Multidisciplinary Doctor’s Clinical Practice, Confident And Difficulties To Diagnose, Manage And Care For Dementia In Remote Area Hospital

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Abstract

Objectives: To examine multidisciplinary doctor’s clinical practice, confident and difficulties to manage and care for dementia in remote area hospital.

Method: A structured self-completed questionnaire, purposive sampling method with 18 multi-specialist doctors from united mission hospital.

Results: Key findings are dementia is a complex condition to diagnose and management that takes time to diagnose and current dementia assessment process is conflict between GPs and other professionals. As well as specialist did not consider that diagnosing dementia was benefited, nor current applied diagnostic methods are appropriate and they are skeptical about the advantages of dementia medications and methods which they have practice on primary care. Similarly, GPs detection is not final decision therefore better to make collaboration with others specialist professionals- neither confident to diagnose nor easy to get medicine in the local market. Likewise, neither social support nor day care and memory clinic services are available in the community. Lack of epidemiology knowledge, practice and experience, cost of dementia care, no governmental policy, no early diagnosis are additional barriers aspects to reach accurate diagnosis.

Conclusions: Still the diagnostic methodology and practice has not similar to screening dementia so it does not seem significantly benefit in screening. Rather early diagnosis, collaboration with multi specialist doctors, appropriate referral pathways, diagnostic guideline and refined MMSE tool is far better. It is not only issue of primary care doctors’- and not possible to detect the dementia without collaboration of multi experts group. The burden impact of dementia prevalence has been underestimated in developing countries.

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Background

Dementia is a complicated disease to diagnose, management and care for health professionals due to its a dozen of overlapping signs and symptoms. Therefore, the universal question is significantly arising who is dementia specialist (GP, neuropsychiatric, geriatric and neurologist, psychiatrist of older age or later life)? Or who has the pivotal role in dementia diagnosis, management, and care? Also, is there essential of multidisciplinary team’s combination to diagnose, management and care? Is this fact that due to the gap of appropriate knowledge the misdiagnosing rate is increasing? Therefore, we aimed to find the above mentioned and facts and to give a message on this issue.

Dementia is a progressive disease affecting various higher cortical functions and resulting in physical dependency, psychological affective and it is recognized as a crucial part of the dementia syndrome that remains an important for institutionalization [1]. Dementia can show vary from one person to another but over longer periods it makes the person more disabled [2]; [3] and challenges for primary care to detect for both caregivers and general practitioner and multidisciplinary team in their practice. It is a rapidly increasing as common public health issue all over the world that is under recognized in primary care settings [4]; [5] finds that primary care physicians fail to recognize, findings & proper managements. Therefore, dementia and related disorder disease pose a significant public health issue. Also, it takes longer duration to diagnose due to its vague signs and symptoms and slowly it is going to be a future crisis. It is estimated that the number of people with dementia will double every 20 years to 81.1 million by 2040 [6].

In the current practice the final decision goes on the neurologist. However, physician/family doctors, geriatrician, psychiatrists can diagnose others complication out of memory clinic. First visit to the GP or physician can help for more confirmation because patients may have some insight any kinds of medical hidden changes may occurring that cannot diagnose by the other experts [7]. Further, the neurologist should collaborate with multidisciplinary team in primary care as well as should facilitate the development of multidisciplinary teams for appropriate diagnose [8]. [9] finds that to screen the dementia the mini-mental state examination is important test due to its more reliability and validity than other scale. Generally, in the clinical practice the mini-mental test clock drawing test (verbal) 1-4 minute, GPCOG (verbal 4-5) minute & minute screen (verbal-7 minute) memory impairment screen (verbal minute), mini cog (verbal 2-4-5 minute) are frequently using to assess the dementia [10]. Even though due to the lack of specific knowledge skills among the GPs, are not success to diagnose. However there remain others influencing factors such as: education, age and valuable tools these do not help to diagnose dementia properly [11]. So, early detection of dementia is more potential for both patients and HPs [12] who observes mostly in their primary care in hospital [13] because it helps to find accuracy detecting probability and to refer in the correct place in time.

A study stated that delaying process in the diagnosis of dementia is 35 % by the GP in Ireland and almost GP pointed out the some factors are the responsible to be late detection of dementia: 1) lack of time, 2) Lack of confidence 3) lack of education, 4) Lack of confidence [14]; [15]. In next study, only 47.6% of GPs received training in the diagnosis and management of dementia and only 43.9% used specific protocols to diagnosis. As well as rest of them focused some need for more support for families, more respite care, day centres and social activities for people with dementia [16]. A growing number of studies [17] show that the prevalence of dementia increases with age and affects approximately 5-8 percent of individuals over age 65, 15 -25 percent of individuals over age 75 percent and
approximately 15-50 percent of individuals over age 85. Similarly, in Nepalese context the old age population number is increasing as worldwide. In 2011, 2.2 million accounting 8.3% of Nepal’s total population [18]. Initially it is assumed that 78000 over 65 have suffered by any kind of dementia even though there is not any scientific study [19].

All the above-mentioned facts and figures brought the considerable attention to conduct this study because we already knew that burden for health institutions, multi-expert, GPs and nurses, those are facing difficulties in diagnosis, manage and care. Our queries were, “who is who” in the dementia diagnosis like; GPs, Neurologist, psychologist, psychiatrist, Geriatrician and other HPs? Does it necessary to have collaboration of other (support of) health professionals like-psychiatric nurses/admiral nurses, dentist, optometrist, audiologist, physiotherapist, occupational therapist, dieticians, clinical psychologist, speech and language therapist, caregivers and social care staff, optometrists etc.? Do they prepare to address the dementia issues? Therefore, this would not be argued that multidisciplinary service is not helpful. Also, this paper will be an initiative step to assess the dementia health profession condition and to prepare for looming epidemic disease.

Methods:

Study Site and Sampling Procedure

This work was conducted in united mission hospital, where 90 percent are working as full-timer. This hospital is only one hospital in remote area from capital city and oldest, that was first established before 50 years. Twenty-nine were working (including trainees) and 10 mission appointees from six different countries, who work mostly as senior doctors in a teaching role, or in other support roles, at the movement. A purposive sampling approach identified 18 multidisciplinary from twenty-three experts (response rate 5.2 %). Questionnaires were given a self-completed structured with multiple choice items in English version. The medical division comprises the doctors and paramedical departments, Laboratory, Physiotherapy, Occupational Therapy, Dental, Anaesthesia, Out Patient Department, and Pharmacy. As well as, 6 posts for surgeons, at present two are trained orthopaedic surgeons, and 8 posts for senior medical officers, who are general practitioners, paediatricians, an anaesthetist, and medical officers with special training in obstetrics and gynaecology and internal medicine. They were not involved as expert of dementia neither in community nor hospitals. Approximately 70% of its patients come from the surrounding nine districts, Western Nepal, and from nearby parts of North India and total bed capacity is 165.

Design

Purposive sampling method was used to achieve the objectives and it was conducted after the taking permission using self-completed question (English version) set with the specialist doctors in hospital. All these questions were both distributed and collected by the hospital director and it was collected after the information by the same director with in one months of the distributed date. There was not any bias to distribute the questions to the specialist. It was requested to complete questionnaire set according to their own current knowledge but not taking any support from out.

These question set were distributed for those specialists only who were wishing to fill-up questionnaire. The disciplines (numbers of specialist doctors) were only eighteen from the following clinical areas; General psychiatry; general practitioners; pediatrics; gynecologists; orthopedic; (BDS) Dental surgeon as full timer and 6 doctors were from different countries like; UK., Germany, Africa, Nepal, Australia, and USA. The intension was to choose how do the multiple doctors regarding with dementia issues in their profession and
are they aware with this issue or not and to assess the difficulties with the multi doctors to provide dementia services in the hospitals because a minimum survey was needed to create a new policy and increase public concerns. In clinical diagnose group work seems more suitable than individuals examining for better diagnose [20].

Measurement

The questionnaires were covering demographic questions, dementia quiz: diagnosis, medication, epidemiology, and management. It was on multiple choice items for each question as well as in the aspect of dementia quiz there was “do not know” option on the questions. In first part of questionnaire; awareness of local support, dementia care, confident and attitudes, current practices of dementia, difficulties, current diagnostic tools, management and caring process, common sign and symptoms, diagnostic confidence, diagnostic facing problems was measured with 40 questions and in second part: dementia knowledge was measured with 21 questions. These questions were included with anatomy and physiology of dementia, medication effects and its efficacy, perceived difficulties and some remaining questions were open type to measure the specialist doctors’ view, perception and their experiences in the dementia. There were measured the common sign and symptoms on the basis of “Yes”, “No” and “Do not know” option. For Aspects of the difficulties of dementia care was measured with Not at all difficult, extremely difficult and do not know options, similarly, regarding with attitudes to dementia care was measured ranking on scale of agreement (strongly agree, agree, neither agree nor disagree, disagree, strongly disagree and cannot say. There were open types of questionnaires also to measure of theirs view, need and current situation and suggestions.

Data analysis

The questionnaire format was similar with Turner’s et al., (2004) [21]. These questions were coded according to the Statistical Package for the Social Sciences, SPSS version 20. Our data information was using frequencies information with percentages, mean, and standard deviation and we summarized open type of answer manually in descriptive way and analyzed with other related work.

Results

Demographic Characteristics of Subjects

This paper describes diagnosis practices, confident, management and difficulties with multi-specialist doctors on the basis of result. Overall 18 multidisciplinary doctors’ data are collected on the basis of their response and analyzed. The practice confidences, management difficulties to diagnose, diagnostic place, screening tools, sources of dementia updating knowledge and its treatment procedure was measured with the multidisciplinary doctors in remote area hospital. These respondents’ minimum age was 28 and maximum 52 (mean age 39.10/ S.D.7.26). Majority experts (12) were received their final degree from the aboard university like; European Union 2(11.1%), Asia 4 (22.2%), Africa 1(5.6%), Nepal 6(33.3%), Australia 1 (5.65), Russia 1(5.6%), China 2(11.1%), USA 1(5.65) and among of them 6 were foreigner specialist from UK, Australia, Africa, USA, Germany and China, who were working in that hospital since long years ago.

The proportion of female number is nearly 50%; that was equal with the male experts. We could not find the diagnostic and management experiences difference between the male and female respondents. More than eighty percent doctors were full timer and the diagnosis process handling by them in the out-patient’s department. Neither there was Geriatric service nor dementia specialist in the hospital settings even though they could handle up to 13 suspected patients in a
specific month. The duration of detection of dementia was 1-3 months to the suspected dementia patients. But they do not have taken any kind of dementia training which helps for their betterment diagnostic service.

**Over all Knowledge of Dementia with Multi-specialist Doctors**

Of 18 specialist doctors’ overall knowledge was very poor (Mean 12.83, SD= 2.8). See table 1. It shows that dementia is very poorly focused disease than other types of disease in the hospitals.

**Current Diagnosis Practices to the Suspected Dementia Patients by the Multi-Specialist Doctors**

Dementia diagnosis process is not similar globally also, nor medication is. The currently used clinical practice guidelines can be a worthy tool in the diagnose and management of dementia, though some professionals do not agree with their importance in clinical aspects. Even though there is a common agreement with the diagnostic strategies. Examination recommended to start with first signs and symptoms of cognitive deterioration. The majority of the doctors 15 (83.3%) were reported to ask about the mental history at first of their clinical diagnosis process then systemic illness: Cancer, Connective tissue 15(83.3%), Trauma 12 (66.7%), Check renal function 13(72.2%), Check glucose 12(66.7%) etc. See table 2.

**Awareness of local services**

In respect to awareness of day care services in living area fifty percent {no 9(50%)} knew there was day care services, accordingly about the memory clinic at living area one third said “no” 13(72.2%), 7(38.9%) respondents said “no” carer support group at living area, half percent {No’ -9(50%)} could name local support group for people with dementia and locate the name and very less percent were noted 6(33.3%) available to get the medicine for those dementia patients in the market. This result reflects the dementia care is still in shadow in hospital settings.

**Confidence in Making Diagnosis Dementia**

With the specialists were asked ‘how confidence in making the diagnosis’ of dementia {somewhat confident 7(38.9%)} nearly thirty- nine per cent were confident to prescribe medicine to suspected dementia patients themselves. Respondents were not confident to recommend medication on the time of diagnose but GPs are easily accessible [24]. The overall score reflects low confidence with the respondents. There were no significant differences with between received degree from aboard and native country practitioners’ in total knowledge, confident, management and care.

**Aspects of the Difficulties of Dementia Care**

On the basis of dementia care difficulties, the important difficulty was noted “making a diagnosis” particularly in the early stages. Accordingly, establishing a diagnosis 13 (72.2%), telling the patient the diagnosis 8 (44.4%), telling the family the diagnosis 8 (44.4%), responding to the family’s concerns 8 (44.4%), getting information about anti-dementia (cognitive enhancing) medications 7(38.9%) also expressed greater difficulties. Likewise, they added some extra barriers on open opinion like not having clinical research, the complexity of biological and psychological disorder, ethical nature of the condition, limited training to the physicians, neglect of elderly disease etc. [25]. See Table 3.

**Attitudes to Dementia Care (ranked on scale of agreement)**

Dementia is gradually being burden issue to the practitioner in the hospital settings on the basis of survey data. Majority believed that dementia diagnosis is more frustrating issue than rewarding and felt that a diagnostic issue is not only with the general practitioners. Result shows that scale of response towards on dementia is nearly half percentage. Respondent reported in five categories for each statement. Finally, to all practitioners were asked to rate their own agreement of dementia diagnosis and management on a scale of
### Table 1. Numbers and percentages of experts giving correct answers on the dementia quiz (n = 18)

|   | Question                                                                 | Correct Answers | Percentage |
|---|---------------------------------------------------------------------------|-----------------|------------|
| 1 | When the Alzheimer disease (AD) recognized that is most common cause of dementia? A. 1907s B. 1907s | 0(0%)           |            |
| 2 | Which is not the risk factor of cardio-vascular disease? A. Hypertension B. Atrial fibrillation. C. Ebixa D. coronary artery disease | 12(66.7%)       |            |
| 3 | The most common types of dementias of Alzheimer disease takes account for approximately: A. 50-70% B. 20-30% | 11(61.1%)       |            |
| 4 | All of the following are potentially treatable aetiologies of dementia except: A. Hypothyroidism B. Normal pressure hydrocephalus | 14(77.8%)       |            |
| 5 | A patient suspected of having dementia should be evaluated as soon as possible as: A. Prompt treatment of dementia may prevent worsening of symptoms B. Prompt treatment of dementia may reverse symptoms C. It is important to rule out and treat reversible disorders D. It is best to institutionalize someone with dementia early in the course of the disease | 14(77.8%)       |            |
| 6 | Which one of the following procedures is required to definitely confirm that symptoms are due to dementia? A. Mini-Mental State Exam B. Post mortem | 9(50.0%)        |            |
| 7 | Which of the following is not a necessary part of the initial evaluation of someone with possible dementia? A. Thyroid function test B. Serum electrolytes | 7(38.9%)        |            |
| 8 | Which of the following sometimes resembles dementia? A. Depression B. Acute confusional state C. Stroke D. All of the above | 1(5.6%)         |            |
| 9 | When a patient develops a sudden onset of confusion, disorientation, and inability to sustain attention, this presentation is most consistent with the diagnosis of: A. Alzheimer’s disease B. Acute confusional state C. Major depression D. Vascular dementia | 3(16.7%)        |            |
| 10 | Which of the following is nearly always present in dementia? A. Loss of memory B. Loss of memory and incontinence | 3(16.7%)        |            |
| 11 | Which of the following clinical findings best differentiates vascular dementia from Alzheimer’s? A. Word finding problems B. Short term (2 minutes span) visual memory loss | 18(0%)          |            |
The effect of anti-dementia drugs is to:
A. Temporarily halt the disease in all cases  
B. Temporarily halt the disease in some cases
C. Temporarily halt the disease in some cases but often causing liver damage
D. Permanently halt the disease in some cases
7(38.9%)

Which statement is true concerning the treatment of people with dementia who are depressed?
A. It is usually useless to treat them for depression because feelings of sadness and inadequacy are part of the disease 
B. Treatments of depression may be effective in alleviating depressive symptoms 
C. Anti-depressant medication should not be prescribed 
D. Proper medication may alleviate symptoms of depression and prevent further intellectual decline.
7(38.9%)

Which of the following best describes the functions of the Alzheimer’s Society?
A. Central research, information and campaigning role 
B. Provision of local support and education to carers 
C. Providing day and home care for people with dementia 
D. All of the above
7(38.9%)

Which one is correct?
A. Mild dementia – 20-24 out of 30 points MMSE score 
B. Moderate dementia – 9-20 out of 30 points MMSE score 
C. Severe dementia – 6 out of 30 points MMSE score 
D. None of them
1(5.6%)

One of the risk factors for the development of Alzheimer’s disease is:
A. Hardening of arteries  
B. Age 
C. Nutritional deficiencies 
D. Exposure to aluminium
5(27.8%)

A physical disease which causes brain cells to die, plaques disrupt message with in brain is called Alzheimer disease.
A. Yes.  B. No.  C. Don’t know
18(100%)

Multiple little strokes have damaged particular areas of the brain is called Vascular disease.
A. Yes.  B. No.  C. Don’t know
18(100%)

Abnormal lumps called Lew Body Bodies develop inside nerve cells in the Brain. People with LBD often have delusions, stiffness, tremors, visual hallucinations is called LBD.
A. Yes.  B. No.  C. Do not know
16(88.9%)

A progressive disorder of the central nervous symptoms is characterised by stiffness in joints and limbs, tremors difficulty to movement, speech impairment is called Parkinson disease.
A. Yes.  B. No.  C. Do not know
17(94.4%)

Excessive use of alcohol, low level of BI is a cause to be Korkoffs disease. It affects the most valuable parts of the brain which are used for memory social skill and balance judgement and planning organizing.
A. Yes.  B. No.  C. Do not know
16(88.9%)

Huntington’s disease means the inherited, degenerative brain disease which affects the mind and body.
A. Yes.  B. No.  C. Do not know
13(72.2%)

Which of the following medication always not using in dementia disease?
A. Ginkgo Biloba  
B. Glantamine 
C. Rivastigmine 
D. Donepezil
4(22.2%)
Which of the following behavioural features of fronto-temporal dementia not specified in diagnostic criteria?

A. Tau-positive
B. Hyperorality and dietary changes
C. Akinesia, rigidity and tremor
D. Motism

Rivastigmine tartrate (Exelon®) Oral; approved for:
A. mild and moderate Alzheimer’s disease only
B. moderate, and severe Alzheimer’s Disease
C. For mild cognitive impairment
D. None of them

Side effect of Memantine (Namenda®)
A. Headache, Dizziness, Sedation, Agitation, Constipation
B. Nausea, vomiting
C. Nausea, vomiting, and diarrhoea
D. None of them

The correct answer
1 - B, 2 - C, 3 - A, 4 - C, 5 - C, 6 - B, 7 - D, 8 - A, 9 - D, 10 - B, 11 - C, 12 - B, 13 - B, 14 - D, 15 - A, 16 - A, 17a - 1, 17b - 1, 17c - 1, 17d - 1, 17e - 1, 17f - 1, 18 - A, 19 - C, 20 - A, 21 - A.

Table 2. Current diagnosis practices to the suspected dementia patients by the Multi-specialist doctors.

| Yes                          | No                          |
|------------------------------|-----------------------------|
| 1. Check for functional loss | 11(16.7%)                   | 3(16.7%)                   |
| 2. Ask about past mental illnesses | 15(83.3%)                   | 2(17.7%)                   |
| 3. Arrange a chest X-ray     | 7(38.9%)                    | 11(61.1%)                  |
| 4. Check BP, B12 levels     | 10(55.6%)                   | 27(38.9%)                  |
| 5. Check liver function     | 5(27.8%)                    | 11(61.1%)                  |
| 6. Check endocrine gland    | 7(38.9%)                    | 9(50.0%)                   |
| 7. Arrange an ECG            | 8(44.4%)                    | 8(44.4%)                   |
| 8. Check calcium             | 6(33.3%)                    | 9(50%)                     |
| 9. Check glucose             | 12(66.7%)                   | 3(16.7%)                   |
| 10. Check renal function     | 13(72.2%)                   | 3(16.7%)                   |
| 11. Check memory impairment | 13(72.2%)                   | 4(22.2%)                   |
| 12. Depression test          | 10(55.6%)                   | 4(22.2%)                   |
| 13. Test urine infection     | 12(66.7%)                   | 3(16.7%)                   |
| 14. Ask behavioural/ personality changes with carer | 14(77.8%)                   | 2(11.1%)                   |
| 15. Thyroid test             | 10(55.6%)                   | 6(33.3%)                   |
| 16. Screening syphilis       | 11(61.1%)                   | 3(16.1%)                   |
| 17. Psychiatric disease test | 11(61.1%)                   | 2(11.1%)                   |
| 18. Trauma                   | 12(66.7%)                   | 3(16.7%)                   |
| 19. Systemic illness: cancer, connective tissue | 15(83.3%)                   | 3(16.7%)                   |

Dementia diagnosis process is still not similarity with the expert, on the basis of this data, in the current situation. Even though there is a common agreement with the diagnostic strategies. The majority of the doctors 15(83.3%) were reported to ask about the mental history at first of their clinical diagnosis process then Systemic illness: cancer, connective tissue 15(83.3%), Trauma 12(66.7%), Check renal function 13(72.2%), Check glucose 12 (66.7%), etc. Others have given on the above table in detail.
“strongly agree” to “Cannot say” option about their experience in caring for dementia patients. See table 4

Common sign and symptoms of dementia

Large majority respondents were reported that dementia is an umbrella term so there is no specific sign and symptom to determine that patients have dementias problem. There was given to choose 18 symptoms of dementias. However, the most common sign and symptoms identified the forgetfulness 18 (100%), memory loss, social skill loss and difficulty to recognize to the others and conduct disorder by the multi experts. The specialist group reported at least 10 warning symptoms are essential to declare the dementia disease to the suspected patients which are as following: Loss of interest in activities 8 (44.4%), loss of interest in activities 6(33.3%), loss initiative 12(66.7%), Memory loss 17 (94.4%), phobias 8(44.4%), Difficulty performing familiar task 7(38.9%), Recurring thoughts of death or suicide 18(0%), social skills loss 16(88.9%), change in appetites 6(33.3%), low self-stem 8(44.4%), difficulty to recognize 13(72.2%), Conduct disorder 10 (55.6%), forgetfulness 18(100%), fatigue 3(16.7%), problems with language 9(50%),disorientation with time and date 11(61.1%), poor or decreased judgment 5 (27.8%), Depression anxiety 6(33.3%). Above mentioned warning signs help to recognize at first stage of dementia for doctors [26]; [27].

Barriers to good practice in dementia for the doctors

Table shows some barrier aspects regarding on their manage and care for dementia patient on the basis of multidisciplinary responses. Similarly, these barriers are: unsure how to refer patients to take available services, lack of team staff in the practice, unfamiliar with available services to help keep them at home, costs of dementia care,too busy: not enough time during surgery visit, lack of funding within the practice, unfamiliar with advances in the management of dementia-related symptoms and lack of social service support available to the practice dementia-related symptoms. Above mentioned are mainly barrier aspects to detect the dementia in their primary care practice. See Table 5.

Table 3. On the basis of dementia care difficulties, the important difficulty was making a diagnosis, particularly in the early stages. Except this establishing a diagnosis 13(72.2%), telling the patient the diagnosis 8(44.4%), telling the family the diagnosis 8 (44.4%), responding to the family’s concerns 8 (44.4%), getting information about anti-dementia (cognitive enhancing) medications 7 (38.9%) also expressed greater difficulties. Aspects of the difficulties of dementia care.
Table 4. Dementia is gradually being burden issue to the practitioner in the hospital settings on the basis of below data. Majority believed that is more frustrating issue than rewarding and felt that a diagnostic issue is not only with the general practitioners. Below table shows that scale of response towards dementia. Respondent reported in five categories for each statement. Finally, all practitioners were asked to rate their own agreement of dementia diagnosis and management on a scale of “strongly agree” “to ...” “Cannot say” option about their experience in caring for dementia patients.

Multi experts’ attitudes to dementia care (ranked on scale of agreement). See the below.

| No | items                                                                 | Strongly agree | agree | Neither agree nor disagree | Disagree | Strongly disagree | Cannot say |
|----|----------------------------------------------------------------------|----------------|-------|---------------------------|----------|------------------|------------|
| 1. | Providing a patient with a diagnosis is usually more helpful than harmful | 10(55.6%)      | 6(33.3%) |                      |          |                  | 2(11.2%)   |
| 2. | Managing dementia is more often frustrating than rewarding          | 5(27.8%)       | 3(16.7%) | 4(22.2%)                 | 2(11.1%) | 2(11.1%)         | 2(11.1%)   |
| 3. | Much can be done to improve the quality of life for people with dementia | 9(50%)         | 8(44.4%) |                      | 1(5.6%)  |                  |            |
| 4. | Dementia is best diagnosed by specialist services rather than by the primary care team | 4(22.2%)       | 2(11.15) |                      | 2(11.1%) | 10(55.6%)        |            |
| 5. | It's better to talk in euphemistic terms when discussing the condition with someone with dementia | 4(22.2%)       |       |                      | 9(50%)   | 4(22.2%)         | 1(5.6%)    |
| 6. | Families would rather be told about their relative's dementia as early as possible | 10((56.6%) | 2(11.1%) | 2(11.1%)             |          |                  | 2(11.1%)   |
| 7. | The primary care team has a very limited role to play in the ongoing care of people with dementia | 2(11.1%)       | 2(11.1%) |                      |          | 7(38.9%)        | 7(38.9%)   |
| 8. | Much can be done to improve the quality of life of carers of people with dementia | 7(38.9%)       | 7(38.9%) |                      | 1(5.6%)  |                  | 3(16.7%)   |
| 9. | Patients with dementia can be a drain on resources with little positive outcome. | 2(11.1%), 3(16.7%) | 5(27.8%) | 7(38.9%)            | 1(5.6%)  |                  | 3(16.7%)   |
| 10.| There is little point in referring families to services as they don’t want to use them | 3(16.7%)       | 1(5.6%), 4(22.2%) | 5(27.8%) | 5(27.8%) |                  | 5(27.8%)   |
Experiences on current practices regarding with dementia

There was most common agreement with all specialist doctors that dementia diagnosis is very less prioritized problem in Nepal than other public health issue and no adequate facility for screening dementia in the hospital even though the staff member are self-motivating to diagnose, management and care. Neither there was dementia care center, dementia specialist, nor admiral nurses in the hospital. The measuring criteria were as followings: strongly agree, agree, neither disagrees nor agrees, strongly disagree and can’t say.

Open Ended Responses

In this last section, there was valuable comments/perceptions have on the drug treatment (Donepezil, Gliantamine, Memantamine, Rivastigmine etc), diagnosis process/guideline, their perception satisfaction, further recommendation, education (internet, web, journal) and advices. One third multidimensional doctors reported that lees access with the internet and MRI, CT to make more confirm dementias diagnose but In North America there was 60-70% [28]), 72% of Norwegian doctors had Internet access [29]). They have desire to be updated Neuro-degenerative disorder and dementia, desire to cooperation and coordination with patients, caregivers and their loved one, multi-discipline working team and consultant, requesting to arrange social policy, further treatment and investigation and wanting to have access with CT/ MRI as well. Efforts in Nepal need to be directed towards improving financial support, community support, family support, establishing day care home services, memory clinic services with geriatric services, a separate department of dementia in the hospital and in the community. Improvements in dementia knowledge and self-confidence for management and care should lead to an improvement in service delivery in Nepalese hospital and research is essential without delaying.

Discussion

Our main study was concerned to find out of those multidisciplinary doctors’ clinical practices and confidence to the diagnosis, ongoing management and care difficulties of dementia. They diagnosed more as false- positive and false-negative on average of new cases of dementia and the majority show a desire to take dementia specialist training for better diagnose. They were in relation to the use of MRI/CT/SCAN to diagnose dementia: non-user 4 (22.2%), played with 14 (77.8%). Further they noted that due to the less access of MRI/CT scan of brain in time, was taken long duration to determine dementia properly. In Nepalese context, dementia has been very less prioritized public health problem than others disease. It is a complex disease and its management is quite challenging for patients, family

Table 5. Barriers to good practice in dementia care. Below table shows some factors regarding with their skill, manage and care for dementia patient and their care givers on the basis of multi experts response.

|                                  | YES PREVENTS | NO DOES NOT | DON’T KNOW |
|----------------------------------|--------------|-------------|-----------|
| Too busy: not enough time during surgery visit | 11(61.1%) | 5(27.8%) | 2(11.15) |
| Unfamiliar with advances in the management of dementia-related symptoms | 8(44.4%) | 10(55.6%) | .......... |
| Unfamiliar with available services to help keep them at home | 12(66.7%) | 1(5.6%) | 5(27.8%) |
| Unsure how to refer patients to available services to help keep them at home | 15(83.3%) | 1(5.6%) | 2(11.1%) |
| Lack of team staff in the practice | 13(72.2%) | 4(22.2%) | 1(5.5%) |
| Lack of funding within the practice | 10(55.6%) | 7(38.9%) | 1(5.6%) |
| Lack of Social Service support available to the practice | 6(33.3%) | 10(55.6%) | 2(11.1%) |
and society [30]) so WHO has declared dementia as public health problem in 2008 [31]). Specialist services have long waiting lists and patients have to manage by themselves after providing general practitioners. The overall knowledge mean (12.83/SD 2.89% was poor with the 18 experts in the overall dementia quiz. In one study, general practitioner’s knowledge confident and attitudes in the diagnoses and management of dementia in UK 2004, 67% was correctly given by the general practitioner. These respondents’ minimum age was 28 and maximum age was 52 and mean age was 39.10 (SD=7.26).

Across the eight European countries’ a study reveals neither there was systematic registration process nor scientific prevalence data is available in the nations with the old age population [32] however, these countries are concern to control the dementia issues and to established the friendly dementia society. The analogous situation was found in Nepalese hospitals too. In Nepalese context, dementia has been very less prioritized public health problem than others. Specialist services have long waiting lists and patients have to manage by themselves after providing general practitioners. Thus, management and care is quite challenging for patients, family and society [30]. Therefore, WHO has declared as dementia should be as public health problem [31] in each nation.

Mostly dementia patients visited in primary care unit and the detection duration had up to 1-3 months for suspected patients. So, it means that dementia is not easy to detect in an abbreviated time and takes time for confirmation. Referral process and multi-discipline work in the diagnosis often depends on the health care system of that county policy [33]. However, some current studies have shown that no potential effect of the screening [34]; [35]; [36]; [37] as we find in our study too. In our study, early screening of dementia does not show the significant effect to the patients. However, there is the pressure for faster diagnosis- but not possible. Likewise, a study reveals that about 50% people with suspected dementia patients do not get efforts for timely detection [38].

An Ireland [16] survey reflects only 19% often or always disclosed to diagnose patient and (90%) GPs had never undergone any specific dementia training and 83% expressed a desire for such training the indistinguishable situation was with our participants. In terms of diagnosis confidence, most experts showed that somewhat confident 7 (38.9%) to detect the dementia in their practice. Further we examined the knowledge of anti-dementia drug’s effects and its utility with the experts and drew that nearly 7(38.9%) know about it. It shows that need of especial training to the health professional to address the diagnosis and management and information about local services [39].

Lepeleire et al., (2008) [23] claimed the diagnostic process should be in time with appropriate guidelines. That can help to identify the difficulties to diagnose and response with the patients [40] as well as dementia care responsibility should have with the specialist (Robinson, 2008) but not with GP only. Such a finding was the similar with our result. Also, we found, the general concept of dementia in not positive- it is considered a disease of elderly. GP has vital role although GPs felt the early diagnostic process is more challenging [41]) and they suggested for early diagnosis [12]. Even though majority experts were not concerned to take cognitive assessment/ screening to the patients [42] nor especial dementia training as like Sweden. We found majority respondents were interested to attain training for update the overall knowledge but, never get opportunities for raining. However, they were keep going practices own their efforts as like Irish and Swedish HPs [43]. Our limitations were no observational research in their clinical practice, less number from one hospital. This result may not represent true practice and management. Also, we have no national data to compare with dementia to yield reliable data.
Conclusions

Overall, the findings indicate the specialist group claim that dementia is challenging/complex disease to the expert for management due to its multi variables characteristics and longevity diagnostic process. Second, early diagnosis, collaboration with multi specialist doctors [1] appropriate referral pathways, diagnostic guideline and refined MMSE tools is far better. Third, it is not only issue of G. P. The burden impact of dementia prevalence has been underestimated in developing countries like; African and Asian regions (Nepal) and it will shift to poorer countries soon. Dementia cost seems very high for cure. Finally, should investment into research for a treatment and cure and it should be declared that dementia is a public health priority for management and care because it helps to avoid ten percent of dementia cases by improvements in public health. That’s why neither 13 out of 193 WHO countries, nor the 68 countries, all countries from the world and non-profitable organizations must commit to comprehensive global plans with the dementia to have national dementia plans in the country [44].

Limitations: There is limited ability to generalize this findings to all the multidisciplinary doctors of Nepal as large numbers. However, the first step could be to find out the dementia diagnosis, management and care in the hospital settings. Later on, the research should be focused on treatment efficacy, other aspects of clinical process and industrialization. There are very difficult to find research activities in this area and it is necessary to find scientific research. This article just explores issues in dementia and its situation with the health professionals and local area. In the survey the information about the dementia diseases was the perception of the multi-health professionals.

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