

## House Calls

Patients enter my space when they come to my office; I enter their space when I go to their home. I am invited into my patients' kitchens, living rooms, and lives when I make house calls. Patients learn about me by observing the ambience of my waiting room; I learn about them by observing the colors, furnishings, art, and books in their dwellings. Once in their home, I may perceive, within minutes, what eludes me in the examination room. When I pick my way carefully to an elderly man's bedroom, along a narrow path bordered on both sides with walls of piled-up newspapers, I at once understand the severity of his neurosis, which escapes me when I concentrate on his coronary artery disease in the office. A glance into the refrigerator, while getting a cold drink of water, tells me more about my patient's diet than I will find out by exhaustive questioning.

When we stop making house calls, we lose the intimacy of the relationship in which doctors and patients alternate being hosts. Displaying family pictures on the desk is not exclusively the doctor's privilege; patients also can share photographs when the physician visits in their home. The balance of power in the doctor-patient relationship shifts by changing the locale of the encounter from office to home.

House calls can be surprising, frightening, sad, and, at times, inspiring. House calls make me feel humble because they teach me under what adverse conditions the human spirit can survive and even thrive. I also learn things about my patients of which I stay ignorant if I only see them in the office. A grand piano in the home of a lady who has hypertension and is no longer allowed to drive because of epilepsy leads me to ask her if she would play for me. I am deeply moved by the beauty of the music and her expertise. Both of us momentarily forget the reason for my visit and revel in the joyous sound.

House calls can also arouse pity. A childless couple, Mr and Mrs Peters, have been patients for several years. Both hold jobs in spite of Mr Peters' excess use of alcohol. One sunny day, a neighbor of the Peters' calls to say that she is concerned about them. Their car is in the driveway, and she has not seen either Mr or Mrs Peters leave for work. During my lunch hour, I check on my patients. Their house looks disheveled, beer cans scattered among the weeds in the yard, the door ajar. The unkempt appearance of the yard, however, does not prepare me for the scene that confronts me as I enter. Two human forms, on

iron bedsprings, covered completely with worn sheets, rats scuttling across the floor, beer bottles and empty cans piled high, enmeshed in spider webs. I gently pull back the sheet from the head of one of the prone figures, expecting a corpse. Under the sheet lies Mrs Peters; the other sheet covers Mr Peters. Both are breathing air that reeks of alcohol, both passed out. Carefully I replace the sheets, as pity and pessimism overcome me. I realize that my ability to help this couple is minimal, the scope of their problems overwhelming. I am surprised, because, prior to this visit, I did not know that Mrs Peters, as well as her husband, has severe difficulties with alcohol; knowing this makes it clear to me why controlling Mrs Peters' blood sugar has been unusually difficult. When I bill Mr Peters for the house call, he objects. He is unaware that I had been to his house; only my accurate description of the scenery convinces him that my bill is justified. During this discussion, my offer to support him and his wife in any and all efforts to overcome their addiction is firmly and politely rejected.

The element of surprise is ubiquitous in house calls. Sixty-eight-year-old Mrs Gerad has been in chronic mild heart failure for months. She leaves a message with the office nurse that her shortness of breath is getting worse and is told to expect me after office hours. When I arrive, Mrs Gerad is lying in bed, obviously dyspneic, with distended neck veins. I suggest she sit up to ease her breathing and therefore put a sofa pillow under her back. While fluffing up her bed pillow I feel something hard, a loaded revolver. I am scared and taken aback, but on further reflection, I realize that this weapon is meant to protect my helpless patient against unwelcome intruders. It might well have discharged while I rearranged the pillows, but I leave it where I found it, and resolve to be more careful in the future.

Usually I do not make house calls to a stranger. However, a concerned neighbor is desperate and insistent; therefore, I tell her I will come. From the appearance of the small, ramshackle house, I conclude that the owner has been sick for some time. The portly, white-haired lady who called me greets me on her doorstep. She reports that her neighbor has been moaning loudly all night and adamantly refuses to go to the emergency room.

My knocks go unanswered. When I open the door slowly so as not to startle anyone, a strong smell of vomit assails me. I leave the door open to let in some



RENATE G JUSTIN, MD, was in family practice with her daughter Ingrid Justin, MD, until both joined Kaiser Permanente. Dr Justin is now retired, after 45 years of practicing medicine.



fresh air; it is too early in the year to worry about flies following me in. The curtains are drawn, but a weak bulb sheds enough light to reveal a man, about sixty-four, in bed with a shotgun leaning against the bedframe. He greets me loudly: "Who the h... are you?" From the tenor of his voice, I conclude that he is deaf and therefore respond equally loudly that I am a doctor who has come at his neighbor's request. "D... meddler," he comments. After my eyes adjust to the dim light, I see the outline of the man's greatly distended abdomen under the sheet. He is undoubtedly obstructed, given the pain, distention, and vomiting. "Do you want me to examine your stomach?" I query. He pulls down the sheet. He is fully dressed but has unzipped his pants to allow for the distention. I do not have a chance to lay a hand on him because he starts to retch and moan. When, exhausted, he lies back, he looks at me as if he has forgotten our previous exchange. In a hoarse but loud voice, he says: "What do you think you are doing here? Get the h... out." At which point, he starts to reach for his gun. I hasten to tell him again who I am and that I have come to help ease his pain. "None of your d... business!" In my bag are a few demerol and codeine tablets, which I leave on his nightstand next to a glass of murky water. "You may take these if the pain gets too bad; your neighbor has my telephone number if you want me to return." He responds: "I told you to get the h... out of here." I do just that.

I never heard from the neighbor nor from the old man with the gun again. That he could not accept the help I offered, but insisted on suffering alone in his smelly, semi-dark room made me sad, but also I was frightened by his gun, his anger. Driving away from that scene, I wondered about this man's life, his job, his family. What experiences made it impossible for him to accept help, or even to acknowledge that help was being offered in good faith? Also I mulled over my own actions. Would a different approach have been more successful? If I had moved the gun out of his reach when I entered, I would have been less threatened by him; and perhaps if I had stayed longer, he would have relaxed more in my presence? Should I go back and try again, or was it now too dangerous?

Years ago, a young woman called me to the home of her grandmother, who was in pain. The old lady lived in a one-room, wooden cabin. When I entered, she was stretched out on a narrow bed, softly moaning, but she greeted me in a warm, welcoming manner. The source of her pain was a large, creeping cancer,

that had eaten away part of her face. She was small, frail, and her thin body left enough room for me to sit down on the edge of her mattress and hold her hand while I explained how to use the medicines I left for her. Her granddaughter took notes, and when I was finished, we three women held hands silently for a few minutes in that small cabin. I left after a gentle hug with both the young and the old woman, and with a renewed respect for, and joy in the human spirit. The dignity and quietude with which death was expected by this woman was inspiring; she had lived her life and left no major tasks unfinished.

It was different for Helen, the young mother who was dying of breast cancer. She struggled to stay alive; she wanted to celebrate her son's third birthday. She cried, inconsolable, in my arms, unable to accept her fate. Before she died, she asked me to see her son, Thomas, regularly, whether or not he was sick. I promised. About four years after Helen's death, I once again visited Thomas, now six years old. He knew me well and, on this occasion, introduced me to his "new mom." He showed me the house into which he had recently moved with his dad and his stepmother. Once in his room, he sat down on a bean-bag and told me to sit in the rocking chair. Soon he inched closer and closer to the rocking chair, and then, taking a photograph of his mother off the shelf, he sat in my lap. "Tell me about Mom." I had known her for longer than he had and could talk to him about how pretty she was as a teenager, and how smart. "She used to come to my office even before she knew your dad. After college, your mom got a good job and then met your dad. She was a happy, lovely bride, and Thomas, your grandparents loved your dad." I told Thomas about the breast cancer and how sick his mother had been during the chemotherapy treatment, but that she and dad really wanted him to become part of their family. He was born when his mom felt better. "Your mom and dad had two wonderful, happy years with you until mom got sick again and died." Thomas was now snuggled in my arms, and we rocked silently for a while; then he jumped down and went out to play. I sat there alone, thinking about his lovely young mother who did not want to die. Then I left the house, content that Thomas' dad had found a new partner and a "new mom" for his son. This family no longer needed to be followed by me. Thomas and his father had recovered after Helen's death. The new family was well established; the old, deep wounds had healed. After this visit, I stopped mourning for Helen. The task she had given me, to check on Thomas, was completed. I



could let go, say my final goodbye. Home visits can be healing for physicians as well as for patients.

House calls are not part of today's urban medical practice; not cost- or time-effective, they have all but disappeared from the daily routine of physicians. There are occasional articles urging the revival of house calls,<sup>1</sup> and even a movement to create yet another specialty, home-care doctors,<sup>2</sup> but it is likely that physicians will be dispensing medical care in hospitals, emergency rooms, and offices rather than in the home during the next few years. Having prac-

ticed during a time when house calls were part of every day's schedule, as well as more recently, when I did not make any house calls, I feel strongly that I dispensed better patient care when house calls were part of my work. ❖

#### References

1. Giovino JM. House calls: taking the practice to the patient. *Fam Pract Manage* 2000 Jun;7(6):49-54.
2. Guariglia V. House calls seen poised to make a comeback. *Physicians Financial News* 2000 Jul 7;42-3.

## The Seventh-Decade Stretch

Certain changes are unmistakable.

Gratitude replaced attitude.

Blessings are not only counted, but also hoarded.

Kind acts are taken for anything but granted.

Affection is appreciated as a form of interest that has somehow been compounding itself behind your back.

*Larry Gelbart, playwright and screenwriter, from The New York Times Magazine, September 24, 2000*