

## Visiting Care by Family Physicians<sup>\*1</sup>

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### Introduction

In recent years, the need for home care in this aging society has been stressed. However, the debate over this has not been resolved as this would require a system offering care 24 hours a day, 365 days a year since home care includes end-of-life care. Most of the clinics run by family physicians are managed by just one physician, making it extremely difficult to provide 24/7 care.

My clinic is an ordinary internal medicine clinic providing outpatient treatment in the morning and afternoon. I make home visits during the lunch hour and oversee about 40 in-home patients. I provide end-of-life care for about 15 patients a year. This article will outline a picture of how a single physician provides this kind of care.

### Overview of My Clinic's Home Visits

My clinic serves the Ota ward in Tokyo. The clinic is run by myself and my father, but currently my father is not engaged in care to in-home patients. I visit patients in their homes from 1-3 pm a day in an area with a radius of about 2 km. I visit patients in their homes but also in group homes and private nursing homes. I travel primarily by bicycle, and mostly see 5-6 people in a day.

Most of my in-home patients are elderly people too weak to travel to my clinic or patients with cognitive impairment, but late-stage cancer patients account for about 10%. I visit these patients for about one month, with about 80% of cancer patients dying in their own homes. However, there are also end-of-life cases who do

not have cancer but suffer from senility. In the past few years, about half of my end-of-life patients suffer from cancer and about half suffer from conditions not related to cancer.

I receive 5 or 6 requests a month for house calls. Many are not urgent, and I visit during my regular daytime visiting hours. I make home visits in the evening and on weekends about once or twice a month. Because I have received word of respiratory arrest, something that in most cases was anticipated. I make house calls about once a month on evenings and weekends due to unexpected fevers and other causes. At present, I make these home visits myself.

### Steps Needed for a 24-hour System with One Physician

There are several key factors essential in my clinic's being able to provide home care with a single physician. I have discussed a few of these factors below.

#### Use of a visiting nurse

A visiting nurse is the most powerful partner in home care. With instruction from a physician, a visiting nurse can observe the patient's condition, adjust the patient's living conditions and provide medical care. A nurse can set up Intravenous drip when the patient is dehydrated, if so instructed, and can follow special instructions if the patient develops pressure ulcers.

During the period immediately after hospitalization when the patient is not yet stable, a visiting nurse can visit several days in a row and relieve any concerns over living at home. In addition, nurses can take the first call when there

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is an emergency summons from a patient. However, the family physician must accurately ascertain the patient's condition and give instructions as necessary to ensure that the visiting nurse can perform his/her functions well. If the physician does not fulfill this role and leaves it up to the visiting nurse, a trusting relationship with the visiting nurse cannot be developed and the quality of home care overall declines significantly.

The physician's first job is to prepare instructions. There are two kinds of instructions.

#### **Visiting nurse instructions**

When introducing visiting nurses, visiting nurse instructions are always prepared. With these instructions, visiting nurses can be introduced within the scope of long-term care insurance. The instruction period is optional for up to six months. In the case of end-of-life cases, conditions are not stable so visiting nurses are covered by medical insurance rather than long-term care insurance, but as with the attending physician's written opinion in the case of long-term care insurance, "terminal cancer" must be specified in the section for the name of the illness.

#### **Special visiting nurse instructions**

When conditions worsen during this process and the physician wants the visiting nurse to intervene further, special visiting nurse instructions are prepared. For example, when a patient catches pneumonia and the patient's condition needs to be monitored daily and intravenous drip needs to be set up (if the visiting nurse uses intravenous drip three or more times a week, instructions for in-home patient visit IV is needed; the instructions are valid for one week), medical insurance would cover a visiting nurse for a limit of two weeks if such instructions are provided. In recent years, it has been pointed out that using this system so that a visiting nurse can intervene in a concentrated manner in the unstable period immediately after hospitalization is an effective method of stabilizing a patient.<sup>1</sup>

These instructions can be issued up to twice a month for patients who also have severe pressure ulcers and patients who have bronchial catheters.

#### **Clinic nurses participate in home care**

Currently, my clinic has two full-time nurses, both of whom actively participate in home care services. I always visit patients at home with a nurse (changing every week) to share conditions

and guidelines. The nurse plans the home care in consultation with myself, handles inquiries and questions from the family, communications with the visiting nurse and care manager, and coordinates new patients. Moreover, the nurse accompanies me even in the middle of the night to care for terminal patients, and provides "angel care (postmortem procedure)" in collaboration with the visiting nurses. These nurses are a key support bolstering this one-physician home care system.

#### **Reduce concentrated medical intervention**

Patients discharged from the hospital are often provided concentrated medical care in which they need continuous intravenous injections and high-calorie transfusions. However, there are surprisingly many examples in which these medical treatments can be reduced within the scope of home care. For example, a 1,000 mL/day continuous intravenous injection could be changed to a 500 mL/day subcutaneous transfusion.<sup>2,3</sup> Insufficient hydration can be addressed by feeding the patient jellies and practicing swallowing. Even when various medicines are mixed into high-calorie fluids, there are many cases in which no difficulties will result from discontinuing mixed injections. In the past, I have seen cases in which simply reducing the amount of high-calorie fluids eases intractable swelling, as well as cases in which morphine can be administered orally. There are also a significant number of cases in which patients who repeatedly suffer from aspiration pneumonia at the hospital are able to take food and liquid by mouth when they return home. By reducing concentrated medical care in this way, the patient's burden, the family's burden and the physician's burden are all mitigated.

#### **Respond while predicting patient's condition**

Predicting symptoms is crucial in providing home care. Of course, it is very difficult to accurately predict sudden fevers. However, when a patient's condition gradually deteriorates, they are unable to move and they are unable to either eat or drink, it is easy to predict that the patient will die within a few days. This should be explained to the family once it is predicted, as well as the low likelihood of recovery, and if the family is anxious about having this last stage take place at home, the physician or nurse should increase his/her visits and reinforce support.

I often begin visiting daily from that point. Since I can ascertain changes in the patient's condition on a daily basis, it is easier to predict the next change, and even if the patient experiences any uncomfortable symptoms, I can respond more smoothly.

Moreover, I visit in the evening as well as the afternoon when the patient's level of awareness is declining. By doing this, I am able to predict whether the patient will die that night. If I make a house call and the patient's vital signs are stable and I can confirm urinary output, there is a good chance that they will not die that night. In that case, I can also rest easily that night. If I determine that there is a good chance that the patient will die that night, I make sure I am on standby.

When this kind of intensive visiting care is organized, a nurse alone can address even respiratory arrest if I am providing outpatient service at the clinic. Once office visits have slowed down, I can visit the patient's home and confirm his or her death.

### Support in decision-making

It is important to share what I predict from symptoms with the patient and his/her family. Thoroughly explaining where the patient will be treated going forward, whether the patient can remain in his/her current environment and the direction of treatment, based on these predictions, is crucial. Decisions should be made not only before home care is introduced, but several times during the process as well since decisions could change depending on the symptoms and the support that can be provided. Moreover, support is needed for the decision-making process itself. If the family decides on end-of-life care at home, they must be told that they can receive adequate support. When the family is struggling to make a decision, they should be supported in making a choice.

We must understand their fear that their own decision would mean that they are letting an important family member die without helping, and help them find the best course of action for that person.

### Inter-professional collaboration and information sharing

I mentioned collaborations with visiting nurses, but the very essence of home health care is

supporting the patient's lifestyle. This means that collaborating and sharing information with various other professionals who also support the patients is essential. Cooperation with care managers, service providers at the visiting nurse support office, the pharmacist providing visit instructions, dentists and dental hygienists if there are problems with eating, speech therapists if the patient has problems swallowing, and physiotherapists and occupational therapists providing rehabilitation is essential.

We do not only collaborate, but communicate with each other and ascertain conditions so that we can utilize each other's expertise and support the patient and his/her family. I use cloud-based groupware to share information. In addition, if parents participate in groupware, close emotional support can be provided. Family living far away can occasionally participate and see how conditions change daily. This approach has almost eliminated the situation in which some family members intervene to undermine the treatment guidelines that have been used up until that point.

### Ensure a collaborative system for backup hospitalization

End-of-life care cannot always be provided in the home. Some patients want to be hospitalized for their terminal care because they don't want to be a bother to their families. There have also been several cases in which unpredictable events occur that make it difficult to provide treatment at home, so that emergency transport becomes necessary. For this reason, hospitals able to provide backup are essential for home care.

The problem lies in ensuring that such hospitals are available in the region. The family physician must form a trusting relationship with the hospital and build a partnership that goes beyond that of acquaintances to a real friendship. By sharing information with this hospital, the "story" of the patient's home can often be passed on when he/she is hospitalized. Using the groupware I mentioned above, I share information with the nurse providing help with hospital discharge at the backup hospital and, if possible, the physician in charge or the physician from the medical liaison office. By this means, even if the patient dies a few days after discharge, the patient's "story" can be preserved without any refutation of his/her treatment at home.

This kind of relationship cannot be built up in a single day. I repeatedly discussed ways of working with the hospital managers and regularly participate in hospital conferences so that we are able to understand each other's way of thinking and can build relationships of mutual trust. Simply sharing information will not help to build trusting relationships that go beyond the perspectives of a hospital and clinic.

### Family physician attends patients until the end

Family physicians stand by patients and their families with their accessibility, comprehensiveness, cooperativeness, continuity and sense of responsibility. In this process, they build trusting relationships with the patient and family. If the patient has an incurable illness and wants to die at home, having the family physician take care of the patient until the end is ideal from the perspective of narrative-based medicine and the perspective of spiritual care. Watching over the patient during his/her last days—seeing how the patient lived, thought and behaved and then weakened—in the same community in which he spends his days is a matter of pride for the family physician.

Attending the terminal patient who wants to die at home is the key factor in ensuring that home care runs smoothly.

### Closing Remarks

I have discussed the key factors in providing home care with a single family physician, but some of these aspects cannot be put into action

immediately. Community medical systems have their own particular conditions, so this system should be implemented after the necessary time is spent to coordinate the program.

If terminal care for the elderly is provided primarily at hospitals, as it is now, hospitals will be overflowing with the elderly and the inpatient hospital system and emergency medical care system could collapse under the weight. For this reason, it is urgent that we encourage home care and terminal care at home. This is a crucial ordeal that we must overcome. Regional medical associations and municipal authorities will be the main actors in this initiative. We must build not only a home care system, but also a comprehensive community health care system. We are now in an era in which a system run by a single physician such as myself cannot take on the full burden. For the sake of the community, family physicians must cooperate and work together to reduce their responsibilities. The next generations will be called to revitalize the local community and this should probably start with the revitalization of our community of physicians.

### References

1. Koshibe M, Sakuma M, Takase M, et al. Approaches to affiliation between hospitals and stations from perspective of visiting nurse: a consideration of pre-discharge conferences to reassure patients and families. *Japan Nursing Association's Essay Collection*. 2013;43:110-113. (in Japanese)
2. Sasson M, Shvartzman P. Hypodermoclysis: an alternative infusion technique. *Am Fam Physician*. 2001;64:1575-1578.
3. Suzuki H, Ishigaki Y, Fujita A, et al. Field survey on subcutaneous transfusions at home. *Journal of the Japanese Academy of Home Healthcare Physicians*. 2011;12:223-227. (in Japanese)