Domiciliary Visiting by Geriatricians: The Good Old Days?

A Witness Seminar in the History of Medicine

Centre for the History of Medicine
Department of Economic and Social History
Lilybank House
University of Glasgow

Friday 4th May 2007
1.45 – 5.00pm

Sponsored jointly by:
Centre for the History of Medicine
and
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Please note – This is a preliminary version of this transcript, owing to some technical difficulties. We hope to be able to make available a more detailed version in due course.
Introduction

In this Witness Seminar we plan to review the history and practice of domiciliary visiting by geriatricians, a practice that has almost disappeared from our clinical work. Many participants will recall that home visits were instructive in many ways, and that amusing or noteworthy incidents were very common.

As things have changed, it is worth mentioning that primary care services are better developed, and also that training for a career in geriatric medicine has veered towards acute care. As a consequence, recent recruits to the specialty may have little experience of domiciliary visiting, although the role of the community geriatrician is now evolving.

We hope that the audience will comprise geriatricians active during the main period of focus, say 1975 – 2000, plus younger consultants and trainees, together with some medical and social historians.

From the programme you can see that there are 4 general themes, with each session lasting 40 minutes and led by a short talk. These will serve as stimuli for discussion, and we hope for many contributions from the floor. Proceedings will be recorded and subsequently transcribed. Final output will be Archived, probably at the Royal College of Physicians and Surgeons of Glasgow, and we would hope to publish the distilled themes in a peer-reviewed journal.

Please share your views and experiences with us.

Dr Keith Beard, Consultant Geriatrician

Dr Malcolm Nicolson, Director, Centre for the History of Medicine.
# Programme

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Twenty five others also attended, including trainees in geriatric medicine, consultants in geriatric medicine (working and retired), and staff and students from the Dept of Economic and Social History, University of Glasgow.
Malcolm Nicolson: Welcome. This is the first Witness Seminar we’ve had here in the Centre, although we’re following a model established by the Wellcome Centre [for the History of Medicine at UCL] in London and I’m sure it will go very well. Thanks to Keith for organising it substantially and I’ll hand over to Keith without any further ado!

Keith Beard: Thank you very much, Malcolm. My name’s Keith Beard – I know most of you I think or most of you know me; I’d like to add my welcome to that of Malcolm in welcoming you here today. Particularly welcome travellers who have come from hither and yon, from as far away as Edinburgh - the far East - and Aberdeen and especially welcome, perhaps to - oh how can I say it? - our most senior colleagues, John Dall and Joan McAlpine who have come along to join us and share their experiences with us this afternoon.

Some of you will know that I’m something of a part-time geriatrician these days. I may be part-time, but I consider myself rather old-fashioned in some ways. I trained twenty-plus years ago now and I think I learned my trade in domiciliary visiting - it wasn’t as structured and as well organised as it is for you young folks nowadays. And I suppose on the back of that over the years, occasionally at lunch time when five or six of us would sit down and somebody would tell a story or ‘Guess what happened to me’, I was always impressed that as soon as a person told a story somebody else could top it with a better one and thus it would go for many a happy hour at a lunchtime conversation. I talked for some time about trying to formalise this and do something about recording it, and did nothing about it of course, until in a flash of inspiration about a year ago I put fingers to keys and looked up the University website ‘History of Medicine’ - and found the then-Director, Professor Anne Crowther - I sent a brief note to her and basically said what I’ve said this afternoon, and to my astonishment she replied instantly and said ‘Great idea – my colleague Malcolm Nicolson will be happy to co-ordinate it for you.’ [laughter] So that’s sort of how we got to be here with the theme of ‘The History and the Current Practice of Domiciliary Visiting’. So it’s very general - I jotted down some thoughts last night, words that spring to mind and we might enlarge on some of them: Alcohol, Animals, Attitudes, Characters, Fractures, Housing, Medicines, Photographs, Squalor and Students - I might say those last two are separate lines and not meant to be joined together! [laughter] They are just random thoughts of some of the ideas and experiences that I had when visiting patients at home, and I expect we shall hear more on some of those.

I would like to add thanks to colleagues, to Iain Lennox, to Margaret Roberts and Bill Reid who have really been instrumental in helping shape my original thoughts into the format that we’ve got today. My initial thought really was to sit down – six or eight people round a table with a microphone and just talk, as I’ve said a sort of ‘extended lunch-break’ - and record it and see how it would go. But I’m grateful to Malcolm for his guidance on format. We had a very useful talk some months ago and Malcolm thought that, while my suggestion would be good fun, it wouldn’t necessarily be the best way to capture the essence of the thing, hence this fairly structured programme that you have before you with some short talks, but with the bulk of the time being available for discussion and contributions from the floor and that’s what it’s going to be about for sure. We certainly hope to take - you’ll see Steve, our technician in the back corner here recording away in all sorts of formats - we’re going to take this and archive it away and we’re also going to take it and transcribe it, then Malcolm and I will try to make some sense of it and abbreviate it in a summarised format. I spoke briefly with the archivist at the College last night, Carol Parry, and she would be very interested and would hope to get the output for posterity in digital recorded format too. So, be on your best behaviour, you’re going to be recorded for ‘Posterity’.
The only real bit of housekeeping I think we need to say for contributions is just that - because we're recording we will have a microphone that we will have to use for contributions from the floor and we might delegate some volunteers to act as runners to do that, just to hand it round. I think for Malcolm's and my sake, it would be helpful if you could remember to say who you are when you speak. I know it takes away a little bit from the spontaneity of it but I think it's really essential for us.

So, a few short talks, but mostly - "Chiefly Yourselves!" - as they used to say. You'll see from the programme, the only change is that you would be expecting to see Dr Brian Williams chairing this first session. I'm sad to say Brian's had to apologise for absence and, clearly because of his experience in this field and his stature as President of the College we would have liked to see him, but perhaps not surprisingly he's been called off on Presidential duties. However I'm pleased to say we have a more than able stand-in, my colleague Iain Lennox has agreed to chair this first session, Iain, almost as senior as Brian, but not quite! [laughter] I'm going to hand over to Iain to chair this first session. You'll be pleased to know there's no feedback form, no assessments and no voting paper that you'll have to cope with. So with that, Iain, can I ask you to take on this first session.

Iain Lennox: OK, thanks very much, Keith. Just to clear up the Brian Williams connection, his seniority to me - when I arrived at the Victoria Infirmary in July, sorry, August 1972, I met an SHO starting his first day – a tall, bespectacled, distinguished looking chap whose name was Brian Williams, so he's exactly one year ahead of me. I'm not going to say very much at all before getting us under way, just to say how pleased I am to be here, I think this is a unique event and it's nice to see so many of the trainees here because you'll hear about stuff this afternoon that, unless there's a major change in medical practice, you'll never see the likes again, so hopefully we'll all enjoy ourselves.

OK, our first speaker to get the thing rolling, is Dr Jim Davie; Jim has spent most of his career, in fact it's getting on for most of your life now [laughter] at Stobhill - I actually went to Stobhill as a Senior Registrar and Jim was at that time in Pittsburgh, wasn't it, doing some psycho-geriatrics in the United States and I, in fact, did my first faltering domiciliary visits in the North of the city. Jim has a wealth of experience in this subject and we look forward to what you have to say.

Dr Jim Davie: Thank you very much, Iain. Once again can I just reiterate how nice it is to see such a good audience here today and it's very nice to see some old faces that we haven't seen for a number of years and very glad that you could come along today. When I see you I begin to tremble a bit because your experience of domiciliary visits was probably so much greater than mine. I think you all know that domiciliary visits were built in to the health service organisation in 1947 and '48 and it was felt generally speaking to be something that would be valuable and it was well recognised that physicians, geriatricians, surgeons, etc, would go out into the community, meet with the general practitioner and go and perform a domiciliary visit. Of course that was very helpful, in theory anyway, to both sides and I think you've also got to remember that in those days medicine was very 'low-tech' - I mean ECGs were virtually not invented, and I've got a little story about them and also chest X-rays which in fact were pretty 'hi-tech' stuff - it was often based on what this experienced physician felt.

My very first experience of a domiciliary visit was aged ten! Our general practitioner came to the house with a consultant to see my father who was not very well at the time and several things about that: I mean, first of all, I think it's reasonable to say that the general practitioner came with the consultant and I think it was a way that GPs saw, in fact, of having their 'nice' but not particularly rich patients seen quickly by a consultant rather than having to go along to the riff-raff of the Out Patient
Department and it was used a lot in those days. Now following this I didn’t know much more about domiciliary visits until I was an SHO in medicine at Law Hospital and there was a character there called Andy Muir. Andy Muir was a very, very bright man and I think he’d got into maybe a little bit of a rut at Law Hospital but it was great fun to work for Andy Muir. He was a big gruff man and he didn’t do private practice, but he did, as a physician - and he was a physician - a huge amount of domiciliary visiting, and of course I was his SHO. I wasn’t part of a pool, I was his SHO and probably the worst thing to happen to you was the day after you’d been receiving and you got this phone call ‘Hullo Jim, it’s Andy Muir here, this man’s had a massive coronary, you’ll need to admit him right away’ and of course that would be you stuck for another hour because it didn’t go to the Receiving Physician. Andy was one of those very good physicians who’d started practising really before the days of ECG machines, but you got paid an extra £5 if you took an ECG machine out with you on a domiciliary, so he duly did that and he couldn’t work it! Not only couldn’t work it, he couldn’t read it. And it seems extraordinary now when you think, a consultant physician wouldn’t be able to read an ECG, but it hadn’t been part of his training. And so ‘Oh it’s terrible, this ECG’ and up would come the man, terrified, he’d have a little bit of chest pain and you would do a proper ECG and it was completely normal and he would send his one up and it was just a squiggly line - I don’t think he knew where to put the leads! [laughter] And so the big problem was the next morning explaining ‘I think, sir, this must’ve just been a coronary spasm or something, he seems fine now’, and the man was duly discharged!

But physicians did a lot of domiciliaries in those days as well as geriatricians. When I started at Stobhill Hospital as an SpR – or SR in those days as they were called - in 1975, domiciliaries were in full swing and it was a big part of the practice. I worked with Robin Kennedy and he was mainly the person that taught me most of what I know about geriatric medicine. Obviously a lot of domiciliaries came in, he was a busy man, and within about three months of being an SpR I was out doing domiciliary visits. The big problem was that being an SpR, you weren’t paid - and imagine the joy when Robin went away for a three-month sabbatical in the States and I did a locum, I think in my second year as an SpR, and I actually found out how much he got paid for doing all those domiciliary visits! And you really were doing a lot of domiciliary visits in those days and they were a fairly major source of income. I see Roger Smith looking really glum at the back - Roger was a senior lecturer - and senior lecturers weren’t paid for doing domiciliary visits which is most unfortunate! It was actually quite a disincentive to becoming a senior lecturer - I don’t know how academic geriatric medicine survived in fact.

When I started in 1978 as a consultant at Stobhill, domiciliary visiting was a big part of your day and we probably did, sometimes more - Paul Knight was telling me when he did a locum for us he actually did a lot more than this - but I was doing on average about 200 domiciliaries a year, which is quite a lot, it’s about four or five a week - or four a week I think if you calculate it out. And there were a number of reasons for that; I mean nowadays, we just accept that people come up to the day hospital and the GPs refer them or we refer them from clinics. In those days, certainly in our day hospital, we didn’t have direct referrals from GPs and they had to be referred by a consultant and the quickest way of getting them to a day hospital was to come out and do a domiciliary. Also, even 25 or 30 years ago, GPs were not keen to send elderly deteriorating patients into hospital, I mean you didn’t find them turning up in droves as you do now in the acute receiving ward and quite often if a GP felt he wanted a bit of cover he would want a domiciliary - maybe in the hope that you would say ‘I’ll just take them into hospital’ - but also that he had a second opinion. Geriatric clinics then were probably not as widespread as they are today and certainly not as specialised and I think hospital doctors were much less willing to accept elderly patients into a receiving ward.
As the junior SpRs here, you would hardly turn down now, if a GP phoned you up, turn down a 93-year-old lady with a stroke. But in those days, if you were busy, they were quite often turned down. I think you have to remember also, in those days, stroke patients and even patients with an acute coronary syndrome – if they were in their later years it wasn’t necessarily seen that an awful lot could be done for them. It wasn’t seen that necessarily they would benefit from medical care, or medical care in hospital, and so you were often asked to go out and see those types of patients as well. There was this concept too of an ‘Emergency Domiciliary’, which, if you think about it, is a bit ridiculous. Also I think the last factor is that you didn’t have nearly such comprehensive outreach, post-hospital discharge community involvement services. I mean you didn’t have the physiotherapy in the community that you have nowadays, you didn’t have such an extensive system of follow-up from hospital, so there were a lot of factors, which probably made it necessary to have more domiciliary visits.

When I started in 1978 there were a number of GPs who came out with you on the domiciliaries, the majority didn’t, but there were still some who wanted to and of course that was good and you got first-hand information about the patient and the patient was terribly impressed that there was the GP along with the consultant from hospital - whether you did anything or not is another matter - but it was probably quite a good learning experience. But in this modern day when everyone’s so busy, you can imagine that it was not easy to synchronise a domiciliary visit with the GP in a distant scheme in Kirkintilloch and both arrive there at the same time, and you didn’t have mobile phones either! So it could be very disastrous on occasions. Now when you were doing a lot of domiciliaries the ideal was that these domiciliaries would be ‘bunched’ and I suppose a real benefit, if you actually managed to get three domiciliaries in the same afternoon in Barlancock that was great - short time spent, lots of money earned and three patients seen quickly! The real nightmare was an urgent domiciliary in Banton - for those of you who don’t know the district Banton is almost at Stirling, it’s the furthest reach of our catchment area - it sits in at the bottom of the Campsies. No one’s been to Banton and no one in Banton ever comes out! [laughter] It’s got about fifteen streets but none of them with street names on them - they had names but only the local inhabitants know them so it was a nightmare going there in the dark on a Friday afternoon and trying to find your person, you’d spend about an hour and a half doing a domiciliary. And the other bad ones were Possil - darkest Possil, in fact - if you were a lady doctor you should take a large SHO along with you, male preferably - I never had any problems as long as I remembered to take along a 50p piece for the ‘minder’ and some raw meat for the pit-bull! [laughter] So these could be quite interesting.

Now the minimum kit you’d need, I think, for a domiciliary is first of all you need a car, preferably an old one for some of our districts in the North of Glasgow, address and summary, street map and nowadays, of course, if we’re doing them, which we rarely do, we take a mobile phone. When I first started we didn’t have mobile phones, and very few of the elderly people that we were going to visit actually had a phone in the house, and so there were a huge number of frustrations - I mean you could actually – in one afternoon I did three domiciliaries none of which was successful because I didn’t actually get into any of the houses I went to. You need a pen of course, and I always take a doctor’s bag. Now I don’t like dogs and I think I must show fear when I go in and they always come rushing at you so … so that’s why you need a doctor’s bag. And you also need a stethoscope, torch, ophthalmoscope, neurological kit, sphygmo, bottles and all the rest of it. Remember - I quite often still take blood when I’m going on a domiciliary visit and the most embarrassing thing is you get all your syringe and your bottle and everything all ready and you’ve forgotten your wipes and cotton wool and it’s very difficult using your own handkerchief - and unhygienic! In case you do a further examination, - if someone else is in the house, gloves and KY
jelly, and last of all a spare pair of trousers! [laughter] I kid you not, I have done this three times and it’s a very painful experience and you will not repeat it - divan bed, abdominal examination, squelch! [laughter] - very unpleasant - I always look down before I kneel.

I’ve argued to audiences the pros and cons of domiciliary visiting and I think you can argue from both points of view. I think a lot of the arguments we used to use for domiciliary visits such as ‘it gave you an insight into the home circumstances’ - although valuable, that can probably be a lot better done by an occupational therapist - and nowadays with our job plans and the amount – the big increase - of in-patient and out-patient work we do in hospitals, I mean there’s no way that we could fit in a sort of domiciliary commitment that we used to have and I think it would be completely impractical. I think that there are still a few circumstances when a domiciliary visit is necessary - I must say I’ve always enjoyed doing domiciliary visits, I enjoy seeing the home circumstances, sometimes not particularly salubrious, I enjoy meeting people in their own homes - but I think now there are still several areas where it’s probably legitimate still to request a domiciliary and not unreasonable for us to try and do one. Now if you think about it logistically, if you’ve got somebody weighing 250 kilogrammes, they’re three stories up without a lift and they’re immobile - now is it easier for Mohammed to go to the mountain or the mountain to go to Mohammed - and the answer is Mohammed to go to the mountain.

So it’s much easier to go and do a domiciliary at least as a ‘find-out’ thing in those circumstances than to try and hector a 250 kilogrammes lady down three flights of stairs into an ambulance and up to Out-patients - I mean logistically you’d need at least four ambulance men to do that. Also, I suppose, having been here for probably far too long now, I got to know a lot of the general practitioners very well and sometimes you’d be phoned up where a GP really thinks this person should be terminally nursed at home, but there’s been no other opinion, there’s been no hospital opinion, and the relatives are a bit anxious and he’s a bit anxious in case he’s missing something, and what you’re doing there for this very ill patient whom you don’t really want to cart up to hospital, is you’re going there and giving him a genuine second opinion which he can use and will be helpful both for the relatives and to himself. And the third one I find happens sometimes is the patient - and the last two visits I’ve done have been like this – where the patient has been adamant that they’re not going to hospital or not going for any further investigations, the GP feels they’re far from the end of the road, they do need some further investigation and you, I suppose, are brought out as the ‘heavy’ to come in and say ‘Well Mr McPherson, unless I see you in hospital in the next few days you’ll be dead’ - don’t put it quite like that, but it persuades a lot of people that they will have further investigation and that’s quite useful again. I think these are three legitimate reasons for still occasionally doing domiciliary visits. Thank you very much.

laim Lennox: Thanks very much, Jim. The floor’s now open for the next twenty minutes or so, ladies and gentlemen. We’ve got the roving mike just appearing from the back. I just wonder, Jim’s raised a few issues there - the question of difficulty of linking with general practitioners - does anyone from their experience - was it different from that - did GPs always come, or often come? Jim’s reflects my own experience that I can think of only one GP who liked to be on visits. Any other … ?

Christine McAlpine: Christine McAlpine - Stobhill - It’s just a comment - while I was in Stirling, certainly just after I went to Stobhill, the Strathblane GPs always came on domiciliary visits and it was very good and they were the only GPs that did in my experience. But it was very good, you went out, met the GP at the health centre, he had the notes, went to the house, patient knew you were coming, he would discuss with the patient why the consultant was here, you would go over whatever you had to
do, summarise it all, and it did at the time seem a fairly effective use of time. Certainly for somewhere like Strathblane where the residents kind of resented the fact that they belonged to Stirling, they felt they could just nip down to Glasgow much more easily, taking the consultant out in what was a quite effective use of time, I thought worked well. Other than that I must say I enjoyed domiciliary visits, on my own or with the dog or whatever.

Iain Lennox: So perhaps a slightly rural aspect to that. Anything from the North-East?

Willie Primrose: Yes, when I went up to Aberdeen, it was still functioning a bit in the legacy of how Leslie Wilson used to kind of run things, although he had retired by a few years and the culture in the service there was that everybody was visited before they were admitted, so there were visits all the time. They were also seen as ‘Home Visits’ that the department in a sense decided to do, rather than the GP requesting, so in a sense no fee was requested and no fee paid, so it was a service that didn’t charge for the domiciliary visiting service, but included it as basically part of what people did. Now it didn’t quite remain like that but there was a sort of culture of the Department visiting because it reckoned it was a good thing to do. It’s a different story now, but we’ll come to that later.

Iain Lennox: John Dall

John Dall: Thank you very much, I’d like to follow that by saying in the early days there weren’t sufficient consultants, particularly in a speciality like geriatrics and if you go back to Stobhill in the early days, Ferguson Anderson was there with perhaps two assistants and a lot of juniors. Visits were pouring in and if the visits were just shared out anyone could go and see one, so there was no charge for the visiting because these were visits made by SHMOs, JHMOs, Registrar, anybody who was available to go and do a visit, did a visit, and then we sat down and worked out the priority of admission. As Willie has just said, admissions were done from the waiting list and the priority you were establishing was the priority the person would have on the waiting list, so there was no charging at that time.

Now I was partly responsible for a change in this in that I went to my first consultant appointment at Paisley where I was appointed in ‘Medicine with Duties in Geriatrics’ and one day I’d be out doing an acute coronary visit in somebody’s home and the next day I’d be out seeing an old lady with a stroke with the same doctor. The doctors came with us very - well, most times the doctors came with us. So you couldn’t charge for one visit and not for the next visit, so eventually I said ‘Right well I’m charging for all the visits I do and if you want me to cover a visit, I’m charging a domiciliary fee.’ Ferguson Anderson and I had some difficulty over that, but eventually more and more consultants began to do more and more visits because as Jim said, beds were short, and family doctors did not want to put everyone into hospital. A lot of old people did not wish to go into hospital, and you were often called out to reinforce the family doctor’s opinion that there was nothing more to be done, no more investigations needed, no more tests to be done, this elderly person was now in their dying years and it was just a question of looking after them and that was a very valuable service, very valuable. I would say, if I look back, the first hundred visits I did in Paisley - which was my first appointment, Joan will know more about this - most of the doctors asked me to come out and reinforce their opinion. They knew what was going on, there was nothing - antibiotics were fairly scarce at that time, never mind ECG machines - and you just did a good clinical assessment of the patient and said ‘Right, there’s nothing more I can do here and I agree with the family doctor that we just carry on with the sedation we’re doing.’

Iain Lennox: Colin Currie
Colin Currie: Roger and I worked - Colin Currie, Edinburgh - 30 years ago I worked for a chap called Jim Williamson who set up the City Hospital - very, very pro-active visiting policy and I think some survivors of this are amongst us - he was truly remarkable, he touted the GPs when he started the department, he said ‘Let us know, tell us who the patient is, where she lives and we’ll do the rest, don’t ask for admissions we’ll come and see them anyway.’ And it was labour intensive but we were an academic unit so we could rob the university and serve the health service, it was great fun. Some of the GPs took this as ‘Just tell us where she lives and we’ll tell her what’s wrong.’ The word was ‘Just get us there’ and a memorable letter which was pinned on the department notice board for some time read ‘Dear Doctor, this nice old lady who lives at the top of Auchendinny Brae, has been going downhill for some time’ [laughter] Non-specific presentation of disease - and off one went to Auchendinny. It was great fun and it lasted, I think, for about ten, fifteen years and I still meet retired GPs in Waitrose, who say ‘Oh it was great, the City Hospital service, nothing like it!’

Keith Beard I think that was a story from Nether Auchendreich! [laughter]

Iain Lennox Roger Smith from Edinburgh

Roger Smith Roger Smith from Edinburgh - Auchendinny is on some slope, I tell you. No, I think the other issue you that touched on, Jim, was people who didn’t want to come into hospital and the story I always remember was an 83-year-old who’d gone into congestive cardiac failure and having examined her I said, ‘Well we’ve got two ways of treating this – the quickest way would be to take you into hospital for three or four days, but we could treat you as an out-patient, you know treat you at home and get you better but it would take a bit longer.’ She said ‘Well I can’t possibly come into hospital.’ I said ‘Why not?’ She said ‘I’ve got my mother to look after’ - ‘83? Oh really?’ Because I’d done her AMT and it was ten out of ten, I thought ‘Something funny here’ and said ‘Where’s your mother?’ She said ‘In the bedroom next door.’ I said ‘Can I go and see her?’ ‘Yes’ and we went next door and ‘Hello!’ Here was mum 105 lying in bed! So there are good reasons for doing domiciliary visits because, I think, in all seriousness there were a lot of patients who could easily have been shot into hospital but who didn’t want to come in or were better off at home, away from - well those were pre-MRSA days, so - but were better off at home and could be managed at home and it was surprising that if the will were there to stay at home, they stayed at home.

Iain Lennox: Paul Knight

Paul Knight: Thanks, Paul Knight, Glasgow. Jim, you mentioned the irritations of domiciliary visits in the sense of you go out with a fist of visits and hoping for a good pay-day at the end of that afternoon, finding after your third visit you still haven’t got in. These were the days before mobile phones, which weren’t much use even when you got them because they never answered their phone anyway - you could hear it ringing but nothing ever happened. I can recall going out to a house in Baillieston once - and it was the third visit of the afternoon - and I hadn’t managed to get into the previous two and this was on a reasonably busy road, it was a main bus thoroughfare and I pressed the doorbell and nothing happened. I couldn’t hear anything and I looked through the letterbox and I could see this guy lying on the couch and he didn’t look all that well, he was breathing but it didn’t seem by very much. So I went round to the front of the house and I chapped on the window and meanwhile people were going up and down on the road saying ‘Oh there’s a guy chapping on the window’ - and the chap inside waved to me faintly and I opened the top window - I thought ‘I could maybe get in’ [laughter] - this is a true story! And so I climbed up and through the top end of the window, meanwhile a bus went past and people got off at the bus stop saying ‘Hey there’s a guy trying to get in this window - with a bag and a suit and
everything!’ But the counter to that is that the amazing number of older people who just leave their doors open and you knock on the door, push it open and you shout ‘Hello’ and ‘It’s the doctor here’ and they don’t ask for any identification, they just trust that you’re ‘all right’.

Iain Lennox: Joan, did you want to make a point?

Joan McAlpine: I’ve been most interested in the comments and I’ve been handed by a colleague a photocopy of something I wrote on domiciliary visiting, some time ago of course. Now I thought domiciliary visiting was very helpful to me, to the GP and to the patient. It saved unnecessary admissions because if it was a good GP who came with you and gave you the whole history and you saw the patient with them and examined them, you could recommend a form of therapy that you considered probably would be beneficial and so on. And in other cases you would go without the doctor and this was helpful too, because you could uncover things the doctor didn’t tell you and you could see the home circumstances. I know you said that you could find that out from the occupational therapist but they go for a different reason - they don’t look in the drawer where all their medicine is kept and find out what they’re not taking and what they are taking and so on, and so I think it is beneficial to go. There was an instance, shall I say, that the good doctors usually came with you and you had no worries, the other ones who didn’t come with you - you were glad you had gone because of what you found out.

On one occasion I went with the doctor to see an old couple – the lady was the patient, the husband was blind and he was in the house too and it just so happened that he was in his bed at the time I came to see the pair of them - only one, but I knew about the blind man - so it was obvious that I needed to take the lady in, she was obviously very anaemic, not well for whatever cause, and of course we had to get the old gentleman, who could normally get up and about but he was blind, so he was taken in to a residential home. After a few days the residential home phoned me and said ‘You really need to take this man away, he’s so confused, falling out his bed, wetting the floor, he’s making a terrible mess everywhere, we can’t have this …’ Now he wasn’t the least bit confused when I saw him, so I went to see him and I went to see the room he was in. Now I recalled which side of the bed he lay on because I’d seen him in it and they had the bed turned the other way so he automatically came out the wrong side and so this was the problem. So I said, ‘If you turn that bed another way, the man’ll not have any problem at all, he’ll be fine.’ And so it was, otherwise the poor soul might have been in Dykebar! [laughter]

So altogether I thought they were very beneficial and it also kept - I mean - at one time I took emergencies in, but one Saturday I was in doing a visit and a doctor phoned and this was a doctor whom - I knew of him and I’d met him and so on - but I didn’t know just how bad he was - and he said ‘I’ve got a patient here and she’ll absolutely have to come in right away.’ I said ‘Why?’, he said ‘She’s as pale as a sheet - I’ve never seen anyone more ghost-like, have to come in.’ I said ‘Is she ambulant?’ ‘Yes – oh she’ll need to come in, she’s in an awful state.’ So I thought ‘Och well, I had a bed.’ I said ‘Just send her in’ - a very well-known practitioner, high up in the BMA and all that kind of stuff. [laughter] So in she came and she was as mad as a hatter - and she wasn’t pale, she was a bit like Keith there! And not the least bit pale but just absolutely bats! And so I never took one from that practitioner again without going to see her, never; because there are some completely untrustworthy people! I won’t say any more, but I could go on and on - but I’ve overdone my time. Thanks.

Iain Lennox: Thank you Joan, you will get another shot! No other pressing points? I just wonder - we’ve had a kind of flavour coming from Jim and supported from the floor from senior colleagues, that these really were good things to do and the fact is that
we do very, very few now, practice has changed dramatically. Does anyone take the view that ‘Ach this is old-fashioned stuff and not part of modern medicine?’

Colin Currie I’m wondering if it’s not time to look at this again. Among Jimmy Williamson’s many bright thoughts and innovations, one of Jimmy’s great quotes was that the most important research question of all is ‘Who’s going to do it for you?’ - he invented something called ‘The Augmented Home Care Scheme’ which was intensive domiciliary management of some quite sick people. One of the patients delightfully spoonerised it as ‘The Augmented Home Scare Scheme’ - you know, I mean going and knocking on a door in Wester Hailes to see an old lady you’d digitalised overnight was quite interesting, and shuffle, shuffle, shuffle, you could hear the zimmer rattle when she came to the door - ‘Great’ you thought ‘We’ve won.’

Now that was a long time ago and it was really intensive management at home, kind of ‘hospital at home’ stuff. It all went away, but I’m just beginning to wonder, given the perils of bringing older people into hospital and given the downside of incarceration and the risk of late discharge, what’s happening in your IRIS schemes? What sort of - do North Glasgow geriatricians who work with these management schemes often get called out by a GP to give a second opinion on someone who’s having fairly intensive management at home by the, sort of, Intensive Rehabilitation Integrated Service or whatever. Is it time to revisit that?

Jim Davie The IRIS scheme, basically, recently, I mean it’s used a lot to precipitate early discharge from hospital and I think it does do that and they will often consult with us if it’s going to pigs and whistles, but the usual result of that is probably to have to bring the patient back in again. I mean, the IRIS one, certainly, we’re in close consultation with – and that works quite well - the actual community-based schemes we don’t hear nearly so much from.

Paul Knight The IRIS scheme, for the sake of the record, as they say, is an out-reach scheme comprising nursing, OT and physio and sometimes pharmacy and CPN as well. The essence of that is that currently we meet with them, on usually a weekly basis and respond to their queries. The number of times I have had to go out and see somebody at home as a result of that is actually very small, normally they can give me enough information and if it’s - it’s usually a cut and dried thing - either you have to bring them up to the Out Patients or Day Hospital or you have to bring them in and they’re very good at knowing which of these it has to be.

With the other kind of community-based outreach teams, and I think we’ve got to remember that Primary Care has moved on somewhat in the last twenty years and their ability to co-ordinate care is better than it was, that what a lot of these teams need now is guidance and they don’t always get that in a medical sense. That doesn’t mean that you have to see every single patient that there is but you need to be a back-stop for them, so that’s a slightly different role, but it’s very difficult to do that if you’ve never had much experience of seeing people in their own homes.

Iain Lennox: Thanks, Paul. OK, Margaret?

Margaret Roberts: Margaret Roberts, Glasgow. I wonder from what I’m listening to if there’s something about the principles that lay behind domiciliary visiting as opposed to the practice is something we need to re-look at, because what we’ve been hearing is that it helped manage resources. I think there was a bit of that in the early days, people didn’t have lots of beds and we’ve heard about prioritisation, that hospital is not necessarily good for patients and there are other ways of managing a patient, either because all they require is on-going care by the GP or there are other ways of delivering rehabilitation. Whether you need a domiciliary visit to support those
principles is another matter, but I think those principles are probably things that we should reconsider just at the moment.

**Iain Lennox:** Right, thank you. Right, we do have to move on to the second speaker, but just before we do so, although practice has changed very much, we have actually exported the domiciliary visit idea. As I was rummaging yesterday looking for any old stuff that might come up, I came across this book from Dr Aoki. Some of you may remember Dr Aoki who spent some time, certainly, at Mansionhouse or the VGU as we called it then, from 1978 and he gives a breakdown - they did 61 visits that year and a breakdown of all the various things that they saw and it has the beauty of being written in slightly broken English, so among things that they gave advice on was - Advice of Mental Hygiene, Adjustment of Human Relation and Family, and Wiping! [laughter]

So moving on, swiftly, to Session 1B, this is going to be led by Dr Bill Reid. Bill, I was just checking with his title, he of course is a geriatrician at the Southern General who did - Glasgow boy - but who did his training in Edinburgh, so that gives another perspective here. He now has a part-time appointment as Associate Post-Graduate Dean (MMC) so we’re grateful to Bill for taking time out from his twenty hour days of interviewing to be with us.

**Bill Reid:** It’s a real pleasure to see so many of my mentors here from various places - I am a Glasgow graduate but I did my ‘Far Eastern’ early training, first of all in the Royal Infirmary and then I was fortunate enough to go and work in the City Hospital in Edinburgh with Roger Smith, and Bill McLennan who’s not here. Also good to see John Dall back as well, whose term as BGS president I covered when I was back at the VGU at the time, but he was always very supportive to me and I learned a lot when I was in all these places.

For the trainees who are here today there’s a shocking kind of realisation about this point in your career when you realise ‘Bill, would you mind giving an historical perspective on domiciliary visits?’ and you think ‘Hmm? I might not be quite so young and I might not be quite the new consultant that I felt inside.’ But I think there is a lot of relevance to talk about this at the moment because you may or you may not, when you look at your curriculum, realise that there are some opportunities out there for community geriatrics. Now community geriatrics is what I did when I was a registrar in Edinburgh and in fact Jim was wondering how the service was covered in Edinburgh, it’s because we shared out all the ‘dommies’ and George Duncan and I who were registrars together in the department at the time, when we came to look for jobs in Glasgow - and Colin will remember because he wrote a radio play about it called ‘Smart Boy Wanted’ - we were greeted with incredulous surprise that we were doing between two and four domiciliary visits a day and we were, but people did not understand that at the time. It was a fantastic experience and in many ways we operated a ‘mobile medical registrars service’ because a lot of the stuff you got very quickly immersed you in the way that you could manage patients at home or the way that you could temporise with very ill patients.

I think it’s very difficult for trainees now to get a feel for the kind of conditions that some of our patients live in and we did see that. We had a very, very sound grounding in the way that the social circumstances shaped health and it’s one thing to be standing in the receiving ward seeing these people coming in through the door, it’s another thing to be going into the house and immersing your smell ... [laughter] Slight Freudian slip there! - immersing yourself not only in the milieu but in the smells and in the atmospheres in the house. In fact Jimmy Williamson wrote a very good paper about the value of the domiciliary visit that I still have somewhere and I can look out, if anyone wants it I can photocopy it.
I think my role here is to talk a wee bit about some clinical curios, but I can’t leave my Far Eastern period behind without talking about a major piece of research that George Duncan and I never really quite completed, which was ‘The Carpet Classification’ and the carpet classification - in some ways Jim alluded to the spare pair of trousers, but there are grades of carpets and the Grade One was definitely the slippy carpet, Grade One was the early stages, Grade Two was the sticky, but beyond that we couldn’t classify the ‘Sticky-Slippy’, the ‘Smelly-Sticky-Slippy’ so there’s a body of work to be done there, maybe a PhD for one of the more academic chaps!

I thought I would just illustrate my part of it with two or three general themes and some memorable domiciliary visits and again when you’re invited to do your anecdotage, it’s definitely a sign that you’re going down the hill in your career. One was - there’s an area in Edinburgh called Parkhead, and it’s not too dissimilar from Parkhead in the East End, but I was once out doing a visit on a lady who it transpired was a retired old-fashioned nurse from the Royal Infirmary in the days when you had to starch everything and turn up wearing your frilly hat and all the rest. This house was one of the dirtiest houses on the floor that I’d ever seen. I think there was a cat - that’s another recurring theme, cats and dogs with demented patients are always very interesting visits - but there was a cat in the house and the cat had left its business all through the house, or whether it was the woman, it was always very difficult to tell, but the rest of the house was spotless! And in every corner in each of the rooms a beautifully ironed and laundered pile of clothes, perfectly folded, perfectly ironed waiting to be put on. Preservation of some parts of the brain in dementia is a very curious phenomenon and again I think there’s definitely a PhD or two in that kind of work. But you will not get to see that as a trainee now, and you won’t get to see it as a consultant because you don’t see the full spectrum of things and alas the end of the domiciliary visit has meant that you don’t get the exposure that perhaps you should do.

One of the other themes - and Keith was a great collector of slides in the days before you had to get triplicate permission filled in and explained to someone how the slides were going to be used - but both he and I over the years collected lots of slides of patients and I was looking through them for inspiration in this talk. I remember going out to a fairly well-known nursing home in Newton Mearns where there was - what was described as - a very mad woman who had been admitted to the nursing home within the previous couple of months and she’d been mad for a long time and she’d just gone off her feet a wee bit, but she was causing problems because she was shouting at the nurses. And the one thing that I noticed in this woman when I saw her, was a very odd appearance of her eyes that I’ve never seen since and I don’t think I ever will see again, but she had corneal calcification and it transpired that this woman had chronic hypercalcaemia - well she had a calcium of 3.6. I don’t know how long it had been going on that way but again, rushed to bring her in – I didn’t know the calcium was 3.6, but I did actually see the corneal calcification - brought her in, re-hydrated her, brought the calcium down and thought ‘Yes, she’s going to get better’ - no she was completely mad, even after bringing down the calcium. [laughter]

So that kind of therapeutic intervention is the other theme that perhaps we should concentrate on. Perhaps it’s also interesting to reflect on Jim’s point about people being in hospital. Twenty-seven years ago when I was a resident in the Royal Infirmary, if you were over 65 you didn’t get into the coronary care unit with your myocardial infarct. You went to one of the medical wards and took your chances.

I think one of the most memorable visits I ever did was shortly after I came to the Southern General from Edinburgh and went out to a house in South Nitshill - South Nitshill’s a very salubrious area now - but at the time when I moved through (well it’s
not that salubrious now but it’s getting there!) - I went to the house and there was a car in the front garden and Satan, the Alsatian, greeted me at the door and I went into the house; there were no carpets on the floor, there was no wallpaper on the walls. There were some very nice family who directed me to the top floor to see the grandfather of the house - there were actually four generations of the family living in this house - and I did notice that there was a pile of dialysate bags lying under the stairs. I said ‘Oh who’s on peritoneal dialysis?’ ‘That’s ma’ daughter’ says she ‘And they said she would get that peritonitis straight away, she’d not had it and she’s been on it for ten months.’ I very quickly picked up that this family were a very caring family, they didn’t quite have the equipment to deal with all the problems they had because when I got to the top floor, the grandfather was in fact lying in his own faeces, really struggling and very ill. And I’m reminded of this because the slide I have in my slide collection is of his cavitating bronchial carcinoma which was the cause. We agreed to bring him in, really for nursing care, but on the way down the stairs Satan defecated on the stair landing and nobody blinked an eye. I remember the famous teaching session I had when I was a student which was ‘Never show any emotion in that circumstance’ although here it was quite hard.

But that was probably the most memorable one, and it was only when Christine was saying about Strathblane, that I did a locum up there for a short time when Dave Kennie who’s here today was absent from his post – for a good reason of course. I went out to Strathblane to see a lady who’d driven her Mini-Metro into the loch beside her house, she backed into one of the lochs in Strathblane, but quite what a geriatrician was going to do - I think it was a case of saying to her ‘Give up the driving lessons’ but she said ‘Och Doctor, I only go down once a week to the shops at Bearsden and it’s on a Thursday.’ So when I got back I told Christine ‘Don’t drive down on a Thursday morning to Bearsden.’ [laughter]

I think I’ll leave it at that, but it was really just to give you an idea of the spectrum of the visits that we used to do, we don’t get the flavour of that any more, but you know to be honest, community geriatrics was our bread and butter and if you do get the chance to go out and see people in their own homes it’s sometimes a revelation. I think you need to do it.

Iain Lennox: Thanks very much Bill. Keith?

Keith Bill and I did share a lot of this work together some years ago. My recollection of the clinical value was actually going without preconceived ideas of what you were going to find because the referral history could be very patchy, and doing the basics properly. We could do a list of the things we found - corneal calcification’s all very well - but for me it was more about atrial fibrillation, faecal impaction, and undiagnosed fractures and things like that on occasion. We’ll come to talk about the educational value, I think, but for me it was about dead ordinary stuff, doing the job thoroughly, and never being surprised at what you’d pick up - and there was lots of it, I see lots of nodding heads in response to that. And that chimes a little bit with Joan’s comments too, I think.

Iain Lennox: Roger?

Roger Smith: Roger Smith, Edinburgh. I recall one phone call from a GP in sunny Wester Hailes in Edinburgh - and he said I got this call as the on-duty doctor at Sighthill Health Centre, the patient isn’t registered with us but I’d be grateful if you could go out and see the man, ‘ I said ‘OK that’s fine.’ ‘Oh by the way he threatened me with a poker!’ [laughter] And so I went out and pressed the bell, nothing happened, knocked on the door and heard noises behind and the letter box opened and this pair of eyes looked out and said ‘Who’re you?’ I said ‘I’m the doctor from the City Hospital.’ ‘Are you alone?’ I said ‘Yes.’ ‘Are you sure? I could beat you up, you
know?’ I said ‘Yes, I’m sure you could beat me up but I’m alone and I’m here to see Mr. So-and-So. ‘Are you the bailiff?’ ‘Are you from the electric?’ I said ‘No.’ ‘I could beat you up, you know?’ And this went on for about five minutes and eventually the door opened and here was this guy five foot nothing, string vest and, like your story Bill, the house was absolutely bare, except for a mattress on the floor and on it was this very cachectic looking chap who was in the shape of a chair and he must’ve weighed about four stone, if that. I examined him and he clearly had a pneumonia - so I said ‘Well, I really feel he needs to come into hospital.’ ‘No, no, I’m looking after him, you tell me what I’ve to do, doctor, and I’ll look after him.’ So I said ‘OK we can get an antibiotic, but I’ll need to see him at the day hospital because he’s going to need a chest X-ray at some time.’ ‘No, you’re no’ takin’ him into hospital.’ I said; ‘No he won’t come into hospital, he’ll come to the day hospital, you can come along.’ and all the rest of it. So the upshot of it was that when I got the notes I found that he had in fact been in the Royal Infirmary a year previously weighing four stone in the shape of a chair and this wee pal had been looking after him for all that time. But it really is an eye-opener what you find behind the door.

Iain Lennox: Thank you Roger. I wonder if I might share with you a case that I came across not long after I was appointed, really to highlight - there’s quite a lot of pathos in it - and it highlights how much community services have changed and perhaps attitudes as well. I was phoned by the then district medical officer to say that there was a case of a lady that he wished to have admitted to hospital under, I think it was, Section 24 of the National Assistance Act or thereabouts, which I’d never heard of, but the bottom line was he was ordering me to bring this woman into hospital for her own good and for the good of those around her. He didn’t have any beds so he needed me to do it. So I went out to see her and she was one of quite a few people in the Victoria Road area of Glasgow which had a significant Eastern European population. She lived on the ground floor of a tenement flat and I was ushered into the house to find this woman who was quite well looking, but in bed, and it turned out she had been stood up at the altar forty years before, and had taken to her bed and had never left her bed - for forty years! She had bilateral leg contractures of course and she survived because next to her bed was a coal fire with a metal grill on it and she would boil water, make cups of tea, she used pads which she burned on the fire, so there was no incontinence problem. She had a brother who got the shopping for her, no home helps, nothing like that, and basically it had all gone wrong because the brother developed an oesophageal cancer and became ill and was unable to support her, and there wasn’t really any other support around at that time. She refused to come into hospital, but I came out and under the Act she was duly brought into the VGU. When we got her in her biochemistry was normal, her haemoglobin was normal, every test we did was normal, her skin was spotless. She said ‘I want to go home.’ I said ‘I can’t let you home, I’ve been ordered to keep you here’; she said ‘I’ll not eat’. She didn’t eat and several weeks later she died in the hospital. And I’ve never forgotten that case - I don’t think that would happen now, I’m sure it wouldn’t. Partly I was, perhaps, inexperienced, partly community services weren’t there to support that sort of exercise, but I think that’s a salutory case which I’ve never forgotten.

OK, any other curios? Willie?

Willie Primrose: Yes – just to pick up on a couple of things. Community geriatrics and certainly, locally, our services, moving in that direction, we had both community health partnerships supporting that initiative, providing resources. One of the difficulties is in recruitment in that there’s a shortage of people to support development of services, but certainly that direction’s being endorsed. I looked - this is just a year or two back - at the last twenty or so visits I’ve done, one of the things we haven’t talked about is Care Homes and the role in supporting the care home
population, but a third of the visits I’ve done were to those in care homes. I think that’s a very useful support to primary care. And that brings me to a very recent anecdote, it’s just about the last visit - maybe last week - it was up in Insch, and it was to see this rather difficult 91-year-old or so. The GP was worried about what was going on and was it polymyalgia, there was certainly a high ESR and the staff told me this lady’s not very co-operative and difficult. Now almost always - with a degree of charm, and you can examine people - you can get what you want - it was about the first time for decades that actually this lady refused to take me on at all - I wasn’t allowed to touch her, to take her pulse, I wasn’t allowed to do anything and despite care staff around me, and we wheedled and we charmed and we bullied - and nothing worked at all. I mean, I did look at the notes and got the information from that, but I did manage to get one bit of information out of her which was when I was leaving I got her to wave at me, so I was trying to get her to demonstrate good arm movement - you knew that she didn’t have shoulder-girdle stiffness - so she managed to wave at me, so I thought it was not a wasted visit! [laughter]

Iain Lennox: Paul Knight - Oh, sorry, Graeme.

Graeme Simpson: Graeme Simpson from Paisley - following on from Joan, I inherited a large domiciliary practice, that has now disappeared with the new contract, but there you go. Just two very quick anecdotes, maybe three. But one, actually from Newcastle when I was a senior registrar, and it was a visit to the house after the patient was admitted; we’d admitted a chair-shaped lady who had horrendous pressure sores around her back and the backs of her thighs and it really looked terrible. And her brother was looking after her, he came in and we soon picked up that he was completely blind, macular degeneration, and so we thought ‘Wonder what’s been going on at home?’ So the occupational therapist and I went to visit the house which was again one of these houses with no wallpaper, no carpets, black bags and newspapers lying around all over the corners of the rooms, very sparse furnishings and in her bedroom there was the remains of a mattress and a bed and she’d been so incontinent that she’s rotted through the mattress and then she’d rotted through the springs on the base of the bed and we reckoned that her bottom must’ve been just about touching the floor by the time she was actually admitted to hospital. And of course he couldn’t see any of this and thought he was doing a good job looking after her at home.

The second story’s about me and it’s a trousers and dog story, so it kind of links the two speakers together. I went to see a young man, a young disabled patient in Johnstone who had neurofibromatosis and he was very unwell. He had multiple spinal cord neurofibromatosis, he was quadriplegic and the fibromas in his neck were getting bigger and bigger and he basically didn’t have very long to live. Now he was cared for by his father, but the thing that struck me as I came up to the house was the yapping of the Jack Russell terrier and there was a kind of commotion as I rang the bell and eventually there was a sort of ‘Hang on a minute till I put the dog in the kitchen.’ And the dog was duly put in the kitchen. The father had obviously been doing a fantastic job looking after this guy and they were very, very switched on and they were asking very pertinent questions - ‘What’s going to happen next, doctor?’ ‘What can we do?’ sort of thing. And the father at this point said, ‘Well I’m going to go through to the kitchen, you talk to my son and tell him what you think should happen.’ So I had this kind of end-of-life ‘What do you want to do?’ ‘Do you want to stay at home?’ ‘Do you want to come into hospital?’ kind of discussion with the son, during which he burst into tears which said something about my skills in talking to patients - and I was kind of perplexed and I tried to comfort him and I said ‘Well, I better go and get your dad to come back through.’ And I pushed open the kitchen door just a little bit just to say to him ‘I think you should come back through.’ and of course the Jack Russell just went straight through the gap and straight for my leg, I’d upset his master
and he was going to get me! So I ended up needing a new pair of trousers and a tetanus injection! [laughter] Thanks very much.

Keith Beard: My two rules of home visiting were (1) switch television off and (2) dog in another room, so I can sympathise with you, Graeme.

Joan McAlpine: Joan McAlpine – again - this is a story about when I had to go and see this elderly gentleman. I went, it was a very nice house and when I went to the door, it was a small hall and it was absolutely filled - or I thought it was filled - with dogs. There were five red setters and a greyhound and I said to the girl who opened the door, ‘I wonder if I could have a word with you before I go to see your father?’ who was upstairs and she said ‘Oh certainly.’ and she opened the lounge door and all the dogs rushed in and each occupied a chair like people, you know, and I said ‘Could we sit somewhere?’ The only chair that was left was one in which there was folded laundry that had just been ironed, they were very well behaved and I got the message all right and the dogs listened very closely! [laughter] Thank you.

Iain Lennox: Thanks, Paul Knight.

Paul Knight: I recall - you were talking about your classification of carpets - the best classification I’ve ever heard was given to me by my mother-in-law who was a triple duty nurse in Fife, somewhat after the Second World War, and her classification, which I think is excellent, is ‘You’re in real trouble when the carpets are like linoleum and the linoleum is like carpets.’ [laughter]

John Dall: John Dall again. Just to follow on from a thing Joan said, Joan McAlpine said earlier, there were some practices that would phone a case in and you daren’t leave them on a waiting list, particularly over a weekend because they’d be dead if you did. So you went there urgently. There were other practices where you could afford to talk to the doctor about it and perhaps go the following week. But I remember doing what would be called now an ‘emergency visit’ at five o’clock on a Friday afternoon because I did not believe the practice. What they’d phoned in was ‘This man is suicidal and homicidal, please visit.’ [laughter] The only other bit of information I had about him was that he was an 85-year-old retired merchant seaman. So on my way to this visit down in the Gorbals, I went into a local hostelry and purchased a half-bottle of whisky. I went up the stairs, I knocked on the door, eventually he came to the door, very gruff, unclean, unwashed and quite demented-looking, but after he and I sat down in the kitchen and he had consumed most of the half-bottle of whisky, he was perfectly logical and quite amenable and came to the clinic the next week for his X-rays and his ECG! [laughter]

Colin Currie: You know - this is a sort of semi-lecture follow-up - you know the patients you send home and you think ‘This won’t last a week?’ We’ve all done those and this is about a visit one did just because one didn’t believe it would last a week. I’ve already been paid for writing this so I’ll read it for nothing! [laughter] It’s actually an old ‘Sounding’ script, it’s called ‘Fading Away’.

He died last month aged 98. I met him first in 1986 when his wife was admitted to the ward confused, incontinent and said to be dying of fungating carcinoma of cervix. We were wrong about that, she lingered on, muddled, dependent; for several weeks. He spent hours each day and half his pension coming in from the country to visit her. Eventually he insisted on taking her home. They lived in a farm-labourer’s cottage with only basic amenities. After a doubtful pre-discharge home visit, we did what we could with no great faith that it would last very long: - home-help, district nurse, day hospital and the incontinence laundry service were all lined up. The GP was willing, the old lady duly went home. Because I’m interested in Home Care and I thought I might learn something I went out to see them three weeks later. The cottage was
indeed basic, toilet, no bath, kitchen little more than a cupboard, old lady well, 
grinning from her fireside armchair and the old man quite delighted to have her home, 
even the cat seemed happy. I’m allergic to cats and this one was moultng. I sat 
sneezing and wheezing and heard from the old man how well everything had worked 
out.

But there was more to his happiness: it was the 16th August, he was celebrating in 
that summer of 1986 the 70th anniversary of the wounds that had brought him home 
alive from the first battle of the Somme. He was proud and glad and showed me in 
succession an odd shaped elbow, a lump on his left tibia, a minor indentation in his 
skull, shrapnel wounds – Blighty ones – a passport home with nothing important 
missing. Then he told me about the battle, his wife watched and grinned, I was still 
sneezing but the hairs on the back of my neck were trembling to attention, it was pure 
Agincourt, He that shall live this day and see old age, then will he strip his sleeve and 
show his scars, and say; ‘These wounds I had on Crispin’s Day’. He had survived as 
many had not and had already managed a full three-score-and-ten thereafter.

They lasted three years more at home, she broke her hip, but despite her confusion 
did well and got back to the cottage. He bled from an ulcer, was cross-matched from 
home and came up with her to the day hospital for three units of packed cells that 
helped a lot. Months later he got a chest infection and we had to bring them both into 
the ward. They occupied adjoining beds, he was coughing up pneumococci and it 
was suggested he be isolated. I left them together as they wished, to take their 
chances with the same organism. Both survived, but he was too enfeebled to look 
after her at home again. They went on to long-term care together where she pre-
deceased him by two and a half years. [It really was Long-Term Care in those days]

When I joined the trade in the ’70’s there were Boer War Veterans around - former 
Bush Veldt horse soldiers then in their nineties. Their First World War successors 
were so numerous as to be unremarkable, now very few [this is 1986] are left. So far 
as I know that spry Midlothian ploughman who joined Kitchener’s army in 1915 was 
the last in my care, I will miss him.

Now, we took students on home visits and on the way home I always asked them 
‘Tell me six useful things you know about that patient that you wouldn’t know if you’d 
met them staring up from under a blanket in A & E.’ And that’s what you learn; we’re 
losing that, we’re losing it for trainees and we’ve no idea what can be coped with at 
home. And if the main task of the Kerr Report is to keep the ‘Free Range Grannies’ 
free range and stop them becoming ‘Battery Grannies’, we’ve got to teach students 
and trainees about life on the other side, in a hospital-based service we won’t be able 
to do that.

Iain Lennox: Thanks Colin.

Roger Smith Could I put on record, I think for posterity and I apologise to my 
colleagues who have already heard this, but I don’t think the trainees will have heard 
this one - the famous Jimmy Williamson home visit in Leith. He’d been examining in 
the Membership and was wearing his best suit and coat and he’d gone to see this old 
lady in one of the tenements in Leith and he went in and said ‘I’m the Doctor.’ She 
said ‘Oh, I thought you were the Elder.’ and he said ‘No, I’m Dr Williamson. I’ve been 
asked to see you by your general practitioner.’ So he took a history, he did an 
examination, and in these days (this was ‘way back) a very full examination including 
a rectal examination. So he then explained that he would like to see the lady at the 
Out Patients, she agreed and he was just going out the door and the immortal words 
were said ‘You haven’t left a communion card!’ [laughter]

Iain Lennox: Graeme.
Graham Simpson: It might just be worth, after that, a wee word about chaperones. I went to see a lady – again - in Kilbarchan actually, very strange folk in Kilbarchan, and this was a patient with hypertension and headaches or something like that - I can’t remember why it was urgent - but the particular GP I think insisted that he wanted a domiciliary visit or she was refusing to come to the clinic or something like that and she seemed perfectly well when I got there. She was walking about the house, she was entirely independent, the house looked quite neat and tidy, we sat in the front room, and I took a history of her headache, which had been going on for ages and was on the top of her head and didn’t sound in the least bit pathological, and she said ‘Do you want to examine me?’ And I was mindful of my training by Jimmy Williamson and thought that I’d better at least do something, so I said ‘Well. I’d quite like to check your blood pressure.’ and she said ‘Just a minute then.’ and she disappeared out of the room into the bedroom next door and then there was a call ‘Right, doctor, I’m ready for you now.’ So I walked through the door and she went [gesture of removal] with the bedclothes – but she basically stripped off the bedclothes and she was completely naked and said ‘Right I’m ready for you to examine me now, doctor.’ So I said ‘Well. I’m just going out the door now, I’ll tell you what, I’ll send you an appointment for a clinic after all.’ and I left the house. It’s the nearest I’ve felt to being threatened – personally threatened - in all the time I’ve done domiciliary visits. [laughter]

Iain Lennox: Right I think, probably, to keep to time we really need to stop at this point and have a twenty-minute break. If I might just use my chairman's position to finish up with a very minor anecdote. Jim was talking about the stiff doctor’s case in repelling dogs. There is a caveat about that. One of the joys of doing domiciliaries in the Victoria catchment is that we do have our Gorbals and our Castlemilk but we also have Newton Mearns, so there’s a nice spread of domiciliary visiting to be done. On one occasion a number of years ago, just before Christmas I was doing a visit - I was actually seeing a Knight of the Realm no less - knighted for political services - with his wife and his private attendant and various sort of people in the room and it being just before Christmas I had put on my Santa tie which - I think it was the staff lunch that day - and I had my case on my lap, taking notes - and this is a posh, really posh set up - being very professional and trying to do the right thing and I leaned forward, forgetting that my Santa tie had one of these little round discs at the lower end of it, and I treated the assembled gathering to a round of Jingle Bells [laughter] which somewhat took away from my prestige on that occasion!

Right, can I just to thank you to Jim and Bill for facilitating our first two sessions. [applause]

Malcolm Nicolson: Not to put too much stress - given some of the stories we’ve heard, but there are further toilets out the door [laughter] - upstairs and downstairs! ***

Keith Beard: Well, welcome back everyone. After a very lively, stimulating first session, let’s move on and in this second session we’re going to talk about a couple of other specific areas. The first is on thoughts of domiciliary visiting and how it interacted or had a role in education and training, perhaps still does, now and for the future. And to lead off, it’s my pleasure to introduce my colleague Margaret Roberts, known absolutely to all of you, well established consultant colleague of mine. Margaret’s been involved in education and training for a long time, very involved in College affairs, BGS affairs, now in management and I’m pleased to say I learned a lot of my trade that I referred to earlier from her. It was she and Iain - who chaired the first session - who took me on my first home visits and showed me the ropes and helped get me going on this fascinating road. So Margaret’s going to say a little bit about the role of domiciliary visiting in teaching and training.
Margaret Roberts: Thank you, Keith. One of the things I was never trained to do was to talk without slides because as you know, as doctors, we all have to have slides. I feel somewhat exposed this afternoon, but I suppose just about as exposed as you feel on a domiciliary visit when you’re working out of your normal comfort zone. I thought I’d get my own back on Keith a little because he said ‘No slides’ but he didn’t say I couldn’t bring something else. So what I have got is my domiciliary visit bag - [laughter] I brought props! - and unlike Jim, I hadn’t really thought of the way to deal with dogs, what I needed to deal with was how you went up into Queen Elizabeth Square, which has more recently been blown up - most of you will not know Queen Elizabeth Square - which was one of the high-rise blocks in the Gorbals. [beeper sounds - ‘Oh pardon me’] Although it was about fifteen to twenty floors, I can’t remember, it was the loneliest place in the world because you went into the lift and you never saw a soul and there were these endless corridors and all you could hear were rather awful noises off into these flats and you knew if anybody attacked you, you would be utterly helpless. The district nurses would only go in pairs, nobody thought about health and safety for female consultants in those days, so my disguise was not to carry a doctor’s bag, but to carry a shopping bag! [laughter] So that was my safety feature. The other thing is that because I come from a tradition - or have been influenced by - written historical evidence as opposed to oral evidence, I can actually produce my original domiciliary visits book, so I actually know the names of all the people that I have visited and even - for these people who like databases - that is my audit, because that was my little note book and I can tell you that in the first six months I did domiciliary visits as a consultant, I did 96 visits - I ended up doing just over 200 a year for ten years until we started to decline, and 38% were admitted to hospital, and that’s my audit that I managed to produce last night. So that’s my written evidence that I’ve brought all the way in to talk about!

I think a lot of what I was going to reflect upon, people have touched upon already. We’re talking about training and interface with other professionals and I think we’ve covered the greatest interface, which was with General Practice. We talked about that earlier on, so I don’t think I’ll add much more about it, although it was interesting because I did look at Joan’s paper in Advanced Geriatric Medicine just last night and when her survey and the other - there was an Edinburgh survey - of GPs’ attitudes about domiciliary visits. They were not unhappy that we did them alone, so it seemed to be that both sides were quite comfortable in that arrangement. But one of the things I did think about general practice is, did the decline in domiciliary visits and our perception that they were less necessary, relate to the increasing numbers of vocationally-trained GPs, because in the ‘70’s vocational training for general practice hadn’t really got started? I think it was about 1977 that it formally came in - others might remember - but until then, you could do your year in medicine and then you could go off and be a general practitioner and learn on the job, I think. Roger might have some recollections about that. But you didn’t formally start training with two years in the hospital and a year as a GP registrar until the late ‘70s, so perhaps by the middle of the 1980’s when domiciliary visits were declining, we actually had a better-trained group of GPs out there who knew a bit more about how to manage elderly patients and which were more appropriate to be hospitalised or not. I don’t know, it’s just an interesting parallel.

Just to put into context the domiciliary visiting we were doing in the ‘70’s and ‘80’s - when colleagues who are here, apart from Joan and John Dall who were just a little ahead of us, I think we were the first senior registrars (as we were then) who went through formal training - formal training of senior registrars came in and the award of a CCST came in, I think, in the mid-to-late ‘70’s, to my recollection. It was only about then - we were about the first to go through - and I think, certainly, Iain and I were among the first people who were double-accredited in General and Geriatric Medicine, that was a fairly new move at that sort of stage. Training in those days was
all about, that you just worked in a unit that had been accredited, much the same as now, but it was all about time, so long as you’d spent the appropriate time that was all that was necessary. We didn’t have the knowledge-skills-attitudes-curriculum type frameworks that we’ve got now, so trying to tell you what the value of the training was is very much my perception, as you’ve heard other people’s, what the value was around doing domiciliary visits. It is interesting that domiciliary visits don’t seem to appear in the current geriatric medicine curriculum, or the one that is possibly going through, at all now. They just seem to have fallen, completely, by the wayside as far as I can see.

So we were expected as Specialist Registrars - eh, Senior Registrars (I’ve even forgotten the old jargon!) - to do a certain number of home visits and we’ve already heard that we didn’t get paid for them and our consultant colleagues did. But I think it was that we just had got tasters then and it was only when you really became a consultant that you did lots, that I think the real training perhaps started.

I think what wasn’t mentioned earlier, and I was reflecting with Bill at the coffee break, was the very florid pathology that you saw out there. I mean, what you get used to seeing currently, or we all get used to seeing currently in the acute admissions unit, is what you saw out in patients’ homes - patients with hugely advanced cardiac failure that the GPs had been managing at home. They couldn’t just get sent up to A & E, so we saw a lot of clinical pathology. We gained experience, I think, in taking histories, not on our turf but on the patients’ turf. And I’m sure some of the trainees must’ve done some visits, and of course you don’t take a history from one patient, you take a history from the family. Whereas in the Outpatient clinic it’s much easier to ask somebody to leave or be quiet because it’s your territory, it’s much more difficult in somebody’s sitting room when you’ve got three or four members of the family and the elderly person, to say ‘Would you please be quiet, and let me just take the history from the patient?’ So you got used to dealing with lots of different people in the same room. We already heard about examining – well, sometimes you weren’t examining in the ideal situation, so I think it really honed up your clinical skills, just basic good clinical medicine, and you became confident at relying on those clinical skills as opposed to waiting for what the blood results were going to be and what the X-ray showed and you made your management decisions on those clinical skills. I have a feeling that’s something that’s got slightly lost – that everybody feels much more comfortable when their clinical skill is supported by the U&E and blood count. So I still think that’s something that perhaps people might still learn a bit about.

Well certainly it improved your communication skills because, as I say, there were often the multiple communications you were having to do with several relatives at one time. Sometimes communication was problematic - and I’m sure all of us can tell the tale where you turned up on the home visit and it wasn’t that the patient wasn’t in, but the patient had already died, and I certainly remember turning up on one or two wakes. [laughter] In fact, actually, it was always the relatives who rescued you because by the time they’d got to the wake they were perhaps a bit more comfortable about the whole situation, but I mean, huge embarrassment, how you managed to cope with that. So communication worked both ways. Communicating with relatives who already had an expectation ‘Something must be done, you’ve got to take Mother into hospital.’ - sorry I’m not good at the West of Scotland accents, even though I’ve been here a long time - something had got to be done. When somebody comes to your office and says ‘You cannot discharge them, they’re not fit’, it’s slightly different from being confronted by a very aggressive daughter saying ‘You’ve got to take her into hospital, I can’t cope any more’, particularly if your clinical judgement is you don’t actually think they need it, because they’re on their own home territory. So I think it helped you develop those skills and perhaps those skills of negotiation with families.
I thought, as well, perhaps that when I reflect back - and again I think this is something that people already alluded to - that something about the broad issues that you gained experience in and I think contributed to your overall management of patients. People have already touched upon medication and I think we all got used to snooping around cupboards, very diplomatically. I mean I would try and find my way into the kitchen, usually to see what food was around and whether they’d been eating and the state of hygiene and also trying to go through boxes of medication and just seeing whether the patient knew what they were taking. I think, not only did it give me practical insights into the management of that patient, but I think it’s made me much more aware of compliance issues. Now probably since we started doing domiciliary visiting, pharmacy and community pharmacy, labelling, Dosette packs, have all progressed enormously, but patients still don’t actually know what they’re taking and why they’re taking it, and I think that’s a very important bit about what I still call ‘compliance’ - I’ve forgotten what we’re supposed to call it now, but it’s not that anymore, is it? So I think that has helped my insights into looking after patients in hospital.

When we’re doing multi-disciplinary meetings now and somebody says ‘Where does Mrs Bloggs live?’ and somebody says ‘It’s Muirskie Avenue.’ I can tell the OT what that house is going to be like, because I have visited there, and I think that’s still hugely useful. Now somebody can say ‘Well a doctor doesn’t need to know that - it’s just as easy for the OT to go out and find out about that.’ - and as Joan said earlier, it’s not just about knowing how many stairs and whether they’ll cope with the stairs, but I can give you a very good example just at the moment - I’ve got a lady in the ward at the moment who’s incontinent and, if you actually speak to her, she’s had a tendency to ‘urge-incontinence’ for years. Now she coped with that at home because I know the house she’s in - she’s no more than ten metres (no, even ten metres is too far, I’m never good at metres, I was trying to be modern!) - it’s probably no more than ten feet from the bathroom in any of her rooms because she’s got a really small house. You put her into a big ward and she’s miles away from the bathroom and she’s now become incontinent. So I can reassure the nursing staff that she’s going to be much better at home because she can cope with it, just because I’m aware of the sort of housing. So again, I haven’t done a home visit on her, but I’m aware of the sort of situation she’s in, so I think that helps me with current management. And I think again, as somebody’s already said, when you’ve seen frail, elderly, slightly confused people at home, coping well, albeit they may have an intercurrent medical problem, you see the viability of home discharges.

The aim of our specialty has always been to maintain people in their own homes because that’s where they wanted to be and I think that has always been the advantage that we’ve seen it, as Colin was saying earlier, we’ve seen them do it, we’ve seen carers providing the care; we know what’s feasible. It used to be something that we reckoned we were good at because we go around the other wards, we get a referral from a surgeon saying ‘We don’t think we can send this patient home, we think they need to go into residential care.’ and you can actually say ‘No, send them home they’ll be fine.’ It worries me a little bit that perhaps we don’t have that same confidence now in our own teams because there are not enough people have been seen at home. And you’ll see the parallel now because you see the IRIS and DART teams coming into the ward saying to the current physios and OTs ‘No, don’t worry I can take them home; you don’t think they’re ready for home, but they are.’ - so perhaps our domiciliary out-reach teams are beginning to match our own knowledge and recognise it. I think that’s hugely important, because otherwise we’re all going to end up being so cautious because we’re so medico-legally orientated.
Perhaps slightly divergent from actual practical medicine, we all need to grow as people if we’re going to become good medical practitioners and, in his introduction, Keith alluded to some of the issues I think that I have been educated in by doing home visits. It doesn’t seem real, the deprivation that I think all of us have seen, and we already heard about, you see it in the Sundays don’t you, but somehow it doesn’t seem quite so real until you’ve been to a house and you’ve seen somebody who can survive, or does survive with great grace, in a place where there’s nothing but lino, one bed, one chair and a television - and dreadful bedclothes - and I think that has helped me understand not just patients, but hopefully society, just a wee bit better. And almost as the corollary of that we heard earlier, how you can go into the most dreadful housing schemes and you just cannot imagine how anybody can survive, and you can walk through a front door and you can see a wonderful little home, how people can carve out a niche and live in a beautiful little house in a very dignified way, in a way that you just could not imagine how people could do, given the environment they’re in. I think that’s important that we recognise that.

Perhaps just to finish on – what I hope, giving the context of some of our thoughts a slightly serious note - it’s hugely important isn’t it, I think, to become a medical practitioner to be exposed to humanity and to understand human beings just a little bit more. I think domiciliary visits give you that and I think we heard a little bit from Colin earlier on in his soundings about that. You have more time to talk to a patient than you ever do in an outpatient clinic where you’re conscious of the next person coming along. And by going into somebody’s home and seeing their own possessions around them you become aware of their life’s achievements - you see something on a wall, you see a picture and you engage them in conversation to start easing the chat and to make them feel comfortable by your presence there and you hear all sorts of things (and we’ve heard something just earlier on) which are just so impressive that people have achieved. You see people’s lives and losses and you see the fading garden and the fading house, which has been previously kept so well, and so you appreciate that age comes with losses. You see incredible personal kindness to you as an individual where they insist that you have a cup of tea and they want to make you feel comfortable - it’s their territory, they want to make you feel good, yet we all recognise that there are certain homes where you don’t accept the cup of tea! [laughter] You have to graciously refuse it, and you do not sit down and you have to find a reason not to sit down because of the state of the house, but you have to find a way of extracting yourself from that. You see huge human stoicism of coping with their life - not because of their personal circumstances, and I think that just reminds you of the strength of the human character. You see suffering in a way that I don’t think you see in hospital. We get so used to physical suffering, but you see the whole spectrum of suffering that people have in terms of their family and the way they’re living their lives. I think it’s important that we’re reminded, as doctors, that we can relieve suffering, but we can only partially relieve some suffering. There’s a whole bit of human life that we only touch upon tangentially and it’s important that we’re reminded that we only make a limited contribution, because you can get, I think, a bit over-inflated about what medicine and doctors can contribute.

You see huge humour, don’t you? Again you’re exposed to the wonderful repartee. I’m awful, I can never remember people’s jokes, but I have always been so impressed that people can cope and they cope by humour and it just gives you such a good feeling when you come out and you’ve had an older person who’s just sparred off you and it’s been really good. And you really see what care actually is about out there in society. There used to be all sorts of things about the elderly being old and neglected - I’m sure it’s the title of a book Some are Old, Lonely and Neglected - and yes, there are a lot of people who are old and lonely, but in actual fact there’s a huge amount of care that is provided, not just the dutiful care of families, but I think we’ve heard examples of care where families do more than they almost actually need to do and go
beyond it and want to continue to provide that care at home despite the cost to them. Perhaps almost more impressive is the care of the neighbours and the friends who support older people at home - and although you sort of see it in hospital, you’re not exposed to that in quite the same way as when you see it in front of you at home where they almost don’t want you to take somebody into hospital, they’d rather continue to care for them and I think that’s important for all of us that we see that.

Sorry to be a bit serious - but I think it’s important that we recognise that those are the values that I fear we might be losing by being not exposed to patients at home, but perhaps by some of the chat that I’ve been hearing earlier on I’m beginning to think that the real value of home visits in modern educational jargon is that it provides the knowledge to allow certain people to have the skills to tell the witty tales over lunch, [laughter] so it improves the morale of the whole team and keeps us going so we can go and do another bit of our work in the afternoon, but it’s always done with the appropriate attitudes, that it’s not overly-ageist. Thank you.

Keith Beard: Thank you very much, Margaret, a very thoughtful contribution. Willie?

Willie Primrose: Yes, the educational side is, I think, quite important. I have a feeling that the curriculum when it is finally shaped will still have that aspect in it. I mean I think community geriatrics with intermediate care - continuing care- within that whole umbrella are visits and I hope that this is not being lost from what we’re expecting of our future trainees. The other comment – about involvement with other disciplines - in that the way things are working in the North East, we have an understanding with GPs and Health & Community Care Teams that it’s quite OK for the social worker to phone us up and ask about a problem, or the physiotherapist and I’m getting a few - you know the few referrals that I’m seeing at home - are actually not coming directly from the GP. The GP is usually – or certainly aware after I’ve seen them – he’s usually aware, probably, of the discussion and this is a kind of helpful thing, so it’s not just feeding back to the GP, rather it’s the wider Health & Community Care Team.

Keith Beard: Jim?

Jim Davie: Thank you, Margaret, I enjoyed that. I’m just following the same theme. I think with the community geriatric sessions that, you know, we’re now being given in Glasgow, and no one’s quite sure at this juncture in time, exactly what we’re going to do with them and I know Paul’s working on this, but it does seem to me - although we’ve always resisted this in the past - we all know in our own areas, you know, which of the nursing homes where care is good and where we couldn’t improve it very much and others where just a little bit of influence from ourselves might make a lot of difference and I do feel that may be a new domiciliary function for us.

Keith Beard: I’m interested to perhaps stimulate a comment from our silent majority of trainees here about what they’ve heard so far or perhaps a reflection on what they have experienced to date, or potential involvement in the future as this Community Geriatrician roles evolves further. Think about that, don’t jump, but I’d like to hear from somebody in that corner before we close.

David? 

David Sutton: I really enjoyed listening to you. I can’t speak as a trainee but maybe coming at it from a different approach as an historian. Listening to you speak reminded greatly of some of the text I’ve read about issues surrounding domiciliary medical care in a much earlier period. I look at the end of the 19th Century and a lot of the values you put on domiciliary medical care are exactly the values being put on it by professors teaching students in the 1850’s, ‘60’s, ‘70’s. They talked a lot about developing what was called ‘the mens medica’, the idea of a rounded medical
personality, and that only visiting in the home could do this for all the reasons you’ve said. I just really wanted to make that point that there is a great continuity here, and as a kind of a last observation, one of the things that has interested me and I’ve hooked on to is the idea that only through visiting homes could you develop what one professor called ‘The Three Gs’ - this was a professor in the 1870’s. And he said this was ‘Grit, Grace and Gumption’ - the three things that all doctors ought to learn. So I just wanted to offer that.

**Keith Beard:** I should just say that David Sutton’s a PhD student here in the department. Roger?

**Roger Smith:** Thanks Margaret – that was excellent. The one area you didn’t touch on, I don’t think, was medical students and I think this is another area that for the specialty, taking medical students out on domiciliary, or home visits was fantastic for them because they really had their eyes opened. I think they appreciated our specialty much more being out on home visits, rather than just being hospital based and certainly the feed-back I used to get from medical students was that this was one of the highlights of their attachment.

**Keith Beard:** Paul Knight’s next. Just while you’re going over there with the microphone, Iain, I would agree completely with you, Roger. If you were lucky, and there was a bit of luck in the sort of material that came up for a teaching visit with students, you could almost teach the entire curriculum for DME in one afternoon, and I agree students were highly appreciative of that. Patients were sometimes appreciative too. I dug out of my files a couple of scraps - this is a note I got actually from a patient’s neighbour and I recall it because I had a couple of students with me. Top floor flat and it was a perfect teaching visit for he had some physical problems, he had some social problems - he’d lived in the house for years, he had very caring neighbours, a lot of different things - and the neighbour wrote to me subsequently, as did one of the students, so it must’ve been a big impression on somebody, anyway this is from the neighbour:

> Dear Dr Beard, Sorry I have not written to you regarding Mr Jim Buchanan upstairs for your understanding in being instrumental in admitting him into the geriatric ward for recuperation. I just thought you should know he’s doing great considering a nurse said he should have a psychiatric examination. I can assure you at this point he has more marbles than you and me put together. [laughter]

So among the various qualities of the rounded physician that Margaret and David have referred to, humility is certainly one, I think!

**Paul Knight:** I was just thinking, Margaret, you were talking about seeing the patient and their family on their turf and I think that’s very true and then Jim was coming in and talking about the need, perhaps for a bit more input into residential, in the broadest sense, institutions. I often thought doing visits in these places was actually quite different because the patient didn’t have any control and you didn’t have any control and it was a lot less satisfactory than actually going to see them in their own house. You didn’t really get the sense of - well you knew what the circumstances were going to be like - the only kind of slight difference to that I would think is that in the East End of Glasgow we have, fortunately or unfortunately, a grouping - or the largest grouping – of what were called ‘Model Lodging Houses’ – about 85% of Glasgow’s total. We don’t have quite so many of them now, but I certainly have done a number of visits in these places and one which probably most people in Glasgow will remember the name of is The Great Eastern which is in Duke Street. This is a very large ‘hotel’ and if you get picked up at Central Station you don’t want to go to
The Great Eastern. And going into this - this was referred by a GP - I went to see this chap, you arrive at the front door and there’s this very swish reception area with computerised stuff to tell you where Joe Soap was - they didn’t take you to where Joe Soap was! It was a bit different from a nursing or a residential home, you had to find it yourself and you went up these stairs - there was no lift - up the stairs to find this guy’s ‘cupboard’ which you could touch almost all four walls with various appendages. In The Great Eastern it used to be an open dormitory, but I’m not quite that old. By the time I got to see this chap they’d converted them into small cubicles but the tops of the cubicles were open, but slatted. They were open in the sense that they allowed air to circulate, but they were slatted so that the guy in the next cubicle couldn’t climb over and steal the stuff of the chap next door. If you ever brought these chaps in you would always recognise them in a ward in the Royal Infirmary because they would have the bedclothes over their heads and tucked in all the way around because they had all their possessions in their beds. So that’s another kind of, part of, Glasgow folk history. It would probably be the same in Leith I suspect – for these kinds of places.

**Iain Lennox:** Yes, I just want to say I thought it was a marvellously insightful view of the whole thing, Margaret, I really do. And I can answer your question about how high Queen Elizabeth Square is - it’s nineteen storeys and I know this - and it’s also the edge of doing domiciliary visits in certain parts of the city. I had to go and see a lady who was on the 19th floor, very top, and I got into the vestibule, and they have concierges now in all these high blocks, but in these days they didn’t and they were kind of slightly lawless places. As I went in there was a man who must’ve been six feet six tall, tattooed, looked a slightly unsavoury and slightly unsteady customer - not the kind of person you wanted to share the lift with really. However, there was a young woman there and one or two others and I thought, ‘Oh, it’s probably going to be OK.’ The lift duly opened, the man got in, I got in, and the young woman said ‘I’ll get the next one!’ [laughter] The doors closed and we began a very long journey up to the top of this block. In these days I had a fawn raincoat with epaulettes on it and I had my Jim Davie firm, black suitcase, and I became aware of this very tall person had his eyes on me on the way up - eventually he said ‘Are you a detective?’ and I thought ‘No, I’ll tell him.’ - I said ‘No, I’m a doctor.’ - thinking ‘doctor – respected person in the community’ - and he kind of didn’t say anything, and then he eventually said ‘You got any drugs in that bag?’ and I realised my mistake! So we went up and he eventually got out at the 18th floor, much to my relief and I went on up to 19 - went to the door and it was one of these ones we talked about earlier, no answer – back in the lift - you’ve guessed it! - 18th floor, there he is back in again and we shared the journey back down. So it’s nineteen floors!! [laughter]

**Keith Beard:** Yes, for some bizarre reason Iain was mistaken for a detective on visits, while I was mistaken for a priest. It must’ve been my funereal approach to these things that convinced people. Any other thoughts, Christine?

**Christine McAlpine:** Thank you very much, it was more a comment really. But I, certainly as a Senior Registrar, found it very useful to go on visits and I think I learned a lot. I think from a Specialist Registrar point of view it is a bit of a loss if people are not going on visits; it’s good if they still go on them, or go out with the district support teams and so on and see the community. But I also remember, I mean I didn’t really know the South Side particularly, so it was also quite good for me learning geography. I remember going on visits with Keith to the Gorbals when we went two or three different places, then I got completely lost. We emerged out next to a big river and I just looked at it and said ‘What’s that?’ and he looked at me rather strangely, the way he used to, and said ‘The Clyde!’ [laughter]

**Keith Beard:** We like to think we educate our trainees properly!
Bill Reid: I wonder if anyone would want to speculate on the kind of competencies that you might want to pick up on in a competency-based age. I mean one of the things that’s not been mentioned until Christine mentioned it there is navigational skills which were essential, particularly on winter nights. But what kind of things do you think you might want to specify? And how do you measure it?

Joan McAlpine: Thank you. Just to say that we were talking about the interface between one discipline and another, after a great deal of trouble I managed to get a nurse – a sister – specially allocated to me so that when she would come round and see all the patients each day and she would follow them out into the community. They would go out one day, she would call the next day and the next day to make sure they were settled. Now this lady had done particularly well, I had seen her on a visit and I brought her in and she did well and her daughter was very helpful and so out she went. This sister went to visit her the next day and couldn’t get any answer and so she tried to phone the daughter, who didn’t live with the mother and she couldn’t get her, so she tried to phone the GP and he was out and so she came back and told us this story. I said ‘You’ll need to persevere’, she went away again and eventually they got the door opened and she was absolutely flat out. She had taken her drugs, which we gave her, and then she’d also taken all the drugs she was on before because she didn’t want to miss out anything and she was absolutely out for the count, so that was a very useful contact.

On another occasion we had this old gentleman who’d had a slight stroke, not too bad and he’d made good progress, and he was soon walking the length of the corridor, so we arranged for him to go home. The sister visited him and he was fine, and then the GP phoned to say that ‘It was absolutely ridiculous that this man had been discharged, he was falling all over the place, I mean it was ridiculous, how could you think of this?’ I said ‘Well, he had been walking for ages and we had a bit of a job persuading him to go home, that he was really OK.’ He said ‘Oh it’s just ridiculous.’ So anyway she went back out and she spoke to him and she said ‘Don’t you carry on like this, I know perfectly well you can walk and don’t have any of this nonsense any more’ and sorted him out. So it was very useful to have this contact.

Keith Beard: Oh, Janice has taken up the bait! [laughter]

Janice Murtagh I’m one of the trainees from Glasgow. I actually have been fortunate enough to go out on a domiciliary visit when I was at Wishaw hospital with one of the consultants. It was one of the calls from a GP wanting assurance that it was appropriate to keep a man who was terminally unwell with congestive cardiac failure at home. So I went out with the consultant and it wasn’t much of a medical assessment; it was in lots of ways more of a social visit to see him and the wife. It occurred to me at the end of the whole thing that probably the best thing that came out of it was reassurance for the wife, that she was doing an excellent job of caring for him, and that what she was doing was more than sufficient and was probably more than he would get if he came into hospital. The consultant involved actually phoned the wife on a weekly basis after that just, purely, again sort of socially, just to reassure her and to make sure things were fine. The man stayed at home right until he passed away and I think probably that was because of that support.

Keith Beard: Thanks very much, Janice. I think that chimes very well with Margaret’s comments about, well I suppose, our pride that we are very much a patient-centred discipline and that these things really are very important.

Any more comments on this sector before we move on?

I think that’s been splendid, thanks very much Margaret. [applause]
We’re coming now to the last of the, sort of, formal contributions and it’s my pleasure to introduce David Kennie from Stirling, and most of you will know David as a well-established consultant in Stirling for many years. But you will see that we gave David a pretty broad and general remit for this round-up slot - Expect the Unexpected! I think we’ve covered a lot of the unexpected already, actually, in other slots so we’ve really given David carte blanche to round up, perhaps pick up things we’ve not touched on and stimulate some further discussion. So David?

David Kennie: Thank you, good afternoon colleagues. I think as Keith has just said a lot of what I intended to say has already been said, so I think you have two options. One of them is that you can rise and walk out and go and enjoy the rest of the sunny afternoon! Or you can stay seated, and I hope you will stay seated, and indeed I’m standing up so that I can spot those of you who don’t stay seated, and I’ll try and set the scene for when I first began home visiting and take you back 32 years to 1975 when, unexpectedly, I found myself attracted to this embryonic speciality. After an unexpectedly short and very mixed course of specialist training, I found myself at the tender age of 29 joining the consultant ranks. I may say around this time I’d also unexpectedly been called in to see the Professor of Medicine at Glasgow Royal who told me - and he told me with a distinct curl of his upper lip - that I had committed professional suicide and would never be a true specialist! However I was excited about what I’d seen, largely because of my mentor John Dall. I liked the diversity of the clinical work; I liked the emphasis on functional restoration; I liked the idea of building a health-care delivery system for a designated group of people. And I also liked doing something novel and meeting the unexpected, and if that meant going out and meeting people in their homes, then that’s what I wanted to do.

So what I’m going to say relates to probably several thousand home visits, carried out in the posh parts of Glasgow, in the old slums of Govan, the deep south of the United States of America and the beautiful semi-rural area of Central Scotland, where I work at the moment. I would just like to re-emphasise at the start that in the early days of our speciality, home visiting was vital. I had no day hospital; I had no out-patient clinics; I had no out-reach services. I did have an occupational therapy department and you might think that they could perhaps share some of the burden of home visiting with me, but they were actually quite busy teaching people how to weave and make baskets. [laughter] However by using home visits it changed the face of the service. When I went to Stirling I had something like 173 people on the waiting list to get in and, as John Dall has indicated, by home visiting within a few months we’d whittled that down to almost zero, again for all the reasons that have been mentioned round the audience. Now some of you would find it very hard to imagine the huge impact that had because previously it was almost never that anybody was admitted directly to my wards but unexpectedly, at least as far as the GPs were concerned, within three months they could phone up, I would do a home visit that day and we could admit within 24 hours. It was a huge change and it was almost entirely because of home visiting as a prioritisation and sorting house.

Of course home visits at that time also served as an introduction because I was a new boy, the GPs had never seen me before and it was a form of introduction. It was also a form of publicity for the new speciality of geriatric medicine, but unfortunately this almost always took place by phone because I, certainly, found it very difficult to actually mesh-up and do joint visits with GPs. It was logistically difficult; I don’t think it was very effective - I had very few people back at the ranch holding the fort - I think I had a part-time clinical assistant and a part-time GP. But, also I think you have to appreciate there’d be times when you’d disagree and quite frequently disagree with what the GP had said, and to do that in the home setting was quite delicate. The GP would say to you ‘Now, doctor, you see that she’s got cardiac failure and pneumonia,’ and you’d actually think ‘Well, no actually she’s actually got air-hunger because she’s
got a tachyarrhythmia of 160, you silly so-and-so, why didn’t you just listen to her?’

Of course you can’t say that to them, so it takes twice as long. So I never had much success with joint visits. But of course home visiting was a wonderful educational tool for students and doctors alike, and Margaret’s covered a lot of that very eloquently. I always thought that students liked home visiting because it was different; it was sociable and it was a bit of a jamboree that got you out the hospital. So I always used to set them, before we went, Prior Education Goals - a bit like what Colin did when he got back - what are your targets, what are you expecting to do when you go? And they always got a home visit checklist in which they were expected to write down and describe what they’d seen and put it into the notes on their return. I mean, a simple thing, if you decide that you’re going to put a bed rail on the right-hand side of the bed, are you talking about the right-hand side as you look at the bed or are you talking about it as the patient’s lying in it - trivial but quite important.

Also home visiting brought home some messages I hadn’t expected - again some of that has been covered. First of all, how well people with dementia seem to cope provided that they don’t have overt risk behaviours. Another thing that I learned was the enormous stress and burden that was put on families and how, in the early days of our speciality, we were trying to relieve that, but the whole set up was working against them - huge pressures that nobody would consider nowadays. And also, I’m afraid, how poor social work departments were in those early days in identifying priorities for admission to their residential or ‘part four’ homes.

Well, obviously, in amongst all this home visiting there was bound to be unexpected encounters. You’ve heard a few exciting ones today, and I don’t want to be left out! So let me just tell you one that I well remember - I’m called one very cold winter’s evening to a house, isolated miles away on a moor-side, something like out of the Adams family or Psycho and I remember struggling against sheets of rain up this tree-lined driveway, getting to the front door and knocking. Now of course the bell doesn’t work, but also there’s no answer. Now I’ve come almost fifty miles to do that visit, so I push the door open and enter and at that time lunging forward is this snapping, snarling rottweiler, but don’t worry, I had been to the Jim Davie School of Self-Defence! And by the same technique of using my case I get it into the kitchen. I go up the stairs and I find an old guy lying dead in bed and his wife, who’s very demented, is sitting by his bedside quite unaware of what’s happened.

So, nowadays, when I go back to Stirling and I look out the windows and I see this small fleet of well modified 4-wheel-drive vehicles for the GPs when they’re on call and I see them going out with their personal alarms and I see them taking the mandatory paramedic, because nobody does it alone nowadays, I think of the risks we all took and that we all accepted and I think to myself, ‘Is society much more dangerous nowadays, or is that just perception and media-hype?’ If you actually look at the violent crime figures, we’ve never had it so good.

The hospital even then always seemed to be short of beds, but the medical specialities always contrived that they wouldn’t be available for our frail population. And so most GPs thought it part of their role to act in partnership and to delay admission until the last possible moment, until it was really necessary. Now this involved taking calculated risks, for example should you - could you - leave the old man with dementia who’s taken a further ischaemic collapse, could you leave him with the wife for the next few days or do you have to bring him in and put him through investigation, subject them to all the iatrogenic dangers, and end up with the inevitable delayed discharge because of the disorientation involved? Well surprisingly, unexpectedly, the whole strategy usually worked well and indeed families wanted it and so by repeated home visiting in this sort of situation - again as some of the former speakers have said - the geriatrician began to develop patterns of
recognition about who could be kept at home and who couldn’t. It was a way of the geriatricians like myself developing a safe threshold for what is our gatekeeper role for admission and discharge.

Let me go some miles away and shift continents [and I’ll spell that c o n - and so on!] [laughter] In 1978 I was unexpectedly invited to assist Duke University in North Carolina to set up health care programmes for older people. You have to remember at this stage there were only, I think, four Board-certified clinical gerontologists in the USA, and the Rand Corporation had only just begun to put together its document on Geriatric Manpower for the United States. So for the year that I was there it was full of surprises. The Americans’ over-reliance on technology had resulted in them being quite inept at actually managing frail old people and there was lots to teach them, particularly about things like home visiting that they rarely did. Indeed in the Deep South the idea of a white physician visiting a black household was extremely rare and I remember one episode, it took a lot of persuasion, it took almost two weeks to set the whole thing up. I was repeatedly warned about the appalling circumstances that I would go to in seeing this American of African descent. We took incredible precautions; we had fall-back situations in case we got into trouble, and of course, unexpectedly, from my American colleagues’ point of view, and probably as you have guessed, the old man and his family were charming and indeed the house that I went into was probably better than many that I’d been to in Govan. I came away feeling I’d not only given a lesson in home visiting, but also undertaken a lesson in covert racism. Just remember this was the time when the Ku Klux Klan was still active. The Ku Klux Klan killed a black man about 30 miles from where I worked the year after I left.

Let me bring you back to the present day. In the 1970’s I would never, in my wildest dreams, have expected that my department in Stirling would now admit 65% of all acute admissions of very old people to the hospital or that my median length of stay would be five days, when previously it had been measured in many months and sometimes many years. I would never have appreciated the in-hospital effort that would have required, or the fact that I would lose my contacts with the community. I can’t remember when I last performed, or was asked to perform, a home visit. I’m also surprised that the GPs have given up so much of their home visiting, but that’s what’s happened and we now have a category of people who are relatively inexperienced in terms of home care out there, unable or unwilling to cope with risk at home and flooding the hospital front doors with so-called ‘Urgent Admissions’.

Lastly - and again I’m repeating something that’s been said before in a way - lastly, I never expected that for my in-patients the decision as to whether or not they would be fit or not fit for discharge would lie with a young AHP fresh out of college with relatively little clinical experience in the community and only a handful of home visits under her belt. And yet that’s what’s almost happening, at least in Stirling, in terms of the protocol-driven, nurse-led, multi-disciplinary team decisions and I find that intensely irritating. I find it, at times, an incredible waste of resources because we always err on the side of caution, and if you haven’t seen what you can titrate out into the community in terms of risk and ability, then you need to.

So let me finish by saying I hope this contribution’s been of interest. I would, again, just emphasise how important home visiting can be, maybe now an old relic, but it was very important. Some of the more subtle parts, or the benefits of home visiting, I never appreciated at the time and I miss now. Certainly we’re left with quite a group of health professionals out there who have very little real knowledge of how to handle illness and disability and so on in the community. Let me just finish by saying that 32 years ago I never expected to be standing here, like one of the old dinosaurs, telling all you young hot-shots what happened in the dark ages. Well, let me also say to
you, because this is news to you, that at some time in your career, in some sort of way it’s unexpectedly going to happen to you too! [laughter] [applause]

Keith Beard: So I think there’s a certain theme emerging here, very good David - good to bring another continent - certainly better to be On Continent than incontinent, for sure!

Now, some comments or more stimulated thoughts in the wake of David? Yes – more contributions from The Quiet Corner!

Pamela Seenan I’m one of the quiet trainees from the corner here. It was just to really say that throughout my training I think there has been a gradual decline. I’m sort of near to the end of my training now and there’s been a gradual decline in the number of domiciliary visits that have come to each unit that I’ve worked in and it’s been increasingly difficult to actually get to go on domiciliary visits, although I have managed to go on a few and I’ve thoroughly enjoyed those ones that I have. I don’t have any of the exciting stories that everyone else has, but they’ve certainly been entertaining and educational. It was just really a thought from what everyone has said - we’ve almost backed ourselves into a corner, it would seem to me - we have incredible pressure at the front door, people are always taking up our beds therefore we don’t have beds to always admit people to, so when you do go and see a person on a domiciliary visit it doesn’t necessarily circumvent the long wait in Accident and Emergency on a trolley which we would all like to do for our elderly patients. The other thing that has struck me is that we often really, really struggle to get people home to die and that’s something that I find quite difficult, because a lot of families would like to get their relative home to die; we’d brought them in because of, as you said, inexperienced GPs who don’t know necessarily how to keep people at home, and the people who are at the front door don’t want to send patients home because they’re not aware of what can be coped with. We end up with a person who’s in hospital who’s terminally unwell, who – and their family – would like to have home and we can’t do anything about getting them out and everyone throws their hands up in horror when you suggest that you might want to try. And that could possibly be avoided by actually not bringing the person in, in the first place, so I think these are things that we’ve kind of totally gone away from, but we may end up coming back full circle, because we may actually need to do it in the future in order to prevent our front door from getting completely blocked up.

Unidentified speaker Perfectly noisy corner!! I would endorse that.

Keith Beard: I think that is a sensible, very helpful comment.

Colin Currie Given the whole strategy of the Kerr Report - supporting the frail elderly at home, minimising the use, and especially the inappropriate use, of acute facilities which will be fewer in number and far more concentrated - if we don’t get this right the whole thing simply won’t work. To have to re-discover a lost gem called the home visit, which might be absolutely essential to the success of the Kerr strategy just when those who know about it are about to hang up their stethoscopes - seems to me a very dangerous moment in the development of health policy for the frail elderly, about which I can get really boring. But the counter-strategic drift in the decline of medical assessment of the domestic ecology of the frailest elderly, strikes me as tragic, both losing something quite precious and at a time when it’s never mattered more.

Keith Beard: Indeed, and underscores the rationale for this afternoon’s meeting – get it down, I was going to say on tape, but in digital format. Graeme?

Graeme Simpson: I suppose someone ought to put the counter-argument to domiciliary visits. We’ve all been congratulating ourselves on all the good things we used to do
and don't do any more, but there are a number of ‘cons’ and one is that they weren’t always carried out very quickly. Hence you sometimes turned up to find the patient already dead. It did take a lot of time and Margaret’s talk, I thought, was fantastic because here’s our clinical leader telling us that we can have a more relaxed afternoon than trying to cram lots of Parkinson’s’ patients into a very short space. And that’s great! [laughter] But which general manager is actually going to permit consultants to go back to that style of working? There were, occasionally, very acutely ill patients and it did depend on the GPs. I have once had to try and find naloxone to stop someone from dying in front of me and get an ambulance very quickly, and so I think our triage system for domiciliary visits didn’t work and there were people who should obviously just have come straight to hospital. There was also a certain amount of resentment in the hospital that there were with protected beds that ‘We’re keeping two beds in case we do a domiciliary visit today’, and we were only going to see two patients that afternoon, when other consultant physician colleagues were seeing twenty or thirty admissions in the admission ward, so there are two sides to this. I think we’ve swung, probably, too far against domiciliary visiting, but I think we have to be careful that we get the balance right.

Keith Beard: David?

David Kennie: Yes, I certainly partly agree with that. What I didn’t say to you was my heart-sink feeling if somebody does ask for a home visit now, because I think 99.9 times out of 100 it isn’t either feasible or valuable. So I do agree with that. I think we have an unstoppable force, and I think we have to recognise that our role in doing these things is too expensive now and that we have to recognise that there’s probably some other part of the team has to be trained up to have those - I think it’s the gate-keeping skills that I think Margaret and I have tried to talk about. I think that’s what we have to focus on, I don’t think anybody will decide that we can go backwards, but I do think that some of the members of our team, like the discharge co-ordinators, the therapists, maybe there’s a value there. I think there’s also a huge research agenda, even just this restricted agenda as to what our relative views are about the risks of discharge. It’s not been described, not for 20 or 30 years, and it would be a really good piece of work for some of the SpRs.

Joan McAlpine: I just wanted to make this one point - I thought that going on the domiciliary visit, never mind what the reason for it and if you felt the person had to come in, you often had to persuade an elderly person to leave their home. If you could establish a rapport with them when you were there - for whatever reason - they felt happier about coming in and being looked after by me, you, whoever, and I thought that was very important because they are often terrified of going into hospital and maybe never getting home again.

David Sutton: I just want to make one more historical point while we’re on the subject of ‘cons’, and I think it’s quite relevant to the discussion, how it’s been shaped today. It has to do with the tremendous amount of energy it seems to me that’s needed on home visits, and all you guys talking about your experiences. Are talking about your experiences as young men, and I wonder how many of you would be so keen to go back on home visits were it offered today? I think it’s very informative that you’re sitting here trying to encourage the young bucks what a wonderful idea it would be for them to go on these home visits, but I think the point is this, it takes a tremendous amount of energy to go on these visits, and I think historically - this is also a crucial historical point - consultants often used juniors to visit just because of the sheer amount of energy that was needed to do this work.

Keith Beard: Fair point! I had picked up on something David Kennie has said from a different perspective and it was his comments on assessment of danger. I have jotted down the note ‘Is it the world that’s changed or is it us getting older?’ So,
perception depends on where you start and I guess you are saying that from a different angle. I think David wanted to comment.

**David Kennie:** I was just going to come back, really with a sort of extra bit of what you’d said. Yes, we were Young Bucks, or Buckesses! - there weren’t too many buckesses in those days - we were all choleric, we were all highly energised and what we tended to do, most of us, - and I was speaking to Roger Smith earlier - we did our visits in the early evening when we’d do three visits between the hours of five o’clock and nine o’clock at night. But there’s another player in this, and that’s our spouses, and you know nowadays I’m not sure whether that would actually be quite so easy to do. I think we’ve got much more equality in our households and certainly many of us would abandon our families in the old days in order to do this.

**Paul Knight:** Not going to talk about that! [laughter] I would like to return to something you mentioned, David, which is the kind of loss of an ability to manage risk in the community, and I think if we were suggesting to our trainees domiciliary visits were great fun and you should all go out and do some - in fact you should do more - that’s not going to happen. What is needed, though, is a resource of specialism in the community and that can only happen as the focus of a team and that’s the only way that you could cope with the workload efficiently. As a corollary to that you’ve got to be able to appreciate what is in the community, what can be coped with, and what can be linked to other things. I, like David, spent some time in the States and when there I was asked to go out and see a priest in his chapel house in the Mid-West who was having falls. The chap was coping reasonably well at home, so I phoned up the occupational therapy department and said ‘Could you go out and do a home visit on this chap to assess his risk?’ - because I thought he had a number of risks that they could ameliorate - and the reply was ‘Could he not come into the department?’ They had completely and utterly missed the point that there was a requirement for that. Now we do have these structures and I think the possibility of the historical home visit, which was all things to all men, was a creature of its time; it’s because we didn’t have anything else, or not a lot else. My experience in terms of auditing my home visits is very similar to Margaret’s, two-thirds of them you left at home, it wasn’t a case of going out to see them to bring them in, and that was maybe different to Jimmy Williamson’s time, or of previous ages, where you were screening them to come in. That wasn’t the case for us and I think now it’s more about providing a service in the community and providing a link where you need to have the experience of knowing what you can cope with there. That does require you, as part of your training, to have a competence to know what you can deal with there, what you can refer on, what you need the GP for, what the team will do, all these kinds of things.

**Keith Beard:** That’s a very helpful forward look. Margaret, would you like to comment on that?

**Margaret Roberts:** I sort of had started problem-solving Graeme’s challenge about how we’re going to slow down! [laughter] Just a bit conscious about the ageist remark from the back, because I think there’s still quite a lot of activity going on among ‘older people’. It’s just as hard doing a long Out-Patient Clinic as it is packing in three or four home visits in an afternoon which is what we used to do. I think, as ever, I always feel it’s a bit of a balance. I don’t think we should be going back to doing these large numbers. What actually happened in some cases, you could almost walk through the front door and recognise that people ought to be in hospital, and that seemed to me at the time, a waste of time. I think it’s that other bit that we still need to do enough to give us the confidence, as Paul says. I still have this slight concern that if we keep getting too many other members of the team to take on the skills of the doctor, then you end up with the doctor being significantly reduced and
losing leadership, and I do think doctors are better risk-managers than most other people that we've currently got in the team. It takes us back to that team image and we've got to find a way of retaining that grasp, albeit, the current view about work-forces - you get the doctor to do the bare, the absolute essentials and everybody else can do the other bits for them. I think there's a bit of danger in that, but balance, as ever, is the answer, isn't it?

Willie Primrose: Yes, just really to go on from Colin and Paul's other points. Yes, I think there's a need for us to continue to be involved here and to develop where we've let this lapse. But this also requires an awareness-raising in primary care to encourage those in primary care to realise this is a resource that we're willing to deploy but it has to be done sensibly and selectively. Of the last twenty or so that I counted, three required admission, one quickly and one in a planned way and I think the role in involvement here, advising on medication and supporting people in care homes, as I say we haven't mentioned that much this afternoon, but this is a group that previously we did look after in hospital settings. They're highly complex and they do require support and usually not admission, and if we can provide that support to primary care then that's part of the role.

The other area in terms of triage is involvement with social work and psychiatry in, in a sense, deflecting people that should not come our way. Again, sometimes with the referrals that are either by letter or whoever else coming our way, we can actually intervene and keep them in the community and point them in the right direction.

Keith Beard: That's really very helpful. Colin?

Colin Currie: These wee strategic worries that I keep coming up with. I mean I think what we're really discussing is; how strong is the medical presence in the whole system, structure and skill-mix, that is designed to deliver care implementation? You know, what are the GPs and the home teams and the discharge teams and the alternatives-to-admission teams going to do and where do we fit in to maximise their, and their collective, value? I've found this whole day, in that context of change in the way we're going, and all the changes that are happening in the health service, it makes an immense amount of sense to rediscover, with strategic fit to the new environment, some of the skills that used to be great fun at the time, which we did against the odds because there were no community teams, you were out there with your black bag and it was dangerous, it was performance art. I mean you came away — when it went well, for example, if a student was there gobsmacked that you could do all this - you came away feeling great. But we were soloists and there weren't systems around us. I think a little bit of us, and an awful lot of other people, is the answer to maintaining the balance of care, the continuation of geriatric medicine, the Society for the Protection of Free-Range Grannies, against battery care, where possible. I've found the whole day immensely enriching because of that.

Keith Beard: Good, well, I think I'm going to - have we got a last contribution? No? Well, I'm comfortable actually, the last three or four contributions have somehow rounded this out very nicely. We've been looking back, we've been looking forward in this last session of the afternoon, which is really very good. One last anecdote, indulge me!

Since I started to think about this idea - a long time ago, in fact - I dug out some letters from the mid-'90's. At that time I'd decided, not only would I do letters - I used to do my letters in the car immediately afterwards - I decided to write short reflections after I'd closed my letter. Just this one, particularly, homes in on some of the thoughts that Margaret was talking about earlier and I've heard from one or two others and although it's not the forward-look, it's perhaps somewhere in the middle, and I'll paraphrase from it. I might say that with this lady, the initial referral was from
a GP who was most distraught because the dog (again!) had chewed her expensive Italian handbag. So we didn’t get a very good referral!

I visited this 89-year-old woman at home as requested: There’d been three falls in the past week, fortunately she’d sustained no injury, there’s been back-pain, but that’s not new, an extensive past-history - blind for five years on account of glaucoma, she had a myocardial infarction at some time, also told me she has a heart-valve problem, she has emphysema and uterine prolapse. At best she could walk about by holding on to furniture, she could dress slowly, does no cooking, uses her commode in her bed-sitting room, but walks upstairs to empty it! [laughter] Has home-help three days a week, extra help available, is able to go out with help to a club at the local church and also to the local hairdresser by taxi. The main problem is her dog – this is a small friendly creature, she’s very distressed at the thought of what might happen should she go into hospital or into residential care. She said she would rather see the dog put down than sent to another home. Related to that is the fact that she has in her will left her entire estate to a dog-related charity – and she’s vehemently opposed to any form of means-testing with respect to her own welfare because this would, in turn, reduce the eventual donation to this dog-related charity! [laughter]

On examination, after the dog had been banished to another room, I found her not acutely unwell and intellectually sound, nothing much to find. I spent an extremely frustrating fifteen minutes trying to discuss the options for her future welfare [and I go on here] I would be quite happy to have her in the geriatric unit for a while to see if we could restore her to optimum physical state, some temporary arrangement would have to be made for the dog, perhaps we could discuss by telephone.

[Fast-forward three years] I renewed my acquaintance with this 92-year-old woman when I visit her at home in March. Since I last saw her in 1994 she has remained at home with a significant amount of support; the most pressing recent problem is her visual hallucinations, other problems are under reasonable control, aches and pains, occasional falls, mobile about the house, hazardous on account of blindness, she still insists on going up and down stairs; home circumstances remain precarious, carers twice a day, she’s somewhat parsimonious, is quite dismissive of my suggestions that she might invest a little more in a support system that would make life more comfortable. I was pleased to see that her dog is still alive, his welfare clearly figures high on her list of priorities. Her nephew pays heating bills, but I was alarmed to hear that she allows her carers to write cheques which she simply signs. In theory she’d like to keep control of her affairs but she’s not really able to do so and she needs power of attorney.

[And I go on with an examination - nothing much found.] On balance I think we should wait and see how things develop. I have not arranged to see her again. [And my reflection at the time, 1997, reads] ‘She’s soldiering on quite well after three years. I suppose the message for me is that she was right, three years ago, in that she was able to remain at home, and although it might not be my choice, she’s doing all right. I just wish she’d spend a bit more money to make life more comfortable for herself, but she’s determined it should all go to the Bothwell Animal Welfare Home. She also told me that nurses are snooty and she hates them, she does not like being called by her first name and she thinks that home-helps are a bunch of crooks! You can see I was quite lucky to escape unscathed. [laughter]

Fast-Forward to 2000, she was admitted to hospital, and in 2001 she graduated to the one remaining continuing-care ward in the hospital, where she happened to be looked after by me. She died under my care last year (2006), aged 101, so she was right after all! So, a personal reflection just to round things out.
I think it’s been a splendid afternoon actually. I think we’ve looked back with some nostalgia and the youngsters must forgive us for that. We’ve also looked forward, I think, with some vision, with some very interesting thoughts and predictions for the future. Historical views have been valuable, clinical importance that we’ve all felt on home visits has been clearly demonstrated, and we’ve talked about the relevance of this practice, including training and teaching, and its relevance to contemporary themes and future teaching and training too. I should like to thank the four speakers who have done the set-piece talks this afternoon to set things going. I’d like to thank Iain for helping with the chairing and particularly Malcolm for helping to set things up here. Malcolm and I will do our best with the transcript that we’re going to get from all this and we’ll see what comes from that. I do have a list of all the attendees and we shall let you know when something concrete emerges from it. Don’t hold your breath, it might take us just a little while to get to the bottom of it. And lastly I’d like to thank Andy, our technician, in the corner who’s done a splendid job. With that I’m going to close our meeting and thank you very much for coming. [applause]

Iain Lennox: On our behalf, just to congratulate Keith for really dreaming this whole idea up and pulling it together. It has, as he said, been a simply marvellous afternoon, so well done, Keith. [applause]