House Calls: Anachronism or Advent?

SETH B. GOLDSMITH, ScD

HOUSE CALLS ARE RAPIDLY BECOMING historical artifacts of 20th century medical practice. Data from the National Health Interview Survey indicate that in slightly more than a decade (1959 to 1971) the number of house calls made by physicians declined by 77 percent. In the 1958–59 period, 9.2 percent of physicians' visits were house calls, but, by 1971, only 1.7 percent of the visits were still house calls—and as would be expected, almost all calls were made by general practitioners to a population that was most likely to be over 75 years and disabled (*1–4*).

Another and perhaps more dramatic way of looking at these data is to construct a house call rate, that is, the total number of house calls delivered per year divided by the population. Using this statistic, one observes a 1958–59 rate of .43; a 1963–64 rate of .24; and a 1971 rate of .083. In a span of 13 years, house calls became comparatively rare, diminishing from almost 1 per year for every other American to 1 for only every 12th American. This aspect of practice occurred while the total per capita expenditure for medical care grew from $141 in 1960 to $368 in 1971 and to an estimated $547 per capita in 1975 (*5*).

Paralleling these trends of increases in per capita expenditures and the decrease in house calls has been another significant and likely related trend in the utilization of hospital-based outpatient and emergency room services. Specifically, in 1964, hospitals reported a total of 125 million outpatient visits, and a decade later the number had more than doubled to more than 250 million visits (*6,7*). Further, this increase occurred during a period when the national population had increased by 20 percent, outpatient departments had become (and are) deficit operations, the number of physicians was increasing, the number of visits to

Tearsheet requests to Seth B. Goldsmith, ScD, Associate Professor and Chairman, Program in Health Administration, School of Public Health, University of Massachusetts, Amherst, Mass. 01003.

physician's offices was increasing, and the number of hospitals with outpatient clinics was declining. Simultaneously, emergency department visits increased at even a greater rate; in 1964 there were 26 million such visits and by 1974 the total had mushroomed to more than 71 million (*6,7*). Perhaps of greater significance are the indications in various studies that a majority of the emergency department patients use that facility for primary care (*8–10*).

The fundamental question that must be answered is: Are house calls, now apparently considered anachronistic by the medical profession, a more cost effective way of delivering primary medical care services than what appears to be our present mode of hospital based, highly technologically oriented care? To consider that question (which, frankly, is unanswerable with the current state of knowledge about the practice of medicine), the following series of related and somewhat more circumscribed questions will be considered in this paper: What is a house call? Do patients need house calls? What do physicians think about house calls? Are house calls technologically obsolete? What are the economics of house calls? And, finally, what are the legal or malpractice issues relative to house calls?

House Calls Defined

House calls generally are defined as a physician's visit or a request to a physician to visit a patient for an acute or episodic condition at the patient's own home or some temporary lodging place other than a hospital or other medically oriented facility (*1a*). The house call should be differentiated from home care, which has been defined as "any personal assistance or personal services received at home as a result of illness, injury, impairment or advanced age." In the Health Interview Survey reporting on home care, physicians are excluded as providers of this service (*11*).

The role of the physician in home care differs from his role on a house call, though the roles are overlapping in that in both instances the physician is expected to visit the patient at home. In home care the physician is expected to be primarily a team leader and policy maker; that is, he plans and evaluates treatment but he does not himself implement the care that is generally delivered by nonphysician health professionals (*12*). This differentiation has been well conceptualized by a group from the Kaiser health plans who developed a decision grid for selecting patients for a home care program. Two key elements of the grid were (*a*) the likelihood that the patient's case would require little physician involvement and (*b*) the medical condition was such that it was unlikely that there would be a rapid clinical deterioration (*13*).

In practice, this differentiation is best illustrated by the findings of van Dyke and Brown (*14*):

> three-quarters of the (home care) agencies' caseloads were the chronic and longterm sick, physically disabled and terminally ill . . . no one was firmly in charge of the planned outcomes for the individual patient . . . Nominally, a doctor is in charge of each patient's medical care. Actually, physician supervision ranges from a mere formality to close personal attention, with medical attention and coordination of the treatment program for most patients at some uncertain level in between.

Finally one interesting linkage between home care and house calls came in an earlier study by Mather and Hobaugh, who found that physician prescribers of home care services also tended to be the makers of house calls (*15*).

The Need for House Calls

A few years ago Rogers told the pathetic story of a 75-year-old relative by marriage who died of cancer of the esophagus, which Rogers concluded was appropriately treated from a clinical perspective. But he also recounted that (*16*):

> During the two months my friend was at home, no physician—or indeed, any other health professional—ever saw him. No one answered his questions or gave him professional help with his increasing problems. No one with professional knowledge was available to reassure or counsel his wife as she watched him become bedridden, unable to swallow, choke alarmingly, and have trouble with his breathing. No one helped her deal with an increasing ambivalence about the decision to care for her husband at home, outlined the options, or gave her a realistic sense of what medicine could or could not do for him to help them both through this ultimate of human events.
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> During the last two weeks of his life I talked on several occasions with his wife, but I was not able to lessen her increasing hostility, which she dared not express, toward the distant physician. While he had promised on three occasions to make the ten-mile journey, each time he failed to show up or even to call her as she anxiously awaited his arrival. My offer to serve as his substitute did not help. I also talked with the physician, who sounded most knowledgeable, but who stated quite sensibly that there was nothing he could "do" for his patient unless he returned to the hospital—a course stoutly resisted by the patient. He did, however, seem to understand that humanistic support of the family members who were dealing with an escalating series of terrifying events might come within the purview of the physician, and at my coaxing he promised to make a visit—but again, it never materialized.

Was a house call needed in this case? Technically, probably no; however, from a humanistic and total patient care standpoint, probably yes.

The difficulty is to arrive at some reasonable understanding about when a house call is necessary and when it is not—both from standpoint of the physical and the psychological dimensions of medical care. The research data that we presently have, which primarily come from studies of general practitioners in Great Britain and

Canada, indicate that, at a minimum, some house calls do lead to hospitalizations and, as Elford and co-workers found in a study (*17*) of Massachusetts general practitioners, house calls result in significantly more hospitalizations than office visits. However, exact parameters of the situation are somewhat unclear; for example, Wolfe and Badgley found in their study of family physicians in Saskatchewan that 5.1 percent of the house calls resulted in hospital admissions (*18*), a figure that was certainly within the range of the 6 percent rate for the Massachusetts physicians and Parker's 5.4 percent rate (*19*). At the same time Marsh and co-workers found a much lower rate of 2.8 percent (*20*), while a hospital admission rate following house calls of 19 percent was noted by Carey-Smith and co-workers (*21*).

At the other extreme are the clearly unnecessary house calls. Findings on these range from Wolfe and Badgley's 12 percent, Thorpe's 16 percent (*22*), to Pinsent's 56 percent (*23*). Several other studies indicate that the unnecessary house call figure is in the 20 percent range; the reader is cautioned, however, that almost every one of these studies carries value biases that, unfortunately, are poorly controlled.

The single most illuminating piece of work on psychological problems and house calls also comes from a study of general practice in England: Clyne found that physical diagnosis and treatment prevailed over psychological elements; that is, for a significant percentage of patients, the cause for calling was indeed a somewhat serious organic problem (*24*).

The conclusion that can be drawn from these data is that there is an indisputable bottom line of medical care that is needed by patients who, for one reason or another, ask for a house call. If that conclusion is accepted, the next question that must be considered is, What do physicians think and feel about house calls?

House Calls—the Physician's Perspective

Raising the issue of house calls provokes a debate amongst physicians. Opinions appear sharply divided between those who consider them a waste of time and those who consider them a necessary component of medical practice. For example, a few years ago Walter Holland, a distinguished British professor of social medicine, complained in Lancet about his inability to get a house call while sick in the United States (*25*). Two rebuttals in a subsequent issue pointed out that physicians were afraid to make house calls, that physicians believe that they can provide better care in emergency rooms than at the patient's home, and that making house calls was wasteful of a physician's talent (*26*).

Typical of the opposite perspective are other "Letters to the Editor" (*27,28*) and articles such as Warren's (*29*) whose authors argue the importance of surgeons making house calls in order to understand the milieu in which the patient is convalescing, and advance the thesis that "the most important treatment is the physician himself." This proposition, which echoes the title of Rogers' article in Pharos that "The Doctor Himself Must Become the Treatment," suggests that the role confusion and stress engendered by the request for a house call carries with it the notion of a physician's omnipotence—a flattering idea indeed. The response to such a request can range from beneficence to manipulative, depending on a variety of factors—one of the most significant might be the security of the "all powerful being."

Presently, the most illuminating research on physicians' attitudes and behavior comes from Clyne's study of night calls in England (*24*). He found that physicians were almost invariably ambivalent about making night calls for two primary reasons that he labeled "regression" and "idealization."

> We are indeed very heavily emotionally involved with most of our patients whether we see them in day-time or at night, but over the years of practice we have learned to defend ourselves against the consequences of this involvement, so that outwardly we show little of it and can go out to see a dying patient and then go home and immediately be our ordinary social jolly selves again.
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> This is exactly the reason why towards evening, and especially at night, the family doctor feels that he can expend little more of the energy necessary to establish the normal doctor-patient relationship. Dealing with a patient's problems, even on the somatic level only, involves the doctor emotionally and demands a mature attitude from him. Once the doctor has regressed to levels where he leaves all responsibility behind, as every adult most do from time to time, he finds it difficult to rise again to more mature levels.
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> Moreover, in his regressive, relaxed state the doctor is without his usual defenses. He has, in a manner of speaking, taken off his white coat, and with it his professional attitudes and reservations, and has become his private self. The emergency or night call catches him unawares and he needs energy and time to reassemble his (emotional) professional accoutrements (*24a*).
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> The doctor's response was also intimately connected with the doctor's character. Some of the doctors could not bear to feel that they were 'run' by their patient. Patients look up to their doctors for help and relief, and doctors as a professional group are led, almost forced, in this way into an authoritative attitude. They find it difficult to shed the mantle of omniscience and omnipotence pushed on their shoulders (*24b*).

Clyne's analysis fits well with much of the theoretical framework that Parsons has postulated about physicians' behavior, which includes the ideas that the professionalization a physician goes through instills within him four significant values: universalism, collective orientation, functional specificity, and affective neutrality (*30*). The last two of these values have particular bearing on the house call dilemma. In Parsons' terms, functional specificity refers to the specialized role of

the physician to provide medical care and the crucial element of that role is technical competence. This idea suggests that physicians are, should be, and should always strive to be technically competent. Further, it suggests that only physicians have the technical expertise to handle the functions of medical care. Parsons maintains that physicians are expected, both by themselves and by society, to have sophisticated technical competence and to devote themselves intensively to expertise in matters of health and disease (*30a*). The second value that is relevant to this discussion is affective neutrality, which demands that the physician act as a detached scientist who carefully analyzes a situation and eventually makes a logical and practical decision (*30a*).

The relationship of these ideas to house calls is striking. Without dealing with his own personal inconvenience or hostility, a physician can easily fit the elimination of house calls into his professional value system on the basis that he is not able to practice the highest quality medicine in a patient's home without his technical backup services and that, in the patient's (not the physician's) best interest, it is better for the patient to be seen in an emergency room or the physician's office. The accuracy of this analysis leads us to the next question for consideration—Are home calls technologically obsolete?

Technology and House Calls

The technological obsolescence of the house call might be addressed from two perspectives of what can be done in the patient's home and why the office is more technologically appropriate as a site for medical care. Indeed, thanks to advances of the space age, we can now make virtually any device portable, and one can argue that few procedures cannot be safely done at home. For example, the literature has documented home transfusions (*31*), home hemodialysis (*32–34*), and easily adaptable telemetric devices (*35,36*).

However, despite the portability of these new sophisticated devices, the argument is often made that the physician can practice better medicine in his office because more and better equipment is available in that setting than he can carry in his little black bag. How valid is this assertion? Discussions with medical facilities planners, architects, and physicians indicate that despite the increased expenses of opening a practice, due in large part to inflation and cosmetic changes, the typical physicians' offices of the 1970s look much like the offices of the 1950s. One consultant has emphasized the standard nature of the equipment found in office practice by pointing out that in a recently completed group practice building housing 150 physicians, more than 90 percent of the offices were similarly equipped office and examining room suites housing equipment essentially the same as that which would have been installed two decades ago. Further, he noted that the offices of today's practitioners often tend to have less equipment; the small laboratories and X-rays have given way to larger, highly automated private laboratories and radiology groups because the physician finds such procedures time consuming and fraught with a potential for malpractice.

We now have another anomaly: space age technology has developed an impressive range of diagnostic and treatment modalities that can be taken almost anywhere, but they are more likely to be centralized in a hospital; yet the patient must continue to queue up at the physician's nontechnologically sophisticated office for a few minutes of his knowledge. Such a phenomenon is generally explained simply as an efficient use of the physician's time—the next area for consideration.

The Efficiency Issue and House Calls

The practice of medicine is notoriously inefficient. Research on this subject clearly indicates that much of the physician's job can be done by others who are not as highly trained, such as pediatric nurse practitioners, nurse-midwives, and even clerks (*37–40*). Despite these findings, most physicians continue to practice in a manner that might be classified as cost ineffective, with the single exception that they have virtually eliminated house calls, which require the "down time" of travel. Some interesting opinions on the issue of the efficiency of the house call come from a recent telephone survey conducted by Family Health/Today's Health magazine (*41*).

> The utilization of the doctor's time and expense is a very important factor in house calls. It's much more expensive and takes more time to see one patient on a house call than to see four or five patients at the office. With the shortage of doctors and the increased amount of health care given, time is a very important factor.
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> —Joseph Greenen, Racine, Wis., Consultant in Gastroenterology

> The availability of lab and X-ray—I'm afraid we use that as an excuse not to make house calls! In truth, travel time is something you can't charge for in the same way you can for an office visit. Our rates would have to be at least double what they are now.
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> —Julian Elligator, New Kensington, Pa., Internist

> I think many people realize that house calls are not economically feasible. I make a house call for $10. If you call a plumber it costs $20 to $30. I had a fuse put in the furnace one night this winter, and it was $30 because I called at two in the morning. My conscience wouldn't allow me to charge $30 for a house call. Most doctors make house calls as a favor to an old patient. The other people who want house calls are usually the kind who have no intention of paying, so they don't care what the cost is.
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> —Anonymous general practitioner, Dubuque, Iowa

The conclusion one can draw from the limited data on house calls is that house calls do not, for the individual practitioner, make sense. However, the question that remains unanswered is: How do people who are ill substitute for house calls? The alternative answers are obvious: delay medical care, self-medicate, go to the physician's office, or go to a hospital-based ambulatory care service such as an outpatient department or emergency room. The costs to the total health system of some of these alternatives are likely to be higher than that of coupling an efficient office-based practice with an efficient house call service.

Before leaving this issue, one other (and perhaps crude) dimension to be considered is whether a physician can earn a living making house calls. Obviously some physicians can and do supplement their incomes by taking calls (*42*)—however, it is interesting that some eminently well-trained physicians have opted for a career in house calls. For example, in a preliminary review of data from Health Delivery Systems, a public corporation in New York that organizes house call services, it appears that a physician working a 40-hour week (8 hours per day, 5 days per week) can visit approximately 75 patients and gross $1,125 per week less only the overhead item of automobile expenses. This income compares favorably with those of other practitioners who must maintain offices and staff that often represent a 45 to 55 percent overhead expense. Perhaps what this successful service suggests is the need for a "specialty" of house call care that is economically viable and may even be clinically necessary.

The final issue of concern in this paper seems to be of utmost concern to every physician—the legal aspects of house calls.

House Calls and the Law

If a physician does not make house calls, several potentials for lawsuits would seem to be open to his patients. The first and seemingly clearest avenue is that of abandonment; the physician undertook an obligation to care for a patient but failed to fulfill that obligation when asked to make a house call. This consideration does not mean that a physician cannot confine his practice to an office or hospital base, a point that is clearly established in the law (*43,44*), but it does suggest that when a physician offers his services as being comprehensive or including house calls he also opens himself to a potential liability if he does not deliver those services in a timely manner (*45*).

A different line of recovery for patients might simply be a traditional malpractice claim that a physician treating a patient has deviated from a reasonable standard of care and the patient has suffered damages because of that physician's deviation (*46*). The suggested deviation could be related to the quality of the history taken by a physician. For example, how well must a physician understand the environment or home milieu of a patient in order to treat him properly? Obviously this is an untested area—but in our lawsuit-prone society it would seem to be only a matter of time before such a test suit is instituted, and the only logical protection against such a suit would appear to be a clear statement from each physician that lists the services his patients can and cannot expect to receive from him.

What Next?

The reality is that a public policy decision has been made to eliminate house calls. The decision is reinforced by the Government when it does not require house calls as a basic service in programs such as health maintenance organizations or neighborhood health centers, and by the various third-party insurers who do not pay for house calls; current estimates are that only one in nine persons has first dollar coverage for house calls (*47*). This decision has also been made by practitioners who have refused to make house calls and by most consumers who have simply not been offered the option of house calls. Indeed when consumers are offered this option, as they have been by New York's Health Delivery Systems, they seem to respond to it eagerly.

This paper raises more questions than it answers. Most of these are research questions and relate to our fundamental understanding of medical practice. Research in the organization of medical care has been aptly reviewed and criticized by Weinerman (*48*), and many of his criticisms are particularly relevant to the studies on house calls, which have tended to lack both rigorous analysis and linkages with the constellation of other practitioner-patient relations.

What is now necessary is basic research on the cost-effectiveness of house calls. Does this service make sense and should it be reactivated? If so, what are the appropriate strategies—fiscal and manpower—for accomplishing it; and if not, how shall we go about completely eliminating house calls?

One could argue that either a large number of people are being denied an important service, or a small number are being given an inappropriate and inadequate one. Shouldn't we find out?

References

1. National Center for Health Statistics: Physician visits, volume and interval since last visit, United States, 1971. DHEW Publication No. (HRA) 75–1524, Series 10, No. 97. U.S. Government Printing Office, Washington, D.C., 1975; (*a*) p. 49.
2. National Center for Health Statistics: Physician visits,

volume and interval since last visit, United States, 1969. DHEW Publication No. (HSM) 73–1501, Series 10, No. 75. U.S. Government Printing Office, Washington, D.C., 1972.
3. National Center for Health Statistics: Volume of physician visits, United States, July 1966–June 1967. DHEW Publication No. (HRA) 76–1299, Series 10, No. 49. U.S. Government Printing Office, Washington, D.C., Reprinted. 1975.
4. National Center for Health Statistics: Volume of physician visits by place of visit and type of service, United States, July 1963–June 1964. PHS Publication No. 1000, Series 10, No. 18. U.S. Government Printing Office, Washington, D.C., 1965.
5. Mueller, M. S., and Gibson, R. M.: National health expenditures, fiscal year 1975. Soc Secur Bull 39: 6, February 1976.
6. American Hospital Association: Guide issue. Hospitals 39: 15, Aug. 1, 1965.
7. Hospital statistics, 1975 edition. American Hospital Association, Chicago, 1975.
8. Taubenhaus, L. J.: The non-scheduled patient in the emergency department and walk-in clinic. Bull NY Acad Med 49: 419–426 (1973).
9. Olendzki, M. C.: The present role of the community hospital in primary ambulatory care. *In* Community hospitals and primary care. Ballinger Publishing Co., Cambridge, Mass., 1976, pp. 79–87.
10. Goldsmith, S. B.: Five case studies of primary care arrangements in community hospitals. *In* Community hospitals and primary care. Ballinger Publishing Co., Cambridge, Mass., 1976, pp. 145–164.
11. National Center for Health Statistics: Home care for persons 55 years and over, United States, July 1966–June 1968. DHEW Publication No. (HSM) 72–1062, Series 10, No. 73. U.S. Government Printing Office, Washington, D.C., 1972, p. 1.
12. American Medical Association: Development and use of home-care services. JAMA 197: 169–172, July 11, 1966.
13. Greenlick, M. R., Burke, D. S., and Hurtado, A. V.: The development of a home health program within a comprehensive prepaid group practice plan. Inquiry 4: 31–39, October 1967.
14. van Dyke, F., and Brown, V.: Organized home care: An alternative to institutions. Inquiry 9: 3, 6, 7, June 1972.
15. Mather, W. G., and Hobaugh, R. J.: Physician and patient attitudes toward a hospital home care program. Inquiry 4: 47–54, October 1967.
16. Rogers, D. E.: The doctor himself must become the treatment. Pharos 37: 125 (1974).
17. Elford, R. W., et al.: A study of house calls in the practices of general practitioners. Med Care 10: 173–178 (1972).
18. Wolfe, S., and Badgley, R. F.: The family doctor. Macmillan Company, Toronto, 1973, p. 57.
19. Parker, G.: Emergencies in an "emergency" call service. Med J Aust 1: 927–930 (1972).
20. Marsh, G. N., McNay, R. A., and Whewell, J.: Survey of home visiting by general practitioners in northeast England. Br Med J 1: 487–492, Feb. 19, 1972.
21. Carey-Smith, K. A., Dreaper, R. E., and Jenkins, C. W.: Home visits—the patient's viewpoint. J R Coll Gen Pract 22: 857–865 (1972).
22. Thorpe, D.: Analysis of calls on a doctor's time in general practice. Practitioner: 194: 534 (1965).
23. Pinsent, R. J. F. H.: Emergency call service. Lancet No. 7673: 604–606, Sept. 19, 1970.
24. Clyne, M. B.: Night calls. Tavistock, London, 1961; (*a*) p. 81; (*b*) p. 84.
25. Holland, W. W.: Experiences of medical care in the United States. Lancet No. 7665: 202–204, July 25, 1970.
26. Seng, B. S., and Hopp, E. S.: Medical care in the United States. Lancet No. 7669: 415, Aug. 22, 1970.
27. Colling, A.: What could the G.P. treat at home—with proper support? Br Med J 4: 390, Nov. 16, 1974.
28. Bowen, E. A.: Letter ; House calls. N Engl J Med 290: 1029, May 2, 1974.
29. Warren, R.: The surgical house call. Arch Surg 110: 871 (1975).
30. Parsons, T.: The social system. Free Press, Glencoe, Ill., 1961; pp. 428–480; (*a*) p. 435.
31. Rabiner, S. F., and Telfer, M. C.: Home transfusion for patients with hemophilia A. N Engl J Med 283: 1011–1015, Nov. 5, 1970.
32. Chojnacki, R. E., and Keady, K.: Hemodialysis in the home. Am Fam Physician 11: 149–153, February 1975.
33. Kuruvila, K. C., et al.: A model for evening home hemodialysis. Am J Med 57: 706–713 (1974).
34. Cadnapaphornchai, P., et al.: Analysis of 5-years experience of home dialysis as a treatment modality for patients with end-stage renal failure. Am J Med 57: 789–799 (1974).
35. Baltzan, D. M.: Telemetric medical services can provide a voice in the wilderness. Can Med J 112: 1138–1140 (1974).
36. Uhley, H. N.: An inexpensive receiver for ECG telemetry. Am Heart J 91: 346–348 (1976).
37. Yankauer, A., Connelly, J. P., and Feldman, J. J.: Task performance and task delegation in pediatric office practice. Am J Pub Health 59: 1104–1117 (1969).
38. Bergman, A. B., Dassel, S. W., and Wedgwood, R. J.: Time-motion study of practicing pediatricians. Pediatrics 38: 254–263 (1966).
39. Goldsmith, S. B., Johnson, J. W., Jr., and Lerner, M.: Obstetricians' attitudes toward nurse-midwives. Am J Obstet Gynecol 111: 111–118 (1971).
40. Moore, M. F., Barber, J. H., Robinson, E. T., and Taylor, T. R.: First contact decisions in general practice. Lancet No. 7807: 817–819, Apr. 14, 1973.
41. Why doctors don't make house calls. Family Health/Today's Health, July 1976, p. 31.
42. Scher, J. M.: The renaissance of the house call. Ill Med J 141: 50–52 (1972).
43. Holder, J. D.: Law and medicine abandonment. JAMA 225: 1571–1572, Sept. 17, 1973.
44. *Urrutia* v. *Patino, et al.*: (1925) S.W. 512 (Tex).
45. Annot. 57 American Law Reports 2d 434 (1958).
46. Report of the special advisory panel on medical malpractice, State of New York. January 1976, pp. 166–172.
47. Mueller, M. S., and Piro, P. A.: Private health insurance in 1974: a review of coverage enrollment and financial experience. Soc Secur Bull 39: 3–20, March 1976.
48. Weinerman, E. R.: Research into the organization of medical practice. Milbank Mem Fund Q 44: 104–140 (1966).