COMMENTARY

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House Calls

When I was a medical student, 50 years ago, physicians, especially pediatricians, internists, and family physicians, were still making house calls as part of their provision of care for their patients.[1] The symbol of the practicing physician at that time was the "black bag," which contained diagnostic tools like the stethoscope, ophthalmoscope, tuning fork, reflex hammer, and blood pressure cuff, along with bandages and simple remedies. I remember making house calls by myself in a business suit as a fourth-year medical student on the Home Medical Service of the Boston University School of Medicine, an ongoing clinical rotation that dates back to the 1880s.[2] Of course, we were supervised by an attending physician based at the medical school.

Today's acute care patients often come to emergency departments or storefront urgent care centers for treatment, and the routine house call is used much less.

However, the house call still remains an important part of my active private practice in both internal medicine and cardiology. In the practice of cardiovascular medicine, many patients will have a sudden death—often unexpected, with the patient previously looking well, even too well (eg, presenting with obesity). In families in whom the death is unexpected, there is often guilt, silent blaming, and outward accusations made that a specific family member caused the death to happen. One would hear, "Dad would still be alive if Mom didn't make him take out the garbage." "If you had been a better daughter and didn't fight with mom all the time, she would still be here." "If Mom and Dad argued less, he would still be alive."

The house call is not designed to reduce grief, which is part of a normal healing process, but to help relieve guilt in families that can span multiple generations and lead to significant long-term psychopathology.

At the exact time of a sudden death, especially if it was unexpected, close family members may not hear what the physician is saying because of disbelief, which is often part of the immediate grief reaction. In my experience, I don't like to talk about the cause of death at funerals because there are often too many distractions for the immediate family.

Thus, I will sometimes perform a house call a few days after the funeral to speak with the close family members of the deceased. Physicians often feel uncomfortable about making this type of visit because the family may be angry with the physician because he or she could not prevent the sudden death event that had occurred.

The first item I address at this visit—and I do this firmly—is to state that the death was no one's fault. There was nothing that family members could have done, and nobody is to blame. This single statement often prevents years of psychopathology from going forward in the family. As the primary physician, I reaffirm that the patient had heart disease, reminding them that a sudden death event can occur as part of the natural history of the illness. I sometimes use the term that the patient had a "massive heart attack," and nothing could have been done. I also often add that "in my interactions with your dad/mom, he/she always told me how much he/she loved you all."

Again, nothing for the grief, but the last act a physician does on behalf of the patient is to help ensure that blame and finger-pointing don't occur. When the physician leaves the family at the end of the visit, there comes so much gratification from "doing good," and there is no charge for these visits. The family members will always remember "the doctor who came to our house in our time of suffering."

There are 3 other situations where I also find it useful to make house calls.

After an individual goes home from the hospital with their first myocardial infarction, he or she is often anxious about what will happen next. I usually make the house call within 1 week of discharge and use the visit to review medications, answer questions that may not have been dealt with in the hospital, and take a walk with the patient. Going back to my Army days in the 1970s as a Chief of Cardiology, I found that these home visits for patients with infarction greatly reduced stress, both for the patient and their families, and helped to prevent readmission and reinfarction.[3]

Another situation in which I make house calls is after a patient has been discharged from the hospital with their first episode of heart failure, with or without a myocardial

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infarction. During these visits, I review medications, diet, and body weight, and I take a walk with the patient. Again, I have found that these house calls reduce patient stress and the incidence of readmission.

Finally, I will make a house call as part of a geriatric assessment for elderly homebound patients who are new to me. During these visits, I try to make sure the home is safe from obstructions that can cause falls and answer questions the family may have. Again, hospital readmissions and falls are reduced by these visits to the home. The home visit opens up new vistas, proving that you don't really know a patient until you see them in their home.

In most medicine practices, we see our patients in the hospital and in the office, but not in the environment where they spend the most time, the home. There are situations where a home visit can complement the care we provide patients as I have illustrated, and I strongly advocate that the house call be a part of the teaching program in medical schools, nursing schools, and residency training. I also advocate the reinforcement of its application in medical practice where the house call can and should be supported. Not only is it clearly cost-effective, but it is also the right thing to do in contemporary health care.

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