Clinical Problems

Geriatric Patients: Do Their Families Care?

BERNARD ISAACS

British Medical Journal, 1971, 4, 282-286

Summary

A study of the reasons for admission of 280 patients from their own homes to a geriatric unit in the East End of Glasgow showed that in two-thirds of cases patients were admitted primarily because they failed to receive adequate basic care at home (usually because of lack of relatives) or because their relatives suffered undue strain in caring for them. Neglect by relatives played a negligible part in the need for admission.

Introduction

The growth of geriatrics in the 1960s was an astonishing feature of the British medical scene. Geriatric units, geriatric physicians, and geriatric beds multiplied exponentially, but still the demand remained unsatisfied and geriatric patients failed in many cases to receive the care which they required. The increased number of old people in the population obviously underlay this expansion of activity, but many questions remained unanswered about the precise role of a geriatric service in an ageing population.

In 1966-7 a small research team based on the department of geriatric medicine of the Glasgow Royal Infirmary group of hospitals set out to characterize the patients admitted to the unit. It was found that the patients came predominantly from the oldest stratum of the population; that they were socially at a disadvantage, but little more so than the general population of their own age; and that they were distinguished by the high proportion who were deprived of independence by immobility, instability, incontinence, and mental abnormality. The findings of this study have been reported elsewhere.¹

In the same study four reasons were identified for the referral of elderly patients by their general practitioners to the geriatric unit. These were "therapeutic optimism," the belief that hospital treatment would lead to clinical amelioration and early discharge; "medical urgency," the need for immediate hospitalization despite a poor prognosis; "insufficient basic care," the lack of food, warmth, cleanliness, or safety in the patient's home; and "relief of strain," the need to admit the patient to hospital, in the absence of the other three indications, in order to relieve intolerable strain on relatives.

In the present paper the characteristics of these four groups of geriatric patients will be presented, together with an analysis of why they lacked basic care and why their relatives suffered undue strain.

Patients and Methods

Altogether 612 patients who were referred consecutively to one of the two consultant physicians at the department of geriatric medicine in the period 1 October 1966 to 31 December 1967 were studied. The present report is concerned with all 280 of these patients who were referred from their own homes and accepted for admission to the geriatric unit. All patients were seen at home before admission by the consultant physician, and subsequently they and their relatives were interviewed by a social worker engaged specially for the purpose. At weekly meetings the reason for acceptance of each patient was agreed after discussion.

The method of classification was to pose four questions in sequence (see Diagram).

Placement of patients after classification.

(1) Firstly, the geriatrician asked himself, "Is it likely that if this patient is admitted to hospital and treated he can be sent home again within a period of about three months?" If the answer was Yes the patient was accepted and the reason given was therapeutic optimism. If the answer was No the second question was asked.

(2) "Does the patient require to enter hospital as a matter of medical urgency even if it is unlikely that he will return home again?" If the answer was Yes the patient was accepted for medical urgency. If No the third question was put.

(3) "Does the patient need hospital admission because he fails to receive sufficient basic care?" Basic care meant the provision of food, warmth, cleanliness, and safety at a standard at which the patient would have provided these for himself had he been fit to do so. If the answer was Yes the patient was admitted for basic care. If No the fourth question was posed.

Department of Geriatric Medicine, Glasgow Royal Infirmary Group of Hospitals

BERNARD ISAACS, M.D., F.R.C.P. GLASG., Consultant Physician

(4) "Does the patient require admission in order to relieve intolerable strain on relatives?" Intolerable strain was defined as a burden of care arising from the patient's illness which threatened either the physical or mental well-being of the relatives or both. If the answer was Yes the patient was admitted for "relief of strain." If the answer was No—that is, there was no undue strain on relatives, the patient received sufficient basic care, there was no medical urgency, and there was no likelihood of the patient obtaining therapeutic benefit from hospital treatment—then the patient was not accepted for admission to hospital.

Results

The results of this classification are shown in Table I and the outcome after hospitalization in Table II. The number of patients admitted was less than the number accepted because the department was working under pressure, and several patients died or were admitted elsewhere or were withdrawn before a bed could be made available in the geriatric unit.

TABLE I—Reasons for Acceptance of the 280 Patients

Therapeutic optimism	No.	Insufficient basic care	No.
Medical urgency	105 (37%)	Relief of strain	67 (24%)
	19 (7%)		89 (32%)

TABLE II—Outcome Three Months after Admission

	Reasons for Acceptance							
	Therapeutic Optimism		Medical Urgency		Insufficient Basic Care		Relief of Strain	
	No.	%	No.	%	No.	%	No.	%
Discharged home	37	52	3	23	5	11	10	17
Died	14	20	5	38	12	26	31	53
Still in hospital	20	28	5	38	29	63	18	31
No. admitted	71		13		46		59	

Therapeutic Optimism.—Just over one-third of the patients fell into this group. Half of them were discharged home within three months of admission to hospital, one-fifth died, and a quarter remained in hospital. The diagnoses encountered in this group included recent stroke, congestive cardiac failure, pneumonia, Parkinsonism, etc.

Medical Urgency.—This small group, comprising only 7% of the series, included cases of advanced congestive cardiac failure, massive cerebral haemorrhage, etc. These patients seem to have been referred to the geriatric service rather than to an acute medical unit because of accompanying adverse social circumstances. Only one-fifth of the patients in this group were discharged home from hospital after treatment; two-fifths died in hospital and two-fifths were retained.

Insufficient Basic Care.—This group represented a quarter of all the cases accepted for care in the unit. As a result of illness or disability they were unable to provide adequately for themselves food, warmth, cleanliness, and safety and they failed to receive them from others. Only a quarter of them died within three months of admission and only one-ninth were discharged home. Nearly two-thirds were still in hospital three months after their admission; and this group comprised 40% of all patients who remained in hospital for more than three months. Many had symptoms of disturbance of balance and intellectual impairment.

Undue Strain.—One-third of the patients were accepted for admission primarily in order to relieve undue strain on relatives. More than half of them died within three months of admission to hospital and only one-sixth were discharged home. Many had multiple morbidity and advanced disability.

To summarize, if the few cases of medical urgency are excluded the remaining patients fall into three approximately equal groups—one-third were admitted for predominantly medical reasons, and half of these were discharged home within three months; one-third were admitted because of lack of community care, and half of these remained in hospital for more than three months; and one-third were admitted because of the exhaustion of community care, and half of these died within three months.

INSUFFICIENT BASIC CARE

Insufficient basic care meant that the patient lacked food, warmth, cleanliness, or safety at a level at which he would have provided these for himself had he been fit to do so. Little difficulty was experienced by the doctor and the social worker in interpreting this definition. Some patients lacked all four ingredients of basic care and were thus totally deprived. None lacked only food or only warmth, and almost all of those who lacked food and warmth lacked also cleanliness and safety. Few patients were wholly without attention from relatives, neighbours, or the domiciliary services, but the trouble usually was that their needs were not met during part of the day or night. This was most often the case with patients who fell and remained lying on the floor all night till someone came to the door in the morning (lack of safety), or who soiled themselves and had to lie in contact with urine or faeces all day (or all night) until someone was available to change them (lack of cleanliness).

The 91 patients who failed to receive sufficient basic care are compared in Table III with 189 whose basic care was adequate

TABLE III—Comparison of Geriatric Patients with Sufficient and Insufficient Basic Care

Social Characteristics	Insufficient Basic Care		Sufficient Care	
	No.	%	No.	%
Male	33	36	80	42
Female	58	64	109	58
Age:				
Under 65	4	4	21	11
65-74	23	25	42	22
75-84	46	50	95	50
85 and over	18	20	31	16
Married	10	11	60	32
Single	20	22	23	12
Widowed	61	67	106	56
No children in locality	52	57	46	24
Living alone	57	62	31	16
With spouse only	9	10	48	25
With others	25	28	110	58
House has bathroom	44	48	124	65
W.C. but no bath	27	30	28	15
No W.C. and no bath	20	22	37	20
Social class:				
I and II	5	5	12	6
III	20	23	75	40
IV and V	66	72	102	54
Home help	46	50	30	16
District nurse	19	21	53	28
Meals on Wheels	3	3	0	0
Total	91		189	

in respect of social and medical factors. (The 91 includes 25 patients accepted for therapeutic optimism whose basic care was insufficient.)

The two groups were similar in respect of age and sex distribution, but the "low-care" group contained proportionately more single and widowed people, more with no children in the locality, more who lived alone, and more in social classes IV and V. In respect of medical factors (see Table IV) the low-care group had fewer symptoms of dependency and contained a smaller proportion of patients who had been dependent for

TABLE IV—Comparison of Presenting Symptoms in Patients with Sufficient and Insufficient Basic Care

Presenting Symptoms	Insufficient Basic Care		Sufficient Care	
	No.	%	No.	%
Stroke	5	5	38	20
Falls	49	54	81	43
Immobility	56	62	139	74
Incontinence	35	38	73	39
Mental abnormality	35	38	99	52
No. of symptoms:				
1	21	23	52	28
2	29	32	44	23
3	26	29	42	22
4	5	5	33	17
5	1	1	6	3
0	9	10	12	6
Duration of dependency:				
Less than 1 week	12	13	31	16
1 week to 1 month	12	13	25	13
1 month to 1 year	34	37	56	30
More than 1 year	21	23	56	30
Not dependent	12	13	21	11
Total	91		189	

TABLE V—Reasons for Insufficient Basic Care in the 91 Patients

	No.		No.
No Children in locality ..	52 (57%)	Dilemma	4 (4%)
Preoccupation	17 (19%)	Children	2
Health	5	Spouse/children	1
Family	2	Personality	1
Employment	4	Patient refused	7 (7%)
Housing	1	Patient rejected	11 (12%)
Combined	5		

more than one year. They were thus characterized by social deprivation and relatively non-life-threatening disease.

Attention was then turned to why these patients lacked basic care (Table V.) More than half of these patients did not have children living in the Glasgow area. They received help from other relatives, neighbours, and the domiciliary services, but this was insufficient for their needs. The remaining 39 cases who had children living in the Glasgow area yet failed to receive adequate basic care were intensively analysed. Details of this analysis and illustrative case histories are given elsewhere.² In 17 of these the relatives were found to be anxious and willing to give as much help as possible but were unable to do any more than they were doing because of a "preoccupation," defined as an alternative commitment which could not be disregarded without creating severe hardship or an absolute impediment. In five cases this preoccupation was the helper's own state of health—for example, a helper who had suffered a myocardial infarction and was unable to lift a patient with rheumatoid arthritis—in two it was another family commitment—for example, the patient's daughter's invalid mother-in-law also had to be looked after—and in four the only available relative could not surrender bread-winning employment. In one case relatives could have given more help only by bringing the patient into their own home, but their housing conditions were already so unsatisfactory (overcrowded house, outside toilet) that this was impossible. In five cases several of these adverse factors were combined.

Next came four cases classed as "dilemma," where relatives could perhaps have given more help than they did but only by sacrificing aspects of their own life, with potentially harmful consequences. In these difficult cases harm would have befallen the relative's spouse or children, and the relative chose not to run this risk. In seven cases classed as "refusal" the patient refused offers of additional help from relatives. Most of these were ill old men who refused to stay with a son or daughter who was, in turn, quite unable to provide adequate help in the patient's own house.

In 11 cases described as "rejection" the relatives failed to provide adequate help for none of these reasons. In nine of these cases an explanation of the relatives' conduct was found. These

nine subjects had all been alcoholics, prostitutes, or criminals and had neglected their children in the past. In many cases they had threatened the integrity of their own family life. Most of these relatives remained willing to help to a limited extent but were not prepared to open their homes to a parent to whom they felt no debt of affection. In the two remaining cases no explanation for the relatives' reluctance to provide help was forthcoming.

It was concluded that in two cases at least and perhaps 22 at most some "neglect" of old people by their relatives was a factor in their admission to the geriatric unit. Our own preference is for the former figure, which more truly represents "apparently unjustifiable neglect." If this figure is accepted neglect of old people by their families was a factor in the reason for admission of less than 1% of geriatric patients.

STRAIN

Strain of such severity as to constitute a threat to either the physical or mental health of relatives or both was present in 141 of the 280 cases accepted for admission and was the reason for acceptance of 89 of these. The cases with strain were compared with those who received sufficient basic care and whose management at home did not induce undue strain (Tables VI and VII). The two groups did not differ significantly in respect of age, sex, marital status, housing, or social class, nor in the proportion who did not have children living in the Glasgow area. More in the "no strain" group lived alone, indicating that strain was associated with the constant presence of the patient in the same house as the helper. Three symptoms—immobility, incontinence, and mental abnormality—were all commoner in the "strain" than in the "no strain" group. Twice as many proportionately of the strain patients had all three of these symptoms, and in twice as many of the strain group one or more of these symptoms had been continuously present for more than one month before referral. As already indicated the strain patients had a high mortality after admission to hospital. The strain patients were thus characterized by advanced disease in favourable social conditions. They were a group of people who were nursed at home until they became so disabled and made such heavy demands that their helpers could no longer cope. By the time they were admitted to hospital the end was already near.

It was characteristic of strain cases that multiple factors were

TABLE VI—Social Characteristics of Patients who received Sufficient Basic Care with and without Undue Strain

	Undue Strain		No Undue Strain	
	No.	%	No.	%
Male	62	44	18	38
Female	79	56	30	62
Age:				
Under 65	19	13	2	4
65-74	26	18	16	33
75-84	70	50	25	52
85 and over	26	18	5	10
Married	47	33	13	27
Single	13	9	10	20
Widowed	81	58	25	52
No children in locality	33	23	13	27
Living alone	18	13	13	27
With spouse only	39	28	9	19
With others	84	60	26	54
House has bathroom	96	68	28	58
W.C. but no bath	19	13	9	19
No W.C. and no bath	26	18	11	23
Social class:				
I and II	11	8	1	2
III	55	39	20	42
IV and V	75	53	27	56
Home help	22	16	8	17
District nurse	44	31	9	19
Meals on Wheels	0	0	0	0
Total	141		48	

TABLE VII—Comparison of Presenting Symptoms in Patients who received Sufficient Basic Care with and without Undue Strain

Presenting Symptoms	Undue Strain		No Undue Strain	
	No.	%	No.	%
Stroke	26	18	12	25
Falls	62	44	19	40
Immobility	106	75	33	69
Incontinence	61	43	12	25
Mental abnormality	79	56	20	42
No. of symptoms:				
1	39	28	13	27
2	33	23	11	23
3	30	21	12	25
4	28	20	5	10
5	5	4	1	2
0	6	4	6	13
Duration of dependency:				
Less than 1 week	20	14	11	23
1 week to 1 month	16	11	9	19
1 month to 1 year	47	33	9	19
More than 1 year	47	33	9	19
Not dependent	11	8	10	21
Total	141		48	

involved in causing the strain. The causes fell into three groups—factors in the patient, in the helper, and in the helper's "life-space." Factors in the patient included the nature of the symptoms (especially incontinence and mental abnormality) and the personality of the patient. Factors in the helper included her age, physical and mental health, relationship to the patient, living arrangements, and personality. By the helper's life-space was meant the competing demands on her time and the exertions which she was called on to make in order to look after the patient. These involved care of young children and other sick relatives, and surrender of employment, leisure interests, and all normal social life.

PRINCIPAL HELPER

In all but one of the strain cases it was possible to identify a "principal helper" on whom fell the burden of strain. The exception was a case where the strain fell equally on three daughters. The majority were the spouse or daughter of the patient (Table VIII). In nearly three-quarters of the cases the helper was over the age of 50.

TABLE VIII—Age of Principal Helper and Relationship to Patient in the 141 Cases Involving Strain

Relationship	No.	Age	No.
Spouse	35 (25%)	Under 30	5 (4%)
Own child	73 (52%)	30-49	34 (24%)
Child-in-law	9 (6%)	50-69	76 (54%)
Other family member	19 (13%)	70 and over	25 (18%)
Neighbour	4 (3%)	No principal helper	1 (0.7%)
No principal helper	1 (0.7%)		

It was repeatedly our experience that the physical burden of caring for the patient was well tolerated. Even incontinence was often dealt with without complaint. The most burdensome cases were those where the patient was unsafe by virtue of a tendency to fall or of mental abnormality—for example, tampering with gas or fire—so that the helper could never relax by night or day for fear of accidents. The other great straining factor was the excessively demanding, irritable patient who exploited the relatives and expressed no gratitude or appreciation. In cases of this type the expedient of day hospital attendance (which we were unable to offer) would not in our opinion have satisfied the requirements of the exhausted relatives; but it is possible that had this form of management been used from the beginning the request for permanent hospital admission might have been further delayed.

DOMICILIARY SERVICES

The use made by the patients in this survey of the two principal domiciliary services—home helps and district nurses—is shown in Table IX. The other services were very little used by patients in this study. The level of use of these services was low and the pattern differed in the various groups. Those who lacked basic

TABLE IX—Use of Domiciliary Services by the 280 Patients

	Home Helps	District Nurses	Meals on Wheels
No. of patients (%) ..	76 (27)	72 (25)	3 (1)

care made considerable use of home helps but not of district nurses. Those whose relatives suffered strain showed the reverse pattern. It seemed that home helps to a large extent provided the basic needs (including in many cases nursing needs) of those who lived alone, who had no relatives, and who really required home nursing or hospital care; while those with relatives tried to cope without the home help but called in the district nurse to assist them. Many home helps in this survey were found to be exceeding their official duties in that they changed soiled and incontinent patients and provided various other forms of nursing help, even to the extent of taking soiled linen home to wash in their own washing machines. District nurses, who also did a splendid job in difficult conditions, were least likely to be called in where their help was most needed; fuller details are given elsewhere.¹

Discussion

Several previous studies of geriatric patients by geriatric physicians have divided patients into those admitted for primarily medical reasons and those admitted for predominantly social reasons.^{3,4} In the present study all patients were looked on as suffering from a medical disability which had in turn created social difficulties. If numerical scales of medical and social disability were devised each case could be represented in the form of a pair of Cartesian co-ordinates, and these could be plotted on a diagram in the form shown here. The area of the diagram could then be divided into various sections representing the cases accepted for therapeutic optimism, basic care, and relief of strain respectively. (It must be emphasized that the diagram is purely hypothetical.) The therapeutic optimism group would in general be those with high medical and low social disability, the basic care group those with low medical and high social disability, and the strain group those with high disability on both medical and social scales. The diagram also has three "ghost" areas. The one near the origin represents the group of ill old people seen in general practice who have comparatively mild medical and social disability, the area near the vertical axis relates to elderly patients referred to general medical and surgical units who have high medical but low social need, while that adjacent to the horizontal axis corresponds to old people entering residential homes—these have low medical but high social disability. There is in addition an area at the periphery which corresponds to the "hard core" of old people severely medically and socially at a disadvantage¹ who form such a prominent part of the case load of the geriatric service.

In the previous study the geriatric patients were compared with a group of elderly patients admitted to general medical wards and with an age-matched sample of the elderly population as a whole. In that study the statement was made that many geriatric patients represented the survival of the unfittest section of the community; that they suffered from severe and prolonged medical disability which made them heavily dependent on others for their care. The present study shows that in almost two-thirds of the cases accepted for the geriatric

unit referral to hospital was delayed until the patient lacked the basic elements of care or until the help which he obtained from relatives, friends, and domiciliary services threatened to break down. Neglect of old people by relatives played a negligible part in the demand for admission to hospital. On the contrary, the help received from relatives, who were for the most part themselves middle-aged or elderly, was vast and was given willingly and cheerfully, so long as conditions were tolerable. The conditions found most difficult for relatives to bear was the long-continued presence of mental disorder, as noted also by Hoenig and Hamilton⁵ and it is just this form of disability from which originates a very large part of the need of old people for care.

If the conditions shown by the present study are typical of those existing elsewhere in Great Britain it must be concluded that the burden of illness and disability in the elderly will exhaust any conventional system of domiciliary and hospital care. More hospital beds, home helps, and district nurses are certainly required, but this is not enough. New ways of dealing with the problems of ill old people⁶⁻⁸ must be more widely introduced so that troubles are caught earlier and at least in some cases preventive and pre-emptive treatment is applied. If this is to be well done great improvements are required in the education of medical students and graduates in the diseases of old age and their management; more research opportunities must be created in the fields of dementia, incontinence, balance and gait disturbances, and medical care; and the status and conditions of work of departments of geriatric medicine must be enhanced so that more physicians of high calibre are attracted to this rewarding branch of the profession.

The prolonged survival of many severely disabled and ill people into advanced old age is a new phenomenon in our society and has created unprecedented strain on our family and social system. The terminology and thinking of a previous period with entirely different circumstances must be discarded if the solution to our difficulties is to be found.

The present study was conducted by a team of workers who included Dr. W. Mathieson, Mrs. M. Livingstone, Mrs. C. Campbell, and Mrs. Y. Neville, with additional secretarial help from Mrs. J. Gunn. The project was supported by a grant from the Research and Intelligence Unit of the Scottish Home and Health Department, and constant encouragement and advice were received from Dr. M. A. Heasman, director of the unit, and Dr. W. T. Thom, of the Scottish Home and Health Department. Every kindness and assistance was received from the many subjects, patients, general practitioners, hospital staff, social workers, administrators, and officials whose help we sought, and who are acknowledged individually in the publications cited.

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Problems of the Newborn

Some Congenital Malformations Necessitating Emergency Operations in the Newborn Period

P. P. RICKHAM

British Medical Journal, 1971, 4, 286-290

The number of infants born with congenital malformations requiring emergency surgery during the newborn period is small—about 2 per 1,000 live births. The cost of treatment of these infants is high, since it necessitates a team of highly specialized and skilled medical and nursing personnel, as well as a great deal of special equipment. Unless these neonates are collected in a few widely separated special centres, doctors and nurses working in neonatal surgical units will not get enough experience in the management of these difficult conditions and will be unable to obtain consistently satisfactory results. By and large this principle has been accepted in Britain.

For the general practitioner who delivers an infant with a congenital malformation requiring urgent surgery there are three immediate problems to be solved: diagnosis of the condition, initial management, and management during transport, often over considerable distances. A fourth problem, which is

at least as important as the first three, is the support and advice the practitioner has to give to the family of such an infant.

In this article common malformations except meningocele and hydrocephalus will be considered; a separate article will deal with these two.

Diagnosis

Broadly speaking, most malformations requiring emergency surgery during the newborn period are malformations of the alimentary and respiratory tracts, though a few grave genito-urinary malformations have also to be considered. In the diagnosis of the condition the presenting signs and symptoms are all important and will be discussed in some detail.

VISIBLE DEFORMITIES

The diagnosis is usually obvious, and it is mainly the evaluation of the degree of deformity which must be discussed here.