We'd better call the doctor

An anecdotal history of home visits over the last 70 years

John H Chippendale, retired general practitioner

John Chippendale was a general practitioner (GP), and later a partner, at the Dalton Square practice in Lancaster from 1962 until he retired in 1992. At first, he thought the history would begin in 1959, the year he began working in general practice; then he realised he had memories of doctor's home visits going right back into his childhood. The history, therefore, begins in the 1930s and 1940s in his home town in Yorkshire.

MEMORIES OF HOME VISITS FROM MY CHILDHOOD

My mother had all three of her children at home with the doctor in attendance. My eldest brother, now 80 years old, was 4lbs at birth and was kept at home. I never heard any hint that he should have been admitted to hospital. I guess there was no specialised unit for him at that time? My own birth has been rumoured to have been aided by forceps, but my mother never cared to talk of such things. Again, I was a home birth with the district nurse/midwife assisting the doctor. I remember the doctor visiting when my younger brother was born, as he is six years my junior. The doctor had a Wolseley 16 car, which was one of the nicest of the few cars in the area, and it was parked outside our house. What excitement for a six year old. The doctor's car at our house . . . and a new brother!

We did not have a telephone until I was in my late teens. A message had to be taken to the doctor's house, which, like his car, was one of the nicest in the town. His maid would answer the door to take the message and in due course the doctor would arrive. The doctor was on call all the time except when a colleague based in the next town took over for half a day. He was a kindly man and highly thought of in the town.

I remember the doctor visiting when I had measles, infective hepatitis and mumps. It was clean pyjamas and a move to best bedroom in the house when the doctor came. We did not have a television until 1953, so this could not have been left on, as it usually was when I did home visits!

A more dramatic visit occurred when I had stabbed a manure fork into my foot. My non-medical father was bathing and poulticing the wound, but I was in increasing pain and the foot and leg were swelling. Some instinct told my parents to send for the doctor. He feared tetanus and gave me a shot of anti-tetanic serum into the lateral thigh of the affected leg. There was no active immunisation against tetanus in the 1940s when this incident occurred. Also, thinking back now, I realise I could have had a serious secondary infection and penicillin was not then available. However, ATS and my natural defences did the trick and I recovered.

All home visits before 1948 meant a doctor's bill. I remember that we tried home remedies for as long as possible to avoid them.

HOME VISITS IN MY STUDENT DAYS

I have to begin this section on a personal note again because at the age of 19 I had recurrent right-sided lower abdominal pain. One day, my pain was so bad my landlady sent for the doctor from the student health centre. He came to the lodgings, diagnosed acute appendicitis, and off I went by ambulance to have the appendix removed.

My second memory of a doctor's visit is from my student attachment to a district midwife. She, and her shadow (me), were called to a lady in Quarry Hill Flats in Leeds. Labour had started and the midwife alerted the GP who came and examined and thought there were probably a few hours to go and then left. We stayed with our lady. Labour progressed slowly but came to arrest in the second stage. The midwife was saying, 'I need the doctor for a forceps delivery.' Alarm! Where is the doctor? Eventually, he turned up in his evening suit – he had been to a gala performance at the theatre. He then proceeded to do the slickest of forceps deliveries. He finished off by whispering to me that he had been a senior registrar in obstetrics and I might not witness what I had seen very often.

HOME VISITS WHEN IN THE ARMY

In 1959, 'general practice' for me was being in the Army, doing my National Service and working as a garrison medical officer. In the main, I was responsible for the troops, but I was also involved with the families and part of an on-call rosta for three camps.

Most of my troops were fit and healthy youngsters, but they lived in barracks with beds in rows down the sides. When influenza struck it spread rapidly. I remember spending a whole morning doing 'home' visits from one bed to the next, and then it was on to the next hut, and so on.

In a previous *Journal* article I recorded some of my Army home visits,[1] and repeat three of these here as they are so illustrative of the home visit theme.

The first was an officer in his forties with a rash which developed when his children had chickenpox. At my home visit, he was very ill with – was it a chichenpox rash? I was very young and quite worried about my patient. My colleague made things worse by mentioning smallpox. We read that the chickenpox rash never affects the palms, so I used a device of the home-visiting doctor and visited again saying, 'I was just passing'! I contrived to examine the hands and with huge relief I found there was no rash on the palms. The officer's rash went through all the phases of a chickenpox rash and he recovered.

The second was an early morning call to a caravan, where a young soldier and his wife had found their baby lifeless in its cot. It was my first experience of cot death and the anguish of those parents remains with me.

My third memory is of being duty medical officer when a high-ranking officer failed to return from a horse ride on Salisbury Plain. He was found with his leg trapped under his horse, which had died under him. He was taken to his quarter and I was called. He greeted me with a large whisky in his hand and offered me one to make up for the anxiety I had suffered. I looked at his swollen and bruised leg and agreed he could stay at home – and then worried the rest of my night away as I remembered the side effects of crush injury.

HOME VISITS DURING 31 YEARS IN CIVILIAN PRACTICE

Setting the scene

The NHS was just 13 years old when I began doing home visits as part of my work as an assistant in general practice in Wakefield. I mentioned earlier that, pre-NHS, doctors billed for home visits they made to family members. The worker in the family was usually covered by a works-associated insurance scheme. It was a big change when the NHS started and you could now send for the doctor and there was no bill. The regulations, in what was the called the 'Red Book', always stated it was the doctor who had to decide if a home visit was necessary, but there was a national mood which could be summed up in the phrase, 'they have got to come out to see you now.' Most doctors, to their own detriment, took the easy option and tended to visit. This was perhaps just to prevent the hassle of justifying their decision. It looked bad for the doctor if there was an unhappy outcome and the doctor had not visited.

The other thing about visiting in those early days was that few patients had cars. The Victorian terraces of Lancaster would have perhaps three or four parked cars per terrace. Now there are often three cars to each house (ie, the family car and a couple owned by sons and daughters still living at home). With most families being without personal transport, it was not possible for doctors to ask for the patient to be brought to the surgery. The doctor's working day reflected the social situation, with surgeries morning and evening, and plenty of time for home visits in between.

I always had the comfort of a modern car for my home visiting, but Dr Aitken, who founded my practice in 1903, made calls using a pony and trap. I thought of him when I came across the painting of the 'Country Doctor (Night Call)' by Horace Pippin, in a book on American art.[2]

Doing home visits throughout the year meant dealing with inclement weather. Snow was always a problem. I remember walking the last quarter of a mile to a farm cut off by snow. I don't think I ever felt as isolated as Horace Pippin's doctor appears to be in the painting.

Consultant home visits

It was part of the new NHS that a GP could call in a consultant colleague to give a second opinion at the patient's house. It was recommended that this should be a meeting of the two doctors, but there was a loophole in the wording of the regulation and somehow this aspect of the NHS became

Country Doctor (Night Call), 1935, by Horace Pippin (1888-1946)[2]
Photograph © July 2010 Museum of Fine Arts, Boston

diluted, so latterly, the consultant would visit alone and the principle of the two doctors conferring at the foot of the bed was lost. Towards the end of my career, the whole idea lost favour with the consultants. They preferred, increasingly, to see patients at their clinics, where they had means of further investigation easily to hand; but the losing of the home consultation was, to my mind, a loss to the NHS.

Dr William Hay, general physician, Lancaster and Kendal, was always happy to see a patient with the GP at the house. I go back now to the portable ECG being a rare thing. Dr Hay had a rather cumbersome and heavy machine and one of my duties, if an ECG was needed, was to run out a wire to the bathroom and earth it to a bath tap with a crocodile clip. I had a request for a consultant domiciliary visit backfire in a most embarrassing way. Dr James Brown, consultant radiologist, agreed to do a chest X-ray at an outlying farm. I had not noticed there was no mains electricity at the farm and Dr Brown went all the way out and could not use his portable machine. Anticipating my embarrassment he took over and brought the patient back to his department. When he reported, he slipped in the words, 'brought patient in – no electricity at the farm.'

Communication when on rounds or on call

In these days of easy communication by mobile phone, it is hard to believe that the GP would set off on the round of home visits without any means of being contacted by the surgery staff. The only thing they could do was to look at the list of calls being made and then try to catch the GP at a house with a telephone. The same thing happened when a GP's spouse was taking calls at home during evening or night duty. Often, the GP doing a call was 'not found' and, if this happened, the spouse signalled to the returning GP that there was another call by turning the house lights on. Then it was straight back into the car and off on the new call! Another device was to ring back to base from a telephone box.

A GP friend headed for a telephone box to ring home to see if there were any more calls. A young woman was just leaving the box. The distress on her face turned into a broad smile. 'My, my! That was quick, Doctor. I have just rung for you – my baby is really poorly . . . '!

I had the use of a bleep for about the last decade of my home visiting and on-call duties. The bleeps became more sophisticated and could display an address. Mobile phones had not come into widespread use when I retired at the end of 1992.

Some statistics

I have looked at my 1992 diary and found I made 116 home visits on 20 working days in February and 109 on 20 working days in June. This averages at between five and six calls a day. I am sure this could be easily doubled – even trebled – for the earlier years of my time in practice. Weekend duty consisted almost entirely of making home visits, although occasionally one opened up the surgery and saw one or two patients in a consulting room. I kept a record of my 'out of hours' work over my last 11 years in practice and found that I averaged 26.5 home visits per weekend. During ten years of this period, I also recorded the night calls which actually got me out of bed, and these totalled 254. Extrapolating from this figure, my 'out of bed' home visits, in three decades in practice, become 762!

Many patients were surprised to see a hint of pyjama at the neck or showing below the trousers. 'Were you in bed, Doctor? We thought you would be on stand by at the surgery'! One always went to bed hoping the telephone would not ring.

Was this a record?

I happened to be the partner on evening and overnight duty when the 1969-1970 influenza epidemic struck. There was no chance of a public announcement to advise, 'stay at home – don't call the doctor', or, 'send a friend to the NHS Trust for Tamiflu'. At that time, working persons required a 'sick note' from their doctor if they were off work due to illness. Self-certification for short periods of illness was a long way off. We taped extra pages in the diary to receive the mass of requests for home visits. We divided the town into zones – I was given 'Bowerham and Scotforth' and simply went on and on from house to house all day. Then, I was on duty all through the evening. On the Ridge Estate, at about 9:00pm, I met Dr Ted Anderton from the Owen Road practice, Skerton, Lancaster. Between us, we were covering 23,000+ patients. I wound down my window and called across, '… just done my 50th call.' Ted's reply, after a quick look at his diary, was, 'I'm just going to my 60th.' Dr Anderton has kept his diary. The day was the 29th December 1969, and he went on to do 64 calls in the day.

SOME MEMORABLE HOME VISITS

Not all of these cameos are about my own visits but all are true.

Knock and walk in

I did a few calls with one of the partners in Wakefield. This was to familiarise me with the geography of the city. I noticed the doctor always just 'knocked and walked in' – calling out 'Doctor!' I asked him about this and he said the patient was always expecting the doctor and it saved time. Then he added a lovely story. Wakefield, like Lancaster, has the rows of terraces with identical houses. One day, he 'tapped and walked in' to find the family at lunch, but all sitting at the table naked. He was in the wrong house and this family were naturists!

Chamber pot problem

Chamber pots were used extensively in the Lancaster terraces. When indoor toilets had been fitted, they were often downstairs. The rather heavy lady I was asked to visit urgently had had the pot break under her and her buttock was lacerated. This was a good-sized wound and I advised she should be taken to Casualty for stitching. But she was embarrassed by the injury and pressed me to stitch her up at home. So, I got my drum of obstetric stitching items out of the car and did a nice job for a very grateful patient.

A visit by boat

My partner, Dr Roger Lomax, had his small sailing boat moored on the Lune at Glasson Dock. One day, he received a call to make a home visit at Sunderland Point, which is on the west bank of the Lune (south and west of Glasson and only reachable by road at low tide). Roger knew he would be sailing in the afternoon – his half day – so he took his bag, stethoscope and prescription pad, landed at the Point, saw the patient and is now rightfully famous! His exploit is not forgotten at Sunderland Point.

The practice had patients at Sunderland Point because Dr Howat senior had a holiday caravan there during the Second World War. We also had a few patients at Aughton, which is quite a way up the Lune Valley. This was because Dr Howson's wartime holiday cottage was at Aughton!

Scared stiff

One late evening, I was called to a young man by his girlfriend. He was in an acute anxiety state. It was bit puzzling as the girlfriend was not with him when I arrived. I can't remember what was underlying his distress but I counselled him for nearly an hour and then felt I had talked him down enough to leave him. I felt he was safe but he should see his own doctor in the morning. Almost as soon as I reached home the girlfriend called again asking me to go back as the patient was still distressed. Back at the house, the door was ajar and in the dimly lit hall a figure was hanging. My heart sank – surely not, suicide – then a voice called out, 'that you, Doctor? I'm OK. My girlfriend rang because she is still worried about me; she has just brought back my wetsuit. It's hanging in the hall.'

Did you say forceps, Doctor?

This is about my patient having her third baby at home. The midwife was in attendance, and I was called when there was delay in the second stage. The midwife and I conferred at the foot of the bed. We must have wondered aloud about my using the Wrigley's forceps I always carried with me. Then we heard a voice, 'Did you say forceps, Doctor?' I had not had time to explain our thinking when our patient made a huge effort and the baby appeared! The baby was face to pubes, which explained the delay. Obviously my patient did not fancy the idea of a forceps delivery.

Dead patient says 'Hello, Doctor'

A doctor friend was called to certify that an elderly lady had died. He went up to the bedroom alone and when moving the nightie to check that there was no heartbeat heard, 'Hello, Doctor. Why are you here? We haven't sent for you.' With commendable cool, the doctor said he was 'just passing' and had thought he would drop in! When going downstairs and giving the news that Grandma was alive he was greeted with, 'In that case, we had better stop the undertaker coming as well'!

Dr Chippendale, what are you doing here?

This cry came from a young married woman who was a severe insulin-dependent diabetic. In the small hours, her husband had realised that she was in a hypoglycaemic coma

and called me. I injected glucose intravenously and she came round. She was quickly lucid (as I found often happened with treated hypoglycaemic coma) and immediately took in bedroom, night time and doctor, and cried out, 'Dr Chippendale, what are you doing here?' Her husband was at the foot of the bed, relieved at the prompt recovery, and highly amused by her remark.

Using the obstetric flying squad

When doing home confinements, as we did for the first decade of my time at Dalton Square, it was always comforting to know there was the flying squad available at the hospital. My partner, Dr Lomax, required this service for a post partum haemorrhage and I used the service for two patients who had bled heavily with incomplete abortions. On both occasions, I found a white, shocked patient with evidence of serious blood loss and in seconds I had called downstairs, 'Phone RLI – 999, if necessary. Say – Doctor needs obstetric flying squad immediately at ____.' One patient's home had a telephone, but at the other home, the relatives had to rush to a neighbour's house to telephone. The response was quick, and in both cases, by the time I had done basic first aid, ie lifted the legs and was looking to set up a drip, the obstetric registrar arrived. We got the drips going together and the patients survived.

Two unexpected babies

Two young women were pregnant and had reached a late stage without their families knowing. My first call was to 'suspected kidney trouble causing backache'. In fact, I found labour well advanced and arranged urgent admission to the labour ward, where a fine baby was produced. The young woman's mother commented, when the enormity of the event sank in, that she had been worried seriously about her daughter putting on weight.

The second call was to a scene of drama where another unexpected, but equally fine, baby had actually been produced. I think a neighbour with midwifery experience, or a hastily summoned district nurse, had dealt with the cord and afterbirth. As in the first case, there was was an attentive boyfriend or fiancé. The remarkable thing about the second case was that the young woman's parents were abroad on holiday and I heard the fiancé on the telephone telling them they were first-time grandparents. Their response was of joy – thank goodness.

Chronic visiting

I inherited a list of patients who were being visited at home by my predecessor on a regular basis. Often, these were the elderly with a number of medical problems. The previously mentioned absence of personal transport contributed to this part of the doctor's work at that time. Also, there was no easy wheelchair access to the surgery until the 1990s. In the case of patients expected to die, it was good that the doctor was in attendance to prevent referral to the coroner and possibly a post mortem examination. Many people in the Lancaster of the 1960s and 1970s had a hatred of post mortems (and also an illogical fear of being admitted to the Infirmary – 'People die there').

A GP visiting regularly was much appreciated by the patients. Dr Howat also inherited a list of 'chronics' from his father. In his early days in practice, as he was leaving after a call at a nursing home run by nuns, he was asked if he would like a glass of milk. 'Your father always liked a glass of milk', the nuns said. A bit mystified, he said, 'Yes' and the 'milk' was produced. It was laced heavily with whisky!

The chronic visiting list would also include terminally ill patients. There was no hospice care for at least half of my time in practice. In my last year, 1992, 34 of my patients died, but only six of these died under my care – at home, or in a nursing home. Nineteen died in hospital and nine at St John's Hospice, Lancaster. Only ten babies were born into my section of the practice in 1992, and they were all born in hospital.

About meningitis

In my 31 years in general practice, I saw just three cases of bacterial meningitis. I saw quite a number of cases of viral meningo-encephalitis, but only the three cases of meningitis, and I was taking a full share of the acute calls of a 13,000-patient practice. The first case was straight forward – urgent admission quickly arranged.

The second case I remember more clearly, as the little girl's father rang saying, 'I don't want you to come, Doctor, but . . .' and then went to describe his daughter as being delirious with high fever. It was about 5:00am and fortunately I ignored his opening remark, got up and saw the child. I found meningitis and took the child with her mother to the children's ward at Beaumont Hospital, Lancaster. The little girl recovered fully.

My third case was an adult who had tried to 'run off' his headache and then deteriorated over six hours the next day. He had a stiff neck but no rash that I could see (but see below). He was ill and I diagnosed meningitis and quickly fixed up admission. The ambulance was at the door, so I went for quick transport of a short distance to hospital rather than delay in giving him penicillin. As he was being stretchered into the ambulance, I saw the soles of his feet were developing the rash of meningococcal septicaemia. Was his rash starting on his feet because of the pounding they had had the previous day? He made a full recovery.

I could go on!

A patient with severe asthma who, as he collapsed, pulled the washbasin off the bathroom wall; a lady, who feared being buried alive, who left an instruction that she had an artery opened after death; a patient at an outlying farm being carried on a quickly detached barndoor to the ambulance two fields away; the death of a barman behind his bar and the landlord saying that, by regulation, he could not close down his pub; being called to a breech presentation during the opening ceremonies of the new St Martin's College; creeping along a landing behind a burly policeman with a riot shield because a disturbed patient was throwing metal objects . . .

CONCLUSION AND COMPARISON WITH PRESENT-DAY CARE

What I have described is a mixture of routine home visiting dictated by the social circumstances of the times, and being a lead person of the 'first on-call' system of my time in practice. In a crisis at home, the GP would always be first person to be contacted; sometimes we would advise calling an ambulance, or be the one to decide to call an ambulance after seeing the patient. Latterly, we always took the portable ECG machine and a nebuliser with us when on call and I kept a drip set in the boot of my car to the end. One kept one's bag topped up with emergency drugs. Oxygen was available if an ambulance came and the district midwives carried a miniature oxygen apparatus for newborn babies.

Over the last 20 or so years, the ambulance service has changed and developed its paramedical section. Calling the ambulance now means that highly trained personnel will arrive quickly. They will have all the modern equipment, ie defibrillator with built-in ECG, oxygen, inhaled analgesia, etc. In acute myocardial infarction, speed in giving the patient a clot-busting drug is now vital. These drugs were just coming into use as I retired. Alongside this service, the hospitals have expanded their accident and emergency departments so that medical emergencies can be received, investigated, diagnosed and appropriate further care decided in a few hours. This method of pre-admission assessment and investigation is also available for children. Recently, in Lancaster, the local GPs have started doing sessions as part of this investigating team. In mental health care, there is a team available to deal with acutely disturbed patients at their homes. My successor will not need to creep along behind a riot shield as I did.

My equivalent doctor in practice no longer has the 24-hour, 365 days of the year responsibility for his or her patients. From 8:00am until 6:30pm on weekdays, they are responsible for emergency care, but after 6:30pm and throughout the weekends they may pass that responsibility over to the Primary Care Trust (PCT). The GPs lose income if they pass over the responsibility. Of course, they may prefer to be on call for their own patients or be available to be part of the PCT team doing the 'on-call' work.

My guess is that the population is still producing the variety of cases I have described, but the cases are being dealt with by teams, no longer led by the GP. In emergencies, the calling of the ambulance is the first move now. No longer is the first thought, 'We'd better get the doctor'. A GP might be thought to be mismanaging the emergency if the paramedical ambulance is not called first.

POSTSCRIPT

I end with a couple of whimsical thoughts. An 'old' GP once told me, 'Do not be too worried if you find the curtains drawn at the house you are visiting. Yes, it may mean a death, but it could just be measles.' The curtains were drawn because a child with measles was usually photophobic. After retiring from general practice, I continued working for the DHSS on a part-time basis. Appropriately for this article, my work including making home visits to house-bound claimants. Often, a couple needing attendance allowance would be failing to attend to their front garden due to infirmity. So, if uncertain about which house to visit, one looked at the state of the front garden. My wife and I are still keeping ours tidy!

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