LETTER TO THE EDITOR

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Exploring dementia management attitudes in primary care: a key informant survey to primary care physicians in 25 European countries

I read with great interest the study of Petrazzuoli *et al*. (2017) on exploring dementia management attitudes in primary care. The authors made a laudable effort to evaluate this important issue, which certainly needs timely attention. The high response rate from 25 member countries of the European General Practice Research Network is astonishing.

I would like to comment on the responses received from the participants. First of all, the title of this study indicates the participants of key informants and "Key informant interviews are in-depth interviews of a select (non-random) group of experts who are most knowledgeable of the organization or issue" (Parsons, 2008). The use of key informants is an effective method, which might give us clear clues on the questioned issue, given that the key informants are knowledgeable about the subject. In this study, however, the participants seem to have different knowledge on factual issues. Even a representativeness of the key informant sample to the total population of GP's is not expected, and a representative gender distribution would be desirable in some country samples. Further information on the experience level in years, work setting (surgery, hospital, community center, etc.), location (rural, urban, and metropolitan), share of elderly patients in patient list, etc. would be very helpful to interpret the results of this study.

Looking at the large diversity of responses of Turkish "Key" informants, I would like to add following concrete information, without leaving any doubts to this study. Even all doctors have the privilege to prescribe drugs to people with dementia; reimbursement issues of the Turkish Social Security Institution make the specialists of neurologists, psychiatrists, and geriatrists the first point-of-contact of dementia diagnosis and treatment. The GP's (with/without vocational training) sole official contribution is the re-prescribing (re-fill) of drugs (according to a maximum two year issued specialist medical treatment report) in these patients. However, this situation, which allows seeing the people with dementia at least every three months, could be turned into an opportunity to quickly asses the cognitive, physical, psychological, and social status. This assessment should be addressed in CME/CPD programs, which would enhance the quality of care in dementia and also relieve the time burden in a routine practice. The WHO Age-Friendly Primary Health Care Centres Toolkit is an important approach and framework for this (Yaman *et al*., 2016b; WHO, 2017).

Besides dementia, cognitive screening is requested from authorities (i.e. notary public) to prove cognitive stability in patients over 65 years, from police department for driving license attestation or from the municipality for marriage attestation at first instance. The Mini-Mental State Examination (MMSE) is the most recommended test with some limitations for this examination (Creavin *et al*., 2016). The Clock Drawing Test is another strong tool, which could be applied easily. However, the key informants forgot to mention the high rate of people with illiteracy in older people, especially in Turkey. Therefore, the MMSE for illiterates is recommended (Babacan-Yıldız *et al*., 2016). In Turkish context, the MOCA test is also widely used, especially in mild cognitive impairment. Short tests such as the Mini-COG or GPCOG are also available at primary care level.

In a survey conducted on Turkish GP's, the level of self-confidence in diagnosis and treatment in dementia was found to be low (Yaman *et al*., 2016a). Due to the lack of reimbursement of drugs for dementia, the GP's contribute by providing preventive services to these patients and their caregivers. The management of the dementia patient has a higher priority than just to treatment and diagnosis. The patients and their relatives are in need of other services. These services such as neuropsychological assessment, assessment of driving eligibility, caregiver training, case management, day care, respite care, nutritional counseling, recreational activities, etc. should be integrated firmly to the GP health services network (Yaman, 2014, 2015).

The integration of the GP into this Age-Friendly Community Center would lower the time and financial burden on GP's and caregivers. The quality of life of patients and the "silent patients," i.e. the caregivers, could be increased by this approach. Nevertheless high working hours, low salaries, isolation, burnout, and need of training are global, universal problems of GP's. Integrative care models need to piloted and implemented in community setting. Age-Friendly Community Centers with a special emphasis on dementia care

are needed. The "Blue House" in Antalya, Turkey, might be a good model for this need in community.

Conflict of interest

None.

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