Management of dementia in primary health care: the experiences of collaboration between the GP and the district nurse

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**Objective.** The objective of this study was to explore the context and experiences of collaboration between the GP and the district nurse (DN) in diagnosing dementia, in order to identify possible procedures to improve care.

**Methods.** Two group interviews were conducted with four DNs and five GPs, respectively, working in the municipality of Copenhagen.

**Results.** The group interviews revealed that the suboptimized collaboration could be due to different inter-professional diagnostic strategies and a lack of understanding of the importance of early, shared, decision making. This could create conflicts between the groups.

**Conclusions.** This study indicates a possibility for improved collaboration between the two professional groups in diagnosing dementia. Possible approaches for improved care should focus on an inter-professional understanding of the importance of early, shared, decision making, emphasizing early identification and care of diagnosed demented patients. Establishing a shared collaboration model including out-patient memory clinics, GPs and DNs could be a first step. This model should also take into account an evaluation of possible consequences for the diagnosed demented patients in terms of treatment and care and consider the indication for referrals to a comprehensive diagnostic evaluation. We are at present planning a study to address these aspects.

**Keywords.** Collaboration, dementia, district nurse, general practice, inter-professional relations.

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**Introduction**

Within the last decade, an increasing awareness of the importance of diagnosing and managing dementia has resulted in numerous guidelines on diagnostic evaluation and management of dementia.1-3 Both the district nurse (DN) and the GP are key figures in identifying as well as managing dementia. Information from DNs and GPs can be supplementary for this purpose.4 However, collaboration between the two groups may not be very developed.5

Even though the two groups have a great potential for collaboration, this relationship may also be characterized by tensions, conflicting expectations, poor coordination and separate professional decision making.6-9 A lack of collaboration could contribute to problems in quality and efficiency of patient care. In order to explore determinants for collaboration between the two professional groups, qualitative research has been suggested.7

The preconceptions of the authors [two GPs (FBW and KM), a specialist in neurology (GW) and an administrative nurse (LBB)] were that the collaboration between DNs and GPs in diagnosing dementia is not sufficiently developed, and that better collaboration between DNs and GPs could improve the quality of the diagnostic evaluation as well as the management of dementia in a primary care setting. We consequently carried out a study intending to explore the experiences...
of collaboration between GPs and DNs in managing dementia.

Subjects and methods

Material for analysis was drawn from qualitative group interviews with GPs and DNs.

The group interview study

Group interviews inspired by focus group principles were conducted with a group of four female DNs in October 1999 and a group of five GPs (three male and two female) in January 2000.

The participants were recruited from different areas in the municipality in order to cover variations. Characteristics of the participants are presented in Table 1.

The group interviews with the DNs were held during working hours. The GPs who participated in the group interviews received a fee from the municipality for their participation.

Both interviews began with a short introduction where the participants were informed about the objective. The participants were informed that at any time they could regret statements, which subsequently would be erased.

The first author (FBW) was the moderator. The interviews were conducted as open-ended interviews using the critical incident technique. Participants were asked initially to present examples of successful interprofessional collaboration, while later in the interview the moderator requested examples of non-successful collaboration. Both interviews lasted ~1 hour and were conducted in an open-minded and friendly atmosphere.

The group interviews were tape-recorded and later transcribed by FBW. During the transcription, each DN and GP was given an identification number (GP-1 to GP-5 and nurse-1 to nurse-4.)

For analysis of the material, we used the phenomenological method originally described by Georgi and modified by Malterud following an editing analysis style. Afer the transcription, we identified text elements (units) containing information of relevance for the research question, without using an already defined template. These units were sorted and organized into categories representing different collaborative issues identified across the material.

Results

Group interviews

The group interviews revealed different diagnosing strategies, explanatory factors and areas of conflicts between DNs and GPs when diagnosing dementia in a primary health care setting. Below, we present descriptions of matters indicating possible procedures for improved care.

Diagnostic strategies

All the DNs spontaneously mentioned the importance of a well-functioning, hospital-based clinic where the GP could refer patients for diagnostic evaluation of dementia.

The nurse (nurse-3) who said that the possibilities for referral were not adequate, also stated that the GPs had a lack of interest in demented patients. On the contrary, the two DNs (nurse-1 and nurse-2) who told us that they related to a well-functioning out-patient memory clinic explained that the collaboration with the GPs in general was good. It seemed that the possibilities for referral were crucial for the GPs’ readiness to refer and to listen to the DNs’ suggestions.

“We have an excellent geriatric specialist out there . . . and all the GPs have heard about her and know she is competent, and when we are calling then they (. . . the GPs . . .) take us seriously.” (nurse-2)

For patients with possible dementia, the GPs agreed that they applied two levels of diagnostic strategies: a basic level including blood samples and a physical examination of the patient, and another level where they referred the patient to an out-patient memory clinic. All GPs agreed that the basic level should be offered to all patients, but they did not agree that all patients should be referred to out-patient clinics. Three of the GPs (GP-1, GP-4 and GP-5) stated that the patient’s age was an

Table 1 Characteristics of the participating DNs and GPs

| Nurse-1  | Female, 42 years, working part time in District S. No information on dementia training status |
| Nurse-2  | Female, 38 years, working part time in District SN. No information on dementia training status |
| Nurse-3  | Female, 57 years, working full time in District N. Participated in dementia training course |
| Nurse-4  | Female, 31 years, working full time in District B. Did not participate in dementia training course |
| GP-1     | Female, 52 years, working in single-handed practice in District O. Member of the Danish College of GPs (DCGP). Received a guideline on dementia in 1997 |
| GP-2     | Female, 57 years, working in group practice in District O E. Member of D C G P. R eceived a guideline on dementia in 1997 and 1999 |
| GP-3     | Male, 52 years, working in group practice in District K. Member of D C G P. R eceived a guideline on dementia in 1997 and 1999 |
| GP-4     | Male, 55 years, working in single-handed practice in District B. Member of D C G P. R eceived a guideline on dementia in 1999 |
| GP-5     | Male, 67 years, working in single-handed practice in District S. Not member of D C G P. R eceived a guideline on dementia in 1997 and 1999 |
important factor to consider when referring a patient for further diagnostic evaluation. All the GPs emphasized the importance of the patient’s consent to referral.

Explanatory factors

Even when the DN suspected a patient of having dementia, the GP was not always contacted. Three of the nurses (nurse-1, nurse-2 and nurse-4) remembered specific situations when they had not contacted the GP to share their suspicion. If, according to the DNs, the patient was well managed at home and content with his situation, that might be one reason not to contact the GP.

“It is an elderly male living alone, a widower, and he has maximum home care that means that he is looked after in the morning. We ask him what happens and who comes and he says his breakfast is served and he is content and then he feels that he is in charge but otherwise he sits in front of the television and then his sister-in-law visits him and then his son calls. He lives in his own world but he has contacts and he feels happy . . . No we never spoke with his GP.” (nurse-3)

All the GPs stressed that a diagnostic evaluation of dementia should lead to consequences for the patient in terms of treatment or care. Two of the nurses (nurse-3 and nurse-4) and all of the GPs had personally experienced situations when a referral to an out-patient memory clinic had no impact on the overall situation for a patient.

“It was an elderly woman in her seventies who had been referred for diagnostic evaluation of dementia because her daughters insisted . . . But it ended with a song and a dance and she was not demented and they did not conduct a real diagnostic evaluation. And that did not make us any the wiser, because none of us doubt that she was demented.” (GP-1)

Conflicts

Both the GPs and the DNs agreed that diagnosing dementia could also create tensions and conflicts between the groups.

The DNs explained that conflicts often arose when the GP did not want to take action when they themselves wanted the patient to undergo diagnostic evaluation, e.g. in order to move into a residential home. They stated that some doctors were reluctant to refer for diagnostic evaluation because the doctors did not see that it had any consequence in terms of care or treatment for the patient.

All the GPs told us that their impression was that the DNs wanted the GPs to refer the patient for diagnostic evaluation of dementia in a hospital clinic setting. In such cases, the GPs regarded the DNs as rigid professionals with a standardized way of thinking.

“The nurses press me to do more examinations than I actually want. It is fair enough if it is a long time since I ran blood samples, but then I think it should stop here . . . I am more interested in problems, e.g. do they have gas in their apartments . . . are they able to find their way back to their apartments . . .” (GP-2)

Discussion

The group interview is a rational method for gaining qualitative data and requires fewer resources for fieldwork and analysis than individual interviews. On the other hand, the information that may be obtained from group interviews is different from that obtained from individual interviews because of the different context. The objective of the present study was to explore the experiences of collaboration between the GPs and the DNs in managing dementia. Group interviews may tend to suppress controversial or divergent points of view, but can enhance associations related to experiences shared by the participants in the group.13,14 The conversation in our groups was energetic and confident, and no serious conflicts arose within the groups. This could be the explanation for the saturation of data from just two group interviews. We do not believe that further interviews would illuminate the research aim.

We used the critical incident technique in order to hear the participants’ experiences and in order to counteract the influence of our own preconceptions by discussing very concrete matters perceived as significant by the participants. The group interview with the DNs could be influencing by the fact that the moderator (FBW) is a GP. However, the atmosphere in both group interviews was good and it was not perceived as a problem.

One explanation for the suboptimal collaboration could be the different understanding of diagnostic strategies revealed in the group interviews. The GPs operated with two levels of diagnostic evaluation of dementia: a basic level and a comprehensive level where they would refer to out-patient hospital memory clinics. However, when the DNs approached the GPs, they often wanted the GP to refer to an out-patient memory clinic. Often they had tried to deal with the situation at home without contacting the GP and they would not contact the GPs until severe complications, e.g. behavioural problems, occurred. From a medical point of view, this may be alarming, because it can delay diagnostic evaluation when relevant treatment is within reach.

On the other hand, there is no doubt that the DNs’ decisions were based on their individual interpretation of what might be in the patient’s interest. Both the DNs and GPs had experienced that a comprehensive diagnostic evaluation of dementia did not have any treatment consequences for the patient. This aspect is important, because it clearly influences the decision on referral to an out-patient memory clinic.

The fact that three out of five GPs regarded age as an important factor when considering referral to an
out-patient memory clinic is an aspect that should be addressed. Because of the present development in knowledge about care aspects as well as medical interventions for diagnosed demented patients, age is not a good factor to consider in terms of referral. It is not well established which patients the GP should refer for further diagnostic evaluations at out-patient memory clinics and which patients the GP can diagnose. This specific aspect needs further evaluation.

The experience of the DNs of the importance of a well-functioning memory clinic for the inter-professional collaboration between GPs and DNs could be due to an understanding that GPs are either reluctant to diagnose dementia themselves, or are not capable of diagnosing it. However, the study was conducted prior to a clinical practice guideline on the diagnostic evaluation of dementia which was published in September 1999, which has contributed to improving professional standards.

This study indicates that shared inter-professional understanding between DNs and GPs about when and how to diagnose dementia is not always present. Our findings confirm the impression that the inter-professional communication on patient care may be poorly coordinated and characterized by separate professional decision making. Our informants suggest the possibility that this could be due to different perceptions of when and how to diagnose dementia, different professional skills and behaviour or barriers in the organization e.g. referral to a comprehensive diagnostic evaluation of dementia.

Because of the development of new knowledge of care aspects as well as medical interventions for diagnosed demented patients, we anticipate that the GP will be involved in problems concerning possible dementia at an earlier stage than today. As a consequence of this, the future newly diagnosed demented patients typically would not require the services of the DN. This led us to the conclusion that the GP should be the key professional person in a future structural organization of the management of dementia in primary care.

Implications

This study indicates potential for improved collaboration between the two professional groups in managing dementia. Possible procedures for improved care should focus on an inter-professional understanding of the importance of early, shared, decision making, emphasizing early identification and care of diagnosed demented patients. It is important to establish a shared collaboration model including out-patient memory clinics, GPs and DNs. This model should also take into account an evaluation of possible consequences for the diagnosed demented patients in terms of treatment and care and consider the indication for referrals to a comprehensive diagnostic evaluation. We are at present planning a study to address these aspects.

References