Position paper on House Calls

Hippocrates saw patients in their homes and in the olden days all patients were seen in their homes. Visiting patients where they live is good medicine, the most incredible diagnostic experience that a physician can have and it's also good for the soul.

Certain patients require house visits by their doctors. These patients include the very elderly who are infirmed or disabled or bed bound, the disabled of any age and also the terminally ill patients. Therefore there are instances when house calls are necessary. Often these house calls will be multiple and long term.

There are also instances when house calls are requested when a patient has taken ill suddenly and the family perceived this to be an emergency requiring urgent medical attention. Hereto, one has to examine the value of house calls: the emergency ambulance services maybe more useful here. In the absence of good emergency ambulance services, we should discuss what should be the better options for the patients? Often, in a real emergency, the visiting doctor can do little but await transport to the nearest A&E department.

Doctors have the social obligation to respond to any house call. As primary gatekeepers, it is our responsibility and obligation. Responding to a house call is not the same as physically attending to the call at the patients' residence. Thereby should or should not is not an appropriate question to address to our profession.

There are basically two types of house calls: 1. emergency call; 2 non-emergency calls.

The patient and the family's perception of an emergency call are different from us. Our first assessment is to determine the urgency or non-urgency of the situation.

According to the American Medical Association (AMA), 6 million Americans receive medical care at home. And a study in the *Archives of Internal Medicine* found that 65% of family doctors and 44% of all internists reported that they might make house calls.

A doctor may realize that a patient hurts not just from the physical pain, but because he or she is lonely. In the patient's home, a doctor can see much

more about the patient's life and apply the personal touch. A thing of the past is becoming part of the medicine of the future.

More and more, we are rediscovering what our predecessors practiced without a second thought: going to see our patients where they live. The modern twist is that they live not just in the family home but in the nursing home, assisted living center and hospice house. As the population ages, family physicians will increasingly have to make the choice between seeing patients where they live or transferring their patients' care to other doctors who will.

You could enquire about the patient's condition carefully, from the person who arrives to summon a house call. You could then conduct a "triage" based on the history of the patient, as given by the summoning person, into three groups: mild, moderate and severe.

Those who are in the "mild" group would be abusing the facility of house calls merely for sake of convenience. They should be advised to bring the patient to the nearest health facility, which is open. Those who are in the "severe" group would not probably NOT benefit very much from just a single doctor's visit to the house, and would probably require further investigations or hospitalization or monitoring.

Patient care. Very simply, house calls are good medicine. As family physicians, we often talk about our ability to provide high-quality, continuous, comprehensive care. House calls can help us fulfill that mission by keeping us in touch with our patients, even those who cannot come to the office. In addition, by visiting patients where they live, we can learn more about them and connect with them on a more personal level.

A feel-good approach to medicine. As we have less and less time to spend with patients during office visits, visiting them at home or at their institutions could be more satisfying. When I go into my patients' homes and see them in the their own surroundings a better knowledge of the risks involved are better understood. Even visits for simple problems take on a meaningful hue. Of course there are risks involved with expanding the scope of your practice to include house calls. Two of the greatest concerns are its effects on patient mix and practice efficiency. If you enjoy a broad mix of patients, you may worry that by expanding your services through house calls you will end up with a disproportionate share of elderly patients in your practice. In my experience, house calls have certainly added some geriatric

patients to my practice, but they have added even more adults and adolescents as the children and grandchildren of my elderly patients join my practice. You may also worry about the implications of seeing one homebound patient at the expense of a half day of office patients. New efficiencies must be learned, but if you consider the care of your homebound patients an essential part of your practice, you'll find a way. The following tips will get you started.

Don't admit patients to a nursing home you do not plan to visit. It is better to lose that patient to another doctor than to give telephone medicine when a monthly exam is more appropriate. Also don't rely on patients being transported to your office for monthly visits. This quickly leads to unhappy patients and families.

Make sure that you or a partner visits the nursing home once a week and sees every patient at least once a month. Block out the office schedule for the nursing home doc for that half-day. A partner can see patients who become ill between visits with you on his or her turn at the nursing home

The black bag

As you begin doing house calls, you will quickly customize your black bag to include those things that you find necessary and convenient. Here is a quick list of things to get you started:

- Street map,
- Stethoscope,
- Blood pressure cuff (regular and large),
- Pen light,
- Tongue depressors,
- Otoscope & Ophthalmoscope,
- Prescription pad,
- Cell phone, palm-held computer, etc.
- Dictaphone/forms/progress notes,

- Get the nurse from that area to accompany you.

How to manage an inpatient hospice population.

For "house calls" to an inpatient hospice population, here's what to expect:

Hospice patients need routine visits for months, which can be scheduled ahead of time. Eventually, they will require unscheduled visits as symptoms worsen. You can use all the above techniques to manage the care of these vulnerable, special patients. But here, you have one additional advantage: the hospice nurse (another free nurse for you). These well-trained professionals will do all they can to make your job easy. They will almost certainly already have standing orders for you to approve, and they are highly autonomous at managing patients' symptoms. You will almost never receive a trivial phone message or a needless request from a hospice nurse. Care of the hospice patient in the home or in the hospice house combines the best of home care and nursing home care. This is a good model to apply to all your homebound and nursing home patients.

I like house calls. If I hated them, I wouldn't do them even if they were profitable. I suspect you wouldn't either. The biggest obstacle to incorporating house calls into regular practice isn't inadequate reimbursement; it's inadequate training. When we don't have a good, thorough experience with a particular aspect of medicine as residents, we tend not to gravitate toward those things in our practices. Comfort comes from experience. Without comfort in making house calls, we don't do them even though we can and should.

My advice to those doctors who do not have enough patients in their clinic to encourage house calls to broaden their base. After the first two or three home visits you will be more comfortable at doing them. If you don't like them, no sweat. Do them when you have to, but otherwise leave them to your colleagues. If you like them, don't look back. It may be the most rewarding experience you have as a doctor.

Below is the experience from the Singapore Medical Association.

In their course of practice, doctors are sometimes faced with practice situations arising out of conflicting demands. As we are trained to manage difficult clinical problems, we must also acquire the knowledge and skills to navigate these situations.

SMA-News is therefore starting a new series called 'Ethics Clinics'. The first article is based on an actual complaint made to the Press against a doctor who refused a request for house call. The journalist following up the story thought the verdict cut-and-dry – that

The uncaring doctor should be censored. We however deliberated on the case with advice from our legal advisors, analysing the case from different dimensions. These are the Legal, Ethical, Administrative and Practice dimensions represented by the acronym "LEAP".

The views of our legal advisors on several key issues specific to the case are written as a case study. We also like to share with you some related issues arising out of this case study.

Legally, we were advised there is no duty to attend to and treat a 'stranger' in an emergency. Even if there was a legal duty of care, the other three (of the four D s needed to prove negligence) must be kept in mind. These are dereliction of the duty, damage or injury caused by it and direct (or proximate) relation of the dereliction and damages. For example, it may not be dereliction of duty not to do the house call if in the professional judgement of the doctor; an ambulance should be called instead to bring patient speedily for emergency care not possible in the house. Time wasted waiting for the doctor's arrival may not be in the best clinical interest of the patient.

Ethically however, Prof. SY Tan cited two cases (when he conducted the Medico-legal course in November 2000) to show that the Singapore Medical Council (SMC) censured two doctors for failure to provide care to 'legal strangers' in emergency situations (1992 SMC report). SMC stated that the 'public expects a doctor to respond promptly to a request for medical help in an emergency'.

These two cases of course did not involve request for house call but Prof. Tan wrote that 'although its opinion do not constitute legal precedent, its discussion nevertheless set the tone for what might be expected for doctors practicing in Singapore'. The jury is still out on the specifics.

What about the administrative dimension? Can polyclinic or restructured hospital doctors refuse to do house calls because that duty is not administratively contracted during working hours? Has a polyclinic doctor or specialist who is regularly following up a patient for chronic ailments less legal and ethical duty than a GP seeing the patient sporadically for minor ailment when a house call is needed for complications arising from the chronic disease? Can GPs, if they wish to also administratively declare that house calls are not part of their professional service? These are vexing questions indeed.

The Practice dimension is another consideration. Some GPs may want to provide comprehensive care to their current and potential patients and accept all request for house calls. Others may not want to provide such service to 'strangers' and do not mind risk losing the custom of related persons who may be unhappy such of refusal.

A lady, upon seeing her father in a semi conscious state, rushed to the nearest clinic for assistance. The doctor who was consulting in his clinic at the time replied that he was unable to perform the house call. His reasons given were that firstly, his priority was to the patients in his clinic, and secondly, he did not have his medical record for immediate reference, as he had not seen him before.

ISSUES FOR DISCUSSION

The dilemma here is how can the doctor discharge his legal duty of care to the patient who is sitting in the waiting room of his clinic and to a person requesting urgent/ emergency attention for someone at home.

Q1 Is it correct to say that the law in general does not make it a necessity to rescue a stranger? If so, does this therefore mean that there is no duty owed by the doctor to the semiconscious man that he does not know?

Q2 Is there a diminishing duty of care owed when there I s multiple demands on the doctor's time as in the following order:

(a) the patient in the doctor's clinic;
(b) the patient seen 3 days ago requesting urgent treatment at home;
(c) the regular patient of the doctor for last 2 years but last seen 6 months ago requesting urgent treatment at home; and
(d) the person not previously seen by the doctor.

The Case Study Scenario

Q3 What would be prudent for the doctor to do from the legal and ethical perspectives under circumstances where he was unable to do more than one thing at a time?

The following are comments from our legal advisors:

WHAT IS THE DUTY OWED TO THE SEMICONSCIOUS MAN?

Mr. K Shanmugam:

The position in law is that generally, a medical practitioner owes a duty to exercise fair, competent and reasonable skill and care in his treatment of a patient. The relationship and duty are created when the doctor accepts the patient for treatment. A doctor can be liable for negligence only in a situation where a duty is found to exist.

A doctor is not in general to rescue or render assistance to a stranger. He is thus under no duty to attend to and treat a stranger, even in an emergency. However, you should be aware that whether a duty is created depends on the factual circumstances of such case.

For instance, there is case law for the proposition that a doctor owes a duty to attend to a Person in urgent need of medical care, where a direct request had been made for him to do so and there is no reasonable impediment preventing him from attending. In general, whether such a duty exists depends on:-(

i) the doctor's physical proximity to the patient; and

(ii) the 'causal proximity' created by the information given to the doctor and his consequent understanding that this was a life-threatening emergency with dire consequences if not treated.

However, as the man was semi-conscious and may be in a life-threatening situation, the doctor should not ignore the call for help. Whilst that doctor may not be able to attend to the problem personally, it would be prudent for him to seek assistance appropriate to the situation.

Dr Myint Soe:

As a matter of public policy, the area of duty of care has to be limited. One must not mix up the three duties.

- contractual duty;
- tortuous duty (negligence);
- professional duty.

It is trite knowledge that even a common prostitute can refuse to deal with persons she dislikes. In contract, a doctor can, likewise, refuse any patient. In tort, there had to be a duty of care, and the test is laid down in Donohue V Stevenson. In my opinion the doctor can foresee that once he is called for an emergency, and if he does not go, grave injury may result. However, I am not prepared to say that as a matter of tortuous duty, a doctor must go whenever he is called. Public policy would step in to limit that area; otherwise no one will be a doctor. Negligence always depends on the facts of that case.

In my view, the doctor's professional duty of care must be considered. It may overlap with the legal duty of care. Supposing a doctor and his friends are having dinner at a poolside. A young child is drowning and is luckily brought out. Can the doctor who is having dinner there and is enjoying a juicy steak, say that the kid is a stranger and he has a right to refuse treatment, and will therefore finish his juicy steak instead. He could have easily resuscitated the child. In such a case, I have no doubts it will be professional misconduct, and may be even sued in tort for damages. A court of law may well take into account a doctor's special duty as a member of an honorable profession whose professed aim is to save lives, and impose a legal duty on the special facts.

IS THERE DIMINISHING ORDER OF DUTY WHEN THE DOCTOR HAS MULTIPLE DEMANDS ON HIS TIME?

Mr. Lek Siang Pheng:

If a person has never been a patient of a doctor, then that doctor is not Legally obliged to attend to a house call. Even if a person is an existing

patient of a doctor, there is generally no legal obligation on a doctor to attend to a house call. However, there may possibly still be some situations in which that doctor may have some legal obligations to attend to a house-call by his patient. For example, the patient takes the prescribed medication immediately on reaching home and suffers a reaction. His family telephones the clinic. Can the doctor legally refuse to attend the house call? Possibly the doctor can discharge his legal obligation by giving instructions to the family members and telephoning for an ambulance. There is some doubt here. What if the patient's home is very close by, for example, an apartment located in the same apartment block as the doctor's clinic? There may well al so be ethical questions arising if the doctor refuses to attend to an emergency house call very nearby, especially if the doctor does not have any seriously ill patients inside his clinic requiring immediate attention.

Mr. K Shanmugam:

On emergency treatment, there is no duty for the doctor to drop everything and attend immediately to the emergency patient. In general, there are no varying degrees of duty of care. A duty is either created or it is not. In order to consider if a duty is owed, one has to consider the factual circumstances in each case.

For example, it would be relevant to consider what the doctor was doing at the time these different requests were made of him. It would also be relevant to consider the degree of urgency in each case and whether - there was any reasonable impediment preventing the doctor from attending to the patient. Subject to the above, the doctor's duty is owed to the person that he is treating at that time. In a situation where multiple demands are made, a doctor owes a duty to his patient not to take on so many matters that he is unable to properly and adequately care for his patient.

Although there is no legal duty to attend to a stranger, there is a professional obligation to do so because of the 'causal proximity' created by the information given to the doctor.

Mr. Leo Fernando:

On the one hand the law does not impose any duty on a person (including a medical practitioner) to treat a stranger who he knows requires or may require his professional help. On the other end of the scale once a person has been accepted as a patient, the doctor must exercise reasonable care and skill in his treatment of that patient and any negligent omission to provide

adequate treatment will be actionable in negligence.

In Barnett v Chelsea & Kensington Hospital Management Committee (1969) 1 QB 428, the Court held that hospital authorities owe a duty to any patient admitted for treatment including a patient presenting himself at a casualty unit.
In Barnes v Crabtree, The Times November 1 & 2, 1955 the Court held that a general practitioner owed a duty in law to attend to an emergency in his "practice area". Similarly a doctor owes a duty to every person on his N.H. S. list (in the UK).
It would therefore appear that a doctor owes a duty to treat a person who is his patient even if that means making a home call. This requirement would be qualified by the fact that the call has to be from an existing patient. It's an emergency and the doctor concerned does not have any emergency case in his clinic at that time and the standard of reasonable care and skill would require that the doctor make the house call in such circumstances. In other words, a reasonably competent general practitioner would have patient and lawyer/client exists and ends in respect of a particular transaction.

WHAT IS PRUDENT FOR THE DOCTOR TO DO?

Dr Myint Soe:

In my view, one must balance the two harms of leaving and not leaving the clinic. If the clinic has about two patients having a cold, and there are clinics nearby which can take care of newcomers, there is no reason why he should not answer an emergency call within a reasonable area and leave the patients with an apology. At least go to the place and get an ambulance. He would have satisfied the standard of care. He should be back at the clinic in 45 minutes or so. No disaster can take place at the clinic during that time. Nor can a big hole be made in his pocket.

Mr. K Shanmugam:

As the man was semiconscious and may be in a life-threatening situation, the doctor should not ignore the call for help. Whilst that doctor may not be able to attend to the problem personally, it would be prudent for him to seek assistance appropriate to the situation.

TAKE HOME MESSAGES

From the above discussion, the following are take home messages

- Although there is no legal duty to attend to a stranger, there is a professional obligation to do so because of the "causal proximity"
- created by the information given to the doctor and hi s consequent understanding that this is a life-threatening emergency with dire consequences if not treated.
- The doctor should endeavour to discharge his professional duties and not ignore the call for help: whilst the doctor may not be able to attend to the problem personally, it would be prudent for him to seek assistance appropriate to the situation.

recognised from all the facts available to him that attendance was necessary. If however from all the available facts it would be more prudent or reasonable to call for an ambulance, then it cannot be said that the doctor has been negligent in doing so.
As the authors of Clerk & Lindsell on Tort (16'h Ed, page 629) noted "general practitioners must be allowed some discretion in determining which calls to respond to."

The situation is slightly more removed if the person requesting his professional help is not an existing patient. If the doctor and that person have absolutely no existing relationship, then it is less likely that the law would impose a duty on the doctor to act.
However it must be noted that there is no case which sets out this principle clearly although the law does say that no one is obliged to act in a given situation I f there is no preexisting relationship between the 2 parties.

Mr. Kumar Lal:

A doctor/patient relationship is contractual. He has a contractual obligation to exercise due care and skill expected of him as a doctor and if he falls short of it; and the patient suffers loss or injury, he is liable to make compensation.
Until a contractual relationship comes into being there is no legal duty on the part of a doctor to attend to any person.
If there is a contract to treat a patient over a period or until the happening of an event, neither can terminate without being in breach of contract. Of course like any other contract, a contracting party may be entitled to terminate the contract in certain circumstances. It is unnecessary to go into this here. In common parlance, a doctor refers to his regular patient as his patient in the same way a lawyer refers to his regular client as his client. In the absence of any agreement to the contrary, the contractual relationship of a doctor/

The doctor should endeavour to discharge his professional duties and not ignore the call for help.

From the Australian Medical Association we have:

"AMA Position Papers

Out-of-hours Primary Medical Care - Discussion Paper (December 2000)

Introduction
The AMA supports the right of all Australians to timely, appropriate primary medical care.

The AMA endorses the RACGP definition of general practice, defined as 'medical practice that offers primary, continuing, comprehensive whole-person care for individuals, families and communities' [RACGP Presidential Task Force 1996].

It is unreasonable to expect any doctor to be available 24 hours a day. The AMA interprets the RACGP definition to mean that GPs have a responsibility to ensure that their patients have access to appropriate primary medical care when they themselves are not available. Responsibility includes the establishment of systems to ensure the treating doctor maintains an active involvement in that continuous care.

General practitioners and their practices have an ethical and professional obligation to provide both continuous accesses to appropriate care and continuity of care for patients who choose to engage them in their care. Provision of such care is deemed essential eligibility criteria for GP Recognition, Practice Accreditation and the General Practice Incentive Program (PIP). (After hours is defined, for PIP purposes, as any time outside 8am to 6pm on weekdays and 8am to 12 noon on Saturday.)

GPs are committed to after hours medical care. They can and do provide a primary medical care service for patients in their rooms, by opening for extended hours, by telephone and by home visiting in and out of hours. In many rural areas the GP is also involved in acute and emergency care often delivered from the local hospital. All GP's can provide part of a more comprehensive service in consultation and collaboration with the Emergency

Department. High quality care for all patients is possible with a combined approach amongst GPs and from all disciplines and craft groups with the GP based community delivered model.

The PIP provides financial incentives for providing access to after hours care. Payments through PIP encourage practices to provide after hours care but do not approach the necessary level of funding to adequately resource these services. In particular, for those that have no choice but to provide comprehensive 24-hour cover.

General practitioners and Other Medical Practitioners (OMPs) are inadequately recognized and remunerated for providing after hours primary care. The Medicare Benefits Schedule must provide markedly improved benefits to patients, commensurate with the skills and responsibility required to properly conduct such consultations, and recognize the particular demands the delivery of such care places on general practitioners.

It is dishonest of policy makers to promote a market model in health care, and at the same time blame the market, or expect it to take responsibility, for limited access to services at times when market conditions are unfavorable. The current model fails to recognize the skills and sweat factor that such work engenders, places little value on it and then laments as 'lack of access' that which is necessary for the health of the GP and the survival of their practice.

Models of After Hours Care Service

A variety of models currently exist to address the needs of patients for medical care when their GP is not available after normal working hours. Local circumstances will dictate the most appropriate model to meet this need. The particular circumstances which impact on the provision of after hours services by GPs in rural and remote communities, for example, often require different approaches as do areas of high need, particularly in the suburban fringe of some metropolitan areas and areas of social deprivation. The overarching requirements of adequate remuneration increase in overall funding for existing and new services, and improved patient Medicare rebates, remain constant.

The various models currently most commonly used by general practice to meet after hours service obligations include:

- provision of care from within the practice on a rotational basis;
- arrangements with neighbouring practices to provide cover on a rotational basis;
- Formal collaborative agreements and other arrangements with hospital Acute and Emergency Departments;
- Establishment of formal co-operatives;
- The use of medical deputising services (both independent and co-operatives) for the provision of the after-hours component of 24-hour care, particularly in non rural/remote practices;

In most rural and remote communities the functional after hours model with the limited medical workforce available is centered on the local hospital, or equivalent, where the doctor provides both traditional primary care and acute care, including accident and emergency. Establishment of separate after hour's primary care facilities would not be sustainable, doubling the complexity of such services and adding to administrative costs;

Barriers to Provision of After Hours Care

Factors that impact on the capacity of general practice to provide effective after hours primary care directly impact on differing levels of access by patients across Australia. Key factors that impact on the provision of after hours care by general practitioners include:

- Inadequate total number of GP after hours workforce (reflecting the significant impact of the paucity of the rebate);
- Safety risks for GPs attending unfamiliar situations and patients alone, particularly late night and early morning – this is a particular concern for rural GPs often required to provide a service to a patient in an isolated area;
- extremely limited access to locums in all areas;
- inadequate financial support for existing after hours GP arrangements (including deputising services);
- Access in rural remote Australia due to geography/demography together with downgrading and closure of local hospitals and facilities;

- no adequate on call allowances for most rural GPs servicing state hospitals;
- Insufficient provision of hospital facilities for primary after hours medical care as triage and assessment centers and bases for visiting doctors;
- poor advertising of available GP services;
- insufficient patient education which contributes to:
    - increased expectation that the service will be timely, free and convenient, though not necessarily appropriate;
    - lack of awareness of other available services that may be more appropriate in emergency situations, e.g. ambulance in cases of severe asthma or chest pain.

Improving Access to After Hours Care

In any after hours primary care arrangements it is critical to ensure the engagement and active participation of local GPs. Maintenance of home visits where appropriate is a key goal. Any strategy or combination of strategies which seek to improve provision of, and access to, 24 hour care for patients must, at a minimum, address the barriers outlined above and consider and respond to the following critical underlying factors:

- the overall increase in demand for extended hours services;
- lower and inadequate patient rebates for after hours care;
- GP attitudes:
    - more GPs are working part-time;
    - concern and attention to safe working hours;
    - interest in other lifestyle activities/quality of life;
- increased demand for family friendly work practices.
- the increased burden of early discharge, community care of chronic conditions, palliative care, care of the elderly and those with psychiatric illness at home, and;

maintaining state rural (community) hospitals with adequate resourcing to all aspects of those hospitals including remuneration to the VMO GP workforce.

Summary

General practice is pivotal to the success of primary health care (PHC). PHC is not a substitute for general practice. Nor can it be implemented as a complementary system. Primary health care should be delivered through general practice.

The AMA considers that the current focus on PHC provides a singular opportunity to consolidate the primary care sector by utilising the particular characteristics and capacities of GPs. The unique clinical skills of GPs in providing holistic/social care, and the pivotal role of general practice in the management of integrated and continuous care, must be recognised.

A social model of health is critical to PHC and uniquely the province of general practice. The key social role of the GP is to be responsible, as an advocate, for his/her individual patients through time. It is because this role is so important for patients that the PHC system must be built around general practice."

Some of our local doctors responded with the following through the internet:

"Doctor who failed to live up to oath

A COUPLE of weeks ago, one of my daughter's friends in a nursery passed out about 6.30pm.

The girl's father found out about this when he went to the place to fetch her. We thought she was sleeping at the time. Her father knew what needed to be done because it was not the first time such a thing had happened. He rushed her into the toilet to cool her down. At that point she started to have convulsions.

We asked a teacher to get a doctor. The poor girl was not breathing properly and I thought at one point that she would not make it. After about 45 minutes she did start to breathe again.

It was only then that the teacher came back with a doctor and he revived the girl. We are grateful for the doctor because he came although he had patients waiting for him in the clinic.

But the first doctor approached by the teacher at another clinic in Seri Kembangan refused to come.

I am writing this letter to express my disappointment over this doctor.

How can a doctor refuse to attend an emergency? He was needed to save a life. He failed his calling and the oath he took upon graduation."

"It is 9.55 pm, you have just worked the whole day and just about to close your clinic. You are tired, hungry (last meal 3pm, a cup of tea only), angry because the last 3 patients had irritated U.As U are about to pull down the shutter an unidentified person runs to U and pleads for help as his father is very ill. They are not your regular patients. Their house is 15 kms away and deep in the kampong and it has just been raining the whole evening. The previous 2 clinics he has gone to, the doctors have refused to go. He is on a scooter so U have to drive and he says that he only has 30 bucks! On close inspection this guy in the scooter looks like a cross between Bentong Kali and Botak Chin. He has a packet of Gudang Garam in his shirt pocket. There is a bulge in his pants which either looks like a weapon or he has just seen the latest Tamil movie!

WHAT WILL U DO? "

"You could enquire about the patient's condition carefully, from the person who arrives to summon a house call. You could then conduct a "triage" based on the history of the patient, as given by the summoning person, into three groups: mild, moderate and severe.

Those who are in the "mild" group would be abusing the facility of house calls merely for sake of convenience. They should be advised to bring the patient to the nearest health facility, which is open. Those who are in the "severe" group would not probably NOT benefit very much from just a single doctor's visit to the house, and would probably require further investigations or hospitalisation or monitoring. Usually, if the patient is too sick to come to the clinic, they would be in this group. There would be very few patients which would fall into the (narrow) middle group where we, as doctors, armed with just a house-call bag, would be able to treat *adequately*, but who cannot come to the clinic. (For patients who are

"moderately" ill usually CAN present themselves to the clinic anyway, but simply requires extra effort from the relatives concerned.)

If you can establish that the patient is in the severe group, then make a call to the hospital, to summon an ambulance on their behalf. The summoning person will appreciate your concern and help, even if it is just to make a phone call. "

"Real story from Muar in April this year. Happened to two maternity homes during night clinic closing hour, one week apart.

A solo robber armed with a brand new kitchen chopper, price tag still on, entered the clinic and threatened the staff, took away the days takings in the till as well as jewellery worn by staff members. Both occasions the last patient had just left.

Be on look out for Bentong Kali/ Botak Chin reincarnate at that hour. Plenty of people are out of jobs and do desperate things during recession time. Their intention may not be just house calls. Scary but true. "

"thought I'd share my house-call experience today.

An old makchik, 70yrs, used to be a regular at my clinic, Hypertensive follow-ups.

She developed a CVA while visiting her son in Johor about a year ago, has been bedridden there since, and just last week came back to Kulim to stay with her daughter's family. I was asked to see her at home, and was happy to oblige for she used to be a really friendly makchik, sort of like the aunty everyone wishes they had.

Saw her today, she was sitting up in 'bed' (a large mattress on the floor) and she was in good spirits despite the L hemi paresis, gave me a good strong grasp of her right hand and a hug and many pats on my chest.

Some checking, some small talk, lots of smiling and joking... I declined to accept any fees for my visit, and promised her I'd drop by regularly to see how she was doing.

I feel quite good today. House Calls can be uplifting experiences sometimes. "

" Doctors have the social obligation to respond to any house call. As primary gatekeepers, it is our responsibility and obligation. Responding to a house call is not the same as physically attending to the call at the patients' residence. Thereby should or should not is not an appropriate question to address to our profession.

The patient and the family's perception of an emergency call are different from us. Our first assessment is to determine the urgency or non-urgency of the situation. If it is truly an emergency, perhaps our best help is to advise them to calm down and provide whatever first aid they could offer by our instructions. Maybe we could offer help in calling the ambulance or providing the telephone no; or instruction for them to bring their kin to the nearest hospital, medical centers, or clinic, whichever is appropriate, It is often a waste of time to travel all the way there just to write a referral.
For non-emergency cases, it is obligatory for the doc concerned to attend to his own patient or at least he/she provides written info for the other doc who attends. Doc who attend to house calls must also be aware of their own personal security (personally, I have "blacklisted certain areas that I will not go at night or even day, unless accompany by members of the family); a nurse may have to accompany if the patients is of the opposite sex. Others factors are his own waiting patients in the clinic, distance to travel transport and safety, presence of other members of the family, etc Normally I will tell patients or their families that I shall be available only during lunch, after day-working hours or in between patients, say ah hour or so later. If they could not afford to wait, they have to seek other sources of help - a solo practice does have its limits. As I grow older, I do less to negligible night calls, except for non-paying relatives! The 24 hr clinic really helps. Thanks!
There are certain ethics involved for doc who attends to such a call. For instance, if a doc decides on an IV line or hydration for his/her patients, it is only proper for him to observe the care, with or without private nursing staff. It is not proper to "walk-out " of such care in the process.
Experiences are usually abundant. In patients who arrested upon your arrival, you have to decide what measures you would partake. ? Heroic acts, or patients interpret your non-action as callousness. Other examples are rivalry within siblings and collusion that seek the doc to join force with one against the other (esp. the one who is paying the bill) members of the families. Doc must learn to recognize the last 48 hrs clinical picture in terminally ill. You may get undue praise, and so with blame. Don't take both too personally. "

"Certain patients require house visits by their doctors. These patients include the very elderly who are infirmed or disabled or bed bound, the disabled of any age and also the terminally ill patients. Therefore there are instances when house calls are necessary. Often these house calls will be multiple and long term.

There are also instances when house calls are requested when a patient has taken ill suddenly and the family perceived this to be an emergency requiring urgent medical attention. Hereto, one has to examine the value of house calls: the emergency ambulance services maybe more useful here. In the absence of good emergency ambulance services, we should discuss what should be the better options for the patients? Often, in a real emergency, the visiting doctor can do little but await transport to the nearest A&E department.

Perhaps to make the discussion more productive, one can discuss on when and why house calls are requested, when house calls are entertained, when house calls are not entertained, who should be making house calls, should house call be a compulsory service provided by the doctors, what constitutes an emergency house call, what constitutes non-emergency routine house call, what are the problems of house calls, the limitation of house calls?

Can the ethical code ever be worded to guide the doctors on when to accept or not to accept house calls? (I suspect this guide cannot be all-inclusive and still requires doctors to make individual judgement when a house call is requested. For instance, a patient who has all the time being treated at the tertiary levels including seeking treatment there for primary care problems requesting house call because their specialist does not offer this service and he has no family doctor.) How should doctors be guided in accepting patients for house call who are not their patients; these patients only seeking their help in this time of need and being turned down by their own doctor for house calls?

What are the benefits of house calls to the patients and to the doctors? What are the downside of house calls, egg. unproductive use of doctor's time particularly when house call request was inappropriate? Many GPs in UK do house calls routinely and in group practices, almost daily. Presently, the trend there is towards less house call being done.

We should try to understand why doctors are reluctant to make house calls? Perhaps the remunerations are not right? Perhaps the patients who requested are not his patients and he is not obligated, or perhaps the patients never really nurtured the relationship with the doctor over time in the manner, which the doctor perceived to be a healthy doctor-patient relationship/partnership? For instance, a diabetic who saw a doctor twice 3 years ago and subsequently had been renewing his medications from the pharmacist requesting a house visit? He identifies and proudly proclaims that you are his beloved doctor and therefore you are obligated to entertain his request for house call. How does one define a patient's personal doctor? I have patient's relatives who requested house call and when told that this privilege was reserved for my long-term patients, promptly brought the patient into the clinic for treatment and after having done so, proclaim that this patient is now my patient and that I should do house call for

Maybe you can give us your views on these to begin this discussion. What is your interest in our views and experiences on house calls?"

"Will go:
1. If I know family well.
2. No one is in waiting, priority is given to attending registered patients.
3. Short distance.

Bad experience.
Being driven to house at very high speeds and recklessly, on two occasions. Was lucky the driver did not get into any accidents. "

"Do or don't in answering that
is a tough one

for me I will go for house call if he or she is my regular customer.

Well if he is a new comer he has to forget about me doing his house call"

Conclusion.

As primary gatekeepers, it is our responsibility and social obligation to respond to any house call. As family physicians, we often talk about our

ability to provide high-quality, continuous, comprehensive care. House calls can help us fulfill that mission by keeping us in touch with our patients, even those who cannot come to the office.

From the above discussion, the following are take home messages

- Although there is no legal duty to attend to a stranger, there is a professional obligation to do so because of the "causal proximity"
- created by the information given to the doctor and his consequent understanding that this is a life-threatening emergency with dire consequences if not treated.
- The doctor should endeavour to discharge his professional duties and not ignore the call for help: whilst the doctor may not be able to attend to the problem personally, it would be prudent for him to seek assistance appropriate to the situation

recognised from all the facts available to him that attendance was necessary. If however from all the available facts it would be more prudent or reasonable to call for an ambulance, then it cannot be said that the doctor has been negligent in doing so.

As the authors of Clerk & Lindsell on Tort (16'h Ed, page 629) noted "general practitioners must be allowed some discretion in determining which calls to respond to."

The situation is slightly more removed if the person requesting his professional help is not an existing patient. If the doctor and that person have absolutely no existing relationship, then it is less likely that the law would impose a duty on the doctor to act.

However it must be noted that there is no case which sets out this principle clearly although the law does say that no one is obliged to act in a given situation if there is no preexisting relationship between the 2 parties.

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