Editorial

Whither the housecall?

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If an idea's worth having once, it's worth having twice.
Tom Stoppard

Patients frequently complain that doctors no longer make house calls."[1] This was written by Loftus et al in a 1976 study in *Canadian Family Physician*. What might they say today? Of all the things family physicians do, perhaps our greatest ambivalence is toward the housecall—on the one hand recognized as an important part of general practice throughout the history of medicine, on the other hand in steady decline since the 1930s (including a brief precipitous decline after World War II).[2-4] The many reasons for this decline have been well described and include inefficiency, lack of diagnostic support, inadequate compensation, lack of role models (as fewer of us do them), being overwhelmed by patient complexity, dealing with squalor, bad manners, and getting lost, or even fear of assault.[5]

The benefits of home visits—mostly relational—are also well known, but these have not prevented this decline. Older, frailer patients with multiple comorbidities are still most likely to receive home visits, and researchers have sought to demonstrate the cost-effectiveness of home visits in just such people. This has been difficult to do.[6]

In this issue, which focuses on care of the elderly, Stall et al (**page 237**) make the case for the importance and effectiveness of home-based primary care for the housebound elderly.[7,8] Like many family physicians, I have had personal experiences that speak to the value of such visits.

For more than a dozen years I looked after a woman who taught me some of the unexpected benefits of housecalls. She became my patient in her early 60s. For most of her adult life she had lived with her mother because a debilitating mental illness prevented her from holding down a job. When her mother passed away she was left alone and impoverished. For a time she lived on the street, panhandling to raise money for meals, cigarettes (something she considered a staple), and a place to sleep at night. Mabel was frail, and although she had no clear neurologic diagnosis, she relied on a wheeled walker to get around.

At first I saw her just a few times a year, but, tellingly, each week I received at least 1 or 2 reports of her visits to local emergency departments (EDs), usually with chest pain. She had risk factors for heart disease—high blood pressure and a 2-pack-a-day smoking habit—but the pain invariably resolved when she was given a "pink lady." The collection of ED reports and test results or referrals generated by these visits accounted for the several thick volumes of paper chart she had accumulated by the time I became her doctor.

Cet article se trouve aussi en français à la **page 235.**

Recognizing that many of these ED visits might be preventable, at first I tried to see her every 3 or 4 weeks. When that failed, I saw her every 2 weeks. And when that again failed, I saw her every week. Over a period of more than 2 years, nothing I did altered the frequency of her ED visits. Her chart grew by 2 more volumes, as did my frustration.

During this time I decided to make a housecall. Mabel was living in a seniors' home for the very poor. She had her own bed on a "ward" with 3 other women, the beds separated by curtains, and a communal bathroom. Because she was such a heavy smoker, Mabel spent most of her time in the cramped confines of a fenced-in yard, regardless of the weather. Although her appearance belied it, until her mother had died Mabel had lived in comfort, surrounded by books, and she kept a journal of her own writing that she would occasionally share with me. She hated the place she now lived, with its lack of privacy and "rough" characters.

A few months later, Mabel was offered a bachelor suite in a residence for people with disabilities—a place of her own with a small kitchen and a bathroom. I agreed to visit her at home each month to monitor her health. Over the next 2 years I dutifully visited her on Wednesdays, before or after my morning clinic. She would usually greet me at the door, then retire to her bed sitter. She would update me on her current health concerns and share a story or two about her mother, her past, or a book she was reading. I would check her pulse and blood pressure, perhaps listen to her chest or heart sounds as need be. Last, I would count and sort her medications, which she had scattered on her coffee table amid ashtrays and paperback books, back into their bottles (she refused to use a dosette). With that I would be gone until the next month. Although I occasionally had to change the time or day of my visits, I made sure not to miss them.

Almost immediately her ED visits ceased. In spite of her poverty and loneliness she seemed content. For my part, I began to look forward to these visits, and I think of them often, more than 5 years after her death. Whether this change in Mabel was because she had found a home or because of the power of the timeless ritual of the home visit, I cannot say for sure. Perhaps it was both.

References

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