Geriatric care in general practice

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IN the Spring of 1972, the practice organisation committee of the Royal College of General Practitioners received a copy of the publication *Age Concern on Health*,[1] relating to the provision of medical and social care for the elderly in this country. The publication, which criticised existing standards, acted as a catalyst which prompted the committee to set up a small working party to examine published reports on geriatric care in the community and to suggest ways in which it could be improved.

This paper is the result. It reviews the relevant literature concerning the care of the elderly outwith hospitals since the inception of the National Health Service in 1948 and offers some suggestions regarding the organisation of geriatric care with a short commentary on implications for the future.

The authors of the *Age Concern* booklet did not claim that the views of the old people interviewed were statistically representative of all elderly patients, but they did suggest that they reflected widely held attitudes and experiences among the elderly. The stated reason for publishing the document was to "draw attention to anxieties which many elderly people have about their health and to some of the ways in which present arrangements do not cater for their needs".

Much of the disquiet expressed in the *Age Concern* document has previously been described by different authors at different times. Those criticisms levelled specifically at general practice are summarised below:

(1) The organisation of general practice has made it more difficult for elderly patients to consult their doctors, for example by the centralisation of consulting premises and the growth of appointment systems.

(2) The general practitioner's changing attitude towards home visiting makes the geriatric patient reluctant to call the doctor, and the general practitioner less likely to call on the patient.

(3) Transport difficulties make access to the general practitioner and the pharmacist more difficult, especially for the very old and those living alone.

(4) There appears to be an increasing use of repeat prescriptions in place of consultations.

(5) There is disquiet about the increasing chance of seeing different doctors within a group practice.

(6) There is often lack of continuity of care when elderly patients are discharged from hospital or from convalescence.

(7) Some complain of the lack of continuing supervision by general practitioners and health visitors of the very old and high risk groups.

(8) General worries exist among the elderly as to how they should act in emergencies.

What then should be done to improve the quality of care provided? Writing in 1964, Warren[2] summarised the extent to which planning was required: "In order to assess the adequacy of plans now being made, we need to know much more about the medical, social and economic indications for and against the alternative types of care which can be provided in hospitals, in institutions and in the home. Well-designed controlled trials are needed to see with what treatment and which environment (general hospitals, geriatric hospitals, day hospitals, welfare accommodation, special or sheltered housing or home), with what degree of support (social worker, health visitor, general practitioner or family) and with what community services (clubs, sheltered workshops) we can best meet the diverse and complex medical, psychological and social needs of elderly people."

As Downie[3] has suggested, this necessary planning has to be accomplished against a background of change that has occurred generally since the end of the second World War. The main medico-social changes are summarised below. Their implications in planning for the care of the elderly are obvious.

1. There is a realisation that traditional methods of dealing with the elderly sick are now no longer able to meet more than a fraction of the demand, let alone the need.
2. It has been recognised that reliance on patient-initiated demand for medical and social care is especially inappropriate in satisfying the needs of the elderly.
3. Despite an upward trend in marriage rates, changes in family structures associated with declining birth and death rates have led to a situation in which fewer sons and daughters have been born to take responsibility for the greater number of old people who have survived to an age when they require support.
4. With better education and career opportunities more readily available to the unmarried woman, there has been a slow disappearance of the single daughter who traditionally was available in the home to look after her elderly parents. This also enhances the chance of the career-orientated single woman ending her days in an institutional setting. Indeed, as has been stated by Kemp[4]: "All that has been done to discover the basis of geriatric problems could be set aside if the existence of an effective daughter could be assumed."
5. There is an increasing tendency for married women to go back to full-time or part-time employment.
6. The increasing mobility of labour means the greater isolation of old people from close family contact.

The net effect of these factors has been to create a demand for services based in the home, that could replace some of the functions formerly provided by the extended family. The deficiencies in geriatric care cannot be attributed simply to an abdication of responsibility by the younger generation (Lowther and Williamson,[5] Isaacs[6]).

The nature and extent of the problem

Since Warren's plea for more planned research into the care of the elderly, much has been accomplished. It is suggested that the time has now come to take stock of this in looking to the future. With limited resources of time, manpower and money, it is important that further research efforts are directed towards those areas that have been identified as being most likely to yield the greatest benefit in terms of improved care of the elderly in the community.

Many published surveys have been concerned with incidence of morbidity in the geriatric population. As far back as 1948, Sheldon[7] interviewed a random sample of old people in their homes in Wolverhampton, using the ration card register as the means of identifying his sample. He found a high proportion of unmet need amongst the group,

with locomotor difficulties, hearing and visual defects predominating. Findings of unmet need have subsequently been confirmed by numerous observers (Hobson and Pemberton,[8] Miller,[9] Richardson,[10] Williamson *et al.*,[11] Thomas, [12] Burdon,[13] Millard, Johnson and Ward,[14] Carey,[15] Bendkowski,[16] Burns,[17] Meyrick and Cox,[18] Paulett and Buxton,[19] Sheard,[20] Andrews *et al.*,[21] Williams *et al.*[22]).

Contrary to the above reports, Evans and his colleagues [23] in Baslow held a screening clinic for their over 65s and surprisingly found little evidence of important unknown disease, and Irwin[24] in Finaghy reported few instances of established organic disease unknown to the family doctor.

Player and his colleagues[25] from the health department in Dumfries investigated elderly populations for psychiatric and social conditions, and reported a prevalence of 16·3 per cent of psychiatric illness in the community studied. Varying proportions of unreported mental disability had previously been described by Sheldon,[7] Hobson and Pemberton,[8] Primrose,[26] Miller,[9] Kay, Beamish and Roth,[27] Williamson *et al.*[11] and Andrews *et al.*[21]

The conclusions which emerged from all of these surveys are:

1. There is a substantial amount of unknown morbidity and need in the elderly.
2. There is a high proportion of defects which affect the locomotor, sensory and cerebral systems.
3. There is a marked variation between town and country practices in the amount of unknown morbidity—there being much less in country or small town practices.
4. Patient-initiated consultations do not reveal this morbidity.
5. Screening or assessment clinics have been found to be very successful in uncovering unmet needs.
6. Health visitors, district nurses and social workers can play an important part in the assessment and care of the elderly.
7. Many of the defects are in themselves minimal, but when added together can have a marked effect on function.

What then should be the general practitioner's role in this field? Ashworth's conclusion in 1959[28] is still valid, that "It is the general practitioner's responsibility to see that all forces are mobilised to keep the patient healthy and happy at home". Forsyth and Logan[29] found that the range of services and depth of patient care varied directly with the quality of the family doctor. Their conclusion was that someone was required to accept continuing responsibility for the care of the elderly, not only in prevention and delaying the onset and progress of disease, but also in postponing disability and reducing handicap. That person should be the general practitioner.

The role and importance of the health visitor have been outlined by Williamson,[30] Lowther *et al.*[31] and Hodes.[32] It is essential to the provision of a first-class geriatric service that a policy of attachment of health visitors, district nurses and social workers to general practitioners be pursued. Although other factors undoubtedly play a part, it may not be coincidental that the quality of geriatric care available in rural and small town areas seems to be better than in large towns and cities, for it is in the latter that it has been found more difficult to attach local authority health visitors and district nurses to general practitioners (Anderson *et al.*[33]).

How, then, can we improve the situation? In their report, *Care of the Elderly in Scotland*,[34] the Royal College of Physicians of Edinburgh saw the aim of medical care for this section of the population as the maintenance of independence, comfort and contentment in their own homes, and when independence begins to wane, to support them by all means necessary for as long as possible. MacLeod[35] has pointed out that simply

to assess independence might fail to recognise the high incidence of depression in the elderly, and for this reason has suggested the concept of contented independence. He also warns that we must not impose our standards on our patients, or attempt to interfere with conditions which patients have found satisfactory over a lengthy period. However, it is only fair to note that Lowther and his colleagues[31] in their early diagnosis clinics in Edinburgh, followed up patients recommended for treatment 18 to 30 months previously, and found clinical improvement in 23 per cent of the whole group.

Suggested programme for geriatric care in general practice

Bearing these points in mind, we suggest for discussion amongst the relevant professional bodies the following programme for geriatric care:

A. Identification of patients over the age of 65 from general practitioners' lists

(1) Age-sex register—practices possessing a register have a readily available list of over 65s.

(2) Lists from executive councils—executive councils should be able to supply a list of the such patients.

(3) The patient's record card.

B. Identification of those requiring assistance

The initial identification of patients requiring assistance can be made very competently by a health visitor, or by a district nurse, as reported by Miss McNabola in Edinburgh,[3] and by Milne *et al.*[37] in the same city. Knox and Patterson[38] have questioned the professional expertise which may be required to identify obvious medical and social needs among the elderly population, and have suggested that untrained caseworkers could be used to alert the professionals of priority cases at least in the initial stages of any geriatric care programme. This is undoubtedly an area for further research.

The details recorded by the health visitor or district nurse should include the following:

(1) The age, sex, marital status, social class, religion and previous occupation.

(2) Information about the house and its facilities, including heating, laundry arrangements, accessibility of W.C., possession of adequate clothing, and most important, the dietary state of the old person. An inspection may be made for obvious hazards.

(3) Information about the patient's family, with particular reference to support given.

(4) Information about social contacts, attendance of the district nurse, home help, and other forms of welfare assistance and supportive services, including effective neighbours.

(5) Information about luncheon and other social clubs attended.

(6) Information about the old person's ability to summon help in emergencies.

(7) Information about current medication, and also a search for any drugs that may be about the house.

(8) Information about financial state. This may have to be omitted according to the patient's wishes.

At the same time as gathering this information, the health visitor or district nurse can carry out a simple medical assessment. This may include:

(1) Assessment of mobility, to include an inspection of the feet for conditions requiring chiropody.

(2) Inspection for oedema and measurement of the pulse to note the rate and any irregularity.

(3) Simple tests of hearing, with inspection of the ears with an auriscope for the presence of wax, if there is any suspected deafness.

(4) The testing of vision, with or without glasses, using a newspaper.

(5) Enquiry and inspection of the teeth and symptoms suggestive of digestive disease.

(6) Inspection of the skin, especially for signs of malnutrition.

(7) A general impression of the patient's mental state, using the method described by Milne and his colleagues in Edinburgh.[37]

(8) Enquiry about incontinence, nocturia and bowel habit.

It is a matter of discussion whether at this stage one should include:

(i) A recording of the blood pressure

(ii) Taking a specimen of blood for laboratory investigation of possible anaemia.

(iii) Urine testing for albuminuria and glycosuria, and possibly collecting a clean specimen for microscopy and culture when incontinence of urine or frequency of micturition is encountered.

It may be argued that these measures could involve a certain amount of disturbance to the patient and also require more time and skill.

After this initial assessment, the general practitioner can further examine the patient, either at the surgery or in the patient's home. Alternatively, he can organise special assessment clinics without previously involving the health visitor or nurse, as described by Hodes[32] and Evans and his colleagues.[23] The mechanism of this can be arranged in several ways:

A. After an initial visit by health visitor or district nurse

B. Invitation by letter.

Acceptance by patients of the invitation to attend appears to be high by either method. Irwin[24] had a high acceptance rate in Co. Antrim, using health visitors for initial contact. In an urban situation, Lowther,[31] again using health visitors for initial contact, had an acceptance rate of 83 per cent for his early diagnosis clinics. On the other hand, Williams[22] reported an acceptance rate of 87 per cent when contacting patients by letter. The desire to be medically examined appears to increase with age. Hodes,[32] found that one in three of the 60–69 age group, one in two of 70–79, and 90 per cent of over 80s responded.

The format of the examination could include:

(1) Standardised case sheet for symptom elicitation of each body system, using questions similar to those described by Milne and his colleagues.[37]

(2) Physical examination with special reference to:

(*a*) the existence of cardiac failure and chronic bronchitis,

(*b*) disorders of locomotion—inspection of hands, feet, simple tests of function, such as hand movements, observing the gait, asking the patient to do a "knees bend" and to lift the arms above the head.

(3) Psychiatric assessment:

(*a*) simple tests of memory and orientation, such as asking questions about address, date and age,

(*b*) seeking depression by questioning about mood patterns, sleep patterns, appetite, feelings of inability to cope and observing of any agitation.

(4) Haemoglobin estimation.

(5) Urinalysis for albumin and sugar, and possibly sending a specimen for microscopy and culture.

(6) Sight testing.

(7) Examination for deafness.

(8) Review of medication.

If the preliminary report about the patient's domestic circumstances and social life has not been made by the health visitor or district nurse, this should be done during the attendance. After this examination, a list showing action recommended should be compiled. It can be argued that the workload involved in examining all patients over 65 in a practice is too great. To reduce this workload to manageable proportions, at least in the first instance, special ' at risk ' groups would include, as suggested by Lowther and his colleagues:[31]

(i) Those living alone,

(ii) Those recently bereaved,

(iii) The housebound.

Extension of these groups might include the poor social mixers, isolated non-gregarious people and the over 75s.

Other factors affecting practice organisation in the care of the elderly

1. Appointment systems

The publication *Age Concern on Health* commented on the difficulty that some old people have in dealing with appointment systems, both in initial contact and in seeing the doctor of their choice. It should be possible to overcome any difficulty by making special efforts to educate the elderly in how to use the appointment system, and by a flexible approach in the making of the appointment at a time that is likely to be more suitable for the older person, namely later in the morning or in the afternoon. Difficulties in the use of the appointment system must be offset against the possible benefit to the elderly patient of not having to wait for long periods at the surgery.

2. Transport

The lack of mobility of many elderly patients requires the provision of special transport arrangements. Some general practitioners, Smith and Seddon,[39] Sowerby[40] and Floyd,[41] have organised their own transport systems. Lance,[42] in her report on transport services in general practice, suggested that one of the most important indications for using a transport service in general practice would be to bring elderly patients to surgeries for assessment. She found that in her survey of five practices using a transport service, 15 per cent of elderly patients had difficulty in getting out of doors, and of this group 26 per cent used the service in 1969. The great limiting factor, of course, is cost. The answer may be in the expansion of the present ambulance services with suitable vehicles, or several groups combining together to organise such a service. It is suggested that further research needs to be conducted before the ideal system is found.

3. Visiting

This is a subject on which there is a great variation of opinion. It is, of course, of importance, because of its effect on workload and the use of the practitioner's time. Marsh[43] holds the view that "Chronic visiting of the aged, if for other than clinical reasons, has little to offer compared with frequent intensive care during acute episodes." The justification for this attitude is firstly that the added workload would be intolerable, and secondly, that such visiting tends to degenerate into a social call at which medical issues are avoided, and pathology consequently missed.

Marsh, McNay and Whewell,[44] in their survey of home visiting by general practitioners in North-east England, found that although a great proportion of their chronic visiting was to the elderly, during these visits only 40 per cent of the patients were examined. This in itself does not mean that the patient did not benefit from a visit when no clinical examination took place.

However, if we abandon regular visiting of the elderly by members of the health team, knowing that self-reporting of illness amongst the group is unreliable, then the cost will have to be reckoned not in the saving of general practitioners' time but in the increase of hospital and community resources, which may be required to cope with infirmity discovered too late for the patient to be managed in his own home. There is no doubt that we are faced with the problem of defining priorities. It seems sensible, at least in the first instance, to concentrate visiting by the health visitor, district nurse or general practitioner on the special 'at risk' groups and those who are found to be in clinical need, without completely losing sight of the morale boosting 'social call'.

4. *Geographical distribution of the elderly*

It is well known that in popular places of retirement and in areas of depopulation the proportion of old people may rise to 30–40 per cent of the community as a whole. In such areas it is important that resources are provided to meet the increased medico-social needs.

It is perhaps unjust that communities with a high proportion of retired citizens should be asked to pay for all the necessary additional medical and social services. Funds from central government may be necessary to augment local resources in these areas.

5. *Practice records*

There appears to be a need for a special assessment form to record the patient's pathology, social profile and action needed on the lines of that produced by Stokoe,[45] or in more simple versions as described by Thompson,[46] and used by Forman.[47] These records should be available to all those involved in the care of the elderly in any practice.

The role of members of the health team

The concept of the health team in the care of the geriatric patient is all-important. The roles of the individual members of the team may be as follows:

(*a*) The general practitioner—diagnostic at three levels, physical, mental and social. operational and supervisory.

(*b*) The health visitor—health education, identification of physical and social needs, follow up; supervisory, and as a link with the social services.

(*c*) District nurse—in addition to traditional nursing duties, she would assist in supervision and identification of physical needs and follow-up.

(*d*) Social worker—identification of social needs and assessment of social functioning, guidance about special benefits and other support facilities.

(*e*) Home helps—housekeeping and preparation of meals; company.

(*f*) Voluntary workers, including the good neighbour—these should provide an essential support, both materially and psychologically. They may also summon help when required.

(*g*) Geriatrician—the general-practice team looks to him for specialised advice about the care of the elderly, through the agencies of domiciliary consultations, hospital outpatient clinics, clinics in health centres, and where necessary, admission to hospital under his care and supervision, either on a short-term or a long-term basis. The

geriatrician should also play an important role in organising special assessments or surveys of the elderly population.

Discussion

There is ample evidence that there are deficiencies in the medical and social care of the elderly in the United Kingdom, especially for those old people living in our cities. The problem will grow with the increasing proportion of old people in the community. At present, 12 per cent of the population are over 65 years of age, and this proportion will reach 15 per cent before the end of the century. These facts have been known for some considerable time, yet society has been remarkably slow in realising the implications of this in terms of planning for the medical and social care of its elderly. One reason for this may be that geriatric care has been the responsibility of all three branches of the National Health Service, with no one body having control over general policy-making decisions, or the responsibility of overseeing the quality of care which was being provided. It is to be hoped that the situation will improve with the reform of the social services and the re-organisation of the National Health Service. This should make the planning and execution of services more efficient and effective. Such optimism may, however, be naive, unless the present gulf between social work departments and the National Health Service is effectively bridged by the closest possible co-operation.

Three questions of paramount importance require to be answered. What requires to be done? Who should do it? Who should ensure that it has been done?

A. What requires to be done?

The fact that emerges most strikingly from a review of published work is that there is a considerable proportion of old people in the community who have difficulty in getting about, suffer from defective vision or hearing, and are depressed or have other mental instability. Many of these disabilities have been found to be treatable, some with relative ease. Groups have also been identified as being at special risk—those recently bereaved, those living alone and the very old. There is also evidence that old people living in cities fare worse in both medical and social care than those living in small towns or rural communities.

Self-reporting of illness or disability cannot be relied upon for the geriatric patient. It may be that the high incidence of locomotor difficulties and depressive illness could account for this, but many old people equate their medical and social problems with being part and parcel of the business of growing old and put up with them. This often means that the general practitioner does not see the condition until a crisis occurs.

A system of geriatric care is therefore needed, which will identify the elderly in the community, sort out those in need and those 'at risk', and meet their requirements within the resources available. Having done this, continuing surveillance of the group as a whole and those who are continually being recruited to it will be necessary. This will require the closest integration and co-operation amongst all those at present engaged in the care of the elderly in any community, and it is for this reason that we suggest that the planning and execution of future geriatric care be undertaken at a local level to ensure a greater involvement of all those responsible.

It is also of paramount importance in the organisation of comprehensive care for the elderly that a special record card be devised. This is essential if omissions in recording are to be avoided and will also enhance the element of continuity, especially when members of several disciplines are involved in total care. Furthermore, it should act as a check to ensure that appropriate action has been taken when required.

Another problem affecting old people is their lack of transport. This is often the factor which prevents them from receiving medical attention at an early stage. There is

obvious need for the organisation of transport services for the elderly. The growth of day centres has already created a great extension of ambulance services, particularly in the use of minibuses. This may be further extended to include the transport of an elderly patient to his general practitioner.

The problems which some patients have in dealing with appointment systems could almost all be resolved by a more flexible approach by individual practices and better education of the patient in the use of the system. A well-administered appointment system should make it more likely that elderly patients are able to see the doctor of their choice, at a time that is suitable for them.

B. Who should do it?

Ideally, no one in any community should be absolved from the responsibility of looking after the aged. Inevitably, however, there are professionals who have a clear duty in this field. At a neighbourhood level, the main responsibility must lie with the general practitioner and his team. This team is the key factor and should be supported by the resources available to the geriatric specialist and by the geriatrician himself, who should not only have a clinical role, but should be responsible for the continuing education of the general-practitioner teams. He should also have an important part to play in collaboration with members of community teams in the planning of future geriatric services in the area. The finer detail as to who should do the initial medical and social assessment of the elderly should be decided at a local level. Experiments could be conducted using various methods and different people.

C. Who should ensure that it has been done?

This is the most difficult question of all three, but the most important. The problems associated with quality control apply not only to the field of geriatrics but to the whole range of medical and social care. Other professions like law and accountancy, where practitioners also work on an independent basis, have similar difficulties.

Although general practitioners are paid more for looking after patients over the age of 65, this is within a system that relies predominantly on self-reporting of illness, and does not guarantee that extra payment results in an improved service. Rather, the reverse holds true, in that the practitioner who provides a comprehensive caring service for his older patients, seeking out their medical and social problems, is at a financial disadvantage compared with his colleagues who rely on giving attention solely on demand. It has been one of the defects of the pay structure for general practitioners in the National Health Service that preventive care often goes unrewarded in purely financial terms.

Added to this is the fact that during his undergraduate days, the practitioner was taught to regard the very young as a special part of his practice. A greater involvement of geriatricians as teachers both at the undergraduate and postgraduate levels is of the utmost importance if the next and subsequent generations of hospital specialists and general practitioners are to see the care of the elderly in a similar perspective.

There is little doubt that the problems of ageing are seen at their worst in highly populated areas, where old people can be, and feel, very isolated. These are the same areas where social work and medical care resources are stretched to the limit, and where it has been found difficult to attach health visitors and district nurses. The urban general practitioner tends not to be identified with any particular community, often works in widely scattered practices and can assume a greater degree of anonymity than the rural or small town practitioner.

There is often a lack of community spirit in cities. This affects the supervision of the elderly in two ways. First, individual members of the community can more easily

escape from any caring obligation to the sick and infirm, and secondly, when services are found to be inadequate, there tends to be no informed group willing to accept the responsibility of exerting pressure directly or indirectly on those whose duty it is to provide these. The effect of community opinion itself on the standard of care dispensed by general-practitioner teams in small towns or rural areas is unknown, but an intelligent guess would be that it is substantial.

The answer, therefore, to the question of who is responsible for monitoring the quality of care provided should be the whole community. This implies that the community itself should be well-informed, inward-looking and close-knit. In urban areas we must try to create such close-knit communities served by easily identifiable general-practitioner teams, possibly based on community health centres. Ideally, the communities should have a good social class mix—the urban ghetto with visiting professionals is all too common at present. It also implies that there must be greater co-operation and flexibility among general practitioners themselves in setting up an organisation for general practice, that would consider problems such as zoning and transport for patients among its priorities.

We also feel that if practitioners wish to remain as independent contractors within a health service totally financed by government, then they must impose upon themselves standards acceptable to the profession as a whole and to the community that they seek to serve. They must be willing to subject the work they do to the scrutiny and criticism of their colleagues.

It is only by accepting this challenge that we shall have any hope of achieving the scope and quality of medical care that our society should provide for its old people.

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BODY TEMPERATURES IN THE ELDERLY

Two large-scale surveys of body temperatures in elderly people living at home were carried out in the winter of 1972. Most of the homes visited were cold with room temperatures below the minimum recommended by the Department of Health. Deep body temperatures below 35.5°C were found in ten per cent of those studied, and the difference between the skin temperatures and the core temperature was also reduced in this group. Such individuals are at risk of developing hypothermia since they show evidence of some degree of thermoregulatory failure. Further research is needed, but meanwhile there are practical measures that could be taken to reduce the risk of hypothermia in the elderly.

Fox, R. H. *et al.* (1973). *British Medical Journal*, **1**, 200–206 (Authors' summary).