Practice Research

Characteristics of patients aged over 75 not seen during one year in general practice

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Abstract

A study was carried out in two large urban practices to determine the number of patients aged over 75 years who had had no contact with the primary care team during one year using an interview of their medical and social characteristics. Although their general health was considered to be good, over half needed treatment or other action and half had no identifiable carers.

Introduction

It is now 25 years since Williamson demonstrated the phenomenon of unreported need among elderly patients.¹ Although his findings have not always been confirmed,²⁻⁴ it is now accepted that this feature of ageing presents an opportunity for preventive intervention. Difficulty has arisen in determining how best this may be achieved. An early response was to introduce multiphasic screening programmes in general practice.⁵⁻⁷ Few follow-up studies have been undertaken, however, and there has been no clear and definitive answer to the question whether screening produces measurable health benefit in elderly patients.⁸⁻¹⁰ It has also been shown that general practitioners are unconvinced of the value of screening total populations.¹¹

For elderly patients the aim of prevention is the early detection of established disease and disability so that the chance of cure or alleviation is increased—that is, tertiary prevention, which Williamson suggested should be more correctly called "case finding."¹² Recently, interest has centred on a more selective approach on the assumption that some elderly people are more likely to need preventive care than others. Taylor and Ford, in a careful study, tested the hypothesis that certain groups at risk—for example, the very old, recently widowed, those living alone, and those recently discharged from hospital—might contain a high proportion of patients with unreported and untreated illness.¹³ Eleven groups were examined. It was, however, shown that concentrating on these groups was not an efficient method of selective screening. An alternative system described by Barber and Wallis consisted of identifying by postal questionnaire those who seemed to require comprehensive assessment.¹⁴⁻¹⁶ They showed that it is possible by such a method to identify a higher proportion of patients requiring action than by screening all patients in previously defined groups.

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Another method of case finding is to seek unreported illness during normal doctor-patient contacts, the rationale being that although an elderly patient may seek consultation for various matters, important problems are not reported because their relevance is not appreciated. This widening of the consultation to include prevention is good standard practice and Tudor Hart argues that because patients in general practice are identifiable the opportunity for preventive work exists without the need for episodic screening exercises.¹⁷ This approach might be called opportunistic case finding. Although the idea is attractive, there is one major difficulty: how is it possible to be sure that all elderly patients in the practice are seen sufficiently often for the method to be effective and that nobody slips through the net? Three questions need to be considered. Firstly, what proportion of the elderly population of a practice is seen by any member of the primary health care team during one year? Secondly, is it possible to devise a scheme that would monitor contacts between a practice and its elderly patients? Thirdly, what are the characteristics of elderly patients who are not seen?

To examine these questions a study was carried out in two practices in the north west of England, one in an inner city area and the other in a suburb of an industrial town. The objectives were: (a) to determine the number of patients aged over 75 who had no contact with the primary health care team during one year; (b) to test the feasibility of using a practice attendance register of patients over 75; (c) to determine the characteristics of the patients over 75 who were not seen by any member of the team during the study year.

Method

For one year a practice receptionist recorded all face to face contacts between a member of the health care team and patients over 75. These included home visits by doctor or deputising service, surgery consultations, and contacts with the district nurse, health visitor, or practice nurse. When a repeat prescription not requiring personal contact was issued this was also recorded. The doctors continued their normal practice of clinical care. This did not include emphasis on screening. Although some doctors undertook an occasional record review of their elderly people. Within three months of the completion of the study those patients who had not had contact with the practice were visited at home by the practice health visitor, who completed a form recording the patient's medical and social characteristics.

Results

USE OF PRIMARY HEALTH CARE TEAM (TABLE 1)

The number of patients over 75 on the age-sex register was 3% of the patients in both practices, which is lower than would be expected if the practices were typical of national figures (5%). Possible explanations for this are that one practice was in an inner city with a shifting population and a high proportion of under-

care shown in this study describes the type of approach that is necessary when caring for old people, and case finding might be a way of achieving this by combining prevention with care and cure. Furthermore, including a checklist of important points in the clinical notes might be an "aide memoire" to the doctor.

The practice health visitor is ideally the person to visit the patients who are not seen. A research project will be set up to test the benefits of this method of case finding.

I thank the doctors and receptionists at the Rusholme Health Centre and the Westhoughton Group Practice for their help in carrying out this project. I also thank Mrs Brenda Firth and Mrs Joan McFarlane, the health visitors, for their enthusiasm, and Dr H W K Acheson for general advice.

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Value of ultrasonic measurement of spinal canal diameter in general practice

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Abstract

The diameter of the spinal canal was measured by ultrasonic scanning in 193 patients with back pain and 183 matched controls. The spinal canal was found to be significantly narrower in the patients compared with all 183 controls ($p < 0.01$) and compared with 132 of the controls with no history of back pain ($p < 0.001$), but measurement of canal size was found not to have any value in the prognosis or management of back pain in general practice.

Introduction

In 1980 Porter *et al.* reported that in roughly half the patients attending hospital with symptoms of disc abnormalities ultrasonic measurement of the spinal canal yielded values below the

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10th percentile for asymptomatic subjects.¹ We report here the results of a study of the diameter of the spinal canal in patients attending a general practice and the value of this measurement in the management and prognosis of back pain.

Patients, methods, and results

A training practice of four principals, based in a south Yorkshire mining and manufacturing town and serving a population of 8000 patients, agreed to take part in a prospective study of its patients using the same diagrammatic technique, and technicians as in previously published hospital studies.¹ All patients attending the practice with back pain over 12 months were asked to undergo spinal scanning. A similar number of patients attending the surgery during the same period for some other condition were also asked to volunteer for the spinal measurement and were matched for age and sex. Any history of back pain was recorded.

Twelve months after presentation the patients were asked to complete a questionnaire on treatment, time off work, and their present experience of back pain. The general practitioners' records provided information about frequency of attendance for back pain and for other conditions, time off work, and the use of hospital orthopaedic services. The attendances of the control patients were also noted as were their records of any previous back pain.

During the 12 months of the study 207 patients attended the practice with back pain. Of these 193 attended for spinal scanning and were compared with 193 matched controls. One hundred and sixty five patients completed the questionnaire 12 months after

graduates, and the other was in a new housing estate with a relatively young population. Before the study began each practice's age-sex register was amended by removing patients who were known to be dead or to have left the district. At the end of the study the register was amended after the health visitor had visited patients who were not seen. Some patients had left the district.

Both practices were similar in the proportion of patients over 75 who were seen by the doctor during the year. No patient had been seen by the health visitor or district nurse without also being seen by the doctor. In one practice 36 patients (9%) had received repeat prescriptions without seeing the doctor, health visitor, or district nurse, compared with 3% in the other. In both practices nearly 91% of the population over 75 years old had been seen during normal consultations or home visits during the study.

CHARACTERISTICS OF PATIENTS NOT SEEN

Eighteen patients from practice I and 26 patients from practice II had no contact with the practice during the year. The distribution by age, sex, and marital status of all patients over 75 was the same in both practices and identical with national figures. Thus the 44 patients not seen may be regarded as a single sample for considering these variables (table 1). Compared with the national figures there were relatively more men than women in the sample. Half the sample was in the age range 75-79 and there were relatively more in the age range 80-84 than expected from national figures. The marital status of the sample showed little difference from national figures, although there were slightly more single, widowed, and divorced people.

The health visitor's records showed that no patients were bedfast but four were confined to home. Most were able to cook, do housework, dress, and manage daily life. Only 25 were able to bathe without help. Most lived in a house or bungalow, but only 39% were owner occupiers compared with Audrey Hunt's sample, of whom 45% owned their own house.¹³ Half of the 24 widowed were widowed for over 10 years. Just over half the sample of patients lived with relatives: the remainder lived alone, except one who lived with a friend.

When asked who they perceived to be their principal carer if they were unable to look after themselves, half of the sample had no one. Seven indicated that they were on treatment despite never having seen a doctor or received repeat prescriptions during the previous 12 months. Two thirds of the patients had seen a doctor in the past two years. Only two had seen a health visitor and two a district nurse in the same two year period. The main reason given for not attending was that there had been no need (70%). Four had transport problems.

The general condition of the patients in the sample was assessed by the health visitor as good. Forty one were in effective health groups 1 and 2 and only three were in effective health group 3 as described in an earlier study.¹³ Impaired mobility due to restricted movement was found in 14 people (31%); six had early dementia characterized by memory loss and loss of urinary incontinence, but none had focal incontinence; ankle oedema was present in eight. Unsteadiness was the most common symptom, occurring in 20% of

the group. Sixteen (36%) had some abnormality that had not been reported to the doctor. The health visitor thought that just over half the patients in the sample needed treatment.

Discussion

In these two practices nearly 93% of the patients aged over 75 were seen during the study year, thus supporting the claim that general practitioners see most of their old people reasonably often. It is notable that the findings in the two practices were similar despite being in different geographical areas. The inherent inaccuracy of age-sex registers is once more shown.¹¹ The method of maintaining the old persons attendance register was efficient and the reception staff did not find that it added greatly to their workload. Apart from those not seen, the register also identified patients who were attending only for repeat prescriptions. This group was small and not studied, but the fact that they exist indicates a need for careful surveillance by general practitioners. A useful addition to the register would have been details of patient admission and discharge from hospital, especially to alert the practice to the resettlement needs of the patient on discharge.

The sample of patients not seen during the year was small but the corrected population from which they were drawn (627) was reasonable. The "not seen" group were, because of their uniqueness, nevertheless interesting. The results show that lack of contact is more likely to occur with men, particularly in the age group 80-84, and in those who are widowed or single. Men tend to see doctors less, the older age group might find access more difficult, and widowed or single men would not have another person to prompt them to go to their doctor. In general, the group seemed in good health, but some important points emerged. In half the group there was no identifiable carer, rendering them likely to be in need of hospital care in the event of illness. Although a high proportion of the patients in the sample said that they did not consider it necessary to see a doctor, there was evidence that many needed some help. Over half the group needed some action to be taken as a result of the health visitor's examination. Unreported need was present in 36% of the group although most of the incapacities found were at an early stage. The results also suggest that inability to bathe without help may be a feature of self care that appears early and may be a useful indicator of increased dependency. These results indicate a worthwhile benefit from identifying this group of patients and vindicates the work required to keep a practice attendance register for patients over 75.

It seems therefore that case finding is practicable. An accurate age-sex register is necessary when preparing a practice attendance register for elderly patients. Individual practices must decide which age groups to include, but an age under 75 may be more appropriate.

The term "anticipatory care" has been given to this type of activity, although there are difficulties about the definition of this term. Nigel Stott defined anticipatory care as planned intervention to achieve early diagnosis or treatment, or both, for a condition that may not be producing symptoms or be recognised as causing symptoms.¹⁴ But the term is used by the General Practitioners report *Health and Prevention in Primary Care* describes anticipatory care as meaning "care with an eye to the future."¹⁵ Although not formally defined, the view in the report is that anticipatory care includes all aspects of prevention of disease together with health promotion undertaken along normal care and treatment. The wider definition of anticipatory

TABLE 1—Age, sex, and occupation of patients and controls

	Mean (SD) age (years)	Men: women	Heavy manual	Light manual	Semi-sedentary	Sedentary	Minor	Housewife	Unemployed
Patients with back pain (n = 193)	44.5 (14.8)	104:89	66	66	26	10	6	23	4
Controls (n = 183)	44.5 (14.8)	104:79	66	66	26	10	6	23	4

presentation. The mean (SD) age of the patients with back pain was 44.5 (14.8) years, and 104 (54%) were men (table 1). The patients were fairly well matched with the controls for age, sex, and occupation. Of the patients with back pain, 147 (76%) had attended previously with back pain compared with 62 (33%) of the controls. Fifty nine (56%) of those who were employed had had time off work: two thirds were back at work within four weeks and only 16 still unable to work after eight weeks; three patients were still unable to work after a year. Sixteen (8%) of the patients with back pain were referred for spinal radiography. Eighteen (9%) were referred for orthopaedic investigation; in three this was their first referral for back pain. A further 32 had previously been referred to the hospital, at a level of the control group.

Table 1 shows a significant difference in the mean diameter of the spinal canal between the 193 patients and all 193 controls ($p < 0.01$) and between the patients and the 132 controls who did not have a history of back pain ($p < 0.001$). The patients and the controls who

TABLE 2—Mean (SD) diameter of spinal canal (cm) measured with ultrasound in patients and controls

Lumbar level	Patients (n = 193)	All controls (n = 193)	Controls with no history of back pain (n = 132)
L1	1.48 (0.073)	1.51 (0.082)	1.52 (0.079)
L2	1.46 (0.072)	1.49 (0.084)	1.49 (0.077)
L3	1.43 (0.074)	1.46 (0.083)	1.47 (0.078)
L4	1.40 (0.073)	1.43 (0.081)	1.44 (0.076)
L5	1.41 (0.073)	1.43 (0.079)	1.44 (0.074)

had a history of back pain had narrower canals than the patients who attended with their first attack of back pain, but the difference was not significant. There was no significant difference in canal size between those patients referred to hospital and those managed in the practice. Patients who lost time from work had narrower canals than those who kept at work, but the canal size was not related to the duration of time off work. There was no relation between canal size and either recurrence of back pain over 12 months or recovery.

Twenty (43%) of the patients attending with their first attack of pain had no further trouble over 12 months, but 19 (81%) of those with a history of back pain still had pain 12 months after their initial presentation. Unknown to the general practitioners, 21 patients admitted to attending an osteopath or physiotherapist and 18 of them reported recovery.

Discussion

Patients and doctors alike recognise the difficulty in diagnosing the cause of low back pain, and many patients, especially those attending with recurrent back pain or whose pain does not settle quickly, expect to be offered some investigative procedure. The diagnostic limitations of radiography are well recognised. Investigation of the spine by ultrasonic scanning, if proved to be of value in the management or prognosis of back pain, could help general practitioners because it is a non-invasive technique of low cost.

The results of this study confirm that not only patients attending hospitals but also those attending general practices with back pain tend to have shallower spinal canals than those without pain. The morbidity of back pain, as measured by a history of back pain and the need to take time off work, seems to be related to the size of the spinal canal. There was

no relation, however, between canal size and incidence of referral to hospital or recovery over 12 months. In practical terms, therefore, although the canal size is of interest epidemiologically, it does not have any value in the management or prognosis of back pain in general practice.

Management of back pain in primary care is helped by careful clinical examination and history taking; the best prognostic variable, as shown in this study and previously by Roland *et al.*,¹ is a history of back pain.

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TABLE 3—Age, sex, and marital status (percentages) of 44 patients over 75 who were not seen during one year

	Men	Women	75-79 years	80-84 years	85+ years	Married	Single, widowed, or divorced
Sample of patients (n = 44)	41	3	50	39	11	30	70
People in England and Wales (1981) aged over 75 years	35	65	53	39	11	34	66

*Percentages refer to corrected total after study.