dementia Caregiver’s Toolbox)</li> <li>• Guidelines</li> <li>• Other staff reporting missed appointments; change in routine for patient</li> <li>• OT, PT, nursing staff providing feedback on patient’s cognitive states</li> <li>• Time—multiple short office visits facilitate thorough investigations</li> <li>• Depression scales</li> <li>• Specialist referrals and clinics</li> <li>• Comorbidity</li> <li>• Family corroborating evidence</li> <li>• Laboratory results</li> <li>• CT</li> <li>• Memory clinics</li> <li>• Pharmacists</li> <li>• Expert opinion</li> <li>• Community agencies</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of family member involvement in patient care</li> <li>• Complexity of the brain</li> <li>• Access to specialists</li> <li>• Guidelines</li> <li>• Understanding the clinical utility of tools (eg, MMSE)</li> <li>• Multiple medical conditions</li> <li>• Missed appointments</li> <li>• Office setting vs home setting as optimal</li> <li>• Uncertainty with diagnosis</li> <li>• Access to CT</li> <li>• Time</li> <li>• Level of experience and knowledge base about dementia</li> <li>• Patient’s lack of insight</li> <li>• Medications (clinical decision about whom to give what, when)</li> <li>• Waiting lists for appointments</li> <li>• Driving assessment</li> </ul>

ADLs—activities of daily living, CT—computed tomography, MMSE—Mini-Mental State Examination, MOCA—Montreal Cognitive Assessment, OT—occupational therapy, PT—physiotherapy.

in specific diagnoses, assessment, and management. However, they can at the same time be burdensome, and something of a barrier to practice, when physicians consider that they should follow separate guidelines for each condition. For example, participants mentioned situations where hypertension guidelines, diabetes guidelines, and dementia guidelines were all relevant, but were difficult to integrate into a single care plan.

In discussing enablers and barriers to the provision of dementia care, family physicians in the focus groups identified 5 major themes: diagnostic uncertainty; the complexity of dementia; time as a paradox; the importance of family; and the importance of familiarity with patients.

### Diagnostic uncertainty

Family physicians expressed substantial uncertainty about making the diagnosis of dementia:

Even sometimes I’m wondering if I got the diagnosis right, or if I’m wondering about Lewy body versus, you know, frontotemporal, or if there is [a] big behavioural issue and I’m not sure how much of it is psychiatric versus dementia. (A3)

Assessment was difficult when access to specialists was limited, and when office-visit time was insufficient to undertake cognitive assessment:

Lack of access to, well, uncertainty about who would be the best person to evaluate what kind of dementia and lack of access to memory disorders clinics. (B1)

And sometimes I want or need help in the assessment, and I want to refer them, but it’s just a long waiting time. (A3)

A big barrier, since we’re talking about identifying, is time, in that there usually isn’t enough in the family practice setting to do an adequate job with the identification, and you can have the suspicion early on, but I need to bring people back basically to do the tests formally, testing the Mini-Mental [State Examination] or similar tests. (C3)

### Complexity of dementia

The main reason why diagnosis was uncertain was because dementia was seen as more complicated and difficult than other chronic conditions family physicians managed, because it involved the brain. Participants expressed difficulty with identifying dementia:

[Dementia is] something that’s not necessarily like chest pain, and it can progress, so where in that spectrum, like sometimes it can be very obvious, but early dementia ... can be difficult to sort of even have the clinical acumen to even maybe ask about it. (C)

[T]here is an element of physician unfamiliarity with the whole process of identification of neurological disease ... and that they see that as a barrier that they think, “Oh gee, I can’t remember should I do this? Should I do that?” And choose just to refer. (G2)

Adding to the complexity of caring for patients with dementia was the “artificial” environment of the family physician’s office.

[W]e’re seeing patients in a very artificial, or in a setting where they’ve become accustomed to following certain rote actions ... and they know the right answers to say, so if you see them at home, it’s a different picture. (B3)

[M]aybe it’s too broad, but the very nature of the illness is that it can be impacted by all kinds of different things, so one of the barriers for me is just trying to sort out really the complexity of their cognitive function. (D3)

Physicians also expressed uncertainty about the management of patients with dementia once a diagnosis had been made, including determining the competency of patients; uncertainty about medication and effectiveness (medication response as a complex issue); and dealing with comorbidities:

In terms of barrier[s], one of my big ones is getting a competency assessment. (D1)

It is hard to know what works. Like they were saying [galantamine] for awhile, but then they were saying “the [gastrointestinal] side effects are terrible, I wouldn’t put my worst enemy on that,” and then they changed it to whatever ... it changes so often, and then they’re saying the evidence is not as good as they initially thought it was, and so I just find, “Well, are we using them or aren’t we?” And if we are, there are more side effects, and I don’t know the answer to that. (A1)

Some of the comorbidities and the polypharmacy make it hard sometimes to use some of the medications that you can use, so if they’re already on 15 to 20 medications or if they have heart problems or something like there’s a bit of [inaudible] about using some of the medications. (D3)

People who have dementia are older and they’re likely to have other chronic disease[s], so there’s often a mixed bag of things going on. [It is] very seldom that I would see someone for dementia-only concerns. (B4)

Other factors influencing the management of dementia included patients’ expectations for office appointments; outcomes (ability to “make a difference” [B1]); and inadequate community resources.

And they bring a list of 10 different things they want to talk about, and I think that can make it very challenging, and then we have our preventative things that we’re supposed to be looking at already. So

we’re trying to get that on the table. I think it’s pretty obvious that it’s pretty draining to handle. (P2)

I mean once you’ve identified the problem, you tend to manage it. The question is, do you go ahead and start looking for trouble, when you don’t have time to look for it? I mean you’re not sure you can make a difference on what trouble is coming anyway. (B2)

It’s almost all moved to acute discharge care, you can’t get continuous monitoring, unless you know the coordinator ... but now they’ve cut community funding again, you can’t get it. (B3)

### Time as a paradox: time pressure versus time advantage for multiple visits

Time was a paradox because it reflected both an enabler and a barrier to practice. For example, frequent appointments might make subtle memory changes imperceptible, whereas infrequent visits might reveal a marked and clinically significant decline. But time was also seen as a barrier because dementia patients often present with comorbidities, thereby making time demands greater than can easily be accommodated in a typical office visit.

When asked to describe a substantial barrier to care, physicians simply said, “Time, time, time.” One participant said, “Time is a real constraint, and if you really want to do a Folstein, you almost have to rebook them.” (N2)

But participants also described the advantages of shorter visits:

One of the big enablers is that, as family doctors, we’re not expected to do a 1-hour or 1.5-hour full assessment. We do things over time so we can easily break the assessment down into multiple visits. (B3)

[B]ecause we see people over time, we get to know their personalities very well and so we can, I find I can, interpret responses differently than if it was a brand-new patient. (B3)

### Importance of the family and familiarity with patients

Relationships with both patients and their family members were seen as strong enablers in the provision of dementia care: “Family members ... when they start coming to me and saying there’s some problem with Grandma, then I know there’s a problem with Grandma.” (B2)

Yet, sometimes family members could prevent or delay identification of a problem by downplaying concerns or covering up.

Because some people have the resources, but they have the insight to know something is wrong with mom, so they put the resources in place. Other people are denying it, so they cover up. (B3)

I think it's easier sometimes to miss it, especially if the family member is part of the whole conspiracy, almost where they either take over or they help the person, so they're like a team, so no one really wants to see the problem. (N2)

Differing points of view between a patient and family members presented challenges to physicians in the provision of dementia care.

[S]he felt she was safe and the family felt differently. So I was hearing 2 different—totally different—things, so how much sort of support she needed .... The patient was clearly seeing something else. I thought something else. The family thought something ... so it wasn't clear cut. (C1)

At the same time, relationships and familiarity with patients were also seen as a barrier in the identification of dementia:

I can think of one fellow [who] was an elderly guy, highly educated, highly articulate, who, in retrospect was dementing over a period of time and I didn't notice it because he was quite verbal and hid it fairly well, and I can look back and say, well he had quite a number of lists. (B4)

## DISCUSSION

Previous studies that examined the role of family physicians in the provision of dementia care have been survey-based and have evaluated family physicians' knowledge of and attitudes toward dementia.<sup>3</sup> Other studies have used focus groups to explore and understand factors and challenges that affect the recognition, diagnosis,<sup>5</sup> and disclosure of dementia.<sup>3</sup> To our knowledge this is the first study using qualitative methods to explore in-depth the spectrum of challenges that family physicians face in providing care to patients with dementia.

Canadian family physicians identified several challenges and 5 major themes in the provision of dementia care. These included the role of diagnostic uncertainty, the related theme of the complexity of dementia, the paradox of time, the importance of family, and the importance of familiarity with the patient.

### Diagnostic uncertainty and the complexity of dementia

In several previous studies the diagnosis of dementia by primary care physicians was identified as a substantial problem.<sup>1,2</sup> Given that dementia makes up only a small proportion of family physicians' case loads, it is not surprising that they can find diagnosis and management of the problem difficult. Recognition

rates for dementia by primary care physicians, however, range widely, from as low as 33% to as high as 91%.<sup>15,16</sup> Several barriers to earlier diagnosis have been identified in previous research, including the failure to recognize and respond to symptoms of dementia, a perceived lack of need to make a specific diagnosis, and limited time.<sup>7</sup> In the past, GPs might have been unconvinced about the benefits of early diagnosis, contributing to these problems.<sup>2,16</sup> There is, however, evidence that such attitudes are changing.<sup>2,17</sup>

Physicians in our study were reluctant to label patients as having the "disease" of dementia if they were uncertain about the diagnosis. They expressed a strong need for experts to either make or verify diagnoses. This is reflected by high referral rates (greater than 80%) seen in our previous study.<sup>17</sup> This lack of certainty about making a dementia diagnosis has been alluded to in other studies,<sup>3</sup> even when GPs' knowledge of dementia diagnosis and management was good. Family physicians might be more capable of making accurate diagnoses of dementia than they perceive themselves to be. A comparison of GPs and physicians in a memory clinic in Holland demonstrated agreement on the diagnosis in 76% of 93 cases.<sup>1</sup> They also found that GPs were able to assess the firmness of their own dementia diagnoses, and thus inferred that GPs are also able to determine which patients are most appropriate for specialty referral.

Geneau et al<sup>18</sup> have examined the work of GPs using a social science perspective. In so doing, they identified that *ontological security*—defined as a sense of safety largely dependent upon predictable routines—has substantial implications for understanding the work of GPs. Developing a sense of security was identified as one of the predominant facets and preoccupations that shapes their professional experience and practice. That GPs are driven by the desire to reduce the level of uncertainty might be reflected in the high referral rates to specialists in our previous study.<sup>18</sup> It has been shown in other studies that primary care physicians with lower levels of tolerance for uncertainty tend to refer patients more often to specialists.<sup>19</sup>

Family physicians recognized that dementia is a complex condition both biologically and psychosocially. They discussed the challenges of trying to maximize quality of life for their patients with dementia who are also often burdened with other complex comorbid medical conditions. Physicians described every patient as unique, and different approaches were often used to plan their care, rather than relying exclusively on algorithms such as CPGs. This approach to care that they described is consistent with the framework of general practice described by McWhinney,<sup>20</sup> in which family physicians view their patients as integrated wholes (organismic), rather than the sum of their broken parts (mechanistic), necessitating a highly individualized approach to each patient.

Family physicians' views about the complexity of dementia and the uncertain nature of its diagnosis are supported by published research.<sup>21,22</sup> For example, there is evidence that commonly used criteria for diagnosis can differ 10-fold in the number of subjects classified as having dementia.<sup>21</sup> More recent studies show that depending upon which criteria are used, the reported prevalence of vascular dementia, for example, can vary substantially.<sup>23</sup> Furthermore there can be substantial variation in interrater reliability between different assessments.

### Time as a paradox

Time constraints in the family practice setting are important, especially in a health care system in which physicians are paid on the basis of individual patient visits. Lack of time has been cited as a barrier by family physicians in the diagnosis of dementia<sup>7</sup> and as a barrier to the uptake of CPGs.<sup>24</sup> General practitioners in Turner and colleague's study from the United Kingdom ranked lack of time as the number 1 barrier to good practice in dementia care.<sup>3</sup> Lack of time has also been cited as a factor in low rates of dementia diagnosis by US primary care physicians,<sup>7</sup> suggesting that these time constraints are found in different primary health care systems.

The physicians in this study viewed the short duration of the average visit as a paradox in the provision of dementia care. On the one hand they described short visits as being an impediment to providing one-stop, comprehensive assessment, but at the same time they identified that care could effectively be done over a series of several shorter visits.

There has been some research examining factors that affect the length of the office visit to family physicians.<sup>25-28</sup> Visit length is determined more by physician factors, such as time pressures, than by patient factors, such as the nature of the presenting complaint.<sup>26</sup> There is less research done to determine whether complex problems such as dementia are best managed with longer, more comprehensive visits, or shorter, focused ones, as described by the physicians. Freeman et al have reported that longer consultations were associated with "a range of better patient outcomes, particularly better recognition and handling of psychological problems."<sup>26</sup> Similarly, Hutton and Gunn in a systematic review of the literature showed that there was some evidence that increased consultation length is associated with more accurate diagnosis of psychological problems by GPs.<sup>27</sup> There is evidence that patients with complex or multiple problems who seek help from physicians who spend more time with them are more likely to have consultations that include important elements of care.<sup>28,29</sup> Conversely, shorter visit times are associated with more unnecessary antibiotic prescriptions and more laboratory tests.<sup>30,31</sup>

Interestingly, there might be a link between the time constraints of practice and the management of uncertainty encountered in dealing with dementia.

Geneau et al have argued that the need for predictable routines and a sense of security in practice can sometimes clash with the structure of the GP's environment.<sup>18</sup> In dealing with conditions like dementia, for example, physicians must react to conditions of uncertainty that they themselves might have helped to create. For some physicians medical uncertainty can be the result of incomplete case histories or excessively long intervals between follow-up visits, which in turn can be linked to initial time management strategies.

The comments on the paradox of time by the family physicians in our study suggest at least 2 avenues for further research. One avenue would involve evaluating whether family physicians tend to provide dementia care over a series of several shorter visits or in 1 or 2 longer, more comprehensive visits. A second and related avenue for further research would be to examine whether or not longer visit times with family physicians are associated with better care in dementia.

### Familiarity with the patient and importance of the family

A familiarity with patients developed over time and through continuity of care is seen by practitioners and patients alike as a strength of family medicine. With respect to dementia care, familiarity with patients was identified as both an enabler of care and a barrier. Physicians' reluctance to give the diagnosis is related to the aforementioned themes of complexity and uncertainty. It is not surprising that family physicians rely on family corroboration and familiarity with their patients when identifying, assessing, and managing dementia. According to McWhinney,<sup>20</sup> family practice differs from specialist practice in that family physicians think of their work in terms of relationships, not diseases, including relationships with other family members. Family members play key roles in dementia care ranging from corroborating information, leading to timely and accurate diagnosis of dementia, to helping to implement care plans. In addition to facilitating care, these relationships can also be barriers to care, and it could be argued that, owing to family physicians' long-term relationships with their patients and the patients' families, overcoming this barrier to diagnosis needs greater attention.

### Supporting family physicians

An overarching theme in this study is that, given the uncertainty of diagnosis, the complexity of dementia, and the time constraints of practice, family physicians require substantial support to provide dementia care. Support ranges from assistance with diagnosis (by corroboration of symptoms and behaviour from family members, corroboration of the diagnosis by specialists) to support in provision of ongoing care (by enlisting the help of family members, other health care professionals, and outside agencies, such as Alzheimer societies). This is at odds

with the current model of practice for family physicians in many countries, including Canada and the United States, which remains that of the “doc in a box.” Practice is heavily skewed toward brief (usually less than 15 minutes), ambulatory, office-based assessment of patients with referral, when perceived to be necessary, to medical specialists, other health care professionals (eg, occupational therapists, physiotherapists, social workers), and community organizations (eg, Alzheimer societies) that are not linked in time, or place, to family physicians’ practices. Many of the themes that family physicians identified in this study as challenges or problems for providing dementia care could potentially be improved by a shift in the model of primary care delivery toward greater integration, in time and space, of other professionals into the primary care setting. There is some limited, but compelling, evidence that such a coordinated system of care can significantly improve quality of life, quality of care, social support, and the level of unmet caregiving needs in persons with dementia ( $P \leq .05$ ).<sup>32</sup>

In Canada, there is a movement under way of family physicians into new organizational structures, such as family health teams, which will physically integrate pharmacists, dietitians, occupational therapists, physiotherapists, and even some medical specialists into family practice clinics. Such models of care delivery have the potential to provide environments in which family physicians might be able to provide dementia care in a model that differs substantially from current practice. A tremendous research opportunity will exist to evaluate whether dementia care is better provided in the new or the old model of family practice care in Canada.

## Limitations

There are some limitations to this qualitative study. The most important is that the study physicians were recruited from urban or suburban academic settings in 3 different cities, and their views might not reflect those of family physicians working in nonacademic settings or in smaller communities. The physicians were chosen because their practices had been audited in a previous study.

## Conclusion

Family physicians face many challenges in the provision of dementia care. Five important themes in this study were diagnostic uncertainty; the complexity of dementia; time as a paradox; the importance of family; and familiarity with the patient. The themes of diagnostic uncertainty and the complexity of dementia were important and have not been identified and explored as fully in previous work. Family physicians’ concerns about these 2 themes need to be taken into account by CPG developers, specialist colleagues, policy makers, and educators. Continuing education strategies and guidelines should focus on strengthening family physicians’ knowledge and skills in the diagnosis of

dementia. Even with greater knowledge and skills, family physicians might continue to need corroboration and support around the diagnosis of dementia from specialists, other health care professionals, and patients’ family members. Such corroboration and support might best be achieved through coordinated, interprofessional models of dementia care. ✦

**Dr Pimlott** is an Associate Professor in the Department of Family and Community Medicine at the University of Toronto in Ontario. **Dr Persaud** was a doctoral candidate in the Lawrence S. Bloomberg Faculty of Nursing at the University of Toronto at the time of the study. **Dr Drummond** is an Associate Professor and Director of Research in the Department of Family Medicine at the University of Calgary in Alberta. **Dr Cohen** is an Associate Professor in the Department of Psychiatry at the University of Toronto. **Dr Silviu** is Regional Chief for the Division of Geriatric Medicine at the University of Calgary. **Dr Seigel** is a family physician in Calgary and participates in research with the Department of Family Medicine at the University of Calgary. **Dr Hollingworth** is an Associate Professor in the Department of Family Medicine at the University of Ottawa in Ontario. **Dr Dalziel** is Chief of the Ottawa Regional Geriatric Assessment Program.

### Acknowledgment

This study was funded through a CIHR Dementia-NET (New Emerging Team) grant. We thank **Susan Hum** for critically reviewing the manuscript and **Heidi Dutton** and **Sophie Sapergia** for conducting the focus groups.

### Contributors

**Drs Pimlott** and **Persaud** conceived and designed the study with substantial input from **Drs Drummond** and **Cohen**. **Drs Pimlott** and **Persaud** were involved in data collection. **Drs Drummond** and **Persaud** provided methodologic expertise and guidance in the analysis of the data. **Drs Pimlott** and **Persaud** analyzed the data with substantial input from **Drs Cohen**, **Hollingworth**, **Seigel**, **Dalziel**, and **Silviu**. **Dr Pimlott** drafted the manuscript. All of the authors had substantial input into the manuscript at various stages, and all authors gave approval to the final version of the manuscript submitted.

### Competing interests

**Dr Dalziel** has participated in national and regional advisory boards and received honoraria for continuing medical education events and development of educational materials from the following companies associated with medications available for treatment of dementia: Janssen-Ortho, Lundbeck, Novartis, Pfizer, and Wyeth. None of the other authors has any competing interests.

### Correspondence

**Dr Nicholas Pimlott**, Women’s College Hospital, 60 Grosvenor St, Toronto, ON M5S 1B6; telephone 416 323-6400, extension 4581; fax 416 323-6351; e-mail [nick.pimlott@utoronto.ca](mailto:nick.pimlott@utoronto.ca)

### References

1. Van Hout H, Vernooij-Dassen M, Poels P, Hoefnagels W, Grol R. Are general practitioners able to accurately diagnose dementia and identify Alzheimer’s disease? A comparison with an outpatient memory clinic. *Br J Gen Pract* 2000;50(453):311-2.
2. Woods RT, Moniz-Cook E, Iliffe S, Campion P, Vernooij-Dassen M, Zanetti O, et al. Dementia: issues in early recognition and intervention in primary care. *J R Soc Med* 2003;96(7):320-4.
3. Turner S, Iliffe S, Downs M, Wilcock J, Bryans M, Levin E, et al. General practitioners’ knowledge, confidence and attitudes in the diagnosis of dementia. *Age Ageing* 2004;33(5):461-7.
4. Boustani M, Callahan CM, Unverzagt FW, Austrom MG, Perkins AJ, Fultz BA, et al. Implementing a screening and diagnosis program for dementia in primary care. *J Gen Intern Med* 2005;20(7):572-7.
5. Fortinsky RH, Leighton A, Wasson JH. Primary care physicians’ diagnostic, management and referral practices for older persons and families affected by dementia. *Res Aging* 1995;17(2):124-48.
6. Brodaty H, Howarth GC, Mant A, Kurrle SE. General practice and dementia. A national survey of Australian GPs. *Med J Aust* 1994;160(1):10-4.
7. Boise L, Camicioli R, Morgan D, Rose JH, Congleton L. Diagnosing dementia: perspectives of primary care physicians. *Gerontologist* 1999;39(4):457-64.
8. Connell CM, Boise L, Stuckey JC, Holmes SB, Hudson ML. Attitudes toward the diagnosis and disclosure of dementia among family caregivers and primary care physicians. *Gerontologist* 2004;44(4):500-7.
9. Pimlott NJG, Persaud M, Drummond N, Cohen C, Silviu J, Seigel K, et al. Family physicians and dementia in Canada. Part 1. Clinical practice guidelines—awareness, attitudes, and opinions. *Can Fam Physician* 2009;55:506-7.e1-5.
10. Kitzinger J. Qualitative research: introducing focus groups. *BMJ* 1995;311(7000):299-302.
11. Patton M. *Qualitative research and evaluation methods*. Thousand Oaks, CA: Sage Publications; 2002.
12. Kuzel AJ. Sampling in qualitative inquiry. In: Crabtree BF, Miller WL, editors. *Doing qualitative research*. 2nd ed. Thousand Oaks, CA: Sage Publications; 1999. p. 33-45.



13. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006;3(2):77-101.
14. Van Hout H. Studies on recognition of dementia by primary care physicians are inconsistent. *Arch Intern Med* 2001;161(9):1238-9.
15. Valcour VG, Masaki KH, Curb JD, Blanchette PL. The detection of dementia in the primary care setting. *Arch Intern Med* 2000;160(19):2964-8.
16. Vernooij-Dassen MJ, Moniz-Cook ED, Woods RT, De Lepeleire J, Leuschner A, Zanetti O, et al. Factors affecting timely recognition and diagnosis of dementia across Europe: from awareness to stigma. *Int J Geriatr Psych* 2005;20(4):377-86.
17. Pimlott NJG, Siegel K, Persaud M, Slaughter S, Cohen C, Hollingworth G, et al. Management of dementia by family physicians in academic settings. *Can Fam Physician* 2006;52:1108-9. Available from: [www.cfp.ca/cgi/reprint/52/9/1108](http://www.cfp.ca/cgi/reprint/52/9/1108). Accessed 2009 Mar 18.
18. Geneau R, Lehoux P, Pineault R, Lamarche P. Understanding the work of general practitioners: a social science perspective on the context of medical decision-making in primary care. *BMC Fam Pract* 2008;9:12. DOI: 10.1186/1471-2296-9-12.
19. Forrest CB, Nutting PA, von Schrader S, Rohde C, Starfield B. Primary care physician referral decision-making: patient, physician, and health care determinants. *Med Decis Making* 2006;26(1):76-85.
20. McWhinney IR. William Pickles Lecture 1996. The importance of being different. *Br J Gen Pract* 1996;46(408):433-6.
21. Erkinjuntti T, Ostbye T, Steenhuis R, Hachinski V. The effects of different diagnostic criteria on the prevalence of dementia. *N Engl J Med* 1997;337(23):1667-74.
22. Chui HC, Mack W, Jackson JE, Mungas D, Reed BR, Tinklenberg J, et al. Clinical criteria for the diagnosis of vascular dementia. *Arch Neurol* 2000;57(2):191-6.
23. Gold G, Bouras C, Bergallo MF, Herrmann FR, Hof PR, Mayor PA, et al. Clinicopathological validation study of four sets of clinical criteria for vascular dementia. *Am J Psychiatry* 2002;159(1):82-7.
24. Langley C, Faulkner A, Watkins C, Gray S, Harvey I. Use of guidelines in primary care—practitioners' perspectives. *Fam Pract* 1998;15(2):105-11.
25. Wilson A. Consultation length in general practice: a review. *Br J Gen Pract* 1991;41(344):119-22.
26. Freeman GK, Horder JP, Howie JG, Hungin AP, Shah NC, Wilson A. Evolving general practice consultation in Britain: issues of length and context. *BMJ* 2002;324(7342):880-2.
27. Hutton C, Gunn J. Do longer consultations improve the management of psychological problems in general practice? A systematic literature review. *BMC Health Serv Res* 2007;7:71.
28. Wilson A, Childs S. The relationship between consultation length, process and outcomes in general practice: a systematic review. *Br J Gen Pract* 2002;52(485):1012-20.
29. Wilson AD, Childs S. Effects of interventions aimed at changing the length of primary care physicians' consultation. *Cochrane Database Syst Rev* 2006;(1):CD003540.
30. Lundkvist J, Akerlind I, Borgquist L, Molstad S. The more time spent on listening, the less time spent on prescribing antibiotics in general practice. *Fam Pract* 2002;19(6):638-40.
31. Van der Weijden T, van Bokhoven MA, Dinant GJ, van Hasselt CM, Grol RP. Understanding laboratory testing in diagnostic uncertainty: a qualitative study in general practice. *Br J Gen Pract* 2002;52(485):974-80.
32. Vickrey BG, Mittman BS, Connor KI, Pearson ML, Della Penna RD, Ganiats TG, et al. The effect of a disease management intervention on quality and outcomes of dementia care. *Ann Intern Med* 2006;145(10):713-26.

\*\*\*