The House Call: Past, Present and Future

Brent J. Herritt, B.Sc. (Pharm), MD Candidate 2015, Faculty of Medicine, Memorial University of Newfoundland

This article is intended to provide the reader with an understanding of the house call. The house call will be explored in terms of its origins, present day practice, and potential future directions.

A house call can be defined as “a visit (as by a doctor) to a home to provide medical care,” but intrinsically it means much more. The classic image conjured may be one of a family doctor carrying a black bag en route to care for a patient in his home. House calls, having been performed for millennia, have allowed the opportunity for a physician to gain a perspective on the patient’s living situation, while interacting in an environment that is both familiar and comforting to the patient. This may be juxtaposed with a clinic waiting room where uncomfortable areas, strangers and even white coats can make patients’ blood pressures rise. Patients, in a hospital or clinic, may feel guarded, intimidated or uneasy. However, in their own homes, without these barriers, they may be at their most vulnerable, which provides the opportunity of establishing a strong relationship with them. On comparing an office visit to a house call, one family physician notes: “As we have less and less time to spend with patients during office visits, it can become more difficult to feel personally rewarded for another ear infection well treated. Compared with this, when I go into my patients’ homes and see them in the most personal and vulnerable state, I get a sense of walking on hallowed ground. Even visits for simple problems take on a meaningful hue.”

Until the 1940s, the majority of physicians in America and Britain saw their patients in their homes. This meant the physician would spend the majority of time on the road, in car or buggy, and considerable amount of time would be spent with each family. A diary from Dr. Richard Kay in 1750 described various house calls. For example, the entry dated June 7th recorded that the doctor was home in the morning, and made house calls or “visits” in the afternoon, not returning home until 1:00 A.M., having been “detained on account of reducing a shoulder that has been dislocated a month of Robert Schofield’s at Mill-hill in Hapton.” In the entry dated June 14th, the doctor saw fellow church member Joseph Baron, who had “pain in his right hip and belly plus gout,” and “the Baron children all had smallpox.” In the entry dated June 16th, the doctor made a number of house calls, but several were omitted because of “Brother Baron’s illness, he having made no water for some days past, has prevented me.”

Another physician from Kentucky chronicled a house call he made in the early 20th century:

“I recall an experience I had one winter day with the thermometer near zero and about five inches of snow on the ground. I was called about eight miles from home and found a young farm boy with a well marked case of appendicitis with apparent abscess formation. I called a very fine, competent surgeon from Henderson, Kentucky, to come prepared to operate in the home. . . . The patient being satisfactorily anesthetized, the surgeon removed the appendix and sutured the wound in about forty minutes. After the operation, the surgeon got in his buggy and started home, a distance of about twenty-five miles. I spent the night with the family and saw the patient daily for several days. He made a very rapid and satisfactory recovery.

Some years later the family had a son operated on in a hospital with modern skill and care. A few days later this son died. Sometime after the death the good old mother stated to me, ‘If he had been home where you and me could have cared for him, I believe he would have gotten well.’ I am sure the son had better care than he could have in the home. Some people manifested such explicit confidence and esteem of me, it made me love them and realize how great my obligation to them.”

The profound impact on the patient-physician relationship by interacting with patients in their own homes is evident in this passage.

Not only was the amount of time spent with each patient drastically different, but also the frequency of visits was astonishingly higher. Towards the end of the 1920s, American Family Physicians were making 3.6 calls for the average illness, 2.4 calls for a cold, 3.6 calls for a typical case of mumps or other “communicable disease”, 4.7 calls for a “nervous disease,” etc. This idea of expecting to be seen by a physician multiple times throughout an illness was echoed in Britain, as evidenced by a guide written about general medical practice instructing physicians that, “In the majority of cases, unless quite trivial, the patient expects to be seen every day for several days at least. . . . Even if you stay only two minutes and talk about the weather all the time, it comforts the patient and the relatives. . . .”

This was quite an extraordinary time period for the physician-patient dynamic. While there weren’t the same offerings

Corresponding Author:
Brent J. Herritt
Faculty of Medicine, Memorial University of Newfoundland
300 Prince Philip Dr.,
St. John’s, NL, Canada A1B 3V6
Email: bherritt@mun.ca
History of Medicine

The House Call: Past, Present and Future

in terms of biochemical knowledge, or more recent technological advances, patients had a very intimate relationship with their physician, and felt satisfied by that. The taking of time to explain concepts, frequently check in, demonstrate empathy etc., did well to increase trust in the physician, which has been shown to be inversely related with the incidence of malpractice lawsuits.10

The Decline of the House Call

Of American physicians practicing in 1928, high percentage, 74, were general practitioners (GPs).11 By 1942, the percentage of GPs had fallen to below half.12 This decline continued, as in 1980, while there were 403,000 practicing physicians in America, only 15% comprised family physicians.13 This turned out to have a devastating effect on the house call. In 1980, the National Centre for Health Statistics showed that it essentially became extinct, with 0.6% of patient visits occurring in the home.14 The trend of declining home visits has persisted over the decades, and has certainly played a role in the changing doctor-patient relationship. Whereas once a physician visited a patient in their home, often multiple times for a single complaint, now the patient may be placed in a ten minute block in a clinic setting, clearly altering the doctor-patient dynamic. In 2000, Canadian Family Physician noted that most commonly cited reasons for practitioners’ being unable to do house calls were the lack of efficiency, the time required, and poor reimbursement.15 Further reasons noted by the Journal of American Geriatric Society were the result of an explosion of biomedical knowledge and technology, increased access of patients to a growing medical system, the growth of third-party payers, and heightened liability concerns.16

The House Call Today

The demand for the house call today is stronger than ever. In Canada, the projected increase in the number of Canadians aged 65 and older from 2010 to 2020 is 2,029,299. This, coupled with the fact that 50% of health care spending in 2008 was devoted to Canadians aged 65 and older17 is cause for concern. Fortunately, as some physicians abandoned the house call due to decreased reimbursement in favor of the efficiency of clinics, provinces like British Columbia have begun to increase reimbursement for the house call in an attempt to spur its resurgence. This idea was successful in the United States, as in 1998 Medicare increased reimbursement for a house call by nearly 50%. Since this change, the number of house calls billed to medicare has increased annually.18 Between 1998 and 2003, the amount of house calls completed by geriatricians increased by 92%, compared with 41% for family practitioners and 59% for internists, while family practitioners continue to make the greatest total number of house calls.19 Given this information, provincial governments should look at reimbursement rates as a way of fostering house call growth. In a study published in the Journal of the American Medical Association, house call reduced emergency department and hospital use.20 Clearly, caring for people in their homes and keeping them out of emergency departments, hospital beds, etc., will have positive effects on healthcare spending. Given that both physicians and patients experience great satisfaction with care at home, and home care reduces healthcare expenditures, practicing physicians and medical students should be encouraged to practice this.

To further illustrate how house calls not only improve patient care but healthcare spending, National Public Radio (NPR) published two articles21,22 in 2005. A family physician who helps run the Medical House Call Program at the Washington Hospital Center in Washington, D.C., Dr. De Jonge, noted that while the average house call costs $100 (on par with current Canadian reimbursement as well), a typical 9-1-1 phone call, ambulance ride and emergency department visit cost $2,000. He argues: “On a day-to-day basis, making urgent visits and coordinating the care in the home is clearly going to prevent some of those high-cost events.” And when elderly patients in the program are hospitalized, De Jonge says, “they are discharged, on average, two-and-a-half days sooner than those not enrolled. In part, that’s because staff from the program will check up on them at home.” Also, considering that according to the Centres for Medicaid and Medicare services, the average hospital stay costs $3,500 per day, these are tremendous savings.

Furthermore, a house call program in Las Vegas, NV produced a 62% reduction in hospital days in a sample of 91 patients, producing annual savings of $439,825 for acute, skilled, and sub-acute days, and net savings of $261,225.23 A similar study published in the New England Journal of Medicine looked at intervention by a multidisciplinary team in patients with congestive heart failure to prevent hospital readmissions, and found that there was a 50% reduction in hospital readmission in high-risk patients.24 Given the impending financial pressure on healthcare spending due to the aging population, any measure that reduces healthcare expenditures will prove to be invaluable. House calls, proven to decrease healthcare costs, improve patient-physician relationships, patient care and physician job satisfaction, they can be a lesson from the past and a true asset in shaping the future of medicine.

Physicians often balance long driving times, decreased billable time or a feeling of “I could be seeing a patient instead of sitting at this red light” as cons to conducting house calls. Interestingly, a creative business plan called “Care Level Management”, pioneered by a businessman and a physician in 2001, aimed at providing a solution to that.25 Their idea was that they believed the house call saved money. To prove so, they contract insurance companies to provide house calls in exchange for a portion of the money the companies save as a result of decreased hospital visits. Physicians are salaried and carry a patient base of up to 120 patients, and are only responsible for these patients. The patients are organized by
proximity to the physician to decrease driving distances, and while they are on call 24/7, it is up to the physician to determine how and when they visit their patients. The company has been profitable since 2003, noting that in a study they commissioned, in six months they saved one insurer $7,000,000, an average of $22,013 per patient. Learning from this model, the Canadian Government could implement a similar program to encourage house calls here in Canada. Should this program decrease hospital admissions and save money, as it has in the United States, physicians could receive a percentage of funds saved as an incentive to continue this work and foster its growth.

While the recent trend in increasing house calls is encouraging, what are future physicians thinking? Student attitudes are changing as well. A medical school in the United States gave a survey to 123 medical students following a clinical experience with a preceptor doing a house call, and “student insights about the social learning process they experienced during house calls to geriatric patients characterized physician role models as dedicated, compassionate, and communicative. They also described patient care in the home environment as comprehensive, personalized, more relaxed, and comfortable. Student perceptions reflect an appreciation of the richness and complexity of details learned from home visits and social interaction with patients, families, and caregivers.”26 This was echoed in another study published in 2009 which showed that, as compared with controls who did not partake in house calls, general attitudes towards the elderly, time and reimbursement issues surrounding the elderly and home care training improved more in students who took part in house calls.27 The positive shift in thinking towards care in the home is encouraging, and demonstrates that using physicians as preceptors in these situations is a beneficial use of resources.

The House Call in the Future

The future of the house call remains uncertain. It, like the medicine profession as a whole, has undergone significant transformation over the previous century. Medicine now embraces an interprofessional team approach, as does home care. Often nurse practitioners, physician assistants, registered nurses, social workers, etc., all work together to coordinate care for patients not only in the hospital but also at home. Collaboration among these professionals is centered on providing a broad, comprehensive level of care for the patient. This quality of care, once available only at the hospital bedside, is now available at the patient’s home, and is aimed at reducing hospitalizations.18

The black bag may now contain a pulse oximeter, portable ECG, glucometer and digital thermometer, but both its purpose and essence remain the same. The opportunity to walk on hallowed ground and be with the patient in their most vulnerable state is one that few are fortunate enough to experience, and those who do, rediscover an art of medicine that was all but lost.

Acknowledgements

I would like to thank Dr. T. Farrell for his kind words and inspiring tales of house calls performed in rural Newfoundland. I would also like to thank Dr. J. Connor for his guidance.

References

11. Peebles A. A Survey of Statistical Data on Medical Facilities in the United States (Washington: Committee on the cost of Medical Care, 1929).