blood pressure in someone already hypertensive. In this case hypotensive therapy is undoubtedly something one must consider. In geriatrics we do not see many people with severe hypertension producing symptoms, although we see a good deal of the end result, the type of arteriosclerotic dementia our last speaker was talking about. There are people in late middle-age who have a dementia, which has been regarded in the past as partly due to recurrent attacks of hypertensive encephalopathy, but acute episodes are not common in old age.

Dr Pasmore (*London*): I am thinking of one particular patient, an intelligent woman of about 80, who fell over and sustained a bad cut on the forehead. On going into her background I found that she had been treated in the past for cervical spondylosis and I must admit that I had not realized until this evening that these falls probably resulted from ischaemia and I had not thought of suggesting a collar for her. The important point is that if this is unnoticed and untreated for any length of time, the patient may become an invalid. This particular woman is afraid to move because of these falls and it has been difficult to know what positive measures to suggest. I wonder if Dr Brocklehurst could make any suggestions as to the correct sort of collar to use in this case. One which seems fairly acceptable is a strip of polythene foam put into stockinette which the person can use as a scarf when he goes out.

Dr Brocklehurst: Try a home-made collar first, to see if it is going to be helpful. If it is accepted by the patient, and it does seem to diminish the incidence of drop attacks, then I am sure it is worthwhile getting a proper one made. I do not think it would have to be a great big collar like those used in cervical spondylosis where there is pain in the arm or perhaps a developing weakness in the leg. All that is needed is something simple which prevents backward and forward movements of the head, and this is easily obtainable through the National Health Service.

Dr Lucas: We appreciate the dangers of anticoagulant drugs in stroke but what about the dangers of angiography?

Dr Brocklehurst: Angiography may precipitate further cerebral infarction, and if there is some good reason to use angiography then I think it must always be used with great circumspection. It should probably be ordered by a neurosurgeon rather than by a geriatrician, unless he is a specialist in this field.

Dr Godfrey (*East Grinstead*): What about the use of drugs for the treatment of depression in the elderly patient at home following small strokes?

Dr Brocklehurst: Imipramine is the drug that I would use, giving 25 mg three times a day for a fortnight or so and then reducing it to 10 mg three times a day as a general guide. There are so many drugs that I think we should become familiar with just one and continue to use it.

'G' is for general and geriatric

Dr J. R. Caldwell, M.B., B.S., M.R.C.S., L.R.C.P., M.R.C.G.P. (*general practitioner*)

I am greatly honoured at being asked to speak here in such distinguished company. Indeed I am reminded of a drunk on a Glasgow tram who bent over to the man opposite and said "I know who you are." "Indeed?" "Yes, you're one of the professors from the University who thinks he knows everything." Silence. "But I know something you don't know. My old woman does your washing." "Indeed?" "And I know something else you don't know. This is one of your shirts I'm wearing." Unfortunately I have neither his Dutch courage nor I fear any secret fund of knowledge.

Certainly I do not propose to teach my grandmothers how to suck eggs; I am sure you all know at least as well as I how to treat your patients with cerebrovascular disease.

Instead I propose to pose some questions which are I hope pertinent and which may stimulate some thought and discussion.

First, have we family doctors a part to play in the treatment of geriatric patients in general and those with cerebrovascular disease in particular? Or should we concede that anything we can do others can do better, and withdraw? With 11 per cent of the population already over 65[1]—in East Sussex the figure is over 20 per cent[2]—and in some of our coastal towns 30 per cent with 50 per cent of our elderly patients in need of our care, only eight per cent requiring hospital care, and only one half of these, permanent hospital accommodation, the answer would appear to be "Yes, we can and must attend them."

But are we really necessary, or can home care be delegated to partially trained ancillary personnel responsible to the medical officer of health or hospital consultant? And do not deceive yourselves, there are those who think it could. Politicians know it would be cheaper, administrators suspect it would be easier, and some consultants having a poor opinion of family doctoring, might like thus to reach into the patients' homes before and after hospital treatment. I do not think the patients have thought this far, but I suspect they might not approve. Personally, I am sure that the care of these elderly folk, often with multiple pathology, should be in the hands of qualified general physicians interested in all aspects of health and accepting full and continuous responsibility for their care. I believe that where ancillary helpers are employed they should be responsible to and work with the family doctor.

As an example of how things should not be done may I instance the case of the psychiatrist who wrote to the general practitioner that she was arranging for a welfare officer to visit one of his patients and keep her under observation, then no one did anything except the patient, who, a week or two later, jumped in the well.

How much of the care of our patients should be delegated to others? As lists swell, as patients become more demanding and certificates more complex, the general practitioners, myself included, tend to withdraw, with full Ministerial approval, into the relative tranquillity of group and health centres behind a screen of ancillary dragons, venturing forth less and less into the homes of their patients where the elderly remain depressed, lonely, unwilling or unable to be a nuisance, perhaps forgotten; after all Professor Henry Miller and such great folk repeatedly label our home visits unnecessary and wasteful and it would seem from recent correspondence many of our own colleagues agree. All this may be unavoidable, but necessity is not always virtuous, and if necessity consists of fitting into the frame work of the existing National Health Service, perhaps that framework requires modification.

The late Lord Horder on leaving the pathology laboratory for clinical medicine is reputed to have said "I have not deserted the bench for the bedside but brought the bench to the bedside." May a future generation look back on us as the family doctors who deserted the patients' bedsides for our centres? If so will it be considered to our credit? Not I suggest unless alternative arrangements are made for us to keep in contact with those genuinely unable to attend the centres, especially in rural areas.

But back to cerebrovascular disease. What can we do to prevent these catastrophes? There should be a unique bond of trust between us and our patients, and if anyone can influence them to give up bad habits and cultivate good ones, it should be us, or is this an excessively pastoral view? And incidentally need the 'pastoral' be unscientific or vice versa? Failing that, the early diagnosis and proper treatment of conditions such as hypertension, diabetes, obesity, renal disease, hyperuricaemia and the like can all help to protect our patients' cerebral arteries and minimize the effects of damage—as yet such early diagnosis and treatment depends entirely on the family doctor except in isolated mass screenings.

When cerebrovascular disease is established what is our function then? First we are likely to be responsible for the immediate diagnosis. A drop attack? A little stroke? A big one? Is this headache the herald of a subarachnoid haemorrhage? Are these the early mental changes of cerebral arteriosclerosis, anticipation of which may lead to early treatment and the execution of appropriate domestic, financial and legal arrangements before the patient becomes helpless and compulsion distressingly necessary.

Are these cases suitable for treatment at home? Drop attacks and little strokes, requiring primarily advice and reassurance, are surely best treated at home. Even in major cerebrovascular accidents the essential treatment seems little changed since Caelius Aurelius in the fifth century advocated active and passive physiotherapy with the active co-operation of the patient. And, incidentally, I include in active physiotherapy the patient making the effort to sally forth independently to shop, park seat or doctor's surgery. Unfortunately, such sturdy independance seems likely now to cost him his exemption from prescription charges. This cure can, and in many cases should, be possible in the patient's home. Indeed in 1957 Rankin[3] showed that of cerebrovascular accidents treated at home 58 per cent died in a few days and this includes those dying instantly or very early; of the rest 76 per cent regained the ability to walk; 60 per cent became independent and seven per cent died within five months. Figures not all that different from those obtained in hospital. Nor do I see great merit in reducing the numbers of those granted a quick and easy release only to swell the ranks of the wretched, crippled, aphasic and demented.

Also I believe the confused and demented sufferers from cerebrovascular degeneration will generally do better in familiar home surroundings amongst familiar faces, attended by an old friend, the family physician.

But to achieve all this efficiently there must be co-operation with our specialist colleagues and ancillary workers. How good is the co-operation? For it must be a sturdy two-way exchange, not a mere swapping of pleasantries on occasions such as this. Unfortunately, the domiciliary visit seems too often to have degenerated from a true consultation between the family doctor and consultant at the patient's bedside to the great advantage of all three, and to have become a mere unaccompanied visit by a specialist to the patient's home. Indeed in some cases the family doctor finds it almost impossible to talk to the consultant on the 'phone—messages and replies having to pass exclusively through a secretary. Most commonly this seems to occur in psychiatry and geriatrics, which is sad as these patients are those least able to communicate and most likely to lose their liberty. Now that the rot has set in a definite effort must be made if this trend is to be reversed and I, having a venal mind, feel a fee payable to the attending general practitioner and an addition to the consultant's fee when the general practitioner attends might serve this purpose.

Local authorities provide, directly or indirectly, all manner of facilities—meals on wheels—home helps—incontinence pads—night sitters—occupational and physiotherapists—aids for the disabled etc. Do they always ensure that all the family doctors know what is available and how to get it? Surely this is quite as important.

In one case there may be involved a day hospital, a physiotherapy department, one or more specialists, nurses, social workers, the family doctor and may be a locum or stand in. Is there perhaps a place for a personal communication card to travel with the patient as is now customary in obstetrics? At least it might list current medication.

Finally, once cerebrovascular disease has developed, be it the insidious creep of mental confusion or the dramatic crash of cerebral haemorrhage, terminal care is inevitable and often imminent. Who can do this better than us, where better to do it than at home?

But—my final question—How well trained are we for this important and often

difficult task? Indeed I do not recall receiving any formal instructions myself as a student, I wonder if things are different nowadays? Perhaps because many hospital teachers themselves seldom cope with the dying and their relatives. A patient of mine died recently in one of London's leading hospitals, his wife later told me how well he had been looked after and asked me to thank the staff on her behalf adding "I did see the professor the day before he died but he was in a hurry and just nodded to me." From the family doctors, the relatives of our dying patients rightly expect more than a passing nod. On this and other matters we can I believe all learn a lot from the book *Doctors and patients* written by a fellow general practitioner, Dr Mark Hodson, who knew himself to be a dying man when he wrote it.

Adams in 1961[4] showed that even those surviving six months after a stroke have a greatly reduced expectation of life and that death, when it comes, may bring welcome relief to tragically stricken invalids and sorely tried relatives. Hinton in 1963[5] showed that 11 per cent are unconscious in their last week, 33 per cent in their last day, 66 per cent in their last six hours, but Osler in 1904[6] found 15 per cent of patients dying in distress, and nearly 60 years later Exton Smith[7] still found 13 per cent in moderate to severe pain and seven per cent distressingly nauseated, dyspnoeic or dysphagic, a marked lack of progress in our age of computers and cardiac transplants. During the terminal stage of life, after cerebrovascular disease, it may be difficult to remember that this poor, paralysed, confused, incontinent wreck was once a decent, able man or a kind and loving woman, but we family doctors have no excuse for forgetting our patients as they were before being thus cruelly stricken.

I believe most elderly folk wish to end their days at home. I believe most relatives wish to extend this last service to their loved ones. I believe it is our duty and privilege to help them to do so, easing symptoms, advising and encouraging relatives and finally ensuring a peaceful, painless death.

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Discussion

Dr Irvine (*consultant geriatrician*): I was interested in Dr Caldwell's point about not being able to get hold of a geriatrician on the telephone or have a domiciliary consultation with him, because he can never get further than his secretary. The reason is that both in geriatrics and in psychiatry the consultant's case-load is anything from three to five times as great as the case-load of a general physician, and I think this point should be realized. I hope that one day there will be an appropriate redeployment of consultants in the National Health Service.

Dr Lucas (*London*): I feel I ought to say something about the problem of consultation. Great changes did take place with the introduction of the National Health Service, but I and most of my doctor friends have persisted in trying to fit in with the consultant and this is much more helpful to everybody concerned. I have been gently edged out of psychiatry by the specialist because when the psychiatrist sees the patient at home he decides it would be most