Contemporary Themes

An evaluation of home visiting of patients by physicians in geriatric medicine

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Abstract

The practice of preadmission home visiting of patients referred to geriatric medicine units has in recent years been criticised as being unnecessary on the grounds that if there is no waiting list there is no need for allocation of priority for admission; as being wasteful of doctors' time; as being resented by general practitioners; and as failing to provide adequate clinical information. The geriatric medicine department at the City Hospital with no waiting list for patients referred by general practitioners has retained home visits for most referrals because of the advantages in terms of acceptability to general practitioners (98-100%); the quantity and quality of information obtained; the usefulness of this information in deciding appropriate management and in planning discharge from hospital; and the provision of a unique teaching opportunity, which is highly valued by students and teachers alike.

Introduction

As early as 1948, Brooke[1] was pointing out that by visiting old people in their homes before admission to the geriatric medicine unit a proper assessment of their priority could be obtained. In 1951 Amulree *et al*[2] re-emphasised this and also pointed out other advantages. The patient became a real individual and not just a name on a waiting list, while many could be managed appropriately as outpatients after initial assessment at home.

For the next two decades the preadmission home visit remained standard practice, but in recent years referral to the outpatient department or direct admission to the geriatric unit has been encouraged.[3] The implication was that by abandoning preadmission home visiting the pace of the geriatric medicine department was speeded up and waiting lists avoided. It was then argued that if there was no waiting list then there was no need to assess priority for admission.

The department of geriatric medicine, based on the professorial unit at the City Hospital, Edinburgh, has been in operation for four and a half years. We have 40 admission beds and 150 continuing care beds. These serve a population of about 150 000, of whom about 20 000 are over 65. During this period there has been no waiting list for patients referred by general practitioners, with 81% being admitted on the day of referral and a further 12% next day. The medical staff have retained the practice of routine home visits despite earnest discussion as to its necessity. Since these visits are clearly not to determine position on a (non-existent) waiting list, what are the other reasons for visiting and how relevant are they to modern practice and to securing optimum care for patients and support for their families?

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Plan of study

From 8 December 1980 to 3 March 1981 all 209 patients referred to the unit by 80 different general practitioners were visited. Of these referrals, 90% were made by telephone, when information was sought as to reason for referral, drugs being prescribed, and sources of support for patients. The remaining 10% were referred by letter.

Two-thirds of home visits were done by honorary consultants and the remainder by either a senior registrar or registrar: 89% were seen on the day of referral, two-thirds within three hours. It cannot, therefore, be said that the practice introduced delays.

Results

CHARACTERISTICS OF PATIENTS

The 209 patients (70 men, 139 women) ranged in age from 64 to 103 (mean 78·5 for men, 80·7 for women).

Two-thirds lived either alone or with an elderly spouse. Mobility was assessed as: 10% freely mobile outside, 25% freely mobile indoors, and 65% mobile only with help or confined to chair or bed.

One-third were "confused," and two-thirds were already receiving some form of statutory service (home help, district nurse, meals-on-wheels, etc).

FEATURES OF HOME VISITING

Of the 209 patients, 92% were visited at home, the remainder in residential accommodation or a relative's home (to which the patient had been taken on account of the illness).

Fifty-one per cent were entirely new referrals, the rest being re-referrals (but usually after a substantial interval). The average duration of visit was 29 minutes for first referrals and 23 for a re-referral. Total travelling time averaged 17 minutes a visit (4-60 minutes).

REASONS FOR REFERRAL

In general the main problems necessitating referral by the general practitioner were physical (86%), mental (9%), and social (5%).

The commonest were (in order of frequency) locomotor, stroke, cardiorespiratory, dementia, gastrointestinal, Parkinsonism, and adverse drug reactions. In 50% rehabilitation was requested.

INFORMATION OBTAINED AT THE HOME VISIT

History-taking in elderly patients is notoriously difficult for reasons of deafness, poor memory, speech disorders, and confusion. The

patients were able to give a full and reliable account in 57% of cases. Relatives, however, were able to augment the history in 65% of cases and "others" in 18%.

Physical examination is usually easily carried out in the patient's home, and no difficulty was recorded in 82% of cases, slight difficulty in 14%, and considerable difficulty in only 4%. Full physical examination was carried out when the visiting doctor thought necessary (20%), partial examination in 78%, and no examination in 2%.

Samples of blood were obtained in 4%, sputum culture in one case, and electrocardiography and portable chest radiography also in one case each. Visiting doctors were asked to record whether they thought that electrocardiogram or radiograph had been needed to decide on further management. Such an examination would have helped in 19%. When, however, patients who were subsequently admitted or attended the day hospital were excluded, only 6% had to be brought to hospital, mainly for radiography or electrocardiography.

OTHER INFORMATION OBTAINABLE AT HOME VISIT

Many other important observations made could not have been recorded had the patient been seen in outpatient clinics or directly admitted (table).

Evidence that could not have been recorded had the patient been in an outpatient department or admitted to hospital

	% of all visits
Social	
Neglect of household	9
Poor catering	13
Inadequate heating	9
Interpersonal tension	28
Inadequate social support	35
Approaching or actual family exhaustion	49
Nursing	
Self-neglect	14
Inability to visit essential areas of house	41
Inadequate nursing care	32
Medical	
Poor compliance with a prescribed diet	10
Alcohol abuse	3
Poor compliance with prescribed drug regimen	14
Drugs being taken that were not mentioned by referring general practitioner	23
Prevention and rehabilitation	
Accident hazards	23
Need for special aids	25
Opportunity for patient (or carer) to demonstrate problems within the home, such as difficult stairs, chair or bed too low, etc	58

OUTCOME OF HOME VISIT

Altogether 32% were admitted to the geriatric unit, 59% were dealt with in some other way by the geriatric service (day hospital, etc), 6% were admitted elsewhere (psychiatric, orthopaedic, etc), and in 3% a respite admission was planned to suit the needs of the patient or carers or both.

OPINIONS OF OTHERS ON THE PRACTICE OF HOME VISITING

General practitioners' opinions

Seventy-five of the 80 general practitioners completed the following questionnaire anonymously to facilitate free comment and criticism.

(1) Do you find the geriatric service satisfactory? 99% Yes

(2) Do you think the unit's practice of home visiting is beneficial

- (a) to patients 99% Yes
- (b) to supporters 100% Yes
- (c) to general practitioners 98% Yes, 1% No, 1% "equivocal"

(3) Do you have any reservations about this practice? 91% No, 9% Yes
(Reservations concerned the few patients in whom the problem was simple and circumscribed and for whom the general practitioner thought that outpatient referral or direct admission would have sufficed. This agrees with the 9% estimate of doctors from the geriatric unit—see below)

(4) Do you think we could obtain equally complete and valid information by seeing referred patients in outpatients or by straight admission to our wards? 89% No, 11% Yes

(5) Do you think the general practitioner and the doctor from the geriatric unit should make the visit together?

- (a) Always 5%
- (b) Yes, but in special cases; (c) Yes, but impracticable 76%
- (d) Not necessary 19%

Opinion of doctors who made the visits

Of the 41% of patients admitted to hospital, the visiting doctor considered that the home visit had helped in deciding on appropriate management in 91%. In 9% the condition was a simple clear medical need that could have been fully met by direct admission or referral to the outpatient clinic. Some patients would have refused to come to hospital and hence the benefit of specialist advice could be obtained only by a home visit.

For patients admitted, in 89% the information obtained at the home visit helped considerably when deciding discharge arrangements and in 9% this information was of minor help. Currently, 73% of all general practitioner referrals admitted are subsequently discharged home so this factor is of considerable importance.

Patients' opinions

A sample of 40 consecutive patients who had been visited by doctors from the geriatric unit were contacted to obtain their views. Twenty-six responded: 88% preferred being visited to attending the outpatient department, while the remainder, having previously attended as outpatients, would not mind doing so again. Non-response was due to deaths, severe illness, and difficulties in contacting patients.

OTHER CONSIDERATIONS

Although the total travel time averaged 17 minutes, which might be construed as wasted time, medical students accompanied the doctor in 104 of the 209 visits. This time was therefore available for teaching. Had these patients been referred to the outpatient department about 87% would have needed ambulances because of impaired mobility, mental confusion, and severity of illness plus inclement weather.

Discussion

Although home visiting by doctors has tended to be regarded as useful mainly in terms of allocating priority for admission and in avoiding admissions by providing other care,[4-6] the value of this practice has been questioned in recent years. Some departments have declared that it is rarely necessary,[3-7] as when a waiting list does not exist allocation of priority is unnecessary and home visiting not only slows things down but is resented by the general practitioner. This rather heated argument has generally been based on strongly held opinion rather than on fact, and we have attempted to correct this deficiency.

Why should we persist in this practice (despite the absence of any fee or financial advantage to the honorary consultants in the unit)?

Firstly, a home visit is useful in assessing the needs of the patient and those providing care; 59% of patients are subsequently dealt with by the geriatric service in ways other than by admission and, secondly, information obtained at the initial home visit helps in facilitating discharge for the minority who are admitted. All this helps in the effective and economical use of limited resources.

What outpatient service can supply a skilled opinion so rapidly? This speed is crucial as we believe that in geriatric medicine there is no such thing as a non-urgent problem. Even

if the patient's condition is not itself urgent the tolerance of relatives or other carers may be nearing breaking point, and once this point has been reached the likelihood is that "rejection" will occur, which is commonly irreversible.

The non-availability of laboratory resources was not a common problem—only 6% had to attend hospital, mainly for another investigation.

Rather than resenting home visiting, 81% of general practitioners saw the chance of exchanging information with the consultant as an advantage, but only 5% were in favour of making joint visits standard practice. One in five were unequivocably against joint visiting. The difficulty of finding a mutually convenient time may lead to undesirable delays in seeing the patient.

The quantity and quality of data obtained about social, nursing, medical, psychiatric, and rehabilitation needs are impressive. In 49% of visits family members were judged to be "approaching exhaustion or actually exhausted." Another valuable discovery was that 23% of patients were taking drugs not mentioned by the general practitioner.

Finally, there is no better opportunity for teaching than taking students into patients' homes to see for themselves how old people and their families cope with illness and disability.

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References

1 Brooke EB. The place of the out-patient department in caring for old people. *The Medical Press* 1948 May:400-2.
2 Amulree Lord, Exton-Smith AN, Crockett GS. Proper use of the hospital in treatment of the aged sick. *Lancet* 1951;i:123-6.
3 Hodkinson HM, Jeffreys PM. Making hospital geriatrics work. *Br Med J* 1972;iv:536-9.
4 Bendall MJ. Changing work pattern in a geriatric unit and the effect of a day hospital. *Age and Ageing* 1978;**7**:229-32.
5 Wilson LA, Levy MG. The domiciliary visit in hospital geriatric practice: pressures and decisions on needs for admission. *Age and Ageing* 1979; **8**:152-9.
6 Kimber J, Silver CP. Home visiting by a geriatric department. *J R Coll Gen Pract* 1981;**31**:41-4.
7 Bagnall WE, Dalta SR, Knox J, Horrocks P. Geriatric medicine in Hull: a comprehensive service. *Br Med J* 1981;**282**:102-4.

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Medicine and Books

Challenging the child-care system

Childhood, Welfare and Social Justice: a Critical Examination of Children in the Legal and Childcare Systems. Ed Michael King. (Pp 145; £5·95.) Batsford. 1981.

Childhood, Welfare, and Justice comprises four separate papers by different authors aimed at providing a critical examination of children in the legal and child-care systems. The composition of the book makes a brief comprehensive critique difficult.

I had hoped that "Childhood in history" by Pat Thane would —as implied on the back cover—set a historical perspective for some of the more contemporary problems discussed elsewhere. A somewhat selective and at times ambiguous presentation, however, left me preoccupied with the writer's stance. Two extracts perhaps disclose her prejudices: "The many problems and conflicts in child psychology . . . to the historian . . . appear as further links in the long chain of adult control." "The beliefs of doctors and psychiatrists have influenced the treatment of children by the law, by parents and by social services, as the beliefs of clerics influenced such treatment in the 17th century" (p 22).

Roger Smith describes his experiences in a law centre in "Children and their lawyers in the Juvenile Court." The chapter is interesting for its description of the different parts the lawyer can play in the child-care system, especially in delinquency. His whole approach to the title becomes suspect, however, when you then read: "In care cases, the client is often in a vulnerable, threatened and emotional state. . . . It is the lawyer's job to do the best for his client. . . . There may well be occasions where success for one's client may leave one uncomfortable about the innocent object of the dispute, the child." (p 41). Some of the author's case examples reinforce the impression that he identifies closely with the parents' rights no matter what the outcome for the child. It would be interesting to know whether the children concerned would perceive their parents' behaviour in quite the same generous light as the author. The failure to grapple with the question of representation of the child on care issues is, given the title, a major omission. Surprisingly, his cases contain factual information that could lead to the identification of certain families.

Perhaps the most important contribution of the book is "Science in court" by Andrew Sutton, which can be read in conjunction with the chapter "Welfare and justice" by Michael King. Their common underlying thesis may be described briefly. Philosophies of child care are unvalidated by scientific means and are used as the basis for many decisions made by local authorities and the courts and in discussion with parents and (sometimes) children. Decisions are therefore based on unsound premises. Both chapters are very readable. Sutton gets side tracked into (justifiable) criticism of how local authorities operate internally, but he provides useful information on how to tackle their vagaries in court. His ultimate message seemed to be that claims to scientific support for theories of child care are often unjustified, but he recognises many principles about which we should seek to further our knowledge.

In a somewhat arrogant and dismissive style that will doubtless raise the hackles of many King is more negative about the present system: "Many of the present debates about the welfare of children, their rights and interests are distractions, drawing attention away from concern over the way in which power is distributed and expressed in our society, both at large and within specific social institutions" (p 134). He takes too little account of the common and validated ground that exists in