



Why we do not make housecalls

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The three articles on housecalls in this issue of *Canadian Family Physician* (pages 2022, 2044, and 2053) summarize the world literature concerning their value as well as their decline. Physicians of ancient times went to see patients; barber-surgeons always had their clientele visit the “surgery.” Today, family physicians act like the latter of our medical ancestors and have the sick, the tired, the frail, and the old dust themselves off and traipse into our offices.

Although I do up to 10 (and rarely fewer than five) housecalls per week, I have compiled a list of why family doctors in Canada do not make such visits. Perhaps this list is incomplete or, alternatively, is too malicious for your delicate tastes. If not, read on.

Lack of role models

Ferrier and Lysy (page 2053) note that one third of housebound elderly people do not have family doctors. Such people will not get housecalls if all doctors’ practices are closed. Meanwhile, doctors who have never been trained in home care of the elderly are unlikely to be comfortable with sick, old, housebound people and are unlikely to seek out this kind of activity. Younger doctors lose the chance to learn if the doctors who teach them do not make housecalls. As a result, this part of the healing art gets lost.

Lack of diagnostic support

Modern medicine has supplied the technology to expedite the diagnostic process and, for some conditions, the criterion standard demands laboratory or radiologic input; however, these wondrous developments contribute to the deterioration of bedside clinical skills. Twenty-five years ago, we did not have computed tomography scanners, HbA_{1c}, or cardiac enzyme assays. Today, however, we are so accustomed to using these hospital-based diagnostic appliances that some doctors cannot make a diagnosis and develop a plan of care without them. Pereles (page 2044) notes that pelvic and speculum examinations can be done at home with the help of an assistant and good light.

Still, doing routine procedures in an unfamiliar environment puts some doctors off and prevents them from assessing their patients at home.

Bad manners

Unfortunately, some patients can be inconsiderate to physicians by not respecting their schedules. “Don’t dare come visit Mom during her bridge afternoon.” Or even better, “Sorry Mom wasn’t there when you visited. She had to get her hair done.” “Seeing as how you’re coming over, I want you to examine our next-door neighbour. He hates doctors, and anyway his own doctor won’t make housecalls.”

Environmental contamination

Some people live in squalor and others fail to keep the sink free of dirty dishes or the bathroom towels clean. To quote a sage surgeon of yore: “In some houses you don’t take off your boots and you don’t sit down.” Still, sick people in a house without proper washing facilities make for a potentially dangerous situation. Doctors who worry about the lack of appropriate hygiene will not visit these patients, and concerns about spreading disease to themselves or others will prevent them from making housecalls at all.

Getting lost

“Keep going on past the church. Third last house on the left. You can’t miss it.” In 1968 it was the third last house on the left, but now it sits two houses shy of a huge subdivision. Houses with poor lighting and shaded numbers, addresses with no street signs, dirt roads, and one-way streets frustrate physicians into abandoning the exercise.

Interdisciplinary teams

Managing medical and surgical conditions has gone from institutions into patients’ homes, the care being delivered by a team of professionals from various disciplines. Some of these teams function without family physicians, which I find interesting in that, at some point in people’s illnesses,

physicians need to be involved in diagnosis, treatment, and follow-up care. Also, if we do not make housecalls, we will not misappropriate our valuable time by attending low-paying (or no-paying) interdisciplinary rounds. As if that were not deterrent enough, many doctors are intimidated by such teams, preferring instead the autonomy of the office.

Fear of assault

If a patient or family demonstrates anger, entitlement, and exhaustion, and if the visiting doctor becomes the focus of this triangulation, things could get ugly. Worry about such potential trauma will keep physicians away. Fear of litigation, accusations that the physician stole grandpa's watch, apprehension about vehicle vandalism, or concern over parking tickets are all real worries.

Overawe

Most of the people receiving housecalls are elderly; many are frail, forgetful, or preparing to die. Any doctor could easily feel overwhelmed by the complexities of geriatric care and intense family entanglements. Apprehension over physicians' role in end-of-life care and the ensuing frequent follow-up visits causes many doctors to avoid this kind of care.

Although psychobehavioural problems and caregiver stress and burnout are assessed equally well in the office or at home, home visits might be the only way to deliver medical care to frail patients. On the other hand, doctors can quickly exhaust their eagerness and energy for plunging into these complex clinical situations and simply refuse to make housecalls.

Inefficient use of time

In the office I can see five patients in the same time it takes me to see one patient at home, even after clumping my home visits geographically and setting aside half-days for the process. A daytime emergency visit takes a doctor from the office for at least an hour and sets the clinic schedule on its ear. An after-hours visit cuts into family time while early morning calls coincide with rush hour and require longer travel and parking times. Housecalls are not in the least bit time efficient.

Money

I gave a speech to a group of senior accountants, the type who run large companies and know how much everybody costs. They were amazed at the low rate of remuneration for housecalls. I called a plumber, an electrician, and an architect to see how much they charged for a home visit. None charged less than twice what I get paid for a housecall. Singer Bob Dylan said, "Money doesn't talk, it swears." Government agencies will pay for housecalls but not travel time and, because most of those needing housecalls are frail financially as well as medically, our travel time is not

recompensed. The science of medicine is being funded but not the art. Intraluminal stents and computed tomography-guided arterial wires are flashy and new and exciting; housecalls are neither.

None of the above

What if, however, one enjoys making home visits? Personally, I like the type of patients I attend at home: the fearfully frail, the defiant demented, the generally sick. I enjoy the challenge of diagnosing people in a dark bedroom corner, of leaving instructions concerning care and therapies, and of holding family meetings around the kitchen table or on the porch.

Justice for all

As I no longer work in the emergency department, most of the acutely sick people I see are at home. If I stayed in my office at the hospital, I would see mostly ambulatory, anxious, overly concerned consumers of health care with self-limiting illnesses. I am not saying that such people do not deserve our care and expertise or that we should not engage in preventive care or in general support during our patients' crises. Yet we do not need to spend all our time on such office-based activities. We could spare a little time to attend those who really need our skills and attention.

Although home visits are grossly underfunded in our cliché world of procedure-driven, fee-for-service financial practice, the question festers: how much efficiency and cash flow does one need these days to live a fulfilling life? By scheduling some time for daytime housecalls and by setting a definite geographic boundary, family physicians can legitimately break away from the captivity of the clinic and get a charge out of the real world. A change can be as good as a rest.

I am not asking that you give up your riches and follow me, but I am asking you to reflect on who needs you the most and how you can work to increase the common good in your community. Today people want "the

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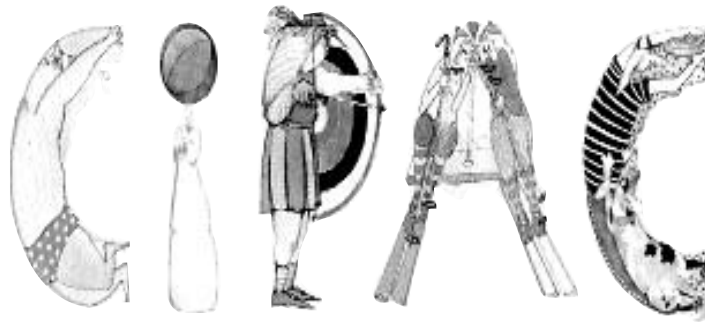
best specialist” for serious problems and expect the highest level of technologic expertise for such problems. Yet, this same public condemns the lack of home-care services when they want to keep their frail, confused relatives at home. We family physicians can function in the home while our technology-dependent colleagues at the hospital cannot. We have a role in our patients’ illnesses, a role that they and their families will remember long after the machines have been turned off.

The longer I am in practice, the more I value the opportunity to make housecalls and get out of my comfort zone of the clinic where my patients are scrubbed and on their best behaviour. To see where and how people live, to overcome the challenge of physical examinations in cramped quarters, to support caring family members are all legitimate goals of family physicians. My personal contribution toward this goal is to make as many housecalls as I can and encourage my younger colleagues in training to do so too. How about you? ♦

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