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Dementia care: the view from general practice

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Dementia is a topic of major concern internationally because of increasing prevalence rates, rising costs to healthcare systems and the considerable impact that dementia has on the lives of patients and their families. There are currently approximately 46 million people living with dementia worldwide, a figure that is expected to almost treble to 131.5 million by 2050 [1]. The worldwide cost of dementia has been estimated to be in the region of US$818 billion per annum, an increase of 35% on the previous estimates in 2010, accounting for 1.09% of the world's gross domestic product [1]. Beyond monetary terms, there is also a very significant personal and social cost to dementia care. The intensity of care needs exceeds the demands associated with almost every other chronic condition [2], while dementia is the health condition that most strongly predicts transition into long-term care [3].

General practitioners (GPs) play a central role both in diagnosing dementia and in its further management. In most countries, GPs act as the first point of contact for individuals suspecting memory problems and thus they have an important role in ensuring early detection. This early diagnosis of dementia ensures access to much needed psychosocial supports and pharmacological interventions, and can be cost-effective too since it may help to keep patients living in the community for longer [4]. In common with other healthcare professionals, GPs are challenged by many aspects dementia care. They have been criticised for suboptimal dementia care, including missed and delayed diagnosis, despite the fact that the initial clinical picture can be very diverse, with initial symptoms that may mimic depression and the normal signs of ageing [5]. Stakes are high too, making and disclosing a diagnosis of a progressive, life-limiting condition for which there is no disease-modifying treatment available. GPs have reported clinical uncertainty around the management of behavioural and psychological symptoms of dementia, prescribing dilemmas and signposting to local services and supports and have identified dementia as an area of educational need [6].

Now in *Swiss Medical Weekly*, dementia care in general practice is examined from the perspective of GPs. Giezendanner and colleagues report their findings from a cross-sectional postal survey that was mailed to GPs who are members of the Swiss Association of General Practitioners and Paediatricians [7]. In addition to demographic and workload details, the survey focused on GPs' clinical approach, their confidence in the diagnosis and management of dementia and also their perception of the adequacy of health care services.

Overall, findings suggest that many GPs are comfortable with the diagnosis, disclosure and management of dementia and are content with local dementia healthcare services. Most GPs use either the Mini Mental State Examination (MMSE) and/or the clock-drawing test as cognitive screening tools. Similarly, the majority indicated that there is sufficient access to diagnostic services, most commonly referring to memory clinics. However, there are areas in which GPs appeared less comfortable. Just over half of GPs were confident in the pharmacological management of dementia, only 29% of respondents stating that they would start a cholinesterase inhibitor after a diagnosis of mild dementia. Areas of concern emphasised by the authors centre on patients with a migration background and patients with suicidal ideation. Just 16% of GPs felt confident in caring for patients with dementia who have a migration background, whereas 30% of GPs felt that suicidal ideation in patients with dementia made them insecure.

The present study has a number of important strengths. It highlights an increasingly common and complex area of primary care, and is opportune too, set against the backdrop of the Swiss National Dementia Strategy. The authors were comprehensive in their attempts to gain a representative, national perspective from GPs. Despite the relatively low response rate, which is common in many GP surveys [8], the overall sample size is impressively large and all GPs across all regions of Switzerland were invited to participate. The questionnaire was piloted for content validity, readability and acceptability and was translated into French and Italian.

The authors address the potential shortcomings of using the MMSE in primary care, in terms of the limited evidence for its use in detecting mild cognitive impairment (MCI) and its relatively high false-positive rate in detecting dementia. They might have considered offering suggestions for other dementia screening tools appropriate for use in the primary care settings. The GPCOG, Mini-COG, MIS and 6CIT are good alternatives to the use of the MMSE when considering factors such as application time, user error, sensitivity and specificity within the setting and constraints of every-day general practice [9]. Regarding GPs' uncertainty to prescribe dementia medications despite this confidence in making a diagnosis, the authors explain that this may suggest a nuanced weighing-

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up of the relative merits of these medications, cognisant of the low level of clinical effectiveness of these medications, poly-pharmacy and cholinergic side-effects.

The authors' discussion around the complexities of dementia care in the migrant population, with the attendant language, cultural, education and illiteracy challenges, is timely. They conclude that GP training needs to address this issue, but much more than this is needed, with the rapidly rising numbers of older immigrants. In order to optimise health care delivery for this vulnerable population, there is an urgent need for organisational changes and adequate resourcing too, strengthening collaborations between primary care, secondary care and governmental organisations [10].

Several important aspects of the study warrant further careful consideration.

The positive findings around diagnosis and disclosure in this study contrast with results from other studies internationally, which have found that GPs lack knowledge and confidence in dementia care, struggle with uncertainty about disclosure and are often reluctant to make an early diagnosis [11, 12]. GPs weigh up many competing dilemmas in caring for a patient with early dementia, such as dilemmas about consent, autonomy, safety and harm, and value the timeliness of making a diagnosis rather than making an early diagnosis. The authors rightly concede that their positive findings may be, in part, explained by the low response rate and social desirability bias. However, does this knowledge and confidence necessarily translate into routine practice? Frequently, other barriers to change exist that impede the routine application of knowledge, confidence and evidence-based guidelines into clinical practice [13]. Whether corroborative statistics exist nationally and locally on actual dementia diagnosis rates and disclosure patterns in primary care is not reported.

The findings regarding GPs' discomfort with dealing with suicidal ideation are unsurprising. Fortunately, this is a relatively rare phenomenon in dementia care and consequently would inevitably trouble any clinician involved.

In conclusion, the study by Giezendanner et al. is important, shining a light on an increasingly pressing area of primary care and identifying gaps in knowledge, confidence and healthcare services. The triangulation of GPs' views with the views of patients with dementia and family carers would add further validity to the positive findings. It would be interesting to explore Swiss GPs' perspectives of other topical issues in this field too, such as the management of behavioural and psychological symptoms of dementia, antipsychotic medication prescribing and dementia palliative care. Training and education of GPs is essential but so too is a political consensus that prioritises the development of dementia services, with sufficient resourcing of health and social care systems in the community.

Disclosure statement

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