Housecalls

Essential art in family medicine

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> *We define family medicine in terms of relationships, and continuity of the patient-doctor relationship is one of our core values. How can we justify breaking our long-term relationships with patients whenever, in sickness or old age, they become housebound?*[1]
>
> Dr Ian R. McWhinney

Almost 2 decades after Dr Ian McWhinney's lecture,[1] the call to champion home-based practice in primary care remains as urgent as ever. Patients who are homebound, whether owing to increasing frailty, medical complexity, or mental illness, experience difficulty in accessing care in the usual outpatient clinic setting. There are ample benefits to patients and their families receiving timely, high-quality primary care in their places of residence.[2] There is also growing evidence that clinicians and primary care providers find it meaningful and rewarding to provide vital services to this underserved and rapidly growing population.[3]

How do we prepare family medicine residents to have the competencies required to provide home-based primary care? There is a paucity of literature on the training of future family physicians in this important aspect of care,[4] and close to a quarter of family medicine residents report never having received training in home visits by the time they graduate.[5] Visiting your own patients in their places of residence as a teacher and taking along a learner brings the principles of family medicine to life. A housecall is a unique opportunity to see patients in their own environments, to provide essential care, and to informally mentor learners, all in one encounter.

Demonstrating CanMEDS–Family Medicine competencies during home visits

Most family physicians easily and readily provide feedback to learners on the CanMEDS roles of family medicine expert or communicator (eg, in field note format).[6] Opportunities to assess a learner as an advocate or collaborator might be less common in a typical clinic setting. In contrast, a housecall is intrinsically rich in opportunities to provide feedback to learners. Before arriving at the patient's home, the preceptor can prime the trainee to pay special attention to his or her role as the following.

Health advocate. A home visit is a chance to truly see the patient as a part of his or her community. What do the neighbourhood, housing, and home environment tell the resident about the patient's determinants of health (**Figure 1**)?

Collaborator. Nowhere is an interdisciplinary team approach more essential than when caring for a patient in the home. After an environmental scan in the patient's residence, ask the learner whom he or she might connect the patient with to help address the health needs identified (**Figure 2**).

Manager and leader. Compared with an office visit, the patient's home setting allows for a more contextualized evaluation of the effectiveness of the health care system in addressing his or her needs. Prompt the learner to think about health care organization, resources, and efficiencies; there are many examples of these concepts, especially in an urgent or a posthospitalization housecall (**Figure 3**).

After the visit, use the family medicine expert role to guide a reflection on the experience of seeing the patient in his or her own home, and a debriefing about the learner's experience. A simple prompt could be, "How would this visit have been different had we been in the office?"

Learner safety and supervision

Official policies related to safety during housecalls might vary depending on the educational institution or the learner's representative advocacy group (eg, the Professional Association of Residents of Ontario). Safety is paramount, just as it is in office or hospital settings. If the patient is unknown to your practice, an important first step is establishing that the patient, his or her in-home support persons, and the geography and environment are reasonably safe. But many, if not most, patients will be well known by the family physician and stepping into their homes will hold the same risks as other community activities and encounters in the neighbourhood around the family practice do. In fact, in one survey of an academic housecalls program in Toronto, Ont, 94% of family medicine residents did not see safety as a barrier to looking after their patients at home.[4]

Experienced clinicians can model this common-sense approach to safety for the learner on a joint home visit. Reference tool kits contain practical advice on how to prepare for possible problems, from bedbugs and barking dogs to the risk of crime and personal safety.[7,8] Professional liability for home visits by physicians and interprofessional team members can be addressed through standard insurance, as outlined in *A Canadian Provider's Handbook to Home-Based Primary Care*.[7]

Figure 1. Thinking like a health advocate

Neighbourhood

Do the housing and roads appear safe?

Is the housing low income, subsidized, or supportive?

Are the buildings accessible?

What is nearby (eg, grocery store, pharmacy, community)?

Home

Is the front door kept locked?

Is the home clean (eg, washrooms, kitchen)?

How does the patient navigate his or her space (eg, stairs)?

Do photos or decorations tell you about what is important to the patient?

Social supports

Who lives with the patient?

Who helps the patient with activities of daily living and instrumental activities of daily living?

Does the patient feel lonely or isolated?

Figure 2. Thinking like a collaborator

Medications

Could a community pharmacist help with medication management?

Could a support worker help with pill taking?

Are there medications prescribed by non–family physician specialists for reasons you are not sure of?

Self-care

Do family members help with groceries?

Can the patient pay for any housekeeping services?

Would a meal service help with nutrition?

Social supports

Do the patient's caregivers feel adequately supported?

Is the patient interested in volunteer friendly visitors?

Would a day program be appropriate?

Figure 3. Thinking like a manager

Resources

Does the patient need those non–family physician specialist appointments?

Would a palliative approach be appropriate?

Is the patient using his or her rented mobility equipment?

Systems

Can home visits keep the patient out of the hospital?

Is the patient accessing the right care at the right time?

Practice management

Do housecalls help or hinder practice efficiency?

How could technology better serve your patients?

Can physician remuneration be optimized for this housecall?

Geriatric and palliative medicine at its best

To reiterate Dr McWhinney's words from the beginning of this article, housecalls for geriatric and palliative patients are worth discussing, as they can be part of the long-term relationships physicians have with their patients. The importance of geriatric functional assessments, such as home safety checklists and fall risk questionnaires, becomes evident when keenly observing older adults in their own home environments, when they open the door to care providers, walk them into the living room or kitchen, or get up to find their pills. The importance of medication management is clear with one look at a tidy blister pack in an accessible location, compared with searching for and finding a bowl of mixed tablets, bottles, and empty puffers up in a cabinet. Encourage learners to "watch the patient in action" and follow up with prompts to translate their observations into a comprehensive and practical assessment of the patient.

Most Canadians, given the choice, want to be in their own homes at the end of life; only a small fraction actually have that option.[9] Whatever the model of palliative care is in your local practice area or your own level of comfort in managing symptoms, the unique honour of participating in end-of-life care can start simply with a supportive housecall to your terminally ill patient and his or her family.[10] Taking learners along will allow them to experience how natural and often spiritual the process of dying can be when witnessed outside the sterile hospital environment, in the midst of the person's belongings, and (if so lucky) surrounded by a caring family. Many competencies as a family medicine expert and communicator can be reviewed and reflected on when caring for palliative patients in their homes.

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Competing interests
None declared

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Teaching tips

- Taking a family medicine resident on a home visit offers unique opportunities for both the learner and the teacher to assess and provide one-on-one feedback on the CanMEDS–Family Medicine roles of collaborator, manager, and health advocate—competencies that are not easy to demonstrate and evaluate routinely in a standard clinic supervision setting.
- It is a safe and rewarding experience for learners to see a patient at home even once; if learners see patients longitudinally, the experience will encourage a greater sense of responsibility and increase their confidence in looking after homebound patients in the future.
- Allow the humanity and compassion that comes with visiting a patient at home to naturally lead the way in teaching residents. On both sides of the stethoscope, patients and physicians struggle to find the meaning in their relationship. Share the journey in reinvigorating the patient-physician relationship with your learners on housecalls.

Teaching Moment is a quarterly series in *Canadian Family Physician*, coordinated by the Section of Teachers of the College of Family Physicians of Canada. The focus is on practical topics for all teachers in family medicine, with an emphasis on evidence and best practice. Please send any ideas, requests, or submissions to **Dr Viola Antao,** Teaching Moment Coordinator, at **viola.antao@utoronto.ca.**