Is conferring about seriously ill nursing-home patients really that difficult?

# Playing to each other's strengths

The authors of the article *One patient, two worlds – coordination between nursing-home and hospital doctors* in this issue of the Journal of the Norwegian Medical Association (1) conclude that these two groups have different approaches to their patients and there is little communication between them. As a hospital geriatrician – i.e. someone who sees this from one side – I have read the article with recognition as well as wonderment. Is it true that we have such different approaches to seriously ill elderly patients? And that we fail to discuss this together? If so, why?

Nursing-home patients include many frail older persons with complex medical conditions and considerable functional impairment. An increasing proportion of them suffer from various forms of dementia (2). Despite efforts to prevent this happening, many of them are admitted to hospital for emergency treatment. The hospital will take a clinical approach. There is, however, a solid evidence base to indicate that a broader assessment that includes frailty and level of function will produce better results, and that this should apply also to emergency admissions (3). Usually, such interdisciplinary geriatric assessments focusing on physiological reserves and comorbidity are not undertaken, unless the patient is admitted to a geriatric unit (4). However, proper information from the nursing home may perhaps be a substitute for such assessments.

Few studies have been made of differences in approach to seriously ill nursing-home patients among different medical specialties. Local conditions, cultures and traditions most likely have an effect. From my viewpoint, the work of Romøren and collaborators (1) is an important reminder that we (the hospital doctors) ought to contact the nursing-home doctors more often to discuss these patients.

The article reveals that the organisation of the medical services has a bearing. Many admissions from nursing homes to hospitals are made by out-of-hours doctors who are unfamiliar with the patients and the provisions that have been made for them, for example how intensively a specific patient should be treated. The hospital doctors describe how patients often arrive with scant or no admission records. This makes it difficult to assess treatment intensity, and the result will often be over-examination and over-treatment based on the notion that the patient was after all admitted and as much as possible should be done. This is an area for improvement, the responsibility for which rests with the nursing-home services. The hospital doctors claim that it is easier and more time-saving to provide information in the discharge summary than to attempt to reach the nursing-home doctor on the telephone. This approach eliminates the opportunity to receive important feedback from the nursing-home doctor and discuss the further treatment plan. Moreover, the quality of the discharge summary will determine the treatment that the patient will receive after his or her return to the nursing home.

Time will also be a critical factor for us in the future. We will not have more time to communicate with our colleagues across the health services. We thus need to communicate in a time-efficient manner. Having more meetings is unlikely to solve the problem. Telephone conferences are regarded as a useful solution and a good meeting-point for communication and should perhaps be used more often – and not only on matters pertaining to admissions, but also from the hospital doctor to the nursing-home doctor. Part of the problem lies in the fact that it is easier to contact an on-duty hospital doctor than a nursing-home doctor with responsibility for patients. Simple measures, such as adding the nursing-home doctor's telephone number to the referral document, could improve this situation. In addition, increased use of communication systems between doctors may perhaps be useful. My impression is that electronic nursing and care messages (PLO messages) work well in the communication between the primary health services and hospitals, and this system might perhaps be used more extensively also for purposes of doctor-to-doctor communication – preferably with the added message «could you call me (on number xxx xx xxx), so that we can discuss this».

Differences in attitude are often associated with differences in «language», different diagnostic methods and differences in competence. The nursing-home doctors observe the patients in their accustomed environment, while the hospital doctors observe them in emergencies where it is hard to tell how they normally are doing. On the other hand, the hospital doctors will be able to make a more specific diagnosis of acute illnesses and have better opportunities to treat these. Both these issues need to be taken into account in decisions. We need an understanding in the hospital that information that can be obtained from our colleague in the nursing home could help improve the decision-making process (3). A systematic identification of functioning and clinical problems and a preparatory conversation in the nursing home might accommodate the hospital's needs and provide important information (5).

It is not difficult to endorse the concluding commentary in the article: «The expression «to play to each other's strengths» could perhaps provide inspiration in this effort to achieve change. Nursing-home and hospital doctors could obviously enjoy benefitting more from each other – in the patient's best interest». I propose that we should make more use of locum schemes and invite each other to exchange knowledge as part of internal training programmes.

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**References**

1. Romøren M, Pedersen R, Førde R. En pasient, to verdener – samhandling mellom sykehjemsleger og sykehusleger. Tidsskr Nor Legeforen 2017; 137: 193–7.
2. Helvik AS, Engedal K, Benth JŠ et al. Prevalence and Severity of Dementia in Nursing Home Residents. Dement Geriatr Cogn Disord 2015; 40: 166–77.
3. Conroy SP, Turpin S. New horizons: urgent care for older people with frailty. Age Ageing 2016; 45: 577–84.
4. Gladman JR, Conroy SP, Ranhoff AH et al. New horizons in the implementation and research of comprehensive geriatric assessment: knowing, doing and the 'know-do' gap. Age Ageing 2016; 45: 194–200.
5. Beslutningsprosesser ved begrensning av livsforlengende behandling. Revidert 2013. Oslo: Helsedirektoratet, 2009.