

## A Study of Hemiplegic Patients at an Outpatient Clinic

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### Abstract

This survey was designed to study hemiplegic patients visiting an outpatient clinic. The subjects were 38 hemiplegics utilizing the outpatient clinic at Kawasaki Medical School Hospital. The items in the survey included : 1) the length and frequency of visits, 2) FIM (functional independence measure), 3) the purpose of the visit, and 4) activities outside the home. The mean length of treatments was  $65.2 \pm 40.6$  months, and the mean FIM score was  $108 \pm 18.9$ . Nineteen patients visited the clinic to maintain motor function. Twenty-two patients did not leave their homes except to visit the hospital. The results showed that visiting the outpatient clinic was a long-term habit and many of the patients showed a high degree of independence concerning their ADL.

### Introduction

Physical therapy at outpatient clinics plays various roles in the lives of hemiplegic patients, including improvement or maintenance of motor function, improvement or maintenance of the abilities of ADL, advice on adapting the home, and promoting social activities. However, care at outpatient clinics tends to become a long term process, and the real purpose for visiting the clinic becomes unclear. The purpose of this survey was to understand why hemiplegic patients visit outpatient clinics, to determine the problems and to find solutions.

### The subjects and methods

The subjects were 38 hemiplegic patients of the outpatient clinic at Kawasaki Medical School Hospital. The mean age was  $65.6 \pm 9.6$  years, and the mean time post stroke was  $85 \pm 51$  months. The items in the survey included: 1) length and frequency of visits, 2) Functional Independence Measure (FIM), 3) the purpose of the visits, and 4) activities outside the home. The investigation was by direct interviews with the patients.

### Results

1) The mean length of treatment was  $65.2 \pm 40.6$  months. Nineteen patients came to the clinic every two weeks. 11 patients visited once a week, and 6 patients visited once a month.

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Table 1 Mean FIM scores

Mean score		Mean score	
<b>Self Care</b>		<b>Locomotion</b>	
Eating	6.7	Walk/Wheel Chair	5.6
Grooming	6.3	Stair	4.5
Bathing	4.6	<b>Communication</b>	
Dressing upper	5.1	Comprehension	6.9
Dressing lower	5.1	Expression	5.8
Toileting	5.8	<b>Social Cognition</b>	
<b>Sphincter Control</b>		Social interaction	6.9
Bladder management	6.8	Problem solving	6.7
Bowel management	6.6	Memory	6.9
<b>Mobility</b>			
Transfer bed, chair	6.3		
Transfer toilet	6.2		
Transfer tub	5.8		

**Mean total score 108±18.9**

2) The mean FIM score was 108±18.9 points with 29 patients getting more than 100 points. More than 70% of the patients got a score above 6 points on each item except Bathing, Dressing and Stairs (Table 1). The FIM consists of 18 items organized under the six categories of self care, sphincter control, mobility, locomotion, communication (including comprehension and expression), and social cognition. Using the FIM, patients were assessed on each item on a 7-point scale, ranging from complete independence (value=7) to complete dependence (value=1). The maximum FIM score was 126 points [1]. The results showed that the patients had a high degree of independence concerning their ADL.

3) Nineteen patients said they visited the clinic to maintain their motor functions, and 19 patients went to improve their motor functions. In addition, many of the patients declared that they felt relief after visiting the clinic and that they would continue to visit the clinic until their purposes were achieved.

4) Twenty-two patients did not go out of their homes except to visit the clinic, 4 patients went to work, and the others took part in community activities.

## Discussion

The results of this survey showed that visiting the outpatient clinic was a very long-term habit for these patients, while their FIM scores showed a high degree of ability for ADL. Many of them didn't need assistance for their ADL, and they probably could have maintained their motor functions without visiting the clinic. However half of the patients visited the clinic for improvement of their motor functions, even though they had a high degree of independence concerning their ADL. Improving motor function is important, but it should not be continued on a long term basis, especially 85 months after the stroke. Furthermore, visiting once a week or every other week is not enough to achieve the purpose. Physical therapists understand the contradictions in this situation. Also, 22 patients did not go out except to visit the hospital, which could indicate that the clinic becomes a place for social contact. The author's interpretation of the overall situation is that the patients have achieved the goal of physical therapy in terms of motor function, but not in terms of proper goals of rehabilitation. Many still continue to depend on the clinic.

Why do they continue to visit the clinic for such a long time? The following five reasons are suggested.

First, they feel relief by visiting the hospital. Improvement and maintenance of motor function was the stated purpose, but many also stated that they felt relief when they visited the hospital. They seemed to greatly fear the deterioration of their motor functions [2]. They feel relief by visiting the clinic regularly and having the physical therapist tell them that their functions weren't deteriorating. It seemed to be connected to the idea that if their functions began to deteriorate, they would be hospitalized for a short time or told to increase the frequency of visits.

Second, a hospital is required to play the role of a welfare institution. Judging from their ability of ADL, most can maintain motor functions by continuing present activities. Therefore, home care offered by community-based rehabilitation programs would be more appropriate than treatment at clinics. There is a welfare program offered by local governments, but it is not sufficient because many of the handicapped cannot utilize the services. The result is that hospitals become welfare institutions.

Third, the medical insurance system has an influence. Because the fee for physical therapy treatment is small, a patient hopes to continue with physical therapy. Also, the hospital can give treatments as long as the patient wants them. For this reason, physical therapy is given to patients who really do not need it. The national medical insurance system is good, but it results in unnecessary medical examinations and treatments, and an increase in medical costs which has become a serious problem recently. According to OECD Health Data, the average number of hospitalization days in Japan is 4 times that of other countries, and the frequency of visiting hospitals is 3 times greater. Therefore, the Japanese Government is considering reform of the medical insurance system, and alternative payment systems are being considered. If a better payment system can be found, the problem may be solved.

Fourth, there is a lack of proper judgement in assessing the need for physical therapy. The need for physical therapy is usually determined on the basis of functional assessments such as FIM. However, the assessments do not have real meaning because the patient can determine if he wishes to continue treatment.

Fifth, medical staff are unable to communicate with the patients. Most of the patients considered their hemiplegia to be an illness, not a disability. Unless they can be convinced otherwise, they will continue to seek physical therapy for extended periods of time.

Members of medical staffs must take responsibility for this situation. If long-term outpatient clinic visits are permitted, patients will continue to expect improvement of their paralysis, which in turn will make them more dependent on the clinic. To achieve the proper goals of rehabilitation, patients must be freed from dependency on the hospital.

## References

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