PRACTICE OBSERVED

Practice Research

Old people not known to the general practitioner: low risk group

EDWARD S WILLIAMS, NEVILLE H BARLEY

Abstract

The elderly patients in a large general practice aged 75 and over who lived at home (n=877) were divided into two groups according to the general practitioner's knowledge of their risk status and were designated "risk status known" (n=679) and "risk status not known" (n=198). Forty three high risk patients in the risk status known group had a functional disability score and experience of mortality that was not dissimilar to those of elderly people in institutions. The medical and social characteristics of a random sample (n=150) of the risk status known group, after excluding the high risk patients, were compared with the risk status not known group using a Barber Wallis questionnaire. A response rate of 90% was achieved from both groups and a cumulative risk score was calculated by totalling unfavourable replies to the questions.

The risk status not known group, which comprised 14% of the patients who lived at home after correcting for the number who had died and moved, had appreciably less contact with the general practitioners, had an appreciably lower cumulative risk score, were confined at home less because of ill health, were less concerned about their health, and were less in need of nursing attention. The findings of this study suggest that the elderly patients who are not known to their general practitioners are in relatively good health when compared with the patients that the general practitioner knows well.

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Introduction

The most appropriate way of identifying elderly patients at high risk and therefore in need of medical or social intervention is still being debated. The results of several studies from general practice have shown unreported need among elderly patients.¹⁻³ For example, Williams, in his recent study of elderly patients aged 75 and over who had no contact with the primary care team for one year, showed that half needed treatment or other action.⁴ In a similar study Goldman showed that over half of elderly people who did not attend their general practitioner required some action to be initiated.⁵ This suggests that it might be useful to trace and visit non-attenders. On the other hand, Freedman *et al.*, in a screening survey of elderly patients in general practice, found little treatable but previously undiagnosed illness,⁶ and Ebrahim *et al.* reported low levels of ill health among elderly non-consulters⁷ and suggested that case finding for problems among the elderly should initially be confined to consulters.

Nevertheless, physicians who care for the elderly commonly believe that older people are often referred to them late in their illness and have felt that more could have been done if the individual had sought medical attention earlier. According to Anderson, "the idea has thus evolved that older people cannot tell when they are unwell, so that disease is not detected at an early stage and that there is an iceberg of unreported illness among older people in the community."⁸ It is widely accepted that a search for unreported disease and disability will increase the likelihood of cure or alleviation.^{9,10}

Hence several attempts have been made to identify high risk groups—for example, patients recently discharged from hospital, those who recently moved, those who are recently bereaved, or those who live alone—that might have a high proportion of patients with unreported illness which requires attention. The assumption behind these attempts to identify high risk groups is that patients at high risk are, in fact, not known to the general practitioner. Our study was based on the hypothesis that the general practitioner knows the high risk patients in his practice, and so the best method of case finding is for the general practitioner to scan

there was no way of knowing whether these patients had moved or were dead, other than by visiting the address. We assumed that patients who had never been seen or who had not been in contact with the practice for 10 years or longer, and whose names were not listed in the telephone directory, were no longer part of the study population. The adjusted response rate for this group was 87%. 50 had moved, seven had died, and 14 were assumed to have died or moved, leaving 16 who did not respond. The cumulative risk score for each patient was calculated by totalling unfavourable replies to the nine Barber Wallis questions, and the need for nursing attention, giving a maximum possible risk score of 10. The cumulative risk score of the two groups is compared in table II. Of those who responded to the questionnaire, 24% of the risk status known group had a risk score of 5 and above compared with 10% of the responders in the other group.

Tables III to V give the patients' characteristics and perceived medical and social risk factors. In the risk status not known group 46% of the patients had not consulted in 18 months compared with 4% in the risk status known group.

Discussion

The idea of an iceberg of unreported ill health among the elderly is still widely accepted.¹⁻¹⁰ Williams, in his study of old people at home, suggested that a general practice service based on the self reporting of illness is likely to be seriously handicapped in meeting the needs of old people because a great proportion of ill health—the clinical iceberg—is not known to the general practitioner.⁴ Thus many people advocate screening the elderly population to uncover health and social problems that may be alleviated to a degree by appropriate action.

TABLE I—Level of incapacity as measured by total activities of daily living score, comparing Merton non-consulters with Leicestershire elderly who were residents in institutions (for less than one year)

Activities of daily living score	Merton non-consulters living at home		Leicestershire elderly residents less than one year	
	No.	%	No.	%
1-11	5	12	29	16
12-14	5	12	29	16
15-17	11	24	112	62
18-20	9	21	182	100
Total	42	100	405	100

$\chi^2=4.18$, $p=0.020$.

There is no statistically significant difference between the two groups.

*Frequencies in each age group calculated from data in Davidson.¹¹

†Percentages in each age group calculated from data in Davidson.¹¹

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TABLE IV—Social risk factors identified using Barber Wallis questionnaire by general practitioner's knowledge of risk status

	Risk status known (n=111)		Risk status not known (n=111)	
	No.	%	No.	%
Living alone	54	48	12	11
Difficult with walking	45	40	11	10
Dependent on regular help	45	40	11	10
No car/mobility	7	6	5	5

TABLE V—Medical risk factors identified using Barber Wallis questionnaire by general practitioner's knowledge of risk status

	Risk status known (n=111)		Risk status not known (n=111)	
	No.	%	No.	%
Confused at home through ill health	12	11	28	25**
Concerned about health	49	43	28	25**
Difficult with walking	12	11	28	25**
Difficult with hearing	15	13	12	11
Worried during visit	15	13	12	11
Needs direct nursing	18	16	7	6***
No contact at home	5	4	1	1

* $\chi^2=17.7$, $p=0.000$; ** $\chi^2=1.7$, $p=0.004$; *** $\chi^2=5.7$, $p=0.02$.

†Question added to Barber Wallis questionnaire.

In our study the general practitioners were able to comment on the risk status of 86%—after correcting the age-sex register—of the elderly patients living at home. The 43 patients identified as not coping were found to be a high risk group, having a degree of functional disability and mortality not dissimilar from patients living in institutions.¹¹ Because this group was so vulnerable it was considered inappropriate to send postal questionnaires. Patients in Part III and sheltered housing were excluded because they were considered to be a disabled group identifiable as such by their address. The exclusion of these two groups from the risk status known group, in fact, minimised the differences found.

The risk status not known group had a statistically significant lower cumulative risk score compared with the risk status known group. They were significantly less confined at home because of ill health, less concerned about their health, and less in need of nursing care. This evidence suggests that the group that is not known to the general practitioner contains a high proportion of relatively healthy, low risk patients.

The social characteristics of the two groups were remarkably similar except that the not known group had a lower proportion of men than was expected, but this did not differ greatly from the practice as a whole.

These findings are highly dependent on the general practitioners' knowledge of their patients and the standard of note keeping. It is likely that the results apply only to practices that have reasonable case notes and an age-sex register. Though it is possible that we studied a well organised, above average practice, three of the doctors having practised for over 20 years, none the less 14% of not known patients corresponds roughly with the percentage of elderly non-consulters in other studies, suggesting that the pattern of patient care is similar to that in other practices.¹² Our findings are consistent with Ebrahim's, who found that elderly non-consulters are a low risk group.⁷ The results of these studies suggest that the idea of a clinical iceberg of unreported disease may need to be revised. It should be noted that our results are based chiefly on data from a self administered questionnaire, whereas other studies included a medical examination and interview.¹³

We conclude that most of the frail elderly people at high risk are readily identifiable using case notes and the general practitioner's knowledge of the patient. The use of an age-sex register, combined with the general practitioner's previous knowledge seems to be the easiest and cheapest way of screening a practice population for high risk elderly patients.

through the practice case notes. The aims of our study were: (a) To establish the proportion of elderly patients in which at risk status is known to the general practitioner; (b) To quantify the number of high risk patients, as designated by the general practitioner; (c) To compare the social and medical characteristics of the two groups: risk status known and risk status not known.

Method

We studied a large six doctor group practice in the London Borough of Merton with a total number of patients of 14 500, which has a manual age-sex register. The practice is staffed by three attached health visitors, four district nurses, nine ancillary staff, three practice nurses, and a practice administrator.

Age-sex register population: 1032

Amended → known dead and moved 49

Practice population

Institutions 106

Study population 877

General practitioner screen, using case notes

Risk status known 679

Risk status not known 198

General practitioner's opinion of risk

Coping at home 636

Not coping at home 43

Random sample 150

Health visitor assessment of ADL

Dead and moved 22

Barber Wallis questionnaire

Response

No response

113

15

Selection of study sample: ADL = activities of daily living.

We used the manual age-sex register to identify patients aged 75 and over, who make up 6% of the practice population. The age-sex register, introduced in 1982 from patient records cross matched with family practitioner committee records, contained an initial inflation rate of roughly 14%. It is updated weekly with additions and removals. Doctors' notes are kept on PP18 cards, are usually concise and complete, and record presenting symptoms or diagnosis and drugs prescribed. The cards of patients who were known to have died or moved away were removed from the register. Patients who were known to be resident in Part III homes, sheltered housing, nursing homes, or long stay hospital were excluded. A data sheet was prepared by the practice administrator on the remaining patients, who formed the study population.

The six general practitioners were given the case notes of patients on their list and asked to classify patients into two groups according to their knowledge of the patient's risk status. If the general practitioner knew the patient's medical and social situation well enough to comment on the risk status the patient was classified "risk status known." The remaining patients were classified into the "risk status not known" group.

The general practitioners were required to complete a questionnaire,

group who felt that they were not coping were contacted by their general practitioner.

Results

The method by which the study sample was obtained is summarised in the figure. Of the group risk status known, 43 patients were identified as "not coping." Eight of this group died within seven months, a death rate of 36% a year (calculated on the