Dementia Dialogue; The System Journey, Episode 7

Transitions: Shared Care in Dementia
Transcript of interview with Dr. Ajantha Jayabarathan

David - Welcome to Dementia Dialogue and the fifth episode in our series The System Journey, where we are discussing people's experience with healthcare in the context of dementia. Today, we are talking with a family physician, Ajantha Jayabarathan, who practices in Halifax, Nova Scotia. Ajantha is also affiliated with the Department of Family Medicine at Dalhousie University and has been a practice for 30 years.

And thank you very much for joining us today in this conversation.

Ajantha - My name is Ajantha Jayabarathan. My name is rather long and difficult to remember so most people call me Dr A.J. and as of 2022 I will have practiced family medicine for 30 years. Hard to believe.

I was born and raised in India. My family immigrated to Kincardine on the shores of Lake Huron in Ontario, and I did my two years of undergrad and four years of medicine at Western Ontario. And then I came out to Nova Scotia to do two years of family medicine. I fell in love with the people and the place, and I stayed. I am married with two children and I initially worked in the Dalhousie Department of Family Medicine and by 2005 I wanted to practice in community and so I moved into the community. I've been located in four different sites. All of it has been within urban Halifax.

I have a collaborative family practice. In fact, the choice of the name of my current clinic and business is Coral Shared-Care Health Centre. And it was done very consciously and it was done because of the impact that the shared mental health care movement has had on me as I was developing as a practitioner. The tenets of collaborative care to me are now germane to my practice of family medicine. My primary collaborative partner is my medical office administrator.

Most people, when I ask medical students that, they'll often say a nurse or somebody else. But no, it is the woman who sits and answers all the phones and greets every patient who comes into my office. You know, First Link was really for me, it was like a lifesaver; something that was thrown into the sea, where we're in primary care drowning because of the increase in demand and lack of resources. But what was remarkable about First Link was how practical and on the ground and easy to access it was.

David - So then coming to dementia, I'm wondering whether you might position yourself as in your family practice and one of your patients, who you may have had for a period of time, either begins to display some of the symptoms that we've identified with dementia or perhaps their care partner may have spoken to you about his or her concerns about their partner. I'm wondering how you might see yourself responding as a clinician to that very initial identification of what may be an emerging condition for a person.

Ajantha - There's two points that stand out to me when you bring that up as a scenario. I mean, certainly as a family doctor, I'm trained to look after people from birth until end of life. We call it Cradle to Grave care, and it's comprehensive, office based care that I've developed over these years. The only thing I had to give up was delivering babies because it was just quite difficult to juggle that. And most recently, I was probably challenged with one of the most difficult dementia diagnoses because it ended up that both husband and wife had it. And I had known this couple for the better part of a decade. And one of the issues that a family doctor can fall into is sometimes you know each other so well that it’s almost like you don't have to say very much before one knows what the other needs. And it's a trap that a family doctor has to be careful about because you are so accustomed to seeing and hearing from someone in a certain pattern that if that pattern is maintained and there is a dementia process happening in the background, you're unlikely to pick it up.

And even if a family member is pointing out that maybe there's an issue, when that patient presents, they are already going to defensively sort of barricade that information in a way that they help to reassure you based on your relationship with them, that all is well, that there is an issue with the family member.

Those are tough. Those are very tough. And when I was a younger practitioner or when I was earlier in my career, I've certainly learnt from that. And there was one particular lady who was one of those personalities who was larger than life. And nobody dared question her, including me as her doctor, because she was such an authority. And it was her daughter who was in my practice who said, “We are very concerned, but we don't dare bring it up. We're looking to you”. And so to actually be able to do the MMSE and then look at how poorly she did on that, for me was a wakeup call that I have not forgotten.

So with this particular family was much the same. The wife was the one that looked after everything in terms of medical visits and appointments. And the gentleman was very happy with that setup. And unfortunately, she developed a fairly rapid onset neurodegenerative process that affected both her memory, speech as well as her mobility. So suddenly his foundation was shaken up and he reacted with a lot of anger and grief over the loss of a partner who he could no longer rely on. But remarkably, he developed chest pain and she still had enough of her caregiving ability that she convinced him to go to the hospital and saved his life.

But afterwards, nothing was the same for either of them. You know, whether the heart attack itself had some kind of anoxic damage, very slowly when they would come in together for her care. I was starting to look at him to ask questions about how well he was actually doing and he wasn't doing well. So, of course, depression in the caregiver is a big issue. And he acknowledged that. We did the testing and confirmed that. He did not want any treatment for it. But the more he presented, the more I started to question whether there was a dementia process there as well. And you can imagine how difficult that was. And it was.

At the end of it, we were able to establish a diagnosis and his MMSE was also very low and going down very rapidly. And he became quite defensive because he was also driving. So I really had to lay the law down, so to speak. He truly was a danger to himself and her. And now I had nobody within the household to be able to rely on for getting any kind of information about everything from: what did you eat to has she had any falls to have you been driving?

So my next step always is to include the family. In fact, one of the things I try to do proactively and I'm not successful all of the time because so many competing things. But when my patients reach sixty to sixty-five, I start to talk to them about advanced care planning. And it's from a wonderful program that really lays out steps towards really thinking about the fact that our life is finite and how we wish to be treated as time goes on. And it opens up the doorway for me to ask about who has Power of Attorney, who is going to be the executor of your will, who will be your substitute medical decision maker. So thankfully, in this case, we are able to do that. And thanks to virtual care, literally one family member was somewhere else in Canada so we actually had a family conference. And I cannot stress how important that is because you want everybody to hear the same message from the doctor so that the kinds of issues that then rise within families are perhaps or hopefully managed at the point of care.

One of the other barriers that I find I face is the ability to test somebody who is showing evidence of dementia in terms of their safe driving. And so in Nova Scotia, we have two sources; one is the DriveABLE program that a couple of physiotherapists, thankfully, have set up, and it costs about four hundred dollars. The waitlist is not long because it's privately funded. But the other is the publicly funded, which is from the rehab hospital. But they have a two year waitlist and now they, too, are charging for it. So unfortunately, this group of individuals who absolutely need to have testing done on a regular basis so that they don't inadvertently lose their licenses, that service is just either not available or for some not affordable.

I generally don't mince words when it comes to driving. And I acknowledge how critically important it is. In this particular presentation, the gentleman who now himself is presenting with dementia symptoms is the one that likes to feel the independence of being able to even just drive to go for a walk down a pathway that they have close to their home. So losing his ability to drive would make them incredibly dependent on others, which I know is the most difficult transition. Just as bad as the diagnosis itself and as you start to see someone's memory failing.

And this is where family members, of course, are very important. You know; what they do with the keys, what they do with the actual vehicle, if somebody is resistant.
This is where things get a bit conflict ridden and very stress provoking. Very stress provoking. I always feel for the family members and caregivers.

So the other area as a family doctor I look at is how do you support the caregivers? And First Link was just a godsend in terms of the part about driving and the part about actually supporting families.

I would love to see more mental health services where there may be groups or there may be one on one where the whole family sits together. I have now started to develop a new linkage with some of the general internal medicine specialists so that we do a shared care; physiotherapists who specialize in managing activity in the elderly, urban poling and the use of activator poles and urban poling sticks, and having my physiotherapist starting to work with people in terms of their mobility.

Working, as I said, with some of the mental health therapies within our group. There was one instance where within a nursing home facility, there was an area for independent living and one of our members was just presenting with behaviours that the nursing staff just did not know what to do with. What I actually was not able to get, was this team but instead there's a group called FMPE, which is out of McMaster, and they produce modules to train family doctors about what is emerging. And they give us evidence and we sit in groups and we manage to have discussions which balances evidence with actual experience. And they had just done two or three excellent modules on care of the elderly, care of dementia, and there was an entire sheet for behavioural intervention. Well, I literally took that sheet and I sat down with the nursing staff and I gave it to them and said, when the person says this, here's what you can do that will not cause them to get more agitated. And I've used that as a resource and I give it to patients and their caregivers as well.

So I'm trying to bridge a gap, but those are the kinds of things I've turned to.

Last but not least is pharmacists. So in Nova Scotia, pharmacists have been given expanded scope. There's no things they can do and they can do a medication review for which they are paid. And as you know, and I think we don't do a good enough job with this, as people are ageing and if there is a diagnosis of dementia, one of the first things that they must have is a medication review.

In some of the places where it might be a community based, small home where it's two or three people and it's usually the staff of those places. So either in the community or it might be a senior’s facility. And in the example that I gave you, I knew my patient was presenting with behavioural issues that was beyond sort of what that group would hold on to, in terms of even letting her be there. But we've had a shortage of beds in long term care, and the staff there recognized that. So I think because they have a relationship with me that is collaborative, they are often willing to keep some of my patients there longer, knowing that I'm available at the drop of a hat to support them.

So it was the woman who supervised the entire health care of the residents in that senior’s facility is a nurse by training. So she had to L.P.N.s that would actually be doing everything from taking blood pressures to giving medication. So that was the group that we sat down with and I shared them with them the information. And I think they went on to take that and actually did an in-service because they recognized that was a gap that they did not have training in behaviour based interventions for somebody with early onset an emerging evidence of dementia.

David - It's been a pleasure talking with you.

It is interesting to hear another clinician’s perspective and to hear some similar themes, such as gaps in patient care identified by Dr. Ajantha Jayabarathan including accessible allied health professionals, driving assessment, family counselling and paramedic and police training that were mentioned at our interview but for reasons of time not included in this podcast.

Our next episode ends our System Journey, when we will take a look back at some of the themes that have emerged in this series.

Our participants include Jim Mann, a pioneer in dementia activism in Canada, and Jacobi Elliott PhD, an associate of the Geriatric Health Systems Research Group at the University of Waterloo, co-sponsors of this series.

Thanks to our listeners for connecting to us on Twitter, Facebook or signing up on our website.

Thanks also to the Centre for Education and Research on Ageing and Health at Naked University, our sponsoring partner.

Thank you. My name is David Harvey. Take care.